

**ORGANISATIONAL FRAMEWORK
FOR
HOSPITAL ACCREDITATION SYSTEM IN INDIA**

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EXECUTIVE SUMMARY

This is the report of the sub-panel on organisational options for quality assurance. This document provides organizational options for an envisioned national and state accrediting organizations and considers important issues in operationalising the proposed system.

This document indicates:

- a. The establishment and composition of the new organisation;
- b. The major functions of the new organisation; and
- c. The implementation priorities.

Our proposals are a blueprint for the future rather than an operational manual. Specifying the details of the arrangements will be the task of the new quality assurance organisation following consultation, development and piloting of the arrangements proposed in this report.

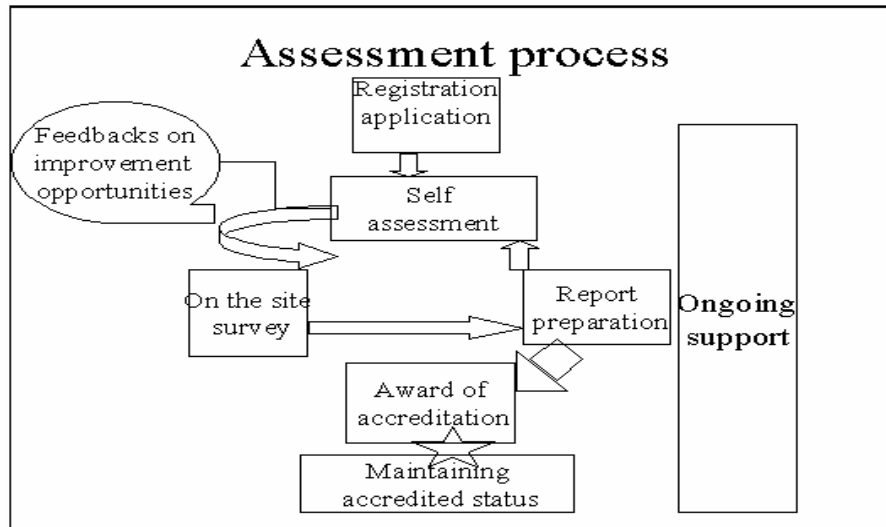
THE ESTABLISHMENT OF A NEW QUALITY ORGANISATION.

1. We propose that:
 - the new quality organisation be a company limited by guarantee and registered as a charity; or be an autonomous body of the central govt. to be empowered later by legislation
 - the organisation's members be the representative bodies of the professional , paramedical and specialists associations, teaching institutions and other parties involved and interested.
 - there be 13 members on the governing board of the company including nominees from these bodies and the funding bodies and representatives of the wider community with a balanced representation of all the stakeholders.
 - Wide consultation will ensure an appropriate range of experience and expertise on the board
2. There would be national and state level organisations for implementing accreditation and national institutes for quality and standards could also be constituted.
3. The national level organisation could be the body to
 - build partnership and reach a consensus with the stakeholders
 - Generating policy and accreditation design by the above process
4. The state level organisations would act as the executive and training/support bodies at the local levels, and would mobilize support and resources for their functioning at the local level. All would implement the national body's recommendations.
5. The key objective is to attain effective, efficient and rational care in all health care organisations in India.
6. The role of the body has been envisioned to be facilitatory, supportive and educative, rather than inspectatory.
7. The organisation should be constituted by the number of stakeholders concerned with health care.
8. The organisation may contract, as appropriate, with Government Departments and other bodies

THE PROCESS OF QUALITY ASSURANCE

To build up a system that enables provision of quality health care based upon principles and practices of ethics, equity, redress, access, integration, partnership, sustainable use of resources, and cost-effectiveness. The main elements of the proposals for a credible and affordable process of quality assurance are

9. A broad and enabling national framework of quality should be developed to tailor assessment to the most critical areas of performance in the context of our political, cultural and financial constraints. The framework will also take into account, as far as possible, the requirements of other funding bodies, if any, professional and statutory bodies.
10. The process of assessment should have significant benefits for health care institutions and its customers and should be sufficiently flexible to accommodate wide variations in types of services provided.
11. Standards of excellence should assure the management of ethical, humane, rational and competent care.
12. The basic objective of the strategy of accreditation is to ensure that areas of critical importance to the delivery of quality health services are evaluated by appropriate methods and methods are developed to confirm their efficacy, validity and reliability.
13. The focus of accreditation should be on continuous improvement in the organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards.
14. A balanced system of assessment would involve on-site hospital surveys, both announced and unannounced; an ongoing capacity to respond quickly and effectively to complaints and adverse events; development and application of standardized performance measures; and, a mechanism for conducting retrospective reviews of the appropriateness of hospital care. It would also ensure that current systems of audit are maintained
15. Taken as a whole, the process will assess the extent to which health care organisations are delivering safe health care effectively. It would indicate areas of strength and weakness, including aspects requiring attention; involve an evaluation of the validity and reliability of an institution's internal review procedures, and provide reassurance that each institution has in place effective arrangements for assuring optimal standards in the organisation and has procedures securely in place which will enable it to continue to do so.
16. The assessment process will involve visits to institutions and result in reports published by the accrediting organisation.



17. Key performance indicators which will be submitted by the accredited hospital on a periodic basis will be a mandatory requirement to renew accreditation. This will:

- Confirm that institutions' internal quality assurance procedures are working effectively.
- Focus on those issues necessary for the funding bodies to secure their responsibilities for public accountability and public information.

18. Training of lead assessors could be carried out at the national level whereas that of the other members of the assessment team could be carried out at the state level organisations.

Strategies to implement the above have been drawn out and important issues in implementation identified and discussed.

IMPLEMENTATION PRIORITIES

The organisation's immediate tasks on establishment will be to:

- Invite representation from all the stakeholders
- Build a consensus with the stakeholders
- Prepare a National timetable, to assist state organisations in planning their monitoring and assessment arrangements
- Pilot, develop and consult upon the new processes.
- Assess cost implications and design processes accordingly

This document is divided into three sections; the first deals with the policy framework and gives a short introduction to accreditation; the second with the organizational options for the proposed accrediting body; and the third with the issues regarding implementation of the proposed guidelines.

SECTION 1

SITUATIONAL ANALYSIS

INTRODUCTION AND BACKGROUND

In majority of the countries, quality of care provided by the health care delivery system has become the focus. Since quality is a crucial factor in health care, initiatives to address quality of health care have become world-wide phenomena. Many countries are exploring various means to methods to improve the quality of health care services. In India the quality of services provided to the population by both public and private sectors is questionable. The current structure of the health care delivery system does not provide enough incentives for improvement in efficiency. Mechanisms used in other countries to produce greater efficiency, accountability, and more responsible governance in hospitals are not yet deployed in India. The for-profit private sector accounts for a substantial proportion of health care in India (50% of inpatient care and 60-70% of outpatient care), but has received relatively less attention from the policy makers as compared to the public sector. Thus the private sector health care delivery system in India has remained largely fragmented and uncontrolled, and there is a clear evidence of serious quality of care deficiencies in their practices. Problems range from inadequate and inappropriate treatments, excessive use of higher technologies, and wasting of scarce resources, to serious problems of medical malpractice and negligence. Current policies and processes for health care are inadequate or not responsive to ensure health care services of acceptable quality and prevent negligence.

A commitment to quality enhancement throughout the whole of the health care system involving all professional and service groups is essential to ensure that high quality in health care is achieved, while minimizing the inherent risks associated with modern health care delivery. One of the methods that is being proposed is accreditation system. The focus of accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards. The process of accreditation is envisaged to result in a process of fundamental change in the technical procedures of service delivery, in the appropriate use of available technologies, in the integration of relevant knowledge, in the way the resources are used, and in the efforts to ensure social participation. Quality Assurance should help improve effectiveness, efficiency and in cost containment, and should address accountability and the need to reduce errors and increase safety in the system. (For more details kindly refer to the background paper submitted earlier “Accreditation System for Hospitals in India”.

In the present situation there is a need to establish bodies and systems to monitor clinical and non-clinical effectiveness of the services offered in the public and private facilities. In India concerns about how to improve health care quality have been frequently raised by the general public and a wide variety of stakeholders, including government, professional associations, private providers and agencies financing health care. There attempts to establish systems and process that would ensure quality of care by the health providers. Many state governments are in the process or have drafted legislations that incorporate standards for private institutional health care providers.

The present initiative by the Ministry of Health and Family Welfare, Government of India in supporting a National Panel on Quality Assurance to map out a course for the development of a quality improvement in health care in India would facilitate improvements in quality of health care in India. To enable the panel to arrive at appropriate decisions, concerning important aspects

and procedures to be adopted for quality assurance, four sub panels were formed to assist in this task. The sub panels were organisational options for quality assurance, clinical standards, quality systems and physical standards. Various groups with required expertise and knowledge were identified to carry out the said tasks with specific terms of reference.

This report concerns the organisational options for quality assurance undertaken by CEHAT, under the convenership of Sunil Nandraj. The terms of reference for this sub panel were

- review the existing system of licensing health facilities and practitioners and
- develop an organisational framework for an accreditation system for hospitals at the National and state level.
- propose other institutional mechanisms (existing or newly proposed) required for facilitating quality management in health care organisations in addition to accreditation.

The sub panel was constituted taking into consideration the needs of the exercise and the expertise of the individual sub panel members. The sub panel members have met formally in the initial stages when the plan of working and issues to be address was presented to them. There were many valuable suggestions provided by the sub panel members that has enriched the report. Further a review of literature on accrediting organisation across various countries was undertaken. In addition individuals and key persons were elicited for their inputs. The present report is a draft that needs to be reworked based on the suggestions and comments provided by the panel members.

SCOPE AND LIMITATIONS

Firstly this document is not a blueprint for establishing organizations for accreditation at the national and state level since this document provides a framework and suggests options for establishing them. Some major aspects that need to be understood are that this concept is new in India due to the elements of no legislative support (unlike medical councils), involvement of stakeholders, voluntarism and absence of such an organization in the country. Various factors affecting the functioning of an accreditation system, such as the group dynamics among the stakeholders as well as the existing social, political and economic ground realities need to be taken into account while implementing it. Much would depend on the involvement and initiative of the stakeholders. The accreditation system itself should be an outcome of discussions and debates on issues of concern among all the stakeholders. Collaboration, transparency between related parties and open communication are the hallmarks of the system whose framework we are proposing. Only then would it be meaningful and viable.

This document is an attempt to lay down principles and guidelines for implementing the formation of an accrediting body that is credible, and transparent. The policies and processes related to the development of a credible, effective and transparent system of accreditation has been discussed in the various sections of the document. Within this framework, the group has sought to identify critical areas of weakness. Key action areas that would allow weaknesses to be addressed have been identified for implementation.

Options have been proposed that would best serve the needs of implementing quality systems keeping in mind the nuances of the health care system in our country. Further there is no time frame suggested since it would be based on the initiative and support the panel receives from various quarters.

It should be noted also that this document provides only the organisational and policy options and broad framework for implementing accrediting systems. This sub-group is not attempting to

provide a complete framework required in implementing a quality program. Actual standards and quality systems development has been entrusted to other sub-groups, this work will have to be put together with that of the other sub-panels constituted by the MOH, to arrive at a complete picture implementing the quality program.

Strong leadership and clear aims for improvement are the need of the hour. Commitment by the MOH will provide important national leadership in coordinating and focusing ongoing safety and quality enhancement efforts so that all Indians receive the highest quality health care achievable. A commitment to quality enhancement throughout the whole of the health care system involving all professional and service groups is essential to ensure that high quality in health care is achieved, while minimizing the inherent risks associated with modern health care delivery.

POLICY FRAMEWORK

Context

Current policies and processes for health care are inadequate to ensure that health care delivery is of high quality and malpractice is prevented. The years of neglect and the lack of a comprehensive system for addressing quality issues in the health sector are quite well known.

The Government's commitment to quality health care for all needs to translate into sustainable mechanisms for the delivery of effective health care. It is the intention of this policy framework to put in place a system that will begin to make quality health care a reality for all who require it.

Goals

The main purpose of our policy is to help planners to promote, implement, monitor and evaluate robust practice in order to ensure that occupies a central place in the development of the health care system. In doing so it recognizes the roles to be played by a multiplicity of stakeholders from the public (state), non-governmental and private and economic sectors. Quality should be an integral part of the overall national health policy.

It is believed that accreditation if sensibly designed can have a significant impact on improving quality and safety in health care; improving health outcomes; ensuring more equitable health service provision; enhancing management practices; and improving decision making. Such a system must be founded on equity, it must respect diversity, it must honour learning and strive for excellence, it must be owned and cared for by the communities and stakeholders it serves, and it must use all the resources available to it in the most effective manner possible.

The national organisation should promote the practice of holistic medicine and the integration of the various systems of medicine in the most beneficial manner.

Above all, the policy seeks to develop an enabling environment in which high quality of health care can flourish throughout the country. This is to be done through providing guidance to providers, rather than through control and prescriptive measures.

Framework

Constitution and Functioning: Accreditation emphasizing participation of various stakeholders has the potential to be more successful than regulation. This partnership should provide a platform for consensus building based on the principle of sharing, democratic and transparent functioning. The effectiveness of the development and management of the organization will be enhanced through actively staff, key stakeholders, clients and potential clients in decision making about our strategic and service planning, management and service delivery processes and service

evaluation. Consensus should be built between the stakeholders around the concept for the national quality framework. There should be a balance in stakeholder representation on the board.

National Quality Framework: A broad and enabling national framework of quality should be developed to tailor assessment to the most critical areas of performance in the context of our political, cultural and financial constraints. The framework will also take into account, as far as possible, the requirements of other funding bodies, if any, professional and statutory bodies. To develop a general conceptual foundation and framework for a process of quality assurance for guaranteeing commonality of approach to institutions, delineating the domains of quality to be measured and the development of a credible, effective and transparent system of accreditation, meaningful participation of the stakeholders is essential.

Assessment Process: A balanced system of assessment would involve on-site hospital surveys, both announced and unannounced; an ongoing capacity to respond quickly and effectively to complaints and adverse events; development and application of standardized performance measures; and, a mechanism for conducting retrospective reviews of the appropriateness of hospital care. It would also ensure that current systems of audit are maintained. It should promote internal evaluation and assessment processes as well as external assessment processes.

Ethics: Patients are increasingly and appropriately aware of healthcare issues, and desire participation in decisions affecting their health. The ultimate responsibility of a health care system is to the patient. Adherence to high standards, such as those related to timeliness of treatment, diagnostic accuracy, clinical relevance of the tests performed and interventions, qualifications and training of personnel, and prevention of errors, is an ethical responsibility of all hospital staff. Accreditation of health providers should ensure that the owners, managers and staff comply with ethical standards, such as maintenance of confidentiality of patient information, adherence to appropriate technical and professional standards regardless of cost pressures and avoidance of personal, financial and organizational conflicts of interest

Developing National Standards: Standards should be defined by the national accreditation body and assessed by peer review. The process of developing valid, measurable and reliable national standards should be practical, should take place within realistic time frames and should emphasize transparency.

Stakeholders must be included and need to participate on an informed basis; where necessary, capacity building amongst stakeholders should take place, ensuring skills transfer, so as to achieve this goal. Specialists in fields relevant to quality and training should be invited to participate sensitively in the standard setting process. The use of a cross-section of international examples can be used in order to broaden thinking around developing national standards.

A detailed multi-year plan, which operationalises the process should be developed. The detailed plan, facilitated by the MOH must aim at reversing the historic neglect of the private sector. This plan should, amongst other things, set clear targets, time frames and costing should be done. The plan should also have a financial strategy. Most importantly, the plan must be a national plan, in which all stakeholders will participate and have joint ownership and responsibilities. Development of projects or models that will further develop and implement the policy guidelines must be planned and facilitated.

SECTION 2 ORGANISATIONAL MECHANISMS

MISSION & PRINCIPLES

This accreditation organization is committed to and exists to provide leadership in enhancing health care quality and to promote accountability and rationality in health care.

This mission will be achieved through

- a) Accreditation
- b) Partnership and Collaboration - promoting networking, partnership and collaboration between disciplines and organisations at regional, national and international level
- c) Research and Dissemination - promoting research which is of a quality and scale to achieve a national reputation in all fields and an international reputation in quality areas encouraging and facilitating the development of multi disciplinary research groups which are of sufficient size and quality.
- d) Training
- e) Quality culture - Promoting innovative and flexible policies in the employment and development of staff

Vision for The Organization

The following vision has been formulated:

A quality conscious and accountable health care system within which all stakeholders have a say and that enables rational, effective, safe and cost-effective provision of care to enhance the health of the Indian people.

Principles

The organization believes in furthering the process of quality consciousness and accreditation by maintaining rigorous quality standards and by being a rigorous learning organization with the highest regard for efficiency, effectiveness. The organization should strive for effectiveness and innovation in standard setting and monitoring for the sustained impact of these on the improvement of quality. The overarching core values that could be adapted by the organisation are:

Democratic functioning: One of the corner stones of the organization that prepares people for full and active participation in all initiatives. Demonstrating and ensuring good governance leading to greater accountability and transparency.

Access: Specific measures should be taken to ensure access for special target groups: disadvantaged women, women with special needs, disadvantaged youth, youth with special needs, disabled, the elderly so as to redress imbalances.

Responsibilities and Participation: The stakeholders have a right and responsibility to participate actively in the policy formulation, planning, implementation, monitoring and evaluation of quality programmes. Adopting practices that are truly participative and collaborative, involving the stakeholders in the development and implementation of the accreditation process. The organization recognizes the right of all the stakeholders to participate in all the matters relating to the credibility and transparency of the accreditation process.

Resource Usage: Planning processes should make resources and facilities available. Such resources should include guidance for both trainees and trainers. Maximum use should be made of existing facilities and human resources. Linkages should be established between the various institutions involved in health care, including all other government departments, the economic sector and non-governmental organisations with a view to achieving the optimal use of existing infrastructure. The organisation should optimize resource use through appropriate manpower planning. Complimentarily between various functions and their synergy is essential

Cost-effectiveness: Innovation and new initiatives invariably are expensive, we must not have our vision clouded in terms of understanding the cost-savings: these savings cannot be measured in monetary terms alone. Thus the organisation should endeavor to continuously make rigorous analyses of the financial implications as well as financial benefits that accrue from the implementation of the accreditation process and related policies

Honesty and integrity: This should be reflected in all aspects of work are central to this organization's existence and functioning. This organisation believes in being fully accountable and transparent in it's functioning. The organisation should develop systems for excellence, accountability and learning.

People orientation: This organisation believes in developing a professional and committed human capital base. The organisation will value and nurture individuals as the key to meeting organizational goals. The members operating as assessors should be governed by a code of conduct.

Role of the organization: The organization's role should be that of a promoter, facilitator and evaluator, rather than a regulator. It should provide high quality leadership in matters relating to health care quality and in ensuring accountability. It has to be highly responsive and sensitive to various issues regarding health.

OBJECTIVES

It is suggested that the organization of the accreditation system be at two levels namely at the state and national level. Recognizing the need for and working towards the realization of the mission and vision of the organization and its accompanying policies and plans require the building of appropriate infrastructure at the national and state levels. The roles and responsibilities at the national and state levels have been identified initially to facilitate the structuring of the organization.

The key objectives of the accreditation organization

- To have an organization which can deliver high quality leadership in matters relating to accreditation, quality and in relevant research in a cost effective way.
- To have an administrative organisational structure which can provide the necessary support to the organisation's core activity in a cost effective way.
- To have in place procedures for making strategic decisions which enables all relevant views to be taken into account without being unnecessarily unwieldy or protracted.
- To maintain a culture of openness and transparency where information is made widely available

State Level: The state level accreditation body would have the primary responsibility of accrediting.

Objectives

- Conduct comprehensive assessments of health care organizations in consonance with the national framework, for the promotion and maintenance of quality and standards.
- To engage and train conscientious surveyors and to develop training systems generally for accreditation surveyors.
- To promote accreditation, including its values, purpose and results to health care organizations, medical profession, patients and the community.
- To collaborate with relevant organizations
- To regularly monitor and evaluate all aspects of the accreditation system and accreditation decisions and provide feedback on the standards and
- Address issues related to grievance redress.
- To do anything else which is incidental or conducive to attaining these objectives.

National Level: The national level accreditation organization could be entrusted with overall policy making at the national level, support state level accreditation bodies in education and establishing training institutions and modules for the accreditation process and liaison with other accrediting bodies. It could develop national level standards, guidelines & protocols. It could conduct research, documentation, information dissemination and evaluating the state level accreditation bodies. It could function in a supportive role and as a federation of the state accreditation bodies. The accountability and audit of the accreditation bodies in terms of its functioning, relevance needs to be incorporated within the existing system.

Objectives

- Develop a national quality framework. Co-ordinate the development and implementation of national standards in relation to the National Quality Framework that are developed in consultation with relevant stakeholders.
- Develop a comprehensive, credible and transparent system of voluntary accreditation, considering the medical, social, economic and legal implications to health care organisations.
- Support state level accreditation organization in all possible manners.
- Develop and continually refine methods of assessment and incorporate measures in the accreditation process to rationalize health care (to reduce irrational and unethical practices), establish, encourage and foster high professional standards.
- Promote the involvement of the private sector in national initiatives and in offering preventive services.

- Monitor and affect public policy affecting the provision of quality health care; and promoting quality as a coherent national health policy, and of the integrated health care system, which allows and enhances rational and equitable care with a commitment to quality and ethics.
- Provide a national education program as the basic foundation that enables trainers to develop their full potential and to engage in further education and training and lifelong learning.
- Facilitate partnerships between government departments; the member institutions, the insurance sector and others in order to stimulate accreditation design development and training.
- To ensure timely publication of reports on quality and standards and the effective dissemination of appropriate information to members and others concerned;
- Conduct essential research to promote the above objectives.
- The provision of advice to government as and when requested.
- Any other matter that is conducive to the attainment of the above objectives.

Note: The primary objectives of an organization are normally made clear in the legal documentation necessary for its proper registration and establishment with government or other authorities. They are usually general in nature leaving the detailed objectives to other documentation such as byelaws and rules. Alternatively their development may take place in subsequent policy formulating activities as the organization grows and expands.

The registration document, which can be in the form of a Charter or similar formal manner. It should be carefully prepared after the organization has reached agreement with its constitution and membership on the details it wants included. Expert legal draftsmen should undertake this task because the text may have to stand up to challenges in court at some unknown time in the future.

Byelaws: Bye-laws are an essential organizational element, based firmly on the charter or similar legal document. They elaborate the objectives laid out there in greater detail and in particular provide the legal basis for the machinery and the structure of the organization. They may provide for all, or only some of, the following:

- carry out any of the purposes of the organisation;
- qualify, elect, classify and suspend members - including the contributions to be paid by the various categories of membership;
- the election, nomination, appointment, removal, continuance of office and the duties of Officers, of Members of the Council, Executive Committee, Sub-committees and other sub-organisations of the association;
- the issue, renewal and forfeiture of certificates of efficiency (where an organisation undertakes this function);
- summoning and holding and preparing the proceedings of General Meetings including voting at such meetings and conforming to legal requirements of such;
- summoning, organising and the recording of decisions at meetings of Council, Executive Committee, Committees, Sub-committees etc. etc.;
- management of the funds, property and archives or records of the organisation;
- any matters connected with, or related to, the affairs of the government of the organisation.

LEGAL ASPECTS

May be registered as a non-profit and autonomous organization.

The registration of the state level body could be done as per the provisions available in the respective states relating to societies, trust or company.

Note: The Memorandum of Understanding so drawn up should adhere to the principles mentioned in the policy framework mentioned earlier.

SCOPE, ROLES & RESPONSIBILITIES OF NATIONAL AND STATE LEVEL ORGANISATIONS.

National Level Organization

It would be the ultimate authoritative central body responsible for health care quality in India. It would where possible involve and evolve its strategies in consultation with the stakeholders. It would monitor quality improvement in the country and would support and guide the functioning of the state level organisations. It could also function as the body, which accredits and audits the functioning of the state level organizations. The organizational structure must accommodate machinery to provide close management relationships between the two levels. The national level organisation could be the body build a consensus with the stakeholders and generating policy and accreditation design.

Roles

- Policy making in consultation with stakeholders
- The national quality framework and accreditation process, in consultation with stakeholders
- Training, information dissemination, conducting relevant, problem based research
- Developing implementation plans and monitoring.
- Co-ordination and supervision of regional offices
- Facilitate sharing of experiences and skills transfer.
- Mobilizing the human, physical and financial resources to strengthen state implementation plans.
- Making recommendations to the MOH concerning quality aspects and matters relating and falling within their terms of reference.

The National Institute For Quality (optional): Since the national body has a predominant function of training, it would serve well to have an institute the main function of which will focus on building effective learning through the development of strategies and human resources. It will interact with the national organization and its (sub-) organisations at the states to build adequate experts in quality in health, through partnerships and co-ordination.

State Level Organizations

Likely to be regionally or geographically-based and its activities and programs will be organized in venues within easy reach. These bodies would execute the strategy of accreditation designed by the National body. It has been envisioned to act as the executive and training/support body at the local levels, and should mobilize support and resources for their functioning at the local level without dependence on the national organisation. Each state body, would be responsible for all the activities it has carried out.

Roles

- Implementation of Accreditation as designed by the national body.
- Support services to participants at regional level including training
- Regional monitoring of implementation of accreditation
- Review of the decisions and reports generated by the body to determine their robustness and usefulness to the providers and consumers.
- Redress: participating hospitals, consumer (optional)

Scope

The accreditation should include all such places where health care is provided on an in-patient or on an outpatient basis, and all such support services that may be needed to deliver such care.

Types of provider / service targeted could be :

- Maternity homes
- Surgical clinics
- Nursing homes
- Corporate hospitals
- Polyclinics
- Dispensaries
- Mental hospitals
- Health care networks
- Charitable trusts
- Clinical laboratories
- Physiotherapy and diagnostic centres
- Blood banks.
- Ambulance services
- Rehabilitation centres
- Other health care providers

CONSTITUTION & MEMBERSHIP

Voluntary, peer-led accreditation supported by the various stakeholders is likely to succeed in India. The establishment of a credible accreditation body calls for representatives from the various stakeholders involved in the health care delivery system. This is necessary in order to make this system acceptable to all and to ensure its creditability since its inception. This partnership should provide a platform for consensus building based on the principle of sharing, democratic and transparent functioning. Care should be taken to allow each of the stakeholders to be equally represented.

The organization should be composed of representative from various groups concerned with health care. These groups include consumers (i.e. potential and actual users of health services), clinical service providers (mainly doctors, nurses and other health professionals), boards of governance and health service managers (predominantly at the hospital/network/area level) and purchasers (in particular at the state level).

Below we have provided the constitution of the state level organization, as it is the primary organization that would be accrediting health care institutions. (The constitution of the organization at the national level is discussed later)

Representatives from the hospital owners: They should be involved as they have a pivotal role to play in the provision of health care services. Moreover, ultimately, they would be most affected if such a system were implemented.

Representatives from specialists associations: The specialists associations should be involved as they have the required expertise. The specialists associations that need to be involved should be both from the medical (OB/Gyn., Surgeons etc) and non-medical fields (hospital administrators, x-ray technicians etc.). They would help in the setting up of standards and processes. At a later stage they could assist in providing inputs to the participating hospitals in upgrading their standards.

Representatives from professional associations: Representatives from the medical profession should be involved as they have a pivotal role to play in the provision of health care services. The representatives could be from among the association of consultants, general practitioners, nurses, technicians, etc.

Representatives from consumer organisations: As the consumer is the end user of a health care facility, any system which looks at quality should involve them especially when increasing attention is being paid to the issue of consumer rights.

Representatives from Non Governmental Organisations (NGO's): An accreditation body should represent an amalgam of interests. There is a need to involve NGO's doing work related to the hospital-based care as they have the expertise and knowledge of the present systems operating in the hospital.

Representatives from local and state government level: There is a need to involve the government from the local and state government level to ensure legitimacy of the accrediting body. The govt. should participate in these bodies to the extent necessary to ensure acceptance and public accountability of the accreditation system.

Representatives from insurance companies and financial institutions, legal professionals could be included. This in turn would help establish the creditability of the body.

Membership:

The state organisations could have membership facilities as it facilitates local management of meetings. Member ship could be periodical or lifetime. There are various types of individuals and Institutions / organisations that would want to join. Different categories of membership need to be devised to accommodate them.

Individual Membership: They may be drawn from the ordinary public with no more than an interest in supporting quality initiatives. These could include, among others

- Hospital managers and administrators
- Clinicians
- Nurses and other paramedical
- Chartered accountants
- Social Scientists
- Proactive social workers
- Environmentalists
- Public health specialists
- Research specialists
- Educators

- Students
- Any other

Those educated with professional qualifications and trained can be subdivided further to indicate recognition of individuals who are professionally qualified and those who are not. The former may be granted rights not available to the others. In other words there may be restrictions placed on those possessing only education and training but with no professional qualifications with regard to voting or such matters as holding high office. Categorization of the personal membership file can separate these two groups if it is so desired. Subscription rates may differ primarily to reflect the different requirements and range of services required by them.

Honorary: the organisation may well wish to honour distinguished individuals who have made a major contribution to the profession or the organisation itself. The methods open to it are limited. One, however, is the award of honorary membership. It usually carries with it free membership and certain other benefits.

Institution / Organisational membership: usually with a subscription rate much higher than individual rates. Care should always be taken to ensure that the national influence exerted by large bodies is not permitted to overwhelm the functioning of the state organisation. Types of institutions that can become members are the following:

Health provider, health professional and consumer organisations, medical and nursing colleges willing to support quality in health care and accreditation can become members:

Professional organisations-

Medical and surgical councils and other such similar professional associations

Teaching institutes

Hospital owner's associations

Others

Consumer organisations

NGO's working on quality

Health insurance companies

Pharmaceutical companies

Hospitals interested in accreditation could have a separate fee structure, incorporating costs of providing materials and training etc.

It will be found that some elements accrue to a body as it develops in size and the range of services it provides and the activities undertaken on behalf of its membership. The problem is to assess these elements and to reduce them in the interests of keeping a stream-lined and efficient operation. A useful maxim to apply then is - are they nice or necessary? The former can be dumped the latter cannot.

Suspension of membership: It is essential to ensure that a rule or bye-law exists and that it is operated to strike from membership those individuals, or institutions that delay beyond a stated period their payment of subscriptions. The organisation may also consider the application of the practice of denying voting rights to those who have not paid the current year's subscription.

Membership Entitlements

Personal

- * Provide continuing professional development opportunities for relevant persons;
- * Provide channels of communication through the publication of a journal or newsletter.
- * Entitlement to become surveyors on demonstration of competence.

Institutional

- * Serve as a centre for information on quality & related activities;
- * Encourage and promote regional and international co- operation between institutions and between the professional organizations. and interests representing them;

Health Care Institution interested in accreditation

The membership fees should be based on the size and complexity of the organisation. However, as a non-profit independent organisation, the membership fees will be as low as possible. Membership could provide support to health organisations in achieving accredited status. The options could be the following:

- Self-assessment support
 - Quality planning workbooks
 - Tailored self-assessment tools
- On-site planning visit and education session for staff on accreditation
- One Organisation-wide survey could be offered free for members
- Assisted development of quality action plan
- Progress visits
- Discount on scheduled workshops, conferences and publications
- Public relations support
- Access to the information services offered
- Internet membership support network

Additional surveys and education sessions are at the member organisation's cost. Membership could entitle the organisation to one survey in a two year period. If no accreditation is awarded after the survey and another survey is required within the two year period, that survey will be at a cost to the organisation equivalent to an additional one year's membership fee. This will cover the direct costs of the survey only.

ORGANIZATIONAL STRUCTURE AND MANAGEMENT

The organisation of the accreditation system would be at two levels namely at the national and state level. Recognizing the need for and working towards the realization of the mission and vision of the organization and its accompanying policies and plans require the building of appropriate infrastructure at the national and state levels.

The roles and responsibilities at the national and state levels have been identified initially to facilitate the structuring of the organization. The purpose of this section is to expand in detail on the organization, structure and management of the organization necessary for effective organization at the national and state level.

As mentioned earlier the national level accreditation body would be entrusted with overall policy making at the national level, support state level accreditation bodies. Develop and evolve in

establishing training institutions and modules for the accreditation process and liaison with other accrediting bodies. It could develop national level standards, guidelines & protocols. It could conduct research, documentation, information dissemination and evaluating the state level accreditation bodies. It could function in a supportive role and as a federation of the state accreditation bodies. The national level could consist of representatives from the state accreditation bodies. The accountability and audit of the accreditation bodies in terms of its functioning, relevance needs to be incorporated within the existing system.

The state level accreditation body would have the primary responsibility of accrediting. It is envisaged that there would be a Governing Board (GB) that would have representation from various associations and organizations as well as the government and other stakeholders. In its composition, care should be taken to allow each of the stakeholders to be equally represented. This would prevent the GB from being monopolized and overtaken by dominant stakeholders. The composition of the GB could be changed periodically. The main function of the accreditation body would be to assess whether hospitals comply with set standards, to assist them to upgrade their standards and to play an educative and informative role. To carry out these functions such as assessment, educational, marketing, administration and so on staff would be employed. The staff could work either full time or part time depending on the resources available. The staff at various levels would be responsible and report to the governing board.

Structure: It is envisaged that the organizational structure would be similar at the national and state level. Each of them would have a governing board and an executive body supported by appropriate divisions, cells and committees.

At the **national level** there would be an administrative and training division, a strategic planning cell and advisory committees and task forces based on the need.

As the **state level** there would be an administrative, marketing and assessment division, a support cell and advisory committees and task forces based on the need.

For more details kindly see the organogram (**Annexure 4 & Annexure 5**)

Governing Board: The governing board would be the supreme authority, which would be the statutory body, entrusted with the responsibility of managing the organisation. The basic premise of this framework is that it would be a result of discussions, debates on areas of concern, collaboration and transparency between related parties, and open communication among all the stakeholders.

- It would be the final authority in decision-making and an arbiter of major issues.
- It would provide a platform for the various stakeholders to meet.

Democratic participation of all members that allow expression of differing points of view is essential, with each member given equal voting rights. The participation of all stakeholders is to be ensured and mechanisms could be worked out for meaningful participation of consumer representatives also.

Any member may raise issues of importance; issues may be graded in importance and be taken up in their order of importance.

Evolving a consensus would be the guiding principle of all decisions. When serious differences of opinion occur, however, the decision of the majority would stand. The governing body would

have to meet at least four times a year, with invited observers from the Government Health Departments, including Public Health.

Constitution of the governing board: At the **state level** the board would be composed of nominees of representative associations and organisations as well as the govt. and other stakeholders. In its composition, it would allow each of the stakeholders to be equally represented. This would prevent the board from being monopolized- and overtaken by dominant stakeholders. The composition of the board should be changed every year with a fresh set of nominations.

The composition of the governing board would be the following:

Totally there would be 12 members. A chairperson and a secretary elected by this group would have tenures of 3 years each.

- One representative each from hospital owner's associations;
- One representative from a medical association of the area;
- One representative each from two specialists associations;
- One representative from a consultant's association;
- One representative from the nurses association;
- One representative each from two consumer's associations;
- One representative each from two NGOs;
- One representative from the local government;
- One representative from the state government.

Other than the representatives of the hospital owner's associations, none of the other nominees are associated with private hospitals.

The chairperson and secretary's terms of office would be limited, as would the number of times they might be re-appointed.

Balance of membership of the board: In respect of both initial and subsequent appointments to the board, we believe that it will be important to ensure that a balance is achieved, and maintained, among the various stakeholders. With this in mind a representative sub-committee could be appointed by the board, chaired by a member of the board, to be responsible for ensuring wide consultation concerning the appointment of members to the board.

At the **National level** the governing board would consist of the representatives from the state level accrediting bodies. Each state would be able to have two members at the national level organizations.

Executive Body: The executive body would consist of the director of the accreditation body, assistant directors of various divisions and cells. This would be the constitution of the Executive Body. The Executive Body would be accountable and answerable to the Governing Board. It would be entrusted with the responsibility of implementing the decisions of the Governing Board. Reporting and financial-decision mechanisms will need to be established leading to the ultimate authoritative body. Its terms of reference could well include responsibilities for policy overviews and their planning and coordination and the allocation of resources. The executive body would be entrusted with the responsibility of implementing the decisions of the governing board. It would be accountable and answerable to the governing board. There could be separate chief executives appointed by the Board to carry out the diverse functions.

Administrative Division with responsibility for statutorily - required activities - e.g. organizing elections, meetings and managing the financial affairs of the organization. It would be responsible for the general administration, which would include finances, human resources, operations, documentation and legal issues. The manner in which the body works, its terms of reference and its administration and servicing etc should receive careful attention. The creation, arrangement, appraisal, maintenance and preservation and access to the records forming that archive are tasks often overlooked in an organization and for which guidelines would be a useful tool. All these will be tasks of one of the

There is a need to develop effective processes for strategic planning, and integration of key management information. Separate sections need to be developed to meet management information needs. Plans to be developed to ensure greater availability and integration of consistent data for management information purposes. Assess major risks and prepare risk management strategies.

Advisory committees and Task force: The Board is also served by advisory committee specially formed with specific terms of reference as per the need. It could be to define and review standards, assess applications, recommend surveyors and advise on major decisions. For matters relating to accreditation design, there could be discipline-specific Specialist Advisory Committees (SACs), constituted by the governing board as and when required. The Advisory Committees would provide advice to the Board as and when necessary.

For matters relating to research and development, there is a multi-disciplinary Advisory Committee fulfilling a similar role. These committees rely on a major input from relevant specialist societies which have the right to nominate members. The specialty committee Chairmen are appointed by the Board. These committees report to the governing board and their recommendations would have to be approved by the governing board, which could also make the necessary clarifications and recommendations.

The purpose of these is to serve as task forces to bring together members with relevant knowledge and expertise to help to formulate policies and to provide advice on the conduct of activities. Ideally they will draw on the reservoirs of expertise represented in the local specialist groups. These national level sub-organisations should be linked with the main board through cross-representation of memberships. The size of the committees, sub-committees, task Forces will depend on the work they are established to perform.

Premises: The organization's headquarters would have permanent staff that includes the directors and assistant directors together with secretarial and administrative assistants. The office is responsible for all organizational aspects, for the arrangement of inspection visits, and for the dispatch of occasional bulletins detailing news of importance. If premises are beyond the financial means of the organization, then keep a permanent post office box number or make arrangements with a bank to credit subscriptions directly into the organization's account could be worthwhile for the time being.

FINANCING OPTIONS

Stable financial resources are critical to the existence of the body and for the proper functioning of the body. Therefore it is important that the organization operates programs with sustainability in mind. Initial funding for the organization could come from grants.

Ongoing financial support could include

- Survey fees for assessment paid by participating providers. The advantage of this option is that it would capitalize on the private sector initiative and interest. Disadvantages of this option include potential problems with funding.
- Possible public funding: A combination of private and public sector involvement could be essential for any system of accreditation of hospitals.
- Membership fees: Contributions from medical associations, member pharmaceutical companies, leading corporate hospitals? Such contributions raise important questions about the influence that such bodies may have on the accreditation process.
- Third party payers: In the near future, third party payers would be interested in paying for relevant information. Also, if the accreditation system proves itself to be credible and reliable, insurance companies may use accreditation as tool to decide which health care organizations to reimburse. Therefore it could be a priority that such information that could inform these also should be available and its quality should be ensured.
- Grants from various bilateral / multilateral funding agencies, state governments, philanthropic organizations, corporate sponsorships etc.
- Other options could include Public share holding, alliance with international quality organizations, and income generating activities.

SECTION 3

CORE ACTIVITIES AND OPERATIONAL ISSUES IN IMPLEMENTATION

A strategy is in effect, the underlying basis for the design and implementation of any coherent system for functioning of an organization. Strategies reflect desired policy directions and ideas on how best to move in those directions. Without a conceptually clear strategy, any system will suffer from inconsistencies and unclear objectives. The strategy is based on identifying core activities and addressing operational issues for establishing the accreditation organizations. Some of the core areas identified at the national and state levels are:

National level

- Staffing
- Training
- Research & Dissemination Systems
- Monitoring & Evaluation
- Management & Information Systems.
- Influencing Public Policies
- Marketing
- Collaborative Alliances
- Fund Raising

State Level

- Assessment Principles
- Surveyor Management
- Survey Report
- Regional Forum

Each of the above has been dealt with in detail in forthcoming sections

STAFFING

The staff whether honorary, or unpaid are important elements in the organisation. The number, their functions and responsibilities will vary according to the size and nature of the organisation. Equally important are paid staff - their number will depend on finances available and the tasks to be performed and will vary also according to the size and nature of the organisation. In an organisation where all, or the greater part, of the staff are honorary they should, be involved in the day-to-day administration of the organization and therefore on its executive committee.

Objectives: To ensure that all staff are effective in their roles, and have opportunities to develop their capabilities, To make available, and encourage staff to participate in, a wide range of staff development programmes which meet the job-related training needs of all staff, encouraging a lifelong learning culture and providing qualifications and accreditation where appropriate, with the aim of ensuring that all staff are effective in their current posts, equipped to cope with change, and to advance their careers.

Resourcing: Getting the right people and training them in the particular skill needed for the organization. Recruitment is the responsibility Personnel Department and is undertaken on the basis of the skills and experience needed to undertake the specified role.

Job responsibilities : Even in a body with only voluntary officers and no paid staff job descriptions are useful in that they define the responsibilities of individual posts and ensure no overlap that can lead to dissension and conflict and they serve also to indicate hierarchical relationships. They are also useful as measures by which performances can be judged by the electorate when officers comes up for re-election.

Organisational chart: Job descriptions should be supplemented by an organisational chart. This is particularly important when posts are filled by paid staff. It must indicate clearly the individual staff member's relationship to a committee or sub-committees that he or she may be responsible for servicing ie. calling together, preparing agendas and minutes and carrying out the agreed actions. It should also serve to further clarify inter-office relationships.

Staff development: Motivation, behavior and attitude- develop an understanding of the mission, vision, objectives, and style of functioning and the creation of a work culture in which agreed goals and objectives can be attained fully within a given time frame.

Training and capacity building- to improve their capacity in interpersonal relations, training, to document and disseminate information and other identified needs and to develop the principle of lifelong learning and improve self confidence

There is a need to identify specific strengths of people, utilize and develop them.

The structure and systems of the organization is the key to human resource development. Democratic and decentralized functioning will strengthen the organization. Development of appropriate systems and procedures at work will enhance work efficiency.

Staff appraisal and performance management: To develop competency-based job evaluation schemes for all academic, academic-related and support staff, with the aim of supporting the development of individual staff members and identifying areas which need particular training. Appraisal is not linked to promotion or other reward structures, but is a way of demonstrating that issues have been addressed and future action agreed by both appraiser and appraisee. Where staff are on commercial contracts, their annual salary increases are subject to satisfactory annual performance review. For any staff, where staff performance is identified as less than satisfactory in any area, staff may be required to participate in a programme of performance management, designed to assist the individual to attain the standards of performance required, and to ensure proper documentation of actions taken to monitor progress.

Performance and reward management: Promotion criteria for academic and academic-related staff to be made more explicit, so that the organisation's expectations of the level of performance at each grade are more transparent.

Develop and introduce a rewards and benefits strategy which more explicitly links rewards and benefits to achieving core objectives.

Create an environment conducive to commitment, teamwork, and quality enhancement.

Employee relations: Negotiations on terms and conditions of employment, representation of the organization in matters of individual or collective grievance, encourage free dialogue between the staff and the senior management and among the staff.

TRAINING

Human resource development is ensuring availability of people and skills for the future. An organization is only as good as the people it employs, and it must equip them to perform efficiently the tasks assigned to them.

Objectives

- Design open and flexible training programmes that can integrate learning area content and outcomes with varying degrees of specificity depending on needs and contexts
- Facilitate the development of training programmes with appropriate local level customisation.

Training methodologies

The training methodologies should be participative, in common with the training of professionals.

1. Active learning and interactive approaches
2. Collaboration and co-operation
3. Contextually relevant learning
4. Exploratory learning
5. Reflective learning strategies
6. Learner-centredness, relevance, critical and creative thinking, flexibility and progression better the outcome of the process

Accreditor Methodologies

JCAHO - Adult learning technique; classroom; audio (telephone) conferences, written material, audiotapes, computer-based training

CC - Didactic..., teleconferences, video, workshops, mock surveys, role play exercises, instructional guide

ACHS - Workshops seminars, written material, satellite and video conferencing

KFOA - Information giving (lectures, Q and A), role play, master classes

HAP - Review of documentation, lectures, role playing, mock surveys

NZC - Small group work, role plays, overheads, interactive groups

Precepting experience: Precepting experience is also employed by some accreditors.

JCAHO - 3-4 surveys

ACHS - Access to preceptor indefinite

HAP - 6 surveys (3 surveys as a trainee, 3 with experienced surveyors)

NZC - 5 years

Content of Training

Surveyors should have a general conceptual foundation on quality, Quality procedures, Quality systems, Quality control and Standardisation.

Training content should include the following areas:

1. Standards knowledge
2. Surveying processes
3. Communication, interviewing and report writing skills.
4. Training in relation to legal and regulatory requirements

Accreditor experiences: Most accreditors use the observation of real surveys as a part of the training.

Training topics

JCAHO - Standards interpretation, survey process, laptop technology; Life Safety Code; Core competencies, i.e. interpersonal skills and consulting techniques, performance measurement

CC - Strategic directions, quality, standards, survey process,(i.e. team interviews, report writing), recognition (award) guidelines, surveyor skills

ACHS understanding standards, role of the surveyor, survey process, survey report writing

KFOA information giving (lectures, Q and A), standards framework, team work, interview skills, report writing, feedback skills, KFOA process details

HAP Documentation review, understanding data, interpretation of the standards, team interaction, observation skills, the survey process, report writing techniques

NZC New standards/processes, standards where surveyors are having difficulty; overseas developments, up to date knowledge in specific areas, e.g. infection control; report writing; how to assess

Surveying experience and activity

The average days a surveyor works each year give an idea of the activity undertaken by a surveyor. A minimum number of days are usually required in order to assure surveyors maintain and develop their knowledge of the standards and their surveying skills. The maximum days can give an idea of the maximum workload a surveyor can undertake yearly. When the surveyors are volunteers working in other health organisations, there may be a maximum number of days per year in order not to disturb the normal job of the surveyor. These three figures are important when planning the surveyor resources required.

The voluntary systems, and the British ones in particular, require less commitment owing to the fact that the surveyors are employed by their organisations. These systems require a proportionately higher number of surveyors to deal with the workload.

Training Outcomes

It is vital is that the training process should give assessors a proper sensitivity to the aims and objectives of the organisation to which they belong and also recognise the high degree of diversity in the organisations which they will assess. It is axiomatic that assessors should go about their business with tact and proper consideration for their colleagues who are undergoing assessment and, clearly, the importance of good communication skills cannot be over-emphasised.

Specifically, the training must enable individuals to :

1. Work effectively with others as a member of a team, group, organisation.
2. Organise and manage oneself and one's activities responsibly and effectively.
3. Communicate effectively using visual, mathematical and/or language skills in the modes of oral and/or written presentation.
4. Develop a general conceptual foundation, technical and practical skills, knowledge and understanding necessary for carrying out or directing accreditation and training activities in the field.
5. Collect, analyse, organise and critically evaluate information.
6. To develop core skills required to become effective trainers and learners

All surveyors to undertake training at the beginning of their surveyor careers. Classroom training is to be sponsored by the organisation who bears the costs of the training. Usually the first surveys are followed by a senior surveyor and its results are a part of the selection process.

Accreditor Experience

Most accreditors require 2 to 4 days of initial training, an exception being the Joint Commission which requires surveyors 15 days orientation and training. Thereafter surveyors receive ongoing update and education between 1 and 5 days per year.

Development of training strategies

The implementation of the national curriculum framework will be informed by needs assessment, research and monitoring and evaluation of pilot programmes, to ensure its ongoing refinement.

Assessment of training needs

Effectively contextualise the learning outcomes based upon an accurate analysis of the surveyor's training needs and an assessment of their capabilities and prior knowledge. Such an analysis should inform the process of assessing and selecting or developing materials for use within the training programme.

The needs assessment can be carried out by interview technique, by the technique of job analysis or by field observation.

A national curriculum framework should thus be drawn out and it should equip learners with the knowledge, attitudes, skills and critical capacity to attain expertise in quality processes and systems, training and rating procedures if so required.

The curriculum framework should emphasize the outcomes of learning rather than the means or way of learning, so that learners will be able to attain the learning outcomes through a wide range of experiences encountered in a variety of contexts and settings. Learners will be able to attain these outcomes at different rates of learning in a wide and rich variety of programmes developed at national and state levels. An outcomes-based approach is characterised by the following features:

- An emphasis on the results of learning (outcomes)
- A focus on learning by doing, and on what learners can do as well as learning of content
- An emphasis on the applications of learning in new and different contexts.

Training Options

- A central training unit could train all lead assessors on assessment methodologies.
- Core team of assessors (experts on quality) who train other assessors to be full time workers

- Training of the other members of the team can be decentralized by building the capacity to train within the state, by exploring the establishment and/ or development of existing national and state training units as internal agencies to provide overall and sustainable co-ordination and management of training and capacity building.
- The training could otherwise be sub-contracted.

Planning training programs

A timetable should be drawn out for training lead assessors throughout the country in a time-bound manner and should be widely circulated and adhered to.

Professional and technical support

A back-up system of professional and technical support needs to be built. The professional resources of society located at local, state, national and international levels must be identified, accessed and used to provide professional services and support.

Development of training Materials

Well designed learning programmes and materials that can help learners to attain the required outcomes are essential. They are better modularized rather than presented as a full course. Thus, potentially, there will be a great variety of modular units of learning materials, either discrete, or integrated, that meet the needs of a diversity of learners and institutional settings and which can be combined in the most effective way.

With materials that are used in distance education or self-instructional programmes there may be a shortage of time for trainees to engage with the materials. This, together with a recognition that adults have different levels of knowledge as well as learning rates, necessitates that materials be carefully structured into appropriately sized modules or units of material.

All learner materials, where appropriate, should have a strong self-instructional component built into them.

Cost is another key consideration in choices for materials developers: learners often have to pay for their own materials if they want anything more than basic course books. The organisation should provide leadership on the provision of low-cost, innovative and well designed materials.

Training of Assessors

Training of lead assessors could be conducted at the national level

- By the national level body. This option could be unwieldy as thousands of assessors would have to be trained in a limited time frame.
- Training could be carried out by collaboration with other national or international organisations. This would require a high level of networking and collaboration.
- Self study by potential assessors of quality assessment and proving of their competence by passing an assessor selection examination could simplify the process of training. The modules to be disbursed to eligible candidates selected through a process of application and screening have to be prepared in advance.

Training of the other members of the assessment team could be carried out at the state level organisations by the lead assessors themselves. The lead assessors could be full time workers while the other members of the assessment team could be part time or voluntary workers, who carry out assessment for a specified time period in a year. Regular reaffirmation of competence could be assured by re-exams.

RESEARCH AND DISSEMINATION

Research would be an essential activity in order to ensure credibility of the assessment process and to keep abreast to the changes in the regional and international health, technology and quality scenario. The dissemination of issues regarding accreditation would play a vital role in the development of quality consciousness in the health care system of the country.

Objectives

- Develop and refine methods of assessment including scientific, economic and social tools
- Develop and refine tools of assessment.
- Detect changes in medical practice, consumer perceptions, and give renewed direction to the assessment process
- Conduct comprehensive assessments of medical technologies considering their scientific, economic, social, ethical and legal implications and to perform evaluations at the request of providers and third parties
- Surveillance of use of drugs, devices and medical interventions

Develop an agenda of problem-oriented research topic alternatives on which the members could vote and prioritize. This should lead to a comprehensive research agenda. Advisory councils/ Research committee- may be set up for research into priority areas, with representation of the specialists associations, may be set up for on-going research responsive to needs. Working in partnership with a range of research agencies and institutions.

Dissemination

Objectives

- To provide, in explicit public format, information on the quality assurance program, standards, their development etc.
- Creating a reliable database on identified quality issues to facilitate interventions
- To enable staff, members and trainees to have access to all sources of published information on quality to support their learning, teaching and research activities, using a range of means including access arrangements with other institutions, electronic access, and any other appropriate means.
- To encourage the development and use of more extensive resource-based learning.
- Production of high quality publications on identified issues.
- Develop book and journal stock in quality and areas of particular need
- Develop electronic resources in order to extend range and coverage by providing a high quality and fast network infrastructure
- Provision of access to electronic resources in the form of bibliographic, numerical, scientific and fulltext databases, either locally or remotely located. The active management of the collections (acquisition, withdrawal, stocktaking and optimal deployment), by Information Services and academic staff in partnership, to ensure that the resources are relevant and appropriate to the training and research programme.

Web Site

Responsibility for maintaining and developing the hardware and software environment of the web site lies with Information Services, who also train departmental contributors. Departments are responsible for maintaining their own entries. The immediate priorities are to have a wide base of contributors while maintaining and improving the quality and currency of the information content, to encourage use of the web as a platform for innovative learning and teaching

applications, and to develop the web site as a powerful external marketing tool for the courses, research activity of the organisation.

Publications

To develop comprehensive audio-visual media and communication materials for the support of all educational, meeting and conference activities, and training in their effective use.

- Accreditation manual and survey protocols for all programs recognized and notification of revisions;
- Self assessment manuals and workbooks
- Listings of accredited providers, including accreditation status and survey due date;
- Access to data contained in performance reports (organization survey score and comparison with other organizations; The publicness of this information to be decided after deliberations with the various stakeholders
- Immediate notification of serious situations that may jeopardize patient safety identified upon survey;
- Notification of organizations placed in conditional, preliminary accreditation, or non-accreditation status, including follow up plan of correction;
- Educational opportunities, staff and/or provider briefings;
- Input into standards development process and representation on the organisation's Task Forces or work groups as available;
- Active information-sharing practices that can include survey findings, complaint tracking and so forth.
- Serious complaints or sentinel event information

MONITORING AND EVALUATION

Assessment and review of performance is essential, because knowledge of performance stimulates improvement. Monitoring and evaluation of institution's efforts to integrate quality systems will be monitored by regional monitoring teams. There could be a minimum necessary MIS which could guide the process. It would involve selection of key indicators and also submission of the involved health care providers of minimum essential information to the organisation on a periodic basis.

Objectives

- Oversee implementation of quality systems
- Monitor the quality of accredited organizations through the prioritization and investigation of complaints received from various sources, reports of sentinel events, and out of compliance notifications

Regional monitoring team will oversee quality systems implementation in hospitals. Whilst the institutions will assess their own performance, the regional team monitors performance over time and therefore can compare institutions, rank them and give feedback at the regional forum. Monitoring should be carried out using a comprehensive checklist.

The regional monitoring team will provide supportive supervision by:

- Frequent monitoring of institutions
- Assisting in problem identification, analysis and solution
- Advising on implementation strategies,

- Responding to new problems
- Encouraging high performance by comparing institutions and promoting best practice.

Members of the regional monitoring team should be trained as QA facilitators. Members of the team should be drawn from the regional levels so that there are resource people available in the districts.

Key performance indicators which will be submitted by the accredited hospital on a periodic basis will be a mandatory requirement to renew accreditation. This will:

- Confirm that institutions' internal quality assurance procedures are working effectively.
- Focus on those issues necessary for the funding bodies to secure their responsibilities for public accountability and public information.

MANAGEMENT INFORMATION SYSTEMS

A comprehensive MIS for the storage and retrieval of descriptive and evaluative data and information flowing from participating institutions is useful and is a priority. The MIS could also pull together the fragmented and duplicated health related data collection activities currently practiced.

MIS for

- Documentation and information systems
- Drug information system for doctors
- Newsletters, journal publications, conferences organize regular fora for quality
- Information skills training to staff
- *Organizing seminars and conferences*

Performance Indicators

A set of minimum indicators of the achievement of the goals of the organisation should be defined to ensure a standardisation and uniform analysis of data collected by an MIS.

Influencing Public Policies

- Carrying out policy research and analysis on issues identified for influencing, which have a major bearing, positive or negative, on quality, rationality and accountability in health care.
- Networking, coalition building
- Capacity building
- Information dissemination

MARKETING

Objectives

- To advance the mission and aims of the organization through marketing and public relations activities, including internal communications, media
- to develop a marketing policy which is coherent, targeted and customer-focused, ensuring best value for money.
- To develop coherent marketing and promotional strategies based on a clear definition of the organization's market positioning and image.
- To identify the different markets within which the organization is operating, and within an overall strategy, develop effective targeted promotional campaigns. Evolve strategies to involve new market players in the quality initiative
- To develop a strategic approach to fundraising.
- To coordinate resources and activities related to promotion, to ensure the most cost-effective level of activity.
- Produce printed and electronic promotional materials

Market positioning and target markets

- Identify potential markets and their segmentation
- Evaluate the appropriateness of marketing mix
- Consider the effectiveness of marketing materials and promotional approach

Marketing policy

Establish a marketing group to bring together all those involved in marketing to develop a marketing policy which is coherent, targeted, customer-focused and gives best value for money. The group will work together to develop coordinated approaches to the promotion and marketing of the organisation's activities, to both the internal and external markets. This develops coordinated and combined activities

Marketing strategy to consider

- Marketability to participating hospitals:
- Accreditation to be a service development model rather than an inspection.
- Involvement of local clinical experts in the team of assessors
- Facilitation of networking
- Public relations support
- Marketing support by indicating accredited institutions in publications and web-site

Marketability to consumers

- Addressing the interests of consumers regarding the process of accreditation
- Their involvement in the assessment process
- Making available useful information about participating hospital's quality standing in each area of function
- Generating consumer interest and awareness by regularly publishing in local newspapers

Marketability to insurance companies

- Collaboration with insurance companies and other market players in a systematic way
- Generating data meaningful to the insurance companies

Market research

A substantial amount of market research has to be undertaken in relation to different groups involved. Additional areas for research to be identified with a view to evaluating and helping to form promotional strategies in relation to the organisation's external image and profile.

COLLABORATIVE ALLIANCES

Objectives

- To improve communications with health care professional groups.
- The network ensures that the organisation gets important input when developing its services and products and helps maintain and strengthen the relationships between the organisations and these institutions.
- The intent is to build relationships with organizations in the network by sharing information about the quality of patient care.

Implementation

- Networking, coalition building
- To facilitate the exchange of information, each organization has an assigned organisational staff contact.
- Liaison Network Forum to be held annually to inform its members about the current initiatives of the organisation and to solicit feedback from participating organizations on the latest trends affecting their organizations.
- Throughout the year, Liaison Network members should receive newsletters, field reviews, and informational materials to keep them up to date.

Possible Liaison Network Organizations

Academic bodies, Associations of various specialists, Blood Banks, Health Care Administrators, Occupational and Environmental Medicine specialists, Medical Technologists, Nurses, Pharmaceuticals, Clinical Laboratory Science, Telemedicine Service Providers, Association of Managed Healthcare Organizations, Social Work Administrators in Health Care, Voluntary service providers, Insurance administrators, NGOs, International Accrediting Agencies, National Institutes such as NABL, NTI, ICMR, JIPMER, AIIMS etc.

Government

This deals with the interactions of the organisation with the government and key external constituencies.

- Expand the growth of the organisation's accreditation services by soliciting potential new customers, facilitating program growth through increased governmental recognition and reliance.
- Cultivate and enhance communications and collaborative relationships with state hospital associations and other healthcare associations in pursuit of increased recognition of the value of accreditation.
- Duplicative private accreditation and state performance measurement requirements could be reduced through the coordination of measurement and reporting

In any relationship between an external institution and the organisation, the ingredients to be obtained should be mutual trust, respect and a recognition that, on both sides, there are legitimate concerns that may not be easily harmonised. In the latter the reasons for these should be known and discussed even if harmonisation proves immediately to be impossible. To permit positions of

conflict to develop help neither side and will damage the credibility of the organisation. Engage in the relationship with tact and diplomacy.

FUND RAISING

A separate Development Office to be established, to have responsibility for the fundraising activities. Identify and as appropriate, combine funding available for promotion

FRAMEWORK & PROCESS FOR ACCREDITATION

This section of the report contains a more detailed discussion of the proposed system of quality assessment, and sets out a number of recommendations for its future operation. It is divided into the following sub-sections:

Assessment

- Principles of assessment
- Registration
- The pre-assessment program
- The self assessment
- The documentation required for quality assessment
- The assessment visit
- Period of accreditation
- The assessment cycle
- Maintaining Accreditation.
- Public disclosure
- Fee structure.

The stakeholders should have significant benefits from the process of accreditation, the significant benefits being based on the priorities of each stakeholder. Priorities for the potential accreditee are that it should experience accreditation as helpful, it should have a continuous relationship with the accrediting body, and the process should be minimally intrusive and expensive (Schyve, 1995).

Getting quality of care on to the agenda in a shared arena which brings together policy makers, professional bodies and service users. To facilitate continuous quality improvement by support health care institutions in discharging their responsibility for the maintenance and enhancement of the quality and standards of their health care provision

To assure the safety and effectiveness of medical practice.

Assessment Principles

- Sufficiently flexible to take account of the dynamic and diverse nature of health care institutions, the variety of sources of evidence, and the changing environment within which they operate.
- The assessment process should recognize the positive aspects of the existing system, stimulate considerable debate on the strengths and weaknesses of practice, be a positive experience and identify areas where it can act to remedy particular problems or deficiencies.
- Opportunity to improve should not be lost in a plethora of bureaucracy and grading
- The quality assurance process itself should be under assessment and to ensure its continuing appropriateness to the achievement of the purposes of quality assurance set out above.

- Operate as cost-effectively as possible in order keep to a minimum the level of external demands on institutions.
- The assessment experience should be developmental rather than judgemental and foster a sense of 'ownership' and 'partnership' among all those involved.
- The assessment process should be integrative, relevant to all the stakeholders, and transparent.
- Systems should be available for moderation of assessment.

Registration

Application by hospital and dispatch of :

- application
- self-assessment materials,
- questionnaire (basic data on staff and activity, comprehensive checklist of criteria for compliance with standards)
- Detailed report on preparation for the survey for achieving compliance with the standards (optional) and the set of internal documents to be submitted-resource and activity data, internal audits, policies, procedures

Pre-assessment Program

- To provide effective support required by hospitals to be able to implement the quality program.
- Induction programme which introduces them to quality and the assessment procedures
- Development of opportunities for experience
- Provision of manuals, self assessment workbooks, information sheets on key assessment areas, survey visit information.
- Self assessment support
- Training of in-hospital staff to form a steering group/quality action team
- Provision of a professional service manager who provides support for survey preparation
- Mock survey
- Progress visits by a surveyor to support ongoing quality improvements

Self-Assessment

Self-assessment is regarded within the discipline of accreditation as a critical first step and as a developmental instrument. It gives an organization the opportunity to undertake a structured, critical and comprehensive assessment of its performance, improve the efficiency of its operations, enhance staff morale and teamwork and demonstrate to the facility's peers and the public a conscious and active effort to maintain high professional standards of care. Internal organisation and management needs can also be identified during this process. Self assessment will therefore provide the basis for continuing quality improvement - an integral part of the accreditation cycle. In addition, as the second cycle of assessment begins, institutions should use the initial self-assessment to describe how they have responded to their earlier quality assessment experience.

Self-assessment of this sort is consistent with practice in industry and with total quality management. Self-assessment also has the potential to play an important part in the enhancement of quality by encouraging staff to identify opportunities for improvement and to reflect critically on their part in ensuring the quality of health care.

The self-assessment document should set out clearly the aims and objectives of the assessment and give an account of how these aims and objectives are met. The document should be structured using the aspects of provision contained in the National Quality Framework which will

be used also in determining the form of assessment visits, and in governing the structure of assessment reports.

The self-assessment should give an opportunity to the institution to identify any problems which may exist in health care delivery in a particular area of care, and to describe how it is addressing these problems. There should be no invitation to institutions to assess the overall provision in the cognate area, or individual aspects of that provision, in terms of any rating scale as organisations usually tend to overrate themselves and it has no value in the overall rating process. The self-assessment should highlight recently introduced or proposed developments in the organisation of health care. The format of self-assessment should reflect institutional variations in each cognate area such as size, type and structure.

In the second cycle of assessment visits, institutions should be invited to use the self-assessment to provide an account of how they have responded to their earlier Assessment experience. The length of time between the submission of the self-assessment document and the assessment visit should be as short as possible. Support services may be provided during the period of self-assessment.

Documentation Required for Quality Assessment

Review of documentation should include organisational policies and procedures, minutes, care plans, clinical records.

Recommendations

The requirements of documentation made should be clearly able to enlighten the assessors and not result in loads of paper work.

Such documentation should not be requested where the burden on institutions is not clearly balanced by the enlightenment of assessors; and

The Assessment Visit

The Assessment division of each state organisation to devise a standard programme for visits. A timetable based on this programme to be agreed between the assessors and the institution at the pre-visit meeting. Certain features of the programme will be determined by the nature of the cognate area and the institution's organisational arrangements.

The on-the site assessment will include review of documentation; interviews with directors, managers, committees and service teams; observation; assessment of client care through reading clinical notes; discussions with clients and families; and discussions with managers and health practitioners to verify any provisional findings. The surveyors hold a summation conference for management and staff at the end of the survey to outline their major findings and suggestions for future action.

All institutions should be subject to an institution-wide review once in each two year cycle, involving:

- Observations of care
- Meetings with groups of staff, including, for example, probationary staff, more senior staff and administrative and secretarial staff;
- Meetings with various support services – labs, x-ray, counselling etc;
- A meeting with a representative group of patients;
- Meetings with the head of the institution and managers, and
- Reading other documentation.

Taken as a whole, the process will assess the extent to which an institution is discharging its responsibilities for safe and effective health care effectively. It would indicate areas of strength and weakness, including aspects requiring attention; involve an evaluation of the validity and reliability of an institution's internal review procedures, and provide reassurance that each institution has in place effective arrangements for assuring academic standards in the institution.

Recommendations

The programme should be flexible enough to allow assessors to give adequate consideration to complexities.

Review cycles for individual subject/speciality areas could be different in order to maintain speed and simplicity of the process. During the assessment, areas of duplication and overlap should be avoided.

Aspects of review could be classified as those that require continuing reassessment every few years and those not requiring reassessment at every visit in order to reduce the quantum of work and also to simplify the process.

At all times visits should be conducted in a spirit of co-operation and dialogue between assessors and institutional staff with clear communication and explanation of the assessment process.

A distinction should be made, in the assessment of central services, between 'speciality specific' services and those services which are common to other areas. While it is appropriate that the first group should be assessed within the assessment of each cognate area, the assessment of common services should be conducted without unnecessary duplication of effort or burden on institutions.

The introduction of a method for the systematic evaluation of the experiences of the major participants in the assessment process. Assessors and representatives of the institution are asked to complete a questionnaire which allows them to report on their experiences with the quality assessment process in each individual visit. Such feedback could be very helpful both in evaluating particular visits, and in monitoring the operation of the system as a whole.

Period of Accreditation

Accreditation is for two years, subject to continued implementation of the agreed Quality Action Plan (optional), and the maintenance of standards. If a survey reveals that there is a major risk to client, staff or visitor safety or there are significant deficits in a number of key areas, no accreditation status will be awarded. If there is an area of risk or a limited number of significant improvements needed to achieve the standards, and these can be actioned in a short timeframe, accreditation may be deferred until the risk is eliminated or the improvements have been made. For those few applicants with major problems, approval of any sort is withdrawn until the difficulties have been corrected, and re-application is required.

If a provider is not granted two year accreditation it may appeal this decision on the grounds that the survey report is inaccurate or incomplete and that those inaccuracies or omissions were not due to shortcomings on the part of the provider during the survey.

The Assessment Cycle

The second cycle of assessment visits should be arranged initially on the basis of a two year cycle, but the length of the cycle should be reviewed in the light of the survey report. Where particular area is considered to be 'deficient' as a there would be a requirement for a further review visit in accordance with procedures to be laid down by the organisation.

Consultation with institutions on the definition of the cognate areas in which second assessment will take place should be undertaken.

Two years is a long period between reviews; a good deal can happen in that time. Having shorter cycles would greatly add to costs. Progress visits could instead be arranged as in New Zealand, to oversee developments

Progress Visits are made 12 months after the survey by a Quality Health surveyor (larger services will require more than one surveyor) and are designed to support ongoing quality improvements, confirm standards are being maintained or exceeded, review the organisation's achievements and outcomes in relation to its quality action plan, and assist with interpreting the intent of the standards. It also provides an opportunity to advise the client on new or revised standards pertinent to their next survey, and discuss significant changes in service delivery. The organisation receives a report containing the findings of the progress visit and suggestions for improvement.

Maintaining Accredited Status

A self declaration form stating continuing compliance with the standards will be required. It is also incumbent upon the applicant to notify immediately of any substantial or important changes in staffing, service provision, organization, resources or performance as failure to do so may jeopardise the accreditation status. Guidance on what is considered "important" in this context should be available from the organisation.

Options to ensure compliance:

A system of minimal reporting by participating hospitals could be arranged which could be half yearly/yearly. This would go into an MIS and a regional monitoring team could monitor progress. Interim reports by accrediting body every year on progress made in the quality initiative (optional)

By using a limited core-group of indicators, with more frequent less-intensive visits (eg.six monthly or annually), the focus could be on achieving incremental and continuous quality improvements.

Quality Action Plan :After receiving the survey report, organisations are requested to draft a Quality Action Plan (QAP) that specifically addresses the surveyors' recommendations within a timeframe. This Quality Action Plan becomes an agreement between the organisation and Quality Health. Accreditation may be withdrawn should action not be taken to address recommendations within the agreed timeframe.

Public Disclosure

Careful attention would needed to be given to how information in individual providers is handled, so that accreditation is not perceived by them as a punitive tool or as a way for taxation authorities to assess tax liability. Accreditation is not a substitute for regulation ; using the former as a tool for identifying and taking action against poor or dangerous PPs risks jeopardising its aims (Salisbury, 1997). In South America and the Caribbean, accreditation combines public dissemination of whether or not a facility has complied with a minimum set of standards, for which it receives accreditation, and confidential communication to the organisation of its performance against higher standards (WHO, 1993). Where relevant, and in the light of the procedures of individual professional and statutory bodies, accreditation reports could be placed in the public domain by an institution.

Accreditation Fees

The accreditation fee structure could be composed of four elements: the application fee, the annual fee, the cost of a comprehensive on-site survey every three years, and the on-site education session. These four elements are detailed below(adapted from CC)

Application fee: An initial one-time fee upon submission of the application form. This amount covers the administrative overhead costs related to the processing of the application and the shipping of standards documents and CCHSA related material to the applicant. This fee also signals the seriousness of the intent of the organization applying for accreditation.

Annual Fee: The annual fee paid by health service organizations is based on the operating budget that they submit to the organisation each year. This fee supports the cost of the activities involved in operating the accreditation program and is not directly related to the cost of conducting surveys. The activities associated with operating the program are: research and development, representation, and office overhead.

Survey Fee: Participating organizations undergo a full accreditation survey every three years design an approach to the survey to ensure that the objectives of both parties are met. As well, the type of organization and the range of care and services provided determines the size and composition of the survey team and the time required to conduct the survey.

Education Session Fee: It is recognized by health service organizations that an education session is an essential component of achieving the most benefit from participation in the program. Participation in an education session, developed by the organisation in consultation with each institution undergoing assessment should be strongly encouraged. These sessions are provided on a cost recovery basis and include a small administrative fee for the development of customized materials and agenda.

Accreditation is a resource-intensive process and pilot programmes should focus on those, possibly a minority of, private clinics and hospitals that offer a range of inpatient and outpatient services, have a high turnover of patients and indicate an interest in participating. Because accreditation visits require external teams of trained surveyors, and focus on organisational indicators of practice, it is unlikely to be feasible or suitable for small facilities or single-handed practices. A two-stage process may be undertaken to phase in accreditation at both the outpatient and in-patient levels.

Principles which characterise the successful introduction of accreditation systems include : a process of consensus-building between government, professionals and purchasers, and the application of concepts of quality and implementation processes which are appropriate to the local context and current performance of the health services. Perhaps, the biggest initial obstacle to introducing accreditation is the resources necessary to initiate the process.

The organisation should publish a timetable for assessments. This timetable would assist institutions in planning their monitoring and assessment arrangements.

SURVEYOR MANAGEMENT

This section deals with the methods used to select, train and evaluate the performance of assessors. The experience of the accrediting organisations across the world has also been provided along with the options that could be applied in India.

The surveyor is a health professional who is trained and skilled in surveying techniques and gathers the relevant information to enable hospital's compliance against a set of standards to be assessed. Surveyors are health professionals with basic training in medicine, nursing, administration and other related healthcare professions. Surveyors are practicing or have practiced in health services management. Surveyors around the world share many common features in terms of careers, training, profile and expectations. Surveyors are trained and retrained by the accreditors in the knowledge of the standards and in evaluation techniques. Surveyors see surveying as a role of helping health care institutions to improve their quality performance. These similarities probably arise from the objectives of the accreditors who try to make the survey process educational as well as a rigorous evaluation.

The management of surveyors is a critical activity for an accrediting organisation. A great deal of the credibility and validity of the programme depends on this important function.

Recruitment and Selection

The main eligibility criterion for recruiting surveyors is experience in the health sector within the defined professions of doctor, nurse and administrator or chief executive. Leading health practitioners and managers, not full-time auditors who are detached from the "real life" issues of service delivery, will be more acceptable as surveyors. Essential attributes are competence and credibility; training needs vary according to tasks within survey teams (e.g. clinical, technical, managerial - or as team leader)

Options for prospective surveyors

The options for recruitment could be as follows.

- Volunteers/others from the senior ranks of the health care industry
- Representatives, nominees from member organizations
- Recruited from successfully accredited hospitals.
- Selected trained consumer representatives, in line with the strategy of increasing consumer participation

The surveyor should be independent of the clinical and other staff being surveyed. In particular the surveyor should not:

- be working in the same region as the staff undergoing assessment
- be the former trainer of one of the departmental clinical staff members being surveyed
- be the (former) promoter of one of the departmental clinical staff members being surveyed.

Need to define recruitment/experience criteria; required knowledge; attitudes and skills; training process; individual assessment; continuing development and monitoring

A team of local assessors to be developed in each district by inviting of applications from eligible persons, who are committed to quality and act as surveyors whenever need arises, for a specific duration in a year.

Accreditor Experience

All accreditors require a minimum of experience in high managerial positions. Experience is measured in years of work and varies between 2 and 5 years. The accreditors that employ volunteers prefer their surveyors currently holding a specific hospital position.

JCAHO: 5 years clinical, 2 management

CC: minimum 3 years in senior position

ACHS at least 5 years in senior position in hospitals of more than 50 beds

KFOA must hold one of the positions required: Hospital Chief Executives, Executive Directors (incl. Nursing Directors), Hospital Medical Consultants, Directors of Paramedical Services

HAP 3 years experience (General Practitioner or Clinician/nurse manager)

NZC currently practising or recently retired/resigned

Education: All accreditors require profession specific educational certification. All accreditors require profession specific educational certification.

JCAHO: MD/DO, Masters for RN and Administrator

Other CC currently employed in accredited organisation

ACHS knowledge of the Australian system, good interpersonal skills, commitment to ACHS accreditation

HAP knowledge of HAP system and standards, commitment to accreditation, currently employed in similar organisations to those being accredited

NZC knowledge and experience in Continuous Quality Improvement (CQI), up to date health care knowledge, competencies

CCHSA [Competency Dictionary](#) provides complete descriptions of the surveyor competencies.

Recruitment process

The recruitment process usually involves the following steps: advertise, application, interview, training and surveys in trial. A rigorous selection process is applied to eligible candidates, Initial appointments could be made for two years after which a review could determine reappointment for a further term of four years.

Surveyor selection process (adapted from CC)

1. Application
2. "360-degree" Reference Check. confidential references are required
3. An interview - thorough assessment of their suitability as surveyor candidates.
4. Behavioural Assessment (during Orientation)
5. Internship. On successful completion of all elements of the selection process a phase of internship
6. The internship phase spans two surveys. At the conclusion of the internship period, Council will make a decision about appointment as a full surveyor.

Ensuring Credibility of Surveyors

Impartiality

Many of the assessors could be drawn from institutions engaged in some amount of competition with each other. Impartiality is therefore of the utmost importance. The practice of using assessors drawn from outside the city in which the assessment is being carried out could well circumvent the problem. Since it would not be logistically feasible to have all assessors from other places, the lead assessor alone could be drawn from a distant area to provide a clear element of independence and neutrality.

There should be no concerns in participating institutions about the objectivity of assessment teams and individual members of those teams. There could be value in institutions having a right of 'veto' on a limited basis on particular members of assessment teams, where they believed that a conflict of interest might exist. Such vetos would have to be handled with sensitivity.

Competence and Knowledge

Errors of fact are not uncommon. Assessment teams could misinterpret evidence that they obtain in the course of assessment. Such criticisms strike at the heart of the assessment process and at its credibility. Methodologies of assessment should be as objective as possible so that misinterpretations are avoided. Performance criteria should be monitored regularly and organisations are asked for formal feedback on various aspects of their surveyors. CCHSA has a credentialling process for surveyors and provides on-going education and evaluation of surveyors.

Code of conduct

Surveyors are required to comply with a Code of Conduct to be developed by the national organisation.

Nature Of Contractual Relationship Between Surveyors And Accrediting Bodies

The number of surveyors is driven by the volume and complexity of hospitals being surveyed in a year. An accreditor that has a higher workload, should have a more formal relationship with their surveyors, while the accreditors with lower workload tend to have volunteers or independent contractors. A small accreditor does not have enough workload to employ full time surveyors and relies on part time, contractors or volunteers. When this accreditor becomes bigger its dilemma is to keep their part time surveyors or to employ full timers.

Full timers have as an advantage their mastery of surveying techniques and greater surveying experience

Volunteers are frequently considered more current with hospital management issues and can introduce themselves as doing the work now. A drawback of the volunteers is that they require the accreditor to invest more resources in survey organisation and management. Accreditors who use volunteers and part-time surveyors must not allow a surveyor to conduct surveys at the hospital when he or she is employed to avoid conflicts of interest.

Accreditor Experience

The Joint Commission employs full time surveyors, part time surveyors who work two weeks a month, and intermittent surveyors who generally does one survey a month. The Canadian Council works mainly with part time surveyors. These professionals are generally employed in the health sector. The Australian Council, the King's Fund and the Hospital Accreditation Programme depend mainly on volunteers. These volunteers are professionals working in healthcare organisations sector that find a professional reward in being surveyors although they do not make any money out of this. The New Zealand Council combines contractors, who are independent professionals hired to undertake a specific survey and volunteers. Contractors are different from part timers. Part timers usually devote a fixed part of their professional time to surveying while maintaining a position in the health service. They also may receive a partial benefits package.

The Survey Team

Selecting a well-trained and acceptable assessment team is an important part of creating and maintaining confidence in the assessment and reporting processes. Therefore, ensuring an appropriate appointment procedure for members of the teams and providing effective training and guidance is central to a credible system. Assessment teams and their members must be demonstrably *competent* and demonstrably *impartial*; and the institutions being assessed must have confidence that this is the case.

The core members of the team typically are doctor, nurse and administrator with several variations. When the hospital is small, it may require only requires two surveyors, they will be a doctor and a nurse, a specialist could be added to the team if the hospital has a special service that requires a particular expertise to be applied to the surveying process. For large acute hospital surveys up to 8 surveyors are used in New Zealand.

The average number of surveyors in a team is three. This number, as well as the number of survey days, varies according to the expected surveying work. This work varies mainly with the size of the hospital, the number and types of services provided and the organisational structure.

Each review team would consist of academic, and where appropriate, professional peers selected by the organisation, against published criteria. Each team would be chosen from a list of trained assessors. Training should be the organisation's responsibility. The lead assessor of each assessment team would be appointed by the organisation, and could be responsible for the team's published report.

Options: Professional profiles and team roles

There should be a balance of doctors and non-doctors on the survey team. The non doctor is someone who is currently working in general with considerable experience in the area, usually a nurse or hospital administrator. More surveyors may be allocated to larger hospitals

A doctor, a nurse and a social worker/administrator

A doctor, a nurse and a public health practitioner/administrator

1 doctor, a public health practitioner, nurse

The hospital has the right to veto the allocated surveyors.

Simple checklists, that form the basis of facility assessments, could be used by trained non-medical surveyors, with follow-up visits by teams of professional colleagues to discuss results and identify training or resource needs to improve practice.

Accreditor Experience

JCAHO 2-3 physician-nurse, phys-nurse-Adm. depending on size of the hospital and the number and types of services provided.

CC 1-5, the mix depending on number assigned individually for each organization, depends on feedback from organization and previous survey teams.

ACHS generally 3, adm/med/nurs depending on type of facility, services provided, size of hospital, layout.

KFOA 3-5, Hospital Chief Executives, Nursing Directors, Hospital Medical Consultants, Directors of Paramedical Services size of hospital depending on services provided.

HAP 2-3, general practitioner- clinician/nurse manager with experience matching services provided, size of hospital.

NZC 2-8, medical, nurse, administrator to match background and experience to type of facility where possible.

Team leaders

The Team leader usually interacts with the client to co-ordinate the details of the survey. Sometimes the team leader writes the report using the data collected by their colleagues. Team leaders or lead assessors are found in several accreditors.

Survey planning and co-ordination is usually done by the central office staff. In the King's Fund Organisational Audit this liaison work is done by a survey manager, who also provides support to the client site while they are implementing the standards for anything up to a year before the survey takes place. A survey manager leads the survey team on survey and writes the final report by collating the individual reports of the surveyors.

Measures of surveyor performance

An important element for future analysis is defining and measuring the quality of the surveyor performance. All the accreditors keep records of their surveyors and some use measures of performance. Evaluation of performance management systems for surveyors is an area for further study.

THE SURVEY REPORT

Following each survey a summary of the surveyors' findings is compiled to provide the participating health care provider with

- A detailed assessment of its performance against National standards and criteria
- Identification of areas where performance is satisfactory or where further improvement is required
- Commendations for areas of best practice
- Suggestions and recommendations for improvement.

Assessment reports will be based on evidence provided by an institution of the quality and standards, and on evidence gathered by the assessment team during the on the site survey.

The report could also consider:

- The institution's overall quality strategy,
- The arrangements by which it assures its standards,
- Its infrastructure, and its internal and external communications.
- Consideration of an institution's policies and arrangements for securing its objectives, and the
- Management by it of its quality and quality assurance processes.

They will describe the extent to which an institution as a whole is discharging its responsibilities and has procedures securely in place, which will enable it to continue to do so.

Reporting Procedure

The format and style of reports should be such that they be easily interpreted and readable, and provide maximum developmental value. The content of reports should be readily accessible to all those to whom the reports are addressed.

The period of time between assessment visit taking place and the publication of the report should be as short as possible.

The lead assessor could be responsible for the compilation of the report or it could be the responsibility of an Accreditation Committee (URAC). The Accreditation Committee could consist of representatives from member organizations and experts and could recommend or delay accreditation.

Compilation and approval of reports

Objectives

- Eliminate flaws in the preparation of assessment reports
- Address misperception, misinterpretation and factual errors
- Provide an opportunity for the institution to present its views on the assessment process.

Implementation

Preventing misperceptions and misinterpretations

- An extended dialogue between assessors and assessed, so that the assessed see a draft of the report and are given a chance to comment.
- Sending institutions a copy of the draft report, together with a form on which the institution might report any factual and procedural errors. The institution could then receive confirmation that appropriate changes had been made to the report.
- The introduction to the assessment team of a *facilitator* who would work with the assessment team, have an active role in the provision of information and clarification to the team in the course of the visit and comment on the 'draft collated' report.

Preventing factual errors : The appointment of a 'professional assessor' by the accrediting organisation, to provide guidance on the assessment procedure and on the use of assessment criteria, rather than participate directly in judgements of quality. The professional assessor would be able, among other things, to ensure that the assessment team did not stray into examination of aspects of provision which were beyond their capacity for informed judgement. It would promote consistency in the approach taken by assessment teams and in the outcome of assessments.

The Assessment Scale

A four-point assessment scale could be as follows. The definitions applied to each grading are:

Excellent: Satisfactory in all and outstanding in most aspects
Highly Satisfactory: satisfactory in all aspects and with areas of particular strength
Satisfactory: satisfactory in most aspects; overall, strengths outweigh weaknesses;
Unsatisfactory: unsatisfactory in several aspects; overall, weaknesses outweigh strengths.

Clearly, the need to express the views of assessors in a single rating increases the demands made on them, increases the 'tension' present in the assessment procedures and may draw attention from the content of the report. To this extent, 'developmental' aspects of the report, wherein good practice may be commended and areas susceptible to improvement identified can be overshadowed when the spotlight is turned on the single rating.

It is particularly important to consider how far the assessment scale and its use are compatible with the development of the 'partnership' with institutions which it is believed to be necessary if Quality Assessment was to contribute fully to enhancement of the quality of care. Rather than contributing to the development of health care quality, Quality Assessment might represent a system of accountability and control with the assessment scale as a central part of this mechanism. The terminology of Excellent, Highly Satisfactory, Satisfactory and Unsatisfactory may stir considerable emotions. Leaving aside questions of whether such a scale can be applied consistently and reliably, it could be that it militates against developmental aspects of the assessment process, while emphasising its judgmental nature.

Recommendations

Assessment should

Not focus on a single overall rating.

Provide by the same virtue, opportunity for more mature reflection on how clinical practice in each of its aspects is meeting the aims of providing safe and effective health care.

Therefore overall grading or 'summative judgement' with a 'graded profile' reporting on aspects of the Quality Framework could be recommended. A four point assessment scale would be applied to the individual aspects of provision in a graded profile, with a summative judgement applied at a threshold level.

The aim of the threshold system could be to identify the 'unsafe' (and to prevent it becoming a hazard to the public) through operating a system where, although degrees might be awarded with various forms of commendation, the dichotomy is pass-fail. The terminology '**Quality Approved**' or '**Quality Not Approved**', may be used to designate threshold judgement grading.

It is clear that the implications of a '**quality not approved**' assessment are sufficiently grave that an opportunity for re-assessment within a limited period should exist. Reassessment should take place within 12 months of the first assessment visit. In the interim period, such provision could be given the emotionally neutral label of '**quality subject to re-assessment**'.

It is important also that adequate opportunity should be given to institutions to make representations on a judgement of '**quality not approved**', and consideration should be given to who might consider such representations. Representations should be based on one or more of a limited number of grounds.

- perversity in the assessors' judgements (such as might be indicated by a clear divergence of the text of a report from the relevant grading);
- procedural deficiency; and
- new information not available to the institution at the time of the visit. The establishment of clearly understood means to deal with institutions' dissatisfaction with the means of arrival at judgements is essential if the organization is to reduce the number of confrontational episodes and damage to its reputation.

It is important that there should not develop, gradually or otherwise, a situation where assessments of '**quality not approved**' are inevitably followed by representations or appeals. For this reason, 'appeals' should, in the first instance, be referred to an independent assessor whose task it should be to decide whether there is a *prima facie* case, in terms of the grounds for 'appeal', for the case to be taken further.

The opportunity for institutions to exercise a veto on a limited basis on the appointment of members of assessment teams where there were believed to be potential conflicts of interest between the assessor and the department being assessed could be of value.

REGIONAL FORUM

In addition to the regional monitoring, forums or workshops should be organised on a regular basis by the state organisations to :

1. Review progress
2. Exchange experiences
3. Discuss problems

4. Plan further developments
5. Plan more advanced training
6. Present quality awards

It will also serve as a forum to provide feedback to the institutions.

OPERATIONAL PRIORITIES

The immediate priorities for creating an enabling environment and infrastructure are the following:

1. The resourcing of the organisation and developing a resourcing policy
2. Analyzing cost implications and developing budgets and projections including strategies to obtain the necessary resources
3. Facilitating the development of a legislative framework for the provision of quality care The company's Memorandum and Articles of Association will be finalised.
4. The company's first governing board to be established
5. The first board would appoint the first chief executive after advertisement of the position.
6. The agency will have as one of its first tasks the negotiation of service level agreements.
7. Piloting projects
8. Create and implement a multi-year plan.
9. Implementation to be phased after prioritisation
10. Establishing operational goals and targets within clear time frames
11. Clarifying roles for stakeholders that are appropriate and the context in which these functions are to be performed
12. Establish a National Institute for training and national standards bodies;

Constituting The First Governing Board (Suggested for State level)

- a. The first Chairman of the board would be identified and invited to accept appointment by the Chairman of the Panel on Quality Assurance, after consultation with the members of the Group.
- b. The Chairman of the Panel on Quality Assurance and the Chairman-designate of the company's board would receive nominations from the representative bodies for filling the places available to them. There would be consultation between the representative bodies and the funding bodies before names are put forward in order to ensure, as far as possible, a spread of experience.
- c. The Chairman-designate and the board members-designate would then invite suggestions for filling in the board's membership, and the approval of the members of the company to appointments would be sought.
- d. The first board thus constituted would take steps to appoint the first Chief Executive after advertisement of the position.

Annexure 1

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<http://www.quality-foundation.co.uk/>- British Quality Foundation

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<http://www.cpa-uk.co.uk/>- CLINICAL PATHOLOGY ACCREDITATION (UK)

Annexure 2

GLOSSARY of TERMS

ACCREDITATION: A self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.

ACCREDITATION BODY: Is "the organization responsible for the accreditation program and the granting of accreditation status" Alternatives are accreditation organisation, accrediting organisation.

ACCREDITATION FEDERATION: An international non-governmental, voluntary, professional federation of accreditation organisations and interested associates, as a committee/special interest group"

EFFECTIVENESS: The extent to which something achieves its aim.

EFFICIENCY: Delivering maximum services with minimum expenditure of resources.

EQUITY: Ensuring fairness and lack of discrimination in access to health.

HEALTH SERVICES: All services designed to improve health and well- being.

INDICATOR: Aspect of service selected for measurement.

MANAGEMENT QUALITY: Most efficient and productive use of resources.

MEASUREMENT: A numeric value given to an attribute which facilitates comparison with standards.

MONITORING: Observation and recording of events over time.

MULTI-DISCIPLINARY TEAM: A group of people working together from different professions.

OUTCOME: The end result of effect of care

PATIENT QUALITY: What the patient expects from health services

PATIENT SATISFACTION: Extent to which patient expresses positive attitudes to health services in general

PEER ASSESSMENT: A process whereby the performance of an organisation, individuals or groups are evaluated by members of similar organisations or the same profession or discipline and status as those delivering the services"

PROCESS: All components of health care delivery including diagnosis, treatment, after care etc

PROFESSIONAL QUALITY: Whether health services meet the needs as defined by professional standards

QUALITY: The degree of excellence or fitness for purpose of a service

QUALITY ACTION TEAM: A group of people working together to identify and implement procedures for quality improvement.

QUALITY ASSURANCE: A systematic and planned approach to assessing, monitoring and improving quality of health services within available resources constraints on a continuous basis.

QUALITY ASSURANCE CYCLE: Sequence of related activities comprising of appraisal, action and improvement.

QUALITY SYSTEM: Defines the roles, responsibilities and procedures within the organisation in order to ensure that staff are able to and do carry out quality assurance.

STANDARD: Specification of expected or desired measurable attributes of a product or service.

STRUCTURE: Availability and quality of human and physical resources.

TARGET: Statement of expected performance

Annexure 3 REVIEWS OF OTHER COUNTRY EXPERIENCES

UNITED STATES OF AMERICA

1. Joint Commission on Accreditation of Healthcare Organisations (JCAHO)

Mission: To continuously improve safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organisations.

Short history: Developed from the end result system of hospital standardisation” in 1910. The JCAHO is the first institution created to evaluate hospitals and the largest one. It was created in 1951 as Joint Commission on Accreditation of Hospitals and later renamed as Joint Commission on Accreditation of Healthcare Organisations (JCAHO). Its accreditation work continued the activity of the American College of Surgeons that started in 1919 called the Hospital Standardization Programme.

Type of provider / service targeted

Health Care Networks Hospitals
Long Term Care Facilities
Behavioral Health Care and Related Services
Home Care Agencies
Ambulatory Care Facilities
Clinical and Pathology Laboratories

Nature of accreditation: Voluntary,

Type of organization: nationally recognized non-profit accrediting organization

Method of setting standards: In consultation with health care experts, providers, measurement experts, purchasers and consumers. Updated every two years.

Type of standards: In February 1997, the Joint Commission launched [ORYX](#): The Next Evolution In Accreditation to integrate the use of outcomes and other performance measures into the accreditation process.

Method of assessment:

1. Hospital to request a survey application
2. After return of the application, the hospital receives a complimentary copy of *Comprehensive Accreditation Manual for Hospitals (CAMH)*.
3. Initial survey: four-month track record of compliance with JC standards.
4. Surveyors evaluate compliance with each of the standards using a five-point scoring scale. scores are first summarized into performance areas by applying *aggregation rules*. These rules are formulas that consolidate the scores for a group of related standards into a single performance area score.

5. If interested in practicing continuous accreditation: perform ongoing self-assessments

Compliance:

1. To validate compliance with the standards on an ongoing basis, unannounced surveys of 5% of accredited hospitals (chosen randomly).
2. At the Triennial surveys, surveyors look for a 12-month track record of compliance.

Functioning of the body: Governed by a 28-member board of commissioners, more than 200 professional organizations are involved in the Liaison Network.

Membership of the body: Includes nurses, physicians, consumers, medical directors, administrators, providers, employers and labor representatives, health plan leaders, quality experts, ethicists, health insurance administrators, educators.

Policy/ legislative support:

1. To obtain Medicare certification through a process known as "deemed status."
2. Reliance for licensure purposes for hospitals and other types of provider organizations in many states that have adopted statute or regulation to use accreditation by a national recognized and/or state recognized private accrediting organization as demonstrating compliance with licensure requirements.
3. In addition, the Joint Commission also monitors and, when appropriate, seeks to influence federal legislative activity through its Washington, D.C. office.

Involvement of consumers:

1. Consumers involved in setting of standards.
2. A public information interview (PII), is available to patients and their families, patient advocates, consumers, organization personnel and others, during each full on-site survey.
3. An organization scheduled for survey is required to post public notices at least 30 days in advance of the scheduled survey. Individuals requesting a PII forward their requests in writing to the Joint Commission. The Joint Commission's survey team conducts the PII, considers the information gathered in the PII along with the team's findings during the survey process in making the accreditation decision.
4. The Joint Commission's toll free complaint hot line, **(800) 994-6610**, allows patients, their families, caregivers and others to report their concerns regarding quality of care issues at accredited health care organizations. The Office of Quality Monitoring evaluates each complaint relating to quality of care issues addressed by the accreditation standards.

Supportive activities

1. Sponsors education programs
2. provides relevant publications
3. offers standards related educational support for the organizations it accredits
4. Comprehensive guide on the internet- Quality Check.

2. URAC (AMERICAN ACCREDITATION HEALTHCARE COMMISSION)

Mission: Central mission is to promote the accountability of health care organizations, especially organizations that provide managed care services.

Type of provider / service targeted

The entire spectrum of managed care services

1. HMOs
2. PPOs,
3. case management organizations,
4. workers' compensation managed care

Nature of accreditation: voluntary

Type of organization: Nationally recognized, Non profit charitable organization.

Method of setting standards: Member organizations of URAC, and experts from across the country debate and discuss what standards are appropriate for a particular aspect of managed care. The standards development process is very inclusive and broad-based.

Method of assessment:

URAC offers ten different accreditation programs for managed care organizations, each focusing on a different aspect of managed care.

1. Submit documentation of compliance with each standard.
2. This documentation is then reviewed by a member of urac accreditation staff, who works with the applicant to resolve any issues that have been identified.
3. Urac staff then visit the applicant to ensure that its operations are consistent with the documentation submitted.
4. Finally, the application is reviewed by the accreditation committee and the executive committee, which are composed of representatives of urac's member organizations.

Compliance: Accreditation status may be rescinded if an accredited company is unable to comply with URAC Standards.

Functioning of the body: Include representation from the range of health care stakeholders: employers, consumers, providers, regulators, and health care organizations.

Membership of the body: URAC membership includes a balance of organizations representing providers, regulators, business, consumers, and the managed care industry and the worker's compensation

Selection of assessors: The Accreditation Committee consists of representatives from URAC member organizations and industry experts.

Marketing:

1. Encourage accredited companies to use the appropriate URAC accreditation logos on their printed materials,
2. Communicate their accreditation status to member/patients, employers, purchasers, providers, and anyone else who deals with the company

Length of programme: 2 years accreditation

Policy/ legislative support: regulators in over half of the states recognize the URAC's accreditation, purchasers and consumers recognize

Involvement of consumers:

1. URAC standards are widely circulated for public comment and beta-tested before they become final.
2. Web site NRCCPH

Supportive activities:

1. Research projects to assess and identify new approaches to improve performance measurement in a variety of health care settings.
2. Publishing cutting edge books on the health care delivery system.

AUSTRALIA

ACHS (AUSTRALIAN COMMISSION ON HEALTHCARE STANDARDS)

Mission: To develop a national system of accreditation for hospitals and continually improve the quality of health care in Australia.

Short history: Established as The Australian Council on Hospital Standards in 1974 by the Australian Medical Association (NSW Branch) and the Australian Hospital Association (Victorian Branch).

Type of provider / service targeted

- Public and private hospitals
- Community health care centres
- Aged care facilities
- Home and community nursing services
- Day procedure facilities
- Aerial medical services
- Ambulance services
- Rehabilitation centres
- Other health care providers

Nature of accreditation: Voluntary and not explicitly linked to third party payment.

Type of organization : Independent not-for-profit organization.

Method of setting standards: The ACHS Performance and Outcomes Service (POS) has a primary role of developing objective measures of the management and outcome of patient care in Australia's acute health care organisations. This has been achieved through collaboration with the various Australian Medical Colleges and associations, by developing clinical indicators'.

The ACHS POS has identified three basic requirements when developing clinical indicators:

1. That they be relevant to clinical practice
2. That the relevant data are available
3. That the measure is achievable

The development process which is followed by the POS when developing clinical indicators involves a series of stages.

Type of standards: Clinical indicators are defined as measures of the clinical management and outcome of patient care'. They are not exact standards against which hospitals must measure their clinical performance, but rather are designed as flags which can alert to possible problems or opportunities to improve patient care. They are a measurement tool to assist in assessing whether or not a standard in patient care is being met. Outcomes such as morbidity from particular procedures are measured by some indicators, while others measure processes, such as compliance with criteria for management of a particular condition. The sets of indicators are reviewed annually with the relevant College and additions, deletions or enhancements are made.

The ACHS Evaluation and Quality Improvement Program

EQuIP provides a framework for effective delivery of health services. The ACHS Education and Support Service aims to help organisations improve the quality of care they deliver using the ACHS Evaluation and Quality Improvement Program (EQuIP).

Effective use of EQuIP requires the whole organisation to be committed to improving its performance and assists health care organisations to:

- develop strong leadership
- enjoy a culture of continuous quality improvement
- focus on customers
- focus on outcomes
- strive to be the best
- improve overall performance

Selection of assessors: Recruited from the senior ranks of the health care industry, most of whom are volunteers. A rigorous selection process is applied to eligible candidates, (at least five years' recent experience in a health care organization at a senior level). Initial appointments are made for two years after which a review determines reappointment for a further term of four years. Volunteer surveyors make a commitment to ten days of surveying per year.

Training of assessors: assessors attend annual update sessions and, for newly appointed surveyors, orientation sessions. Surveyors are required to comply with a Code of Conduct. Performance criteria are monitored regularly and organisations are asked for formal feedback on various aspects of their surveyors.

Involvement of consumers: A cohort of consumer surveyors will be trained in the coming year. Initially the consumer surveyors will take part in the accreditation of mental health organisations.

Supportive activities

1. Present a national education program
2. Advise and consult on health care quality improvement
3. Publish books and other resource materials
4. Offer library and information services on quality in health care

NEW ZEALAND

HEALTH ACCREDITATION PROGRAMME FOR NEW ZEALAND (HAPNZ)

Mission

Promote, measure and recognise quality and to promote excellence in the health and disability support sector. It provides the framework for establishing and maintaining quality care, services and safety.

Short history: HAPNZ has been developed by Quality Health New Zealand. It's standards incorporate the features of ISO9001 relevant to health and disability services. The Quality Health model has been developed for health services, is written in health and disability terminology, and has over 70 years of practical experience.

Type of provider / service targeted

- Hospitals,
- Rest homes,
- Mental health services,
- Community and home care services,
- Hospices,
- Voluntary welfare organisations,
- Primary care services,
- Maori health providers and
- Retirement villages

Nature of accreditation: a voluntary program used by providers to guide the complex process of quality improvement;

Type of organization: Independent non-profit incorporated society established by the health sector

Method of setting standards: Developed in consultation with providers, consumers, funders, and professional organisations and medical colleges, and thus have credibility with them.

Type of standards:

The whole spectrum of client service –

Clinical standards,

Client rights,

Management and clinical systems, and

Management leadership.

They cover all the dimensions of quality –

Access,

Appropriateness,

Participation,

Effectiveness,

Efficiency,

Safety and

Continuity, and incorporate a strong consumer focus.

They meet the requirements of the health and disability sector standards.

A set series of 5 criteria are available for each of the 48 indicators that cover all the domains suggested by the Goodfellow Quality Assurance Unit. Some of these indicators include

minimum standards, reflecting legislative requirements and the criteria that are regarded by the practice standards working Party as critical. Other criteria and their standards are goals that give practices a range of ideas about what could be achieved and not necessarily what should or must be achieved. They allow practices to assess the gaps between where it is desirable to be and what the present situation is.

Method of assessment:

The purpose of the Quality Health model is continuous quality improvement, not just compliance with minimum standards. HAPNZ member organisations are guided and supported by Quality Health through a three year cycle comprising of the following elements

1. CLIENT SERVICE PLAN: This plan details services to be provided by Quality Health
2. SELF-ASSESSMENT: Of achievements and outcomes regularly to improve performance. Six months before a survey and a progress visit, to complete and return a self-assessment to Quality Health
3. SELF-ASSESSMENT SUPPORT SERVICE
4. SURVEY: Organization-wide survey by health peers who provide feedback on overall performance. They review
 - Documentation
 - Interviews with directors, managers, committees and service teams;
 - Observation; assessment of client care through reading clinical notes;
 - Discussions with clients and families; and discussions with managers and health practitioners to verify any provisional findings

Surveyors assess:

- whether organisations have selected indicators which reflect the services they provide,
- data collection and verification processes used, how the organisation has determined if further action or review is necessary, what
- specific actions and reviews implemented to improve the quality of patient care as a result of indicator monitoring,
- the outcomes

5. SURVEY REPORT

6. QUALITY ACTION PLAN

After receiving the survey report, organisations are requested to draft a Quality Action Plan (QAP) that specifically addresses the surveyors' recommendations within a timeframe.

7. QUALITY HEALTH NEW ZEALAND ACCREDITATION

Organisations that successfully achieve Quality Health New Zealand standards through participation in HAPNZ

8. ANNOUNCEMENT OF ACCREDITATION

PROGRESS VISIT-18 months after the survey, designed to support ongoing quality improvements, confirm standards are being maintained or exceeded, review the organisation's achievements and outcomes in relation to its quality action plan, and assist with interpreting the intent of the standards.

This is in sharp contrast with most other quality certification models which tend to be inspectorial in nature, mandated by purchasers, and concerned with minimum compliance with contractual or statutory requirements. ACCREDITATION - A JOURNEY, NOT AN END-POINT

Compliance: Awarding accreditation status and other certificates of endorsement and achievement Accreditation may be withdrawn should action not be taken to address recommendations within the agreed timeframe.

Membership fees: Based on the size and complexity of organisation, staged over a three year period, the annual membership fee is fixed for three years on joining the programme. Membership entitles the organisation to one survey in a three year period.

Selection of assessors: Our surveyors are health professionals who provide a largely voluntary service. Leading health practitioners and managers, not full-time auditors who are detached from the "real life" issues of service delivery.

Supportive activities: HAPNZ membership provides the following tools and services over a three year cycle:

- Self-assessment tool tailored for your services
- Accreditation standards appropriate to your services
- Self-assessment support
- On-site planning visit and education session for staff on HAPNZ and accreditation
- Assisted development of quality action plan
- 20% discount on scheduled Quality Health education workshops and publications
- 30% discount on a pre-survey review
- Public relations support
- Access to the Quality Health quality network
- Internet membership support network (still to be developed)
- HAPNZ forums and conferences.

Additional standards and education sessions are at the member organisation's cost.

Information provision: Clinical Indicator Comparative Results Service

Support to hospitals: Work in partnership with health providers - to assist them to improve the quality of care and services they provide to their clients.

CANADA

CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION (CCHSA)

Mission: To promote excellence in the provision of quality health care and the efficient use of resources in health organizations throughout Canada.

Short history: The CCHSA was incorporated in 1958 to set standards for Canadian health care organizations and assess their compliance against these standards.

Type of provider / service targeted: Has specific accreditation programs for
Acute care,
Long term/continuing care,
Mental health, rehabilitation,
Community health,
Regionalized health organizations,
Cancer treatment centres,
Home care and
Regional health organizations.

Method of setting standards: Collaboration with the health care community and related stakeholders..

Type of standards: The assessment is designed to address processes, outcomes, and structures with the focus on continuous improvement within the health service delivery system. One of the requirements of CCAP is that organizations identify and monitor performance indicators as part of their efforts to improve the quality of their care and service. Council is most interested in how teams develop, use, and refine performance indicators {{ performance of their core processes (client care, support services, leadership and management) and outcomes}} that are meaningful to them and to their clients.

Method of assessment: Peer review and a self-assessment process that focuses on ways to continuously improve the health care system. The survey is planned in partnership with the organization and recognizes areas of excellence as well as areas for improvement. The principle of self-assessment is the fundamental basis of accreditation. It serves as the mechanism by which an organization can assess its own performance, on an ongoing basis, against a set of nationally developed standards.

CCHSA does not use the indicator data to make an assessment of an organization's performance as there is insufficient knowledge about the relationship between indicator results and quality of care and services.

Selection of assessors: There are 4 steps in the surveyor selection process as outlined below.

1. Application
2. "360-degree" reference check. **Confidential** references are required
An interview - thorough assessment of their suitability to surveyor candidates.
3. Behavioural assessment (during orientation)

4. Internship: On successful completion of all elements of the selection process
The internship phase spans two surveys. At the conclusion of the internship period, council will make a decision about appointment as a full surveyor. A competency dictionary provides complete descriptions of the CCHSA surveyor competencies.

Training of assessors: CCHSA has a credentialling process for surveyors and provides on-going education and evaluation of surveyors. Council has established a Code of Ethics to govern the behaviour of individuals carrying out the functions/activities of Council.

Other activities:

The AIM Project is under way to:

- Revise the framework of the accreditation program, the standards, indicators, rating scale, survey, supporting material, survey report, and accreditation recognition.
- The revised standards will continue to assess the following within an organization:
- The quality of care and service, leadership, and support services
- Quality improvement
- Risk management.
- Development of standardized performance indicators. The revised accreditation program will assess how well organizations use the indicator data to understand and improve their processes and outcomes.

UNITED KINGDOM

1. HEALTH QUALITY SERVICE (previously The King's Fund Organisational Audit)

Mission: To improve quality of management in the NHS

Short history: The King's Fund Organisational Audit was created in 1989, to evaluate general hospitals. Became an accreditation program in 1995, 4 years after being launched as an organizational development initiative.

Type of provider / service targeted

Acute general hospitals and teaching hospitals
Mental health, learning disabilities, community services units

Nature of accreditation: Voluntary

Type of organization : Independent health care charity

Method of setting standards: Continual revision of standards by specialists and working groups

Type of standards : Focus on organizational systems and processes for the delivery of health care.

Method of assessment

Internal assessment of systems and processes in the delivery of health care.

1. Voluntary application by hospital
2. Assigned co-ordinator from the KF assists the hospital through 12 months of preparation for the final survey
3. Steering group appointed within hospital, participatory learning
4. Mock survey, then the final survey
5. Surveyors write down their impressions and discuss with hospital authorities.

Compliance: Awarding or deferring accreditation

Financing of the body: The program covers basic operational costs, with some overheads being subsidised by the charity, king edward's hospital fund.

2. TRENT ACCREDITATION SCHEME

Mission: Development for organisations and staff.

Short history: Evolved from the HAS, but is now, entirely separate.

Type of provider / service targeted: Community hospitals and other services.

Nature of accreditation: Voluntary.

Type of organization: Operates in the trent region.

Method of assessment: Submission of documentation from the participating facility.

1. Pre-survey by the lead surveyor.
2. Main survey, lasting 2-3 days
3. Includes a night visit.

Compliance: The board awards full, conditional or deferred accreditation, based on the survey report, which includes recommendations for change, some of which are compulsory in order to achieve accreditation and commendation of good practice.

Membership of the body: Members of the board include CEO's, consultants, senior nurses and GP's from across the region.

Financing of the body: Funded within the NHS, on a budget of £30,000 per annum, and at present, is free to participants.

Selection of assessors: elected from participating trusts, on recommendations of their CEO's, must have relevant experience as hospital managers or other senior professional within the NHS. The scheme is managed by a core staff of two with around 70 voluntary external peer reviewers.

Training of assessors: They are assessed and attend annual training workshops run by the TAS.

Involvement of consumers: Surveys may involve patients and public

3. HEALTH SERVICES ACCREDITATION

Mission: Its purpose is the identification and publication of National Service Standards for adoption within the NHS, and the objective measurement of their practical achievement through a freely available Accreditation Programme.

Short history: Health Services Accreditation (HSA) is a programme developed and operating within the United Kingdom National Health Service (*NHS*). It was established under the aegis of the UK Department of Health. A new organisation, United Kingdom Accreditation Federation (UKAF) is being developed to draw together the mutual interests of more than 30 accreditation organisations.

Method of setting standards: Developed by working groups of health care professionals, represented by the royal colleges and other professional bodies, and patient representatives.

Type of standards: Specific, achievable, clinical standards, reflecting EBM. Assesses specific areas of health care and their supporting services.

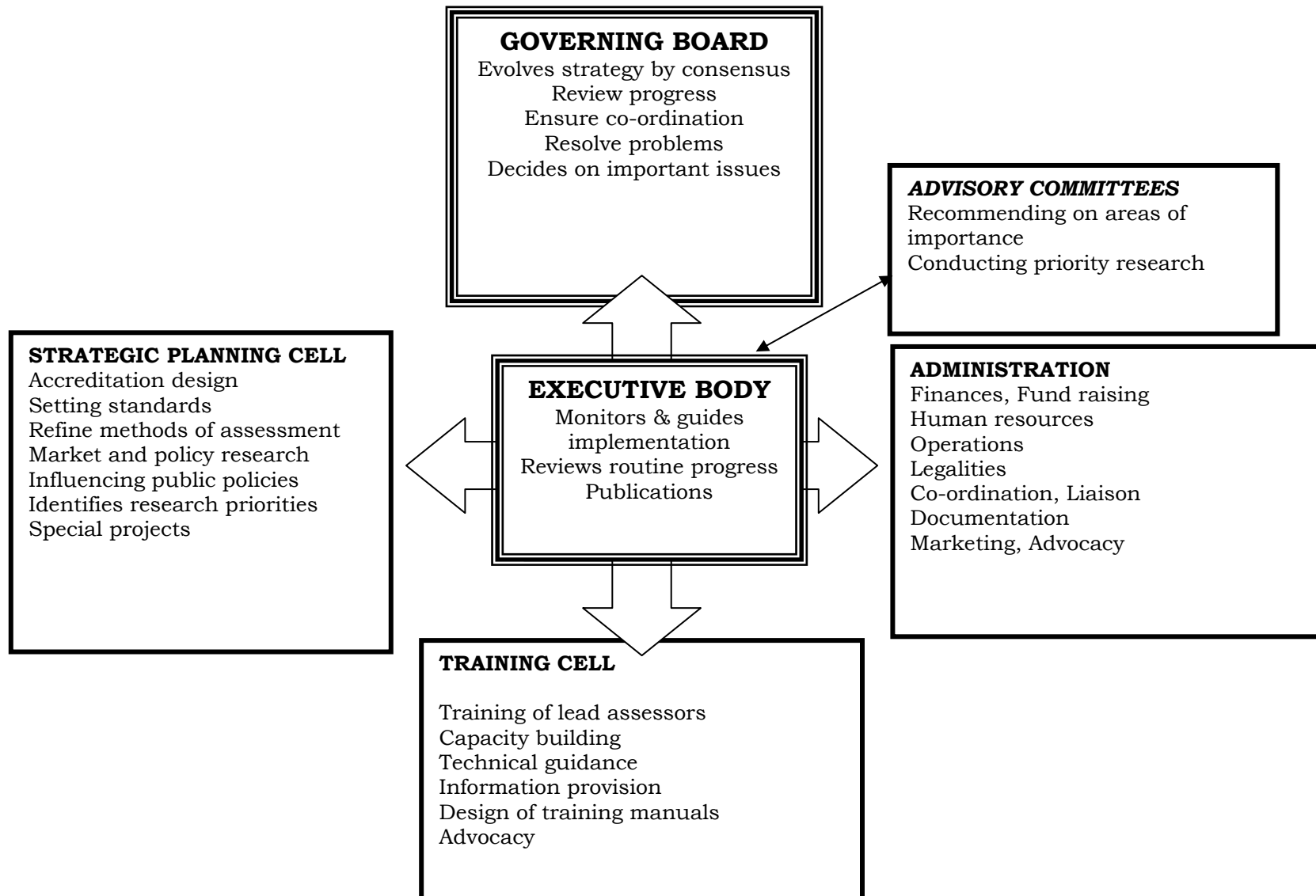
Method of assessment: A HSA accreditation visitor and a clinician from the appropriate field, confirm or deny the evidence gathered by staff to demonstrate achievement of the standards it claims to meet.

Compliance: Rather than awarding an accreditation, HSA presents the service with a statement of endorsement, listing all possible standards and specifying which are met by that service.

Functioning of the body: Run by 11 full time staff, and up to 2000 health care workers have contributed to the development of standards. Based on the internet, the HSA co-operative links health care providers, health authorities, representatives of patient interests and individual clinicians and managers who develop the programme and use its materials.

Financing of the body: A total of 19 modules in service areas are available, each of which costs between £1500 and £2350, which together with the central NHS finance funds the scheme.

ORGANOGRAM OF NATIONAL LEVEL ORGANIZATION



ORGANOGRAM OF STATE ACCREDITING ORGANIZATIONS

