Vergelijkende studie van ziekenhuisaccrediterings-programma's in Europa

KCE reports 70A

Federaal Kenniscentrum voor de Gezondheidszorg
Centre fédéral d'expertise des soins de santé
2008

Het Federaal Kenniscentrum voor de Gezondheidszorg

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Titel : Vergelijkende studie van ziekenhuisaccrediteringsprogramma's in Europa

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VOORWOORD

Contuïteit in de kwaliteit van zorg in ziekenhuizen is een veelbesproken item binnen de gezondheidszorg. Getuige daarvan zijn de vele discussies hierover, het ruime aanbod aan studiedagen en andere iniatieven terzake georganiseerd door diverse overheden, universiteiten, ziekenfondsen, ziekenhuizen en zorgverstrekkers.

Hoewel België vaak geprezen wordt om zijn uitstekende kwaliteit van gezondheidszorg, is er van het systematisch meten van die kwaliteit in de Belgische gezondheidszorg (zie rapport KCE 41 A klinische kwaliteitsindicatoren) en een bijpassend kwaliteitssysteem tot nog toe geen sprake.

Er zijn verschillende modellen voorhanden voor de externe audit van kwaliteit in ziekenhuizen, zoals de ISO certificering, accreditering, het EFQM model, visitaties of andere op peer – review gebaseerde programma's,.. Tot op vandaag zijn deze modellen het onderwerp van louter individuele initiatieven.

Onderhavig rapport heeft als doel de haalbaarheid van ziekenhuisaccrediteringsprogramma in België te onderzoeken en geeft verder een antwoord op volgende vragen: Zijn er bewijzen dat ziekenhuisaccreditering een bijdrage levert aan de kwaliteit van zorg voor de patiënt? Wat gebeurt er mbt ziekenhuisaccreditering in de ons omringende landen? Wat kunnen we leren uit hun ervaringen? Wat zijn de succesfactoren en de valkuilen van accrediteringsprogramma's?

Het KCE dankt van harte de vele Belgische en internationale experts en belanghebbenden voor hun waardevolle en erg geïnteresseerde inbreng en hun bereidwillige medewerking.

Het KCE hoopt met dit overzichtsrapport op een objectieve manier nuttige informatie te leveren aan de diverse betrokken partijen en vooral aan de beleidsmakers die zich zullen moeten uitspreken over het opzetten van een eventueel programma, wie daarbij de actoren zullen zijn en waaruit hun respectievelijke bevoegdheden zullen bestaan.

Jean-Pierre Closon
Adjunct Algemeen Directeur

Dirk Ramaekers
Algemeen Directeur

Samenvatting

INLEIDING

Historisch was ziekenhuisaccreditering gericht op vrijwillige, professioneel gedreven, continue verbetering; maar sinds halverwege de jaren '90 zijn nieuwe en bestaande programma's steeds meer geëvolueerd naar mechanismen ter verantwoording naar het publiek en de regulerende en financierende instanties. Steeds meer landen zetten ziekenhuisaccrediteringsprogramma's op waarbij vooral processen, inputs en outputs worden beoordeeld. De nadruk is hierbij verschoven van het loutere bereiken van een bepaald kwaliteitsniveau naar een proces van continue kwaliteitsverbetering.

Gezien de Europese stand van zaken inzake ziekenhuisaccreditering, lijkt voor België de tijd rijp voor een haalbaarheidsstudie die rekening houdt met alle Europese en nationale elementen. De voornaamste doelstellingen van deze studie zijn een inventarisering van de bestaande ziekenhuisaccrediteringsprogramma's in Europa, een vergelijking van hun verschillende karakteristieken (inhoud, organisatie, financiering, wetgeving) en evaluatie van hun haalbaarheid in de Belgische context. Om deze doelstellingen te bereiken heeft deze studie 3 pijlers uitgezet: het aantonen van de effictiviteit van accreditering, internationale vergelijking van bestaande accrediteringsprogramma's in de Europese lidstaten en een haalbaarheidsstudie voor de Belgische context.

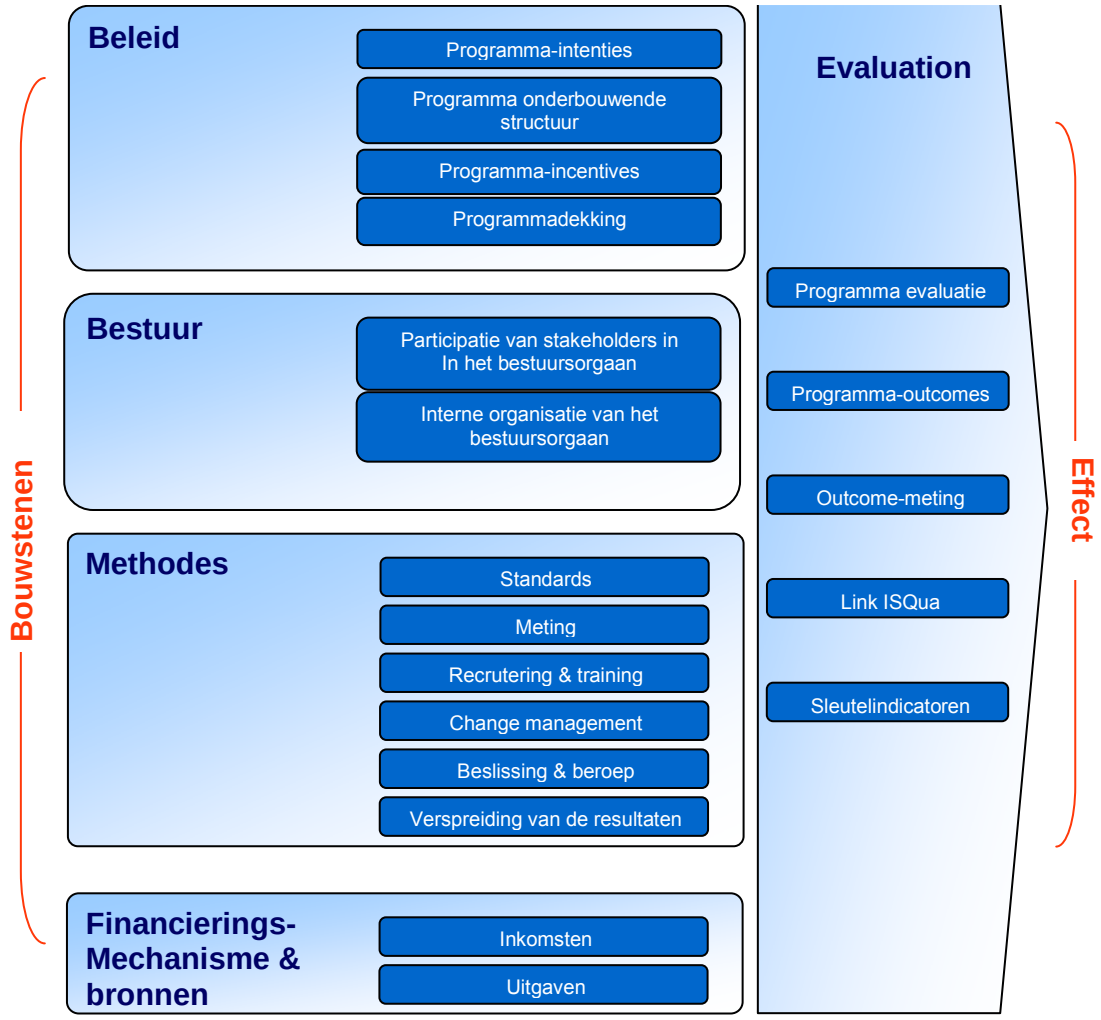
Ziekenhuisaccreditering wordt in deze studie in ruime zin gedefinieerd als alle programma's die ziekenhuizen normatief evalueren met het oog op verbetering van de kwaliteit van zorg:

"initiatieven die gericht zijn op de externe evaluatie van een ziekenhuis tegen vooraf gedefinieerde, expliciete en gepubliceerde standaarden met het oog op het bevorderen van continue verbetering van de kwaliteit van de gezondheidzorg".

METHODOLOGIE

De rode draad doorheen het project is een algemeen kader dat de onderzoeksresultaten van de internationale vergelijking en de Belgische haalbaarheidsstudie analyseert en samenvat (fig 1 algemeen kader).

fig 1 algemeen kader.



Met betrekking tot het bewijs van effectiviteit van accreditering, de internationale vergelijking en de Belgische haalbaarheidsstudie werd een uitgebreide literatuurzoektocht gedaan in meerdere databanken.

Voor de internationale vergelijking is een elektronische vragenlijst gestuurd naar de betrokken overheden van de 27 lidstaten van de Europese Unie. Hierna werd een expertenvergadering georganiseerd met vertegenwoordigers van 5 lidstaten om de bevindingen van de internationale vergelijking te becommentariëren.

Aangezien de Belgische haalbaarheidsstudie ook inzoomt op de lokale contextkarakteristieken zoals het wettelijk kader en financiële mechanismen van het Belgische zorgsysteem, zijn ook websites van de Belgische overheden en juridische bronnen geconsulteerd. Vervolgens werden de voornaamste Belgische betrokken partijen geïnterviewd over een mogelijk toekomstig ziekenhuisaccrediteringsprogramma. Aanvullende informatie werd geleverd door individuele contacten met experts terzake. Ten slotte werden de studie van de Belgische situatie en de resultaten van de internationale vergelijking aan een SWOT[1] analyse onderworpen.

[1] Strengths, Weaknesses, Opportunities and Threats (zie figuur 2)

BEWIJS VAN DE EFFECTIVITEIT VAN ACCREDITERING

De vraag naar het bestaan van door accreditering gegenereerde evidence-based outcomes lijkt een logisch uitgangspunt van de studie aangezien het de meerwaarde van ziekenhuisaccreditering kan aantonen. Het is daarmee één van de hoekstenen die bepalen of men al dan niet een ziekenhuisaccrediteringprogramma dient op te zetten.

In onze definitie is 'outcome' de uiteindelijke impact van een accrediteringsprogramma, namelijk de kwantiteit- en kwaliteitsmaatstaven die b.v. de incidentie van infecties, het aantal ingrepen per jaar van een bepaald soort, patiënttevredenheid en -kennis, zorgcontinuïteit, accuraatheid van diagnose, enz. uitdrukken.

Ondanks de tijd en het geld dat aan ziekenhuisaccrediteringsprogramma's is besteed hebben onderzoeksresultaten geen bewijs geleverd van de effectiviteit van ziekenhuisaccreditering, noch is er een bewijs dat de voor accreditering gebruikte standaarden ondersteunt.

Er zijn vele mogelijke redenen voor het ontbreken van een causaal verband tussen outcome en accrediteringsprogramma's. Een eerste reden bijvoorbeeld is dat standaarden die in de meeste accrediteringsprogramma's worden toegepast, geen betrekking hebben op outcome-gerelateerde prestatie-indicatoren. Een andere mogelijke reden is dat accreditering geen eenduidig gedefinieerde interventie is. De impact op de outcomes is niet louter gerelateerd aan de acties van het ziekenhuis maar ook een resultaat van de interacties met andere (f)actoren.

De ervaring van het laatste decennium leert ons echter dat accreditering een waardevol middel was om in vele ziekenhuizen een dynamiek van kwaliteitsverbetering op gang te brengen.

RESULTATEN

INVENTARIS EN VERGELIJKENDE ANALYSE VAN ZIEKENHUISACCREDITERINGSPROGRAMMA'S IN EUROPA

In vele landen [2] (14 op 18) die aan het onderzoek deelnamen, bestaat al een accrediteringsprogramma. De meeste van de landen hebben een nationaal programma, terwijl het VK, Spanje en Italië regionale programma's hebben. Met betrekking tot de 4 bouwstenen van het algemeen kader kunnen de volgende conclusies worden getrokken (zie fig 1).

Beleid

Er is geen duidelijk patroon betreffende het verplicht of vrijwillig karakter van de accrediteringsprogramma's, hoewel er een lichte tendens is naar vrijwillige systemen.

In de meeste programma's is ziekenhuisaccreditering ingebed in een gestructureerd kader via wetgeving en/of een overheidsbeleid.

De meeste accrediteringsprogramma's passen standaarden toe als streefdoel, d.w.z. niet als vastgestelde grenswaarden maar als eindpunten die via een continu verbeteringsproces moeten bereikt worden.

Er is geen duidelijk patroon in het gouvernementele- of niet-gouvernementele karakter van de organisatie van ziekenhuisaccreditering. Wel is er een duidelijke trend naar meer overheidsinmenging in ziekenhuisaccrediteringsprogramma's aangezien een toenemend aantal programma's worden beheerd binnen het Ministerie voor Volksgezondheid of door een overheidsinstantie.

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2 Bulgarije, Duitsland, Finland, Frankrijk, Ierland, Italië, Letland, Luxemburg, Nederland, Polen, Portugal, Spanje, Tsjechische Republiek, VK

De meest geciteerde drijfveren om deel te nemen aan een ziekenhuisaccrediteringsprogramma zijn de 'wens voor verbetering' en de 'wettelijke verplichting'.

Bestuur

De gezondheidszorgbeoefenaars, ziekenhuisdirecties en regelgevers zijn de meest vertegenwoordigde categorieën in de bestuursorganen en zetelen over het algemeen met de andere betrokken partijen.

Methoden

Bij het ontwikkelen van standaarden geven de meeste programma's de voorkeur aan het 'accrediteringsmodel' als referentie boven ISO of EFQM. Bovendien dekken de standaarden voor de meeste programma's alle processen binnen een ziekenhuis.

Wat de verschillende methoden betreft worden zowel 'zelfevaluaties' als 'geplande externe inspecties' gebruikt als onderdeel van het accrediteringsprogramma. 'Een onaangekondigde externe inspectie' is uiterst zeldzaam.

De geldigheidsduur van een accrediteringscertificaat is 3 jaar of meer. In de meeste programma's is er de mogelijkheid voor de ziekenhuizen om in beroep te gaan tegen de accrediteringsbeslissing en is er een zichtbare trend om die beslissing te publiceren.

Voor het soort beslissingen dat wordt genomen bestaan er 2 verschillende modellen, een binair systeem (accreditering of niet) versus een systeem met verschillende niveaus. Het laatste wordt in de meeste programma's toegepast.

Financieringsmechanismen en -bronnen

Het opzetten van de meeste programma's werd aanvankelijk gefinancierd door de overheid of internationale hulp.

Een focus op 4 landen (Frankrijk, Ierland, Luxemburg en de UK Health Care Commission) toont aan dat de jaarlijkse exploitatiekosten van het accrediteringsprogramma hoog oplopen, tussen 3,5 mio € (Ierland) en 60 mio € (UK Health Care Commission) in 2006.

In de meeste programma's dienen de ziekenhuizen te betalen voor de diensten, ofwel via honoraria of via een jaarlijks abonnement, afhankelijk van het dienstenpakket (van 450 tot meer dan 10.000 €).

Wat het effectperspectief betreft (5^{e} element van het algemeen kader) is het opvallend dat de meeste programma's niet beschikken over outcome-gerelateerde gegevens. Er is een duidelijke trend naar het toepassen van ISQua standaarden

HAALBAARHEID VAN EEN ACCREDITERINGSPROGRAMMA VOOR BELGISCHE ZIEKENHUIZEN

Bestaande wetgeving

De federale structuur van België noodzaakt een bevoegdheidsverdeling inzake gezondheidszorg tussen de verschillende overheden. De gemeenschappen zijn verantwoordelijk voor gezondheidszorg in en buiten de ziekenhuizen. Geen enkele overheid is exclusief bevoegd om een geïntegreerd kwaliteitssysteem op te richten dat alle aspecten van de organisatie omvat.

Tot dusver heeft België geen gevestigd accrediteringsprogramma voor acute ziekenhuizen. Toch hebben zowel de federale overheid als de regionale regeringen een aantal kwaliteitsinitiatieven genomen. We vinden een dualiteit in de wetgeving en verschillende visies tussen het regionale en het federale niveau. De federale structuur en de bevoegdheidsverdeling bemoeilijken een harmonisering van de te nemen initiatieven.

Sectoriële initiatieven

Diverse sectoriële initiatieven getuigen duidelijk van de wil van de betrokken partijen om werk te maken van kwaliteit. Deze initiatieven worden echter vaak los van elkaar en ongestructureerd opgestart. Het ontbreekt aan een globale visie.

Toepasbaarheid van standaarden & beschikbaarheid van gegevens

De standaarden van bestaande accrediteringsprogramma's in een aantal buurlanden[3] werden aan een grondige analyse onderworpen. Deze accrediteringsprogramma's zijn vooral gericht zijn op de organisatorische en transversale aspecten terwijl het gebruik van specifieke klinische prestatie-indicatoren zeer beperkt is.

België beschikt over een aantal databanken betreffende outcome of Klinische Kwaliteitsindicatoren (Studie KCE 30A 2006 en studie 41A 2006). Zoals hoger vermeld heeft ziekenhuisaccreditering voornamelijk betrekking op algemeen organisatorische en transversale aspecten die het hele ziekenhuis omvatten. Juist die aspecten zijn nauwelijks beschikbaar in de Belgische databanken.

Synthese van de interviews met de Belgische betrokken partijen

Als onderdeel van de haalbaarheidstudie van een accrediteringsprogramma voor Belgische ziekenhuizen, zijn er met de verschillende betrokken partijen interviews gevoerd op basis van een gestandaardiseerde enquête.

Op basis van de 4 bouwstenen van het algemeen kader kunnen de volgende conclusies worden getrokken die de opinie vertegenwoordigen van de meerderheid van de bevraagde betrokken partijen.

Beleid

Zolang ziekenhuizen ge(co)financierd worden door de overheid is de eerste doelstelling van ziekenhuisaccreditering verantwoording naar patiënten en de overheid. Er is echter geen consensus of ziekenhuisaccreditering het juiste of het enige 'model' is om dat te bereiken.

Er is geen globale visie op welk niveau een eventueel ziekenhuisaccrediteringprogramma zou moeten worden opgezet. Er wordt als voorbeeld gerefereerd naar de 'erkenning' van ziekenhuizen met de bijhorende bevoegdheidsverdeling tussen de federale overheid (die de na te leven normen bepaalt) en de gemeenschappen (die de inspecties uitvoeren). Er is algemene overeenstemming tussen de bevraagde partijen dat dit niet optimaal is en dat er minder ruimte voor regionale verschillen moet zijn in het voorwerp, de frequentie en de wijze van inspectie. De meeste betrokken partijen vinden het ook logisch dat de federale overheid de leiding neemt in de organisatie van een nationaal programma, zolang zij hoofdzakelijk voor de financiering zorgt.

De meerderheid van de betrokken partijen zijn ook van mening dat alle ziekenhuizen op lange termijn aan accreditering moeten onderworpen worden.

Accreditering zou op het hele ziekenhuis van toepassing moeten zijn. Toch vindt een niet te verwaarlozen minderheid dat men moet voorzien in een model dat stapsgewijze naar het stadium van volledige accreditering leidt en waarbij gedeeltelijke accreditering dus in eerste instantie een optie kan zijn.

Ziekenhuizen zouden moeten worden gestimuleerd om deel te nemen aan ziekenhuisaccreditering (zelfs als het om een verplicht programma zou gaan).

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[3] France Haute Autorité de Santé (HAS), The Netherlands Nederlands Instituut voor Accreditatie van Ziekenhuizen (NIAZ) and UK Health Quality Service (HQS))

Bestuur

Een significante meerderheid zegt dat het bestuursorgaan van een accrediteringsprogramma (indien gevestigd in België) onafhankelijk moet zijn. Dat betekent dat dit orgaan geen overheids- noch een sectorieel orgaan (b.v. NIAZ[4]) mag zijn.

Verschillende betrokken partijen zoals de overheid, beroepsverenigingen, ziekenfondsen, RIZIV/INAMI, ziekenhuis- en patiëntenverenigingen moeten vertegenwoordigd zijn. Vanuit het oogpunt van personeelsbezetting moet dit een een "light" orgaan zijn met contractacten voor uitvoering van de evaluaties en mogelijke bijstand aan de ziekenhuizen om de evaluatie voor te bereiden.

Methodes

Een significante meerderheid van de betrokken partijen is van oordeel dat de standaarden die tijdens de (zelf)evaluatie van een ziekenhuis worden toegepast, moeten gedefinieerd worden door een groep experten bestaande uit wetenschappers en 'beroepsbeoefenaars' om zuiver theoretische standaarden te vermijden. Nadat dit team een lijst van standaarden heeft opgesteld, valideert het bestuursorgaan deze lijst wat dan resulteert in een formeel 'erkende en aanvaarde' set van standaarden.

Deze standaarden moeten niet alleen focussen op processen (zoals ISO) maar ook op prestatie-indicatoren (vooraf bepaalde outcomes & outputs) en efficiëntie-indicatoren. Bovendien moeten de standaarden als streefdoel worden beschouwd. Er bestaat ook de bekommernis om niet alleen te focussen op het bereiken van standaarden, maar ook te verifiëren in hoeverre de ziekenhuizen concrete acties hebben ondernomen. Dat zal minder performante (in absolute termen) ziekenhuizen stimuleren om te blijven werken aan kwaliteitsverbetering.

Auto- of zelfevaluatie moet een sleutelelement zijn van het accrediteringsproces.

In de logica van de meerderheid zal de bestuursstructuur in het accrediteringsorgaan verantwoordelijk zijn voor recrutering en selectie van het inspectieteam. Het inspectieteam dat verantwoordelijk is voor de externe evaluatie moet bestaan uit contractuelen met een multidisciplinaire achtergrond. Het hele team krijgt dezelfde training om standaarden te auditen om er zeker van te zijn dat alle leden tijdens hun evaluaties dezelfde regels en filosofie zullen toepassen.

De meesten vinden het van het grootste belang dat ziekenhuizen onmiddellijk feedback krijgen op het einde van de externe evaluatie. Telkens er beslissingen worden genomen en meegedeeld aan de ziekenhuizen moet er voor het betrokken ziekenhuis een mogelijkheid zijn tot het instellen van een beroepsprocedure.

Een significante meerderheid is het erover eens om de accrediteringsresultaten te verspreiden, maar er is nog onenigheid de modaliteiten van de verspreiding.

Financieringsmechanismen en -bronnen

De grote meerderheid van de betrokken partijen vindt dat de financiële middelen voor het ontwikkelen en het voeren van het accrediteringsprogramma moeten komen van de federale overheid omdat die de hoofdfinancierder is voor de (meeste) ziekenhuizen. Bovendien mag het programma geen bijkomende 'kosten' voor de ziekenhuizen genereren.

4 NIAZ: 'Nederlands Instituut voor Accreditatie van Ziekenhuizen'

SWOT

Door de studie over de Belgische situatie te confronteren met de resultaten van de internationale vergelijking kan voor België een SWOT worden ontwikkeld die de mogelijkheid van een Belgisch ziekenhuisaccrediteringsprogramma kan kaderen. Het startpunt voor de SWOT ontwikkeling is de definitie van accreditering die is toegepast op dit onderzoeksproject.

Uit deze input kan schematisch de volgende SWOT worden afgeleid :

Fig 2 : SWOT



CONCLUSIES

Op basis van de beschreven bevindingen en resultaten van de 'Inventaris en vergelijkende Analyse van Ziekenhuisaccrediteringsprogramma's in Europa' resp. 'Haalbaarheid van een accrediteringsprogramma voor Belgische Ziekenhuizen' kunnen de volgende conclusies worden getrokken.

1 .'INVENTARIS EN VERGELIJKENDE ANALYSE VAN ZIEKENHUISACCREDITERINGSPROGRAMMA'S IN EUROPA'

- Het is voorkopig nog niet bewezen dat ziekenhuisaccreditering ook de patiëntenuitkomsten verbetert.
- Kwaliteitsinitiatieven worden gestuurd door een vraag naar verantwoording; er is druk om transparant te zijn over financieel beheer van publieke middelen en over de effecten van zorg in ziekenhuizen.
- Uit de bestaande accrediteringsprogramma's kunnen volgende succesindicatoren worden afgeleid: betrokkenheid van de sector, de culturele bereidheid van de organisaties, multidisciplinaire teams om de externe evaluaties te voeren, het belang van 'zelfevaluaties'.
- Accreditering is in verschillende landen en regio's de gemeenschappelijke noemer geworden, maar er is nog geen gemeenschappelijke Europese visie.
- De standaarden vertonen veel variëteit in spreiding en diepgang. Ze zijn zelden gericht op klinische outcome, maar eerder op organisatorische zaken

2. 'PEILING NAAR ACCREDITERINGSMOGELIJKHEDEN VOOR BELGISCHE ZIEKENHUIZEN'

- Er lopen kwaliteitsinitiatieven in België, maar er is geen afstemming in aanpak en snelheid.
- Het bestaande financieringsmechanisme moedigt geen kwaliteitsdynamiek aan: er zijn geen financiële incentives die kwaliteitsverbetering stimuleren
- Internationale patiëntenmobiliteit kan accreditering bespoedigen: Internationale Patiëntmobiliteit zal de vraag naar een Internationaal/Europees referentiekader versterken.

AANBEVELINGEN

Vanuit de conclusies van dit rapport, kan er geen aanbeveling worden geformuleerd of in België al dan niet een ziekenhuisaccrediteringsprogramma moet worden opgezet. Hoewel voorlopig nog niet bewezen is dat ziekenhuisaccreditering de patiëntenuitkomsten verbetert, kan uit evaluaties en uit ervaringen in andere landen worden afgeleid dat ziekenhuisaccreditering een waardevol instrument is voor dynamiek van kwaliteitsverbetering in de ziekenhuizen. Indien de politieke besluitvorming zou leiden tot de implementatie van een ziekenhuisaccrediteringsprogramma, dienen de volgende principes in rekening te worden gebracht:

- Een eerste stap die genomen moet worden is de beleidsbeslissing die bepaalt op welk niveau ziekenhuisaccreditering moet worden georganiseerd? Vanuit efficiëntieoogpunt moet elke bevoegdheidsoverlapping tussen federaal en gemeenschapsniveau worden vermeden.
- Het succes van een eventueel accrediteringsprogramma voor België zal afhangen van een aantal basisvoorwaarden
    - Ondubbelzinnige definitie van de te bereiken doelstellingen
    - Duidelijk omlijnde functies en verantwoordelijkheden van de verschillende betrokken partijen.
    - Vertaling van de doelstellingen in meetbare indicatoren, inclusief outcomes en de ontwikkeling van een gepaste set standaarden
    - Impactanalyse van
        - de bestaande wetgeving en regulering betreffende de organisatie van de kwaliteit van zorg in de ziekenhuizen op een eventueel accrediteringsprogramma. Hoe kan men de bestaande kwaliteitsinitiatieven die in de bestaande wetgeving zijn geïncorporeerd op één lijn brengen met een eventueel accrediteringsprogramma?
        - de ziekenhuisfinanciering : blijft de ziekenhuisfinanciering ongewijzigd of zal ze (op positieve of op negatieve wijze) gelinkt worden aan de resultaten van accreditering ?
        - de inspanningen/kosten die op individueel ziekenhuisniveau worden gegenereerd.
    - Uniformisering van reeds bestaande registratiesystemen voor meting van de noodzakelijke gegevens.

Scientific summary

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1 INTRODUCTION

Until recently, standards and quality in health care focused on the availability of staffing and equipment, and on the accessibility of services. In the past 3 decades, most developed countries have turned attention to the safety, accessibility, and effectiveness of care (in terms of individuals, populations and costs). This shift from "capacity" to "performance" is associated with several trends such as new technologies and rising costs, combined with evidence from many countries of unacceptable levels of harm to patients and staff, variations in clinical practice and outcomes, and systematic failures of service delivery.

On the Belgian level quality initiatives within the health care launched by the different stakeholders, are fragmented and without an integrated vision behind. One way to assess quality of care in hospitals is accreditation, defined in this report as "initiatives to externally assess hospital against pre-defined explicit published standards in order to encourage continuous improvement of the health care quality". The object of evaluation in the definition of hospital accreditation is the hospital and not the individual health care provider.

Historically, accreditation aimed for voluntary, professionally-driven continuing improvement; but since the mid-1990s, new and existing programmes have increasingly become mechanisms for accountability to the public and to regulatory and funding agencies, and they have become progressively aligned with statutory mechanisms [1]. In the past 16 years many countries, with widely different health systems, have established (national) hospital accreditation programmes. The first regional programme started in Catalonia, Spain in the 1980s, and 2 independent national programmes began in the UK in 1990. The number of hospital accreditation programmes has grown since the 1990s up to 25 programmes (both National and regional programmes), currently covering 52% of the European Member states. In addition, 2 countries are in full development of a national hospital accreditation programme, namely Denmark and Lithuania.

The increase of the number of countries engaging in hospital accreditation programmes has been accompanied by a shift in the 'subject' of the assessment i.e. an evolution towards evaluation of process measure as well as inputs and outputs. Within the process focus, attention in recent years moved towards an emphasis on quality improvement, rather than just quality attainment, or to put it in other words, there has been an evolution in hospital accreditation programmes from Total Quality Management (TQM) towards Continuous Quality Improvement (CQI), where employees and organisations are judged on their ability to meet a standard, but exceed it [2].

Whereas the number of countries that have engaged in hospital accreditation programmes has increased and the content of these programmes has evolved, to date Belgium has not initiated a hospital accreditation initiative. Yet at the same time, and one may speculate about the correlation with the lack of such a programme, within the Belgian landscape there is a wide variety of initiatives, pilots and reflections on the matter.

So, given the European state of play on hospital accreditation and the initiatives amongst the stakeholders in the Belgian landscape, which indicate a readiness and willingness to explore hospital accreditation, the time seems right for a feasibility study taking into account all European and national elements. In this context, the main objectives of this study are: to create an inventory of the existing hospital accreditation programmes in Europe, to compare their different characteristics (content, organisation, funding, legal) and to assess their applicability to the Belgian context.

First, the existence of a causal link between hospital accreditation and outcomes was studied. Then, an inventory of the existing accreditation programmes in Europe was drawn up. Different modalities and characteristics of the programmes, covering the aims, content, organization, financing, etc. were described and assessed. Subsequently, there was an exploration of accreditation opportunities for Belgian Hospitals, covering the issues to what extent the different dimensions and aspects are applicable to the

Belgian situation, if the required registered data are sufficiently available and which conclusions and recommendations can be distilled for Belgium.

Patient issues did not fall in the scope of our study. Consequently questions with regard to patients' perception linked to accreditation (e.g. public reporting and accreditation) were not addressed. For the same reason patients were not included in the stakeholder interviews.

2 GLOBAL METHODOLOGY

The global methodology that has been applied throughout this project consists of 4 components

1 The methodology related to the development of a framework to analyse accreditation,

2 The methodology related to the Evidence on the effectiveness of Accreditation question,

3 The methodology related to the 1st research question, namely the Inventory and Comparative Analysis of Hospital Accreditation Programmes in Europe, and

4 The methodology related to the 2nd research question, namely the Exploration of Accreditation Opportunities for Belgian Hospitals

For the development of these 4 components, the team engaged Dr. Charles Shaw who has contributed to multiple previously conducted comparative studies on (hospital) accreditation programmes and who is considered to be the scientific authority as far as hospital accreditation is concerned. Besides, additional experts were approached to ensure consistency and relevance in terms of project steps and deliverables. Both Prof. Dr. Agnes Jacquery from the ULB and Pascal Garel[i] from HOPE contributed as experts at the very start of the project to make sure that the research questions defined were sound and complete in terms of scope coverage.

At the start of the project, before entering into the specific methodologies for the 2 research questions, an exhaustive list of exploration questions was drafted, which served as a starting point and anchor for the 2 sub-methodologies. This list of research questions can be found in Appendix 3.

2.1 DETERMINATION OF THE FRAMEWORK TO ANALYSE ACCREDITATION

In order to respond to the objectives put forward in Chapter 1 'Introduction', it is crucial to apply a common framework that allows, on the one hand the analysis and synthesis of the research results, and on the other hand a comprehensive formulation of recommendations or possible scenarios for Belgium.

The results of the literature search and analysis show that there is not one single common framework, yet different explicit or implicit models containing the main characteristics of an accreditation programme are used by different sources. Especially previously released comparative analyses strive for a framework that allows for relating countries in terms of accreditation programmes. For instance, The Joint Commission International[ii] uses a 13-dimension-model to compare the philosophy of accreditation programmes between countries/regions[3].

---

[i] General Director European Hospital and Health Care Federation

[ii] See details about the Joint Commission International (JCI) in Appendix 1

Table 1 : Philosophy of Accreditation

• Mandated	⟷	Voluntary
• Punitive	⟷	Improvement oriented
• Cyclical	⟷	Continuous
• Prescriptive	⟷	Non-prescriptive
• Confidential	⟷	Publicly disclosed
• Minimum requirements	⟷	Cutting edge requirements
• Reactive	⟷	Proactive
• Announced	⟷	Unannounced
• Retrospective	⟷	Prospective
• Standards based	⟷	Performance measured based
• Process oriented	⟷	Outcomes oriented
• Absolute measurement	⟷	Comparative measurement
• One-level award	⟷	Multi-level award

Source: Joint Commission International

Another example is the classification used by the International Society for Quality in Health Care (ISQua), in their 'Toolkit for Accreditation Programs', as developed for the World Bank in 2004[4]. This classification groups the different variables that determine the potential effectiveness, affordability and sustainability in 4 main categories:

Table 2 : Variable factors determining the potential effectiveness, affordability and sustainability of a programme

Policy:
- What is the purpose of the proposed program?
- How might it complement or replace alternative mechanisms, such as licensing and certification?
- How would it match the culture of the population and professions concerned?
- What incentives would encourage participation?

Organisation:
- How would the people most likely to be affected ("stakeholders") be identified and involved?
- How would the program be governed?
- How would it ensure compatibility with associated regulatory and independent agencies?

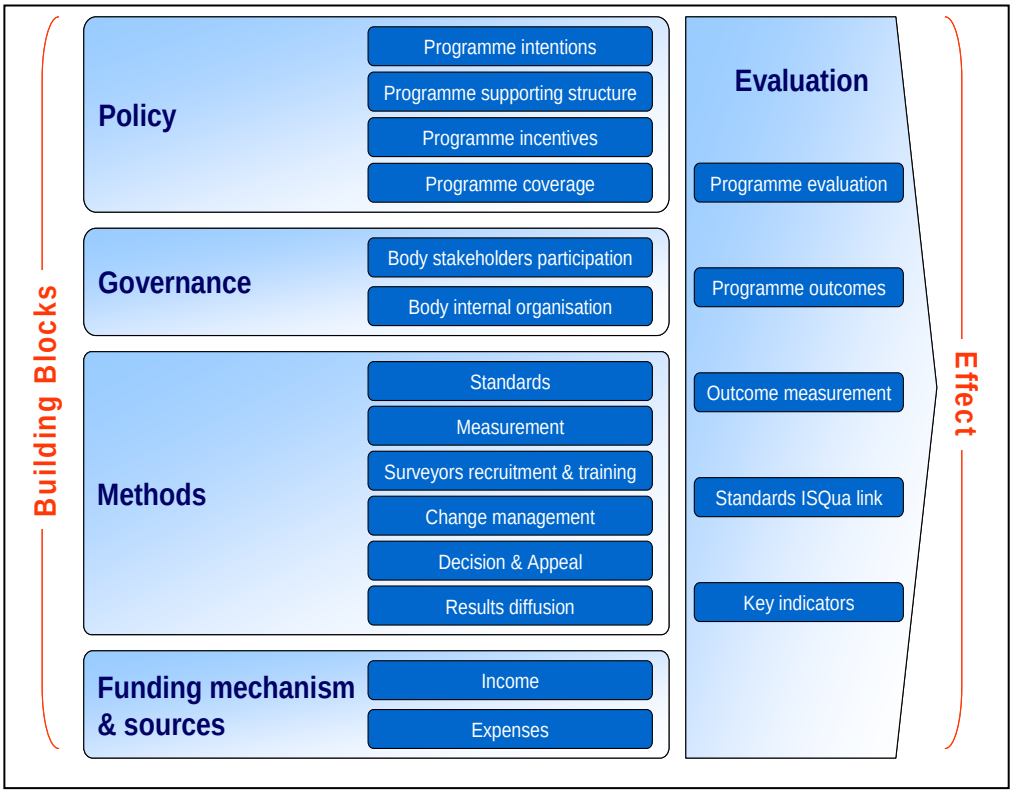
Methods:
- How will standards be made valid?
- How will assessments be made reliable?
- How will assessors be trained and re-validated?
- How will procedures and results be made transparent and fair?

Resources:
- What are the implications for data, information and training?
- What are the costs to participating institutions?
- How long does it take to set up a sustainable program?
- What does it cost to set it up?

For the purpose of this report, a framework to analyse accreditation was developed in function of the 2 research questions defined (1, the Inventory and Comparative Analysis of Hospital Accreditation Programmes in Europe; 2, the Exploration of Accreditation Opportunities for Belgian Hospitals), of the literature search strategies applied and of the (International and national) surveys conducted. To some extent the proposed framework combines certain elements already applied in other reports as this will allow to point out trends and tendencies (see 5.1.3., 5.1.4. and 5.2.4).

The proposed framework is directly linked to the applied literature study and the survey questions and is composed of 5 elements, of which 4 'building blocks' (Policy, Governance, Methods and Funding mechanism & sources) related to the characteristics of the programme, and 1 'effect' perspective related to the evaluation of possible (tangible) results of the programme. In the figure underneath the framework is presented.

Figure 1 : Framework to analyse accreditation



Source: Eurogroup Consulting 2007, based on JCI and Word Bank frameworks

- The **Policy** building block refers to the political choices and strategic principles which determine the fundamental basics of the accreditation programme in place:
  - *Programme intentions* deals with the (implicit or explicit) purpose of the programme i.e. what is it meant to achieve and how much margin is left to hospitals to participate
  - *Programme supportive structure* is about the different legal and regulatory structures that have been created to sustain the programme. Also the degree to which the programme is embedded in larger (healthcare) policy programmes plays an important role
  - *Programme incentives* looks into the formal incentives and other motivators which are put in place to stimulate hospitals to participate in the programme
  - *Programme coverage* concerns the comprehension of the programme in terms of types of hospitals included, hospital services included in the programme and national versus regional programme(s)

- The **Governance** building block refers to the organisation implications of the existing accreditation programme in terms of a (separate) organisational entity on 2 levels:
    - *Body stakeholders participation* is about how corporate governance is reflected in a (sub) structure within the entity and by which composition
    - *Body internal organisation* deals with the practical internal organisation of the organisational entity, in case one exists
- The **Methods** building block covers all elements of the practical side of implementation and operation of the accreditation programme i.e. what approaches are used to complete the accreditation programme:
    - *Standards* relates to the development of standards, consultation process, approval and revision
    - *Measurement* deals with the way the assessment (or evaluation) of an individual hospital is organised: what assessment methods applied, is an on-site visit organised and if so what team
    - *Surveyors recruitment and training* explains how surveyors are selected, recruited and trained
    - *Change management* describes the tools that are made available at the hospitals that will enhance the buy-in and facilitate the accreditation process
    - *Decision and Appeal* is about levels of decision that may be taken for accreditation, steps in the decision process and existence of possible appeal processes
    - *Results diffusion* concerns the availability of results, what results and for whom
- The **Funding mechanism & sources** building block covers the revenues and costs of the accreditation programme i.e. the budget of the programme
    - *Income* deals with the origin of funding at the programme development step and the sources of revenues perceived once the programme is launched, especially those generated by the participating hospitals
    - *Expenses* concerns the costs involved to run the programme, including operational costs of staff
- The **Evaluation** component refers to the possible indications of the relative success of the programme and the according measures that have been put in place to evaluate the programme and its effects:
    - *Programme evaluation* deals with the ways the authorities evaluate the accreditation programme
    - *Programme outcomes and outcome measurement are about* the outcomes that have been realised, in function of the pre-defined objectives, as a result of the accreditation programme in place and how are they measured
    - *Standards ISQua link* deals with the steps taken by the authorities to link the programme to the Internationally renowned ISQua standards

- *Key indicators* looks into the effects of the accreditation programme in terms of the activity generated by the programme (the number of on-site visits) and the participation rate of hospitals

For details about the framework, the relation to the literature study and survey questions, see Appendix 5.

2.2 THE METHODOLOGY FOR EVIDENCE ON ACCREDITATION

The question on evidence based outcomes generated by accreditation was explored via a systematic literature study, as a guarantee for scientific independent valid results, and via an international electronic survey detailed in Chapter 2.3 'The methodology for the 1st research question'.

To elaborate the literature search strategy, relevant headings covering the concepts of outcomes, accreditation and hospital were identified in Medline and Embase and gathered to form specific search strategies[iii]. Next, these ones were run with search restrictions on publication date, language and database. Additionally a literature search was done in Econit and EBSCO.

2.3 THE METHODOLOGY FOR THE 1ST RESEARCH QUESTION, 'INVENTORY AND COMPARATIVE ANALYSIS OF HOSPITAL ACCREDITATION PROGRAMMES IN EUROPE'

The 1st research question was dealt with in 2 ways: a systematic literature study and an international electronic survey addressed to the 27 relevant authorities member states of the European Union[iv].

To determine the scope of the search, a global definition of accreditation (cfr Chapter 1 'Introduction') was developed, a list of questions aiming at capturing the main characteristics of an accreditation programme was drafted to compare the existing systems and the decision was taken to focus on the 27 member states of the European Union. The themes covered by this questions list were Policy, Strategy, Implementation, Impacts, Financials and Outcomes.

To elaborate the literature search strategy, first the relevant databases were selected. The bibliographic databases Medline and Embase, the WHOLIS library database, The COPAC library catalogue, the catalogues of the British Library, The OAIster catalogue, the website of OECD, EBSCO and the search engine Google appeared to be relevant and were therefore the subject of a search strategy. On the 9 selected databases, Medline and Embase proposed a thesaurus: adapted headings-based search strategies were thus developed with headings covering "accreditation", "hospital" and "countries" dimensions. The other databases were first searched via the index when available, but it was then decided to build individual keywords-based search strategies as these indexes appeared unreliable. These search strategies were next run with specific search restrictions when possible.

An international survey was conducted covering the themes Policy and governance, Management, Standards, Surveyors, Assessment, Awards, Finance and Information. On the basis of the list of research questions and the questions covering topics treated by the literature study, a draft survey was created and sent to 2 external experts for comments. After amendment and review, the survey was mailed to 3 accreditation agencies of the European countries for testing.

[iii] For the detailed methodology on Evidence on Accreditation, see Appendix 2

[iv] For the detailed methodology on the research question 1, see Appendix 3, 4 and 5

A quality check evaluating the correspondence of the data obtained by the literature search and the survey was performed to ensure the information found was reliable. Then the obtained data were linked to the developed framework (cfr Chapter 2.1 'Determination of the framework to analyse accreditation'), summaries per country were made and a quantitative analysis of all the information was performed. The answers received by the survey were also compared to the data transmitted by Charles Shaw regarding his previous surveys[v] in order to identify possible evolutions and trends.

A country expert meeting[vi] was organised in order to validate the key findings resulting from the literature study and the survey and to complete lacking information on the 'Methods' building block of the Common Framework as well as on the 'Effect perspective'. Moreover some do's and don'ts based on the lessons learned from the concerned systems abroad for a possible Belgian accreditation system were discussed.

Furthermore the national accreditation websites available in French, Dutch or English were in addition explored together with case studies presented on the conference on Hospital Accreditation organized by the Association Belge des Hôpitaux in March 2007.

It is important to note that the international comparison has some limitations. Country specific material on accreditation is incomplete. Reports and documentation are of varying quality, data from websites are often unreliable, unrepresentative, not up to date or solely in the national language. Representation of country experts at our expert meeting did not cover the full scope of the studies member states. Consequently most complete sources of information stem from our neighbouring countries. Much less is available on countries of the Mediterranean. This must be taken into account when considering fragmentary information, for instance on some regions.

In the international survey it was impossible to manage open questions since feasibility with regard to time spending to complete the survey and treatment of the answers afterwards were factors to be taken into account. The limitation of closed questions is that less qualitative information could be derived from the survey.

Since the study focuses on the European systems there is no thorough study of the older accreditation systems, such as those in Canada or Australia. Where European programs are based on similar systems, reference was provided.

2.4 THE METHODOLOGY FOR THE 2ND RESEARCH QUESTION, 'EXPLORATION OF ACCREDITATION OPPORTUNITIES FOR BELGIAN HOSPITALS'

A systematic literature study, which focused on Belgian quality initiatives falling within the definition of hospital accreditation, was performed. Given that information on quality initiatives in Belgium had already been collected via the 1st literature study (cfr Chapter 2.3 'The methodology for the 1st research question') and the databases then explored were inadequate to find information on the Belgian system, it was decided to explore exclusively Google.

A search strategy using 8 keywords combinations, including the words "compétences", "agrément", "visitatie" and "accréditation" was performed[vii].

Some additional information on quality initiatives was obtained by contacts in the sector.

---

v Charles Shaw carried out surveys in 2000 (gathering data for 1999), 2002 (for 2001) and 2004 (for 2003)

vi 5 countries participated to this meeting, i.e. Czech Republic, National Programme, Italy - Marche, Regional Programme, Spain – FADA-JCI, Regional Programme, The Netherlands, National Programme, and UK – HAQU, Regional Programme

vii For the detailed methodology on the research question 2, see Appendix 6, 7 and 8

Since the second research question also focuses on the 'local context' characteristics such as the legal framework and financial mechanisms of the Belgian healthcare system the Belgian authorities' websites legal sources consulted.

Next, a survey was conducted by means of individual interviews with the main Belgian stakeholders of a potential hospital accreditation programme. The stakeholders to be consulted were determined based on their implication in the matter, the stakeholders as involved in accreditation programmes in the neighbouring countries and taking into account the language distribution (French – Flemish). Therefore, the stakeholders approached include the communities, Sickness Funds, RIZIV-INAMI, professional associations, patient-organizations, umbrella organizations, a number of individual hospital and experts. All of them were formally approached in order to foresee plenty of time to schedule an interview within a 3 month timeframe (June – August).

Finally a SWOT analysis was performed in order to position the Belgian situation based on the interviews conducted with the stakeholders confronted with the results of the 1st research question.

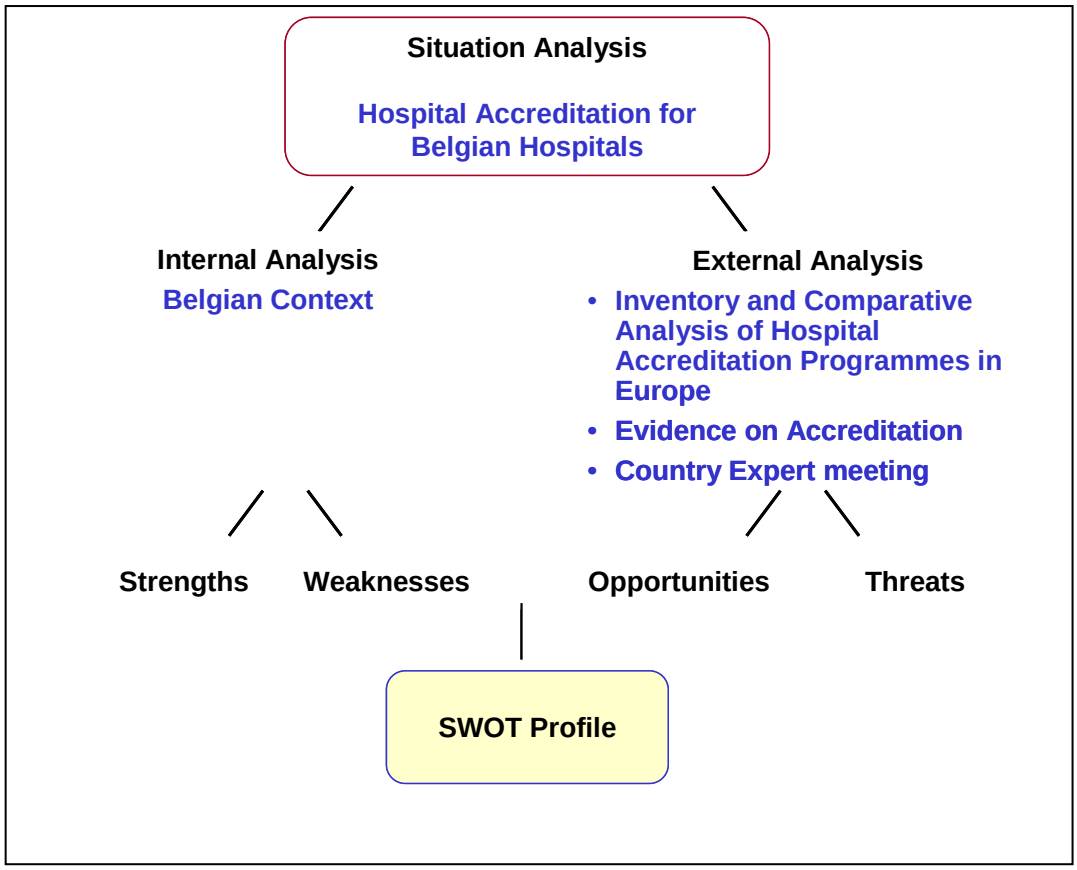
SWOT analysis is a simple framework for generating strategic alternatives from a situation analysis. The situation analysis in the context of this project is composed of 2 perspectives, namely the International one and the Belgian one. SWOT stands for Strengths, Weaknesses, Opportunities, and Threats. The SWOT framework was described in the late 1960s by Edmund P. Learned, C. Roland Christiansen, Kenneth Andrews, and William D. Guth in Business Policy, Text and Cases (Homewood, IL: Irwin, 1969).

Typically the internal and external situation analysis can produce a large amount of information, much of which may not be highly relevant for the kind of strategic/policy decision making which is served. The SWOT analysis can serve as an interpretative filter to reduce the information to a manageable quantity of key issues. The SWOT classifies the internal aspects, which are the Belgian context elements (existing law, initiatives, interviews with the stakeholders, etc.), as Strengths or Weaknesses.

The external situational factors, stemming from the 1st research question 'Inventory and Comparative Analysis of Hospital Accreditation Programme in Europe', the research on Evidence on Accreditation and the Country Expert Meeting, are classified as Opportunities or Threats. By understanding these 4 factors the Belgian policy makers should be able to draw the right conclusions for Belgium and to determine a feasible roadmap in function of the decision taken.

The following diagram shows how a SWOT analysis fits into a strategic (policy) situation analysis, and how this is linked to the specific scope of this project.

Figure 2 : Elaboration of a SWOT profile



In short, the starting point for the executed SWOT analysis is the key question for the policy makers, namely whether, and to what extent, the applied definition of accreditation is opportune for Belgian hospitals.

Therefore, an analysis of the Belgian context (the Internal Analysis) is carried out by means of the 2nd research question, taking into account the lessons learned from the International experience and scientific elements gathered via the 1st research question (the External Analysis). The Internal & External analyses allow the definition of the Strengths, Weaknesses, Opportunities and Threats.

Based on the listing of the Strengths, Weaknesses, Opportunities and Threats a SWOT profile can be drawn.

3 HOSPITAL ACCREDITATION: DEMARCATION AND DEFINITION

3.1 DEMARCATION OF THE CONCEPT

Health care quality policies can be defined from the level at which they act. Health system assessment schemes are acting at the level of the overall health system and include national legislation and policies, patient safety, registration and licensing of pharmaceuticals and medical devices, health technology assessment and training and continuing education of professionals. At an organisational or service level, there are organisational quality assessment schemes directed at the evaluation of organisations providing care and cover a wide variety of mechanisms. Hospital accreditation is an example of such an organisational quality assessment scheme. Clinical quality assessment schemes involve, amongst others practice guidelines, quality indicators and information systems, quality circles, medical speciality peer review, patient surveys, clinical governance and audit processes[5].

3.2 DEFINITION(S) OF ACCREDITATION

The concept of "Accreditation" was introduced in the United States in 1917 as a voluntary mechanism for recognition of training posts in surgery and then developed into multidisciplinary assessments of health care functions, organizations and networks. The Joint Commission model spread first to other English-speaking countries and Europe, then to Latin America, Africa and South East Asia during the 1990s. Accreditation standards are generally tailored to individual countries, but there is a growing trend towards consistency with other countries and with other standards such as ISO and EFQM [6] [viii].

Today there is not 1 universal definition of accreditation. Different definitions can be found in the literature [4]:

"a public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards" or

"a voluntary program, sponsored by a non-governmental agency, in which trained external peer reviewers evaluate a health care organization's compliance with pre-established performance standards".

For the purpose of this study however, a large definition of accreditation is applied in order to cover all programmes aiming at assessing hospitals against standards with a quality improvement goal:

"initiatives to externally assess hospital against pre-defined explicit published standards in order to encourage continuous improvement of the health care quality".

In that sense the study applies a definition which is 'wider' than the existing ones in literature, and as such possibly also covers other quality concepts like Licensure and Certification. In appendix 9 the link between the concepts hospital accreditation, certification and licensure is described.

---

viii See description of project Kwadrant in Chapter 5.2.1.2 and details about the EFQM model in Appendix 9

4 EVIDENCE ON THE EFFECTIVENESS OF ACCREDITATION

In the study carried out for this project, the question on 'evidence based outcomes generated by accreditation' was explicitly integrated as it seems a logical starting point for the study as it aims to establish the added value of hospital accreditation and consequently is one of the keystones to determine whether hospital accreditation should be pursued.

Based on the lengthy experience of hospital accreditation programmes in the neighbouring countries one could expect that this would allow Belgium to profit of evidence of improved healthcare quality as a result of these schemes.

4.1 POTENTIAL IMPACTS OF ACCREDITATION

When referring to 'evidence based outcomes' it has to be clear what is meant by 'outcomes'. In our definition, 'outcome' is the ultimate impact of an accreditation programme, namely the quantity and quality measures, reflecting e.g. the incidence of infection, number of procedures performed per year of a certain kind, patient satisfaction and knowledge, continuity of care, accuracy of diagnosis, etc [2]. In that sense, so called output indicators like waiting times are also considered as outcome.

Apart from 'outcomes', one may expect other potential impacts of hospital accreditation programmes which do contribute directly or indirectly to improved outcomes in the long run. In the existing literature different opinions exist on what the benefits or potential impacts of hospital accreditation are and who (which stakeholders) benefits from them.

In 'Accreditation and other External Quality Assessment Systems for Healthcare' the following overview on positive benefits is presented:

Table 3 : Who benefits from accreditation?

- Who benefits
  - Patients
    - Benefit from improved quality
  - Providers
    - Benefit from association with a reputable facility
  - Staff
    - Benefit from job satisfaction and pride involved in the process
  - Organizations
    - Quality conscious

Source: Health Systems Resource Centre

A much broader 'impact range' is presented in the Journal on Quality and Patient Safety of May 2006, after the authors have stated that there is much debate about whether accreditation is effective, and about what evidence there is to support the answer [1].

Table 4 : Ten potential impacts of accreditation

Impact	Associated aims and mechanisms
1. Health system governance	Government, legislation, regulation
2. System design, development	Strategic planning, access to service, functional specification
3. System financing	Resource allocation, cost-containment, efficiency
4. Population health	Health education, preventive programs, protection of public health and safety; reduced geographic and social variation in provision and performance; standardized measurement of system performance
5. Knowledge management and transfer	Research (clinical, health service, consumer); technology assessment
6. Clinical effectiveness	Clinical interventions compliant with evidence-based medicine (EBM); improving institutional performance and results; continuity of care; safety and risk management
7. Consumer empowerment and decision-making	Providing information, choice, safety, respect, accountability; responding to need
8. Professional and personal development	Education, training, continuing professional development (CPD); credentialing; improving individual performance; workforce empowerment
9. Management development	Leadership, team building, accountability, communication, performance, marketing
10. Quality systems development	Defined policy, organization, methods; allocating quality resources (human, information, financial)

Source: C. D. Shaw[1].

Clearly, in this list of 10 potential impacts, the 4th and 6th, Population health and Clinical effectiveness respectively, relate most to what is considered to be 'outcomes' whereas the other impacts may be considered as impact elements that directly or indirectly contribute to effectiveness and improved outcomes.

It needs to be borne in mind that these impacts or benefits as presented are not necessarily solely linked to (formal) accreditation programmes i.e. quality initiatives which contain key elements of the applied definition of hospital accreditation most likely contribute to these potential impacts as well.

4.2 LITERATURE: LACK OF EVIDENCE

Research results have not established any evidence on the effectiveness of hospital accreditation, nor any evidence that supports the standards used in accreditation.

Historically, accreditation programs focus on structure and organisational processes, as is done e.g. in ISO certification and EFQM. Outcome related measures are to a variable extent incorporated in quality assurance programs. This may explain why a positive causal relation between accreditation and outcome has not been demonstrated.

Attempts have been made however to incorporate quality indicators in accreditation. In the United State, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) linked since 1997 clinical outcome indicators to the accreditation process through ORYX, a measurement system intended to provide a more targeted basis for the regular accreditation survey.

The Australian Council on Healthcare Standards (ACHS) developed the Care Evaluation Program (CEP), since 2000 replaced by Performance and Outcomes Service (POS) where a set of 23 domains is used to increase the clinical component of the Evaluation and Quality Improvement Program (EQuIP).

Much research done is focussed on the accreditation and certification programmes of the JCAHO and health institutions in the USA.

For instance, the JCAHO published its national standards and conducted its first certification evaluation for disease-specific care in February 2002 [7].

The Disease-Specific Care (DSC) Certification Program is fundamentally based on an evaluation of a disease-specific care programme's compliance with the Joint Commission's standards, implementation of adherence to clinical practice guidelines and its outcomes of care. 30 standards have been determined encompassing 5 functional areas of performance like delivering or facilitating clinical care (5 standards) and performance measurement and improvement (5 standards). These standards are intended to reduce practice variation and emphasize 'doing the right things and doing them well'. In the article there are anecdotes of hospitals who received the DSC certificate and have reported remarkable results in performance like reduced visits to the emergency department, the increased use of ACE inhibitors by 85% with CHF patients, a decrease in the length of stay for Medicare patients in specific Disease-related Groups, … The article concludes that the DSC programmes that have successfully achieved Joint Commission DSC Certification have reported impressive results in both utilization activity and clinical performance measures. Yet there is no evidence on the causal relationship between the certification programme and the results achieved.

In another research carried out amongst 134.579 patients treated at 4.221 hospitals in the USA, and published in 2003, the authors examined the association between the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation of hospitals, those hospitals' quality care, and survival among Medicare patients, hospitalized for acute myocardial infarction [8]. In the USA, obtaining JCAHO accreditation is important for hospitals, as the Medicare Act of 1965 decreed that accredited hospitals were deemed to have satisfied federal health and safety requirements necessary to participate in Medicare. In 2003, as a result approximately 80% of the 6.000 U.S hospitals had sought for accreditation by JCAHO. From the hospitals that were in scope of the research carried out, about 1/3 were not surveyed by JCAHO. The JCAHO philosophy is that hospitals accredited based on compliance with relevant standards would be likely to achieve good outcomes. The research revealed that patients admitted to non-surveyed hospitals were less likely to receive aspirin and beta-blockers, both on admission and during hospitalisation; and less likely to receive acute reperfusion therapy. Moreover the non surveyed hospitals had higher 30-day mortality rates than surveyed hospitals after adjustment for patient characteristics. The authors conclude that accreditation does provide some information concerning hospitals' quality of care and outcomes in the aggregate. Indeed, knowing that a hospital participated in the JCAHO survey process suggests superior quality and outcomes compared with non-surveyed hospitals. It is unknown, however, whether the process of undergoing JCAHO accreditation improves quality of care or whether this association reflects self-selection against JCAHO evaluation by more poorly performing hospitals.

Furthermore the results of the research showed that there was considerable variation within accreditation categories in quality of care and mortality among surveyed hospitals, which indicates that JCAHO accreditation levels have limited usefulness in distinguishing individual performance among accredited hospitals.

In the very same period another research was conducted aiming to identify what is driving hospitals to engage in patient-safety efforts [9]. This research was based on specific data collected since 1996 by means of site visits in 12 U.S. metropolitan areas. In addition 1.000 semi structured interviews were conducted between September 2002 and May 2003. Three general mechanisms for stimulating hospitals to reduce medical errors are 1) professionalism, 2) regulation and 3) market forces. Whereas one may assume that market forces are becoming more important, the researchers found that a quasi-regulatory organization, like the JCAHO, has been the primary driver of hospitals' patient-safety initiatives.

And so, although JCAHO policies identify organizational outcomes that hospitals must achieve (e.g. effectiveness of communication) and that evidence on accreditation by the JCAHO is limited, there seems to be a positive effect in the dynamics that it creates, namely a clear driver for hospitals subject to the JCAHO accreditation to engage in patient safety efforts.

Barker et al. conducted a study of medication errors in a stratified random sample of 36 hospitals comprising 12 JCAHO accredited hospitals, 12 non-accredited hospitals and 12 skilled nursing facilities in Georgia and Colorado Medication errors were witnessed by observation, and verified by a research pharmacist[10]. There was no significant difference between error rates in the three settings.

Another study analysed the possible relationship between JCAHO scores and independently measured patient satisfaction ratings. According to the definition for 'outcomes' provided in the beginning of this chapter, patient satisfaction is rather an impact than an outcome. The study mentioned, published in 2004, involved a total of 41 acute care, 200-plus bed, non for profit hospitals in New Jersey and Eastern Pennsylvania[11]. The consolidation of these results revealed no relationship between these quality indicators, neither a meaningful pattern of categorical relationships. An article from October 2004, focusing on the JCI (The Joint Commission International, the Joint Commission's International Affiliate) hospital standards argues that comprehensive patient records as defined by the specific elements of the standards (applied to 50 hospitals in 12 countries in 2004) have greatly contributed to the capability of accredited organizations to monitor and improve essential aspects of good patient care [12]. The article talks about the indirect relationship one may expect between accreditation and the quality and safety of patient care as it concludes that accreditation often serves as a comprehensive and powerful tool for quality improvement in cultures and countries with very different systems of healthcare delivery. Improvements realized in many processes of care have the potential to positively influence this quality.

Another study, focusing on JCAHO accreditation, examined the association between the JCAHO accreditation scores and 2 sets of indicators from the Agency for Healthcare Research & Quality, namely Inpatient Quality Indicators (IQI) and Patient Safety Indicators (PSI)[13]. The analysis was based on information received from 24 states between 997-1999. No significant relationships existed between JCAHO accreditation decisions and the performance on the mentioned indicators.

More recent research (2006), once again with a focus on North America, focused on determining whether the accreditation of trauma centres does result in improved patient outcomes [14]. Outcome is defined as the mortality rate. The study concludes that there is little evidence to support the benefit of trauma accreditation on patient outcomes other than improvements in survival. In order to assess performance of designed trauma centres there's a need for studies comparing long term trauma patient morbidity rather than only comparing mortality.

Outside the USA, namely in Canada, and on a more ad-hoc or individual basis a study was conducted which does point out the positive difference in performance between an accredited trauma centre versus 2 non-accredited ones [15]. The main outcome measure was actual versus predicted mortality and Length of Stay (LOS) was also presented. They conclude that over the 7 years of the study, the hospital with the trauma programme consistent with the Canadian accreditation criteria was statistically better than the other centres. Also the LOS for blunt trauma at the accreditation candidate bettered the other 2 centres on average by > 2 days.

Salmon et al conducted a randomised control trial of hospital accreditation in KwaZulu-Natal province in South Africa among 20 randomly selected public hospitals [16]. 8 Indicators of quality were measured among which nurse perceptions of quality, client satisfaction, accessibility and completeness of medical records, hospital sanitation,… With the exception of nurse perceptions of clinical quality, there was little or no effect on the quality indicators in the intervention hospitals.

Also outside the USA, and within the country scope of our International comparison of hospital accreditation programmes, it is interesting to refer to a lengthy (5 year) research initiative, known as Quest for Quality and Improved Performance (QQIP), which was conducted by The Health Foundation in 2006 with a focus on the quality of healthcare in the UK [17]. The study focused on the impact of regulatory interventions on quality of healthcare. Institutional regulation is divided into 2 categories:

- those concerned with direction, that is defining and communicating expected levels of performance
- those concerned with surveillance and enforcement, often referred to as external oversight

Target and standard setting are considered to fall within the 1st category whereas the researchers include accreditation and inspection into the 2nd category. The report states that within systems that rely heavily on accreditation, accredited organisations generally provide higher quality care. Yet it continues to conclude that there is no evidence to suggest that accreditation has secured improved quality. External oversight models are often used in tandem with directive approaches such as target and standard setting, as well as enforcement processes via the insurance of informal advice and formal reports, and in extreme cases delicensing or takeover. When discussing the link between accreditation as an institutional intervention the authors refer once again to the accreditation programme of the JCAHO. Historically this programme focused on structural standards but in recent years there has been greater emphasis on process and quality improvement. As of 2004, surveys included a methodology for evaluating actual care processes. On evidence of accreditation the authors state despite the huge level of resources spent on accreditation, there have been few evaluations that assess the effectiveness of accreditation as a lever to improve quality in healthcare.

And for the US they conclude in summary:

- Although there is some evidence of an association between quality of care and accreditation status, there is no evidence of causality. That is, the accreditation performance association could be explained by high performing organisations choosing to participate in accreditation, rather than accreditation processes leading to better performance or higher quality healthcare
- No correlation between JCAHO scores and alternative, evidence-based, measures of healthcare quality and safety
- No difference in the medical error rates between accredited and non-accredited hospitals
- No correlation between patient satisfaction scores and JCAHO survey scores
- Disjunction between outcomes measures and JCAHO evaluations
- JCAHO has acted as a key driver in the development of hospitals' patient-safety initiatives although no evidence of patient impact

Within the literature study on individual country level, there was only 1 pertinent result for France. In the International Journal for Quality in Health Care of 2003 [18], discussing the results of the first 100 accreditation procedures in France there is no outcome related evidence. The French accreditation procedure investigates (macro) processes and not outcomes. It is stated that 'until links between clinical processes and outcomes are studied further, we lack information about the relationship between these macro-processes and outcomes. Herein lies an area of research that might even question the overall effectiveness and efficiency of the accreditation process'.

In a study on 'Hospital Accreditation Policy in Lebanon: its potential for quality improvement' there is another reference to the French experience [19].

The authors investigated the impact of accreditation in French health care organizations and they concluded that accreditation in France resembles more an inspection than a continuous quality improvement process. In any case, to meet customers' needs and expectations, accreditation is one way of ensuring that processes to help organizations deliver safe, efficient, and reliable quality care. So, although a relationship between outcomes and accreditation may not/so far has not been proven to exist, its main benefit is its commitment to the quality of care.

An article from the Health Systems Research Centre, published in May 2003 on experience and lessons learned from accreditation and other external quality assessment (EQA) systems for healthcare [2] is the only result from the search strategy that refers to positive outcome effects as a result of accreditation programmes or EQA. In the article, a list of examples of indicators as used by different evaluation methods is presented. 1 of the outcome-related indicators is 'Incidence of infection', yet there is no reference to which schemes use this (or other outcome) indicator(s).

According to the same article, a review, conducted by the World Health Organisation on 12 experiences with EQA in 8 countries in 2002, 'found that in most cases there was evidence that the quality of services did improve'. As the reference is to a 'WHO draft 2002' it has been impossible to track and trace the document, so there is no confirmation to what extent the 'quality of services' does indeed refer to outcomes of healthcare.

And yet, in the International Journal for Quality in Healthcare [20], Charles Shaw states that the problem is, that in an increasingly evidence-based, very little hard data has been aggregated about:

- The uptake or market share of individual accreditation programmes at national level, and their impact on the health system
- The consistency, compatibility and validity of programmes as a basis for comparing health care providers, such as across Europe, and
- The costs and benefits of individual programmes to healthcare providers

From the above, one may conclude that evidence for a causal relation between accreditation and improved outcome is not found in the literature. It may be clear that the impact of accreditation has to be studied further. This can be done by analyzing the analogies with accreditation initiatives in the public health sector.

In addition, the pertinent articles used for this part of the literature research have not shown either any scientific evidence on the determination of standards used by the different programmes (e.g. JCHAO). As shown, the standards applied by the different accreditation programmes, even for similar processes like risk management for instance, vary enormously in terms of spread and depth. And in none of the articles from the literature study, neither from the International survey, there is indication that the starting point for determination of the specific standards is based on scientific research or evidence based.

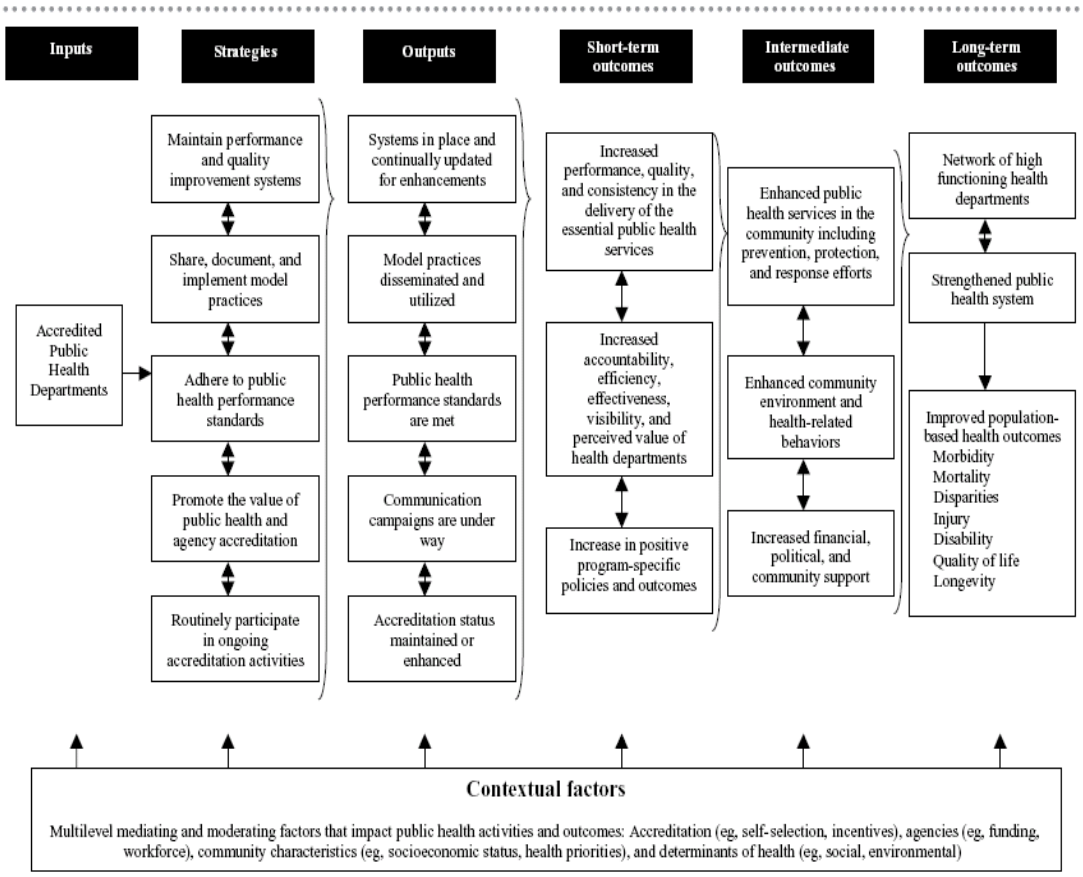
The need to study the relationship between accreditation and outcomes has been clearly formulated by different authors. Since it is hard to prove that outcomes are due to a programme and not due to something else, given the changing nature of each type of programme, their target, the environment, and the time scales involved it is difficult to evaluate them using conventional medical research evaluation methods. A more realistic and useful research strategy could be the description of a programme, its context and the factors which are critical for successful implementation as judged by different parties[21].

In a recent article by B. M. Joly et al.[22] present an investigational model that describes the relation between accreditation and public health outcomes.

The underlying assumptions are as follows:

- public health efforts result in positive changes to health status, and
- accreditation leads to quality improvement that, in turn, lead to the use of best practices thereby impacting community health (ultimate outcome)

Figure 3 : Linking public health accreditation and outcomes



Source: [22]

The model provides a framework for the investigation of outcome and success of accreditation. Inputs, strategy, outputs and contextual factors are identified. It allows for identification and evaluation of each element that may link accreditation and outcome. Example research questions are presented for each of these at the end of this paragraph.

Despite the broader scope of this article, a similar way of analyzing the relation between accreditation and outcome of hospital care might be interesting.

Inputs concern obviously the accredited hospitals. It should be mentioned that besides accreditation other factors may play a role in producing favourable outcomes.

The model describes 3 levels of outcome. For the use of such an approach in hospital accreditation focus should be in first instance on "short term" outcome. Intermediate and long term outcome definitions in this model however should be redefined.

Extrapolation of this experimental model, where the link between accreditation and outcome is analyzed may importantly define success and credibility of an accreditation program.

From the analysis of other service industries Mays G.P. [23] concluded the following:

- Little evidence was found for improved outcomes initiated by accreditation, and
- Different goals and objectives of accreditation could be found: improvement of service, standardization of services, improvement of competitiveness and decrease of political influence

Mays further identified the following possible potential values of accreditation in public health:

- Accreditation holds a potential for promoting improvement in service delivery, operations and outcomes,
- Accreditation programs infer important costs that should be balanced against potential benefits,
- These costs should be distributed and financed to assure participation to the program,
- Strong incentives are essential to make the program successful,
- The accreditation program should be governed by the stakeholders, and
- Accreditation programs should facilitate evidence based practice, with a consistent link to desired outcomes

Expected benefits from accreditation are summarized by P. Russo in a recent editorial [24].

The most evident potential benefits of accreditation should be:

- to set a benchmark of consistent standards,
- to create a platform for quality improvement and
- to provide a means for documenting accountability to the stakeholders.

The formation of a steering committee was endorsed in the US by NACCHO, the Association of State and Territorial Health Organizations, the National Association of Local Boards of Health and the American Public Health Association. The task of this steering committee was to explore accreditation. This steering committee used the above described logistic model to develop final recommendations[ix].

[ix] http://exploringaccreditation.org

Table 5 : Example research questions

Inputs
How do applicants for accreditation differ from nonapplicants?
What is the impetus for seeking voluntary accreditation?
How do successful applicants differ from unsuccessful applicants?
What is the optimum time for reaccreditation?
Strategies
Are accredited departments more likely than nonaccredited departments to have performance and quality improvement systems in place?
Are accredited departments more likely than nonaccredited departments to share, document, and implement model practices?
What capacity and agency characteristics are needed to carry out the documented strategies depicted in the logic model?
Output
Are accredited departments more likely than nonaccredited departments to have continually updated performance and quality improvement systems?
Are accredited departments more likely than nonaccredited departments to meet performance standards?
Are accredited departments more likely than nonaccredited departments to have communication campaigns under way?
Do accredited departments' scores remain level or improve over time?
Does the accreditation process improve the visibility of the local health department in the community?
Short-term outcomes
Are accredited departments more likely than nonaccredited departments to increase the quality and consistency in the delivery of the essential public health services?
Are accredited departments more likely than nonaccredited departments to increase the accountability, efficiency, effectiveness, visibility, and perceived value of health departments?
Are accredited departments more likely than nonaccredited departments to demonstrate an increase in positive program-specific policies and outcomes?
Is there a linear relationship between accreditation and improved performance over time (eg, local health department improvement with first cycle and then plateau)?
What standards have high "sensitivity and specificity" (ie, show the health departments that function below an acceptable level of functioning and the ones that do not)?
Intermediate outcomes
Are accredited departments more likely than nonaccredited departments to have enhanced public health services in the community including prevention, protection, and response efforts?
Are accredited departments more likely than nonaccredited departments to have increased financial, political, and community support?
Are accredited health departments more likely than nonaccredited departments to achieve positive program-specific policies and outcomes?
What performance standards are linked to outcomes?
What specific outcomes can be measured and attributed to accreditation?
Does accreditation foster better connections between the health department and community stakeholders?
Long-term outcomes
Are accredited departments more likely than nonaccredited departments to be part of a network of high-functioning departments?
Is the overall public health system stronger because of accredited departments?
Are accredited departments more likely than nonaccredited departments to have positive population-based health outcomes?
Contextual factors
What incentives and resources are necessary for accreditation?
To what extent do agency characteristics and priorities impact performance scores?

Source: [22]

4.3 INTERNATIONAL SURVEY: LACK OF EVIDENCE

The International Survey carried out in the context of this project did address the question on the measurement of outcomes. More precisely, the following question was included in the survey: Do you have data to quantify beneficial impacts of accreditation on hospitals, staff, patients?

Whenever the answer was positive the country was asked to identify. However, as pointed out in Chapter 5.1.3 'Synthesis of the literature study results and the survey answers' only 1 country, namely Ireland claims to have outcomes related data based on performance statistical indicators. Yet, Ireland did not provide any details.

The NHS QIS in Scotland and the UK Healthcare Commission, both accreditation agencies linked to the respective governments, indicated that currently research/audits on their effectiveness are carried out and will/should be delivered in 2007. Meanwhile the Scottish study has been released and seeks to evaluate the impact of NHS QIS both as a whole and in representative areas of its activity [25].

The evaluation was carried out between September and December 2006 and was conducted using semi-structured interviews at 3 levels of NHS Scotland personnel:

senior management in NHS Scotland Boards, practising clinicians and closely associated managers ("practitioners"), and senior members of the Academy of the Royal Colleges and faculties in Scotland. The views and experiences of patients and the general public were seen as significant, though it was recognised that a different approach would be needed to reliably identify and assess these views. At this stage, therefore, research with patients and public has been deferred. So, the study does focus on reported views (perceptions) on outcomes rather than measurement of direct outcomes.

The main findings of the report can be summarised as follows:

- 60% of senior managers and 55% of practitioners reported an increase in professional knowledge as a results of NHS QIS initiatives
- 72% of senior managers and 65% of practitioners reported a change in policy or practice as a result of NHS QIS initiatives
- 62% of senior managers and 65% of practitioners reported a belief in improved patient outcomes as a result of NHS QIS initiatives

It will be interesting to see what conclusions are drawn from the UK Healthcare Commission report and whether measurement of (direct) outcomes is included.

4.4 POSSIBLE REASONS FOR THE LACK OF EVIDENCE

Given the above, it turns out, both from the literature study and the International survey which was conducted amongst the 26 other Member States of the European Union (cfr Chapter 2 'Global methodology'), that there is surprisingly no unambiguous outcome related evidence to be found:

- The research conducted does not prove that healthcare quality delivered by accredited healthcare institutions does improve (apart from individual cases)
- In case that positive outcomes or quality improvements are reported there is no model to establish a causal relationship between the quality concept in place (accreditation, certification or licensing) and the results, or the association is not statistically significant
- There are some biases hampering the sound proof of an existing causal link:
    - In some cases accreditation leads to paradox results as the improved registration of quality or process related data (initially) leads to increased incidents or cases having a negative impact on the results
    - In voluntary systems, the hospitals participating in accreditation are often those already interested in quality improvement and are already of higher quality (selection bias) [8]
    - A program effect may occur. Organizations that participate in an accreditation program may improve their service in advance to achieve program standards than because of the accreditation [23]

Based on the research there are multiple possible reasons why outcome indicators have not been integrated in the accreditation programmes and why evidence on the outcome effects of accreditation is not present.

For a start, the standards applied in most accreditation programmes do not concern outcome related performance indicators. As a matter of fact the pattern in the different programmes is to focus mainly on 'process indicators' which as such should guarantee optimised exchange of information, communication and rigour of actions.

This in turn should play in favour of the eventual care received by the patient. The reasons why the existing accreditation programmes have (yet) not integrated outcome standards seem many-fold:

- Accreditation is not a single defined intervention [26]: Impact on the outcomes is not merely related to the actions of the hospital but also a result of the interactions with other actors
- Stakeholders rarely agree on the intended outcomes [27]: and as long as the causal relationship between accreditation programmes is not proven it will be 'easier' to include process indicators in the standards
- The respective authorities in the Member States do not formally engage in an evaluation of the respective accreditation programmes in place (except for NHS QIS and Healthcare Commission, who have evaluations underway), meaning that apparently there is belief that the creation of quality dynamics at hospital level, resulting in optimization of processes & procedures, modified organisation structures and creation of a quality culture, does inevitably lead to improved outcomes.

As far as (scientific) comparative analyses were launched to evaluate established programmes of their outcome impact, the lack of evidence is confirmed and/or the evaluations have not used comparable methods to permit synthesis [20].

The experience of the last decade shows that accreditation has been a valuable means for quality improvement dynamics in many settings. Yet, as mentioned no link between outcomes and accreditation programmes can be proven and the International survey did not shed any additional light either. The effectiveness of an accreditation programme, as well as its affordability and whether it will be sustainable, depends on many variable factors (regulation, incentives, perception,…) of the specific healthcare environment of the country or organisation involved. It also depends on the kind of programme, and how it is implemented [4].

To conclude, despite the amount of time and money spent on hospital accreditation programmes, there is relatively little research into the cost effectiveness of these schemes, and therefore still no proof of improved outcomes as a (direct) link to programmes implemented. Based on the articles included in the literature study, with a focus on the JCAHO experience, it could be stated however, that accreditation has been a valuable means for quality improvement dynamics in many hospitals.

Key points

- **No evidence was found for a positive causal relation between accreditation and outcome**
- **Accreditation programs focus importantly on structure and organisational processes with less importance given to clinical outcome indicators**
- **A model based approach to study the relation between accreditation and outcome should be defined**
- **Accreditation may initiate a quality improvement dynamic in an organization**

5 RESULTS

5.1 INVENTORY AND COMPARATIVE ANALYSIS OF HOSPITAL ACCREDITATION PROGRAMMES IN EUROPE

5.1.1 Country overview

An overview of the detailed summaries per country developed in appendix 10 is provided in the following table. The European Union countries have been first sorted out by programme status and then, in each of the 4 developed categories, by descending order of completeness (i.e. information available based on the literature study and survey).

Table 6 : Classification of countries by programme status and completeness of information

Programme status	Countries
Programme	1. France 2. Netherlands 3. UK (3) 4. Ireland 5. Scotland 6. Spain (7) 7. Portugal 8. Germany 9. Latvia 10. Poland 11. Czech Republic 12. Bulgaria 13. Finland 14. Luxemburg (2) 15. Italy (5)
In development	16. Denmark 17. Lithuania
Under discussion	18. Hungary 19. Slovakia
No programme	20. Cyprus 21. Austria 22. Malta 23. Greece 24. Sweden 25. Estonia 26. Slovenia
No information	27. Romania

They appear in this order in the appendix 10. These summaries are based on the information that stems from the literature study AND the International Survey carried out in the context of this project.

The summary for each country is based on the 5 elements of the Common Framework as developed in Chapter 2.1 'Determination of the framework to analyse accreditation':

- Policy
- Governance
- Methods
- Funding mechanism & sources
- Evaluation

Whenever relevant the literature sources are mentioned, the other data used originate from the survey.

5.1.2 Qualitative analysis of the literature study results and the survey answers

5.1.2.1 Programme status

The status of the 27 European Union countries' programmes is detailed in the table below.

It shows that 52% of these countries have 1 or more accreditation programmes on their territory, that 7% are currently developing a programme, that 7% are at the discussion stage and that 30% have no programme at all. Information is lacking for Romania.

Table 7 : Countries programme status

% of countries	Number of countries	Number of programmes	Programme status	Countries
52%	14	28	Programme	Bulgaria Czech Republic Finland France Germany Ireland Italy (5) Latvia Luxemburg (2) Netherlands Poland Portugal Scotland Spain (7) UK (3)
7%	2	2	In development	Denmark Lithuania
7%	2	0	Under discussion	Hungary Slovakia
30%	8	0	No programme	Austria Belgium Cyprus Estonia Greece Malta Slovenia Sweden
4%	1	0	No information	Romania
100%	**27**	**25**		

In the following analysis, only the programmes for which the completed survey was received and which appear as established or in an advanced phase of development will be considered. These 19 programmes are Bulgaria, Czech Republic, Denmark, Finland, France, Ireland, Italy - Marche, Latvia, Luxemburg - Autorisation d'exploitation, Luxemburg - Incitants qualité, The Netherlands, Poland, Portugal, Spain - FADA-JCI, Spain - Andalusia, Spain - Valencia, UK - Healthcare Commission, UK - HAQU and

Scotland. Besides, it was agreed that percentages used for the results' description would be calculated on the basis of the number of programmes for which information was available, what means that the analysis' coverage does not always include all these 19 programmes.

5.1.2.2 Policy

PROGRAMME INTENTIONS

As far as the purpose of the accreditation programme is concerned, only 7 out of 19 programmes (37%) responded and for all of them quality improvement is the main goal. Of those from the remaining programmes, no information was received on the purpose. It is beyond doubt that the implicit goal for a vast majority of the programmes is indeed quality improvement.

10 out of 19 programmes (53%) are based on a voluntary application, 8 (42%) are mandatory[x] and 1 combines both systems. Indeed, the participation to Andalusia's accreditation programme is voluntary for the private health care centres and compulsory for the public ones.

In addition, 54% of the programmes (7 out of 13) assess hospitals against their capability to 'come close to' the defined standards. 31% (4 out of 13) mix them with target standards whilst 2 countries apply minimal standards only, namely Bulgaria and Latvia. These minimum criteria are used to ensure essential requirements while target criteria are implemented to support moving towards excellence.

If both characteristics are combined, it appears that a majority of the programmes (54% - 7 out of 13) proposes a voluntary system which includes target standards. A minority (31% - 4 out of 13) is mandatory but comprises at least developmental criteria. The Bulgarian and the Latvian programmes are the only programmes that are mandatory with minimal standards alone.

PROGRAMME SUPPORTIVE STRUCTURE

Most of the programmes (94% - 16 out of 17) are authorized by law and/or written into a government policy on quality and/or have the composition of their accreditation organization's governing body determined by an enabling legislation, while 1 has none of these characteristics, i.e. the UK - HAQU programme.

Besides, 13 out of 19 programmes (68%) have a link with the government as they are managed within the Ministry of Health, by a separate government agency or by an independent agency with governmental representation, when the 6 left are totally independent of the government. In parallel, the legal status of the accreditation organization is a government agency for 47% of the programmes (8 out of 17), a not-for-profit organization for 35% (6 out of 17) of them and a commercial entity for the last 18%. It then appears that programmes related to the government have an accreditation organization that is a government agency or a not-for-profit organization while independent programmes have a commercial entity or a not-for-profit organisation.

If these characteristics are considered from a global point of view, a significant majority of the programmes (76% - 13 out of 17) are officialised by laws or government quality policy and are linked to the government. 18%, that is the Dutch, the Luxemburg - Incitants qualité and the Spain - FADA-JCI programmes, are embedded in a law or fit within a larger quality policy but are independent from the government. Only the UK - HAQU programme is not included in a law or in a governmental quality policy and is independent from the government.

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x A mandatory programme is a programme whose participation is required by a law or a decree

PROGRAMME INCENTIVES

The desire for improvement is the most cited incentive for the hospitals' participation to the programme (used by 63% of the programmes – 12 out of 19). It is followed by the statutory requirement (used by 47% - 9 out of 19), the marketing (used by 32% - 6 out of 19), the contractual requirement by purchasers (used by 26% - 5 out of 19), the additional funding (used by 21% - 4 out of 19), the academic recognition for training (used by 11% - 2 out of 19) and the staff recruitment (used by 5% - 1 out of 19).

These motivators can be filed in 4 categories: desire for improvement; statutory and contractual requirements; marketing, academic recognition for training and staff recruitment and additional funding.

It appears then that different mixes of incentives are put in place by each programme. Indeed, some programmes (37% - 7 out of 19) use only 1 kind of incentive, so Ireland, Spain - FADA-JCI and UK - HAQU use only the desire for improvement, Latvia, Luxemburg - Autorisation d'exploitation and UK - Healthcare Commission use only the statutory and/or contractual requirements and Czech Republic uses only marketing. Others (42% - 8 out of 19) combine 2 kinds of motivators and few (21%) mixes 3 types of drivers. Denmark, Finland, France and Poland are part of this last category, using desire for improvement and statutory and/or contractual requirements with marketing, academic recognition training and staff recruitment or additional funding incentives.

PROGRAMME COVERAGE

16 out of 19 programmes (84%) include public and private facilities while the 3 left, that is the Bulgarian, Irish and Portuguese programmes, are limited to the public hospitals.

Besides, most of the programmes (11 out of 13 - 85%) cover the entire hospital and the 2 left relate to different services of the hospitals. So, Valencian and Scottish programmes have different programmes for each medical specialty.

Finally, 74% of the programmes (14 out of 19) concern the entire country's territory while 26% are regional, that is Italy - Marche, Spain - Andalusia, Spain - Valencia, UK - Healthcare Commission and Scottish programmes.

If these dimensions are aggregated, 7 out of 13 programmes (54%) are global as they apply to both types of hospitals, to the entire hospital and to the entire country. The countries which have regional programmes are UK, Spain and Italy.

5.1.2.3 Governance

BODY STAKEHOLDERS' PARTICIPATION

The clinical professionals are the most represented in the accreditation organization's governing bodies (represented in 68% of the programmes – 13 out of 19). They are followed by the hospital owners (represented in 37% - 7 out of 19), the regulators (represented in 37% - 7 out of 19), the users (represented in 32% - 6 out of 19), the academic/training institutions (represented in 26% - 5 out of 19) and the health care insurers (represented in 16% - 3 out of 19). The Latvian programme has no external representatives in its body for the moment but there are discussions for changes.

Various combinations of stakeholders appear in respective governing bodies having external representatives. Indeed, a minority of the accreditation organizations (28% - 5 out of 18) has only 1 category represented, so Bulgaria and Czech Republic have hospital owners only, Italy - Marche and Luxemburg – Autorisation d'exploitation have regulators only and Portugal has clinical professionals only. A majority (61% - 11 out of 18) has 2 or 3 categories represented and a significant minority (12%) has 4 or 5 categories represented. The Irish and French programmes are thus the most diversified in terms of stakeholders' representatives with clinical professionals, hospital owners and users, plus academic/training institutions for Ireland, and regulators and health care insurers for France.

5.1.2.4 Methods

STANDARDS

When (first) developing the standards for their accreditation programmes a majority (68% - 13 out of 19) of the programmes was inspired by the accreditation philosophy and programmes already established. The remaining part has been inspired by other models like ISO and EFQM. In the process of developing those standards 12 out of 18 (67%) consulted the stakeholders of the accreditation programme, yet 22% (4 out of 18) did not consult outside the internal organisation at all. (Remark: depending on the composition of the governing body it may still imply that stakeholders were part of the consultation).

For a significant majority of the respondents (83% - 15 out of 18) the same set of standards is applied for any hospital subject to assessment independent of the type of hospital. The fact that standards do not or rarely concern outcome indicators and are to a large extent focused on process indicators explains that most are generic.

As far as the processes are concerned, which form subject to evaluation based on the standards, all respondents who provided information (13 out of 19) except Latvia include clinical processes and actually 69% (9 out of 13) of them do cover the entire process model of the hospital i.e.

- clinical processes;
- internal support processes;
- governance processes

The set of standards applied is not static and does evolve over time:

- 11 out of 17 (65%) have standards which have been approved since 2004 and more recent
- 86% (12 out of 14) have revised their standards at least once of which half have published 3 or more revisions

MEASUREMENT

Looking into the different methods which are used as part of the programme for hospital assessment 'self assessment' (74% - 14 out of 19) and 'scheduled external reviews' (84% -16 out of 19) are common components, and a majority of almost 63% (12 out of 19) apply both 'self assessments' and 'planned external reviews'. The use of 'unannounced external survey' seems exceptional with only UK - Healthcare Commission reporting to do so. Luxemburg – Autorisation d'exploitation uses periodic statistical reporting as unique method of assessment.

In order to prepare themselves for the 'self assessment' and the 'scheduled external review', for a significant majority of the respondents (81% - 13 out of 16), it takes maximum 1 year. The maximum number of days for a full on-site survey for a 100-bed hospital is for 86% of the programmes (12 out of 14) maximum 4 days. The teams are in most cases (81% - 13 out of 16) composed of 3-6 surveyors with only Luxemburg - Incitants qualité and UK - Healthcare Commission having a 'team' of 1-2 surveyors and Scotland a team of more than 6 surveyors. These teams are accompanied by external observers in 71% of the programmes (12 out of 17).

In all cases multidisciplinary teams are formed to conduct the survey with 13 out of 16 respondents (81%) reporting at least 3 different profiles. 5 programmes (Denmark, France, Netherlands, Portugal and Spain - Andalusia) include 4 different profiles: management, nursing, doctors and others.

During the assessment the majority (68% and above - at least 16 out of 19) require documented evidence on:

- Either, adoption of clinical practice guidelines,
- Or routinely availability of clinical governance indicators
- Or clinical practice being subject to formal review

Only for 2 programmes for whom information was available there is no requirement related to clinical practice at all, namely for Latvia and Poland.

In all the 17 programmes, except for Spain - Andalusia, the survey team does report back key findings of the survey to senior management of the hospital at the end of the visit. In addition, in 72% of the cases (13 out of 18), the draft survey is referred back to the hospital prior to submission for accreditation award. Spain - FADA-JCI and Spain – Valencia do not 'communicate' with the hospital in terms of draft reference, as is also the case for Czech Republic, Latvia and the UK - Healthcare Commission.

SURVEYORS RECRUITMENT AND TRAINING

As far as the selection, recruitment and training of surveyors is concerned there is a wide variety on the number of surveyors available by the accreditation organisation and the duration of the induction training they attend, although for 70% (12 out of 17) this is between 1-4 days.

CHANGE MANAGEMENT

In terms of services provided by the accreditation organisation, as a mean to assist the hospitals in getting acquainted with, and preparing for, the accreditation programme, there is very limited information available (7 out of 19 did not provide information). The other respondents provide tools, training or consultancy. Denmark, Portugal, Spain and the UK -HAQU offer all these 3 services.

DECISION AND APPEAL

In the accreditation decisions (the awarding) there are distinct differences:

- 5 out of 11 (45%) apply a binary system i.e. 'accredited' versus 'non-accredited', namely Bulgaria, Latvia, The Netherlands, Spain – FADA-JCI and UK - HAQU
- 6 out of 11 (55%) apply different levels, namely France, Ireland, Spain (Andalusia & Valencia), UK - Healthcare Commission and Scotland

As far as the validity period of accreditation is concerned there is also large variety amongst the different countries, yet the minimum duration is 1 year and maximum 5 years. 53% (9 out of 17) have 3 years cycles whilst for the remaining countries there is a split between 1 (Luxemburg – Incitants qualité), 4 (18% - 3 out of 17) and 5 years (24% - 4 out of 17) respectively. France has recently changed the duration from 5 to 4 years.

The turnaround time between the on-site survey and the delivery of the final report varies widely between the different programmes, yet 44% (7 out of 16) report a duration between 1-4 weeks, while here is the same significant minority where the duration takes between 5-8 weeks. Only in the case of France and Luxemburg - Incitants qualité the turnaround exceeds 8 weeks.

Independent of the mandatory or voluntary character of the accreditation programme in 18 out of 19 programmes (95%) there is a defined mechanism for hospitals to appeal the accreditation decision. Only in Bulgaria an appeal mechanism does not exist.

RESULTS DIFFUSION

Most programmes (63% - 12 out of 19) put the results of the hospital survey reports at the disposal of the public by means of the internet, yet 3 out of those 12 (Czech Republic, Spain - Valencia and UK - Healthcare Commission) make a distinction as to what information is available, for which hospitals or on request.

Only 11 out of those 12 gave information about the nature of the information available on the internet. On these, 2 (18%) provide a detailed report of the results of the hospital, namely France and UK - Healthcare Commission, whereas the significant majority of 82% limit themselves to high level information like the name of the accredited hospital and/or high level summary of the results.

The remaining 37% of the programmes (7 out of 19) do not diffuse survey information to the public at all.

5.1.2.5 Funding mechanism & sources

PROGRAMME INCOME

Most of the respondent programmes (82% - 14 out of 17) have been initially funded by international aid and/or central government and/or local government, while 2 (12%) have been financed by voluntary sector, as the Spain - FADA-JCI and UK - HAQU programmes, and 1 by professional associations, that is the Dutch programme.

Besides, 58% of the programmes (11 out of 19) charge the hospital per product or service provided, 21% (4 out of 19) ask no fee to the participating hospitals, as the Danish, Irish, Luxemburg - Autorisation d'exploitation and Scottish programmes, 11% apply an annual subscription system, as the Dutch and the Portuguese programmes, and the last 11% combine the fee per service with the annual subscription, as the UK – Healthcare Commission and the UK - HAQU programmes.

Amongst the not-free programmes, the majority (54% - 7 out of 13) charge between 450 and 10.000 EUR for the accreditation survey of a 100-bed hospital while a minority (46%) charges over 10.000 EUR. Portuguese and UK - Healthcare Commission programmes have the most important fee.

It includes accreditation decision and certificate for 100% of the programmes (13 out of 13), expenses of the survey team for 85% (11 out of 13), facilitation and preparation for 54% (7 out of 13), self-assessment documentation for 46% (6 out of 13) and induction of hospital staff for 31% (4 out of 13). 1 out of the 13 responding programmes covers only the accreditation decision and certificate, that is the Finish programme. 7 out of 13 programmes (54%) cover 2 or 3 types of cost, and the 5 left (38%) cover 4 or 5 categories. So the Portuguese, Spain - Andalusia, Spain - Valencia, UK - Healthcare Commission and UK - HAQU programmes include all or almost all items.

These fees represent between 51 and 75% of the 2006 total income for 44% of the programmes (4 out of 9), between 3 and 25% for 3 programmes and over 75% for the Dutch and the Latvian programmes.

PROGRAMME EXPENSES

6 out of 10 programmes (60%) have spent a total amount of more than 200.000 EUR for running the accreditation programme, 30% (3 out of 10) spent between 100.001 and 200.000 EUR and Czech Republic spent less than 100.000 EUR. The French and UK - Healthcare Commission programmes are the most expensive, while the Czech programme seems to be the cheaper one. Yet these conclusions have to be out in perspective, amongst others, in terms of:

- The absolute amounts in the light of the welfare level e.g. Czech Republic as compared to UK for instance
- The absolute amounts related to the number of hospitals in scope/covered
- The structure of the accreditation agency, the steps in the accreditation process (how heavy is the process with interventions from the agency, …)
- …

Taking these criteria into account and focusing on the key countries from which we have received relevant information the following table can be developed:

Table 8 : Income, expense and number of hospitals covered by key accreditation programmes

Country programme	Income (fees from 100-bed hospital) in 2006	Expense (total costs of running the programme)	# of hospitals covered in 2006
France	10.380 €	20.275.000 €	2948
Ireland	No Info	3.500.000 €	44
Luxemburg	20.000 €	8.000.000 €	No Info
UK Health Care Commission	37.204 €	59.483.000 €	808

This table shows on the one hand a large variety in terms of fees to be paid, the number of hospitals covered and the total (annual) costs of running the programme. If one considers that costs above 1 million € as 'significant', then the only real conclusion is that for all countries in the table, significant costs are generated. Yet if one were to project these data on the Belgian context one may draw the conclusion that most likely the expenses in order of magnitude will also be in millions i.e. between 5.000.000 € - 10.000.000 €. Once again this figure would have to be related to the actual modalities of the programme.

Besides, 42% of the programmes (8 out of 19) pay their surveyors through a professional fee per day of work, 32% (6 out of 19) reimburse them their actual expenses and 26% use both systems to remunerate the assessors. These professional fees vary from 60 to 1.600 EUR per day.

5.1.2.6 Evaluation

PROGRAMME OUTCOMES AND MEASUREMENT

A majority of the programmes (74% - 14 out of 19) do not have data to quantify beneficial impacts of accreditation on hospitals, staff or patients while a significant minority (26%) states to have such. Amongst them, the French programme cites the perception of professionals gathered through satisfaction surveys and Irish, UK - Healthcare Commission and Scottish programmes specify they have launched a study over the effectiveness of accreditation or have recently undertook impact assessment which results will be published in a near future (cfr Chapter 4.3 'International survey: lack of evidence' for details about the Scottish report).

Besides, 79% of the programmes (15 out of 19) do not use statistical indicators to evaluate their performance, while 21% does as Ireland, Spain - FADA-JCI, Spain - Valencia and UK - HAQU. Curiously, these countries have not reported to have performance data above, except Ireland.

PROGRAMME LINK TO ISQUA STANDARDS

Most of the programmes (63% - 12 out of 19) have formally agreed to align their work on the ISQua standards while the others have not. Some of these ones, as Spain - Andalusia and Spain - Valencia programmes, have however mentioned their interest and have already or will soon establish contacts with that international organization.

PROGRAMME KEY INDICATORS

A way to assess the attractiveness of a programme is to measure the number of participating hospitals on the number of eligible hospitals for the programme, at least for the non-mandatory programmes.

When doing so, 9 out of 14 programmes (64%) have a rate superior to 75%, but these ones are compulsory except Luxemburg – Incitants qualité, 2 programmes (14%) have a rate comprised between 26 and 75% and 3 programmes have a rate comprised between 2 and 25%.

The way to evaluate the sustainability of a programme is to observe the evolution of the number of surveys done. Observations show that 4 out of 6 programmes (67%) grow, 1 keeps the same level of activity and the last 1 decreases.

To the question "What do you consider as the key elements for improvement to optimize the accreditation programme?" following answers were received:

Bulgaria

For each clinical department, the accreditation should be the following:

- Medical standards for quality in healthcare for all activities in the clinics; - developing and performing equal standards for all the countries in EU.
- Management of the medical activities; -establishing and performing the best world and European practices, universal ones, according to the local laws in each country.
- Ensuring the clinics with proper human resources and providing adequate technical equipment. –this supply would be individualised to each country in compliance to it's economical status, but absolutely enough to ensure quality in medical services and patient safety and without compromises with medical standards.

Denmark

Since the programme is essentially mandatory from the point of view of the hospitals, it is essential that standards and indicators are perceived as useful, not too bureaucratic and not associated with an excessive registration burden. As the philosophy is to build quality improvement on data, a key improvement would be the development of methods to extract quantitative indicators directly from electronic patient records, patient administrative systems and all other ready existing data sources.

Ireland

Each characteristic of the programme could be improved but the constant evolution of standards is the priority.

The Netherlands

The key elements for improvements relate to the standards, the internal organisation and the training programme of surveyors accredited by ISQUa.

Portugal

To strength the support provided to the hospitals during the accreditation process is a key element for improvement.

Spain - Valencia

The key elements for improvement are the implementation of a feedback system from the users and stakeholders, the publication of a legal text authorizing the programme and a benchmark.

UK - HAQU

Continuous internal and external evaluation to highlight the areas that need improvement constitutes the key element for improvement. This covers standards revisions, format of standards and other materials, surveyor training, surveyor up-dating, information and support materials for participating organisations, report format, committee procedures to make accreditation decisions, etc.

5.1.3 Synthesis of the literature study and survey results

Many countries who participated in the survey, mainly 14 out of 18 (78%), have an accreditation programme in place.

- Among the accreditation programmes, there are no patterns to be distinguished in terms of the 5 elements of the common framework, and they turn out to be very different in nature.
- As far as the effect perspective is concerned (5th element of the framework), it is striking that the majority (74% of the programmes - 14 out of 19) does not have outcomes related data at their disposal. Within the remaining 26% only Ireland seems to have outcomes related data based on performance statistical indicators. Note: Ireland did not provide any details (the study performed by an external party is not published yet). However, there is a visible trend regarding the adherence to ISQua standards: more and more programmes (8 out of 14 in 2004' survey, 11 out of 14 at present) agree to work towards meeting them.

On the 4 building blocks of the framework, the following conclusions may be drawn:

Policy

- There is no clear pattern towards either the mandatory[xi] or the voluntary character of the programmes, however, apart from Spain - Andalusia applying both depending of the public/private status of the hospital, there is a slight tendency towards voluntary systems (53% - 10 out of 19)
- With the exception of Bulgaria and Latvia, all the responding programmes (85% - 11 out of 13) apply target standards, reflecting the quality improvement dynamics of the programme, namely a clear driver for hospitals resulting in optimization of processes & procedures, modified organisation structures and creation of a quality culture.
- In most of the programmes (94% - 16 out of 17), the accreditation programme is embedded in a strong supportive structure by means of law and/or government policy and/or composition of the governing body except for the UK - HAQU ; 10 out of 14 programmes (71%) have a law
- There is no visible pattern towards the governmental (47% - 8 out of 17) or non-governmental (53% - 9 out of 17) status of the accreditation organization, yet it is interesting to point out the existence of the commercial nature of the entity in 18% of the

xi A mandatory programme is a programme whose participation is required by a law or a decree

programmes i.e. The Czech entity, the Finnish entity and the UK - HAQU entity are all commercial entities

- There is a clear trend of increasing government involvement in the accreditation programmes as more and more (4 out of 14 in 2004's survey, 6 out of 14 at present) are managed within the Ministry of Health or by a separate government agency
- The 'desire for improvement' and the 'statutory requirement' are the most cited incentives by the programmes and are in most cases mixed with other motivators ; Czech Republic uses only the marketing incentive and additional funding is used by 21% of the programmes (4 out of 19).

  It is important to understand the link between the accreditation programme and the health care financing system to be sure to interpret the hospital participation rate in a correct way.
- Most of the countries (79% - 11 out of 14) have a national programme; UK, Spain and Italy are the only countries to have regional programmes

Governance

- The clinical professionals, the hospital owners and the regulators are the most represented categories on the governing bodies and are in general mixed with other stakeholders (72% - 13 out of 18) ; Italy - Marche and Luxemburg - Autorisation d'exploitation have only regulators in their board and Latvia has no external representatives

Methods

- When developing standards, the 'accreditation model' is preferred as a reference above ISO or EFQM by a majority of the programmes (68% - 13 out of 19). In addition, in 69% of the programmes (9 out of 13), the standards cover the entire process model of a hospital.
- In terms of the different methods which are used as part of the programme for hospital assessment there is a pattern to apply both 'self assessments' and 'scheduled external reviews' (63% - 12 out of 19). 'Unannounced external survey' is extremely rare and only used by UK - Healthcare Commission; Luxemburg - Autorisation d'exploitation uses periodical statistical reporting only. From a practical perspective for a 68%+ majority of the accreditation programmes
  - It takes maximum 1 year to prepare and conduct the 'self assessment' and 'scheduled external review';
  - The maximum number of days for a full on-site survey for a 100-bed hospital is maximum 4 days;
  - Multidisciplinary teams composed of 3 profiles or more conduct the survey;
  - Documented evidence is required on clinical practice components;
  - There is dialogue between the survey team and the hospital, both at the end of the visit concerning the main findings of the survey and in finalising the draft for accreditation submission
- Concerning the kind of decisions that are taken, 2 models can be distinguished within the accreditation programmes:
  - A binary system i.e. 'accredited' versus 'non-accredited' which counts for 45% of the programmes (5 out of 11)

- Different levels, namely in 55% of the programmes (6 out of 11)

- The validity term of an accreditation 'award' tends to be 3 years (53% - 9 out of 17)
  - In all the responding programmes apart for Bulgaria (95% - 18 out of 19), there is a defined mechanism for hospitals to appeal the accreditation decision
  - There is a visible trend regarding the publication of this decision: more and more programmes (5 out of 14 in 2004's survey – 9 out of 14 at present) make the hospitals' results available to the public

Funding mechanism & sources

- Apart from The Netherlands, which was created by a professional association, and Spain - FADA-JCI and UK - HAQU which were launched by the voluntary sector, all the responding programmes (82% - 14 out of 17) have initially been funded by governments or international aid
- A focus on 4 countries (France, Ireland, Luxemburg and UK Health Care Commission) shows that the costs for running the accreditation programme are significant i.e. between 3,5 mn. € (Ireland) and 60 mn.€ (UK Health Care Commission)
- There is a clear pattern in 79% of the programmes (15 out of 19) to charge services to the hospitals either by means of fees or by means of an annual subscription system. Yet, the amount of these fees varies heavily, ranging from 450 to over 10.000 EUR. Logically this also depends on the services included e.g. facilitation and preparation, self-assessment documentation, induction of hospital staff, accreditation decision and award, etc.
- For most of those who apply charges to the hospitals (67% - 6 out of 9), in 2006, over 50% of the total income was generated by the hospitals
- From a cost perspective the amounts involved and their nature differ to an extent that conclusions can not be drawn

As France, The Netherlands and UK are the countries for which there is the largest amount of information, a specific analysis regarding the main elements of the Common Framework has been developed.

Policy

- France applies a compulsory system while The Netherlands leaves the choice to participate to the hospitals. In UK, disparities appear between the 2 programmes in place: UK - Healthcare Commission is mandatory but UK - HAQU is voluntary. According to Pomey et al.[19] the fact that accreditation is mandatory lends itself to ambiguity and likens the process to an inspection. The consequence could be that establishments reduce quality processes to nothing more than the completion of accreditation and to focus efforts on standardizing practices and resolving safety issues to the detriment of organisational development. The fact that in countries where accreditation is not mandatory, the majority of the healthcare organisations subscribe to it spontaneously, questions all the more the relevance of a mandatory system.

- A government agency manages the French programme but this role is given to a totally independent organization in The Netherlands. Again in UK, link to the government depends of the programme: UK - Healthcare Commission is managed within the Ministry of Health while UK - HAQU is totally independent
- In France, desire for improvement and marketing are identified as incentives for hospitals besides the statutory requirement while The Netherlands puts the emphasis on the desire for improvement and the contractual requirement by purchasers.

  In UK, statutory requirement and desire for improvement are the only motivators respectively identified by UK - Healthcare Commission and UK - HAQU

→ No pattern in terms of policy

Governance

- France counts 5 categories of stakeholders in its governing body, including clinical professionals, hospital owners, regulators, users and health care insurers while The Netherlands is represented by 3 types, i.e. clinical professionals, users and healthcare insurers. In UK, only 2 categories are involved: clinical professionals and users for UK - Healthcare Commission, and clinical professionals and academic/training institutions for UK - HAQU

→ Clinical professionals are in all cases represented on the programme's governing body

Methods

- Accreditation inspired the design of the French standards while EFQM is also mentioned by the Dutch programme. In UK, accreditation constituted the reference for the UK – HAQU but none of the traditional models has been used by UK - Healthcare Commission
- The current standards cover the entire processes of the hospital in the French, Dutch and UK - HAQU programmes, while UK - Healthcare Commission covers only clinical and governance processes
- 'Self-assessment' and 'scheduled external survey' are used as assessment methods by the French and UK - HAQH programmes while The Netherlands uses also formal survey of patients. UK - Healthcare Commission combines 'self-assessment' with 'unannounced external survey'
- In the French, Dutch and UK - HAQU programmes, the preparation for 'self-assessment' and 'external survey' takes 7-12 months for a 100-bed hospital while the full on-site survey lasts 3-4 days
- An oral feedback regarding the key findings of the survey and a draft report for factual confirmation is given by all of these programmes to the hospital, to the exception of UK - Healthcare Commission which does not submit any draft
- France has different levels of decisions while The Netherlands apply a binary system, i.e. 'accredited' versus 'non-accredited'. In UK, different levels are also used by UK -Healthcare Commission but binary system is preferred by UK - HAQU
- The validity of the accreditation award is 4 years in the French and Dutch programmes, 5 years for UK - Healthcare Commission and 3 years for UK - HAQU

- A defined mechanism of appeal is foreseen in each of these programmes
- All programmes diffuse systematically the results of the survey, to the exception of UK - HAQU which never do it and of UK - Healthcare Commission which apply a different treatment for public and independent sectors

→ In-depth assessment with high involvement of the hospitals for all programmes

Funding mechanism & sources

- The French and UK - Healthcare Commission programmes have been initially funded by their central government while the Dutch and UK - HAQU programmes were respectively funded by professional associations and the voluntary sector
- All these programmes charge hospitals via fees and/or annual subscription. The percentage of total income which was generated by these fees in 2006 vary widely between programmes

→ Financial participation of hospitals is foreseen in each of these programmes

5.1.4 Country Expert recommendations

The following recommendations and remarks were made by the participants to the Country Expert Meeting regarding the implementation of an accreditation programme and served as a basis for the conclusions and recommendation towards the Belgian situation:

Policy

- Take time to discuss the goals and to determine the best solution with all the stakeholders
- Create buy-in during the discussions with all key stakeholders
- Analyze the different existing systems and use useful experiences to head in the right direction and prevent reinventing the wheel
- Identify to what extent the accreditation programme does overlap or replace existing systems and formulate the added-value of the new solution
- Take into account the International mobility of patients (growing trend) and the impact this may have on the conception of the programme Define a catalogue of legislation including national laws and European directives and the constraints they may have on the conception and development of the accreditation programme
- Ensure the independence of the accreditation body, yet clearly define the responsibilities of the accreditation body and its link with other organisations
- Indicate the incentives for hospitals to participate in accreditation: what's in it for them that will stimulate them to participate (versus compulsory measures)
- Link the programme to financial incentives. However, the use of accreditation results for the purpose of financial sanctions can have the effect of diminishing the benefits of accreditation as a learning tool in favour of a system of penalties. The utilisation of accreditation data for funding purposes does not encourage professionals to trust the process.
- Take enough time (2-3 years) to set up the programme, this includes:

  - Development of a masterplan with clear timescale and procedures for implementation
  - Thorough pilot testing before the launching/roll out of the programme
  - Select 'champions' to make it happen
- Expect more problems to come to the surface in the beginning: due to enhanced registration of specific relevant data it may be expected that results seem to exacerbate
- Think through all possible consequences from the accreditation programme conceived e.g. solve the problem of not accrediting the biggest hospital before it occurs…

Methods

- Use ISQua guidance: a practical Accreditation Toolkit has been developed listing all possible pitfalls and critical success factors
- Select and consult 2-3 (international) accreditation bodies to interact and validate decisions
- Ensure the accreditation body creates its own standards: the independence of the body starts by defining the set of standards that they will use for the assessment of the hospitals
- In case an extent of regionalism (for instance execution) will be applied in the accreditation programme make sure that there is uniformity and agreement on the content basics and use of set of standards
- Foresee obligation (clause in the contract) for hospitals to always respect the most recent version of the programme in terms of standards
- Insert a monitoring system to measure how hospitals perform over the years
- Put clear working indicators: put limits, time frames, be realistic
- Foresee registration on medical errors, nosocomial infections and patient complaints
- Define key measurement indicators on the basis of available data
- Plan external assessments as late as possible in order to maintain the pressure
- Involve physicians in the accreditation procedure
- Include international peers in the survey teams in order to prevent conflicts of interest
- Foresee practical training of the surveyors with simulations and on-the-job supervisions
- Start with helping hospitals with their internal (audit) systems
- Assist hospitals in being prepared regarding quality, technology and change management
- Pay attention to confidentiality and data protection issues for the publication of the results

Funding mechanism & sources

- Make clear who's going to finance accreditation

Effects

- International experience learns that individual or regional accreditation initiatives result in unclarity and worse, differences in healthcare quality delivered. The witnesses of both Italy and Spain are striking in this context

Key Points

- **Comparison of the accreditation programmes in the European Member States learns that, all countries with a programme, except for Portugal, have created their own programme. Portugal has 'outsourced' the accreditation activities to UK Health Care Commission**
- **The existing programmes vary in terms of the '4 building blocks' of the Common Framework, yet there is a pattern for:**
  - 'target' standards are applied reflecting the quality improvement dynamics of the respective programme
  - The accreditation programmes are embedded in strong supportive structures in terms of law and/or government policy and/or composition of the governing body except for the UK - HAQU
  - The procedures applied to get to accreditation and the validity of an accreditation 'award' i.e. 3 – 5 years
  - The initial development, which apart from the Netherlands, Spain & UK, was funded by governments or International aid
  - Charging fees to the hospitals for the services delivered (subscription fee)
- **A focus on 4 countries (France, Ireland, Luxemburg and UK Health Care Commission) shows that the costs for running the accreditation programme are significant i.e. between 3,5 mn. € (Ireland) and 60 mn.€ (UK Health Care Commission)**
- **There is a clear trend towards increasing government involvement as more and more are managed from within the Ministry of health or by separate government agency**
- **There are few countries with regional programmes whereas the majority adopt National accreditation programmes**
- **As far as the effect perspective is concerned (5th element of the Common Framework), it is striking that the majority does not have outcomes related data at their disposal**

5.2 EXPLORATION OF ACCREDITATION OPPORTUNITIES FOR BELGIAN HOSPITALS

5.2.1 Literature study results

5.2.1.1 Existing legislation

The federal structure of Belgium necessitates the repartition of the competences for health care policy between the different governmental levels. This was done in the Institutional Reform Act of August 8th 1980.

Art. 5 defines that individuals related matters are the responsibility of the regions. The communities are responsible for health care in the hospitals as well as outside the hospitals. With respect to health policy however are excluded and remain the responsibility of the federal level:

- the organic law,
- the financing of operating costs when regulated by the organic law,
- the compulsory health insurance,
- the basic rules concerning programmation,
- the basic rules concerning financing of infrastructure, included the financing of "costly" medical equipment,
- the national recognition standards that have repercussions on the responsibilities listed above,
- the conditions and the designation of university hospitals in corresponding the Hospital Act

Uncertainties about this repartition of competences are clarified by the Supreme Administrative Court and the Constitutional Court of Belgium. The responsibility concerning the practice of medicine e.g. has not been defined as an exemption in the Institutional Reform Act of August 8th 1980. Yet, following the preliminary parliamentary texts and the judgements and advices of the Administrative Court and the Constitutional Court, this competence remains Federal.

The standpoints in the past of the above mentioned instances have to be analysed to know whether a project, such as accreditation of hospital activity belongs to the competence of the federal level or of the communities.

The Administrative Court as well as the Constitutional Court put in the past that intramural quality policy has to be qualified as "fragmentary". This means that no single authority is exclusively competent to establish an integrated quality system that covers all the aspects of the organisation. An integrated quality policy necessarily needs a collaboration of the communities/regions and the federal authority. As said earlier, only concerning the functioning of practitioners of health professions (Royal Decree nr.78 10/11/1967) including non-conventional health professions exists a relative clarity.

A number of standpoints can be summarized:

- Regulations concerning regular quality assessment for treatment and care of patients including the modalities according to the nature and the structure of the hospitals can be considered as covered by the "organic law", which is the competence of the federal level. Organic legislation means the basic rules of hospital policy.
- Regulations concerning the structuring of medical and nursing practices can be considered as an exception as defined in the Institutional Reform Act of August 8th 1980, Art. 5.
- Communities and regions can define quality standards on condition that the federal competences remain intact. Indeed, the Administrative Court found no contradictions between the federal competences and the Decree of the Flemish community of 17/10/2003 concerning the quality of health and welfare provisions.
- With regard to the regulations on patient rights it has been stated that the federal authority is not competent for the administrative aspects of the legal relation between institutions and patients.

FEDERAL LEVEL

1 The Hospital Act (1963) coordination of August 7th 1987 includes a number of regulations that are related to quality assurance:

a Basic recognition criteria mainly relate to infrastructure of the hospitals and the equipment. The basic criteria for recognition of health institutions (hospitals) are made by the federal Government. Actual recognition is done by the communities. These criteria essentially concern safety, hygiene, quality and continuity of care.

b The tasks of the medical director include quality improvement, hospital hygiene and medical audit. Integration of the medical and the nursing activities is 1 of the specific tasks.

c The tasks of the nursing director include also integration of the medical and the nursing activities.

d The recognition of care programs is closely related to quality assurance of specific treatment and care in a limited number of activities. This includes the supervision by the corresponding Colleges of Physicians.

a The recognition criteria, as defined by the Hospital Act in art. 68-71, 76bis, 76quinquies en 76 sexies, guarantee a minimum level of quality of care. These criteria relate to the general design of hospitals, the design and organisation of all kind of services in the hospital, the organisation and delivery of emergency care. Special criteria relate to university hospitals and services, special services in non-university hospitals and groups, fusions and associations of hospitals. Recognition is given for a limited time period and can be prolonged. The recognition is given by the communities.

The recognition criteria are defined after consultation of the National Hospital board (NRZV/CNES).

A number of Royal Decrees specify the minimum activity level of the hospital, the type of care programs, hospital services, administrative, technical and medical-technical services and the minimal capacity (beds) for hospitals. These include architectural, functional and organisational criteria specifically defined following the different departments.

These criteria are to be considered as minimal standards and do not relate to accreditation.

b The structure of the **Medical department** in the hospitals is defined in the art. 8 (partially), art. 9 and art.13 – art.17 of the Hospital Act.

The medical director has a general responsibility concerning the medical department. The medical activity has to be evaluated internally as well as externally. This is based on a mandatory medical record and an internal registration. A report concerning this medical activity has to be made.

The Royal Decree of December 15 1987 on the execution of the articles 13 - 17 of the Hospital Act coordination on August 7 1987 says in art.3 that the Chief Medical Doctor has to be able to work on quality improvement in the hospital. Art.5, 8° specified that the Chief Medical Doctor has to take initiatives in order to improve the quality of the medical practice in the hospital and to evaluate this in a permanent way.

This implies (art.6): a procedure for admission and discharge of the patients, measures to improve hospital hygiene, the organisation of a medical audit, a yearly medical report, an effective collaboration of the medical staff. The role of the head of the medical department in this is also described (art.13-16).

c Definition and structure of the **Nursing department** is defined in art. 8 (partim), 9quinquies, 17bis-17octies of the Hospital Act coordination August 7 1987.

The nursing activity has to be assessed qualitatively internally as well as externally. This implies the keeping of a patient file which has to be kept together with the medical file under the responsibility of the Medical Director. An internal registration has to be established as well as a report concerning the quality of the medical activity Art. 17quater gives the King the possibility to create organisational structures for systematic quality assessment of the nursing activity in the hospitals. The law further defines that these assessments can be related to criteria on infrastructure, manpower or nursing practice including outcome.

The quality assessment of nursing activity in the hospitals is further defined in the Royal Decree of April 27 2007. This Royal Decree is based on art. 9quinquies and art.17quater of the Hospital Act and defines internal as well as external quality assessment procedures of the nursing activities in the hospitals.

All hospital services, functions and medico-technical services, including the care programs (art. 9quater) are comprised in this Royal Decree. The responsibilities of the head of the nursing department are defined. These include registration, analysis, communication, reporting, quality improvement initiatives and collaboration with the Federal Council for Quality.

The composition and the tasks of this Federal Council for Quality are defined. These tasks are related to the scientific aspects of nursing, the participation of nurses to external evaluation of care processes and dispersion of information on good nursing practice.

d **Care programs** can be identified (based on art 9ter of the Hospital Act) with specific recognition and characteristics. This includes specific quality criteria and follow-up to be defined by a specific College of Physicians (peers).

Art. 15 of the Federal Hospital Act (1963), coordination of August 7th 1987, explicitly gives the legal base for quality assessment of the medical activity in hospitals. This is not in relation with recognition of hospitals. This article gives the King the possibility to create organisational structures for systematic (external) quality assessment of the medical activity in the hospitals. These structures have to be created for each department or function, which means a vertical approach. The law further defines that these assessments can be related to criteria on infrastructure, manpower or medical practice.

The Royal Decree of 15/02/1999 concerning quality assessment of medical activity in hospitals was made in execution of this article 15. This decree regulates the internal evaluation and the external quality assessment of medical activity in the hospitals. A college of physicians has to be installed for each care program and specific departments and functions that are mentioned (radiotherapy, treatment of chronic renal insufficiency (nephrology), radiology with magnetic resonance and nuclear medicine with PET-scanner, function specialised emergency care and function intensive care). The list of care programs that has been defined in the Royal Decree of 15/02/21999 includes: reproductive medicine, cardiac pathology, oncology, geriatrics.

The tasks of these colleges of physicians can be considered as "peer review" and are as follows:

- Definition of quality indicators and assessment criteria on good medical practice (these relate to infrastructure, manpower, medical practice and outcome).
- Elaboration of an electronic registration and standard reporting.
- On site visits and control of the data.
- Annual report for the working group of the Multipartite.
- Feedback to the hospitals and the physicians.

The coordination of these colleges (horizontal integration) has to be done by a coordinating college attached to the "Multipartite" or by the "Multipartite". This coordination implies definitions of uniform guidelines concerning the activities as well as the tasks of the colleges, communication to the authorities of the annual reports and the analysis of these reports.

2 The Health Insurance Act (1963) reviewed and coordinated on July 14th 1994.

A number of initiatives, related to quality of medical care, can be identified in this law:

The Scientific Board of the RIZIV/INAMI (art.19): This board gives recommendations to "assure scientific progress of medical care under the best circumstances in relation with efficacy, economy and quality". This includes planning of medical activity, health technology assessment and evaluation of the medical consumption.

The Committee of the Insurance for Medical Care, the "Insurance Committee" (art.22). This committee can, besides its technical, budgetary and administrative tasks, make conventions, on proposition of the College of Medical Directors (art.23) with multidisciplinary care services or institutions.

These conventions regulate the quantitative and the qualitative conditions for execution of new and innovative techniques.

The College of Medical Directors (art.23) further gives advice to the Insurance Committee concerning supervision and compliance with the principles of Good Medical Practice (art.23 §4) for medical acts as described by the King (art.66).

The Technical Councils (art.27) give advice to the corresponding convention- and agreement committees concerning definition and application rules for the technical acts. After searching the list of the Nomenclature of medical acts (Royal Decree of July 25 1994 appendix to the Royal Decree of September 14 1984) one can conclude that quality assurance is not the first concern these technical councils.

Article 35 §3 gives the possibility to the King to define different fees for technical acts depending on the compliance of institutions or services with additional conditions (to be defined) concerning working conditions of their personnel and have an influence on quality and accessibility of care.

The possibility to establish an accreditation procedure for medical doctors was created in art.36bis of the Health Insurance Act. The composition and the functioning of the accreditation commissions have been defined in the Royal Decree of July 13 2001 article 122quater. The accreditation conditions however are part of the negotiations between the physicians and the sickness funds (Nationale commissie geneesheren-ziekenfondsen - Commission nationale médico-mutualiste.) This accreditation is not compulsory. The system is more an incentive for continuous education of the different specialities and therefore an indirect stimulus for quality. The accreditation criteria that have been defined indeed are comparable to recognition criteria. Direct evaluation of quality is not included in this procedure. The patients are not related to this procedure. Thus the use of the expression "accreditation" may be misleading.

The National Council for the Promotion of Quality (Royal Decree July 3 1996, art. 122bis inserted by Royal Decree July 13 2001) manages this "peer review" system. As defined in §4, this system allows doctors to evaluate the quality of their practices in a critical way.

A specific reference to the article 73 of the Health Insurance Act narrows the application field to more economic aspects: the price and the necessity of the medical acts that are delivered.

Article 56 §1 gives the Insurance Committee the possibility to make agreements for research and comparative research on care models or financing of medical care.

Article 63 allows for conditional reimbursement for analyses carried out in laboratories for clinical biology. The Royal Decree of December 3 1999 concerning the recognition of the laboratories for clinical biology is taken in execution of this article. This Royal Decree defines the quality criteria necessary to obtain the recognition.

A similar article 65 makes a procedure for quality assurance in laboratories for pathology possible. The necessary Royal Decree is not taken at this moment.

A more generally defined article 66 allows for conditional reimbursement of acts. This article refers explicitly to qualitative and quantitative criteria on good medical practice.

The tasks of the Department for Medical Evaluation and Assessment (DGEC/SECM) as described in article 139 of the Health Insurance Act refer primarily to administrative control of medical practice and are intended primarily to control consumption.

3 Federal Public Service Health, Food Chain Safety and Environment (FOD/SPF)

The following initiatives related to quality and safety have been started in the past by FOD/SPF :

- Committee for Hospital Hygiene (1987)
- Systematic registration of infections, falls and other accidents (RD 17/08/1987)
- Medico-pharmaceutical committee and Committee for medical materials (Royal Decree of March 04 1991 concerning the criteria for recognition for hospital pharmacies.
- Committee on blood transfusion (2002)

A more integrated approach has been started since several years. This approach is focussed on risk management and was in collaboration with the Performance Assessment Tool for Quality Improvement in Hospitals project (PATH) of the World Health Organization – Division of Country Health Systems (2003). 5 countries participated in this project. After an inquiry phase and feasibility studies in Belgian hospitals a number of pilot projects were organized. This allowed the start of a "Multidisciplinary and Integrated Feedback" project in 2006. The aim of this project is to deliver to the hospitals a feedback relative to their performance based on the data available in the diverse database of the FOD/SPF. 11 indicators covering 4 dimensions of hospital performance (clinical performance, financial performance, capacity - innovation and patient orientation) were identified, assessed and reported to the individual hospitals in 2006. This project is essentially a tool for the hospitals to define their priorities and to develop their individual quality policy. This feedback is not part of an external assessment procedure.

A number of pilot projects are elaborated on patient safety, on developing safety culture in the hospitals, on the needs of a more structured patient safety policy in the hospitals….

The National Council for Hospitals (NRZV/CNEH) has given a number of recommendations concerning quality related aspects.

- Patient safety should be the central issue in the quality policy.
- A straightforward, non punishing and confidential incident reporting system independent of the recognition and financing systems is recommended.
- The strategy for the development of a specific monitoring structure has to be elaborated.

4 Royal Decree concerning the determination and settlement of the budget of financial resources of hospitals of April 25 2002.

The budget that is given to the hospitals is strictly defined in a number of sub-budgets.

Part A budgets relate to capital an investment costs.

Part B budgets cover the working costs.

Part C budgets relate to additional financial costs.

The obligations for the hospitals that are related to recognition and criteria are essentially covered by these budgets. This includes the regulations as defined in de Hospital Act and in the Royal Decrees that are taken based on this hospital act.

The National Council for Hospitals (NRZV/CNEH) finalised on October 12 2006 the conclusions of a specific working group on financing quality in the hospitals. Hospitals organize a number of quality initiatives that are not financed. A plan to finance quality development is asked.

The government approved a budget of 7.5 mio euro for 2007 to develop a specific quality and safety policy in the hospitals.

Developmental initiatives, initiated by or in collaboration with the Federal Public Service are financed via the working budgets of the FPS.

From the 1st of July 2007 an amount of 6,8 mio euro is divided between the hospitals contracting on a voluntary basis with the Federal Public Service Health, Food Chain Safety and Environment and hospitals[xii]. The contracts aiming at encouraging hospitals to coordinate their activities with regard to quality and patient safety, stipulate that the following conditions have to be met:

- Description of the hospital's mission, vision, strategy and aims with regard to quality
- Presentation of the coordination of quality structures in an organogram
- The hospital has to self assess its patient safety culture by means of an instrument (http://www.zol.be/patientveiligheid)
- If the hospital registers and analyses incidents or "almost" incidents: description of what, who and how is registered, which initiatives are taken to stimulate reporting, etc.

  If the hospital does not have a registration mechanism at the moment of contracting, it has to demonstrate that steps are taken to establish such a system
- Providing descriptive files of the quality and patient safety projects contributing to the realisation of the mission, the vision and the strategy of the hospital.
- Documenting the internal use of the "multidimensional and integrated feedback of hospital data for administrations", including the report "patient safety indicators" (only for general hospitals)

5 Patients' rights Act of August 22, 2002.

This act assigns the following rights to the patients: qualitative care, free choice of care provider, right to be informed, right of consent, rights concerning the patient file, privacy, and mediation in case of complaints.

[xii] In execution of article 56,§4 Koninklijk Besluit van 25 april 2002 betreffende de vaststellingen en de vereffening van het budget van financiële middelen van de ziekenhuizen, ingevoegd bij het Koninklijk Besluit van 19 juni 2007 tot wijziging van het Koninklijk Besluit van 25 april 2002, artikel 13.2° (BS, 28.06.2007)

Since this act explicitly defines the right for qualitative care, care providers have to guarantee good, careful and qualitative health care.

REGIONAL LEVEL / COMMUNITIES

The recognition criteria, as defined by the federal legislation in the Hospital Act in art. 68-71, 76bis, 76quinquies en 76 sexies, guarantee a minimum level of quality of care. These criteria relate to the general design of hospitals, the design and organisation of all kind of services in the hospital, the organisation and delivery of emergency care. Special criteria relate to university hospitals and services, special services in non-university hospitals and groups, fusions and associations of hospitals. Recognition is given by the Communities for a limited time period and can be prolonged.

A number of Royal Decrees specify the minimum activity level of the hospital, the type of care programs, hospital services, administrative, technical and medical-technical services and the minimal capacity (beds) for hospitals. These include architectural, functional and organisational criteria specifically defined following the different departments.

These criteria are to be considered as minimal standards and do not relate to accreditation.

1 Decree of the Flemish community concerning quality of health and welfare provisions. October 17 2003.

The Decree of 17/10/2003 obliges the hospitals to establish a quality policy, a quality management system and a system of self-evaluation. These items are to be reported in a handbook for quality.

A quality policy implies a certain vision on quality including goals to be achieved by the hospital.

The quality management system necessitates the organisational structure and procedures to put this quality policy into practice.

The system of self-evaluation implies that the organisation describes its actual level of quality. The clinical performance has to be measured by means of quality indicators (hospital mortality, pressure ulcers…) Also the performance at the organisational level has to be measured. This implies rather the ancillary services (e.g. kitchen) and eventually waiting list for certain pathologies. A cycle for quality improvement has to be worked out.

A system of inspection (visits, audits) is used to check the compliance of the hospitals with this decree. The compliance with this procedure is critical for recognition or extension of the recognition. This means that the obligations of this decree have to be seen as additional recognition criteria.

2 Decree of the Flemish Government of March 26 2004 concerning the installation of an internal independent agency for inspection welfare and health.

An independent agency is defined within the Flemish administration. The task of this agency is to execute the health and welfare policy of the Flemish government. The mission of this agency is supervision of the application of the regulations with respect to the institutions. This implies quality improvement of the services delivered by these institutions

3 Decree of the Walloon region of June 13 2002 concerning the organization of care institutions.

This decree defines that the additional criteria for programmation and recognition, to be defined by the government of the Walloon region, relate to quality and priorities with respect to the application of the programmation of the care institutions.

The procedure for recognition, prolongation, refusal or withdrawal of the recognition is defined.

A "Council for care institutions" is defined. This council gives advice to the government with respect to the additional recognition criteria, the programmation, recognition, decisions concerning "expensive" equipment ….

5.2.1.2 Initiatives from the sector

A number of quality initiatives from the sector are discussed in this section. These are to be considered as examples, and not as an exhaustive list.

NAVIGATOR – CENTRUM VOOR ZIEKENHUIS- EN VERPLEGINGSWETENSCHAP

The Centrum voor Ziekenhuis- en Verplegingswetenschap (CZV) of the Katholieke Universiteit Leuven, which was set up as a component of the Medicine Faculty in 1961 and fullfils the triple mission of training, research and delivery of services[xiii], developed a performance indicator system called Navigator and implemented it in January 2004 [28].

The purpose of this tool system is to provide a frame of reference for benchmarking purposes concerning the clinical and organisational performance by providing the health care organisations an assistance to monitor patient care continuously and systematically in a user-friendly way, an assistance to identify opportunities for improvement in patient care and a support with their internal quality management.

Navigator is based on 4 major components:

- indicator sets
- software
- website and
- network

These indicator sets cover 3 different areas: acute care hospitals, psychiatric care hospitals and nursing homes for the elderly. Each set is well-structured, well-defined and composed of process and outcomes rate-based indicators that are organisation-wide or unit/patient group specific [28].

Concretely, each participant organisation chooses the indicators corresponding to its priorities, transmits the appropriate data via the software and receives a feedback under the form of a report to download. This feedback maps the organisation's quality and informs it on its own evolution and on its position relative to other organisations. Besides, participants have the opportunity to explore all the data available in the database with the exploration tool[xiv].

The average costs for an individual hospital amounts to 5000€ (excl. VAT) with a contract duration of 3 years.

At present, 59 Flemish health care facilities (36 acute care hospitals, 2 psychiatric care hospitals and 21 nursing homes) are using Navigator[xv]. Studies performed in 2005 have shown positive impacts, such as the continuous monitoring of care, the identification of improvement opportunities and the usefulness for internal quality management [28].

If this initiative is evaluated according to the applied definition of accreditation, which contains 3 main components ('external assessment', 'pre-defined standards' and 'health care quality improvement'), it can be said that:

- the received feedback is the result of an assessment, yet not external

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xiii about the CZV, www.czv.kuleuven.be
xiv About Navigator, www.navigator.czv.be
xv Participants, www.navigator.czv.be

- the indicators represent criteria against which organisations are assessed, even if there is no indication of level to reach and they are optional, and
- the improvement of clinical and organisational performance is likely to generate health care quality performance

In addition, it may be concluded that Navigator can be used as a quality improvement tool and a benchmarking tool, yet it is not intended for accreditation since the indicators that are defined are limited to outcome parameters.

Furthermore, some indicators are chosen by a limited number of hospitals which makes feedback and comparison based on statistical reporting unreliable. A second remark may be that most indicators are mainly related to nursing.

Overall there is no evidence regarding the effects of this initiative.

KWADRANT – CENTRUM VOOR ZIEKENHUIS- EN VERPLEGINGSWETENSCHAP

The CZV developed, in close collaboration with the sector, a management model adapted to health care organizations based on the EFQM model, and published it in 2000. This model is composed of 9 topics: leadership, personnel management, policy and strategy, resource management, process management, assessment by personnel, assessment by clients, assessment by society and key performance results[xvi].

Its main characteristics are:

- adapted for self-assessment
- basis to guide
- emphasis on performance
- striving towards excellence
- support for ongoing improvement
- emphasis on the system-perspective
- attention to processes and results
- strongly client-oriented
- not normative
- flexible[xvii]

3 tools were developed to use Kwadrant for self-assessment, it is to assess in a systematic and independent way the activities and results of the organisation on the basis of the 9 categories of the model:

- the self-assessment report
- Kwadrant Kompas
- Kwadrant Kompas+[xviii]

Specific tools such as a spider web and a dedicated table give the opportunity to have a clear view on the reached scores and can serve as basis to manage and improve the organisation in the short and the long run[xix].

Besides, the Kwadrant network allows among others new member organizations to get support from the more experienced ones in introducing the model in their hospital.

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xvi The management model, www.czv.kuleuven.be
xvii General characteristics of the management model, www.czv.kuleuven.be
xviii Self evaluation and Kwadrant, www.czv.kuleuven.be
xix "Sturen met Kwadrant", www.czv.kuleuven.be

The average costs for an individual hospital amounts to 5000€ (excl. VAT).

If this initiative is evaluated according to the applied definition of accreditation, which contains 3 main components ('hospital assessment', 'pre-defined standards' and 'health care quality improvement'), it appears that:

- the model is a tool for **internal** assessment,
- the assessment is based on performance indicators, and
- the system intends to improve management at all levels and could have effects on health care quality

Overall there is no evidence regarding the effects of this initiative.

ISO CERTIFICATION – HÔPITAL VINCENT VAN GOGH

The International Organization for Standardization (ISO) is a global network that identifies what International Standards are required by business, government and society, develops them in partnership with the sectors that will put them to use, adopts them by transparent procedures based on national input and delivers them to be implemented worldwide[xx].

More specifically, these standards specify the requirements for state-of-the-art products, services, processes, materials and systems, and for good conformity assessment, managerial and organizational practice[29].

The ISO certification has been used in the manufacturing sector for many years. However, more and more other industries adopted these standards recently, including pharmaceutical companies and health care organisations.

The Hôpital Vincent Van Gogh, specialized in the psychiatric pathologies treatment and part of the CHU Charleroi since 1995, decided to launch an improvement project after this last merged with CHU Vésale in 1999. Its main objectives were to facilitate the merger of the psychiatric services and their repatriation on the Marchiennes-au-Pont site in order to improve the patients care [30].

The hospital management looked then for a tool designed to structure the organization but also to ensure the continuous improvement of processes and chose the norm ISO 9001:2000[xxi]. Indeed, this one specifies requirements for a quality management system where an organization needs to demonstrate its ability to consistently provide products that meets customer and applicable regulatory requirements, and aims to enhance customer satisfaction through the effective application of the system and the assurance of conformity to these requirements[xxii].

This project was implemented in 4 steps:

- agents information of their project contribution, setting up of the working groups and definition of everyone's roles
- description of the care processes and inventory of the existing documents/ procedures
- setting up of internal audits/dashboards, review of satisfaction questionnaires and subsequent improvement actions
- handing-over of the ISO 9001:2000 certificate on the 17th of March 2006[xxiii]

More concretely, following improvements for example occurred: optimization of the patients' information transfer between the health professionals thanks to a new tool, setting up of a unique call-centre for all consultation centres' appointments, opening of

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[xx] Definition of ISO, www.sevenpro.org
[xxi] ISO à VVG: de l'idée à la concrétisation, www.chu-charleroi.be/vvg
[xxii] Description of the norm ISO 9001:2000, www.iso.org
[xxiii] ISO à VVG: de l'idée à la concrétisation, www.chu-charleroi.be/vvg

the paedo-psychiatric unit and of the Centre Thérapeutique de Jour Pédopsychiatrique[30].

If this initiative is evaluated according to the applied definition of accreditation, which contains 3 main components ('external assessment', 'pre-defined standards' and 'health care quality improvement'), it can be said that:

- the certification is based on an external assessment,
- pre-defined international standards are used, and
- compliance with standards should generate changes which could increase the health care quality

INITIATIVES LINKED TO THE NIAZ (NEDERLANDS INSTITUUT VOOR ACCREDITATIE VAN ZIEKENHUIZEN) PROGRAMME

NIAZ is the Dutch accreditation organisation, founded in 1998 by the NVZ-vereniging van ziekenhuizen, the Vereniging van Academische Ziekenhuizen en de Orde van Medische Specialisten. It tests if hospitals have thought their organization in a way that they can deliver an acceptable health care quality level with an external assessment based on standards derived from the EFQM model as central element [31].

Virga Jesseziekenhuis accreditation

The Virga Jesse Ziekenhuis is a public hospital located in Hasselt, which besides all traditional medical specialities also has a wide offer of top-clinical services, as the Hasselt's heart centre, the neurochirurgy service or the centre for molecular diagnostic[xxiv].

Up to 2005, it managed different quality-oriented projects, from communication between care providers to shortening of the waiting times, but felt unsatisfied with the dispersed character of these initiatives [32]

The hospital decided to turn towards accreditation for the following reasons [31]:

- quality becomes an opportunity to be distinguished from its competitors
- 1 of its 10 strategic goals is to reach a care quality which is among the best in Flanders
- the step from a 'good' to 'very good' quality is possible with the move from a project- to a integrated approach of the quality management
- the internal quality assessment as change tool is not sufficiently adequate

It comes to the conclusion that hiring an external agency would put a larger pressure on the agenda and would in consequence be a better tool, and chose NIAZ because:

- the opportunity occurred as this organisation wanted to enter in Flanders
- the language barrier is insignificant
- the methodology is 'neutral-approach'
- the Kwadrant-familiars can move easily to the NIAZ-norm

The project followed the NIAZ-accreditation process steps:

- the hospital submitted his application (December 2006)
- the hospital elaborated his self-assessment report (June 2007)

[xxiv] In general, www.virgajesse.be

- NIAZ gives a 'go/no-go' decision on the basis of the self-assessment report and related documents (foreseen for August 2007)
- the hospital selects the processes to be audited (for August-September 2007)
- NIAZ performs the audit-visit and writes the accreditation report (for November 2007)
- NIAZ gives the accreditation status decision (for April-May 2008) [31]

Consequently, more and more people are now busy with quality at the hospital. Indeed, services are anticipating the visit by introducing improvements at a former stage.

The NIAZ fee is composed of different items: a start fee of about 71.000 EUR plus an annual contribution of near 18.000 EUR to pay from the accreditation status. Besides, the hospital must free people to prepare the project [31].

Other initiatives linked to NIAZ

In Belgium and more specifically in the Flemish part of the country, several activities linked to NIAZ exist. For example, directors, managers or quality coordinators of individual hospitals have followed the auditor-training organized by NIAZ at least once a year [33]

This one is composed of 2 parts:

- an initial training of 2 days, which focus on the utilisation of the framework and on the learning of audit skills,
- a training 'on the job'[xxv]

The list of the new auditors is published by NIAZ in its quarterly newsletter.

If these 2 initiatives are evaluated according to the applied definition of accreditation, which contains 3 main components ('hospital external assessment', 'pre-defined standards' and 'health care quality improvement'), it can be said that they completely meet the 3 criteria.

Vlaams Algemeen Ziekenhuis Overleg

The "Vlaams Algemeen Ziekenhuis Overleg" (VAZO), collaboration between VVI (Caritas Verbond der Verzorgingsinstellingen) and VOV (Vereniging der Openbare Verzorgingsinstellingen Nederlandstalige Kamer) recently expressed their joint interest to develop a voluntary accreditation program in Flanders, in collaboration with NIAZ. A voluntary program will be developed in collaboration with NIAZ "as soon as possible". This initiative implies that VAZO should be represented in the board of NIAZ and that a permanent workgroup should be started to treat all aspects of accreditation. The need to include output standards in the assessment is clearly formulated.

ACCREDITATION EXPLORATORY EXERCISE – MUTUALITÉ CHRÉTIENNE

Mutualité Chrétienne (MC) proposed in May 2002 to the Solimut's partners to participate to a medical risk management's accreditation exploratory exercise. The objective was to test the feasibility and the acceptability of the method and to build a pool of experts with practice in the field of hospital accreditation in Belgium. 11 hospitals [xxvi] accepted the proposal and participated to this exercise between the beginning of 2003 and November 2004 [34]

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xxv "Auditor worden", www.niaz.nl

xxvi Amongst these 11 initial participants, 9 went to the end of the project (7 from Wallonia, 1 from Brussels and 1 from Flanders)

The entire project was supervised by the Comité de Pilotage des Initiatives de Qualité, composed for a large part of the participating hospitals.

To prepare the accreditation manual, a working group composed of experts and involved hospitals representatives explored some international experiences via a review of the literature/available accreditation manuals and field visits to Denmark, France and the Netherlands. It developed a manual composed of 5 standards on risk management[xxvii] with a systematic set of 7 objective elements, it is responsibilities, procedures, information, training, equipment, evaluation and indicators, plus specific issues by standard [35].

The participating hospitals were approached to identify volunteers amongst their doctors, nurses and administrative agents to perform the on-site surveys. Once recruited, these volunteers followed a 2 days training schedule oriented on the accreditation models' review, the newly-developed accreditation manual's analysis, the relational aspects linked to an external audit and role games [34].

The project implementation followed a precise calendar:

- Information visit to each hospital to inform the managers about the general philosophy of the project and to ask them to identify the responsible persons for each standard (first months of 2003)
- Pre-analysis visit to go through standards with the dedicated persons in order to identify the problematic aspects to treat in priority and the positive experiences susceptible to help other hospitals (February-April 2003)
- Inter-hospitals meetings relative to various subjects as the accreditation process, the relevant aspects of particular sub-standards and the use of indicators (September 2003-May 2004)
- Preparation of the visit via the filling of an electronic questionnaire covering all sub-standards to send back with relevant documents
- 1 or 1,5 day visit comprising meetings with the management and the project coordination teams, followed by meetings with standards' responsible persons, care units staff and some patients (November 2004)
- Presentation of an intermediate report containing positive and negative observations for each sub-standard together with appropriate recommendations (end of 2004)
- Sending of an accreditation scores table comparing the visited hospitals in an anonymous way (February 2005)
- In-depth assessment of the exploratory exercise in order to evaluate if initial objectives have been reached (beginning of 2005)

The total cost of the project represented about 130.000 EUR for the organisers, covering human resources costs (80%) and general costs (20%). Besides, the participating hospitals have invested in average 1 person during 1 calendar-month for the project.

It is estimated than the 2 main objectives have been met: the exercise demonstrated the feasibility of accreditation in Belgium, and created a capital of expertise and experience.

From the participating hospitals' side, the perception survey conducted by an independent evaluator at the end of the exercise showed the vast majority of the people consider the project was useful and provoked the searched changes in hospitals, as a better management of specific risks, the development and/or the clarification of some procedures and a larger rigour in the execution of some tasks. But the

xxvii Risk management at hospital level, Prevention of fails, Prevention of wrong site surgery, Prevention of decubitus ulcers and Transfusion management

continuation of these changes and the efforts/benefits proportionality could not be proved.

Finally, the analysis of this survey's responses gave key elements to improve the tested model and acceptation/reject factors of such a model.

If this initiative is evaluated according to the applied definition of accreditation, which contains 3 main components ('hospital external assessment', 'pre-defined standards' and 'health care quality improvement'), it can be said that it completely meets the 3 criteria.

As demonstrated at the beginning of this section, due to the federal structure of Belgium, different options should be envisaged regarding the development of an accreditation program.

Until now, Belgium has no established accreditation program for acute hospitals. Apparently, quality assurance and improvement have been pursued mainly by a number of initiatives, focused on clinical performance, risk management and outcome. Nevertheless, a number of quality initiatives were taken by the federal government as well as the regional governments/communities. A central vision however is lacking.

A duality can be found in the elaboration of the legislation between the governmental levels and within the federal level.

The Federal structure of the Belgian State and the repartition of responsibilities complicate alignment of the initiatives to be taken. The architectural, organizational and functional standards, as defined by the federal hospital act refer to homologation and are to be seen as minimal quality level.

On the Federal level, one can identify a duality that exists within the Hospital Act. The general responsibility for quality related aspects in the acute hospitals has been given to the Chief Medical Doctors. A link to the nursing department has been made. The hospital act defines e.g. care programs where specific criteria for quality are defined. These relate to a large extent to recognition while the responsibility for follow up is given to the Colleges of Physicians without specific referral to quality assurance/improvement of nursing activity or evidence nursing practice.

Specific quality improvement for nursing activities has only recently been given to a federal council for quality. It might be a threat that these two legislative initiatives are separately defined while a close collaboration of doctors and nurses is important with respect to quality.

A second and essentially separated legislation has been developed in the Health insurance act. The RIZIV/INAMI works besides its classical insurance mission also on health care economics. Evidence based care, limitation of the variability in the care practices and administrative control are not directly linked to quality of clinical care delivery. Nevertheless, in the Belgian context where most of the doctors are paid by a fee for service system the collaboration of the doctors may be solicited via mechanisms that are the responsibility of the RIZIV/INAMI (nomenclature).

It may be clear that working on quality has to be supported by the doctors as well as the nurses. This implies that both professions have to be involved. A right balance between quality supporting and improving initiatives has to be established: one based on medical aspects (Public Health and Social Affairs) and one based on nursing aspects (Public Health).

The specific initiatives started by the FOD/SPF may add to the development of quality of care in the Belgian acute hospitals, although no evidence is available on their impact. In any case, these initiatives however should be organized in a more generally discussed and developed frame.

The initiatives from the sector clearly illustrate the interest of the stakeholders to work on quality. Apart from accreditation, most of the internationally known methods to assure or improve quality can be found in the initiatives from the sector that are described. Since these initiatives are often started independently, a global vision however is lacking.

Initiatives taken individually by a few hospitals like ISO certification or accreditation certainly comply with the quality standards but are also to be seen as positioning of these hospitals in the relatively competitive hospital market that exists.

Although a number of uncertainties exist in the initiative taken by VAZO e.g. concerning financing, it clearly demonstrates the urgency of the development of a common frame for quality assurance in the Belgian hospitals. In general one can state that quality of hospital care certainly has been developed to a large extent, but not in a structured way or build on a global vision with defined goals. In addition, from a legislation perspective one may conclude that certain elements such as structural, organisational and infrastructural norms are already in place and that there are no legal blocking points (e.g. modification of law required) preventing to move towards hospital accreditation.

Key Points

- **Although Belgium has no established accreditation initiative, quality assurance and improvement have been pursued by a number of initiatives**
- **A duality exists in the elaboration of the legislation between the Federal level and the Flemish community and within the federal level (Hospital act and Health insurance act)**
- **The repartition of the competences for health care policy between the different governmental levels complicates the alignment of further quality initiatives to be taken**
- **Initiatives by the sector clearly demonstrate the urgency of the development of a common frame for quality assurance in the Belgian hospitals**

5.2.2 Survey results

As part of the 2nd research question, 'Exploration of accreditation opportunities for Belgian hospitals', interviews with different stakeholders were conducted based on a developed standard survey. The following stakeholders were approached and as can be concluded from the list, almost 90% participated. It is important to stress that all stakeholders were formally approached and maximum effort was invested and flexibility applied to guarantee that everyone could be consulted within the 3 months timeframe.

Table 9 : Approached Belgian stakeholders for interviews

ORGANISATION	STATUS: INFO Y/N
RIZIV/INAMI	
Rijksinstituut voor Ziekte- en Invaliditeitsverzekering	Y
GOVERNMENT/COMMUNITIES	
Federale Overheidsdienst Volksgezondheid	Y
Vlaams Agenstschap Zorg en Gezondheid	Y
Direction générale de L'Action sociale et de la Santé	Y
Brussel: COCOM VGC	N
SICKNESS FUNDS	
Landsbond der Christelijke Mutualiteiten/Alliance Nationale des Mutualités Chrétiennes	Y
Nationaal Verbond van Socialistische Mutualiteiten/Union Nationale des Mutualités Socialistes	Y
Landsbond der Onafhankelijke Ziekenfondsen/Union Nationale des Mutualités Libres	Y
PATIENT ORGANISATIONS	
Ligue des Usagers des Services de Santé LUSS	Y
Vlaams Patiëntenplatform	Y
PROFESSIONAL ASSOCIATIONS	
Association Francophone de Médecins-chefs	Y
Vereniging van Vlaamse Hoofdgeneesheren	Y
Verbond Belgische Specialisten VBS/GBS	Y
ABSYM/BVAS	Y
Algemeen Syndicaat van Geneeskundigen van België	Y
NVKVV	Y
NNBVV	N
FNIB	Y
ACN Association belge des praticiens de l'art Infirmier	Y
UGIB	N
HOSPITAL ASSOCIATIONS	
Vereniging van Openbare Verzorgingsinstellingen	Y
Association des Etablissements Publics de Soins	Y
Verbond der Verzorgingsinstellingen	Y
FNAMS/NVSMV	Y
COBEPRIVE/BECOPRIVE	Y
Fédération des Institutions Hospitalières (FIH)	Y
CBI Coördinatie van Brusselse Instellingen/ Coordination Bruxelloise d'institutions sociales et de santé	N
Association Francophone d'Institutions de Santé	Y
Raad van Universitaire Ziekenhuizen van België RUZB/CHAB	Y
ABH/BVZ	Y
INDIVIDUAL HOSPITALS	
CHU de Charleroi	Y
Ziekenhuisnetwerk Antwerpen	Y
CHR de Huy	Y
AZ Oudenaarde	Y
Cliniques St.-Joseph	Y
AZ Sint-Blasius	Y
Clinique St.-Luc	Y
St. Vincentiusziekenhuis	Y
	89%

Whereas the different stakeholders have their own specific interest in hospital accreditation, it is interesting to map the different visions and opinions to the Common Framework which has been developed for this project (Cfr Chapter 2.1 'Determination of the framework to analyse accreditation'). The interviews show that the actors within the Belgian healthcare landscape are less diverse in their position than one might expect. The following paragraphs explain in more detail the synthesis of the interview with the stakeholders conducted in Belgium:

Policy

- Programme intentions
  - As long as hospitals are (co)financed by the authorities a very first objective of accreditation should be a accountability measure of hospitals towards their patients, the public at large and the governments, in terms of cost effectiveness i.e. what quality (outcome) delivered for the money spent.
  - Besides the purpose of hospital accreditation should be to generate a quality improvement dynamic which will result in a snowball effect generating better quality for all hospitals. To the extent that this creates a form of competition, this is acceptable as long as the result is more hospitals feeling the need AND support to engage in quality improvement, and not in creating 2nd rang hospitals.
  - It is important to add that, especially on the hospital level, there is no common agreement whether hospital accreditation is the right or necessary 'model' to achieve this.
- Programme supporting structure
  - There is no common vision that, if hospital accreditation should be launched, at what level (federal/regional) this should be done. Where the 'recognition' of hospitals is referred to as an example of actual distinction of responsibilities between the Federal Government (determining the norms to be respected) and the Community Governments (executing the inspections), there is agreement that this is not optimal i.e. there should be less room for regional differences in what is verified, with what frequency and how. Yet, the majority of the stakeholders share the opinion that it is logic for the Federal government to take the lead in an accreditation programme as long as they are the main financial sponsor.
  - Most of the stakeholders are of the opinion that, at least in the long run, all hospitals should be subject to accreditation. Only at hospital level there are some who are of the opinion that this decision should be entirely up to the individual hospitals. The way to engage/enforce hospitals to participate differs between the different stakeholders: there are supporters of a compulsory system (to make sure that all hospitals get the opportunity to improve their quality, instead of the happy few) but also clear convictions for entire voluntary system. Yet, the behind laying objective is mostly the same: get all hospitals accredited.
- Programme incentives
  - Hospitals should be triggered positively to participate in hospital accreditation (even if it would be in a compulsory programme). The majority of stakeholders (not only hospitals!) express the expectation that additional financial resources will be provided for the hospitals as a means to stimulate them. At the same time there is a minority of the stakeholders who are of the opinion that a negative accreditation score, as a result of an assessment, should result in repercussions, either by cancelling the 'recognition' or by reducing the financial funds.

- Programme coverage
    - The majority of the stakeholders share the opinion that all hospitals should eventually be subject to accreditation, yet also that this accreditation should concern the entire hospital for the reason that:
    - Processes within a hospital are interacting to the extent that partial accreditation should be 'artificial'
    - Towards the public this would create confusion
    - Allow 'wrong' competition and create opportunity for marketing purposes
- Yet, amongst a significant minority the conviction exists that a growth model should be foreseen to get to the stage of entire accreditation, meaning that in first instance partial accreditation could be an option.

Governance

- Body stakeholders participation
    - The significant majority states that governance of an accreditation body (if installed in Belgium) should be independent. This means that this body is not a governmental entity neither a 'sector' entity (e.g. NIAZ).
- Body internal organisation
    - The different stakeholders are represented in the governance of this body i.e. there is a governance structure in place (responsible amongst other things for standard setting) in which government, professional associations, sickness funds, INAMI/RIZIV, hospital and patient associations are represented.
    - However, from an operational staffing perspective, this is a 'light' body with contractors engaged for execution of the assessments and possible assistance for the hospitals to prepare the assessment. A minority (mainly at hospital association level) shares the opinion that the execution should be left to the community level, yet organised in a different way than the current process of recognition.

Methods

- Standards
    - The significant majority of stakeholders shared the opinion that the standards to be applied during the (self)assessment of a hospital should be defined by a group of experts containing both scientists and 'professional practitioners' (i.e. professionals with active careers) in order to prevent too theoretical standards. Once this team has developed a list of standards, the governance structure within the accreditation body validates the list so it becomes a formally 'recognised and accepted' set of standards.
    - In addition, these standards should not only focus on processes (like ISO) but also include performance indicators (pre-defined outcomes & outputs) and efficiency indicators.
    - There is common agreement amongst the majority of the stakeholders to create evolutionary standards, meaning that standards become more ambitious over time therefore pushing the hospitals towards continuous improvement rather

than a 'minimum' level to be attained by the respective hospitals for accreditation.

- Measurement
    - In the entire accreditation process the 'step' of auto-evaluation or self-assessment should get special attention as this will:
    - Create buy-in at the level of the hospital and stimulate the focus on systemic quality approaches within the hospitals
    - Limit potentially the work-load to be carried out by the team who will conduct the formal external assessment. This has an important impact on cost level.
    - The survey team who will carry out the external assessment is composed of contractuals of multi-disciplinary background and amongst them professional practitioners. This model is clearly different from the current practice with the 'recognition process' in which the team conducting the assessment is composed of civil servants who are no (longer) active professionals.
    - An important opinion, expressed by the majority of the stakeholders, is the importance of WHAT will be measured or assessed, and what impact it may have on the final accreditation decision. There is a demand to focus not merely on the achievement of standards, but also to verify to what extent the hospitals have undertaken concrete actions to: have the capability to register and monitor the according related data, improve on relative weaknesses, have quality approaches in place, … When this is taken into account during the assessment process and somehow awarded/valued in the accreditation decision it will create dynamics for the hospitals with lesser performance (in absolute terms) to keep working on quality improvement.
- Surveyors recruitment & training
    - In the logic of the majority, the governance structure within the accreditation body will be responsible for validation of the standards-set AND for the recruitment and selection of the surveyors team. Contracts can be extended and or terminated by them as well.
    - Apart from the technical and behavioural competencies required, the surveyors team should have active practioners among them and the entire team should get the same training of 'audit standards' as to make sure that all members will apply the same rules and philosophy during the assessments.
- Decision and appeal
    - Most find it of utmost importance that hospitals will get immediate feedback at the end of the external assessment i.e. although the accreditation decision has to be taken afterwards, the surveyor team should be able to provide the hospital management then highlights of their findings so that decision surprises are minimised. A minority of the stakeholders (excluding hospitals) argues though that no feedback is needed at all.
    - Whenever decisions are taken and communicated to the hospitals there should be an appeal process for the respective

hospital. A minority does not support the idea of an appeal process in case of a voluntary accreditation programme i.e. if a hospital decides to participate and asks for participation it takes the risk not to 'pass'.

- Results diffusion
    - There is a common view amongst the significant majority to diffuse accreditation results, yet there is difference of opinion WHAT results should be distributed: the opinions vary from merely publication of the accreditation decision to the other extreme of putting all 'scores' of an individual hospital on the Internet. The reasons to diffuse results are yet the same:
    - Transparency towards the patients
    - Creating the snowball effect amongst hospitals to participate in accreditation and engage in actions to improve and do better next time
    - A minority doesn't see the reason to announce the accreditation decision to an audience larger than the individual hospital itself.

Funding Mechanism & sources

- Expenses
    - The large majority of the stakeholders states that the financial means for developing and running an accreditation programme should come from the Federal Government in the actual situation as the Federal Government is the main financial source for (most) hospitals.
    - In addition, the programme should not generate additional 'costs' for the hospitals (in terms of ROI[xxviii]). A minority goes further by envisioning a financial compensation for the hospitals to participate in the accreditation process.

As far as the 5th element of the Common Framework is concerned, Effect Perspective, there is a common agreement that (ultimately) output and outcome indicators should allow to measure the added value of the hospital accreditation programme so that programme modifications are carried out in function of the evidence based need. Without being exhaustive, as this overview is merely based on the interviews conducted with the individuals representing the consulted stakeholders, the expectations of the different stakeholders can be summarized as follows:

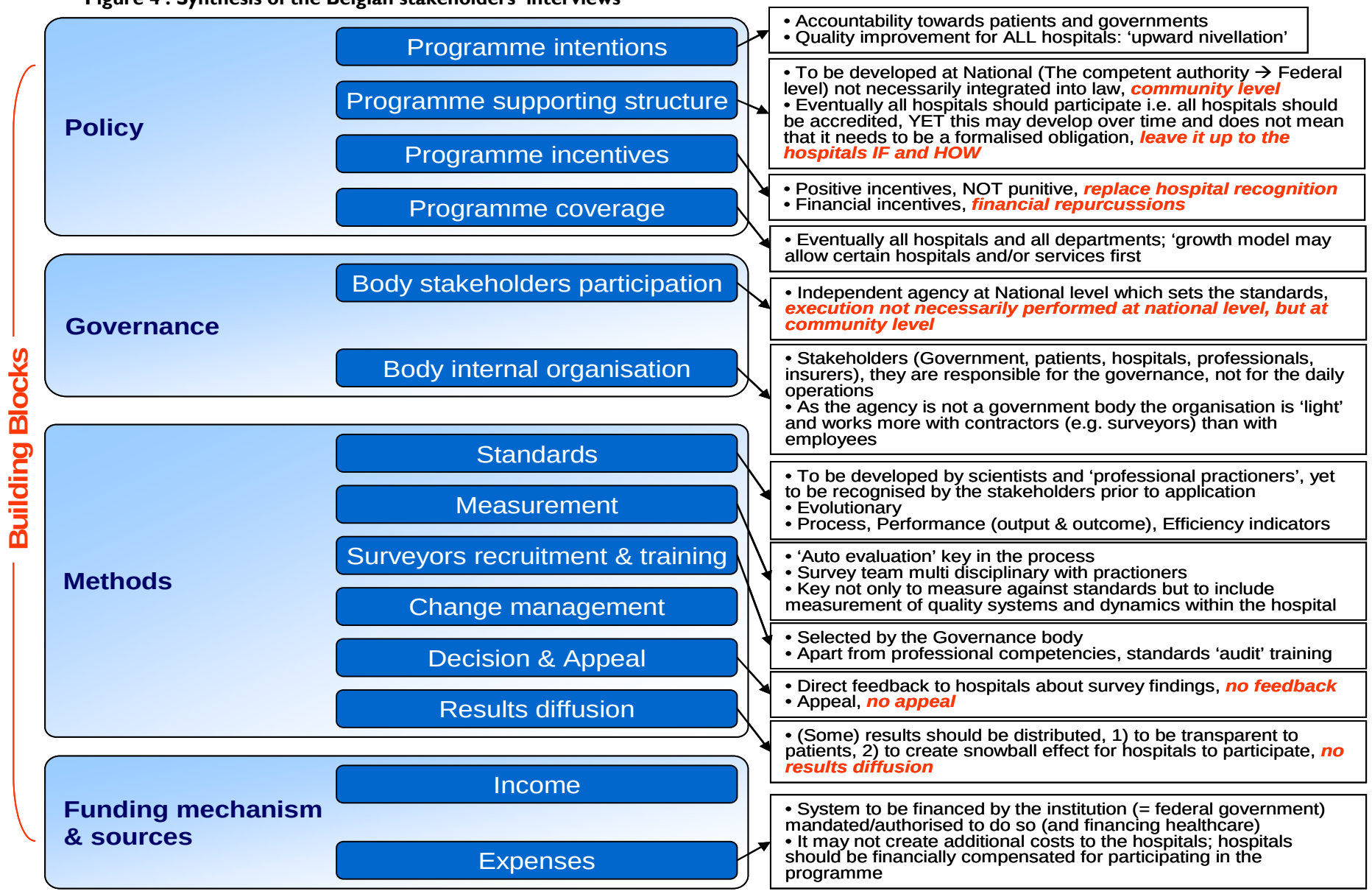
xxviii The Return On Investment is the ratio of money gained or lost on an investment relative to the amount of money invested

Table 10 : Expectation from an accreditation programme per stakeholder

Stakeholder	Expectation from a Hospital Accreditation Programme
Authority/administration	- Outcomes → evaluation of the applied policies - Cost effectiveness - Improved healthcare quality as provided by all hospitals
Medical staff	- Quality measurement & evaluation
Hospitals	- Accountability towards the patient → quality is the ethical duty - Benchmarking - Quality improvement of health care
Insurer	- Linking performance with efficiency - Upward quality nivellation - Providing info to the patients to increase their responsibilities in making choices - Standardization & registration
Patient organizations	- Transparency - Standardization allowing comparison - Accountability of an hospital

In Figure 4, the Common Framework is developed based on the commonalities found by significant majority throughout the interviews, and so in that sense it is indeed about a 'Common' Framework. Whenever deviations are observed from a (significant) minority they are included (in bold italic) as well.

Figure 4 : Synthesis of the Belgian stakeholders' interviews



The interview survey also contained questions on:

- The feasibility to get to an accreditation programme for Belgian hospitals i.e. what are potential blocking points and what should be done to prevent these so that there is buy into such a programme and all elements are in place for a launch.
- Critical Success Factors for a hospital accreditation programme in Belgium i.e. once a hospital accreditation is up and running, hat factors will determine its success.

As this concerns opinions rather than facts, the exhaustive list of arguments is included:

- What are the factors that determine the feasibility for an hospital accreditation programme for Belgium
    - Clear definition of what the aim is: from the very beginning there should be a clear definition of what the final objective of the programme is. This will lead to expectations management and allows the definition of the according expected outcome of such a programme. Only then will it be possible to objectively evaluate the programme once it is up and running
    - Political will and commitment: there needs to be a clear solid position from the policy decision-makers and commitment to liberate the necessary resources and support (structures)
    - Modification of the way healthcare is financed: some state that the current financing model for hospitals would be a threat for a proper launch of a hospital accreditation programme i.e. the different models for financing different hospitals (university, OCMW, public,..) create differences in financial 'margin' and so hospitals would not participate on equal basis
    - Not a compulsory system imposed by the government: there may be strong (financial) incentives for hospitals to participate, yet creating a compulsory system would definitely create opposition from the sector and endanger a good start.
    - Strong involvement of all stakeholders from the start: linked to the previous topic, there is strong belief that the sector has to play a strong role and should be involved in the elaboration and conceptualisation of such a programme. All stakeholders should be actively involved to agree on the objectives and develop a recognised and accepted set of standards and work methods.
    - Gradual implementation with feasible standards and timing: whereas there is a common vision amongst the significant majority of stakeholders that hospitals should be accredited entirely, most think that this may not be necessary feasible from the start. Gradual implementation is needed, with proper preparation prior to it, and this could mean starting initially for instance with the partial accreditation (per department or service), a limited set of standards, or even a selected number of hospitals as pilot prior to general roll out.

- Financial means: An accreditation programme will generate additional costs and so when the programme is developed and conceptualised the according financial means need to be made available, or at least a feasible financial model that would guarantee sustainable programme in the long run should be developed, prior to the launch.
- Investment in the communication and preparation of the hospitals (and other involved actors) about the why: Financial means for operating the programme is one thing, liberating the necessary resources and effort for creating the buy in and preparing the hospitals another. During the preparation phase of the launch a communication campaign towards all stakeholders, and specifically the hospitals, about the objectives and the 'what's in it for them' needs to carried out.

- What are the Critical Success Factors for a 'performant' hospital accreditation programme for Belgium
  - Growth from within the sector: the hospital accreditation programme will gain momentum and become successful in case of a 'bottom up' growth is stimulated. Constant involvement of and feedback with the sector during the further development of the programme is needed.
  - Integration of 'hospital approval' with other audit/evaluation systems like accreditation: the accreditation programme should be relatively light in itself, yet it is even more important to minimize the overall audits related workload for hospitals by aligning audit efforts and for instance explore the possibilities to 'integrate' recognition and accreditation e.g. if accreditation, no separate recognition review is needed.
  - One integrated set of indicators including performance indicators (output & outcome): there needs to be a feasible set of standards which focuses on outcomes (performance indicators) next to others like process and efficiency related standards.
  - Clear responsibility for all actors involved i.e. outcomes are not solely influenced by the hospital: the healthcare provision has a level of complexity and involvement of multiple actors that it has to be ensured that standards applied are indeed related to the performance of the hospitals and/or that interference of other actors are identified and taken into account in the assessment as well.
  - Alignment with International standards: prevent creating an isolated Belgian initiative.
  - Transparency about the system and between the actors: the accreditation programme, the objectives, the guiding principles, methods, process and procedures need to be clear for all involved.
  - Objectivity: the accreditation process and decision need to be taken in a context where objectivity can not be doubted. This plays by the independence of the accreditation body, the composition of the survey team, …

- Competencies of the survey teams and agency personnel have to be recognised as 'best in class'.
- 'Lightness' of the system for the hospitals. It's important to avoid administrative paper mills.
- Accreditation (award) takes into account the relative efforts hospitals put in place to improve their quality and to obtain the standard levels, and not just the standards.

5.2.3 Applicability of standards & availability of data registration

In this section some existing accreditation programs are further analysed. The aim was to compare the parameters used and to see whether relevant information on these items is available in the Belgian healthcare databases. For an overview of the comparision of the used standards see appendix 11.

This analysis is done on programs that are included in section 5 of this report. Details on specific parameters used by the accreditation organisations are sometimes considered as confidential or intellectual property. As a consequence, only limited information is available for detailed analysis.

Programs from the neighbouring countries used for analysis:

- France Haute Autorité de Santé (HAS),
- The Netherlands Nederlands Instituut voor Accreditatie van Ziekenhuizen (NIAZ) and
- UK Health Quality Service (HQS).

Reviewing the web-sites of these organizations it was possible to collect more detailed information:

- The Haute Autorité de Santé presents the most detailed and complete information on the website in the « Manuel de Certification des Établissements de Santé » (édition 2007).
- The Health Quality Service limits detailed information to four standards: Trust Governance (UK only), Risk Management – General, Patient's Rights and Outpatient Service.
- The Nederlands Instituut voor Accreditatie van Ziekenhuizen (NIAZ) presents the structure and detailed information for the criteria that are used.

HQS is the most restrictive organisation in giving detailed information. This limits the comparison of the standards. The standards for risk management were compared in this analysis, as the details of this process were published and accessible for a comparative analysis.

It was not possible to have access to all information of the accreditation programs. The accreditation programs that were analysed have a different background. HAS has a public character, while HQS is a private not for profit professional organisation and NIAZ as a private not for profit organisation supported by the sector. This explains why only limited information is available for detailed analysis.

Nevertheless one can identify differences between the programs. HQS and HAS have a similar approach. A number of standards (références) are grouped in relevant sections. These standards are developed to a similar level of detail.

HQS has 55 standards in the international programme (66 in the UK programme). Taking risk management-general as an example, this standard has been worked out in 21 criteria.

HAS defines 44 "references" grouped in 5 sections with 19 criteria related to risk management. These criteria are part of different "references".

NIAZ uses 73 criteria grouped in 9 "chapters". Eight criteria relate to risk management.

Concerning the specific area of risk management, one can conclude that the three programs are similar. Important items are the existence of a policy on risk management, the use of measured results for analysis and communication and the existence of specific initiatives on safety of care. These are free to define in HAS, while HQS has a number of defined areas. NIAZ uses to a limited extent defined items such as infection and decubitus.

From the standards that are presented one can conclude that the programs focus to a large extent on the organisational and transversal aspects.

HQS defined 65% of the standards to be patient related, 12 of 66 relate directly to specific clinical activity.

In the HAS procedure 57% of the standards are patient related but only 6 are directly linked to clinical activity.

NIAZ in for 91% concentrated on organizational aspects and only 9% can be considered as patient related. This can be explained by the EFQM model that was used as the basis for NIAZ.

HQS uses the largest number of standards to analyse specific medical services.

It may be clear that accreditation is only to a limited extent based on the use of specific clinical performance indicators.

This section was intended to identify typical parameters that are used in the accreditation procedures in other countries and to see whether relevant information on these items is available in the Belgian healthcare databases. A number of databases exist in Belgium on outcome or Clinical Quality Indicators (Study KCE 30A 2006 and study 41A 2006). One has to conclude however that accreditation relates to a large extent to general organisational and transversal hospital wide aspects. These are typically aspects that are hardly available in the Belgian Healthcare databases. Accreditation relates to a varying but limited degree to clinical quality indicators. It is more important that a hospital can demonstrate the efforts that are made to improve than to actually measure in detail the outcome in specific areas.

The standards and references used by HQS, HAS or NIAZ that are summarized in this section cover to a large extent structural and organizational processes in the hospitals. Comparing these topics with the Belgian legislation and existing quality initiatives allows us to conclude that, although Belgium has not an established accreditation program, a number of these topics are indeed covered by this legislation.

Key Points

- **Accreditation is only to a limited extent based on specific clinical performance indicators**
- **Accreditation focuses to a large extent on general organisational and transversal aspects. These are aspects that are hardly available in Belgian healthcare databases**
- **A number of these general organizational and transversal topics are covered by the existing Belgian legislation**

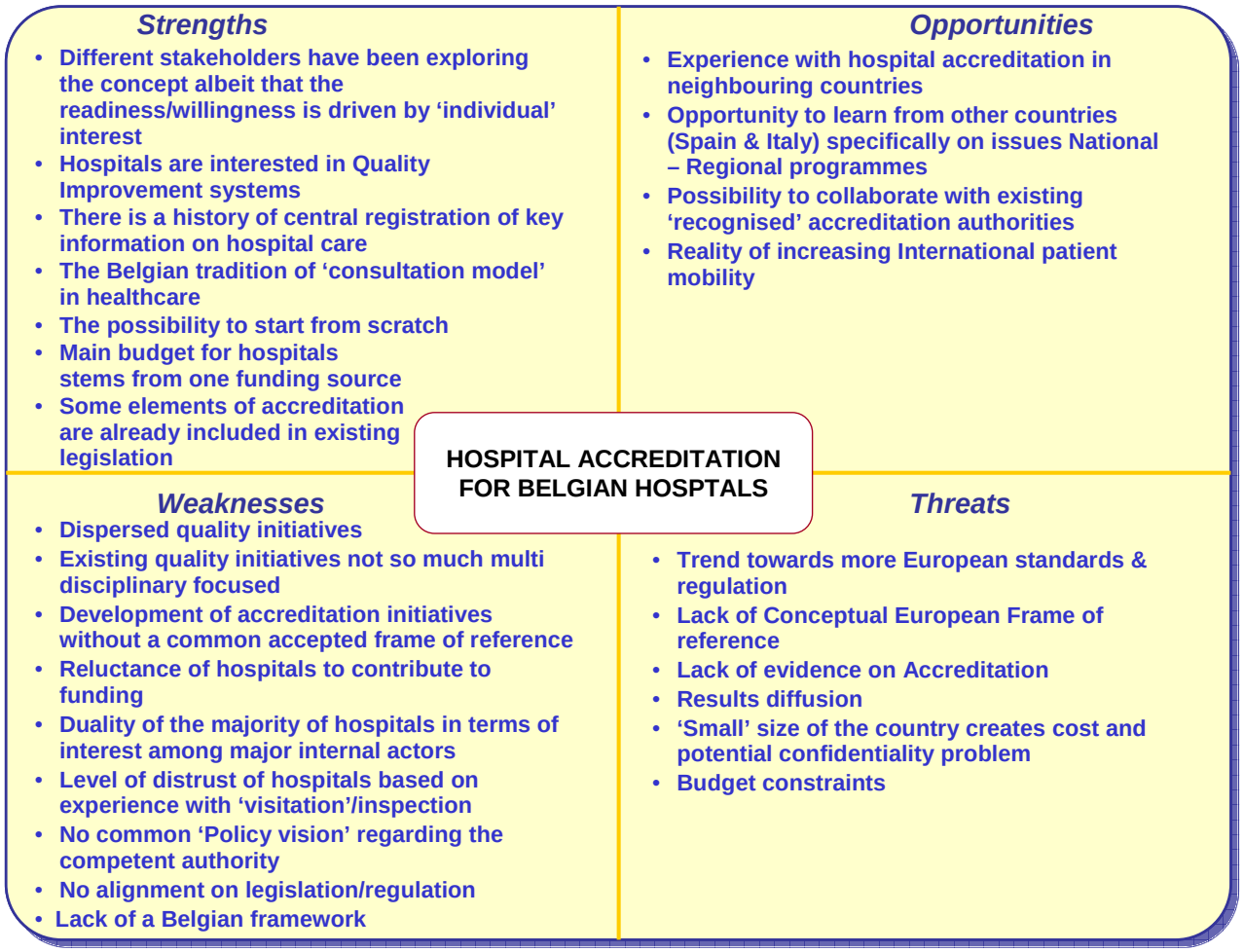
5.2.4 SWOT

Based on the first research question and the second research question it is possible to develop a SWOT for Belgium in the context of exploring hospital accreditation for Belgian hospitals. The starting point for the SWOT development is the definition of accreditation applied for this research project, namely: "initiatives to externally assess hospital against pre-defined explicit published standards in order to encourage continuous improvement of the health care quality".

As explained in the methodology part, the SWOT is based on the inputs gathered from the entire analysis conducted in the Belgian context, the Inventory and Comparative Analysis of Hospital Accreditation Programmes in Europe, the Evidence on Accreditation and the Country Expert meeting of September 12.

From this input we derive, schematically, the following SWOT:

Figure 5 : SWOT



Each of the mentioned elements is further described underneath.

Strengths:

- Different stakeholders have been exploring the concept: Within Belgium it seems that there starts to be a level of readiness or willingness (in function of individual interests) to move towards a quality improvement system for hospitals that is inspired by 'accreditation'. This is based on the different initiatives and

reflections that have been tested and or formulated during the most recent years either by individual actors (hospitals, sickness funds), associations or multiple actor think tank.

- Hospitals are interested in Quality Improvement Initiatives: Hospital associations and individual hospitals feel the importance to engage in quality improvement initiatives albeit for different reasons which may range from 'public accountability' to marketing as 'trigger'. Yet, the result is that many hospitals have initiated quality improvement initiatives.
- There is a history of central registration of key information on hospital care: Belgium has sophisticated databases at its disposal (on different levels: authorities to hospital level) which provide exhaustive detailed data on hospital care. Most likely (parts of) these data can be leveraged for common quality improvement and evaluation purposes.
- The Belgian tradition of 'consultation model' in healthcare: Hospital accreditation may be a complex concept to launch and to agree upon, yet the track record of constructive collaboration and consultation amongst the different stakeholders is a positive element.
- The possibility to start from scratch: despite certain explorations of quality improvement initiatives or even 'accreditation' inspired pilots there is still room to start from scratch which provides the opportunity to make a leap forward rather than some incremental changes of existing initiatives or policies.
- The main budget for hospitals stems from one funding source: this means that decision-making power or mandate is centralised which will make it relatively easier to launch one common direction to follow.
- Some elements covered by accreditation programmes are already enclosed in the existing law i.e. norms concerning infrastructure and lay-out are explicitly part of the recognition process.

<u>Weaknesses:</u>

- Dispersed quality initiatives: although different stakeholders show interest and engagements towards quality improvements there is no single integrated vision behind, which creates a 'spaghetti' of quality improvement programmes
- Existing quality initiatives are to a large extent focused on nursing: as far as quality improvement initiatives for hospitals are concerned, there is possibly a bias to address nursing related aspects rather than broad and medical areas.
- Development of accreditation initiatives without a common agreed frame of reference: As far as initiatives are concerned which have 'accreditation' as inspiration source there is not one single accreditation definition of reference that has served for the development meaning that they can not necessarily be compared and do not have the same assumptions and/or intentions.
- Reluctance of hospitals to contribute to funding: Based on the interviews conducted, most of the individual hospitals and hospital associations reckon that the 'competent authorities' need to fund the exercise and to compensate the hospitals finically for their participation in an accreditation programme.

- Duality of the majority of hospitals in terms of interest among major internal actors: based on the different funding schemes for hospitals and the different contractual status of some actors in the hospitals, a shared vision on accreditation and how to achieve it may be lacking in a number of hospitals and there may be potential conflict of interest.
- Levels of distrust of hospitals based on experience with 'visitation'/inspection: The majority of the hospitals that were interviewed, although partly positive, consider the existing recognition approach, as carried out by regional governments, too heavy and not entirely transparent. This creates suspicion with regards to hospital accreditation if it is going to be organised in the same manner. As far as 'visitation' has developed towards implicit evaluation of standards, resulting in 'shortcomings' in case the hospitals are not compliant, there are some fundamental differences with accreditation which are not well received by the hospitals subject to the 'visitation': standards are not known in advance, which creates the feeling of 'subjectivity', the competencies/profile of the civil servants conducting the assessment are not adapted to the hospital/services visited, …
- No common vision regarding the competent authority: depending on the stakeholder there is a difference of opinion concerning the competent authority to organise and carry out a possible hospital accreditation initiative.
- No alignment on legislation/regulation: as far as legislation of the different actors of the hospitals is concerned this is rather 'individualised' and does not seem to be integrated or aligned.
- Lack of a Belgian frame of reference for the quality concept initiatives which have been launched so far.

<u>Opportunities:</u>

- Experience with hospital accreditation in neighbouring countries: It is evident that Belgium can profit from a richness of information and experience. All information gathered and contacts established in the context of this project are extremely valuable in case Belgium would decide to proceed with hospital accreditation.
- Opportunity to learn from other countries (Spain & Italy) specifically on issues National – Regional programmes: Given Belgium's political structure it is an advantage to have experience from countries which have gained clear lessons from National versus Regional issues as a consequence of the applied hospital accreditation approach.
- Possibility to collaborate with existing 'recognised' accreditation authorities: If Belgium decides to pursue hospital accreditation there is a possibility (cfr. Portugal) to 'shop' abroad for the implementation of the accreditation programme what implies that there is not automatically the need to implement some accreditation body locally. This may prevent (initial) heavy investments and allow a quick start.
- Reality of increasing International patient mobility: Given European and International mobility policies and the central location of Belgium in Europe there is an increasing flow of patients to be expected. Having an Internationally renowned and recognised quality system (cfr. Accreditation) will stimulate patients to opt for Belgian hospitals rather than the ones abroad.

Threats:

- There is a trend of more European standards and regulation, also in the healthcare area which will determine the direction to pursue and may limit the National margins of freedom with quality concepts.
- Lack of a Conceptual European Frame of reference: Despite lengthy experience with hospital accreditation around us, at European level there is yet no single European hospital accreditation frame in place which means that there is no single way to move forward neither.
- Lack of evidence on Accreditation: Although much experience on hospital accreditation and many articles written on the topic there still is no clear scientific evidence based proof that hospital accreditation programmes do effectively contribute to better healthcare quality and most accreditation programmes do actually focus on 'process' indicators rather than performance indicators. So, from a cost effectiveness point of view is it the right thing to do?
- Results diffusion. Based on the comparison amongst the European accreditation programmes it turns out that there is limited transparency as far as the publication of results is concerned. In addition, with the 'limited' knowledge of patients concerning healthcare quality this endangers the misinterpretation and/or wrong perception of those results.
- The relative 'small' size of the country creates 2 potential problems:
    - Costs: regionalisation may generate a multiplication of the minimum necessary costs to develop and run a programme. Based on the experience of the surrounding countries with accreditation programmes (e.g. France, Luxemburg) one can conclude that costs to 'operate' accreditation are significant in itself and regionalisation will most likely only increase these costs as the critical mass and efficiency argument are no longer leveraged.
    - Confidentiality may be a problem: In case hospital accreditation would include peer reviews of representation of sector practitioners during the assessment process there may be a risk of confidentiality and/or conflict of interest with an increased probability of subjectivity.
- Budget constraints: The healthcare sector requires more money and the ageing population has a direct impact on funding priorities, so the question may be if there will be the necessary funding available to engage into hospital accreditation for Belgian hospitals.

Based on this SWOT the Belgian SWOT profile may be summarised as follows:

- Quality improvement initiatives are taking place
- In surrounding countries these initiatives are converted/channelled through hospital accreditation
- Yet, despite a relative long history of accreditation programmes there (still) is no scientific evidence based proof that accreditation has positive impact on outcomes/outputs
- There is a clear call for alignment within and between the different authority levels of Belgium in order to:
    - Create same minimum level of quality for all patients treated in Belgium
    - Assure equal open access for all patients
    - Maximize cost effectiveness for quality
- If opted for Hospital Accreditation multiple scenarios are possible between 2 extremes:
    - Establishment and implementation of a central (federal/regional) accreditation body which will be responsible for the accreditation of Belgian hospitals
    - Accreditation of International existing renowned Accreditation Bodies from which the hospitals can 'shop' for their accreditation
- In any case, involvement of the stakeholders as of the beginning is crucial
- If no decision on one reference frame individual actors will continue to launch quality initiatives in function of their individual interests (quality improvement, strategy, marketing,…)

6 CONCLUSIONS

Based on the described findings and results of the 1st and 2nd research question, 'Inventory and Comparative Analysis of Hospital Accreditation Programmes in Europe' and 'Exploration of Accreditation Opportunities for Belgian Hospitals' respectively, the conclusions can be clustered around these 2 research questions.

6.1 RESEARCH QUESTION 1: 'INVENTORY AND COMPARATIVE ANALYSIS OF HOSPITAL ACCREDITATION PROGRAMMES IN EUROPE'.

Until today there is no evidence on the effectiveness of accreditation.

- After decades of accreditation programmes in place and according money spent, it is striking to conclude that both from the literature study and the international survey no unambiguous outcome related evidence as a result of accreditation can be found. Either outcomes were not measured, and/or outcomes did not improve significantly and/or causality between the accreditation programme and the results could not soundly be established because of different possible biases.

Quality initiatives are driven by increased accountability urgency.

- Whereas quality concepts, amongst which accreditation, were initially voluntary aimed for by professionally-driven continuous improvement, the programmes have increasingly become mechanisms for accountability to the public and to regulatory and funding agencies.
- Like with other governmental money streams, funded by public money, there is pressure to be transparent about financial management of these funds and the effects of hospital care. It is part of the Corporate Governance discussion, where the citizens demand the government to be able to show what outcomes have been realised with the(ir) money spent

Where accreditation programmes have been implemented, there are key success indicators to be taken into account.

- Following key success factors can be identified: Involvement of the sector from the start, working on the cultural readiness of the organisations to move towards accreditation, use of multidisciplinary teams to conduct the external assessments, the importance of 'self assessments'.

Accreditation has become the common denominator in several countries and regions, yet there is no common European vision.

- This research has learned that accreditation is the preferred quality concept applied (16 of the 27 Member States have a programme in place or are launching one shortly).
- Most of the countries, with the exception of Portugal (outsourced to UK HQS), have taken different approaches to implement an accreditation programme based on individual (National) vision and context.
- This translates in variety on all levels of the Common Framework:
    - Voluntary versus compulsory character
    - Accreditation agencies with a governmental versus a commercial character

- Different processes and procedures e.g. peer review, self assessment, …

On the level of standards there is wide variety in terms of spread and depth. Standards are rarely focused on clinical outcomes, but rather on organisational issues.

- Standards, a key element in the concept of accreditation, are very different between the individual programs. Which processes (governance, management, clinical ...) do they cover and which indicators do they focus on e.g. process, patient, human resources, outcome, outputs…?
- Yet there is tendency to move towards ALPHA standards.

6.2 RESEARCH QUESTION 2 'EXPLORATION OF ACCREDITATION OPPORTUNITIES FOR BELGIAN HOSPITALS'

Quality initiatives are under way in Belgium.

- Although Belgium does not have an accreditation programme for hospitals, this does not imply that there are no quality initiatives launched. On the contrary, there are many initiatives under way taken by different stakeholders. The Belgian stakeholders currently act on quality improvement initiatives at different speed. Some are well advanced and anchoring themselves to specific accreditation methods (cfr. Dutch accreditation NIAZ at the Flemish side). Others are very 'individual' and based on other concepts like ISO certification.

Yet, there is no alignment in terms of approach and speed.

- The different initiatives are launched by the stakeholders in function of their interest and/or philosophy without any alignment resulting in multiple approaches and speed which will disperse further over time.

Current financing mechanism does not award quality dynamics

- Whereas the hospitals are to a large extent financed by public funding there is no link with quality dynamics, and so there are no financial incentives that stimulate hospitals to engage into quality improvement approaches. Criteria to receive funding seem to be the level of complexity rather than improved health care quality or quality systems.

International patient mobility may push for accreditation

- International Patient mobility will strengthen the demand for an International/European frame of reference. And although the existing accreditation programmes do differ strongly, 'accreditation' is the logic reference as this is the quality concept applied by most. In case of no accreditation programme for Belgium this could result in 'missed' opportunities.

6.3 RECOMMENDATIONS

Based on the conclusions of the report, a recommendation whether a hospital accreditation programme in Belgium is the way to go or not can not be formulated. Until today there's no evidence on the effectiveness of hospital accreditation sustaining the creation of such a programme. Evaluations and the experiences in several European countries however demonstrate that hospital accreditation

generates a quality improvement dynamics. If political decision making however would end in the implementation of a hospital accreditation programme, the following principles should be taken into account:

A preliminary step to be taken is a policy decision determining at what level hospital accreditation will be organised.

From an efficiency point of view, any overlap of competences between the federal and the regional level has to be avoided.

The feasibility of an eventual accreditation program for Belgium should be the result of determined fundamentals

The following steps are part of the determination of the fundamentals:

- Unambiguous definition of the objectives to be achieved i.e. what should the implementation of accreditation lead to in terms of well defined tangible objectives.
- Clarification of the roles and responsibilities of the different stakeholders. This concerns the agreement on the role and division of competences between the different authorities and also of the other stakeholders if applicable.
- Translation of the objectives into measurable indicators, including outcomes:
    - The validity of any approach opted for ought to be, in terms of effects generated, measurable throughout the life cycle of such a programme. The lessons learned from the International experience, more specifically the lack of evidence on accreditation and its relation with outcome, should be leveraged by the development of a Hospital Accreditation Mechanism (HAM) that assures the causal relationship between the programme and quality improvement.
    - Develop an appropriate set of standards as to make sure that at hospital level the outcomes (amongst other indicators) are assessed. Some of the existing Belgian initiatives do focus on outcome and could be placed in the aligned framework.
- Impact analysis of:
    - The existing legislation & regulation in case a specific accreditation programme should be established.
    - The financing system. Does financing of hospitals remain unchanged? Would financing be linked (positively and/or negatively) to accreditation results?
    - The efforts/costs that would (need to) be generated at individual hospital level.
- Alignment of registration systems, already in place, to make sure that necessary data can be measured.

7 APPENDICES

APPENDIX 1. DETERMINATION OF THE FRAMEWORKT TO ANALYSE ACCREDITATION (CHAPTER 2.1)

Joint Commission International[29]

The mission of Joint Commission International is to continuously improve the safety and quality of care in the international community through the provision of education and consultation services and international accreditation.

Joint Commission International (JCI) is a division of Joint Commission Resources (JCR), the subsidiary of The Joint Commission. For more than 50 years, The Joint Commission and its predecessor organization have been dedicated to improving the quality and safety of health care services. Today the largest accreditor of health care organizations in the United States, the Joint Commission surveys nearly 20,000 health care programs through a voluntary accreditation process. The Joint Commission and its subsidiary are both not-for-profit corporations.

APPENDIX 2. THE METHODOLOGY FOR EVIDENCE ON THE EFFECTIVENESS OF ACCREDITATION (CHAPTER 2.2)

Search strategy

A specific and focused search was performed with regard to the research question "Evidence on Accreditation". This research question falls within the scope of the 1st research question, namely the Inventory and Comparative Analysis of Hospital Accreditation Programmes in Europe (cfr. Infra appendix 3) but it aims at a more theoretical country-independent approach. Therefore the search strategy was refined.

Since the databases Medline and Embase offered most of the relevant results with regard to the 1st research question, these databases and additionally Econlit and EBSCO have been explored.

29 http://www.jointcommissioninternational.com

Table 1: Search strategy Medline

Date	Search strategy elaboration : 14/08/2007		
Database	Medline http://www.ncbi.nlm.nih.gov/entrez		
Search Strategy	1. "standards "[Subheading] Limits: published in the last 5 years, English, French (94466) 2. "Quality Indicators, Health Care"[Mesh] Limits: published in the last 5 years, English, French (2811) 3. "Outcome Assessment (Health Care)"[Mesh] Limits: published in the last 5 years, English, French (149738) 4. ((#1) OR (#2)) OR (#3) Limits: published in the last 5 years, English, French (238379) 5. "Licensure, Hospital"[Mesh] Limits: published in the last 5 years, English, French (16) 6. "Certification"[Mesh] Limits: published in the last 5 years, English, French (2213) 7. "Accreditation"[Mesh] Limits: published in the last 5 years, English, French (2743) 8. ((#5) OR (#6)) OR (#7) Limits: published in the last 5 years, English, French (4843) 9. "Hospitals"[Mesh] Limits: published in the last 5 years, English, French (22354) 10. ((#8)) AND (#9) Limits: published in the last 5 years, English, French (389) 11. (#10) AND (#4) Limits: published in the last 5 years, English, French (320) Strategy 2 : Since the inclusion of the word hospital excludes a significant number of interesting articles a second strategy without the term “hospital” has been run 12. (#4) AND (#8) Limits: published in the last 2 years, English, French (1114)		

Table 2: Search strategy Embase

Date	Search strategy elaboration : 18/09/2007		
Database	Embase http://www.embase.com		
Search Strategy **Note: Licensing covers the concept accreditation and certification**	1. 'outcome assessment'/exp AND ([dutch]/lim OR [english]/lim OR [french]/lim) AND [embase]/lim AND [20 -02-2007]/py (25,605) 2. 'standard'/exp AND ([dutch]/lim OR [english]/lim OR [french]/lim) AND [embase]/lim AND [2002-2007]/py (19,721) 3. 'clinical indicator'/exp AND ([dutch]/lim OR [engl ish]/lim OR [french]/lim) AND [embase]/lim AND [20 02-2007]/py (105) 4. 'performance measurement system'/exp AND ([dutch]/ lim OR [english]/lim OR [french]/lim) AND [embase] /lim AND [2002-2007]/py (318) 5. 'licensing'/exp AND ([dutch]/lim OR [english]/lim OR [french]/lim) AND [embase]/lim AND [2002-2007]/ py (7,914) 6. #1 OR #2 OR #3 OR #4 (45,425) 7. #5 AND #6 (467)		

Additionally some hand searching was performed. 1 review article was found via the Canadian Health Services Research Foundation (http://www.chsrf.ca/home_e.php) and 1 relevant article via the Institute for healthcare improvement (http://www.ihi.org/ihi). Articles from the reference list of these respective articles were also included.

The review article served as a basis for an additional search in Medline and Embase. Since the final run of the search was performed till July 2006, the same strategy was performed in Medline from 01/08/2006 till 21/09/2007. The same search was done in Embase. Since the first 200 results were not relevant, the search in Embase was considered not to be relevant.

Table 3: search strategy Medline

Date	Search strategy elaboration : 21/09/2007		
Database	Medline http://www.ncbi.nlm.nih.gov/entrez		
Search Strategy	1. "outcome"[All Fields] (629201) 2. "performance"[All Fields] (325873) 3. licen* (23718) licen[All Fields] OR licenca[All Fields] OR licencas[All Fields] OR licence[All Fields] OR licence'[All Fields] OR licence's[All Fields] OR licenced[All Fields] OR licenced'[All Fields] OR licencee[All Fields] OR licencees[All Fields] OR licences[All Fields] OR licencia[All Fields] OR licenciada[All Fields] OR licenciado[All Fields] OR licenciados[All Fields] OR licenciamento[All Fields] OR licenciamiento[All Fields] OR licencias[All Fields] OR licenciate[All Fields] OR licenciateship[All Fields] OR licenciatura[All Fields] OR licenciaturas[All Fields] OR licenciature[All Fields] OR licencie[All Fields] OR licenciee[All Fields] OR licenciement[All Fields] OR licenciements[All Fields] OR licencier[All Fields] OR licencing[All Fields] OR licencive[All Fields] OR licencja[All Fields] OR licencji[All Fields] OR licencjonowania[All Fields] OR liceni[All Fields] OR licenia[All Fields] OR licenovski[All Fields] OR licensability[All Fields] OR licensable[All Fields] OR licensation[All Fields] OR licensatura[All Fields] OR license[All Fields] OR license/monopoly[All Fields] OR license'[All Fields] OR licensed[All Fields] OR licensed'[All Fields] OR licensee[All Fields] OR licensee's[All Fields] OR licensees[All Fields] OR licensees/managers[All Fields] OR licensees'[All Fields] OR licensers[All Fields] OR licenses[All Fields] OR licensforskrivning[All Fields] OR licensiate[All Fields] OR licensing[All Fields] OR licensing/accreditation[All Fields] OR licensing/approval[All Fields] OR licensing/certification[All Fields] OR licensing/certifying[All Fields] OR licensing/credentialing[All Fields] OR licensing/disciplinary[All Fields] OR licensing/market[All Fields] OR licensing'[All Fields] OR licenslakemedel[All Fields] OR licensor[All Fields] OR licensors[All Fields] OR licenspreparat[All Fields] OR licenstein[All Fields] OR licensure[All Fields] OR licensure/accreditation[All Fields] OR licensure/authority[All Fields] OR licensure/certification[All Fields] OR licensure/classification[All Fields] OR licensure/economics[All Fields] OR licensure/education[All Fields] OR licensure/ethics[All Fields] OR licensure/history[All Fields] OR licensure/methods[All Fields] OR licensure/resigtration[All Fields] OR licensure/standards[All Fields] OR licensure/trends[All Fields] OR licensure/utilization[All Fields] OR licensure'[All Fields] OR licensureexamination[All Fields] OR licensures[All Fields] OR licentia[All Fields] OR licentiaat[All Fields] OR licentiana[All Fields] OR licentiat[All Fields] OR licentiatavhandling[All Fields] OR licentiate[All Fields] OR licentiate's[All Fields] OR licentiates[All Fields] OR licentiates'[All Fields] OR licentiatgrad[All Fields] OR licentiatgraden[All Fields] OR licentie[All Fields] OR licentious[All Fields] OR licentiousness[All Fields] OR licenza[All Fields] OR licenze[All Fields] OR licenziati[All Fields] OR licenziato[All Fields] 4. certif* (30357) certifaction[All Fields] OR certifcation[All Fields] OR certifed[All Fields] OR certifi[All Fields] OR certifiability[All Fields] OR certifiable[All Fields] OR certifiably[All Fields] OR certifica[All Fields] OR certificaat[All Fields] OR certificaatwaardige[All Fields] OR certificabile[All Fields] OR certificable[All Fields] OR certificacao[All		

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	accreditativn[All Fields] OR accreditato[All Fields] OR accredite[All Fields] OR accredited[All Fields] OR accredited/approved[All Fields] OR accredited'[All Fields] OR accreditedfamily[All Fields] OR accrediteds[All Fields] OR accrediter[All Fields] OR accrediting[All Fields] OR accredition[All Fields] OR accreditive[All Fields] OR accreditor[All Fields] OR accreditors[All Fields] OR accredits[All Fields] 7. #1 OR #2 Limits: Publication Date from 2006/08/01 to 2007/09/21, English, French, Dutch (88326) 8. #3 OR #4 OR #5 OR #6 Limits: Publication Date from 2006/08/01 to 2007/09/21, English, French, Dutch (4218) 9. #7 and #8 Limits: Publication Date from 2006/08/01 to 2007/09/21, English, French, Dutch (706)

Table 4: search strategy EBSCO

Date	28/11/2007
Database **EBSCO**	http://ejournals.ebsco.com.vdicp.health.fgov.be:8080/home.asp
Search Strategy	1 Hospital AND accreditation (41) 2 Hospital AND licensure (3) 3 Hospital AND certification (14)

An additional search was performed in Econlit, but no relevant results were obtained

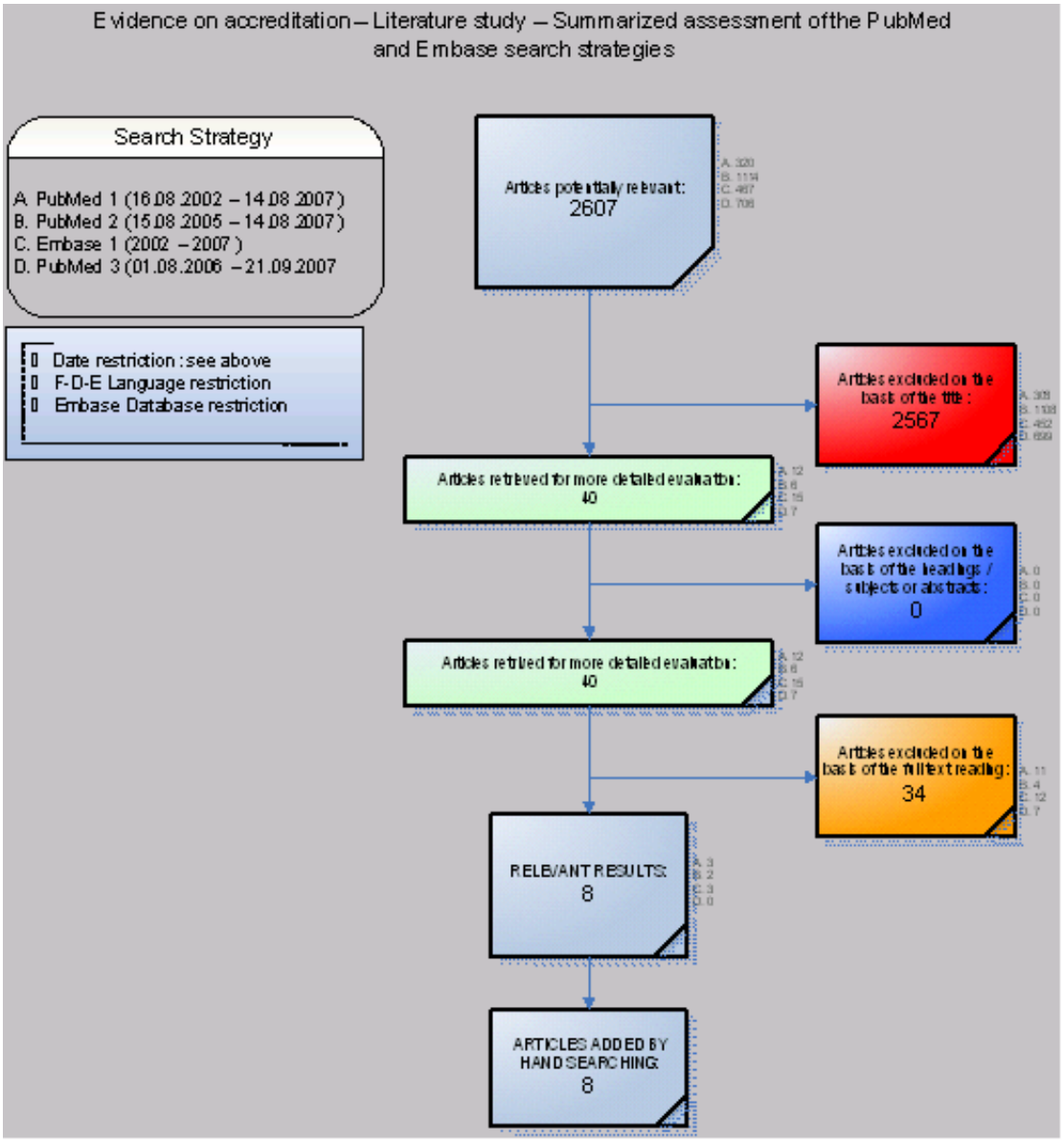
Table 5: search strategy Econlit

Date	28/11/2007
Database **Econlit via OVID**	http://gateway.tx.ovid.com
Search Strategy	1 accredit$.mp. [mp=heading words, abstract, title, country as subject] (93) 2 certif$.mp. [mp=heading words, abstract, title, country as subject] (1084) 3 licens$.mp. [mp=heading words, abstract, title, country as subject] (3741) 4 guidelines adherence.mp. [mp=heading words, abstract, title, country as subject] (0) 5 (outcome and process assessment).mp. [mp=heading words, abstract, title, country as subject] (0) 6 peer review.mp. [mp=heading words, abstract, title, country as subject] (68) 7 quality assurance.mp. [mp=heading words, abstract, title, country as subject] (143) 8 credent$.mp. [mp=heading words, abstract, title, country as subject] (159) 9 austria.mp. [mp=heading words, abstract, title, country as subject] (2112) 10 belgium.mp. [mp=heading words, abstract, title, country as subject] (2459) 11 bulgaria.mp. [mp=heading words, abstract, title, country as subject] (1188) 12 cyprus.mp. [mp=heading words, abstract, title, country as subject] (420) 13 czech republic.mp. [mp=heading words, abstract, title, country as subject] (3245) 14 denmark.mp. [mp=heading words, abstract, title, country as subject] (2635) 15 estonia.mp. [mp=heading words, abstract, title, country as subject] (543) 16 finland.mp. [mp=heading words, abstract, title, country as subject] (3047) 17 france.mp. [mp=heading words, abstract, title, country as subject] (10965) 18 germany.mp. [mp=heading words, abstract, title, country as subject] (16114) 19 greece.mp. [mp=heading words, abstract, title, country as subject] (2659) 20 hungary.mp. [mp=heading words, abstract, title, country as subject] (3927)

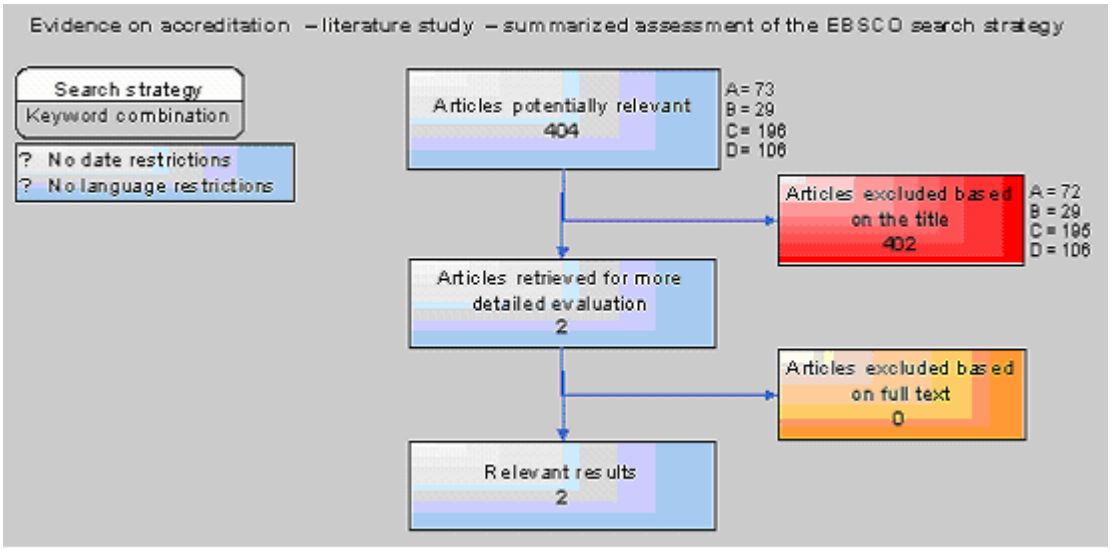
	21 ireland.mp. [mp=heading words, abstract, title, country as subject] (3099) 22 italy.mp. [mp=heading words, abstract, title, country as subject] (9723) 23 luxembourg.mp. [mp=heading words, abstract, title, country as subject] (288) 24 malta.mp. [mp=heading words, abstract, title, country as subject] (139) 25 the netherlands.mp. [mp=heading words, abstract, title, country as subject] (2867) 26 poland.mp. [mp=heading words, abstract, title, country as subject] (3621) 27 portugal.mp. [mp=heading words, abstract, title, country as subject] (1377) 28 romania.mp. [mp=heading words, abstract, title, country as subject] (1109) 29 slovakia.mp. [mp=heading words, abstract, title, country as subject] (790) 30 slovenia.mp. [mp=heading words, abstract, title, country as subject] (1138) 31 spain.mp. [mp=heading words, abstract, title, country as subject] (7279) 32 sweden.mp. [mp=heading words, abstract, title, country as subject] (5492) 33 great britain.mp. [mp=heading words, abstract, title, country as subject] (1233) 34 europe.mp. [mp=heading words, abstract, title, country as subject] (34197) 35 european union.mp. [mp=heading words, abstract, title, country as subject] (5728) 36 Latvia.mp. [mp=heading words, abstract, title, country as subject] (294) 37 1 or 2 or 3 or 6 or 7 or 8 (5227) 38 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 (99805) 39 37 and 38 (854) 40 limit 39 to (yr="2002 - 2007" and (dutch or english or french)) (512)

Results

Flowchart 1: Medline and Embase search strategies results



Flowchart 2: EBSCO search strategy results



APPENDIX 3. THE METHODOLOGY FOR INVENTORY AND COMPARATIVE ANALYSIS OF THE EUROPEAN ACCREDITATION PROGRAMMES - LITERATURE STUDY (CHAPTER 2.3)

Table 6: Research questions

	Comparative analysis of the European accreditation programmes - Literature study - Research questions
	Policy
1	Does an hospital accreditation program exist ?
2	At what level do accreditation programs exist (centralization/regional level) ?
3	What is the purpose of the hospital accreditation program ?
4	Since when does the hospital accreditation program exist ?
5	What law authorises the hospital accreditation program in the country ? Since when ?
6	Is there one single hospital accreditation program or do variants/deviations exist, and based on what criteria ?
7	What is the character of the hospital accreditation program (compulsory vs optional) ?
8	Does the hospital accreditation program fit within a larger quality program ?
9	What are the implications of a positive evaluation for the hospital ?
10	What are the implications of a negative evaluation for the hospital ?
11	Has the accreditation program undergone modifications? If so, based on what reasons?
	Strategy
	Generic
12	What does the hospital accreditation program cover in terms of spread and depth (e.g. dimensions/processes) ?
13	What is the validity term of an hospital accreditation ?
14	Which hospitals are concerned by accreditation program, and based on what criteria ?
15	What kind of reporting takes place ?
16	Are there formal incentive mechanisms in place to stimulate hospitals to apply ?
17	Are there different levels of accreditation? (with recommendations/without recommendations)
	Standards & norms
18	What are the standards and the norms ?
19	Who defines the set of standards ?
20	Who defines the norms ?
21	Is there a focus on proces- or performance-indicators (norms/standards)?
22	Minimal or optimal standards/norms ?
23	Can standards/norms be applied for the global accreditation program or do they differ sectorially ?
24	Do standards evolve i.e. does the required (minimum) level move up over time ?
	Macro organization
25	Is there an accreditation body (responsible for the hospital accreditation process), what is the internal organization ?
26	Who does the accreditation body depend on (ministry, other or independent) ?
27	Who are the stakeholders involved (e.g. are patients represented) ?
28	What is the authority/mandate of the accreditation body ?
29	Is there an evaluation mechanism of the Accreditation Program as such, if so what are the key elements of the mechanism ?
	Implementation
	Procedure
30	What is the hospital accreditation procedure / what are the steps (e.g. peer review) ?
31	What is the average leadtime of the hospital accreditation procedure ?
	Assessment mission
32	What is the assessment survey visits cycle (or the hospital accreditation assessment cycle) ?
33	What are the assessment survey methods ?
34	What are the tools to prepare assessment survey for the surveyors ?
35	What are the tools to prepare assessment survey for hospital ?
36	How long takes an assessment survey mission ?
37	What is the composition of the assessment survey team ?
	Impacts
38	What are the impacts of the hospital accreditation program on the organization and processes of the hospital ?
39	Are hospital accreditation results available, per hospital and how are they made available ?
40	Are there indirect incentives to stimulate hospitals to be best in class ?
	Financials
41	What are the costs involved to run the hospital accreditation program, at what level (ministry, accreditation body, hospitals, other..) ?
42	How is the hospital accreditation financed ?
43	Is hospital accreditation program 'free' or are hospitals supposed to pay a fee ?
44	What are (indirect) financial implications for hospitals (e.g. on premiums they pay to insurance companies) ?
	Outcomes
45	What outcomes have been realised ?
46	How are these outcomes measured ?
47	What is the cost effectiveness of the hospital accreditation ?

Search strategy

Search in databases

A consistent search strategy was next built to find answers to the research questions.

First the relevant databases were selected. 5 keywords combinations covering the hospital accreditation thematic were determined:

- Hospital AND accredit* (accreditation-accredited),
- Hospital AND certificat* (certification-certificate),
- Hospital AND licens* (licensure-licensing),
- Hospital AND "quality improvement", and
- Hospital AND "quality assessment"

They were then tested in most of the databases listed in the Standard Research Procedure in order to get an indication on the engine's relevance. The databases which seemed potentially relevant were all tested[30] while the ones which appeared irrelevant were excluded directly from the start. Besides, it was decided to test OAIster and Bibliothèque des Rapports Publics, and to consider Embase and Google as relevant.

After application of predetermined testing rules, Medline, British Library, COPAC, WHOLIS, OECD and OAIster appeared to be relevant and were therefore the subject of a search strategy, as Embase and Google. Additionally Econlit and EBSCO were explored.

On the 9 selected databases engines, Medline and Embase proposed a thesaurus: adapted headings-based search strategies were thus developed with headings covering "accreditation", "hospital" and "countries" dimensions. The other databases were first searched via the index when available, but it was then decided to build individual keywords-based search strategies as these indexes appeared unreliable.

These search strategies were next run with specific search restrictions when possible: publication date > 01.01.2002 for articles and > 01.01.2004 for books ; language = French, Dutch or English ; database = Embase only.

It delivered a total of 2241 results: 308 for Medline, 216 for British Library, 33 for COPAC, 28 for WHOLIS, 702 for OECD, 412 for OAIster, 184 for Embase, 300 for Google and 58 for EBSCO.

Methodology to test the pertinence of the database:

- Entering extensive keywords combinations if the truncation is not recognized by the database or of truncated terms if it is ; entering additional keywords combination between quotation marks if a combination including the "AND" operator gives more than 250 results,
- Assessment of the 50 first results of each entered combination on the basis of the global definition of accreditation, the list of questions and the list of countries, and
- Definitive selection of the database if at least 1 result is considered as relevant among all the assessed results

30 Medline, Cochrane Library, ACP Journal Club, Evidence-based Medicine, CRD, TRIP, Clinical trials, Controlled trials, OMNI, AHRQ, British Library, COPAC, WHOLIS and OECD

Legend:

° : Relevant results among the 50 first results

❶ : No limits were put for the search because there were no such possibilities on the database

❶ : Limit : the date (>01.01.1997)

❷ : Limit : the language (F-D-E = French, Dutch, English)

❸ : Both limits were put

Table 7: Medline search strategy

Date	**Database pertinence assessment : 13/04/2007** **Search strategy elaboration : 25/04/2007**		
Database	Medline http://www.ncbi.nlm.nih.gov/entrez	Results	Relevant results°
	Hospital AND accredit* ((("hospitals"[TIAB] NOT Medline[SB]) OR "hospitals"[MeSH Terms] OR hospital[Text Word]) AND (accredit[All Fields] OR accreditable[All Fields] OR accreditamento[All Fields] OR accreditata[All Fields] OR accreditate[All Fields] OR accreditated[All Fields] OR accreditatie[All Fields] OR accreditatiesysteem[All Fields] OR accreditating[All Fields] OR accreditation[All Fields] OR accreditation/approval[All Fields] OR accreditation/assessment[All Fields] OR accreditation/certification[All Fields] OR accreditation/classification[All Fields] OR accreditation/economics[All Fields] OR accreditation/education[All Fields] OR accreditation/ethics[All Fields] OR accreditation/history[All Fields] OR accreditation/long[All Fields] OR accreditation/methods[All Fields] OR accreditation/quality[All Fields] OR accreditation/reaccreditation[All Fields] OR accreditation/standards[All Fields] OR accreditation/trends[All Fields] OR accreditation/utilization[All Fields] OR accreditation'[All Fields] OR accreditation's[All Fields] OR accreditational[All Fields] OR accreditations[All Fields] OR accreditative[All Fields] OR accreditativn[All Fields] OR accreditato[All Fields] OR accredite[All Fields] OR accredited[All Fields] OR accredited/approved[All Fields] OR accredited'[All Fields] OR accreditedfamily[All Fields] OR accrediteds[All Fields] OR accrediter[All Fields] OR accreditied[All Fields] OR accrediting[All Fields] OR accredition[All Fields] OR accreditive[All Fields] OR accreditor[All Fields] OR accreditors[All Fields] OR accredits[All Fields]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])	2500	1
	Hospital accredit* (hospital accreditation[All Fields] OR hospital accreditor[All Fields]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])	58	5
	Hospital AND certificat* ((("hospitals"[TIAB] NOT Medline[SB]) OR "hospitals"[MeSH Terms] OR hospital[Text Word]) AND (certificat[All Fields] OR certificate[All Fields] OR certificate/associate[All Fields] OR certificate/enrollment[All Fields] OR certificate/interdisciplinary[All Fields] OR certificate'[All Fields] OR certificate's[All Fields] OR certificated[All Fields]	1526	0

	OR certificaten[All Fields] OR certificates[All Fields] OR certificates/degrees[All Fields] OR certificates/discharge[All Fields] OR certificates/jurisprudence[All Fields] OR certificates'[All Fields] OR certificati[All Fields] OR certificatie[All Fields] OR certificatin[All Fields] OR certificating[All Fields] OR certificatio[All Fields] OR certification[All Fields] OR certification/accreditation[All Fields] OR certification/and[All Fields] OR certification/classification[All Fields] OR certification/economics[All Fields] OR certification/ethics[All Fields] OR certification/examinations[All Fields] OR certification/history[All Fields] OR certification/licensure[All Fields] OR certification/manpower[All Fields] OR certification/methods[All Fields] OR certification/recertification[All Fields] OR certification/recognition[All Fields] OR certification/registration[All Fields] OR certification/resident[All Fields] OR certification/selection[All Fields] OR certification/standards[All Fields] OR certification/trends[All Fields] OR certification/utilization[All Fields] OR certification'[All Fields] OR certification's[All Fields] OR certifications[All Fields] OR certifications/credentials[All Fields] OR certificativa[All Fields] OR certificative[All Fields] OR certificativi[All Fields] OR certificato[All Fields] OR certificator[All Fields] OR certificators[All Fields] OR certificatory[All Fields] OR certificats[All Fields]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT]) Hospital certificat* hospital certification[All Fields] AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT]) Hospital AND licens* (("hospitals"[TIAB] NOT Medline[SB]) OR "hospitals"[MeSH Terms] OR Hospital[Text Word]) AND (licensability[All Fields] OR licensable[All Fields] OR licensation[All Fields] OR licensatura[All Fields] OR license[All Fields] OR license/monopoly[All Fields] OR license'[All Fields] OR licensed[All Fields] OR licensed'[All Fields] OR licensee[All Fields] OR licensee's[All Fields] OR licensees[All Fields] OR licensees/managers[All Fields] OR licensees'[All Fields] OR licensers[All Fields] OR licenses[All Fields] OR licensforskrivning[All Fields] OR licensiate[All Fields] OR licensing[All Fields] OR licensing/approval[All Fields] OR licensing/certification[All Fields] OR licensing/certifying[All Fields] OR licensing/credentialing[All Fields] OR licensing/disciplinary[All Fields] OR licensing/market[All Fields] OR licensing'[All Fields] OR licenslakemedel[All Fields] OR licensor[All Fields] OR licensors[All Fields] OR licenstein[All Fields] OR licensure[All Fields] OR licensure/accreditation[All Fields] OR licensure/authority[All Fields] OR licensure/certification[All Fields] OR licensure/classification[All Fields] OR licensure/economics[All Fields] OR licensure/education[All Fields] OR licensure/ethics[All Fields] OR licensure/history[All Fields] OR licensure/methods[All Fields] OR licensure/resigtration[All Fields] OR licensure/standards[All Fields] OR licensure/trends[All Fields] OR licensure/utilization[All Fields] OR licensure'[All Fields] OR licensureexamination[All Fields] OR licensures[All Fields]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT]) Hospital licens*	3 761	0 0

	(hospital licensed[All Fields] OR hospital licensing[All Fields] OR hospital licensure[All Fields]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])		
	Hospital AND "quality improvement" (("hospitals"[TIAB] NOT Medline[SB]) OR "hospitals"[MeSH Terms] OR Hospital[Text Word]) AND "quality improvement"[All Fields] AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])	41	0
	"Hospital quality improvement" "Hospital quality improvement"[All Fields] AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])	1669	1
	Hospital AND "quality assessment" (("hospitals"[TIAB] NOT Medline[SB]) OR "hospitals"[MeSH Terms] OR Hospital[Text Word]) AND "quality assessment"[All Fields] AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/13"[PDAT])	23	1
	→ RELEVANT Thesaurus available	243	0
Search Strategy	Method A search strategy has been created on the basis of the relevant headings for the scope of our search, i.e. our definition of "accreditation", hospitals and countries of the European Union. As we realized some relevant articles didn't mention "hospitals" but "health care", we added this notion on the form of "health care" to include them. 1. "Guideline Adherence"[MeSH] (7926) 2. "Outcome and Process Assessment (Health Care)"[MeSH:NoExp] (6560) 3. "Outcome Assessment (Health Care)"[MeSH:NoExp] (20418) 4. "Peer Review, Health Care"[MeSH] (702) 5. "Quality Assurance, Health Care"[MeSH:NoExp] (15361) 6. "Credentialing"[MeSH:NoExp] (1413) 7. "Accreditation"[MeSH] (5597) 8. "Licensure"[MeSH:NoExp] (1619) 9. "Licensure, Hospital"[MeSH] (39) 10. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 (55575) 11. "Hospitals/standards"[MeSH] (5213) 12. "Hospital Administration/standards"[MeSH:NoExp] (959) 13. "health care"[Title] (18075) 14. 11 OR 12 OR 13 (23929) 15. "Austria"[MeSH] (2566) 16. "Belgium" [MeSH] (3802) 17. "Bulgaria"[MeSH] (624) 18. "Cyprus"[MeSH] (196) 19. "Czech Republic"[MeSH] (1319) 20. "Denmark"[MeSH] (5921)		

	21. "Estonia"[MeSH] (583) 22. "Finland"[MeSH] (7560) 23. "France"[MeSH] (21122) 24. "Germany"[MeSH] (13755) 25. "Greece"[MeSH] (4014) 26. "Hungary"[MeSH] (1667) 27. "Ireland"[MeSH] (3417) 28. "Italy"[MeSH] (15053) 29. "Latvia"[MeSH] (189) 30. "Lithuania"[MeSH] (467) 31. "Luxembourg"[MeSH] (97) 32. "Malta"[MeSH] (167) 33. "Netherlands"[MeSH] (15162) 34. "Poland"[MeSH] (3226) 35. "Portugal"[MeSH] (1684) 36. "Romania"[MeSH] (635) 37. "Slovakia"[MeSH] (609) 38. "Slovenia"[MeSH] (696) 39. "Spain"[MeSH] (9748) 40. "Sweden"[MeSH] (13216) 41. "Great Britain"[MeSH] (86112) 42. "Europe"[MeSH] (242498) 43. "European Union"[MeSH] (3990) 44. 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 (246774) 45. 10 AND 14 (3927) 46. 44 AND 45 (591) = ("Guideline Adherence"[MeSH] OR "Outcome and Process Assessment (Health Care)"[MeSH:noexp] OR "Outcome Assessment (Health Care)"[MeSH:noexp] OR "Peer Review, Health Care"[MeSH] OR "Quality Assurance, Health Care"[MeSH:noexp] OR "Credentialing"[MeSH:noexp] OR "Accreditation"[MeSH] OR "Licensure"[MeSH:noexp] OR "Licensure, Hospital"[MeSH]) AND ("hospitals/standards"[MeSH] OR "hospital administration/standards"[MeSH:noexp] OR health care[Title]) AND ("Austria"[MeSH] OR "Belgium"[MeSH] OR "Bulgaria"[MeSH] OR "Cyprus"[MeSH] OR "Czech Republic"[MeSH] OR "Denmark"[MeSH] OR "Estonia"[MeSH] OR "Finland"[MeSH] OR "France"[MeSH] OR "Germany"[MeSH] OR "Greece"[MeSH] OR "Hungary"[MeSH] OR "Ireland"[MeSH] OR "Italy"[MeSH] OR "Latvia"[MeSH] OR "Lithuania"[MeSH] OR "Luxembourg"[MeSH] OR "Malta"[MeSH] OR "Netherlands"[MeSH] OR "Poland"[MeSH] OR "Portugal"[MeSH] OR "Romania"[MeSH] OR "Slovakia"[MeSH] OR "Slovenia"[MeSH] OR "Spain"[MeSH] OR "Sweden"[MeSH] OR "Great Britain"[MeSH] OR "Europe"[MeSH] OR "European Union"[MeSH]) AND (English[lang] OR French[lang] OR Dutch[lang]) AND ("1997/01/01"[PDAT] : "2007/04/25"[PDAT])
Note : ❸	

Table 8: Cochrane library search strategy

Date	**Database pertinence assessment : 13/04/2007**		
Database	Cochrane Library http://www.cochrane.org/index.htm Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" "Hospital quality assessment" → NOT RELEVANT	Results 18 29 191 22 1519 0	Relevant Results° 0 0 0 0 0 0
Note : ❶			

Table 9 : ACP Journal Club search strategy

Date	**Database pertinence assessment : 13/04/2007**		
Database	ACP Journal Club http://www.acpjc.org/fcgi/imsearch.pl Hospital AND accredit* Hospital AND accreditation Hospital AND accredited Hospital AND certificat* Hospital AND certification Hospital AND certificate Hospital AND licens* Hospital AND licensure Hospital AND licensing Hospital AND "quality improvement" Hospital AND "quality assessment" → NOT RELEVANT	Results NOK' 2 0 NOK' 2 2 NOK' 0 2 29 25	Relevant Results° - 0 0 - 0 0 - 0 0 0 0
Note : ❷ **' Truncation gives 0 results whereas entire words give results**			
Date	**Database pertinence assessment : 13/04/2007**		

Database	Evidence based-medicine http://ebm.bmj.com/ Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" → NOT RELEVANT	Results 2 4 9 31 5	Relevant Results° 0 0 0 0 0
Note : ❶			

Since Embase was inaccessible for a certain period the database was not tested on pertinence and was presumed to be relevant.

Table 10: Embase search strategy

Date	**Search strategy elaboration : 05/06/2007**		
Database	Embase http://www.embase.com		
Search Strategy	1. 'good clinical practice'/exp/mj 2. 'outcome assessment'/exp/mj 3. 'peer review'/exp/mj 4. 'health care quality'/mj 5. 'professional standard'/mj 6. 'licensing'/mj 7. 'accreditation'/exp 8. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 9. 'hospital'/exp 10. 'hospital management'/mj 11. 'health care':ti 12. 9 OR 10 OR 11 13. 'austria'/exp 14. 'belgium'/exp 15. 'bulgaria'/exp 16. 'cyprus'/exp 17. 'czech republic'/exp 18. 'denmark'/exp 19. 'estonia'/exp 20. 'finland'/exp 21. 'france'/exp 22. 'germany'/exp 23. 'greece'/exp 24. 'hungary'/exp 25. 'ireland'/exp 26. 'italy'/exp 27. 'latvia'/exp 28. 'lithuania'/exp 29. 'luxembourg'/exp 30. 'malta'/exp 31. 'netherlands'/exp 32. 'poland'/exp 33. 'portugal'/exp 34. 'romania'/exp 35. 'slovakia'/exp 36. 'slovenia'/exp 37. 'spain'/exp		

	38. 'sweden'/exp 39. 'united kingdom'/exp 40. 'europe'/de 41. 'european union'/de 42. 13 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 43. 8 AND 12 44. 42 AND 43 (184) = (('good clinical practice'/exp/mj) OR ('outcome assessment'/exp/mj) OR ('peer review'/exp/mj) OR ('health care quality'/mj) OR ('professional standard'/mj) OR ('licensing'/mj) OR ('accreditation'/exp)) AND (('hospital'/exp) OR ('hospital management'/mj) OR ('health care':ti)) AND (('austria'/exp) OR ('belgium'/exp) OR ('bulgaria'/exp) OR ('cyprus'/exp) OR ('czech republic'/exp) OR ('denmark'/exp) OR ('estonia'/exp) OR ('finland'/exp) OR ('france'/exp) OR ('germany'/exp) OR ('greece'/exp) OR ('hungary'/exp) OR ('ireland'/exp) OR ('italy'/exp) OR ('latvia'/exp) OR ('lithuania'/exp) OR ('luxembourg'/exp) OR ('malta'/exp) OR ('netherlands'/exp) OR ('poland'/exp) OR ('portugal'/exp) OR ('romania'/exp) OR ('slovakia'/exp) OR ('slovenia'/exp) OR ('spain'/exp) OR ('sweden'/exp) OR ('united kingdom'/exp) OR ('europe'/de) OR ('european union'/de)) AND ([dutch]/lim OR [english]/lim OR [french]/lim) AND [embase]/lim AND [2002-2007]/py

Table 11: CRD search strategy

Date	**Database pertinence assessment : 16/04/07**		
Database	CRD (DARE, EED, HTA) http://www.crd.york.ac.uk/crdweb Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" → NOT RELEVANT	Results 23 8 43 47 190	Relevant Results° 0 0 0 0 0
Search Strategy			
Note : ❶			

Table 12: Trip search strategy

Date	**Database pertinence assessment : 16/04/2007**		
Database	TRIP http://www.tripdatabase.com/index.html	Results	Relevant Results°
	Hospital AND accredit*		
	"Hospital accredit*"		
	"Hospital accreditation"	266	0
	"Hospital accredited"	NOK[2]	-
	Hospital AND certificat*	7	0
	Hospital AND licens*	0	0
	"Hospital licens*"	240	0
	"Hospital licensure"	1310	0
	"Hospital licensing"	NOK[2]	-
	Hospital AND "quality improvement"	25	0
	"Hospital quality improvement"	380	0
	Hospital AND "quality assessment"	364	0
	"Hospital quality assessment"	4	0
		462	0
	→ NOT RELEVANT	0	0
Search Strategy			
Note : ⓿ [2] Quotation marks associated with truncation give 0 results whereas it gives results for entire words			

Table 13: Clinical trials search strategy

Date	**Database pertinence assessment : 16/04/2007**		
Database	Clinical trials www.clinicaltrials.gov	Results	Relevant Results°
	Hospital AND accredit*	NOK[1]	-
	Hospital AND accreditation	1	0
	Hospital AND accredited	1	0
	Hospital AND certificat*	NOK[1]	-
	Hospital AND certification	1	0
	Hospital AND certificate	1	0
	Hospital AND licens*	NOK[1]	-
	Hospital AND licensure	1	0
	Hospital AND licensing	0	0
	Hospital AND "quality improvement"	10	0
	Hospital AND "quality assessment"	3	0
	→ NOT RELEVANT		
Note : ⓿ [1] Truncation gives 0 results whereas entire words give results			

Table 14: Controlled trials search strategy

Date	**Database pertinence assessment : 16/04/2007**		
Database	Controlled trials www.controlled-trials.com Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement Hospital AND "quality assessment" → NOT RELEVANT	Results 16 12 92 24 7	Relevant Results° 0 0 0 0 0
Note : ⓿			

ISTAHC database was not found : all ISTAHC links give wrong websites

Table 15: OMNI search strategy

Date	**Database pertinence assessment : 17/04/2007**		
Database	OMNI http://www.intute.ac.uk/healthandlifesciences/medicine Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" → NOT RELEVANT	Results 4 2 1 9 1	Relevant Results° 0 0 0 0 0
Note : ⓿			

Table 16: AHRQ search strategy

Date	**Database pertinence assessment : 17/04/2007**		
Database	AHRQ http://www.ahrq.gov/	Results	Relevant Results°
	Hospital AND accredit*	3296	0
	"Hospital accredit*"	NOK[2]	-
	"Hospital accreditation"	45	0
	"Hospital accredited"	0	0
	Hospital AND certificat*	5071	0
	"hospital certificat*"	NOK[2]	-
	"Hospital certification"	0	0
	"Hospital certificate"	0	0
	Hospital AND licens*	2298	0
	"Hospital licens*"	NOK[2]	-
	"Hospital licensure"	19	0
	"Hospital licensing"	42	0
	Hospital AND "quality improvement"	9763	0
	"hospital quality improvement"	112	0
	Hospital AND "quality assessment"	1232	0
	"Hospital quality assessment"	11	0
	→ NOT RELEVANT		
Note : ⓿ [2] Quotation marks associated with truncation give 0 results whereas quotation marks for entire words give results			

Table 17: British Library search strategy

Date	**Database pertinence assessment : 18/04/2007 Search strategy elaboration : 26/04/2007**		
Database	British Library http://www.bl.uk/	Results	Relevant Results°
	Hospital AND accredit*	NOK[3]	-
	Hospital AND accreditation	159	2
	Hospital AND accredited	69	0
	Hospital AND certificat*	NOK[3]	-
	Hospital AND certification	146	0
	Hospital AND certificate	114	0
	Hospital AND licens*	NOK[3]	-
	Hospital AND licensure	6	0
	Hospital AND licensing	65	0
	Hospital AND "quality improvement"	295	0
	"Hospital quality improvement"	11	0
	Hospital AND "quality assessment"	51	0
	→ RELEVANT No thesaurus available (only index)		

Search Strategy	Method As there is no thesaurus, a search strategy (1) has been elaborated on the basis of the keywords identified as relevant during the first step. Besides, the notion of "health care" has been added in order to cover this thematic. Given there is an index, we decided to explore it via a second search strategy (2) in order to control if this second search is more relevant than the first one. During this exploration, we realized that : The index only covers the catalogue records, and not the other sections (journal articles, etc.) All the MeSH terms identified for the Medline search strategy are recognized but headings do not include subheadings The research form allows combinations of headings but these ones are not found in the headings/subjects section of the results → not reliable research form Because of this problem, we explored the Medline headings directly in the alphabetical index Search strategy 1 (limited to catalogue records and journal articles) 1. accreditation (2908) 2. hospital (74388) 3. hospitals (17718) 4. "health care" (44491) 5. 2 OR 3 OR 4 (126612) 6. 1 AND 5 (286) Search Strategy 2 (systematic exploration of the index because subheadings are not included in headings, no possibility to include the date limit) -Guideline Adherence (1) -Guideline Adherence -- organization & administration (1) -Guideline Adherence -- organization & administration -- United States (NOK)[a] -Guideline Adherence -- United States (NOK) -Outcome and Process Assessment (Health Care) (25) -Outcome Assessment (Health Care) (12) -Outcome Assessment (Health Care) -- Collected Works (1) -Outcome Assessment (Health Care) –		

	economics (1) -Outcome Assessment (Health Care) – Georgia (NOK) -Outcome Assessment (Health Care) – methods (3) -Outcome Assessment (Health Care) -- nurses' instruction (NOK) -Outcome Assessment (Health Care) -- organization & administration (2) -Outcome Assessment (Health Care) – standards (5) -Outcome Assessment (Health Care) -- standards – Handbooks (1) -Outcome Assessment (Health Care) -- United States (NOK) -Peer Review, Health Care (1) -Peer Review, Health Care – Standards (1) -Quality assurance, Health care .Brazil. (1) -Quality Assurance, Health Care -- Case Report (1) -Quality assurance, Health care – Congresses (1) -Quality Assurance, Health Care – economics (1) -Quality Assurance, Health Care – England (1) -Quality Assurance, Health Care – Georgia (NOK) -Quality Assurance, Health Care -- Great Britain (1) -Quality Assurance, Health Care – methods (2) -Quality Assurance, Health Care -- methods -- United States (NOK) -Quality Assurance, Health Care -- methods -- United States -- Technical Report (NOK) -Quality Assurance, Health Care -- nurses' instruction (NOK) -Quality Assurance, Health Care -- organization & administration (7) -Quality Assurance, Health Care -- organization & administration -- Great Britain (1) -Quality Assurance, Health Care -- organization & administration -- United States (NOK) -Quality Assurance, Health Care – Periodicals (2) -Quality Assurance, Health Care – standards (3) -Quality Assurance, Health Care -- standards -- United States (NOK) -Quality Assurance, Health Care -- United States (NOK) -Quality Assurance, Health Care -- United		

	States – congresses (NOK) -Quality Assurance, Health Care -- United States – handbooks (NOK) -Quality Assurance, Health Care -- United States -- nurses' instruction (NOK) -Credentialing (5) -Accreditation (20) -Accréditation en santé (1) -Accreditation of Prior Experiential Learning (NOK) -Accreditation of prior learning (NOK) -[Accreditation of work learning] (NOK) -Accreditation; Postgraduates (NOK) -Accreditation practices (1) -Accreditation programs (2) -Accreditation scheme (1) -Accreditation -- standards – United States – Directory (NOK) -Accreditation -- standards -- United States – Periodicals (NOK) -Licensure (3) -Licensure, Medical (NOK) -Licensure, Medical -- United States (NOK) -Licensure, Nursing -- examination questions (NOK) -Licensure, Nursing -- United States -- examination questions (NOK) -Licensure -- United States (NOK) -Licensure -- United States -- Case Reports (NOK) -Licensure -- United States -- Examination Questions (NOK) -Hospitals (169) -Hospital administration (60) -Health care (438) <u>Conclusion</u> The comparison between the results from search strategy 1 and 2 shows that the first one is more relevant. Moreover the search strategy 2 gives only access to Catalogue records. → search strategy 1 will be used		
Note : ⓿ **[3] Truncation give less results than entire words** **[a] The heading isn't in the scope of our search**			

Table 18: COPAC search strategy

Date	**Database pertinence assessment : 18/04/2007** **Search strategy elaboration : 26/04/2007**		
Database	COPAC http://www.copac.ac.uk/wzgw/ Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" →RELEVANT No thesaurus available (only index)	Results 39 44 75 78 5	Relevant Results° 3 0 0 0 0
Search Strategy	Method - As there is no thesaurus, a search strategy (1) has been elaborated on the basis of the keywords identified as relevant during the first step. Besides, the notion of "health care" has been added in order to cover this thematic. - Given there is an index, we decided to explore it via a second search strategy (2) in order to control if this second search is more relevant than the first one. - During this exploration, we realized that : • All the MeSH terms identified for the Medline search strategy are recognized and headings include subheadings • The research form allows combinations of headings but these ones are not found in the headings/subjects section of the results → not reliable research form • Because of this problem, we explored the Medline headings via the headings/subjects section of the results because there is no alphabetical index Search Strategy 1 (three strategies have been developed because "OR" isn't recognized) 1. accredit* (1915) 2. hospital (50848) 3. 1 AND 2 (38) 1. accredit* (1915) 2. hospitals (50848) 3. 1 AND 2 (38) 1. accredit* (1915) 2. "health care" (24891) 3. 1 AND 2 (46)		

	Search strategy 2 (systematic exploration of the Medline headings via the results, no possibility to include the date limit) -Guideline adherence (20) -Outcome and Process Assessment (Health Care) (272) -Outcome assessment (Health Care) (542) - Peer Review, Health Care (13) -Quality Assurance, Health Care (1052) -Credentialing (56) -Accreditation (1957) - Licensure (368) - Licensure, Hospital (not found) - Hospitals (77475) - Hospital administration (3206) Conclusion - Search strategy 2 is not reliable because results found do not contain the required headings → search strategy 1 will be used		
Note : ❶			

Table 19: WHOLIS search strategy

Date	**Database pertinence assessment : 18/04/2007** **Search strategy elaboration : 26/04/2007**		
Database	WHOLIS http://dosei.who.int/uhtbin/cgisirsi/x/0/57/49?user_id=WEB-FR Hospital AND accredit* Hospital AND accreditation Hospital AND accredited Hospital AND certificat* Hospital AND certification Hospital AND certificate Hospital AND licens* Hospital AND licensure Hospital AND licensing Hospital AND "quality improvement" Hospital AND "quality assessment" → RELEVANT No thesaurus available (only index)	Results NOK[1] 6 0 NOK[1] 1 0 NOK[1] 0 0 5 8	Relevant Results° 0 2 0 0 1 0 0 0 0 3 3
Search Strategy	Method - As there is no thesaurus, a search strategy (1) has been elaborated on the basis of the keywords identified as relevant during the first step. Besides, the notion of "health care" has been added in order to cover this thematic. - Given there is an index, we decided to explore it via a second search strategy (2) in order to control if this second search is more relevant than the first one. - During this exploration, we realized that : • All the MeSH terms identified for the Medline search strategy are recognized		

	and headings include subheadings • The research form allows combinations of headings and these ones are found in the headings/subjects section of the results → reliable research form <u>Search strategy 1</u> 1. accreditation (20) 2. certification (133) 3. "quality improvement" (31) 4 : "quality assessment" (54) 5 : 1 OR 2 OR 3 OR 4 (221) 6 : hospital (154) 7 : hospitals (146) 8. "health care" (1944) 9. 6 OR 7 OR 8 (2088) 10. 5 AND 9 (44) <u>Search strategy 2</u> 1. Guideline adherence (6) 2. Outcome and Process Assessment (Health care) (41) 3. Outcome assessment (115) 4. Peer Review, Health Care (1) 5. Quality Assurance, Health Care (95) 6. Credentialing (0) 7. Accreditation (17) 8. Licensure (14) 9. Licensure, Hospital (0) 10. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 (229) 11. Hospitals (118) 12. Hospital administration (12) 13. "health care" (1944) 14. 11 OR 12 OR 13 (1692) 15. 10 AND 14 (204) <u>Conclusion</u> - Search strategy 1 gives more relevant results than search strategy 2, even if there is less results → search strategy 1 will be used		
Note : ❶ ' Truncation gives 0 results whereas entire words give results			

Table 20: OECD search strategy

Date	**Database pertinence assessment : 18/04/2007** **Search strategy elaboration : 27/04/2007**		
Database	OECD http://www.oecd.org/advancedSearch/ Hospital AND accredit* Hospital AND certificat* Hospital AND licens* Hospital AND "quality improvement" Hospital AND "quality assessment" → RELEVANT No thesaurus available (and no index)	Results 88 63 173 65 18	Relevant Results° 2 1 1 1 1
Search Strategy	Method As there is no thesaurus, a search strategy has been elaborated on the basis of the keywords identified as relevant during the first step. Besides, the notion of "health care" has been added in order to cover this thematic. Search strategy (ten strategies have been developed because "OR" is not reliable : accredit* alone gives 219 results but gives only 198 results when combined to other keywords with "OR") 1. accredit* (218) 2. hospital (205) 3. 1 AND 2 (87) 1. certificat* (192) 2. hospital (205) 3. 1 AND 2 (63) 1. licens* (185) 2. hospital (205) 3. 1 AND 2 (173) 1. "quality improvement" (220) 2. hospital (205) 3. 1 AND 2 (65) 1. "quality assessment" (213) 2. hospital (205) 3. 1 AND 2 (18) As "hospitals" gives the same results than "hospital", results with this term will be equal. 1. accredit* (218) 2. "health care" (208) 3. 1 AND 2 (125) 1. certificat* (192) 2. "health care" (208) 3. 1 AND 2 (88)		

	1. licens* (185) 2. "health care" (208) 3. 1 AND 2 (201) 1. "quality improvement" (220) 2. "health care" (208) 3. 1 AND 2 (76) 1. "quality assessment" (213) 2. "health care" (208) 3. 1 AND 2 (22)		
Note : ❶			

Table 21: OAISTER search strategy

Date	**Database pertinence assessment : 19/04/2007** **Search strategy elaboration : 27/04/2007**		
Database	OAISTER http://oaister.umdl.umich.edu/o/oaister Hospital AND accredit* Hospital AND certificat* "Hospital certificat*" Hospital AND licens* "Hospital licens*" Hospital AND "quality improvement" Hospital AND "quality assessment" → RELEVANT No thesaurus available (and no index)	Results 209 919 17 3310 45 169 42	**Relevant Results°** **2** **0** **0** **0** **0** **0** **0**
Search Strategy	<u>Method</u> As there is no thesaurus, a search strategy has been elaborated on the basis of the keywords identified as relevant during the first step. Besides, the notion of "health care" has been added in order to cover this thematic. <u>Search strategy (three strategies have been developed because "OR" and "AND" can't be combined, limited to texts)</u> 1. accredit* (1620) 2. hospital (41795) 3. 1 AND 2 (152) 1. accredit* (1620) 2. hospitals (11186) 3. 1 AND 2 (99) 1. accredit* (1620) 2. "health care" (20512) 3. 1 AND 2 (161)		
Note : ❶			

Table 22: Bioblithèque des rapports publics search strategy

Date	**Search strategy elaboration : 19.04.2007**		
Database	Bibliothèque des rapports publics http://www.ladocumentationfrancaise.fr/rapports/index.shtml French website → translation of the keywords Hôpitaux ET accrédit* Hôpital ET accrédit* Accrédit* Hôpitaux ET certificat* Hôpital ET certificat* Certificat* Hôpitaux ET licence Hôpital ET licence Licence Hôpitaux ET « amélioration de la qualité » Hôpital ET « amélioration de la qualité » Hôpitaux ET amélioration qualité Hôpital ET amélioration qualité Hôpitaux ET «évaluation de la qualité » Hôpital ET « évaluation de la qualité » Hôpitaux ET évaluation qualité Hôpital ET évaluation qualité ^ The only relevant documents found are the activity reports of ANAES from 2001 to 2003 but they are excluded because the activity report of HAS for 2005 is available on the HAS website, which will be explored → NOT RELEVANT	Results 0 0 10 0 0 37 1 1 19 0 0 0 0 1 1 5 5	Relevant Results° 0 0 3^ 0 0 0 0 0 0 0 0 0 0 0 0 1^ 1^
Note : ❶			
Date	**Search strategy elaboration : 10.05.2007**		

Table 23: Google search strategy

Database	Google http://www.google.be Search strategy 1 "hospital accreditation" (Austria OR Belgium OR Bulgaria OR Cyprus OR Czech OR Denmark OR Estonia OR England OR Finland OR France OR Germany OR Greece OR Hungary OR Ireland OR Italy OR Latvia OR Lithuania OR Luxembourg OR Malta OR Netherlands OR Poland OR Portugal OR Romania OR Slovakia OR Slovenia OR Spain OR Sweden OR Europe) filetype:pdf Search strategy 2 "hospital accreditation" report (Austria OR Belgium OR Bulgaria OR Cyprus OR Czech OR Denmark OR Estonia OR England OR Finland OR France OR Germany OR Greece OR Hungary OR Ireland OR Italy OR Latvia OR Lithuania OR Luxembourg OR Malta OR Netherlands OR Poland OR Portugal OR Romania OR Slovakia OR Slovenia OR Spain OR Sweden OR Europe) filetype:pdf Search strategy 3 "hospital accreditation program" (Austria OR Belgium OR Bulgaria OR Cyprus OR Czech OR Denmark OR Estonia OR England OR Finland OR France OR Germany OR Greece OR Hungary OR Ireland OR Italy OR Latvia OR Lithuania OR Luxembourg OR Malta OR Netherlands OR Poland OR Portugal OR Romania OR Slovakia OR Slovenia OR Spain OR Sweden OR Europe) filetype:pdf Search strategy 4 "health care accreditation" (Austria OR Belgium OR Bulgaria OR Cyprus OR Czech OR Denmark OR Estonia OR England OR Finland OR France OR Germany OR Greece OR Hungary OR Ireland OR Italy OR Latvia OR Lithuania OR Luxembourg OR Malta OR Netherlands OR Poland OR Portugal OR Romania OR Slovakia OR Slovenia OR Spain OR Sweden OR Europe) filetype:pdf → 1 additional result was also found via explored links	Results 14.100 12.800 72 343	Relevant Results° 7 1 3 6

Table 24: EBSCO search strategy

Date	28/11/2007
Database **EBSCO**	http://ejournals.ebsco.com.vdicp.health.fgov.be:8080/home.asp
Search Strategy	1 (hospital accreditation OR certification OR licensure) AND (outcome assessment OR standards) (73) 2 (hospital and accreditation OR certification OR licensure) and (clinical and indicator OR performance) (29) 3 Hospital AND quality AND improvement (196) 4 Hospital AND quality AND assessment (106)

An additional search was performed in Econlit, but no relevant results were obtained

Table 25: Econlit search strategy

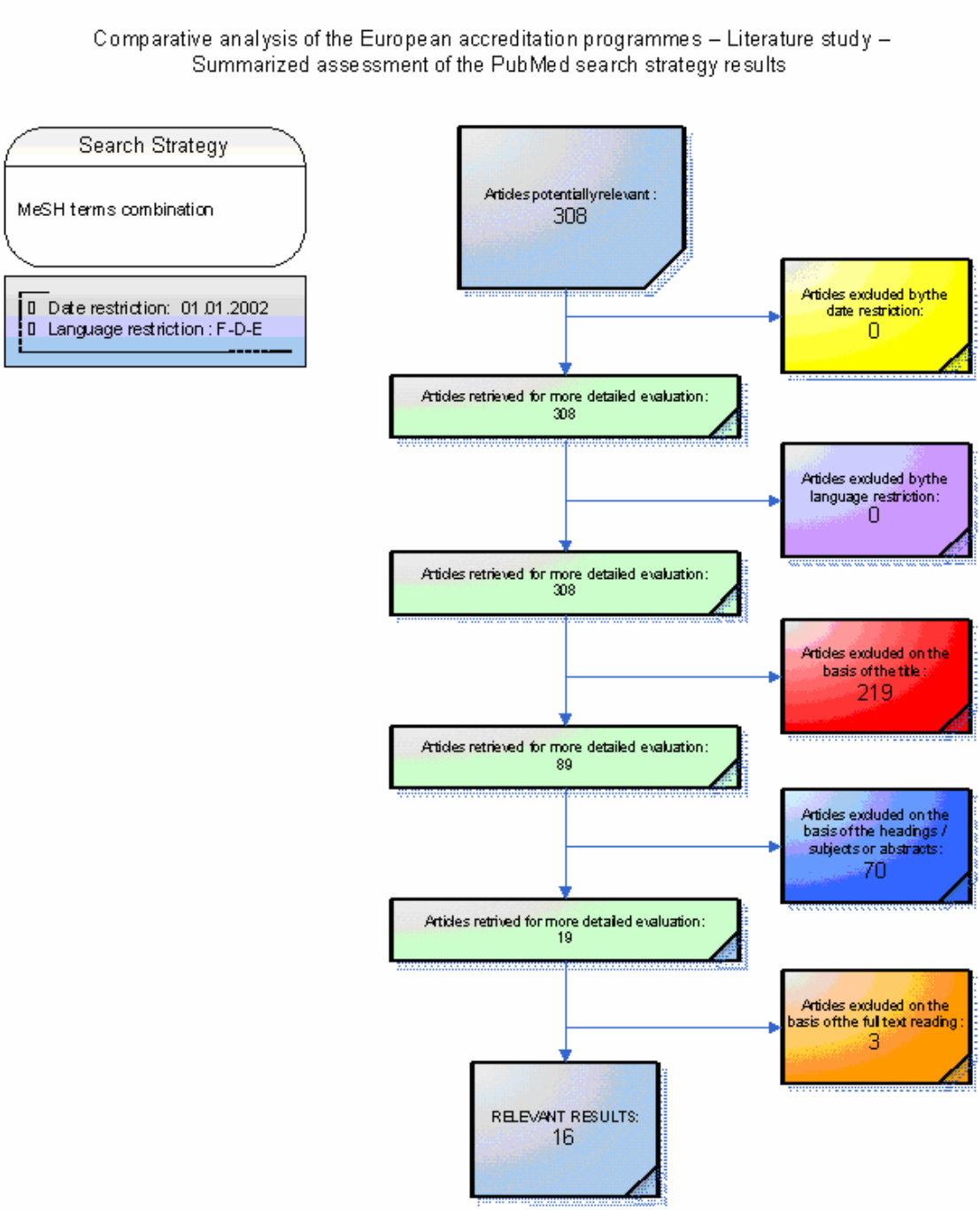
Date	28/11/2007
Database **Econlit via OVID**	http://gateway.tx.ovid.com
Search Strategy	1 certif$.mp. [mp=heading words, abstract, title, country as subject] (1084) 2 licens$.mp. [mp=heading words, abstract, title, country as subject] (3741) 3 accredit$.mp. [mp=heading words, abstract, title, country as subject] (93) 4 standard.mp. [mp=heading words, abstract, title, country as subject] (17280) 5 quality assessment.mp. [mp=heading words, abstract, title, country as subject] (40) 6 performance.mp. [mp=heading words, abstract, title, country as subject] (42794) 7 quality indicator.mp. [mp=heading words, abstract, title, country as subject] (19) 8 outcome assessment.mp. [mp=heading words, abstract, title, country as subject] (2) 9 1 or 2 or 3 (4895) 10 4 or 5 or 6 or 7 or 8 (58840) 11 9 and 10 (688) 12 limit 11 to (yr="2002 - 2007" and (dutch or english or french)) (473)

Additional articles

Additionally, 10 relevant articles were directly delivered by Charles Shaw.

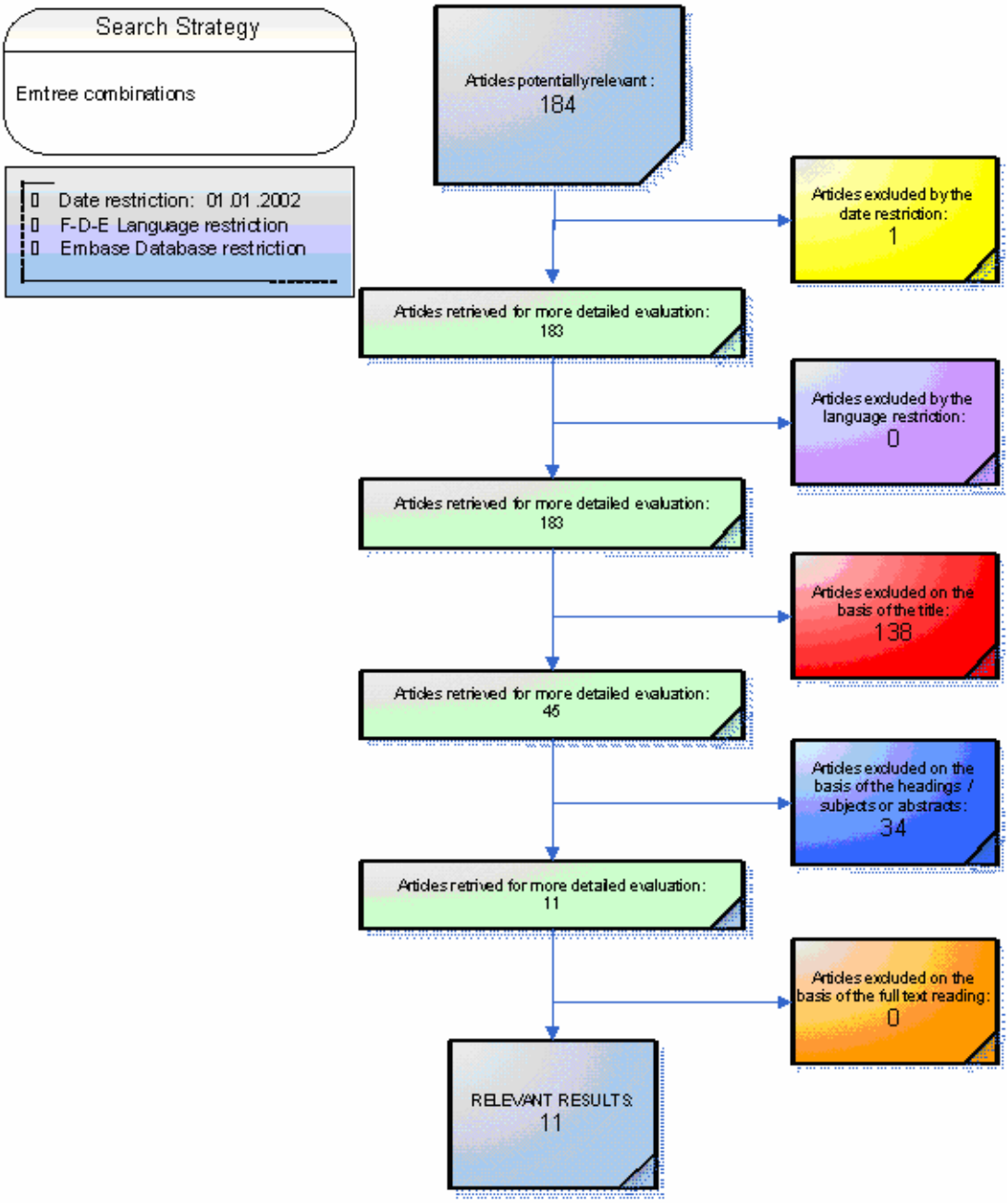
Results

Flowchart 3: Medline search strategy results

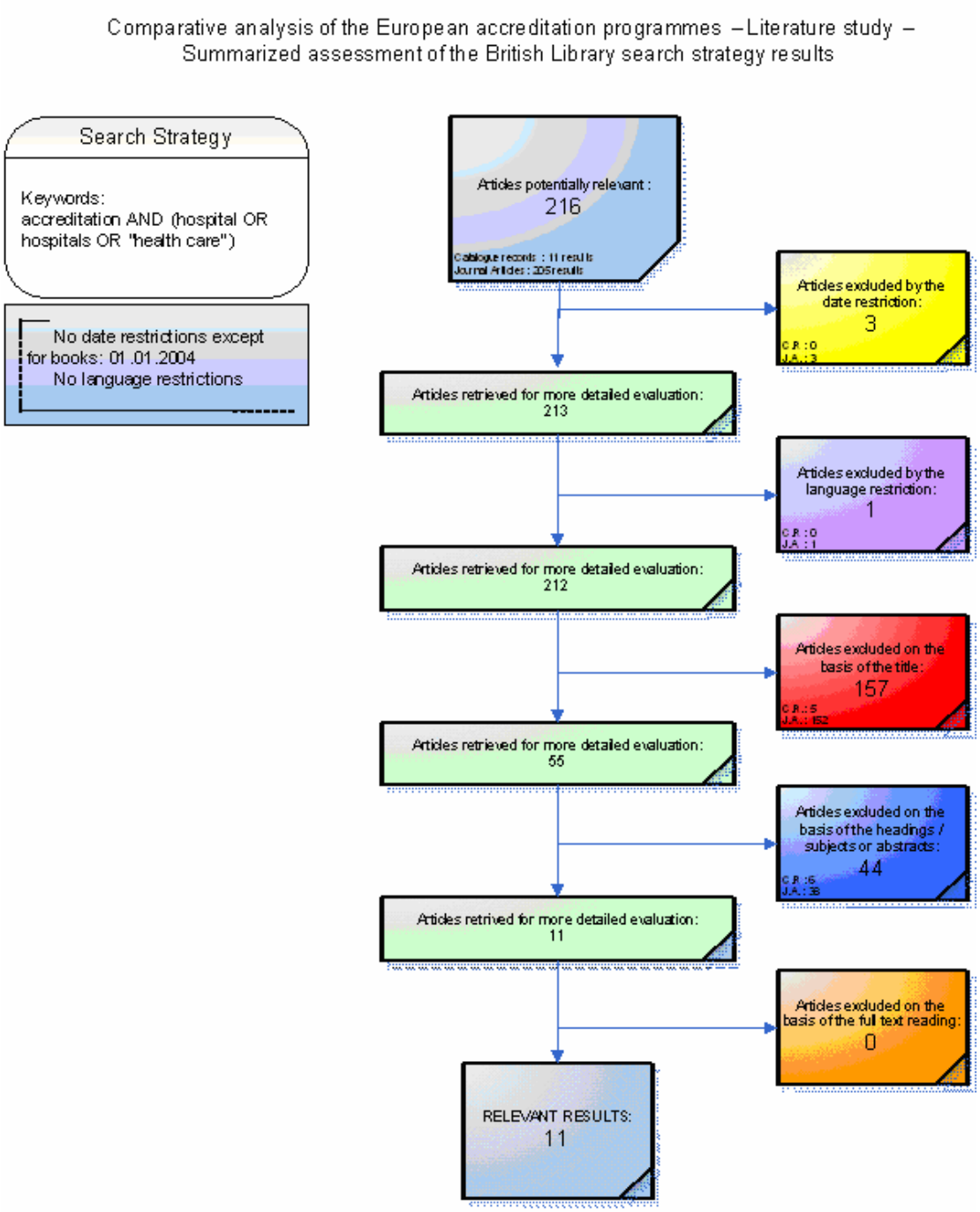


Flowchart 4: Embase search strategy results

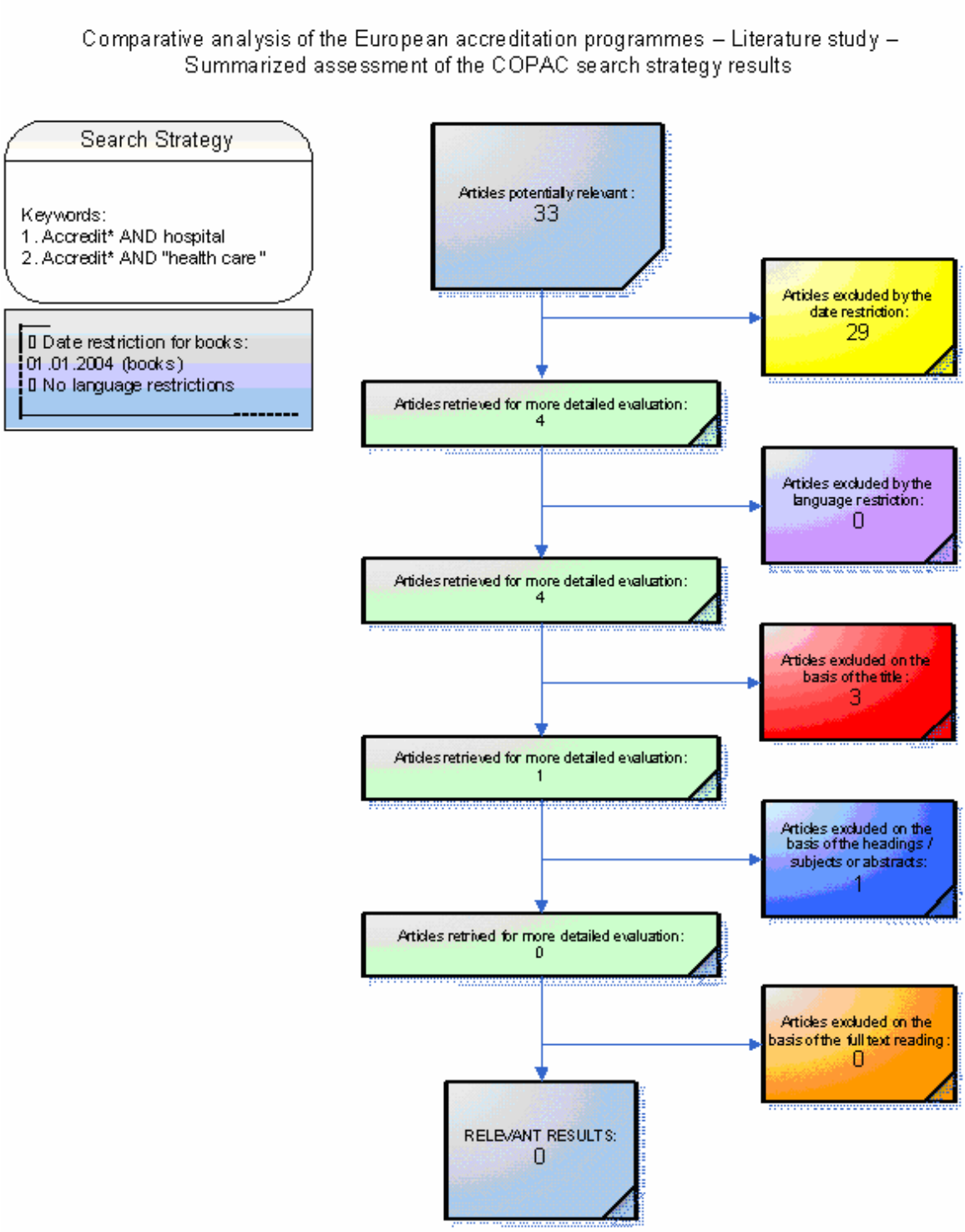
Comparative analysis of the European accreditation programmes – Literature study –
Summarized assessment of the Embase search strategy results



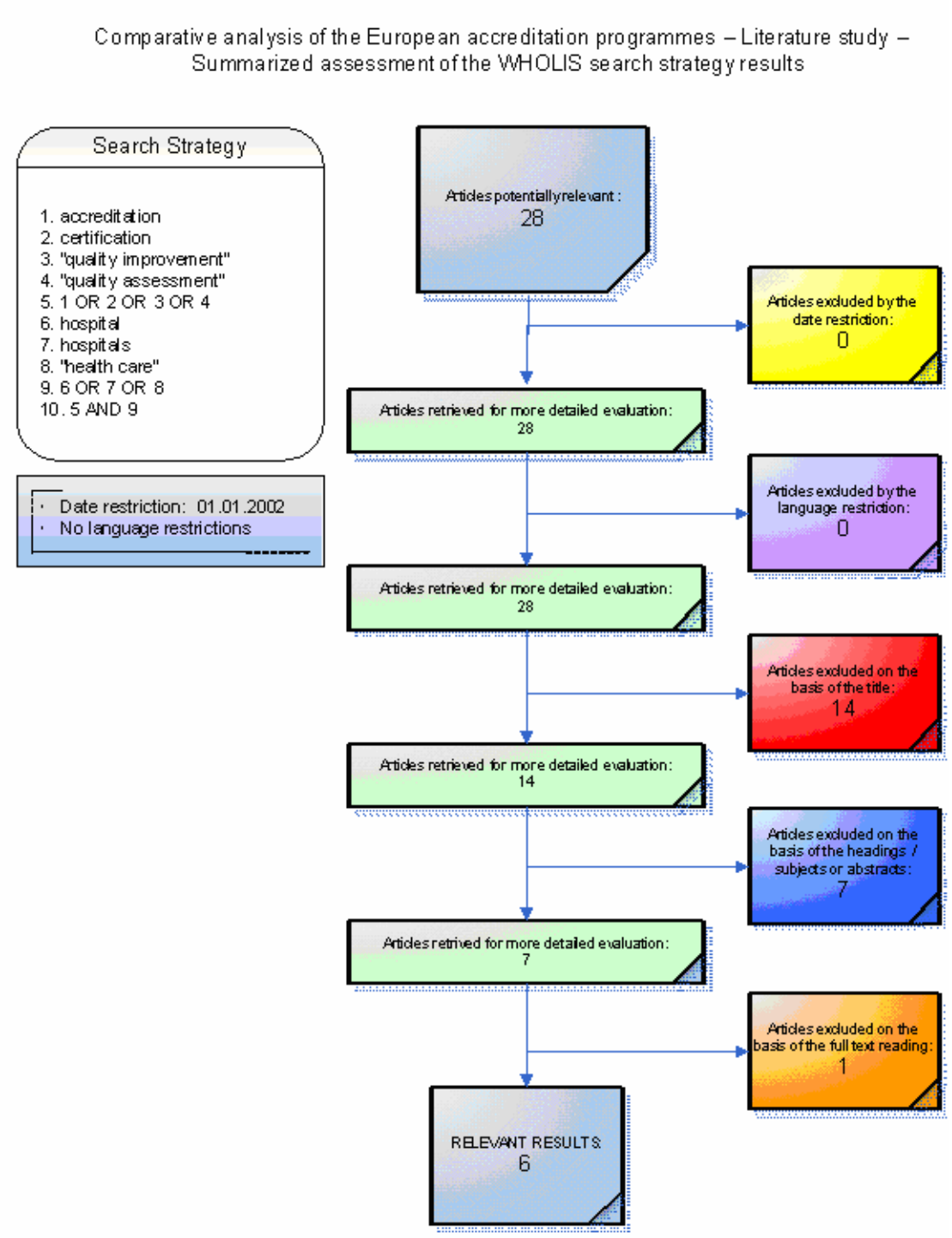
Flowchart 5: British library search strategy results



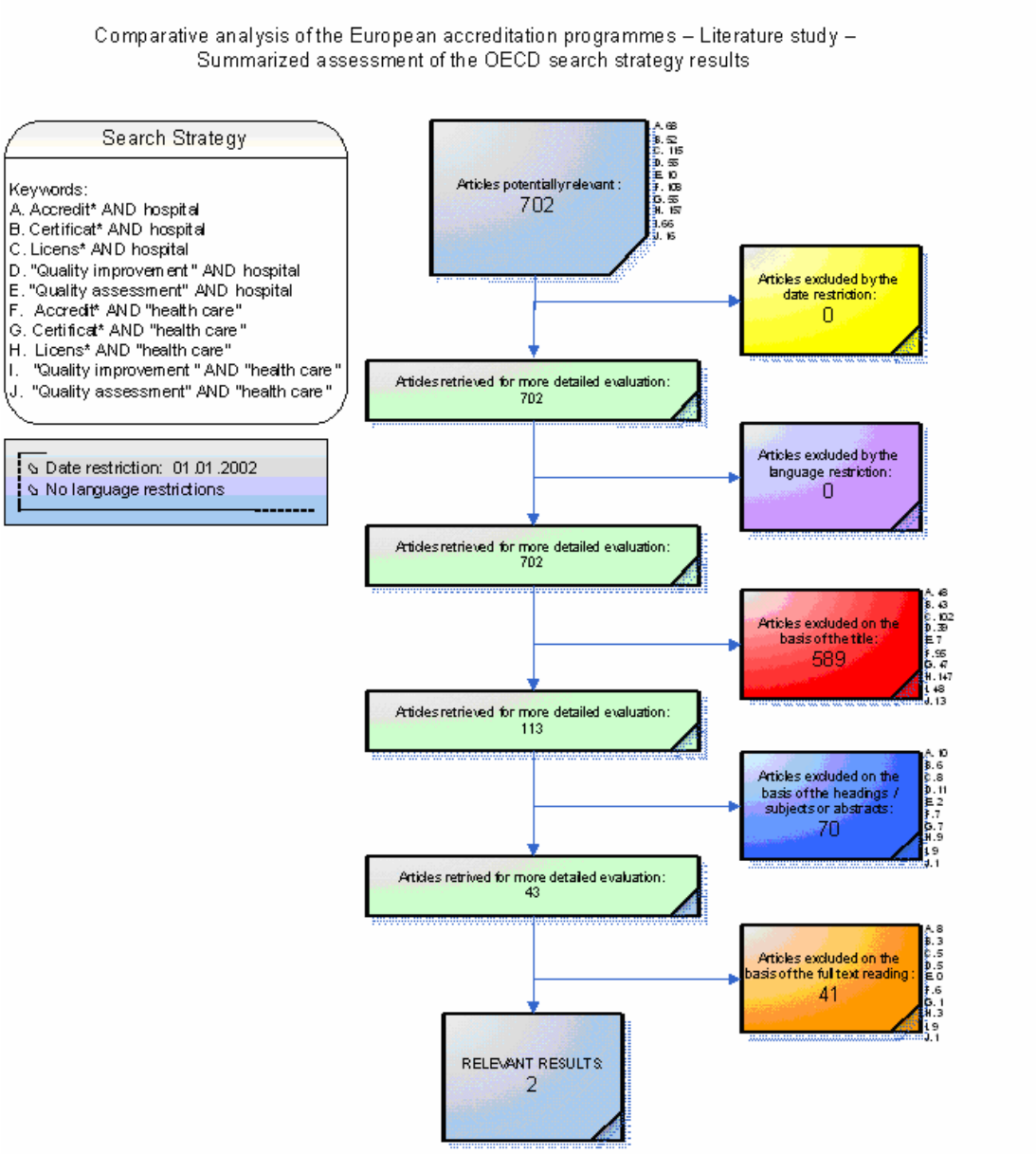
Flowchart 6: COPAC search strategy results



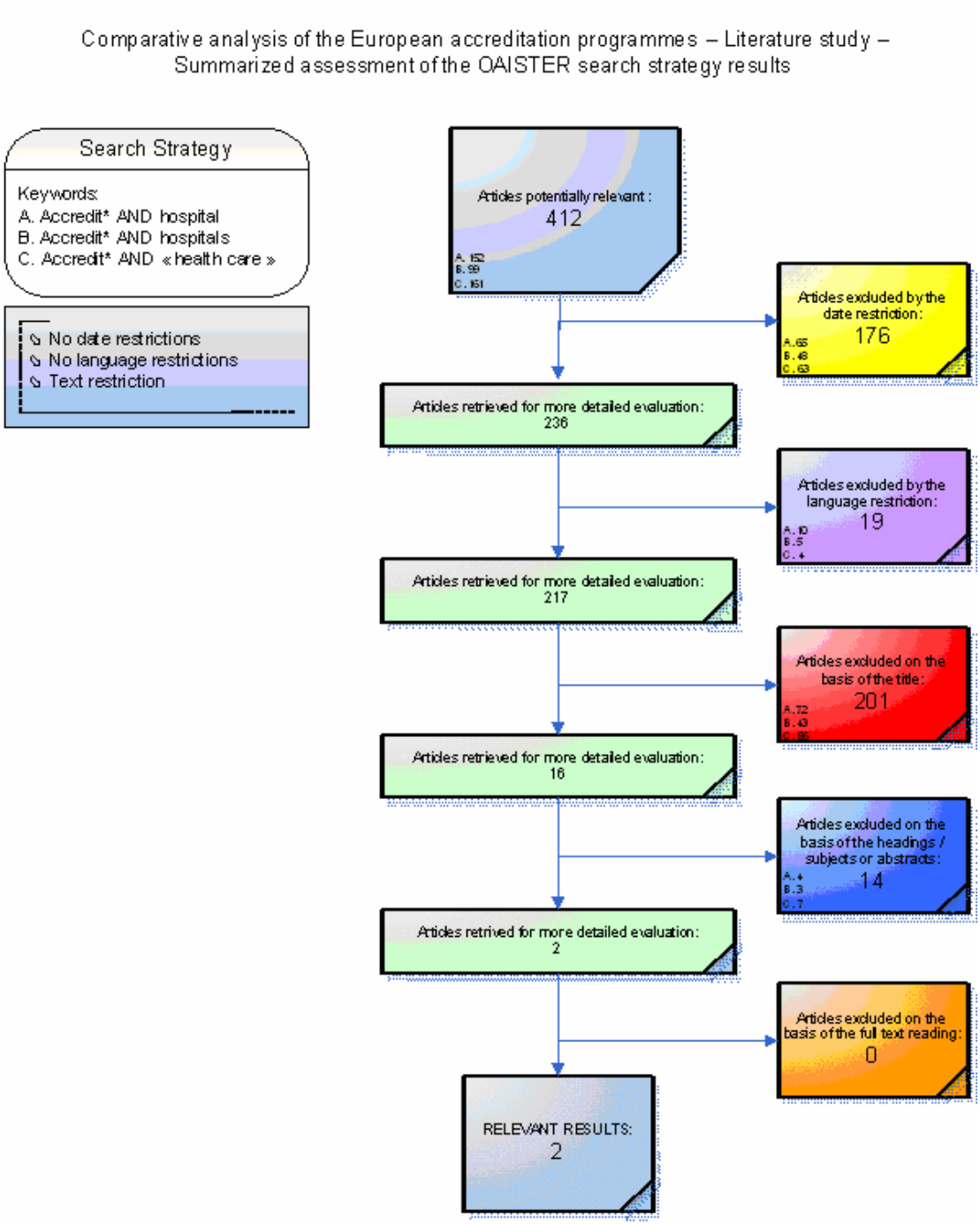
Flowchart 7: WHOLIS search strategy results



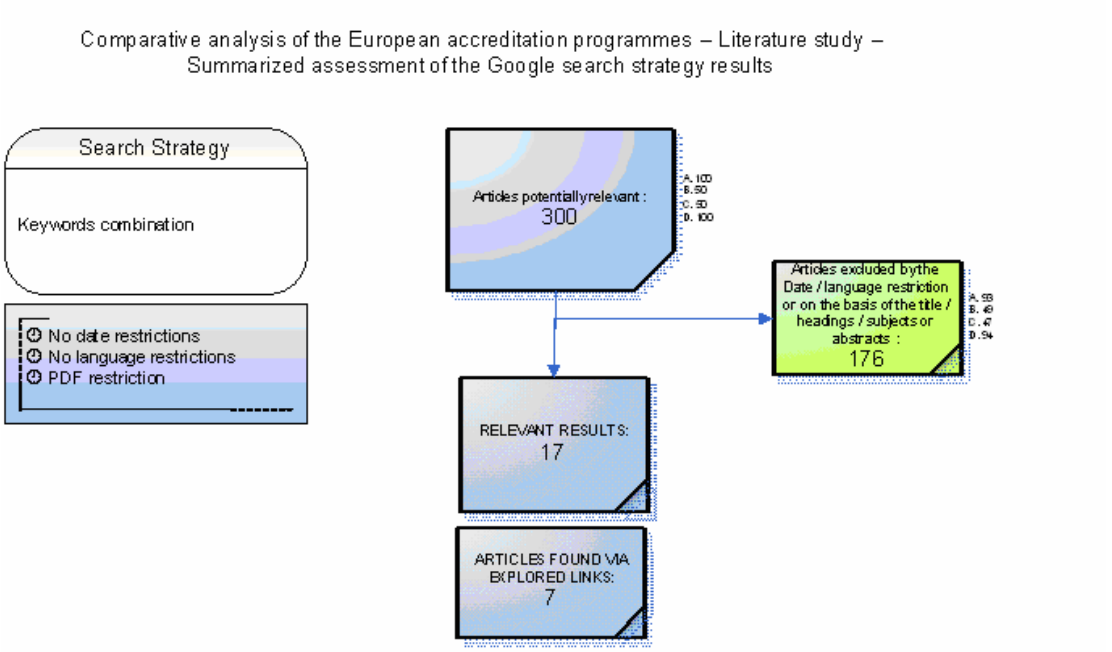
Flowchart 8: OECD search strategy results



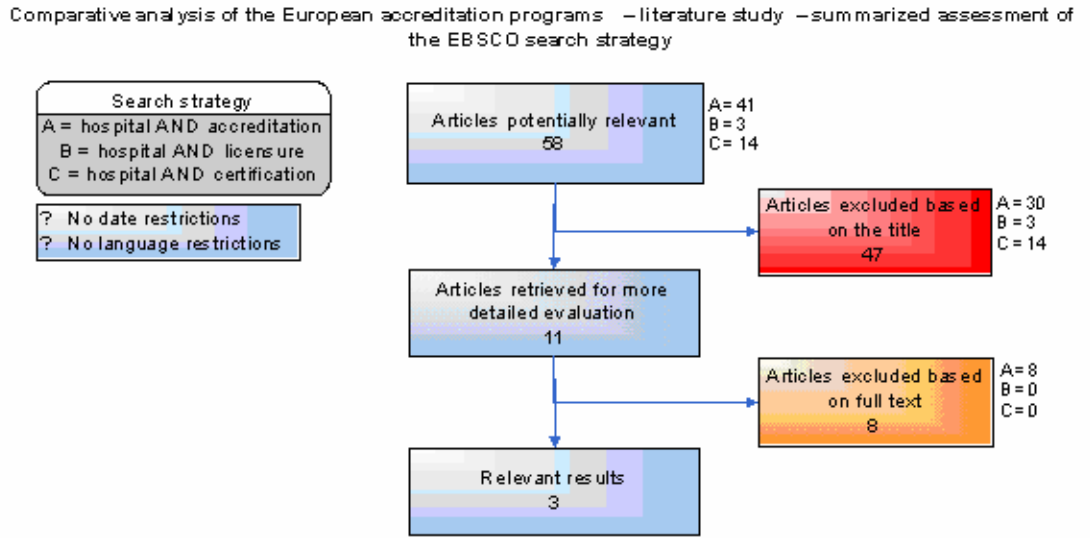
Flowchart 9: OAISTER search strategy results



Flowchart 10: Google search strategy results



Flowchart 11: EBSCO search strategy results



APPENDIX 4. THE METHODOLOGY FOR INVENTORY AND COMPARATIVE ANALYSIS OF THE EUROPEAN ACCREDITATION PROGRAMMES – SURVEY (CHAPTER 2.3)

First the questions to be addressed were determined and then sent to qualified contacts of the concerned countries. On the basis of the list of research questions, a draft of survey designed to be sent to the accreditation agencies of the European Union countries and containing among others questions covering topics treated by the literature study was created.

It was sent to Agnes Jacquery and Pascal Garel for comments and amended accordingly, then in-depth reviewed with Charles Shaw and finally mailed to 3 pilot-countries[31] for testing.

The themes covered in the final version were Policy and governance, Management, Standards, Surveyors, Assessment, Awards, Finance and Information.

The survey was sent by email the 14th of May 2007 to these contacts with specific attachments (see cover letter) with the 23rd of May deadline and proactively followed up.

31 Poland, Spain, United Kingdom respectively represented by Basia Kutryba, Rosa Sunol and Helen Crisp

Table 26: Survey

2 preliminary remarks:

1) For the purpose of the survey, the following defintion for **Hospital Accreditation** will be applied:
Initiatives to assess hospital against pre-defined explicit published standards in order to encourage continuous improvement of the health care quality
2) Column 'D' (Number) is foreseen to enter the number that goes with the (multiple)choices as defined in Column 'C' (Answer options):
* if the answer to a question is 'no', the number 0 needs to be entered
* if the answer is a combination of proposed choices, enter them all in the same cell by putting a ' ; ' between them e.g. 2; 4; 5

All supportive documentation that may facilitate the insight in your country and specifics of the hospital accreditation is welcome!

European survey of standards-based hospital assessment programmes 2007				
#	Question	Answer options	Answer	
			Number	Text
1	Does a standards-based hospital assessment programme (eg accreditation) exist in your country?	1= yes; 0=no		
2	Is there more than one hospital accreditation programme which is available nationally, or in a specific region?	1= yes; 0=no		
		If 'yes', please name the other programmes		
	1 Identification			
3	What is the name of your hospital accreditation programme?			
4	Telephone			
5	Website			
6	Name of director/chief executive			
7	Name of person to contact for this survey			
8	e-mail address of this contact			
	2 Policy and governance			
9	Does the programme include public and private facilities?	1=yes; 0=no		
10	On what country or region does the programme focus?			
11	How much choice do hospitals have to participate?	1= Compulsory; 2= optional with strong incentives; 3 = voluntary		
12	What most motivates hospitals to participate?	1=additional funding; 2=Marketing; 3= Staff recruitment; 4=Academic recognition for training; 5= Statutory requirement; 6= Contractual requirement by purchasers; 7= Risk indemnity insurance; 8=Desire for improvement		
13	Has hospital accreditation been written into government policy on quality and safety?	1=yes; 0=no		
		If 'yes', state title and date or web address		
14	How is the programme related to government?	1= Managed within Ministry of Health; 2= separate government agency; 3= independent agency with government representation; 4= totally independent; 5= other		
15	What stakeholders are nominated as representatives on the governing body?	1= Users e.g. patients, relatives,... ; 2= clinical professionals e.g. nurses, doctors; 3= indemnity insurers; 4= health care insurers; 5= hospital owners; 6= regulators e.g. licensing authorities; 7=academic/training institutions		
16	How was the composition of the governing body determined?	1= Enabling legislation; 2= Adopted constitution		
17	What is the legal status of the accreditation organisation?	1=government agency; 2=commercial entity; 3=not-for-profit organisation; 4=registered charity; 5=academic institute		
18	Has the programme's governing body formally agreed to work towards meeting ISQua (ALPHA) standards?	1=yes; 0=no		
		In what year was that decision taken?		
19	How many hospitals in your region/state are eligible to participate in the programme?			
20	How many of these hospitals are currently enrolled in the programme?			
	3 Management			
21	What year did the programme first begin development?			
22	What year was the first hospital formally accredited?			
23	At the end of 2006, how many staff (expressed in full-time equivalents excluding surveyors and unpaid advisors) were employed for the accreditation programme?			
	4 Standards			
24	Are the standards for assessment generic for all hospitals?	1= yes; 0=no		
		If 'no', what standards exist other than for general hospitals?		
25	What year was the current edition of the accreditation standards approved by the governing body?			
26	Is there a particular model which inspired the design of your initial standards?	1= EFQM; 2= ISO; 3= accreditation; 4=other		
		If '3', please specify which programme		
27	What was the scope of consultation on the original draft standards?	1= No consultation; 2= Internal to the organisation; 3= Stakeholder organisations; 4= Public at large		
28	How many full revisions of the standards have been published?			

	5 Surveyors			
29	What is the usual composition of a survey team for a hospital?	1= Management; 2= nursing; 3= doctor; 4= other		
		If '4', please specify		
30	What is the minimum number of days of accreditation work (training and surveys) expected from each surveyor per year?			
31	How long (in days) is the classroom induction training of a new surveyor?			
32	How many trained surveyors were available to the programme at the end of 2006?			
33	Of these, how many new surveyors completed the training in 2006?			
	6 Assessment			
34	Does assessment require documented evidence that clinical practice guidelines are formally adopted in the hospital?	1=yes; 0=no		
35	Does assessment require documented evidence that clinical performance indicators are routinely available?	1=yes; 0=no		
36	Does assessment require documented evidence that clinical practice is subject to formal peer review?	1=yes; 0=no		
37	For a 100-bed hospital, what is the normal duration (in months) of self-assessment and preparation for external survey ?			
38	For a 100-bed hospital, how many days would a full on-site survey usually last?			
39	For a 100-bed hospital, how many trained surveyors would there be in the visiting team?			
40	Do the survey team (verbally) report back key findings to the senior management of the hospital before leaving?	1=yes; 0=no		
41	Is the draft survey report referred back to the hospital for factual confirmation before submission for accreditation award?	1=yes; 0=no		
42	What methods are used by the programme for hospital assessment?	1= Self-assessment; 2= periodic statistical reporting 3= Scheduled external assessment by surveyors; 4=unannounced external survey; 5=formal survey of patients' experience		
43	Are on-site trained survey teams accompanied by observers?	1= No; 2= Trainee surveyors; 3= New staff members; 4= Regulatory agencies; 5=other assessment programmes		
		If '4' or '5', please specify		
44	How many full on-site visits were done in 2006?			
	7 Awards			
45	What is the maximum duration of a valid accreditation award (in years)?			
46	What is the target turnaround time between the on-site visit and the delivery of the final survey report and recommendations?			
47	Is there a defined mechanism for a hospital to appeal the accreditation decision?	1=yes; 0=no		
	8 Finance			
48	Who funded the initial development of the accreditation programme?	1= International aid; 2= Central government; 3= Local government; 4= Private sector; 5= Academic research; 6= Professional associations; 7= Voluntary sector		
49	How do hospitals pay the accreditation programme?	0=no payment to programme; 1= Annual subscription; 2= Per service or product provided; 3= Combination of 1 and 2		
50	How are surveyors paid?	1= Professional fee per day of work; 2= Fixed rate per diem for expenses only; 3= Reimbursement of actual expenses		
		If '1', what is the standard daily fee (in euro) payable to surveyors?		
		If '2', what is the standard per diem (in euro) payable for overnight accommodation and subsistence?		
51	For a 100-bed hospital, what fee was payable for an accreditation survey in 2006 (in euro)?			
52	What does the fee include?	1= Self-assessment documentation; 2= Induction of hospital staff; 3= Facilitation and preparation; 4= Expenses of survey team; 5= Accreditation decision and certificate		
53	What percentage of total income in 2006 was generated by fees paid for accreditation surveys?			
54	What was the total expenditure (in euro) on accreditation in 2006?			
	9 Information			
55	Are the results of hospital survey reports available to the public on the internet?	1=yes; 0=no		
56	If 'yes', please specify what info is available and include the relevant website or URL	1= Name of the participating hospital; 2= Name of the accredited hospital; 3= Summary report of the results of the hospital; 4= Detailed report of the results of the hospital		
57	What is the address of the web page where results are available?			
58	Do you have data to quantify beneficial impacts of accreditation on hospitals, staff, patients?	1=yes; 0=no		
		If 'yes', please identify for follow-up		
59	Does the programme use statistical indicators to evaluate the performance of the accreditation programme?	1=yes; 0=no		
		If 'yes', please specify		
60	Are you willing for data above to be shared with other participants of this survey?	1=yes; 0=no		

To find authorized persons to answer this survey in each country, the contacts of the Charles Shaw's 2004 survey on Accreditation in European Health Care was adapted according to found information and next submitted to Charles Shaw for completion. The final contacts list contained coordinates of 36 participants.

Table 27: Contact list

Comparative analysis of the European accreditation programmes - Survey - Contacts list				
Country	**Program**	**Contacted person and/or respondent**	**Contacted person e-mail**	**Respondent e-mail**
Albania	National Center of Quality, Safety and Accreditation of the Health Institutions	Isuf Kalo	isufkalo@qkcsaish.gov.al	
Austria		Herbert Stekel	herbert.stekel@akh.linz.at	
Belgium				
Bosnia	AKAZ	Zoran Ridjanovic	zoran@akaz.ba	
Bulgaria	Accreditation of hospitals and diagnostic-consultative centers	Milena Kasapova	milenakas@yahoo.com	M.Kasapova@Vseotdainost.net
Croatia		Ana Stavljenic	ana.stavljenic-rukavina@zg.t-com.hr	
Cyprus			mkazamia@moh.cy	
Czech Republic	National accreditation programme for inpatient healthcare organizations	Ales Bourek	bourek@ivf.cz	frantisek.vlcek@sakcr.cz
Denmark	Den Danske Kvalitetsmodel	Carsten Engel	ce@kvalitetsinstitut.dk	ce@kvalitetsinstitut.dk
Estonia		Teele Raiend	RaiendT@ph.ee	
Finland	Social and Health Quality Service	Marja Pokka-Vuento	marja.pokka-vuento@shqs.fi	marja.pokka-vuento@shqs.fi
France	Haute Autorité de santé	Charles Bruneau	c.bruneau@has.fr	c.bruneau@has-sante.fr
Germany	Kooperation für Transparenz und Qualität im Krankenhaus	Gesine Dannenmaier	gesine.dannenmaier@ktq.de	
Greece		Ask Zoi Kolitsi	kolitsi@vivodinet.gr	
Hungary	Nemzeti Akkreditacios Testulet	Laszlo Gulacsi	lgulacsi@mail.datanet.hu	
Ireland	Irish Health Services Accreditation	Rosin Boland Triona Fortune	rboland@ihsab.ie	tfortune@hiqa.ie
Italy	Accreditation program of the Marche Region Health Care system	Andrea Gardini	a.gardini@regione.marche.it	a.gardini@regione.marche.it
Latvia	Conformity assessment of health care organizations	Igors Trofimovs	igors.trofimovs@vsmtva.gov.lv	igors.trofimovs@vsmtva.gov.lv
Lithuania	State Health Care Accreditation Agency	Juozas Galdikas	vaspvt@takas.lt	vaspvt@vaspvt.sam.lt
Luxembourg		Marie-Lise Lair	marie-lise.lair@crp-sante.lu	Marie-Lise.Lair@crp-sante.healthnet.lu
Netherlands	Netherlands Institute of Accreditation of Hospitals	Hélène Beaard Petra Doets	beaard@niaz.nl	Doets@niaz.nl
Poland	Program Akredytacji Szpitali	Basia Kutryba	kutryba@cmj.org.pl	kutryba@cmj.org.pl
Portugal	National Programme of Hospital Accreditation	Annabel Boavista	aboavista@iqs.pt	aboavista@iqs.pt
Russia	Methodological Centre for Quality	Anna Korotkova	korotkova_anna@healthquality.ru	
Scotland	NHS Quality Improvement Scotland	David Steel Anne Hanley	david.steel@nhshealthquality.org	annehanley@nhs.net
Slovakia	Centrum pre kvalitu a akreditáciu v zdravotníctve	Klara Frecerova	klara.frecerova@health.gov.sk	
Slovenia		Janko Kersnik	janko.kersnik@s5.net	
Spain	Accreditation FADA-JCI	Rosa Sunol	rsunol@fadq.org	fad@fadq.org
Spain Andalucia	Healthcare Centres Accreditation Programme for the Regional Health System of Andalusia	Sagrario Almazan	sagrario.almazan@juntadeandalucia.es	sagrario.almazan@juntadeandalucia.es
Spain Catalunya			rafael.manzanera@gencat.net	
Spain Extremadura			dgfics@sc.juntaex.es	
Spain Valencia	Instituto para la Acreditación y Evaluación de la Prácticas Sanitarias	Patricia Lacruz	inaceps@gva.es	lacruz_pat@gva.es
Sweden		Karl-Henrik Lundell	Karl-Henrik.Lundell@li.se	
Switzerland	sanaCERT Switzerland	Martin Rothenbuehler	martin.rothenbuehler@sanacert.ch	martin.rothenbuehler@sanacert.ch
Turkey		Hasan Kus	hkus@asq.com.tr	hasan.kus@anadolusaglik.org
UK HAQU	CHKS Healthcare Accreditation and Quality Unity	Helen Crisp	hcrisp@hqs.org.uk	hcrisp@hqs.org.uk
UK Healthcare Commission	Healthcare Commission	Kevin Holton Cathy Regan	Kevin.Holton@healthcarecommission.org.uk	cathy.regan@healthcarecommission.org.uk

Federaal Kenniscentrum
Voor de Gezondheidszorg
Centre Fédéral d'Expertise
Des Soins de Santé

Brussels, May 14 2007

Dear collegue,

The Belgian Ministry of Health is seeking the collective experience of hospital accreditation in Europe in order to design a national program for Belgium, and has delegated to the KCE (The Belgian Healthcare Knowledge Center) the task of collecting accurate and relevant information.

You may know that surveys of European hospital accreditation programs were undertaken in 2000, 2002 and 2004; the report of the 2004 survey (draft attached) was never published in full, but a summary appeared in the Joint Commission's journal in 2006 (attached).

We are now requesting that you provide comparable data to update and expand the 2004 survey, enclosed underneath. As previously, the resulting analysis will be provided in full to all respondents. For this survey, the KCE has engaged Dr. Charles D Shaw who is an expert on healthcare accreditation and who conducted the previous surveys based on the methods which were developed for the international survey for WHO in 2000.

We kindly ask you to complete and return the attached questionnaire by Wednesday May 23 latest to Bart Seuntjens: bart.seuntjens@eurogroup.be

For any queries regarding the survey please get in touch with Bart Seuntjens either by e-mail or phone: 0032/477.59.74.35

Yours sincerely

Dirk Ramaekers, General Director KCE



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As it then appeared that more specific information was needed, countries which had answered to the initial survey were approached a second time with additional questions on the 3rd of July.

Table 28: Additional questions

Question	Answer options	Answer
1. What processes are subject of a hospital assessment? The standards used to assess the above selected processes, are they minimal levels to comply with or targets to achieve?	1=clinical processes; 2=internal support processes; 3=governance processes a=minimal levels; b=targets If the standards are public, please attach the list to this mail.	
2. What are the services provided by the accreditation organisation to the hospitals? Are they free of charge for the hospital?	1=tools (guidelines, checklists, methodologies, etc.); 2=training; 3=consultancy; 4=other; 5=none If '4', please specify a=yes; b=no	
3. What alternatives of an accreditation decision exist?	1=accredited/not accredited; 2=different levels (provisional accreditation, accreditation with recommendations, etc.) If '2', please specify	
4. Has the accreditation programme undergone modifications since its creation?	1=yes; 2=no If 'yes', please specify which ones and for what reasons	
5. What do you consider are the key elements for improvement to optimize the accreditation programme?		

Received answers were progressively integrated in a matrix composed of 65 questions – 36 programmes to have a clear view of the current situation. The response rate for the initial survey was 67% for all countries, and 73% for countries of the European Union.

In order to control the validity of the information given by the literature study and the survey, the survey questions which were also answered via the literature study were checked on the correspondence of the information. This check showed that both sources of information delivered for a large part the same data for the selected questions.

APPENDIX 5. THE METHODOLOGY FOR INVENTORY AND COMPARATIVE ANALYSIS OF THE EUROPEAN ACCREDITATION PROGRAMMES - TREATMENT OF THE RESULTS (CHAPTER 2.3)

Regrouping of questions in blocks of the common framework

The literature results and the survey questions covering the same topic were first matched and then regrouped by sub-themes in each 'block' of the new framework (cfr Chapter 2.1. 'Determination of the framework to analyse accreditation') to have structured groups of information to analyze.

Table 29: detailed framework

Comparative analysis of the European accreditation programmes - Treatment of the literature study results and the survey answers - Detailed framework			
1. Policy		**Survey questions**	**Literature study questions**
Programme intentions			
	Programme participation	11. How much choice do hospitals have to participate?	7. What is the character of the hospital accreditation program (compulsory vs optional) ?
	Programme purpose	S. The standards used to assess the above selected processes, are they minimal levels to comply with or targets to achieve?	22. Minimal or optimal standards/norms ?
			3. What is the purpose of the hospital accreditation program ?
Programme supportive structure			
	Law existence		5. What law authorises the hospital accreditation program in the country ? Since when ?
	Policy existence	13. Has hospital accreditation been written into government policy on quality and safety?	8. Does the hospital accreditation program fit within a larger quality program ?
	Body status	17. What is the legal status of the accreditation organisation?	
	Body composition determination	16. How was the composition of the governing body determined?	
	Government link	14. How is the programme related to government?	26. Who does the accreditation body depend on (ministry, other or independent) ?
Programme incentives			
	Hospitals incentives	12. What most motivates hospitals to participate?	16. Are there formal incentive mechanisms in place to stimulate hospitals to apply ?
			9. What are the implications of a positive evaluation for the hospital ?
			10. What are the implications of a negative evaluation for the hospital ?
Programme coverage			
	Concerned hospitals	9. Does the programme include public and private facilities?	14. Which hospitals are concerned by accreditation program, and based on what criteria ?
	Concerned services		6. Is there one single hospital accreditation program or do variants/deviations exist, and based on what criteria ?
	Concerned regions	10. On what country or region does the programme focus?	2. At what level do accreditation programs exist (centralization/regional level) ?

2. Governance			
Body's stakeholders participation			
	Stakeholders profiles	15. What stakeholders are nominated as representatives on the governing body?	27. Who are the stakeholders involved (e.g. are patients represented) ?
Body's internal organization			
	Internal structure		25. Is there an accreditation body (responsible for the hospital accreditation process), what is the internal organization ?

3. Methods			
	3.1. Standards		
	Standards development		
	Standards reference model	26. Is there a particular model which inspired the design of your initial standards?	18. What are the standards and the norms ?
	Standards standardization	24. Are the standards for assessment generic for all hospitals?	23. Can standards/norms be applied for the global accreditation program or do they differ sectorially ?
	Standards spread	S. What processes are subject of a hospital assessment?	12. What does the hospital accreditation program cover in terms of spread and depth (e.g. dimensions/processes) ?
	Standards consultation		
	Standards consultation	27. What was the scope of consultation on the original draft standards?	19. Who defines the set of standards ?
	Standards approval and revision		
	Standards approval date	25. What year was the current edition of the accreditation standards approved by the governing body?	18. What are the standards and the norms ?
	Standards revision frequency	28. How many full revisions of the standards have been published?	18. What are the standards and the norms ?
	3.2. Measurement		
	Generics		
	Assessment methods	42.What methods are used by the programme for hospital assessment?	33. What are the assessment survey methods ?
	Asssessment steps		30. What is the hospital accreditation procedure / what are the steps (e.g. peer review) ?
	Assessment survey cycle		32. What is the assessment survey visits cycle (or the hospital accreditation assessment cycle) ?
	Assessment depth	34.Does assessment require documented evidence that clinical practice guidelines are formally adopted in the hospital?	
		35.Does assessment require documented evidence that clinical performance indicators are routinely available?	
		36.Does assessment require documented evidence that clinical practice is subject to formal peer review?	
	Self-assessment		
	Self-assessment duration	37. For a 100-bed hospital, what is the normal duration (in months) of self-assessment and preparation for external survey ?	31. What is the average leadtime of the hospital accreditation procedure ?
	On-site survey		
	On-site survey duration	38. For a 100-bed hospital, how many days would a full on-site survey usually last?	36. How long takes an assessment survey mission ?
	Team size	39.For a 100-bed hospital, how many trained surveyors would there be in the visiting team?	
	Team composition	29.What is the usual composition of a survey team for a hospital?	37. What is the composition of the assessment survey team ?
		43.Are on-site trained survey teams accompanied by observers?	
	Hospital feedback	40. Do the survey team (verbally) report back key findings to the senior management of the hospital before leaving?	15. What kind of reporting takes place ?
	Hospital report validation		
	Hospital report validation	41. Is the draft survey report reffered back to the hospital for factual confirmation before submission for accreditation award?	30. What is the hospital accreditation procedure / what are the steps (e.g. peer review) ?
	3.3. Surveyors recruitment and training		
	Surveyors recruitment		
	Surveyors availability	32.How many trained surveyors were available to the programme at the end of 2006?	
		30. What is the minimum number of days of accreditation work (training and surveys) expected from each surveyor per year?	
	Surveyors training		
	Surveyors training duration	31.How long (in days) is the classroom induction training of a new surveyor?	34. What are the tools to prepare assessment survey for the surveyors?
	Trained surveyors availability	33.Of these, how many new surveyors completed the training in 2006?	
	3.4. Change management		
	Hospitals tools	S. What are the services provided by the accreditation organisation to the hospitals?	35. What are the tools to prepare assessment survey for the hospital?
		S. Are they free of charge for the hospital?	
	3.5. Decision and appeal		
	Decision levels	S. What alternatives of an accreditation decision exist?	17. Are there different levels of accreditation (with recommendations/without recommendations) ?
	Accreditation validity	45.What is the maximum duration of a valid accreditation award (in years)?	13. What is the validity term of an hospital accreditation ?
	Decision duration	46. What is the target turnaround time between the on-site visit and the delivery of the final survey report and recommendations?	31. What is the average leadtime of the hospital accreditation procedure ?
	Appeal	47.Is there a defined mechanism for a hospital to appeal the accreditation decision?	30. What is the hospital accreditation procedure / what are the steps (e.g. peer review) ?
	3.6. Results diffusion		
	Results availability	55. Are the results of hospital survey reports available to the public on the internet?	39. Are hospital accreditation results available, per hospital and how are they made available ?
	Results contents	56.If 'yes', please specify what info is available and include the relevant website or URL?	

4. Funding mechanism and sources			
	Programme income		
	Programme development	48.Who funded the initial development of the accreditation programme?	42. How is the hospital accreditation financed ?
	Programme running financing	49.How do hospitals pay the accreditation programme?	43. Is hospital accreditation program 'free' or are hospitals supposed to pay a fee ?
		53.What percentage of total income in 2006 was generated by fees paid for accreditation surveys?	
		51.For a 100-bed hospital, what fee was payable for an accreditation survey in 2006 (in euro)?	43. Is hospital accreditation program 'free' or are hospitals supposed to pay a fee ?
		52.What does the fee include?	
	Programme expenses		
	Programme total expenditures	54. What was the total expenditure (in euro) on accreditation in 2006?	41. What are the costs involved to run the hospital accreditation program, at what level ?
	Programme salaries expenditures	23. At the end of 2006, how many staff (expressed in full-time equivalents excluding surveyors and unpaid advisors) were employed for the accreditation program?	
		50.How are surveyors paid?	

5. Evaluation			
	Programme evaluation		
	Programme evaluation		29. Is there an evaluation mechanism of the Accreditation Program as such, if so what are the key elements of the mechanism ?
	Programme outcomes and measurement		
	Programme outcomes	58.Do you have data to quantify beneficial impacts of accreditation on hospitals, staff, patients?	45. What outcomes have been realised ?
	Programme outcomes	59.Does the programme use statistical indicators to evaluate the performance of the accreditation programme?	46. How are these outcomes measured ?
	Programme standards ISQua link		
	Programme standards ISQua	18. Has the programme's governing body formally agreed to work towards meeting ISQua standards?	18. What are the standards and the norms ?
	Programme key indicators		
	Pogramme penetrance	20.How many of these hospitals are currently enrolled in the programme? / 19.How many hospitals are eligible to participate in the	
	Programme sustainability	44.How many full on-site visits were done in 2006?	
Number : correspond to the number of the survey or literature study questions			
S : correspond to an additional survey question			

Then a summary was developed for each country of the European Union on the basis of the 5 elements of the framework.

Quantitative analysis

A quantitative analysis was performed for each question related to a sub-theme, first on the basis of the survey answers, as they are more accurate, and then on the basis of the literature study results if no answer was provided by the survey. It was decided to treat only the European Union countries having responded to the survey and with a programme status identified as active or in an advanced phase of development, which gave a total of 19 programmes to analyze, covering 14 countries.

Besides, it was agreed that percentages used for the results' description would be calculated on the basis of the number of programmes for which information was available, what means that the analysis' coverage does not always include all these 19 programmes.

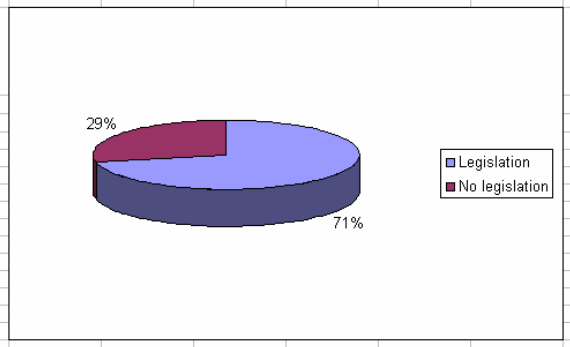
Table 30: Statistical treatments

Comparative analysis of the European accreditation programmes - Treatment of the literature study results and the survey answers - Statistical treatment							
	Program name 2007	**Sending 2007**	**Response 2007**	**Respondant name 2007**	**Respondant e-mail address 2007**	**Program status according to survey 2007**	**Program status according to survey 2004**
UE countries							
Austria	-	v	v			No program	No program
Belgium	-	-	-			No program	Under discussion
Bulgaria	Accreditation of hospitals and diagnostic-consultative centers	v	v	Milena Kasapova	M.Kasapova@Vesotdainost.net	Program	Program
Cyprus	-	v	-			No information	Not contacted
Czech Republic	National accreditation programme for inpatient healthcare organizations	v	v	Frantisek Vlcek	frantisek.vlcek@eskcr.cz	Program	Program
Denmark	Den Danske KvalitetsModel	v	v	Carsten Engel	ce@kvalitetsinstitut.dk	In development (detailed information)	In development
Estonia	-	v	-			No information	No information
Finland	Social and Health Quality Service	v	v	Marja Pokka-Vuento	marja.pokka-vuento@shqs.fi	Program	Program
France	Haute Autorité de Santé	v	v	Charles Bruneau	c.bruneau@has-sante.fr	Program	Program
Germany	-	v	-			No information	Program
Greece	-	v	v	Zoi Kolitsi	kolitzi@vivodinet.gr	No program	No program
Hungary	-	v	-			No information	Under discussion
Ireland	Irish Health Services Accreditation	v	v	Triona Fortune	tfortune@hiqa.ie	Program	Program
Italy	Emilia-Romagna	-	-			Not contacted	Program
	Friuli - Venezia Giulia	-	-			Not contacted	Program
	Lombardia	-	-			Not contacted	Program
	Accreditation program of the Marche Region Health Care system	v	v	Andrea Gardini	a.gardini@regione.marche.it	Program	Program
	Toscana	-	-			Not contacted	Program
Latvia	Conformity assessment of health care organizations	v	v	Igors Trofimovs	igors.trofimovs@vsmtvs.gov.lv	Program	In development
Lithuania	-	v	v	Juozas Galdikas	vaspvt@vaspvt.gamtc.lt	In development (no detailed information)	Under discussion
Luxembourg	Autorisation d'exploitation des hôpitaux et de leurs services médicaux	v	v	Roger Consbruck	roger.consbruck@ms.etat.lu	Program	No program
	Incitants Qualité			Marie-Lise Lair	marie-lise@crp-sante.lu	Program	
Malta	-	-	-			No program	No program
Netherlands	Netherlands Institute of Accreditation of Hospitals	v	v	Petra Doets	Doetz@niaz.nl	Program	Program
Poland	Program Akredytacji Szpitali	v	v	Basia Kutryba	kutryba@cmj.org.pl	Program	Program
Portugal	National Programme of Hospital Accreditation	v	v	Anabela Boavista	aboavista@iqs.pt	Program	Program
Romania	-	-	-			No information	No information
Slovakia	-	v	-			No information	Under discussion
Slovenia	-	v	-			No information	No program
Spain	Accreditation FADA-JCI	v	v	Rosa Sunol	fad@fadq.org	Program	Program
	Healthcare Centres Accreditation Programme for the Regional Health	v	v	Sagrario Almazán	sagrario.almazan@juntadeandalucia.es	Program	Not contacted
	Catalunya	v	-			No information	Program
	Extramadura	v	-			No information	Program
	Instituto para la Acreditación y Evaluación de la Prácticas Sanitarias	v	v	Patricia Lacruz	lacruz_pat@gva.es	Program	Not contacted
Sweden	-	v	v			No program	No program
United Kingdom	CHKS Healthcare Accreditation and Quality Unity	v	v	Helen Crisp	hcrisp@hqs.org.uk	Program	Program
	Healthcare Commission	v	v	Cathy Regan	cathy.regan@healthcarecommission.org.uk	Program	Not contacted
	NHS Quality Improvement Scotland	v	v	Anne Hanley	annehanley@nhs.net	Program	Program
Total UE		**30**	**22**				
		73%					
Non UE countries							
Albania	-	v	-			No information	No program
Bosnia	-	v	-			No information	In development
Croatia	-	v	-			No information	In development
Russia	-	v	-			No information	Under discussion
Switzerland	sanaCERT Switzerland	v	v	Martin Rothenbühler	martin.rothenbuehler@sanacert.ch	Program	Program
Turkey	-	v	v	Hasan Kus	hasan.kuz@anadoluzeglik.org	In development	Under discussion
Total non UE		**6**	**2**				
		33%					
Total		**36**	**24**				
		67%					
Treated in report							

Literature Study 3. What is the purpose of the hospital accreditation program?	Information	No information	Checked		
TOTAL	7	12	19	19	
	37%	63%	100%		
Bulgaria	0	1			
Czech Republic	0	1			
Denmark	1	0	To promote good patient pathways, so as to ensure that the patients experience improved quality, and to improve a continuous clinical, professional and organisational quality in patient pathways		
Finland	0	1			
France	1	0	Améliorer la qualité des soins fournis par les établissements de santé et à mettre à disposition du public une information sur la qualité des prestations délivrées par ces établissements		
Ireland	1	0	To improve the quality of care and the patient safety		
Italy (Marche)	0	1			
Latvia	1	0	To improve the quality of care		
Luxemburg (Autorisation)	0	1			
Luxemburg (Incitants)	0	1			
Netherlands	1	0	To stimulate hospitals to improve the quality of the organisation of health care and in quality assurance		
Poland	0	1			
Portugal	0	1			
Spain	0	1			
Spain (Andalusia)	0	1			
Spain (Valencia)	0	1			
UK (Health Care Commission)	0	1			
UK (HAQU)	1	0	To improve the quality of care		
Scotland	1	0	To improve the quality of care		

Program Supportive Structure

Literature Study 5. What law authorises the hospital accreditation program in the country? Since when?	Legislation	No legislation	No information	Checked	
TOTAL	10	4	5	19	14
	71%	29%		100%	
Bulgaria	1	0	0		
Czech Republic	0	0	1		
Denmark	0	1	0		
Finland	0	0	1		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	0	1	0		
Spain	0	1	0		
Spain (Andalusia)	0	0	1		
Spain (Valencia)	0	0	1		
UK (Health Care Commission)	0	0	1		
UK (HAQU)	0	1	0		
Scotland	1	0	0		

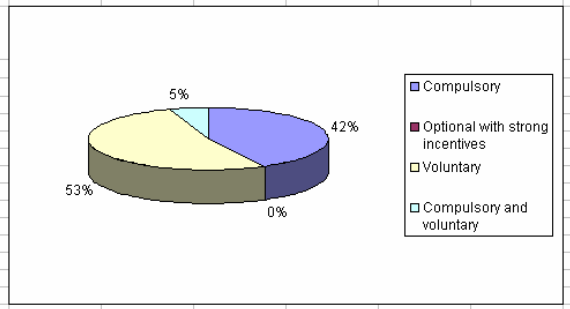


0=no ; 1=yes
No information found
Information found in the survey
Information found in the literature study > 2004
Information found via phone call
Several options chosen while exclusive options
Incoherence with other answer or alone
Specific data -> to consider when treating statistics

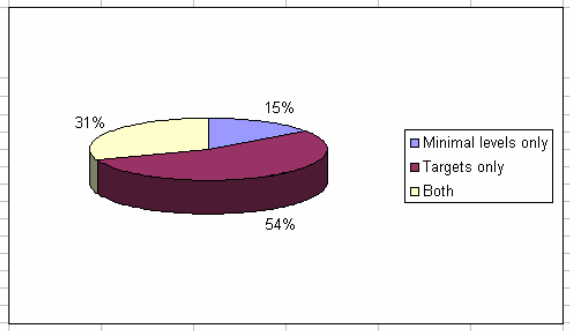
1. Policy

Program intentions

Survey 11. How much choice do hospitals have to participate?	Compulsory	Optional with strong incentives	Voluntary	Compulsory and voluntary	No information	Checked	
TOTAL	8	0	10	1	0	19	19
	42%	0%	53%	5%		100%	
Bulgaria	1	0	0	0	0		
Czech Republic	0	0	1	0	0		
Denmark	1	0	0	0	0		
Finland	0	0	1	0	0		
France	1	0	0	0	0		
Ireland	0	0	1	0	0		
Italy (Marche)	1	0	0	0	0		
Latvia	1	0	0	0	0		
Luxemburg (Autorisation)	1	0	0	0	0		
Luxemburg (Incitants)	0	0	1	0	0		
Netherlands	0	0	1	0	0		
Poland	0	0	1	0	0		
Portugal	0	0	1	0	0		
Spain	0	0	1	0	0		
Spain (Andalusia)	0	0	0	1	0	Compulsory for the public healthcare centres and voluntary for the private healthcare centres	
Spain (Valencia)	0	0	1	0	0		
UK (Health Care Commission)	1	0	0	0	0		
UK (HAQU)	0	0	1	0	0		
Scotland	1	0	0	0	0		



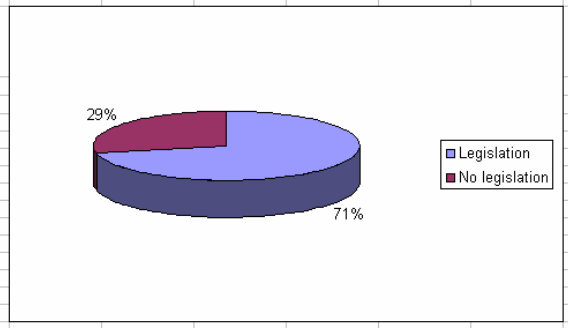
Survey Additional Questions. The standards used to assess the above selected processes, are they minimal levels to comply with or targets to achieve?	Minimal levels only	Targets only	Both	No information	Checked	
TOTAL	2	7	4	6	19	13
	15%	54%	31%		100%	
Bulgaria	1	0	0	0		
Czech Republic	0	0	0	1		
Denmark	0	1	0	0		
Finland	0	0	0	1		
France	0	1	0	0		
Ireland	0	1	0	0		
Italy (Marche)	0	0	0	1		
Latvia	1	0	0	O		
Luxemburg (Autorisation)	0	0	0	1		
Luxemburg (Incitants)	0	0	0	1		
Netherlands	0	0	1	0	Both are used	
Poland	0	0	0	1		
Portugal	0	1	0	0		
Spain	0	1	0	0		
Spain (Andalusia)	0	0	1	0	Both are used	
Spain (Valencia)	0	1	0	0		
UK (Health Care Commission)	0	0	1	0	Both are used	
UK (HAQU)	0	0	1	0	Both are used	
Scotland	0	1	0	0		



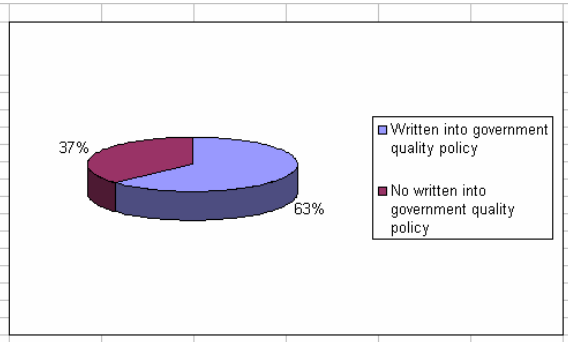
Literature Study 3. What is the purpose of the hospital accreditation program?	Information	No information	Checked	
TOTAL	7	12	19	19
	37%	63%	100%	
Bulgaria	0	1		
Czech Republic	0	1		
Denmark	1	0	To promote good patient pathways, so as to ensure that the patients experience improved quality, and to improve a continuous clinical, professional and organisational quality in patient pathways	
Finland	0	1		
France	1	0	Améliorer la qualité des soins fournis par les établissements de santé et à mettre à disposition du public une information sur la qualité des prestations délivrées par ces établissements	
Ireland	1	0	To improve the quality of care and the patient safety	
Italy (Marche)	0	1		
Latvia	1	0	To improve the quality of care	
Luxemburg (Autorisation)	0	1		
Luxemburg (Incitants)	0	1		
Netherlands	1	0	To stimulate hospitals to improve the quality of the organisation of health care and in quality assurance	
Poland	0	1		
Portugal	0	1		
Spain	0	1		
Spain (Andalusia)	0	1		
Spain (Valencia)	0	1		
UK (Health Care Commission)	0	1		
UK (HAQU)	1	0	To improve the quality of care	
Scotland	1	0	To improve the quality of care	

Program Supportive Structure

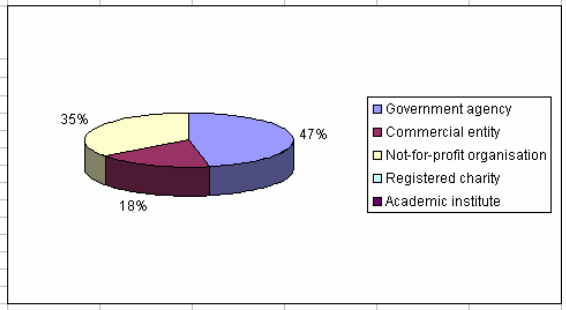
Literature Study 5. What law authorises the hospital accreditation program in the country? Since when?	Legislation	No legislation	No information	Checked	
TOTAL	10	4	5	19	14
	71%	29%		100%	
Bulgaria	1	0	0		
Czech Republic	0	0	1		
Denmark	0	1	0		
Finland	0	0	1		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	0	1	0		
Spain	0	1	0		
Spain (Andalusia)	0	0	1		
Spain (Valencia)	0	0	1		
UK (Health Care Commission)	0	0	1		
UK (HAQU)	0	1	0		
Scotland	1	0	0		



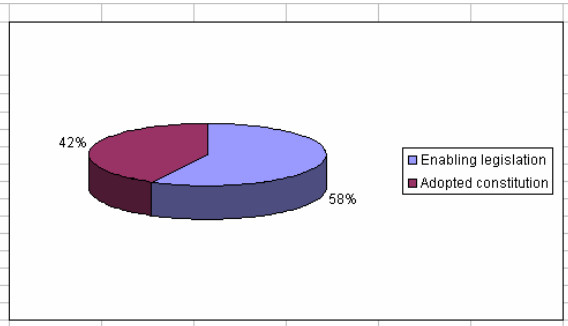
Survey 13. Has hospital accreditation been written into government policy on quality and safety?	Written into government quality policy	No written into government quality policy	No information	Checked	
TOTAL	12	7	0	19	19
	63%	37%		100%	
Bulgaria	1	0	0		
Czech Republic	0	1	0	Planned in near future	
Denmark	1	0	0		
Finland	0	1	0	Recommendation of Ministry of Health and Social Services	
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	0	1	0		
Netherlands	1	0	0		
Poland	0	1	0		
Portugal	0	1	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	0	1	0		
Scotland	1	0	0		



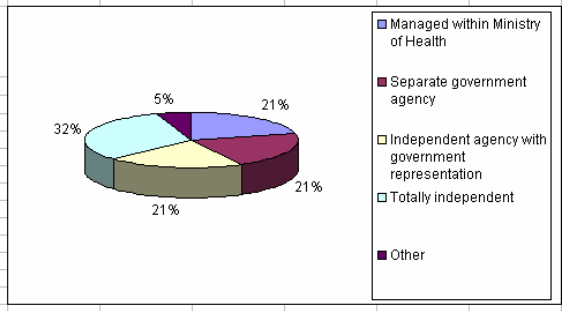
Survey 17. What is the legal status of the accreditation organisation?	Government agency	Commercial entity	Not-for-profit organisation	Registered charity	Academic institute	No information	Checked	
TOTAL	8	3	6	0	0	2	19	17
	47%	18%	35%	0%	0%		100%	
Bulgaria	1	0	0	0	0	0		
Czech Republic	0	1	0	0	0	0	Not-for-profit organisation in near future	
Denmark	0	0	1	0	0	0		
Finland	0	1	0	0	0	0		
France	1	0	0	0	0	0		
Ireland	1	0	0	0	0	0		
Italy (Marche)	1	0	0	0	0	0		
Latvia	1	0	0	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	0	1		
Luxemburg (Incitants)	0	0	0	0	0	1		
Netherlands	0	0	1	0	0	0		
Poland	1	0	0	0	0	0		
Portugal	0	0	1	0	0	0	Governement agency in near future	
Spain	0	0	1	0	0	0		
Spain (Andalusia)	1	0	0	0	0	0		
Spain (Valencia)	0	0	1	0	0	0		
UK (Health Care Commission)	1	0	0	0	0	0		
UK (HAQU)	0	1	0	0	0	0		
Scotland	0	0	1	0	0	0		



Survey 16. How was the composition of the governing body determined?	Enabling legislation	Adopted constitution	No information	Checked	
TOTAL	11	8	0	19	19
	58%	42%		100%	
Bulgaria	1	0	0		
Czech Republic	0	1	0		
Denmark	0	1	0		
Finland	0	1	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	0	1	0		
Netherlands	0	1	0		
Poland	1	0	0		
Portugal	1	0	0		
Spain	0	1	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	0	1	0		
Scotland	1	0	0		



Survey 14. How is the programme related to the government?	Managed within Ministry of Health	Separate government agency	Independent agency with government representation	Totally independent	Other	No information	Checked	
TOTAL	4	4	4	6	1	0	19	19
	21%	21%	21%	32%	5%		100%	
Bulgaria	0	0	1	0	0	0		
Czech Republic	0	0	0	1	0	0		
Denmark	0	0	1	0	0	0		
Finland	0	0	0	1	0	0		
France	0	1	0	0	0	0		
Ireland	0	0	1	0	0	0		
Italy (Marche)	0	1	0	0	0	0		
Latvia	0	1	0	0	0	0		
Luxemburg (Autorisation)	1	0	0	0	0	0		
Luxemburg (Incitants)	0	0	0	1	0	0		
Netherlands	0	0	0	1	0	0		
Poland	0	1	0	0	0	0		
Portugal	1	0	0	0	0	0		
Spain	0	0	0	1	0	0		
Spain (Andalusia)	0	0	1	0	0	0		
Spain (Valencia)	0	0	0	0	1	0	Public firm but they are independent in their decisions because they have two commissions	
UK (Health Care Commission)	1	0	0	0	0	0		
UK (HAQU)	0	0	0	1	0	0		
Scotland	1	0	0	0	0	0		



Program incentives

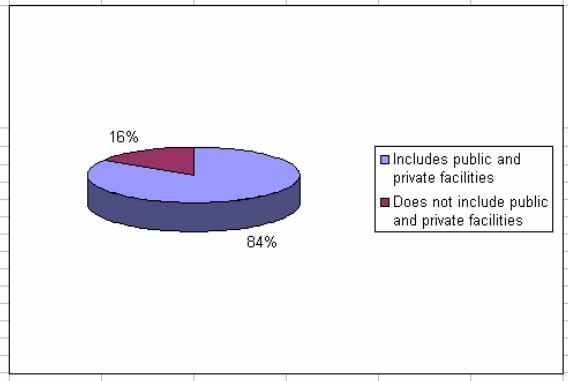
Survey 12. What most motivates hospitals to participate?	Additional funding	Marketing	Staff recruitment	Academic recognition for training	Statutory requirement	Contractual requirement by purchasers	Risk indemnity insurance	Desire for improvement	No information	Checked	
TOTAL	4	6	1	2	9	5	0	12	0	39	19
	21%	32%	5%	11%	47%	26%	0%	63%			
Bulgaria	0	0	0	1	1	0	0	0	0		
Czech Republic	0	1	0	0	0	0	0	0	0		
Denmark	0	1	1	0	1	0	0	1	0		
Finland	0	1	0	0	0	1	0	1	0		
France	0	1	0	0	1	0	0	1	0		
Ireland	0	0	0	0	0	0	0	1	0		
Italy (Marche)	1	0	0	0	1	0	0	0	0		
Latvia	0	0	0	0	1	1	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	1	0	0	0	0		
Luxemburg (Incitants)	1	1	0	0	0	0	0	0	0		
Netherlands	0	0	0	0	0	1	0	1	0		
Poland	1	0	0	0	0	1	0	1	0		
Portugal	1	0	0	0	0	0	0	1	0		
Spain	0	0	0	0	0	0	0	1	0		
Spain (Andalusia)	0	0	0	0	1	0	0	1	0		
Spain (Valencia)	0	1	0	1	0	0	0	1	0		
UK (Health Care Commission)	0	0	0	0	1	0	0	0	0		
UK (HAQU)	0	0	0	0	0	0	0	1	0		
Scotland	0	0	0	0	1	1	0	1	0		

Literature Study 9. What are the implications of a positive evaluation for the hospital?	Information	No information	Checked	In contradiction or less complete than the anwers to the Survey
TOTAL	8	11	19	
Bulgaria	0	1		
Czech Republic	0	1		
Denmark	0	1		
Finland	0	1		
France	1	0	Accreditation carries a major symbolic value akin to a "brand image" that the establishment can 'sell" to healthcare authorities, correspondents, and actual and potential patients	
Ireland	1	0	No direct implications	
Italy (Marche)	1	0	National law states that only accredited facilities can operate within the public system : only accredited facilities are eligible for contracts with (and payments from) the national health	
Latvia	1	0	Obtention of money from the state	
Luxemburg (Autorisation)	0	1		
Luxemburg (Incitants)	0	1		
Netherlands	1	0	NIAZ accreditation certificate guarantees the accountability of hospitals for both internal and external stakeholders	
Poland	0	1		
Portugal	1	0	National health insurance fund will contract only with those facilities that have been accredited	
Spain	0	1		
Spain (Andalusia)	0	1		
Spain (Valencia)	0	1		
UK (Health Care Commission)	0	1		
UK (HAQU)	1	0	CHKS Accreditation Award provides a clear 'stamp of quality' to staff, patients, commissioners and regulatory organisations	
Scotland	1	0	Public confidence, image improvement	

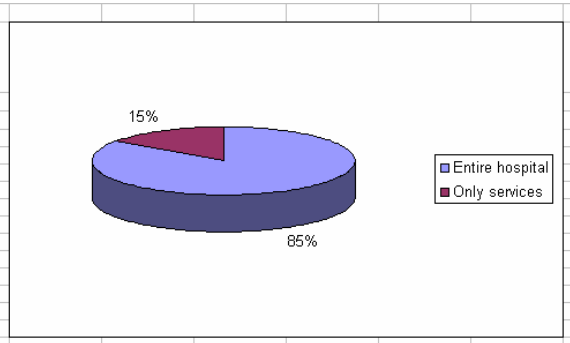
Literature Study 10. What are the implications of a negative evaluation for the hospital?	5/19 answers + ambigous question -> not treated in the report
TOTAL	
Bulgaria	
Czech Republic	
Denmark	
Finland	
France	Negative image for the public and the financing authorities
Ireland	No direct implications
Italy (Marche)	
Latvia	Closing of the hospital
Luxemburg (Autorisation)	
Luxemburg (Incitants)	
Netherlands	
Poland	
Portugal	
Spain	
Spain (Andalusia)	
Spain (Valencia)	
UK (Health Care Commission)	
UK (HAQU)	Obligation of follow-up
Scotland	Lack of public confidence, obligation to give an annual follow-up to the Ministry of Health

Program Coverage

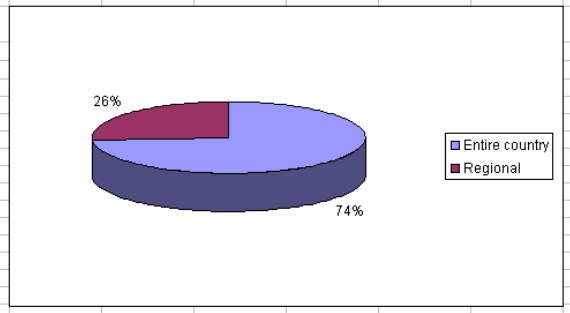
Survey 9. Does the programme include public and private facilities?	Includes public and private facilities	Does not include public and private facilities	No information	Checked	
TOTAL	16	3	0	19	19
	84%	16%		100%	
Bulgaria	0	1	0		
Czech Republic	1	0	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	0	1	0		
Italy (Marche)	1	0	0		
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	0	1	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		



Literature Study 6. Is there one single hospital accreditation program or do variants/deviations exist, and based on what criteria?	Entire hospital	Only services	No information	Checked	
TOTAL	11	2	6	19	13
	85%	15%		100%	
Bulgaria	1	0	0		
Czech Republic	1	0	0		
Denmark	1	0	0		
Finland	0	0	1		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	0	0	1		
Latvia	1	0	0		
Luxemburg (Autorisation)	0	0	1		
Luxemburg (Incitants)	0	0	1		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	1	0	0		
Spain	0	0	1		
Spain (Andalusia)	0	0	1		
Spain (Valencia)	0	1	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	1	0	0		
Scotland	0	1	0		



Survey 10. On what country or region does the programme focus?	Entire country	Regional	No information	Checked	
TOTAL	14	5	0	19	19
	74%	26%		100%	
Bulgaria	1	0	0		
Czech Republic	1	0	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	0	1	0	Marche	
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	0	1	0	Andalusia	
Spain (Valencia)	0	1	0	Valencia	
UK (Health Care Commission)	0	1	0	England and Wales	
UK (HAQU)	1	0	0		
Scotland	0	1	0	Scotland	



2. Governance

Body stakeholders participation

Survey 15. What stakeholders are nominated as representatives on the governing body?	Users	Clinical professionals	Indemnity insurers	Health care insurers	Hospital owners	Regulators	Academic/ training institutions	No external representatives	No information	Checked	
TOTAL	6	13	0	3	7	7	5	1	0	42	19
	32%	68%	0%	16%	37%	37%	26%	5%			
Bulgaria	0	0	0	0	1	0	0	0	0		
Czech Republic	0	0	0	0	1	0	0	0	0	All stakeholders in near future	
Denmark	0	0	0	0	1	1	0	0	0		
Finland	0	1	0	0	1	0	0	0	0		
France	1	1	0	1	1	1	0	0	0		
Ireland	1	1	0	0	1	0	1	0	0		
Italy (Marche)	0	0	0	0	0	1	0	0	0		
Latvia	0	0	0	0	0	0	0	1	0		
Luxemburg (Autorisation)	0	0	0	0	0	1	0	0	0		
Luxemburg (Incitants)	0	1	0	1	0	0	1	0	0		
Netherlands	1	1	0	1	0	0	0	0	0		
Poland	0	1	0	0	0	1	1	0	0		
Portugal	0	1	0	0	0	0	0	0	0		
Spain	0	1	0	0	0	1	1	0	0		
Spain (Andalusia)	0	1	0	0	1	1	0	0	0		
Spain (Valencia)	1	1	0	0	0	0	0	0	0		
UK (Health Care Commission)	1	1	0	0	0	0	0	0	0		
UK (HAQU)	0	1	0	0	0	0	1	0	0		
Scotland	1	1	0	0	0	0	0	0	0		

Body internal organization

Literature Study 25. Is there an accreditation body (responsible for the hospital accreditation process), what is the internal organization?	Information	No information	Checked	5/19 answers + complex to describe and compare all the structures -> not treated in the report
TOTAL	5	14	19	
Bulgaria	0	1		
Czech Republic	0	1		
Denmark	1	0	Board, chief executive and staff	
Finland	0	1		
France	1	0	Collège, sept Commissions spécialisées, des services opérationnels et deux réseaux de collaborateurs externes (chargés de mission régionaux en évaluation et experts-visiteurs)	
Ireland	1	0	Board , chief executive and chairperson	
Italy (Marche)	0	1		
Latvia	0	1		
Luxemburg (Autorisation)	0	1		
Luxemburg (Incitants)	0	1		
Netherlands	1	0	Board, Committe of Experts, Committe for Quality Declarations, Committee of Appeal, staff and pool of peer-surveyors	
Poland	0	1		
Portugal	0	1		
Spain	0	1		
Spain (Andalusia)	0	1		
Spain (Valencia)	0	1		
UK (Health Care Commission)	0	1		
UK (HAQU)	0	1		
Scotland	1	0	Board, chief executive and directors	

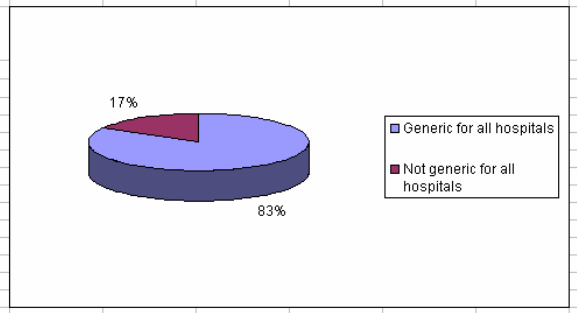
3. Methods

3.1. Standards

Standards development

Survey 26. Is there a particular model which inspired the design of your initial standards?	EFQM	ISO	Accreditation	Other	No information	Checked	
TOTAL	4	1	13	3	0	21	19
	21%	5%	68%	16%			
Bulgaria	0	1	0	0	0		
Czech Republic	0	0	1	0	0	JCAHO	
Denmark	0	0	1	0	0	No particular program	
Finland	0	0	1	0	0	All programs	
France	0	0	1	0	0	CCHSA, ACHS, JCAHO	
Ireland	0	0	1	0	0	CCHSA	
Italy (Marche)	0	0	1	0	0	CCHSA, ACHS, JCAHO	
Latvia	0	0	0	1	0		
Luxemburg (Autorisation)	0	0	0	1	0		
Luxemburg (Incitants)	1	0	0	0	0		
Netherlands	1	0	1	0	0	CCHSA	
Poland	0	0	1	0	0	JCAHO	
Portugal	0	0	1	0	0	HQS program	
Spain	0	0	1	0	0	JCAHO	
Spain (Andalusia)	0	0	1	0	0	CCHSA	
Spain (Valencia)	1	0	1	0	0	JCAHO	
UK (Health Care Commission)	0	0	0	1	0		
UK (HAQU)	0	0	1	0	0	ACHS	
Scotland	1	0	0	0	0		

Survey 24. Are the standards for assessment generic for all hospitals?	Generic for all hospitals	Not generic for all hospitals	No information	Checked	
TOTAL	15	3	1	19	18
	83%	17%		100%	
Bulgaria	1	0	0		
Czech Republic	1	0	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	0	0	1		
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	0	1	0	Criteria and standards are designed, developed and implemented for each medical specialty	
UK (Health Care Commission)	0	1	0	Differents standards for independant and private sector providers	
UK (HAQU)	0	1	0	Differents standards for private acute hospitals, mental health hospitals, hospices	
Scotland	1	0	0	Standards are topic specific and apply within all hospitals providing the service	



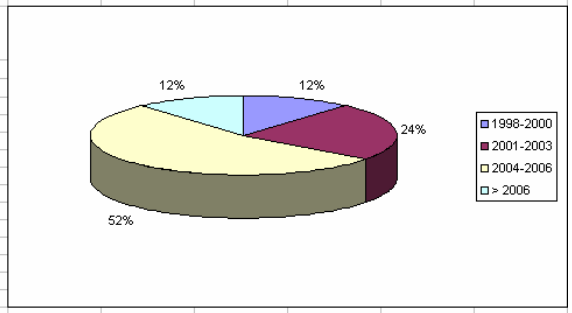
Survey Additional Questions. What processes are subject of a hospital assessment?	Clinical processes	Internal support processes	Governance processes	No information	Checked	
TOTAL	12	10	12	6	40	13
	92%	77%	92%			
Bulgaria	1	0	0	0		
Czech Republic	0	0	0	1		
Denmark	1	1	1	0		
Finland	0	0	0	1		
France	1	1	1	0		
Ireland	1	1	1	0		
Italy (Marche)	0	0	0	1		
Latvia	0	1	1	0		
Luxemburg (Autorisation)	0	0	0	1		
Luxemburg (Incitants)	0	0	0	1		
Netherlands	1	1	1	0		
Poland	0	0	0	1		
Portugal	1	1	1	0		
Spain	1	1	1	0		
Spain (Andalusia)	1	1	1	0		
Spain (Valencia)	1	1	1	0		
UK (Health Care Commission)	1	0	1	0		
UK (HAQU)	1	1	1	0		
Scotland	1	0	1	0		

Standards consultation

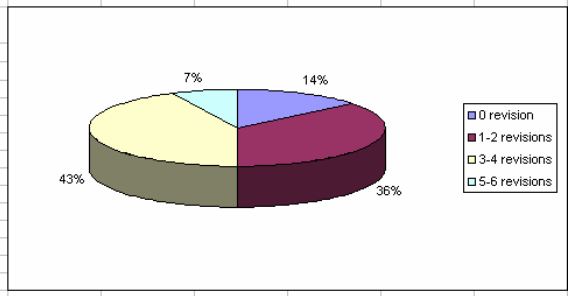
Survey 27. What was the scope of consultation on the original draft standards?	No consultation	Internal to the organisation	Stakeholder organisations	Public at large	No information	Checked	
TOTAL	1	6	12	4	1	24	18
	6%	33%	67%	22%			
Bulgaria	1	0	0	0	0		
Czech Republic	0	0	1	0	0		
Denmark	0	0	1	0	0		
Finland	0	0	1	0	0		
France	0	0	1	0	0		
Ireland	0	1	1	1	0		
Italy (Marche)	0	0	0	0	1		
Latvia	0	0	1	0	0		
Luxemburg (Autorisation)	0	1	1	0	0		
Luxemburg (Incitants)	0	1	1	0	0	And social insurance and research centre	
Netherlands	0	1	0	0	0		
Poland	0	0	1	0	0		
Portugal	0	0	1	0	0		
Spain	0	0	0	1	0		
Spain (Andalusia)	0	1	0	0	0		
Spain (Valencia)	0	1	0	0	0		
UK (Health Care Commission)	0	0	0	1	0		
UK (HAQU)	0	0	1	0	0		
Scotland	0	0	1	1	0		

Standards approval and revision

Survey 25. What year was the current edition of the accreditation standards approved by the governing body?	1998-2000	2001-2003	2004-2006	> 2006	Not applicable	No information	Checked	
TOTAL	2	4	9	2	1	1	19	17
	12%	24%	53%	12%			100%	
Bulgaria	0	1	0	0	0	0	2001	
Czech Republic	0	0	1	0	0	0	2005	
Denmark	0	0	0	0	1	0	Expected in 2007	
Finland	0	0	1	0	0	0	2005	
France	0	0	0	1	0	0	2007	
Ireland	0	0	1	0	0	0	2004	
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	1	0	0	0	0	2002	
Luxemburg (Autorisation)	0	1	0	0	0	0	2003	
Luxemburg (Incitants)	1	0	0	0	0	0	1998	
Netherlands	0	0	1	0	0	0	2005	
Poland	1	0	0	0	0	0	1998	
Portugal	0	0	1	0	0	0	2006 by HQS governing body	
Spain	0	0	1	0	0	0	2004	
Spain (Andalusia)	0	1	0	0	0	0	2003	
Spain (Valencia)	0	0	0	1	0	0	2004 for Primary Care, 2006 for Dyalisis Units and 2007 for Admission of patients	
UK (Health Care Commission)	0	0	1	0	0	0	2006	
UK (HAQU)	0	0	1	0	0	0	2006	
Scotland	0	0	1	0	0	0	2006	



Survey 28. How many full revisions of the standards have been published?	0 revision	1-2 revisions	3-4 revisions	5-6 revisions	Not applicable	No information	Checked	
TOTAL	2	5	6	1	1	4	19	14
	14%	36%	43%	7%			100%	
Bulgaria	0	0	0	0	0	1	27	
Czech Republic	0	1	0	0	0	0	2	
Denmark	0	0	0	0	1	0	0	
Finland	0	0	1	0	0	0	4	
France	0	0	1	0	0	0	3	
Ireland	0	1	0	0	0	0	2	
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	1	0	0	0	0	2	
Luxemburg (Autorisation)	0	0	0	0	0	1		
Luxemburg (Incitants)	0	0	1	0	0	0	3	
Netherlands	0	0	1	0	0	0	3	
Poland	0	1	0	0	0	0	2	
Portugal	0	0	1	0	0	0	3	
Spain	0	0	1	0	0	0	3	
Spain (Andalusia)	1	0	0	0	0	0	0	
Spain (Valencia)	0	1	0	0	0	0	1 of each	
UK (Health Care Commission)	1	0	0	0	0	0	0	
UK (HAQU)	0	0	0	1	0	0	5	
Scotland	0	0	0	0	0	1	Difficult to say as there is a range of standards	

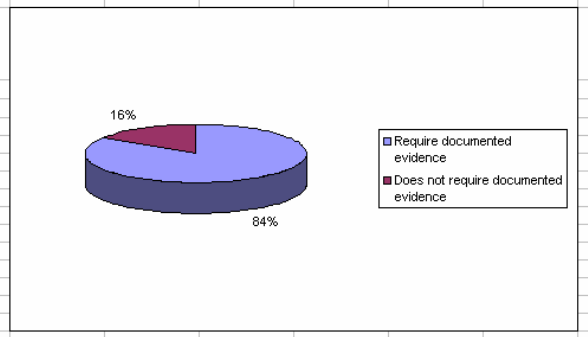


3.2. Measurement																
Generics																
Survey 42. What methods are used by the programme for hospital assessment?	Self-assessment	Periodic statistical reporting	Scheduled external survey	Unannounced external survey	Formal survey of patients	No information	Checked									
TOTAL	14	5	16	1	5	0	41	19								
	74%	26%	84%	5%	26%											
Bulgaria	0	0	1	0	0	0										
Czech Republic	0	0	1	0	0	0										
Denmark	1	1	1	0	1	0										
Finland	1	0	1	0	0	0										
France	1	0	1	0	0	0										
Ireland	1	1	1	0	1	0										
Italy (Marche)	1	0	0	0	0	0	Wait for political decisions to start the on-site surveys									
Latvia	0	0	1	0	0	0										
Luxemburg (Autorisation)	0	1	0	0	0	0										
Luxemburg (Incitants)	1	1	1	0	0	0										
Netherlands	1	0	1	0	1	0										
Poland	0	0	1	0	0	0										
Portugal	1	0	1	0	0	0	For the UK program									
Spain	1	1	1	0	0	0										
Spain (Andalusia)	1	0	1	0	1	0										
Spain (Valencia)	1	0	1	0	1	0										
UK (Health Care Commission)	1	0	0	1	0	0										
UK (HAQU)	1	0	1	0	0	0										
Scotland	1	0	1	0	0	0										

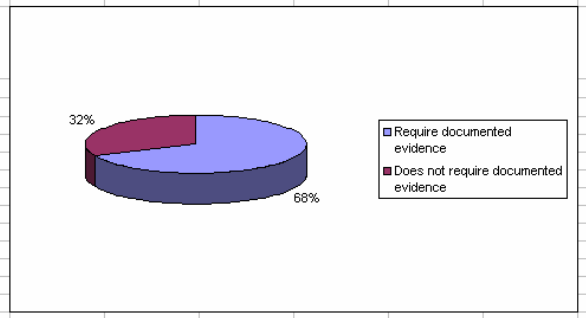
Literature study 30. What is the hospital accreditation procedure?	Same coverage than Survey 42 + complex to compare and describe such detailed
TOTAL	
Bulgaria	
Czech Republic	
Denmark	
Finland	
France	
Ireland	
Italy (Marche)	
Latvia	
Luxemburg (Autorisation)	
Luxemburg (Incitants)	
Netherlands	
Poland	
Portugal	
Spain	
Spain (Andalusia)	
Spain (Valencia)	
UK (Health Care Commission)	
UK (HAQU)	
Scotland	

Literature study 30. What is the assessment survey visits cycle?	1/19 answers (France) + redundant with the decision validity -> not treated in the
TOTAL	
Bulgaria	
Czech Republic	
Denmark	
Finland	
France	
Ireland	
Italy (Marche)	
Latvia	
Luxemburg (Autorisation)	
Luxemburg (Incitants)	
Netherlands	
Poland	
Portugal	
Spain	
Spain (Andalusia)	
Spain (Valencia)	
UK (Health Care Commission)	
UK (HAQU)	
Scotland	

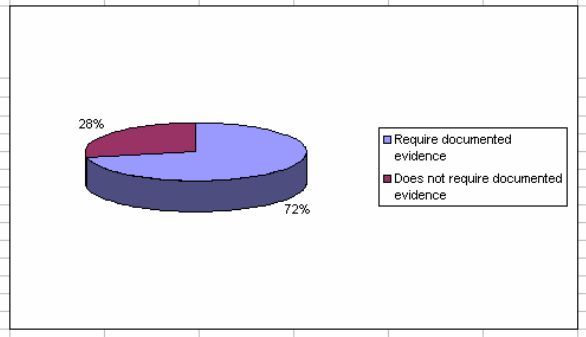
Survey 34. Does assessment require documented evidence that clinical practice guidelines are formally adopted in the hospital?	Require documented evidence	Does not require documented evidence	No information	Checked	
TOTAL	16	3	0	19	19
	84%	16%		100%	
Bulgaria	0	1	0		
Czech Republic	1	0	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	0	1	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		



Survey 35. Does assessment require documented evidence that clinical performance indicators are routinely available?	Require documented evidence	Does not require documented evidence	No information	Checked	
TOTAL	13	6	0	19	19
	68%	32%		100%	
Bulgaria	0	1	0		
Czech Republic	0	1	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	0	1	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	0	1	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	0	1	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		

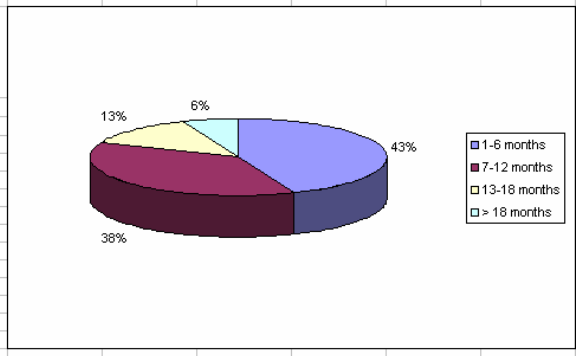


Survey 36. Does assessment require documented evidence that clinical practice is subject to formal peer review?	Require documented evidence	Does not require documented evidence	No information	Checked	
TOTAL	13	5	1	19	18
	72%	28%		100%	
Bulgaria	1	0	0		
Czech Republic	0	1	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	0	0	1		
Italy (Marche)	1	0	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	0	1	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	0	1	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	0	1	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		



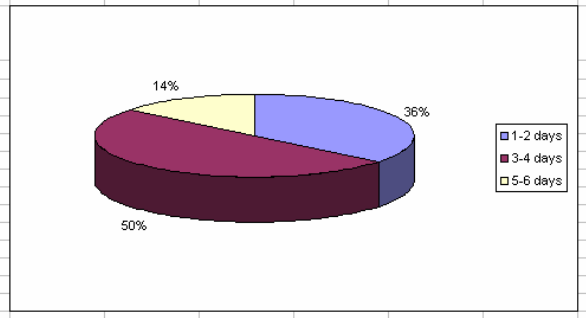
Self-assessment

Survey 37. For a 100-bed hospital, what is the normal duration (in months) of self-assessment and preparation for external survey ?	1-6 months	7-12 months	13-18 months	> 18 months	Not applicable	No information	Checked	
TOTAL	7	6	2	1	1	2	19	16
	44%	38%	13%	6%			100%	
Bulgaria	1	0	0	0	0	0	6	
Czech Republic	0	1	0	0	0	0	12	
Denmark	0	1	0	0	0	0	8-12-> 10	
Finland	0	0	1	0	0	0	12-24 -> 18	
France	0	1	0	0	0	0	9	
Ireland	1	0	0	0	0	0	6	
Italy (Marche)	0	0	0	0	0	1		
Latvia	1	0	0	0	0	0	6	
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	1	0	0	0	0	0	6	
Netherlands	0	1	0	0	0	0	9	
Poland	1	0	0	0	0	0	6	
Portugal	0	0	1	0	0	0	12-16 -> 14 for the UK program	
Spain	0	0	0	1	0	0	18-24 -> 21	
Spain (Andalusia)	0	1	0	0	0	0	8	
Spain (Valencia)	1	0	0	0	0	0	2-6 -> 4	
UK (Health Care Commission)	0	0	0	0	0	1		
UK (HAQU)	0	1	0	0	0	0	12	
Scotland	1	0	0	0	0	0	2-3 -> 2.5	

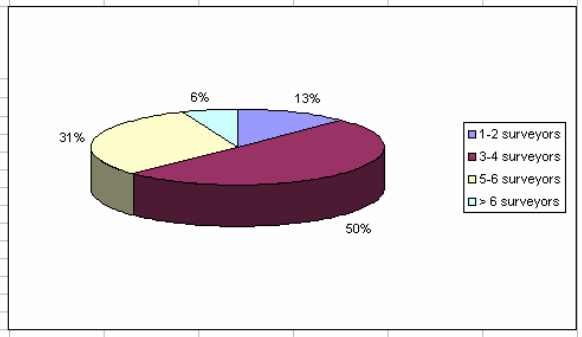


On-site survey

Survey 38. For a 100-bed hospital, how many days would a full on-site survey usually last?	1-2 days	3-4 days	5-6 days	Not applicable	No information	Checked	
TOTAL	5	7	2	1	4	19	14
	36%	50%	14%			100%	
Bulgaria	0	0	1	0	0	5	
Czech Republic	1	0	0	0	0	2	
Denmark	0	0	0	0	1	Not decided yet, probably 3-4	
Finland	1	0	0	0	0	2	
France	0	1	0	0	0	4	
Ireland	0	1	0	0	0	3-4	
Italy (Marche)	0	0	0	0	1		
Latvia	1	0	0	0	0	1	
Luxemburg (Autorisation)	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	1		
Netherlands	0	1	0	0	0	4	
Poland	1	0	0	0	0	2	
Portugal	0	1	0	0	0	3-4 for the UK program	
Spain	0	1	0	0	0	3	
Spain (Andalusia)	0	1	0	0	0	3	
Spain (Valencia)	0	0	1	0	0	5-6	
UK (Health Care Commission)	0	0	0	0	1		
UK (HAQU)	0	1	0	0	0	3	
Scotland	1	0	0	0	0	1-3->2	



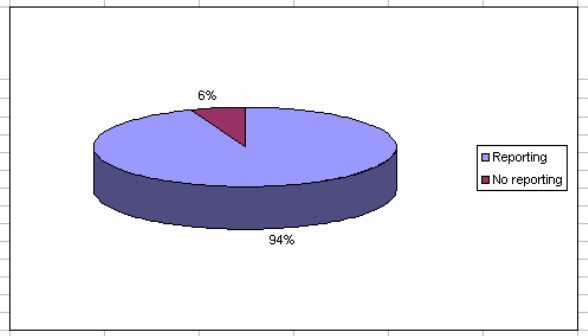
Survey 39. For a 100-bed hospital, how many trained surveyors would there be in the visiting team?	1-2 surveyors	3-4 surveyors	5-6 surveyors	> 6 surveyors	Not applicable	No information	Checked	
TOTAL	2	8	5	1	1	2	19	16
	13%	50%	31%	6%			100%	
Bulgaria	0	0	1	0	0	0	5	
Czech Republic	0	1	0	0	0	0	3	
Denmark	0	0	0	0	0	1	Not decided yet, probably 3-4	
Finland	0	1	0	0	0	0	3	
France	0	1	0	0	0	0	3	
Ireland	0	0	1	0	0	0	4-5	
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	1	0	0	0	0	4	
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	1	0	0	0	0	0	2	
Netherlands	0	0	1	0	0	0	5	
Poland	0	1	0	0	0	0	4	
Portugal	0	0	1	0	0	0	4-5 for UK program	
Spain	0	1	0	0	0	0	3	
Spain (Andalusia)	0	0	1	0	0	0	5	
Spain (Valencia)	0	1	0	0	0	0	3	
UK (Health Care Commission)	1	0	0	0	0	0	1	
UK (HAQU)	0	1	0	0	0	0	4	
Scotland	0	0	0	1	0	0	6-15-> 10	



Survey 29. What is the usual composition of a survey team for a hospital?	Management	Nursing	Doctor	Other	Not applicable	No information	Checked	
TOTAL	12	13	14	9	1	2	51	16
	75%	81%	88%	56%				
Bulgaria	0	1	1	1	0	0	Lawyers, economists	
Czech Republic	1	1	1	0	0	0		
Denmark	1	1	1	1	0	0	Other health professionals	
Finland	1	1	1	0	0	0		
France	1	1	1	1	0	0	Depends of the hospital's activities	
Ireland	1	1	1	0	0	0		
Italy (Marche)	0	0	0	0	0	1		
Latvia	1	0	1	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	0	1		
Netherlands	1	1	1	1	0	0	Quality advisors	
Poland	1	1	1	0	0	0		
Portugal	1	1	1	1	0	0	Physiotherapists or pharmacists for the UK program	
Spain	1	1	1	0	0	0		
Spain (Andalusia)	1	1	1	1	0	0	Engineers	
Spain (Valencia)	0	1	1	1	0	0	Computer science and industrial engineer	
UK (Health Care Commission)	0	0	0	1	0	0	Depends of the hospital's activities	
UK (HAQU)	1	1	1	0	0	0		
Scotland	0	0	0	1	0	0	Depends of the topic reviewed	

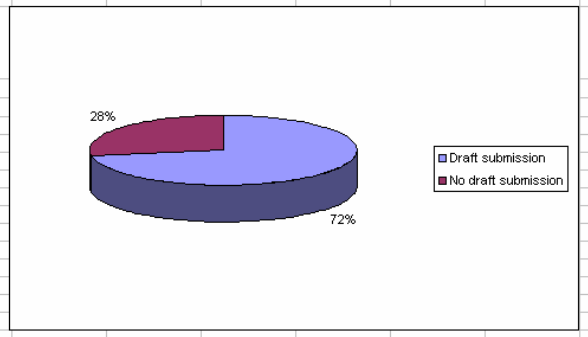
Survey 43. Are on-site trained survey teams accompanied by observers?	No observers	Trainee surveyors	New staff members	Regulatory agencies	Other assessment programs	Not applicable	No information	Checked	
TOTAL	5	11	4	2	2	1	1	26	17
	29%	65%	24%	12%	12%				
Bulgaria	0	1	0	0	0	0	0		
Czech Republic	0	1	0	0	0	0	0		
Denmark	0	1	0	0	0	0	0		
Finland	0	1	0	0	0	0	0		
France	1	1	0	0	0	0	0		
Ireland	0	1	1	0	0	0	0		
Italy (Marche)	0	0	0	0	0	0	1		
Latvia	1	0	0	0	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	1	0	0	0	0	0	0		
Netherlands	1	0	0	0	0	0	0	The survey manager observes the surveyors during some interviews	
Poland	0	1	1	0	0	0	0		
Portugal	0	1	0	0	0	0	0	For the UK program	
Spain	0	1	0	1	0	0	0		
Spain (Andalusia)	0	1	0	0	0	0	0		
Spain (Valencia)	0	1	0	0	0	0	0		
UK (Health Care Commission)	1	0	0	0	0	0	0		
UK (HAQU)	0	0	1	0	1	0	0		
Scotland	0	0	1	1	1	0	0		

Survey 40. Do the survey team (verbally) report back key findings to the senior management of the hospital before leaving?	Reporting	No reporting	Not applicable	No information	Checked	
TOTAL	16	1	1	1	19	17
	94%	6%			100%	
Bulgaria	1	0	0	0		
Czech Republic	1	0	0	0		
Denmark	1	0	0	0		
Finland	1	0	0	0		
France	1	0	0	0		
Ireland	1	0	0	0		
Italy (Marche)	0	0	0	1		
Latvia	1	0	0	0		
Luxemburg (Autorisation)	0	0	1	0		
Luxemburg (Incitants)	1	0	0	0		
Netherlands	1	0	0	0		
Poland	1	0	0	0		
Portugal	1	0	0	0	For the UK program	
Spain	1	0	0	0		
Spain (Andalusia)	0	1	0	0		
Spain (Valencia)	1	0	0	0		
UK (Health Care Commission)	1	0	0	0		
UK (HAQU)	1	0	0	0		
Scotland	1	0	0	0		



Hospital report validation

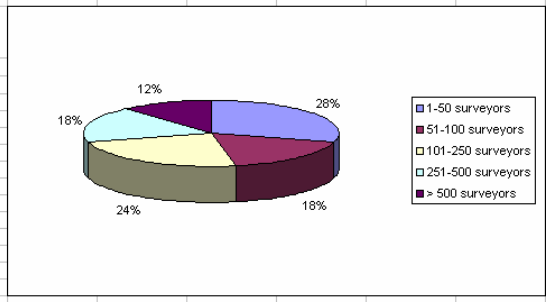
Survey 41. Is the draft survey report referred back to the hospital for factual confirmation before submission for accreditation award?	Draft submission	No draft submission	No information	Checked	
TOTAL	13	5	1	19	18
	72%	28%		100%	
Bulgaria	1	0	0		
Czech Republic	0	1	0		
Denmark	1	0	0		
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	0	0	1		
Latvia	0	1	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	1	0	0	For the UK program	
Spain	0	1	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	0	1	0		
UK (Health Care Commission)	0	1	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		



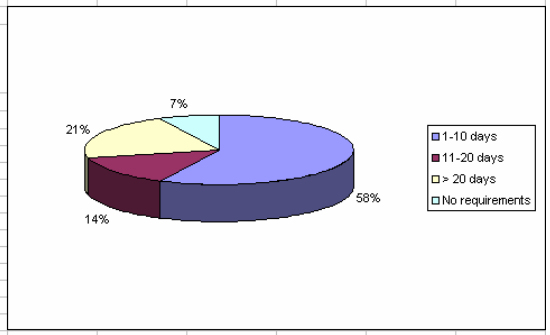
3.3. Surveyors recruitment and training

Surveyors recruitment

Survey 32. How many trained surveyors were available to the programme at the end of 2006?	1-50 surveyors	51-100 surveyors	101-250 surveyors	251-500 surveyors	> 500 surveyors	Not applicable	No information	Checked	
TOTAL	5	3	4	3	2	2	0	19	17
	29%	18%	24%	18%	12%			100%	
Bulgaria	0	0	0	1	0	0	0	401	
Czech Republic	1	0	0	0	0	0	0	7	
Denmark	0	0	0	0	0	1	0	0	
Finland	0	0	1	0	0	0	0	190	
France	0	0	0	0	1	0	0	780	
Ireland	0	1	0	0	0	0	0	80	
Italy (Marche)	0	0	0	1	0	0	0	400	
Latvia	0	0	1	0	0	0	0	120	
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	0	1	0	0	0	0	0	60	
Netherlands	0	0	1	0	0	0	0	170	
Poland	1	0	0	0	0	0	0	22	
Portugal	1	0	0	0	0	0	0	48 for the UK program	
Spain	1	0	0	0	0	0	0	14	
Spain (Andalusia)	1	0	0	0	0	0	0	32	
Spain (Valencia)	0	1	0	0	0	0	0	83	
UK (Health Care Commission)	0	0	1	0	0	0	0	180	
UK (HAQU)	0	0	0	1	0	0	0	420	
Scotland	0	0	0	0	1	0	0	700	

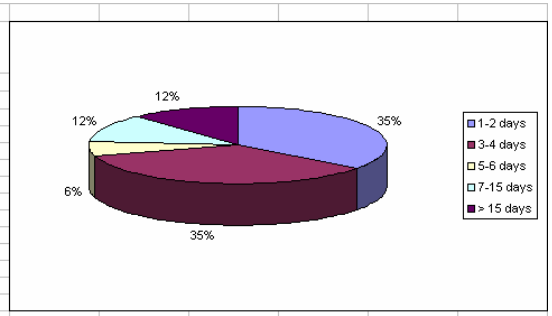


Survey 30. What is the minimum number of days of accreditation work (training and surveys) expected from each surveyor per year?	1-10 days	11-20 days	> 20 days	No requirements	Not applicable	No information	Checked	No interesting information -> not treated in the report
TOTAL	8	2	3	1	2	3	19	14
	57%	14%	21%	7%			100%	
Bulgaria	1	0	0	0	0	0	4-6 days	
Czech Republic	1	0	0	0	0	0	10	
Denmark	0	0	0	0	1	0	15	
Finland	0	0	0	0	0	1		
France	0	1	0	0	0	0	16	
Ireland	1	0	0	0	0	0	5	
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	0	0	1	0	0		
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	1	0	0	0	30	
Netherlands	1	0	0	0	0	0	8	
Poland	0	1	0	0	0	0	18	
Portugal	1	0	0	0	0	0	5 for the UK program	
Spain	1	0	0	0	0	0	6	
Spain (Andalusia)	0	0	1	0	0	0	Staff surveyors: full time, external surveyors: 10 days	
Spain (Valencia)	0	0	0	0	0	1		
UK (Health Care Commission)	0	0	1	0	0	0	180	
UK (HAQU)	1	0	0	0	0	0	5	
Scotland	1	0	0	0	0	0	5	

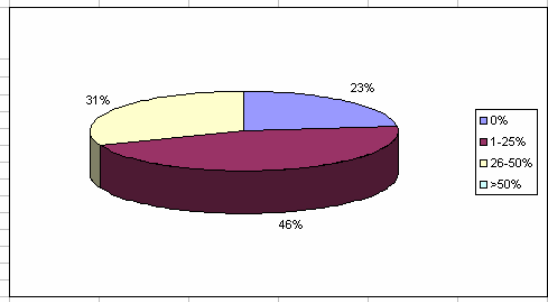


Surveyors training

Survey 31. How long (in days) is the classroom induction training of a new surveyor?	1-2 days	3-4 days	5-6 days	7-15 days	> 15 days	Not applicable	No information	Checked	
TOTAL	6	6	1	2	2	2	0	19	17
	35%	35%	6%	12%	12%			100%	
Bulgaria	0	0	0	1	0	0	0	14	
Czech Republic	0	1	0	0	0	0	0	3	
Denmark	0	0	0	0	0	1	0	5 planned	
Finland	0	1	0	0	0	0	0	4	
France	0	0	1	0	0	0	0	5	
Ireland	1	0	0	0	0	0	0	2	
Italy (Marche)	0	1	0	0	0	0	0	3	
Latvia	1	0	0	0	0	0	0	2	
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	1	0	0	0	10	
Netherlands	0	1	0	0	0	0	0	2.5	
Poland	0	1	0	0	0	0	0	3	
Portugal	0	1	0	0	0	0	0	4 for the UK program	
Spain	1	0	0	0	0	0	0	2	
Spain (Andalusia)	0	0	0	0	1	0	0	6 months	
Spain (Valencia)	0	0	0	0	1	0	0	69	
UK (Health Care Commission)	1	0	0	0	0	0	0	1	
UK (HAQU)	1	0	0	0	0	0	0	2	
Scotland	1	0	0	0	0	0	0	0.5	



Survey 33. Of these, how many new surveyors completed the training in 2006?	0%	1-25%	26-50%	>50%	Not applicable	No information	Checked	
TOTAL	3	6	4	0	2	4	19	13
	23%	46%	31%	0%			100%	
Bulgaria	0	0	0	0	0	1		
Czech Republic	0	0	1	0	0	0	43%	
Denmark	0	0	0	0	1	0	0%	
Finland	0	1	0	0	0	0	5%	
France	0	1	0	0	0	0	13%	
Ireland	0	0	1	0	0	0	38%	
Italy (Marche)	1	0	0	0	0	0	0% (training stopped in 2005)	
Latvia	0	1	0	0	0	0	7%	
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	0	1		
Netherlands	0	0	1	0	0	0	26%	
Poland	1	0	0	0	0	0	0%	
Portugal	1	0	0	0	0	0	0%	
Spain	0	1	0	0	0	0	7%	
Spain (Andalusia)	0	0	1	0	0	0	34%	
Spain (Valencia)	0	0	0	0	0	1	96%	
UK (Health Care Commission)	0	0	0	0	0	1		
UK (HAQU)	0	1	0	0	0	0	4%	
Scotland	0	1	0	0	0	0	13%	



3.4. Change management

Hospitals tools

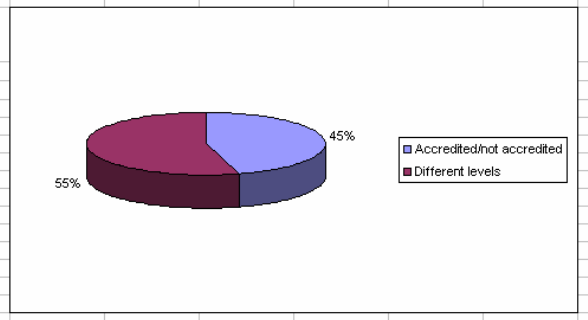
Survey Addtitionnal Questions. What are the services provided by the accreditation organisation to the hospitals?	Tools	Training	Consultancy	Other	None	No information	Checked	
TOTAL	10	10	6	0	0	7	33	12
	83%	83%	50%	0%				
Bulgaria	0	0	1	0	0	0		
Czech Republic	0	0	0	0	0	1		
Denmark	1	1	1	0	0	0		
Finland	0	0	0	0	0	1		
France	1	1	0	0	0	0		
Ireland	1	1	0	0	0	0		
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	1	0	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	0	1		
Luxemburg (Incitants)	0	0	0	0	0	1		
Netherlands	1	1	0	0	0	0		
Poland	0	0	0	0	0	1		
Portugal	1	1	1	0	0	0		
Spain	1	1	1	0	0	0		
Spain (Andalusia)	1	1	0	0	0	0		
Spain (Valencia)	1	1	1	0	0	0		
UK (Health Care Commission)	0	0	0	0	0	1		
UK (HAQU)	1	1	1	0	0	0		
Scotland	1	0	0	0	0	0		

Survey Addtitionnal Questions. Are they free of charge for the hospital?	Free of charge	Not free of charge	Both	Not applicable	No information	Checked	Ambiguous question -> not treated in the report
TOTAL	4	5	1	1	8	19	10
	40%	50%	10%			100%	
Bulgaria	0	1	0	0	0		
Czech Republic	0	0	0	0	1		
Denmark	0	0	0	1	0		
Finland	0	0	0	0	1		
France	0	1	0	0	0		
Ireland	1	0	0	0	0		
Italy (Marche)	0	0	0	0	1		
Latvia	1	0	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	1		
Luxemburg (Incitants)	0	0	0	0	1		
Netherlands	0	0	0	0	1		
Poland	0	0	0	0	1		
Portugal	1	0	0	0	0		
Spain	0	0	1	0	0	Consultancy is not free of charge	
Spain (Andalusia)	0	1	0	0	0		
Spain (Valencia)	0	1	0	0	0		
UK (Health Care Commission)	0	0	0	0	1		
UK (HAQU)	0	1	0	0	0		
Scotland	1	0	0	0	0		

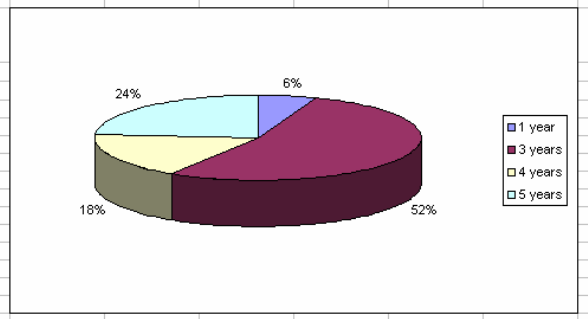
3.5. Decision and appeal

Decision levels

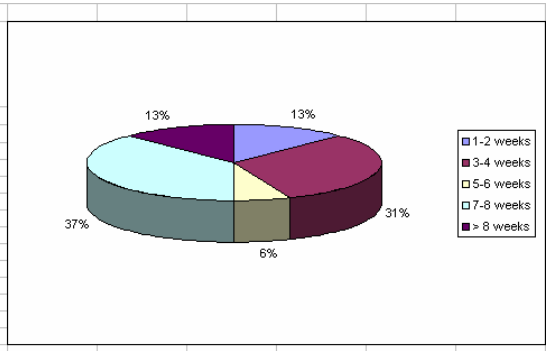
Survey Addtitionnal Questions. What alternatives of an accreditation decision exist?	Accredited/not accredited	Different levels	No information	Checked		
TOTAL	5	6	8	19	11	
	45%	55%		100%		
Bulgaria	1	0	0			
Czech Republic	0	0	1			
Denmark	0	0	1	Not decided yet		
Finland	0	0	1			
France	0	1	0	Certification, Certification avec suivi, Certification conditionnelle, Non certification		
Ireland	0	1	0	Pre-accreditation		
Italy (Marche)	0	0	1			
Latvia	1	0	0			
Luxemburg (Autorisation)	0	0	1			
Luxemburg (Incitants)	0	0	1			
Netherlands	1	0	0			
Poland	0	0	1			
Portugal	0	0	1			
Spain	1	0	0			
Spain (Andalusia)	0	1	0	Advanced, Optimal, Excellent, Waiting to achieve the compulsory standards		
Spain (Valencia)	0	1	0	Accredited, Provisional accreditation, Not accredited		
UK (Health Care Commission)	0	1	0	Rating		
UK (HAQU)	1	0	0			
Scotland	0	1	0	Range of assessment ratings specifically related to the topic being reviewed		



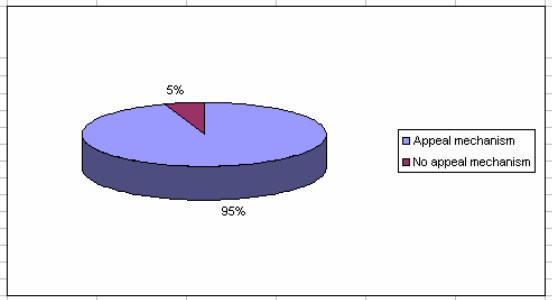
Survey 45. What is the maximum duration of a valid accreditation award (in years)?	1 year	3 years	4 years	5 years	No information	Checked	
TOTAL	1	9	3	4	2	19	17
	6%	53%	18%	24%		100%	
Bulgaria	0	0	1	0	0	3-5	
Czech Republic	0	1	0	0	0	3	
Denmark	0	0	0	0	1	Not decided yet, probably 3 years	
Finland	0	1	0	0	0	3	
France	0	0	1	0	0	4	
Ireland	0	1	0	0	0	3	
Italy (Marche)	0	1	0	0	0	3	
Latvia	0	0	0	1	0	5	
Luxemburg (Autorisation)	0	0	0	1	0	5	
Luxemburg (Incitants)	1	0	0	0	0	1	
Netherlands	0	0	1	0	0	4	
Poland	0	1	0	0	0	3	
Portugal	0	1	0	0	0	3 for the UK program	
Spain	0	1	0	0	0	3	
Spain (Andalusia)	0	0	0	1	0	5	
Spain (Valencia)	0	1	0	0	0	3	
UK (Health Care Commission)	0	0	0	1	0	5	
UK (HAQU)	0	1	0	0	0	3	
Scotland	0	0	0	0	1	Does not give accreditation award	



Survey 46. What is the target turnaround time between the on-site visit and the delivery of the final survey report and recommendations?	1-2 weeks	3-4 weeks	5-6 weeks	7-8 weeks	> 8 weeks	Not applicable	No information	Checked	
TOTAL	2	5	1	6	2	1	2	19	16
	13%	31%	6%	38%	13%			100%	
Bulgaria	0	0	0	1	0	0	0	2 months	
Czech Republic	0	1	0	0	0	0	0	1 month	
Denmark	0	0	0	0	0	0	1	Not decided yet	
Finland	0	0	1	0	0	0	0	4-6 weeks	
France	0	0	0	0	1	0	0	180	
Ireland	0	0	0	1	0	0	0	8 weeks	
Italy (Marche)	0	1	0	0	0	0	0	No more than 1 month	
Latvia	1	0	0	0	0	0	0	10 days	
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	1	0	0	3 months	
Netherlands	0	0	0	1	0	0	0	60 days	
Poland	0	1	0	0	0	0	0	4 weeks for the UK program	
Portugal	0	0	0	1	0	0	0	6-10 weeks	
Spain	0	0	0	1	0	0	0	60 days	
Spain (Andalusia)	1	0	0	0	0	0	0	15 days	
Spain (Valencia)	0	1	0	0	0	0	0	4 weeks	
UK (Health Care Commission)	0	0	0	0	0	0	1		
UK (HAQU)	0	1	0	0	0	0	0	20-40 days	
Scotland	0	0	0	1	0	0	0	8 weeks	



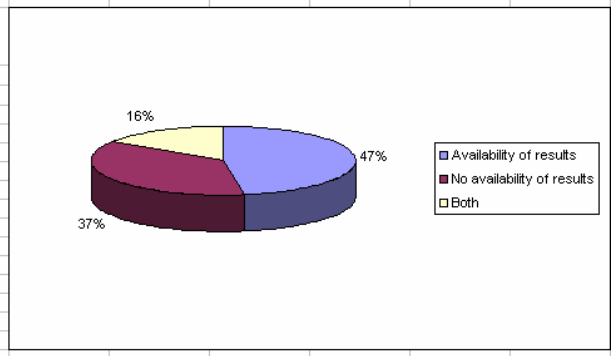
Survey 47. Is there a defined mechanism for a hospital to appeal the accreditation decision?	Appeal mechanism	No appeal mechanism	No information	Checked	
TOTAL	18	1	0	19	19
	95%	5%		100%	
Bulgaria	0	1	0		
Czech Republic	1	0	0		
Denmark	1	0	0	Not in place but will be defined	
Finland	1	0	0		
France	1	0	0		
Ireland	1	0	0		
Italy (Marche)	1	0	0		
Latvia	1	0	0		
Luxemburg (Autorisation)	1	0	0		
Luxemburg (Incitants)	1	0	0		
Netherlands	1	0	0		
Poland	1	0	0		
Portugal	1	0	0		
Spain	1	0	0		
Spain (Andalusia)	1	0	0		
Spain (Valencia)	1	0	0		
UK (Health Care Commission)	1	0	0		
UK (HAQU)	1	0	0		
Scotland	1	0	0		



3.6. Results diffusion

Results availability

Survey 55. Are the results of hospital survey reports available to the public on the internet?	Availability of results	No availability of results	Both	No information	Checked	
TOTAL	9	7	3	0	19	19
	47%	37%	16%		100%	
Bulgaria	0	1	0	0		
Czech Republic	0	0	1	0	Upon agreement of the surveyed organization	
Denmark	1	0	0	0	Will be published, details not determined yet	
Finland	1	0	0	0		
France	1	0	0	0		
Ireland	1	0	0	0		
Italy (Marche)	0	1	0	0		
Latvia	1	0	0	0		
Luxemburg (Autorisation)	0	1	0	0		
Luxemburg (Incitants)	0	1	0	0		
Netherlands	1	0	0	0		
Poland	0	1	0	0		
Portugal	0	1	0	0		
Spain	1	0	0	0		
Spain (Andalusia)	1	0	0	0		
Spain (Valencia)	0	0	1	0	Only the favorable results	
UK (Health Care Commission)	0	0	1	0	Available for public sector, not for independant sector	
UK (HAQU)	0	1	0	0		
Scotland	1	0	0	0		



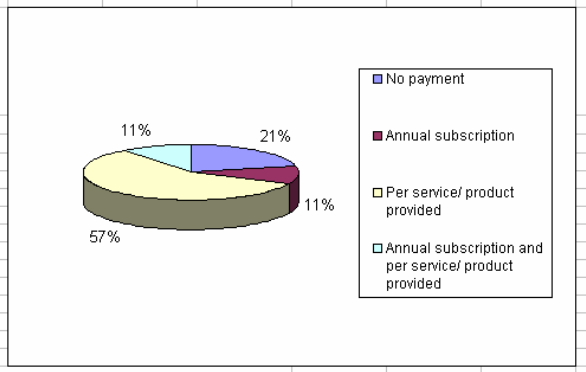
Survey 56. If 'yes', please specify what info is available and include the relevant website or URL	Name of the participating hospital	Name of the accredited hospital	Summary report of the results of the hospital	Detailed report of the results of the hospital	Not applicable	No information	Checked	
TOTAL	3	8	4	2	7	1	25	11
	27%	73%	36%	18%				
Bulgaria	0	0	0	0	1	0		
Czech Republic	0	1	0	0	0	0		
Denmark	0	0	0	0	0	1	Not decided yet	
Finland	1	1	0	0	0	0		
France	0	0	0	1	0	0		
Ireland	0	0	1	0	0	0		
Italy (Marche)	0	0	0	0	1	0		
Latvia	0	1	0	0	0	0		
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	1	0		
Netherlands	1	1	0	0	0	0		
Poland	0	0	0	0	1	0		
Portugal	0	0	0	0	1	0		
Spain	0	1	0	0	0	0		
Spain (Andalusia)	0	1	0	0	0	0		
Spain (Valencia)	0	1	1	0	0	0	Only the score	
UK (Health Care Commission)	1	1	1	1	0	0		
UK (HAQU)	0	0	0	0	1	0		
Scotland	0	0	1	0	0	0		

4. Funding mechanims and sources

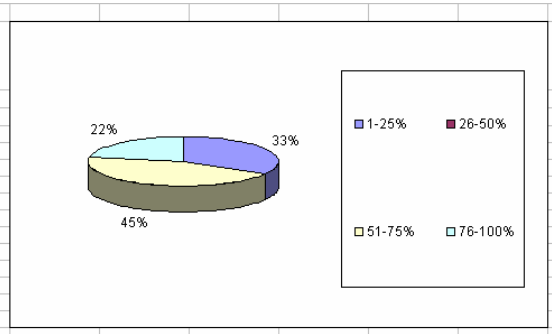
Income

Survey 48. Who funded the initial development of the accreditation programme?	International aid	Central government	Local government	Private sector	Academic research	Professional associations	Voluntary sector	No information	**Cheked**	
TOTAL	3	9	4	0	0	1	2	2	21	17
	82%			0%	0%	6%	12%		100%	
Bulgaria	1	0	0	0	0	0	0	0		
Czech Republic	1	0	0	0	0	0	0	0		
Denmark	0	1	1	0	0	0	0	0		
Finland	0	0	0	0	0	0	0	1		
France	0	1	0	0	0	0	0	0		
Ireland	0	1	0	0	0	0	0	0		
Italy (Marche)	0	0	1	0	0	0	0	0		
Latvia	0	1	0	0	0	0	0	0		
Luxemburg (Autorisation)	0	1	0	0	0	0	0	0		
Luxemburg (Incitants)	0	0	0	0	0	0	0	1	Social insurance and Hospital association	
Netherlands	0	0	0	0	0	1	0	0		
Poland	1	1	0	0	0	0	0	0		
Portugal	0	1	0	0	0	0	0	0		
Spain	0	0	0	0	0	0	1	0		
Spain (Andalusia)	0	0	1	0	0	0	0	0		
Spain (Valencia)	0	0	1	0	0	0	0	0		
UK (Health Care Commission)	0	1	0	0	0	0	0	0		
UK (HAQU)	0	0	0	0	0	0	1	0		
Scotland	0	1	0	0	0	0	0	0		

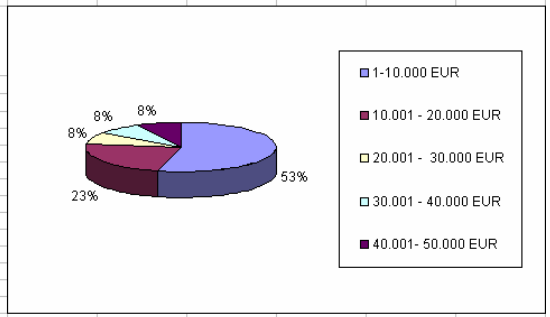
Survey 49. How do hospitals pay the accreditation programme?	No payment	Annual subscription	Per service/ product provided	Annual subscription and per service/ product provided	No information	**Cheked**	
TOTAL	4	2	11	2	0	19	19
	21%	11%	58%	11%		100%	
Bulgaria	0	0	1	0	0		
Czech Republic	0	0	1	0	0		
Denmark	1	0	0	0	0		
Finland	0	0	1	0	0		
France	0	0	1	0	0		
Ireland	1	0	0	0	0		
Italy (Marche)	0	0	1	0	0		
Latvia	0	0	1	0	0		
Luxemburg (Autorisation)	1	0	0	0	0		
Luxemburg (Incitants)	0	0	1	0	0		
Netherlands	0	1	0	0	0		
Poland	0	0	1	0	0		
Portugal	0	1	0	0	0	For the UK program	
Spain	0	0	1	0	0		
Spain (Andalusia)	0	0	1	0	0		
Spain (Valencia)	0	0	1	0	0		
UK (Health Care Commission)	0	0	0	1	0	No payment for public sector providers	
UK (HAQU)	0	0	0	1	0		
Scotland	1	0	0	0	0		



Survey 53. What percentage of total income in 2006 was generated by fees paid for accreditation surveys?	1-25%	26-50%	51-75%	76-100%	Not applicable	No information	Checked	
TOTAL	3	0	4	2	4	6	19	9
	33%	0%	44%	22%			100%	
Bulgaria	0	0	0	0	0	1		
Czech Republic	0	0	1	0	0	0	70%	
Denmark	0	0	0	0	1	0		
Finland	0	0	1	0	0	0	70%	
France	1	0	0	0	0	0	15%	
Ireland	0	0	0	0	1	0		
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	0	0	1	0	0	100%	
Luxemburg (Autorisation)	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	0	1		
Netherlands	0	0	0	1	0	0	95%	
Poland	0	0	0	0	0	1	141.538 euros	
Portugal	0	0	0	0	0	1		
Spain	0	0	1	0	0	0	65%	
Spain (Andalusia)	1	0	0	0	0	0	3%	
Spain (Valencia)	0	0	0	0	0	1		
UK (Health Care Commission)	1	0	0	0	0	0	10%	
UK (HAQU)	0	0	1	0	0	0	70%	
Scotland	0	0	0	0	1	0		



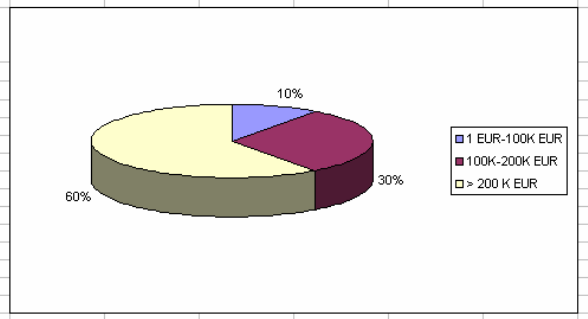
Survey 51. For a 100-bed hospital, what fee was payable for an accreditation survey in 2006 (in euro)?	1-10.000 EUR	10.001 - 20.000 EUR	20.001 - 30.000 EUR	30.001 - 40.000 EUR	40.001- 50.000 EUR	Not applicable	No information	Checked	
TOTAL	7	3	1	1	1	4	2	19	13
	54%	23%	8%	8%	8%			100%	
Bulgaria	1	0	0	0	0	0	0	526	
Czech Republic	1	0	0	0	0	0	0	3000	
Denmark	0	0	0	0	0	1	0		
Finland	1	0	0	0	0	0	0	8000-10000 -> 9000	
France	0	1	0	0	0	0	0	10380	
Ireland	0	0	0	0	0	1	0		
Italy (Marche)	0	0	0	0	0	0	1		
Latvia	1	0	0	0	0	0	0	450	
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	0	1	0	0	0	0	0	20000	
Netherlands	1	0	0	0	0	0	0	9802	
Poland	1	0	0	0	0	0	0	4000	
Portugal	0	0	0	0	1	0	0	50000 for the UK program	
Spain	0	0	0	0	0	0	1		
Spain (Andalusia)	0	1	0	0	0	0	0	14318	
Spain (Valencia)	1	0	0	0	0	0	0	8000-12000 -> 10000	
UK (Health Care Commission)	0	0	0	1	0	0	0	£25000 = 37204 EUR	
UK (HAQU)	0	0	1	0	0	0	0	26500	
Scotland	0	0	0	0	0	1	0		



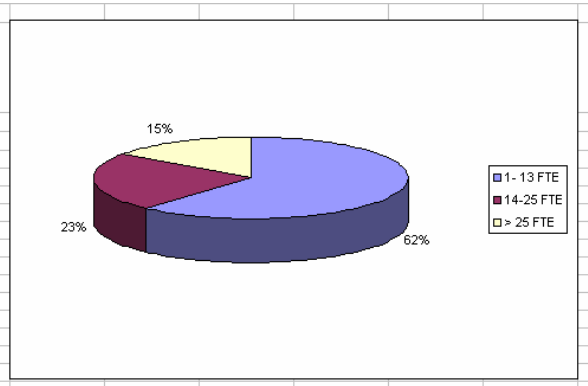
Survey 52. What does the fee include?	Self-assessment documentation	Induction of hospital staff	Facilitation and preparation	Expenses of survey team	Accreditation decision and certificate	Not applicable	No information	Checked	
TOTAL	6	4	7	11	13	4	2	47	13
	46%	31%	54%	85%	100%				
Bulgaria	0	0	0	0	0	0	1		
Czech Republic	0	0	1	1	1	0	0		
Denmark	0	0	0	0	0	1	0		
Finland	0	0	0	0	1	0	0		
France	1	0	0	0	1	0	0		
Ireland	0	0	0	0	0	1	0		
Italy (Marche)	0	0	0	0	0	0	1		
Latvia	0	0	0	1	1	0	0		
Luxemburg (Autorisation)	0	0	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	1	1	0	0		
Netherlands	0	0	1	1	1	0	0		
Poland	0	0	0	1	1	0	0		
Portugal	1	1	1	1	1	0	0	For the UK	
Spain	0	0	0	1	1	0	0		
Spain (Andalusia)	1	1	1	1	1	0	0		
Spain (Valencia)	1	1	1	1	1	0	0		
UK (Health Care Commission)	1	0	1	1	1	0	0		
UK (HAQU)	1	1	1	1	1	0	0		
Scotland	0	0	0	0	0	1	0		

Expenses

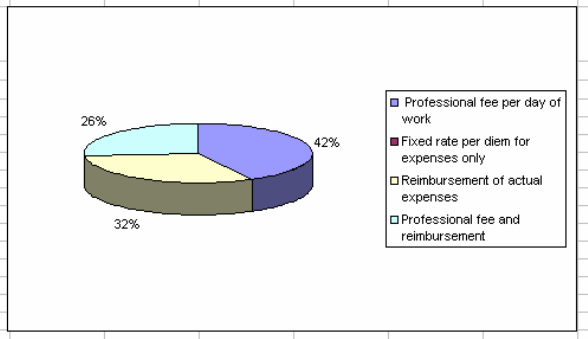
Survey 54. What was the total expenditure (in euro) on accreditation in 2006?	1 EUR-100K EUR	100K-200K EUR	> 200 K EUR	No information	Checked	
TOTAL	1	3	6	9	19	10
	10%	30%	60%		100%	
Bulgaria	0	0	0	1		
Czech Republic	1	0	0	0	30.000	
Denmark	0	0	1	0	3.000.00	
Finland	0	0	0	1		
France	0	0	1	0	20.275.000	
Ireland	0	0	1	0	3.500.000	
Italy (Marche)	0	0	0	1		
Latvia	0	1	0	0	150.000	
Luxemburg (Autorisation)	0	0	0	1		
Luxemburg (Incitants)	0	0	1	0	8.000.000	
Netherlands	0	0	0	1		
Poland	0	1	0	0	141.538	
Portugal	0	0	0	1		
Spain	0	0	0	1		
Spain (Andalusia)	0	1	0	0	188.760	
Spain (Valencia)	0	0	0	1		
UK (Health Care Commission)	0	0	1	0	£40M = 59.483.017 EUR	
UK (HAQU)	0	0	1	0	1.562.000	
Scotland	0	0	0	1		



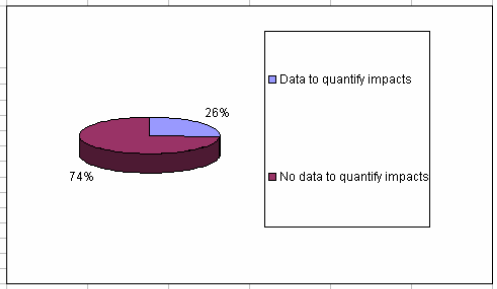
Survey 23. At the end of 2006, how many staff (expressed in full-time equivalents excluding surveyors and unpaid advisors) were employed for the accreditation program?	1- 13 FTE	14-25 FTE	> 25 FTE	No information	Checked	Ambigous question -> not treated in the report
TOTAL	8	3	2	6	19	13
	62%	23%	15%		100%	
Bulgaria	0	0	0	1	401	
Czech Republic	1	0	0	0	5	
Denmark	0	1	0	0	15	
Finland	0	0	0	1		
France	0	0	1	0	80	
Ireland	0	1	0	0	17	
Italy (Marche)	0	0	0	1		
Latvia	1	0	0	0	6	
Luxemburg (Autorisation)	0	0	0	1		
Luxemburg (Incitants)	0	0	0	1		
Netherlands	1	0	0	0	5.5	
Poland	1	0	0	0	4	
Portugal	1	0	0	0	4 for the UK program	
Spain	1	0	0	0	2.5	
Spain (Andalusia)	1	0	0	0	3	
Spain (Valencia)	1	0	0	0	6	
UK (Health Care Commission)	0	0	0	1	750	
UK (HAQU)	°	1	0	0	18	
Scotland	0	0	1	0	45	



Survey 50. How are surveyors paid?	Professional fee per day of work	Fixed rate per diem for expenses only	Reimbursement of actual expenses	Professional fee and reimbursement	No information	Checked	
TOTAL	8	0	6	5	0	19	19
	42%	0%	32%	26%		100%	
Bulgaria	1	0	0	0	0		
Czech Republic	0	0	0	1	0	1= 250 EUR ; 2=100 EUR	
Denmark	0	0	0	1	0	1=130 EUR	
Finland	1	0	0	0	0	1=250 EUR	
France	0	0	0	1	0	1=258 EUR	
Ireland	0	0	1	0	0		
Italy (Marche)	0	0	1	0	0		
Latvia	1	0	0	0	0	1=60 EUR	
Luxemburg (Autorisation)	1	0	0	0	0		
Luxemburg (Incitants)	1	0	0	0	0	1=1600 EUR	
Netherlands	0	0	0	1	0	1=300 EUR	
Poland	1	0	0	0	0	1=150 EUR	
Portugal	0	0	1	0	0		
Spain	1	0	0	0	0		
Spain (Andalusia)	0	0	1	0	0		
Spain (Valencia)	0	0	0	1	0	1= 200-225 EUR -> 212.5 EUR	
UK (Health Care Commission)	1	0	0	0	0	1=£750 -> 1109 EUR	
UK (HAQU)	0	0	1	0	0		
Scotland	0	0	1	0	0		

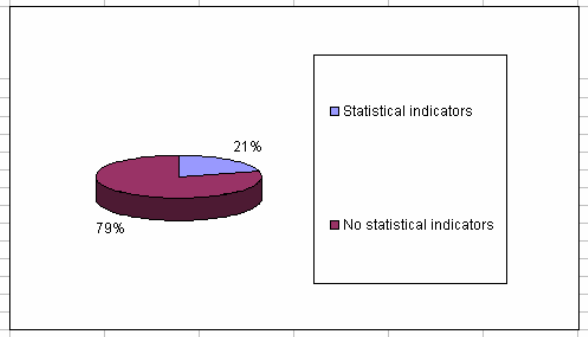


5. Evaluation					
Program evaluation					
Litterature Study 29. Is there an evaluation mechanism of the Accreditation Program as such, if so what are the key elements of the mechanism ?	Less large than Survey 58 + ambiguous question -> not treated in the report				
TOTAL					
Bulgaria					
Czech Republic					
Denmark					
Finland					
France	Yes: questionnaire sent to the hospital after the survey				
Ireland	Yes: questionnaires sent to hospitals, surveyors, etc.				
Italy (Marche)					
Latvia	Yes: satisfaction questionnaire sent to the hospital after the survey				
Luxemburg (Autorisation)					
Luxemburg (Incitants)					
Netherlands					
Poland					
Portugal					
Spain					
Spain (Andalusia)					
Spain (Valencia)					
UK (Health Care Commission)					
UK (HAQU)	No: only hospitals satisfaction survey				
Scotland	No				
Program outcomes					
Survey 58. Do you have data to quantify beneficial impacts of accreditation on hospitals, staff, patients?	Data to quantify impacts	No data to quantify impacts	No information		
TOTAL	5	14	0	19	19
	26%	74%		100%	
Bulgaria	0	1	0		
Czech Republic	0	1	0		
Denmark	0	1	0		
Finland	0	1	0		
France	1	0	0	Essentially perception of professionals	
Ireland	1	0	0	Study to assess effectiveness of accreditation currently performed by an external party (3 years programme) - results will be published soon	
Italy (Marche)	0	1	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	0	1	0		
Luxemburg (Incitants)	1	0	0	Use of performance indicators - hope they can demonstrate some changement in 5 years	
Netherlands	0	1	0		
Poland	0	1	0		
Portugal	0	1	0		
Spain	0	1	0		
Spain (Andalusia)	0	1	0		
Spain (Valencia)	0	1	0		
UK (Health Care Commission)	1	0	0	Full evaluation to be published summer 2007	
UK (HAQU)	0	1	0		
Scotland	1	0	0	NHS QIS has recently undertaken an impact assessment of its work and this will be published shortly	



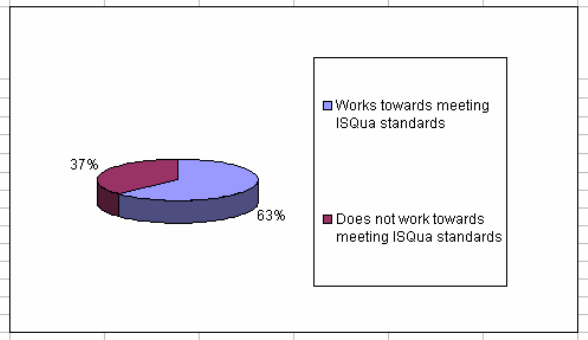
Program outcomes measurement

Survey 59. Does the programme use statistical indicators to evaluate the performance of the accreditation programme?	Statistical indicators	No statistical indicators	No information	Checked	
TOTAL	4	15	0	19	19
	21%	79%		100%	
Bulgaria	0	1	0		
Czech Republic	0	1	0		
Denmark	0	1	0		
Finland	0	1	0		
France	0	1	0		
Ireland	1	0	0	No info	
Italy (Marche)	0	1	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	0	1	0		
Luxemburg (Incitants)	0	1	0		
Netherlands	0	1	0		
Poland	0	1	0		
Portugal	0	1	0		
Spain	1	0	0	No info	
Spain (Andalusia)	1	0	0	Benchmarking of healthcare centres identified and achieve improvements areas	
Spain (Valencia)	0	1	0		
UK (Health Care Commission)	0	1	0		
UK (HAQU)	1	0	0	All clients are asked to evaluate different aspects	
Scotland	0	1	0		



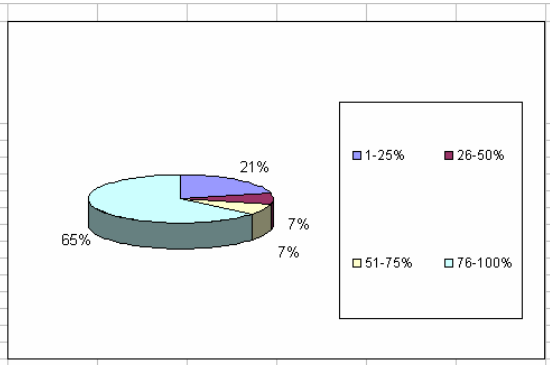
Standards ISQua link

Survey 18. Has the programme's governing body formally agreed to work towards meeting ISQua standards?	Works towards meeting ISQua standards	Does not work towards meeting ISQua standards	No information	Checked	
TOTAL	12	7	0	19	19
	63%	37%		100%	
Bulgaria	0	1	0		
Czech Republic	1	0	0	2005	
Denmark	1	0	0	2002	
Finland	1	0	0	From the beginning	
France	1	0	0	2002	
Ireland	1	0	0	2004	
Italy (Marche)	1	0	0		
Latvia	0	1	0		
Luxemburg (Autorisation)	0	1	0		
Luxemburg (Incitants)	1	0	0	1998	
Netherlands	1	0	0	2006	
Poland	1	0	0	2005	
Portugal	1	0	0	1999	
Spain	1	0	0	2005	
Spain (Andalusia)	0	1	0	Established preliminary contacts	
Spain (Valencia)	0	1	0	Interested in it	
UK (Health Care Commission)	0	1	0		
UK (HAQU)	1	0	0	1999	
Scotland	0	1	0		

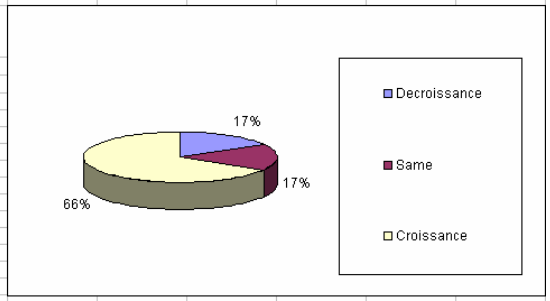


Key indicators

Survey 20. How many of these hospitals are currently enrolled in the programme? / 19. How many hospitals in your region/state are eligible to participate in the programme?	1-25%	26-50%	51-75%	76-100%	Not applicable	No information	Checked	
TOTAL	3	1	1	9	1	4	19	14
	21%	7%	7%	64%			100%	
Bulgaria	0	0	0	1	0	0	80%	
Czech Republic	0	1	0	0	0	0	31%	
Denmark	0	0	0	0	1	0	None, programme to start 2008	
Finland	0	0	0	0	0	1	13 currently enrolled	
France	0	0	0	1	0	0	100%	
Ireland	0	0	0	1	0	0	86%	
Italy (Marche)	0	0	0	0	0	1		
Latvia	0	0	0	1	0	0	100%	
Luxemburg (Autorisation)	0	0	0	1	0	0	100%	
Luxemburg (Incitants)	0	0	0	1	0	0	100%	
Netherlands	0	0	1	0	0	0	65%	
Poland	1	0	0	0	0	0	13%	
Portugal	0	0	0	0	0	1	35 currently enrolled for both programs	
Spain	1	0	0	0	0	0	2%	
Spain (Andalusia)	0	0	0	1	0	0	100%	
Spain (Valencia)	0	0	0	0	0	1	14 currently enrolled	
UK (Health Care Commission)	0	0	0	1	0	0	100%	
UK (HAQU)	1	0	0	0	0	0	16%	
Scotland	0	0	0	1	0	0	100%	



Survey 44. How many full on-site visits were done in 2006?	Decroissance	Same	Croissance	Not applicable	No information	Checked	
TOTAL	1	1	4	3	10	19	6
	17%	17%	67%			100%	
Bulgaria	0	0	0	0	1		
Czech Republic	0	0	0	0	1	5	
Denmark	0	0	0	1	0	0	
Finland	1	0	0	0	0	17 in 2003 ; 14 in 2006	
France	0	0	1	0	0	630 in 2003 ; 744 visites globales en 2006 plus 102 visites ciblées de suivi	
Ireland	0	0	1	0	0	6 in 2003 ; 7 in 2006	
Italy (Marche)	0	0	0	1	0	85 in 2003	
Latvia	0	0	0	0	1	30	
Luxemburg (Autorisation)	0	0	0	1	0		
Luxemburg (Incitants)	0	0	0	0	1	14	
Netherlands	0	0	1	0	0	5 in 2003 ; 24 in 2006	
Poland	0	0	1	0	0	21 in 2003 ; 23 in 2006	
Portugal	0	0	0	0	1	7 in 2003 ; 8 in 2006 for the UK program	
Spain	0	1	0	0	0	3 in 2003 ; 3 in 2006	
Spain (Andalusia)	0	0	0	0	1	6	
Spain (Valencia)	0	0	0	0	1	5	
UK (Health Care Commission)	0	0	0	0	1		
UK (HAQU)	0	0	0	0	1	68	
Scotland	0	0	0	0	1	74 in 2003	



Evolution of data 2003-2006

The answers received for these 19 programmes were also compared to the data transmitted by Charles Shaw regarding his previous surveys[32] when possible. After study, following points appeared:

- 10 questions of the survey are covered by the 2004's survey for 14 of these programmes,
- 4 questions of the survey are covered by the 2000 and 2002's surveys for 11 of these programmes, and
- Analysis does not always make sense as some questions relate to a fix event and is not always possible as some data are missing

The discovered trends were included where appropriate in the summaries per country and statistical analysis.

32 Charles Shaw carried out surveys in 2000 (gathering data for 1999), 2002 (for 2001) and 2004 (for 2003)

Table 31: Evolution of data 2003-2006

Comparative analysis of the European accreditation programmes - Evolution of data 2003-2006

Country	Name of your accreditation programme?			Relation to government? (1= Managed within Ministry of Health; 2= separate government		Year of first development?		Public and private facilities? (1=yes; 0=no)		Source of inspiration? (1= EFQM; 2= ISO; 3= accreditation; 4= other)		# full revisions?		Year of approval?	
	2003	2006	Check	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
Bulgaria	Accreditation of hospitals and diagnostic-consultative centres	Accreditation of hospitals and diagnostic-consultative centers		3	3	2000	2000	1	0	*KTQ, JCAHO*	2	0	27	2001	2001
Czech Republic	Joint Accreditation Commission for Czech Republic	National accreditation programme for inpatient healthcare		3	4	1995	1995	0	1	JCAHO	3 JCAHO	0	2	1998	2005
Denmark	The Danish Health Care Quality Assessment Programme	The Danish Quality Model		3	3	2003	2005	1	1	USA/Canada/Australia.	3 no particular	0	0		Expected in 2007
Finland	The Social and Health Quality Service (SHQS)	The Social and Health Quality Service (SHQS)		4	4	1993	1993	1	1	UK HQS	3 all models have	3	4	2003	2005
France	Agence Nationale d'Accréditation et d'Evaluation en Santé	Haute Autorité de Santé		2	2	1997	1997	1	1	CCHSA, JCAHO	3 CCHSA, ACHS,	0	3	1999	2007
Ireland	Irish Health Services Accreditation Board	Irish Health Services Accreditation		4	3	2002	1999	1	0	CCHSA	3 CCHSA	1	2	2001	2004
Italy (Marche)	Marche Regional Health System Accreditation Program	Marche Regional Health System Accreditation Program		1	2	1997		1	1	JC, Canadian		0		2000	
Latvia	Conformity assessment of health care organizations	Conformity assessment of health care organizations		3	2	1997	1998	1	1		4		2	1999	2002
Netherlands	Dutch Institute for the Accreditation of Hospitals	Netherlands Institute of Accreditation of Hospitals (NIAZ)		3	4	1998	1998	1	1	CCHSA	1; 3 CCHSA programme	1	3	2004	2005
Poland	Hospital Accreditation Programme	Hospital Accreditation Programme		2	2	1997	1995	1	1	JCAHO	3 JCAHO	0	2	1998	1998
Portugal	National Hopital Accreditation Programme	National Hopital Accreditation Programme		1	1	1999	1999	0	0	UK HQS	3 UK HQS	2	3	2003	2006
Spain (FAD)	FAD/JCI Accreditation	Accreditation FADA-JCI		4	4	1994	1996	1	1	JCAHO	3 JCAHO	3	3	2002	2004
UK (HAP)	Healthcare Accreditation Programme			4		1990		1		CCHSA		5		2002	
UK (HQS)	Health Quality Service			4		1989		1		ACHS		5		1992	
UK (HAQU)		HAQU combines three previous programmes: Health Quality			4		1989		1		3 ACHS Hospital		5		2006
Scotland	NHS Quality Improvement Scotland	NHS Quality Improvement Scotland		3	1	1999	1999	0	1	inclusive	1	13 National Overview			
				2	2										
Modification				2	4										
Information found via the the literature study				6	3										
				4	5										

Country	2006 : Are the results of hospital survey reports available to the public on the internet? (1=yes;		# full on-site visits?		# trained surveyors available?		% of new surveyors having completed the training?		Total expenditure (€) on accreditation?		Fee (€) for a 100-bed hospital?		Agreement to work towards meeting ALPHA standards? (1=yes; 0=no)	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
Bulgaria	0	0			401	401			17.600		526	526		0
Czech Republic	0	1		5	10	7	40%	43%		30.000		3.000		1
Denmark	1	1											1	1
Finland	0	1	17	14	173	190	8%	5%			10.000	8000-10000	1	1
France	1	1	630		680	780	28%	13%	11.000.000	20.275.000	8.650		1	1
Ireland	0	1	6	7	30	80	33%	38%	2.100.000		0	0	1	1
Italy (Marche)	1	0	85		450	400	100%	0%			The equivalent of		1	*1*
Latvia	1	1		30	160	120		7%	15.000		400	450		0
Netherlands	0	1	5	24	70	170	46%	26%	45.000		632	9.802	0	1
Poland	0	0	21	23	33	22	36%	0%	36.200	141.538	2.130	4.000	0	1
Portugal	0	0	7	8	36	48	67%	0%	54.312		0	50.000	1	1
Spain (FAD)	0	1	3	3	10	14	0%	7%			16.400	14.318	1	1
UK (HAP)	0		20		60		20%		193.000		10.100		1	
UK (HQS)	0		63		326		11%		1.120.000		25.200		1	
UK (HAQU)		0		68		420		4%		1.562.000		26.500		1
Scotland	1	1	74			700		13%			0	0	0	0
	5	9											8	11
	36%	64%											57%	79%

Comparative analysis of the European accreditation prorammes - Evolution of data 1999-2006

 # full on-site visits? (2004,Q29; 2007,Q44)

	1999	2001	2003	2006
Bulgaria	0	80		
Czech Republic	1	0		5
Finland	12	0	17	14
France	9	164	630	
Ireland	0	0	6	7
Latvia	0	320		30
Netherlands	4	0	5	24
Poland	23	25	21	23
Portugal	0	4	7	8
Spain	8	9	3	3
UK (HAP)	36	19	20	
UK (HQS)	92	125	63	
UK (HAQU)				68

 # trained surveyors available? (Q30; Q32)

	1999	2001	2003	2006
Bulgaria	0	401	401	401
Czech Republic	10		10	7
Finland	130		173	190
France	179	439	680	780
Ireland	0	8	30	80
Latvia		160	160	120
Netherlands	50		70	170
Poland	27	28	33	22
Portugal	0	36	36	48
Spain	9	10	10	14
UK (HAP)	50	41	60	
UK (HQS)	358	480	326	
UK (HAQU)				420

% of new surveyors having completed the training? (Q31; Q33)

	1999	2001	2003	2006
Bulgaria				
Czech Republic	40%		40%	43%
Finland	15%		8%	5%
France	59%	26%	28%	13%
Ireland			33%	38%
Latvia				7%
Netherlands	32%		46%	26%
Poland	33%		36%	0%
Portugal		94%	67%	0%
Spain		10%	0%	7%
UK (HAP)	34%	20%	20%	
UK (HQS)	22%	14%	11%	
UK (HAQU)				4%

Total expenditure (€) on accreditation? (Q32; Q54)

	1999	2001	2003	2006
Bulgaria		176	17.600	
Czech Republic				30.000
Finland	380			
France	10.000	12.000	11.000.000	20.275.000
Ireland	$295		2.100.000	
Latvia		150	15.000	
Netherlands	250		45.000	
Poland	50	70	36.200	141.538
Portugal		210	54.312	
Spain				
UK (HAP)	213	225	193.000	
UK (HQS)	2.720	2.700	1.120.000	
UK (HAQU)				1.562.000

APPENDIX 6. EXPLORATION OF ACCREDITATION OPPORTUNITIES FOR BELGIAN HOSPITALS – LITERATURE STUDY (CHAPTER 2.4)

Search strategy

Given that information on quality initiatives in Belgium had already been collected via the 1st literature study (cfr Chapter 2.3 'The methodology for the 1st research question') and the databases then explored were inadequate to find information on the Belgian system, it was decided to explore exclusively Google.

A search strategy was defined to find information on these themes. 8 keywords combinations were developed to search it, including the words "compétences", "agrément", "visitatie" and "accréditation".

This search strategy was then applied with a PDF files search restriction because web pages did not provide relevant information. Publication date and language restrictions were not used because of their unreliability.

It delivered a total of 404 results for all the keywords combinations. Indeed, as the initial amount of results was too important, only the 50 or 100 first results given by each combination were the subject of an assessment according to publication date, language and content criteria. On the 404 assessed results, 18 articles were so evaluated as relevant.

Table 33: Google search strategy

Date	**Search strategy elaboration : 22.06.2007**		
Database	Google http://www.google.be		Relevant Results
	Search strategy 1 Belgique compétences communautés régions (santé OR hôpitaux) filetype:pdf	524.000	4
	Search strategy 2 Belgique ("compétences des communautés" OR "compétences des régions") (santé OR hôpitaux) filetype:pdf	684	0
	Search strategy 3 Belgique agrément hôpitaux (normes OR procédure) filetype:pdf	85.300	0 0
	Search strategy 4 Belgique "agrément des hôpitaux" filetype:pdf	45	3
	Search strategy 5 België visitatie ziekenhuizen (normen OR procedure) filetype:pdf	688	
	Search strategy 6 België "visitatie van ziekenhuizen" filetype:pdf	6	0
	Search strategy 7		

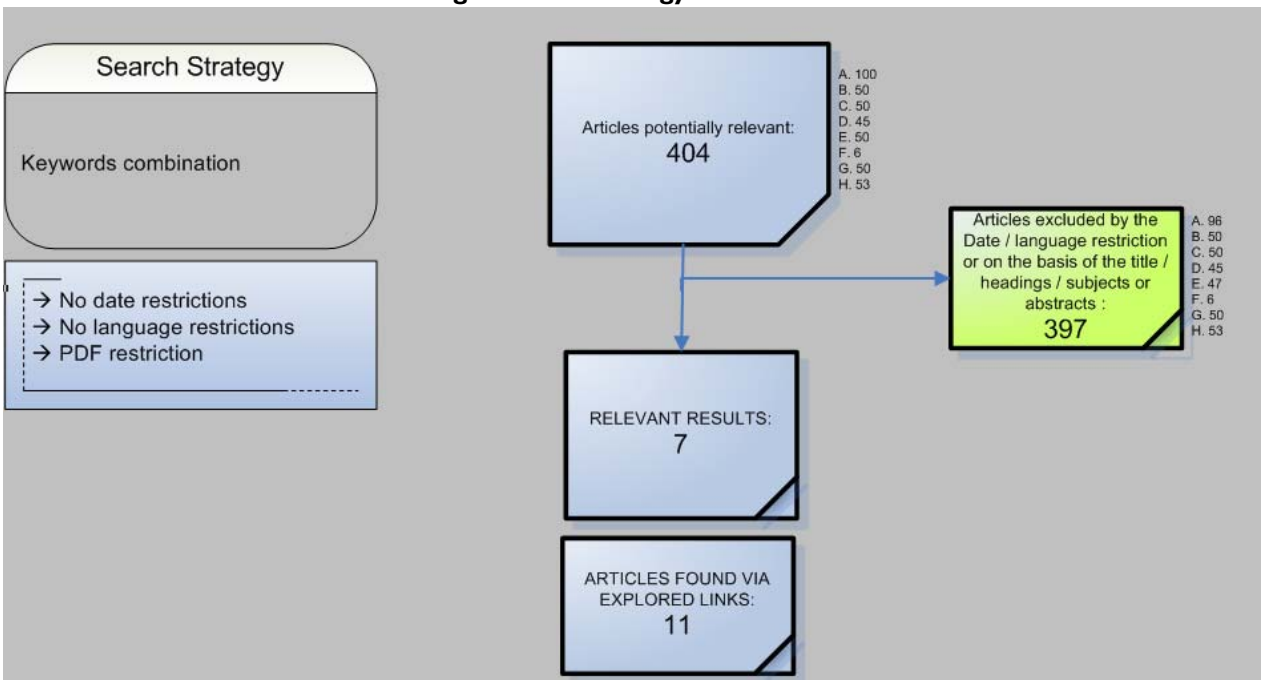
	Belgique accréditation hôpitaux (projet OR initiative) filetype:pdf <u>Search strategy 8</u> Belgique "accréditation des hôpitaux" filetype:pdf → 11 additional results were also found via explored links	39500 53	0 0

The Belgian authorities' websites[33] and the Juridat website were also explored, together with the course 'Législation hospitalière' from the Medicine Faculty of the Université Catholique de Louvain.

Results

Flowchart 12: Google search strategy results

Exploration of accreditation opportunities for Belgian hospitals – Literature Study – Summarized assessment of the Google search strategy results.



33 SPF Santé Publique, Sécurité de la Chaîne alimentaire et Environnement, Ministère de la Région Wallonne, Vlaams Agentschap Zorg & Gezondheid and Cocof websites

Appendix 7. Exploration of accreditation opportunities for belgian hospitals – survey (Chapter 2.4)

A guide was elaborated to interview the stakeholders on the accreditation opportunities in Belgium, covering 4 themes: Previous accreditation experience, Policy, Organisation and implementation, and Feasibility.

Federaal Kenniscentrum
Voor de Gezondheidszorg
Centre Fédéral d'Expertise
Des Soins de Santé

GUIDE POUR L'INTERVIEW

Définition utilisée :

L'accréditation est une évaluation effectuée dans un hôpital sur base de standards préalablement définis, connus et reconnus dans le but d'améliorer continuellement la qualité des soins.

Expérience préalable :

1. Avez-vous de l'expérience en matière d'accréditation des hôpitaux (ou d'initiatives similaires) ?
2. Si oui, quelle est-elle ?

Politique :

3. Existe-t-il en Belgique un besoin d'« évaluer » les hôpitaux de manière uniforme sur base d'un ensemble de standards/indicateurs préalablement déterminés ? Pourquoi, dans quel but ?
4. Quel intérêt y auriez-vous éventuellement ?
5. Si oui, à quel niveau (fédéral, communautaire, etc.) ce « système » devrait-il être applicable ? Pour quelle raison ?
6. Connaissez-vous des « systèmes » (initiatives en Belgique ou ailleurs) dont pourrait/devrait s'inspirer le futur « système » belge ? Pourquoi ?
7. Quelles sont les raisons de l'absence d'un tel « système » en Belgique ?
    a. Politique ?
    b. Régulation/législation ?
    c. Financement ?
    d. Autre ?
8. Quelle devrait être la base légale pour l'accréditation des hôpitaux ?
9. Quels hôpitaux devraient entrer en ligne de compte ?
10. Ce « système » est-il volontaire, obligatoire ou quasi-volontaire avec des incitants « puissants » ? Pourquoi ce choix ?
11. L'accréditation partielle est-elle une option ?
12. Quels incitants sont importants ?
13. Existe-t-il différents niveaux d'accréditation ?

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Federaal Kenniscentrum
Voor de Gezondheidszorg
Centre Fédéral d'Expertise
Des Soins de Santé

Organisation & mise en œuvre

14. Selon vous, quels sont les principes directeurs de ce « système » ?
    a. **Macro-organisation** :
        i. Comment le système doit-il être organisé en termes « d'entité organisationnelle » ou d'agence responsable de l'exécution du programme d'accréditation ?
        ii. Comment est organisé le contrôle de ce système/cette organisation ?
        iii. Quels stakeholders/protagonistes sont impliqués et de quelle manière ?
    b. **Standards :**
        i. Que doit-on évaluer en termes de « processus » (processus de support internes versus processus cliniques) et de « profondeur » (niveau de détail des indicateurs) ?
        ii. Quels indicateurs ?
            1. Indicateurs de processus (pesées, procédures relatives à la formation des patients, etc.)
            2. Indicateurs de ressources humaines (compétences, personnel, nombre d'ETPs, etc.)
            3. Indicateurs de performance (qualité, sécurité, accessibilité, etc.)
            4. Indicateurs d'efficacité (coefficient patients/lits, coûts par service, etc.)
            5. Indicateurs liés aux patients (satisfaction)
            6. Indicateurs d'intégration (mesure de la coopération avec d'autres hôpitaux, etc.)
            7. …
        iii. Standards qui doivent être au minimum atteints par un hôpital ou « système » où il faut être le « meilleur de classe » ?
        iv. Qui détermine ces standards/indicateurs ?
    c. **Evaluation/assessment :**
        i. Quelles étapes devrait comporter le processus d'accréditation ?
        ii. Par qui sont effectuées les évaluations/assessments → profils/composition des équipes ?
        iii. Comment sont « sélectionnées » ces personnes ?
        iv. Quelle formation doit être suivie ?
        v. Quelle est l'expérience/le niveau d'activité requis(e) ?
        vi. Quelle est la durée/fréquence de l'accréditation ?

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vii. Du côté des hôpitaux :

1. Quelle charge de travail (administrative, pratique, etc.) est acceptable (préparation et réalisation) ?
2. Une première réponse immédiate est-elle attendue ?
3. Existe-t-il un « draft » sur lequel il est possible de réagir ?

d. Implications de résultats :

i. Quel est l'intérêt d'une évaluation de la « procédure d'accréditation » ?

ii. Comment (indicateurs) les résultats et effets doivent-ils être évalués ?

iii. Quelle est la disponibilité des résultats (individuels) de l'évaluation?

iv. Quelles doivent être les implications des évaluations pour un hôpital individuel, c'est-à-dire quelle est la conséquence éventuelle (positive ou négative) d'un résultat déterminé ?

v. Existe-t-il des « niveaux » de résultats, par ex. remarques, recommandations, décisions, etc. ?

vi. Existe-t-il des procédures d'appel ?

e. Financement

i. Comment et par qui ce système doit-il être financé (user fee, assureurs, administration, etc.) ?

ii. Que comprend ce « financement », c'est-à-dire quels postes sont couverts ?

iii. Quels frais sont « supportés » par les hôpitaux ?

Faisabilité

15. Selon vous, quelle est la faisabilité d'un tel système ?
16. De quels facteurs dépend-t-elle ?
17. Quels sont les facteurs de réussite essentiels au bon déroulement d'un programme d'accréditation des hôpitaux ?

Autres remarques

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INTERVIEW GIDS

Gehanteerde definitie:

Accreditering is een evaluatie ter plaatse van een ziekenhuis aan de hand van vooraf gedefinieerde, gekende en herkende standaards met als doel de kwaliteit van de zorg voortdurend te verbeteren.

Voorafgaande ervaring:

1. Heeft u reeds ervaring met ziekenhuisaccreditering (of soortgelijke initiatieven)?
2. Zo ja, wat is uw ervaring?

Beleid:

3. Bestaat er in België een behoefte ziekenhuizen op uniforme wijze te 'assessen'/evalueren ten aanzien van een set vooraf bepaalde standaarden/indicatoren? Waarom, met welk nut?
4. Welk belang zou u er eventueel bij hebben?
5. Zo ja, op welk niveau (federaal, gemeenschap, …) zou dit 'systeem' toepasbaar moeten zijn? Waarom?
6. Zijn er 'systemen' (initiatieven in België of elders) die u kent waar aan dit toekomstige Belgische 'systeem' gespiegeld zou kunnen/moeten worden? Waarom ?
7. Welke zijn de redenen van het ontbreken van zo een 'systeem' in België?
    a. Politiek ?
    b. Regulering/wetgeving ?
    c. Financiering ?
    d. Andere ?
8. Welke dient de wettelijke basis voor een ziekenhuisaccreditering te zijn?
9. Welke ziekenhuizen zouden hiervoor in aanmerking moeten komen?
10. Is dit 'systeem' vrijwillig of verplicht of quasi-vrijwillig met 'dwingende' stimulatoren? Waarom welke keuze?
11. Is partiële accreditering een optie?
12. Welke 'incentives' zijn belangrijk
13. Zijn er verschillende niveaus van accreditering?

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Organisatie & implementatie

14. Volgens uw visie, wat zijn de leidende principes van dit 'systeem'?
    a. **Macro organisatie**:
        i. Hoe dient het 'systeem' georganiseerd te worden in termen van een 'organisatorische entiteit' of agentschap dat instaat voor de uitvoering van het accrediteringsprogramma?
        ii. Hoe is het toezicht op dit systeem/deze organisatie geregeld?
        iii. Welke stakeholders/belanghebbenden zijn betrokken en op welke wijze?
    b. **Standaarden:**
        i. Wat dient geëvalueerd te worden in termen van 'processen' (interne ondersteunende processen versus klinische processen) en 'diepte' (het niveau van detail van de indicatoren)?
        ii. Wat voor indicatoren?
            1. Procesindicatoren (gewichtopnames, procedures rond patiënten-opleiding,…)
            2. Human resources indicatoren (e.g. competenties, staffing, aantalen VTE's, …)
            3. Performantie-indicatoren (e.g. kwaliteit, veiligheid, toegankelijkheid,…)
            4. Efficiëntie indicatoren (e.g. ratio patiënten/bedden, kosten afdeling, …)
            5. Patiëntgebonden indicatoren (tevredenheid,
            6. Integratie-indicatoren (e.g. mate van samenwerking met andere ziekenhuizen,…)
            7. …
        iii. Standaarden die 'minimaal' gerealiseerd moeten worden door een ziekenhuis of een 'systeem' waarbij het om 'best of class' gaat?
        iv. Wie bepaalt deze standaarden/indicatoren?
    c. **Evaluatie/assessment**:
        i. Uit welke stappen zou het accrediteringsproces moeten bestaan
        ii. Door wie worden de evaluaties/assessments uitgevoerd → profielen/samenstelling teams?
        iii. Hoe worde deze personen 'geselecteerd'?
        iv. Welke opleiding dienen zij gevolgd te hebben?
        v. Welke ervaring/activiteitsniveau?

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vi. Wat is de duur/frequentie van accreditering?

vii. Aan de kant van de ziekenhuizen:

1. welke werklast/belasting (administratief, praktisch, …) is aanvaardbaar (voorbereiding & uitvoering)?
2. Wordt een onmiddellijke eerste respons verwacht?
3. Bestaat er een 'draft' met mogelijkheid om te reageren?

d. Resultaten-implicaties:

i. Wat is het belang van een evaluatie van de 'accrediteringprocedure'?

ii. Hoe (indicatoren) dienen de resultaten en effecten geëvalueerd te worden?

iii. Wat is de beschikbaarheid van de (individuele) assessment resultaten?

iv. Wat dienen de implicaties van de evaluaties voor het individuele ziekenhuis te zijn i.e. wat is de eventuele consequentie (positief en negatief) van een bepaald behaald resultaat?

v. Bestaan er 'niveaus' van resultaten e.g. opmerkingen, aanbevelingen, beslissingen…

vi. Zijn er beroepsprocedures?

e. Financiering

i. Hoe en door wie dient het 'systeem' gefinancierd te worden (user fee, verzekeraars, administrate,…)?

ii. Wat behelst deze 'financiering' i.e. welke kostenposten worden gedekt.

iii. Welke kosten worden door de ziekenhuizen 'gedragen'

Haalbaarheid

15. Hoe schat u de haalbaarheid in
16. Van welke factoren is deze afhankelijk?
17. Welke zijn de kritische succesfactoren voor een goed lopend ziekenhuisaccrediteringsprogramma?

Andere opmerkingen

…..

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Next, concerned Belgian stakeholders were listed, including 42 organizations from different categories, as RIZIV/INAMI, sickness funds, professional associations, hospital associations, individual hospitals and experts.

Table 34: Contacted Belgian stakeholders

ORGANISATION	STATUS: INFO Y/N
RIZIV/INAMI	
Rijksinstituut voor Ziekte- en Invaliditeitsverzekering	Y
GOVERNMENT/COMMUNITIES	
Federale Overheidsdienst Volksgezondheid	Y
Vlaams Agenstschap Zorg en Gezondheid	Y
Direction générale de L'Action sociale et de la Santé	Y
Brussel: COCOM VGC	N
SICKNESS FUNDS	
Landsbond der Christelijke Mutualiteiten/Alliance Nationale des Mutualités Chrétiennes	Y
Nationaal Verbond van Socialistische Mutualiteiten/Union Nationale des Mutualités Socialistes	Y
Landsbond der Onafhankelijke Ziekenfondsen/Union Nationale des Mutualités Libres	Y
PATIENT ORGANISATIONS	
Ligue des Usagers des Services de Santé LUSS	Y
Vlaams Patiëntenplatform	Y
PROFESSIONAL ASSOCIATIONS	
Association Francophone de Médecins-chefs	Y
Vereniging van Vlaamse Hoofdgeneesheren	Y
Verbond Belgische Specialisten VBS/GBS	Y
ABSYM/BVAS	Y
Algemeen Syndicaat van Geneeskundigen van België	Y
NVKVV	Y
NNBVV	N
FNIB	Y
ACN Association belge des praticiens de l'art Infirmier	Y
UGIB	N
HOSPITAL ASSOCIATIONS	
Vereniging van Openbare Verzorgingsinstellingen	Y
Association des Etablissements Publics de Soins	Y
Verbond der Verzorgingsinstellingen	Y
FNAMS/NVSMV	Y
COBEPRIVE/BECOPRIVE	Y
Fédération des Institutions Hospitalières (FIH)	Y
CBI Coördinatie van Brusselse Instellingen/ Coordination Bruxelloise d'institutions sociales et de santé	N
Association Francophone d'Institutions de Santé	Y
Raad van Universitaire Ziekenhuizen van België RUZB/CHAB	Y
ABH/BVZ	Y
INDIVIDUAL HOSPITALS	
CHU de Charleroi	Y
Ziekenhuisnetwerk Antwerpen	Y
CHR de Huy	Y
AZ Oudenaarde	Y
Cliniques St.-Joseph	Y
AZ Sint-Blasius	Y
Clinique St.-Luc	Y
St. Vincentiusziekenhuis	Y
	89%

A letter introducing the project and the future interviews was sent on the 4th of June 2007 to these institutions.

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Voor de Gezondheidszorg
Centre Fédéral d'Expertise
Des Soins de Santé

Brussel, 4 juni 2007

Geachte collega,

Het Federaal Kenniscentrum Voor de Gezondheid (KCE) heeft onlangs een project aanbesteed dat tot doel heeft mogelijke scenario's voor ziekenhuis accreditatie uit te werken voor België. Deze studie is begin april gestart en wordt uitgevoerd door Eurogroup Consulting in samenwerking met Prof. Dr. Charles Shaw (UK) en Prof. Dr. Karel Vermeyen. Om te komen tot de uitwerking van deze scenario's bestaat het project uit twee luiken:

1. Een vergelijkende analyse van bestaande ziekenhuis accreditatie programma's/initiatieven binnen Europa;
2. Een inventarisatie van initiatieven en opinies van de verschillende belanghebbende partijen binnen België.

In het kader van dit tweede luik zullen er gestructureerde interviews afgenomen worden met de geïdentificeerde belanghebbende partijen. U, en de instantie die u vertegenwoordigt, wordt beschouwd als één van de 'stakeholders' voor een mogelijk ziekenhuisaccreditatie programma in België. Derhalve willen we u bij deze vragen deel te nemen aan een interview dat in de komende weken gepland gaat worden. Hiertoe zal Eurogroup Consulting u kortelings benaderen om een afspraak te maken. Wij hechten veel waarde aan uw inbreng, hopen op uw constructieve medewerking, en zullen u ook betrekken bij het vervolg van deze studie.

Met de meeste hoogachting

Dirk Ramaekers, Algemeen Directeur KCE



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Telephone contacts were next taken in order to plan an interview date, and interview guides were sent in advance in order to facilitate their preparation. The interview guide questions have been classified in the developed framework (cfr Chapter 2.1 'Determination of the framework to analyse accreditation'). Individual answers were next analysed, synthesized by sub-themes and presented in the framework to get a global view on the Belgian stakeholders' position on accreditation.

APPENDIX 8. EXPLORATION OF ACCREDITATION OPPORTUNITIES FOR BELGIAN HOSPITALS – TREATMENT OF THE RESULTS (CHAPTER 2.4)

Regrouping of questions in blocks of the common framework

The interview guide questions have been classified in the developed framework (cfr Chapter 2.1 'Determination of the framework to analyse accreditation'). Individual answers were next analysed, synthesized by sub-themes and presented in the framework to get a global view on the Belgian stakeholders' position on accreditation

Table 35: detailed framework of interview guide questions

Exploration of accreditation opportunities for Belgian hospitals - Treatment of the survey answers - Detailed framework			
1. Policy			**Survey questions**
	Programme intentions		
		Programme participation	10. Ce « système » est-il volontaire, obligatoire ou quasi-volontaire avec des incitants « puissants » ? Pourquoi ce choix ?
		Programme purpose	14.b.iii. Standards qui doivent être au minimum atteints par un hôpital ou « système » où il faut être le « meilleur de classe » ?
			3. Existe-t-il en Belgique un besoin d'« évaluer » les hôpitaux de manière uniforme sur base d'un ensemble de standards/indicateurs préalablement déterminés ? Pourquoi, dans quel but ?
			4. Quel intérêt y auriez-vous éventuellement ?
	Programme supportive structure		
		Law existence	8. Quelle devrait être la base légale pour l'accréditation des hôpitaux ?
		Policy existence	
		Body status	*14.a.i. Comment le système doit-il être organisé en termes « d'entité organisationnelle » ou d'agence responsable de l'exécution du programme d'accréditation ?*
		Body composition determination	
		Government link	*5. Si oui, à quel niveau (fédéral, communautaire, etc.) ce « système » devrait-il être applicable ? Pour quelle raison ?*
	Programme incentives		
		Hospitals incentives	12. Quels incitants sont importants ?
			14.d.iv. Quelles doivent être les implications des évaluations pour un hôpital individuel, c'est-à-dire quelle est la conséquence éventuelle (positive ou négative) d'un résultat déterminé ?
	Programme coverage		
		Concerned hospitals	9. Quels hôpitaux devraient entrer en ligne de compte ?
		Concerned services	11. L'accréditation partielle est-elle une option ?
		Concerned regions	*5. Si oui, à quel niveau (fédéral, communautaire, etc.) ce « système » devrait-il être applicable ? Pour quelle raison ?*
2. Governance			
	Body's stakeholders participation		
		Stakeholders profiles	14.a.iii. Quels stakeholders/protagonistes sont impliqués et de quelle manière ?
	Body's internal organization		
		Internal structure	*14.a.i. Comment le système doit-il être organisé en termes « d'entité organisationnelle » ou d'agence responsable de l'exécution du programme d'accréditation ?*
			14.a.ii. Comment est organisé le contrôle de ce système/cette organisation ?

3. Methods		
	3.1. Standards	
	Standards development	
	Standards reference model	6. Connaissez-vous des « systèmes » (initiatives en Belgique ou ailleurs) dont pourrait/devrait s'inspirer le futur « système » belge ? Pourquoi ?
	Standards standardization	
	Standards spread	14.b.i. Que doit-on évaluer en termes de « processus » (processus de support internes versus processus cliniques) et de « profondeur » (niveau de détail des indicateurs) ?
		14.b.ii. Quels indicateurs ?
	Standards consultation	
	Standards consultation	14.b.iv. Qui détermine ces standards/indicateurs ?
	Standards approval and revision	
	Standards approval date	
	Standards revision frequency	
	3.2. Measurement	
	Generics	
	Assessment methods	
	Asssessment steps	14.c.i. Quelles étapes devrait comporter le processus d'accréditation ?
	Assessment survey cycle	
	Assessment depth	
	Self-assessment	
	Self-assessment duration	
	On-site survey	
	On-site survey duration	
	Team size	
	Team composition	14.c.ii. Par qui sont effectuées les évaluations/assessments -> profils/composition des équipes ?
	Hospital feedback	14.c.vii. Une première réponse immédiate est-elle attendue ?
	Hospital report validation	
	Hospital report validation	14.c.vii. Existe-t-il un « draft » sur lequel il est possible de réagir ?
	3.3. Surveyors recruitment and training	
	Surveyors recruitment	
		14.c.iii. Comment sont « sélectionnées » ces personnes ?
		14.c.v. Quelle est l'expérience/le niveau d'activité requis(e) ?
	Surveyors availability	
	Surveyors training	
		14.c.iv. Quelle formation doit être suivie ?
	Surveyors training duration	
	Trained surveyors availability	
	3.4. Change management	
	Hospitals tools	
	3.5. Decision and appeal	
	Decision levels	13. Existe-t-il différents niveaux d'accréditation ?
	Accreditation validity	14.c.vi. Quelle est la durée/fréquence de l'accréditation ?
	Decision duration	
	Appeal	14.d.vi. Existe-t-il des procédures d'appel ?
	3.6. Results diffusion	
	Results availability	14.d.iii. Quelle est la disponibilité des résultats (individuels) de l'évaluation ?
	Results contents	

4. Funding mechanism and sources			
	Programme income		
		Programme development	
		Programme running financing	14.e.i. Comment et par qui ce système doit-il être financé (user fee, assureurs, administration, etc.) ?
			14.e.iii. Quels frais sont « supportés » par les hôpitaux ?
	Programme expenses		
		Programme total expenditures	14.e.ii. Que comprend ce « financement », c'est-à-dire quels postes sont couverts ?
		Programme salaries	
5. Evaluation			
	Programme evaluation		
		Programme evaluation	14.d.i. Quel est l'intérêt d'une évaluation de la « procédure d'accréditation » ?
	Programme outcomes and measurement		
		Programme outcomes	
		Programme outcomes	14.d.ii. Comment (indicateurs) les résultats et effets doivent-ils être évalués ?
	Programme standards ISQua link		
		Programme standards ISQua	
	Programme key indicators		
		Pogramme penetrance	
		Programme sustainability	

Appears 2 times in the framework

Number : correspond to the number of the interview guide questions

APPENDIX 9. DEFINITION OF ACCREDITATION (CHAPTER 3)

Table 36: Definitions of accreditation, licensure and certification

Process	Issuing Organization	Object of Evaluation	Components/Requirements	Standards
Accreditation (voluntary)	Recognized tools, usually an NGO	Organization	Compliance with published standards, on-site evaluation, compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Licensure (mandatory)	Governmental authority	Individual	Regulations to ensure minimum standards, exam, or proof of education/ competence	Set at a minimum level to ensure an environment with minimum risk to health and safety
		Organization	Regulations to ensure minimum standards, on-site inspection	
Certification (voluntary)	Authorized body, either government or NGO	Individual	Evaluation of predetermined requirements, additional education/training, demonstrated competence in speciality area	Set by national professional or speciality boards
		Organization or component	Demonstration that the organization has additional services, technology, or capacity	Industry standards (e.g. ISO 9000 standards) evaluate conformance to design specifications

Referring to the definition of accreditation used for this study, which gives no indication on the voluntary or compulsory character of the process and on the character of the issuing body, the key differences with the other 2 quality concepts, namely Licensure and Certification, are related to the standards applied and their specific character e.g. maximum achievable level versus minimum level.

Peer review (visitatie) i.e. systematic visits conducted by medical peers based on clinical assessment falls in this category.

On the organisation side, the International Society for Quality in Health Care (ISQua) has among others developed[hh]:

- The International Principles for Healthcare Standards, an internationally tested and approved framework of requirements i.e. principles and their criteria, which should underpin health care delivery standards, and
- The International Accreditation Standards for Healthcare External Evaluation Bodies, statements of outcomes that are necessary for the provision of excellent evaluation services which are supported by criteria that are the measurable components of the standards

An organization which is developing a programme can use the International Principles for Healthcare Standards to guide its standards development and revision processes thereby being assured that they meet international best practice requirements or may apply to ISQua to have its standards assessed during this first phase.

The second edition[36] of these Principles, which was published in 2002, contains 5 main principles:

hh www.isqua.org.au

- Standards contribute to quality and performance improvement in the health organization and the wider health system,
- The scope of standards is patient/client focused and encompasses the management and support infrastructure of that organization or service,
- The content of the standards is comprehensive and reflects the following dimensions of quality: accessibility, appropriateness, capacity, continuity, effectiveness, efficiency, responsiveness, safety and sustainability,
- Standards are planned, formulated and evaluated through a defined process, and
- Standards enable consistent measurement

As for the Principles, an organization under construction can initially base itself on the International Accreditation Standards for Healthcare External Evaluation Bodies to put its structure in place and may apply to ISQua to have its organization accredited once fully operational.

The second edition of these Standards[37], which was published in 2004, includes 8 standards:

Governance and Strategic Directions,

Organisation and Management Performance,

Human Resources Management,

Surveyor/Assessor Selection, Development & Deployment,

Financial and Resource Management,

Information Management,

Survey/Assessment Management, and

Accreditation/Certification Process

ISQua's Principles and Standards are currently undergoing review: new editions will be available in a near future.

Certification is a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Although the terms accreditation and certification are often used interchangeably, accreditation usually applies only to organizations, while certification may apply to individuals, as well as to organizations [2].

Certification usually implies that a provider has:

- Received additional education and training, and
- Demonstrated competence in a specialty area beyond the minimum requirements set for licensure (e.g. a physician who receives certification by a professional specialty board in the practice of obstetrics)

For example, the "International Organization for Standardization" (ISO)[ii] developed a series of standards for service industries that has been used to assess quality systems in specific areas of health services and in hospitals. In each country, a national body tests and recognizes independent agencies as competent to certify organizations that comply with the standards, which relate more to administrative procedures than to clinical results [6].

Licensure is a process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession [2].

Licensure:

- Exists to ensure that an organization or individual meets minimum standards to protect public health and safety,
- Is usually granted after some form of examination or proof of education for individuals and following an on-site inspection to determine if minimum health and safety standards have been met for organizations,
- May be renewed periodically through payment of a fee and/or proof of continuing education or professional competence, and
- Is an ongoing requirement for the health care organization to continue to operate and care for patients

The EFQM Excellence Model[jj]

Regardless of sector, size, structure or maturity, to be successful, organisations need to establish an appropriate management framework.

The EFQM Excellence Model was introduced at the beginning of 1992 as the framework for assessing organisations for the European Quality Award. It is now the most widely used organisational framework in Europe and it has become the basis for the majority of national and regional Quality Awards.

The EFQM Excellence Model is a practical tool that can be used in a number of different ways:

- As a tool for Self-Assessment
- As a way to Benchmark with other organisations
- As a guide to identify areas for Improvement
- As the basis for a common Vocabulary and a way of thinking
- As a Structure for the organisation's management system

The EFQM Excellence Model is a non-prescriptive framework based on 9 criteria. Five of these are 'Enablers' and four are 'Results'. The 'Enabler' criteria cover what an organisation does. The 'Results' criteria cover what an organisation achieves. 'Results' are caused by 'Enablers' and 'Enablers' are improved using feedback from 'Results'.

The Model, which recognises there are many approaches to achieving sustainable excellence in all aspects of performance, is based on the premise that:

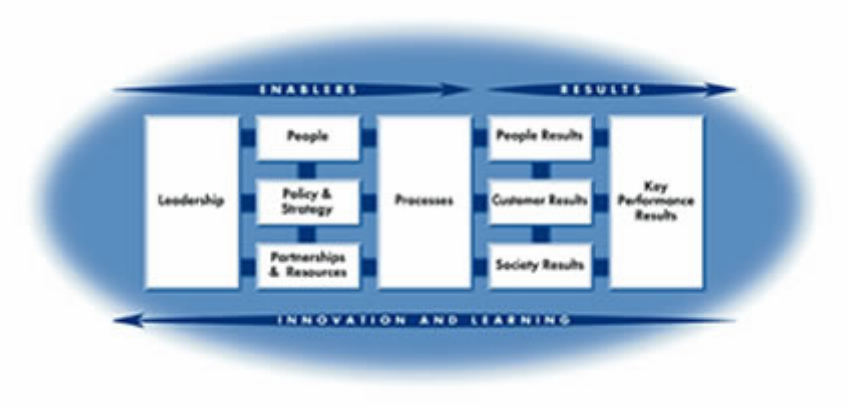
Excellent results with respect to Performance, Customers, People and Society are achieved through Leadership driving Policy and Strategy, that is delivered through People, Partnerships and Resources, and Processes.

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ii http://www.iso.org/iso/home.htm
jj http://www.efqm.org

The EFQM Model is presented in diagram form below. The arrows emphasise the dynamic nature of the Model. They show innovation and learning helping to improve enablers that in turn lead to improved results.

Figure 1: The EFQM model



APPENDIX 10. SUMMARY PER COUNTRY (CHAPTER 5.1)

Countries with programme

France

Policy

The French accreditation programme was developed in 1998-1999 by a government agency called Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES) following legislation:

- stipulating that all health organisations have the obligation to participate in an external evaluation procedure called accreditation to ensure continuous quality and safety improvement of care, and
- detailing the structure and function of the ANAES [18]

In 2004, a law created the Haute Autorité de Santé (HAS) following the need to have a unique and independent structure regrouping the expert organizations and transferred among others the ANAES' missions to it[kk]. This change was accompanied by the introduction of the term "certification des établissements de santé" instead of "accréditation des établissements de santé" to avoid confusion with the accreditation of doctors [38].

The purpose of this certification process is to improve the quality of care provided by the health organisations and to put information about this quality at the disposal of the public[ll].

The certification includes private as well as public hospitals. It concerns also the health care cooperations between health care institutions (groupements de coopération sanitaire[mm]) and the interhospital unions having an authorization to provide health care activities, as well as the health networks (réseaux de santé[nn]) and the installations for aesthetic surgery.

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kk http://www.infirmiers.com/inf/protocole/anaes.php
ll www.has-sante.fr
mm See for instance http://www.uhno-bretagne.fr/fr/maj-e/c1a2j11832/sanitaire/dossiers/les-groupements-de-cooperation-sanitaire.htm
nn See for instance http://www.mutuellesdefrancereseausante.fr

Besides, it applies to the entirety of structures and activity sectors, to the exception of the medico-social activities, even if they are practiced in the health care institution.

The incentives motivating hospitals to participate to this programme are:

- statutory requirement,
- desire for improvement, and
- 'brand' image they can 'sell' to authorities, correspondents, and actual and potential patients [19]

Governance

The HAS is composed of a Collège, 7 specialized Commissions, including the Commission certification des établissements de santé, different operational services and 2 networks of external collaborators[oo].

The stakeholders nominated as representatives are:

- users,
- clinical professionals,
- health care insurers,
- hospital owners, and
- regulators

Methods

Different certification procedures have been developed. The V1 was initiated in 1999, the V2 was initiated in 2005 and the V2007 has been recently developed[pp]. This procedure concerns all the health organisations which will be surveyed from the 1st April 2008, the organisations with a survey planned between September 2007 and March 2008 have the choice of V2 or V2007.

These different versions evolved to a more simple, readable and understandable procedure. Several important innovations have so been introduced:

- Adaptation of manual including standards (references)

The new certification procedure aims to insert a procedure focusing on the core business of hospitals: quality of care. It appeared that the former accreditation programme failed to reflect the evaluation into results since there were a few accredited hospitals where adverse events showed up anyway. Therefore the new procedure includes less organisational standards and more standards relating to the evaluation of care.

More specifically, 3 clinical evaluation standards linked to physicans' clinical practice have been added:

- Pertinence of care (référence 40): prescriptions, hospital stay, risky interventions, laboratory tests, etc.
- Evaluation of risks for the patient and the personnel linked to medical and medico-technical activities (référence 41)
- Evaluation of clinical practice guidelines (référence 42)

Where the accreditation procedure essentially aimed at installing and assessing a quality dynamics in hospitals, the certification procedure also focuses on the evaluation of the actual situation (at the moment of the visit) in each hospital in terms of quality management and results.

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oo www.has-sante.fr

pp In 2006 all French hospitals were visited. In 2005 the second round of visits started.

With regard to the new referential, another innovation is the introduction of the notion of efficiency.

- Simplified self-assessment procedure

The self-assessment procedure has been simplified. Where the 1st procedure included the creation of a multi-professional self-assessment group per theme of the manual, the 2nd procedure maintains this requirement but inserts the possibility for the hospital to make use of existing structures to perform the evaluation. For instance, the hospital hygienic structure can realize the self-assessment with regard to prevention of infections. These modalities not only aim at the simplification of the procedure but also drive at the integration of the certification requirement in their regular organization.

- Complementarity of external procedure for quality assessment in different health care sectors

In the more technical domains that are part of the HAS certification (linen-room, catering, etc.), HAS has recognised the ISO 9001 certification. For the ISO certification focussing at a larger sector (management, establishment, etc.) the impact of ISO certification is rather marginal considering that ISO is more focussed on quality and HAS more stresses the risks.

- Measures aiming at the improvement of the pertinence and the comprehension of the results of the certification procedure
  - In order to insert quality control as a continuous process, the interval of certification has been reduced from 5 to 4 years.
  - An elaborated system to assess the level of quality and the dynamics has been implemented: the quality level is evaluated by scoring items against criteria that are based on precise and measurable elements of evaluation. For every dysfunction, the surveyors evaluate if the hospital is in a state of improvement dynamics.
  - The modification of the decision levels to following categories: certification, certification avec suivi, certification conditionnelle, non-certification
  - The certification reports are published entirely on the HAS website, a presentation of the report for the broad public is also available[39].
- Increased participation of the users of the provided care (patients, patient organisations, e.g. by means of surveys on patient satisfaction) in the self-assessment part as well as in the external assessment. Physicians' involvement has also been included in the self-assessment procedure and in the external assessment.

Standards

The standards used in the V2007:

- were inspired by CCHSA, ACHS and JCAHO,
- were submitted to the consultation of the stakeholder organizations,
- are generic for all types of hospitals, and
- cover clinical, internal support and governance processes

More specifically, the 'Manuel de certification des établissements de santé et guide de cotation'[40] includes 44 standards (références) and 138 criteria divided in 4 chapters:

- Policy and quality management, containing 7 themes such as strategic orientation of the organisation, human resources policy, risk management and quality improvement policy, etc.,

- Transversal resources, organized in 5 fields such as human resources, logistics, information systems, etc.,
- Caring of patient, covering the patient's rights and trajectory, and
- Evaluation and dynamics of improvement, covering professional practices, users and external correspondents, and policies and management

Each "référence" regroups different criteria on the same theme. The criteria:

- include requirements that are formulated as goals to achieve,
- are measurable and objective and regrouped per theme, and
- have been defined in collaboration with professionals of the concerned domain

Each criterion is linked to:

- useful precisions focusing on the field of application of the criterion,
- elements of appreciation in order to fulfill the criterion,
- a list of indicative documents-resources, and
- a list of indicative persons-resources

An example

In chapter 2 (transversal resources), reference 10) Quality management 10 c). includes: "the training of professionals with regard to quality aspects"

Elements of appreciation are:

- Being aware of the needs in quality training (harmony with the outline of the quality program)
- Plan for quality training (professionals concerned, obligatory character of the training, frequency, content of the training, etc.)
- Functioning of the training

Documents – resources are:

- Book of charges
- Training plan

Persons – resources are:

- Person responsible for quality management
- Person responsible for training
- Health care professionals

Measurement

The measurement is divided into 2 main steps: the self-assessment prepared by the hospital, which is followed by an external assessment performed by a specialized team[qq].

The objectives of the self-assessment are:

- to realize a quality diagnostic,
- to measure the attained quality level, and
- to assess the improvement dynamics

qq http://www.has-sante.fr/portail/display.jsp?id=c_458784

Its duration depends of the hospital characteristics but lasts in average 9 months for a 100-bed hospital. It must be elaborated 3 or 4 months before the survey and its results must be communicated to HAS 2 months before it at the latest.

Organisation modalities for self-assessment are proposed to the hospital, consisting in the creation of a board committee and of 2 teams (working group and synthesis group) charged with the main steps of the self-assessment, it is collection of information, analysis of data, proposal of improvement actions, synthesis of performed work, redaction of self-assessment tables and meeting with the surveyors. The criteria to be checked depend of the hospital size.

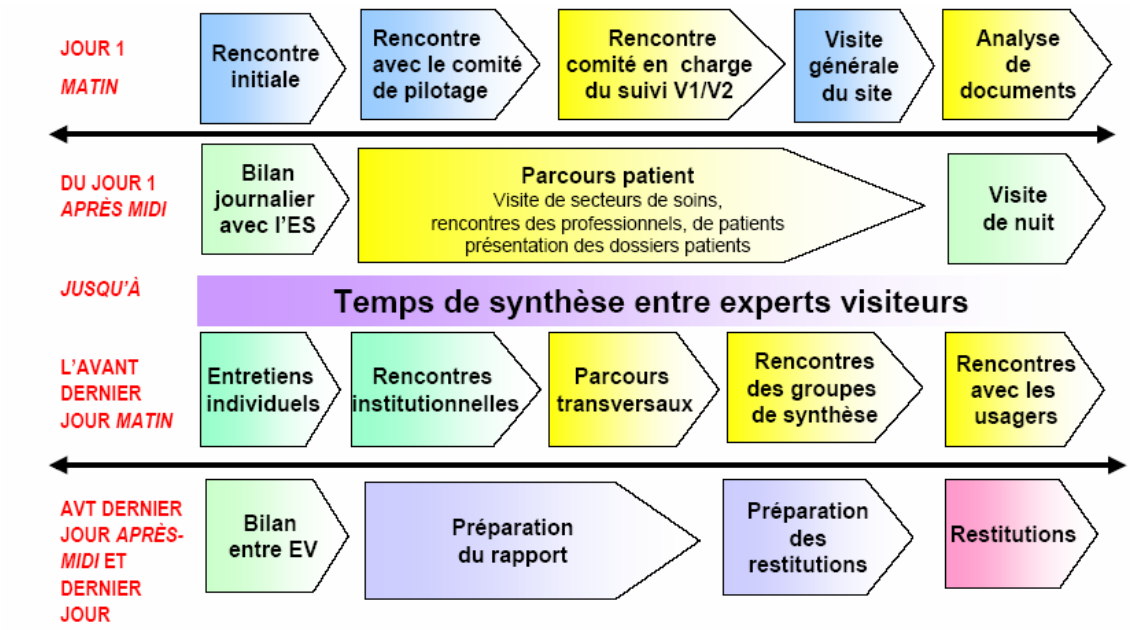
The self-assessment team has to give an overview of the results for all criteria with comments on all elements of appreciation. The findings have to be descriptive, synthetic, well argued and based on controllable facts. Each criterion has to be scored (see scoring system). The results for all criteria also include a synthesis of the positive aspects and the points of improvement with the provided preventive or corrective measures. For the corrective actions the delay and the modalities have to be described.

The external assessment objectives are:

- to assess the attained quality level, and
- to assess the quality dynamics

It consists in 3 phases:

Figure 2: HAS external assessment steps



Source: http://www.has-sante.fr/portail/types/FileDocument/doXiti.jsp?id=c_569712

and:

- lasts on average 4 days,
- is performed by a 3-person multidisciplinary team composed of doctors, nurses, and other experts depending of the surveyed hospital's activities,
- ends with a verbal feedback from the team,
- is followed with the submission of the draft report to the hospital for comments

The scoring system

The scoring scale (used in the self-assessment as well as in the external assessment procedure) includes 4 levels relying on the elements of appreciation per criterion. First one has to evaluate if each element of appreciation per criterion has been fulfilled. In a second phase the spatial/temporal approach has to be assessed, considering the regularity and the diffusion of the level of satisfaction to the sectors of the establishment.

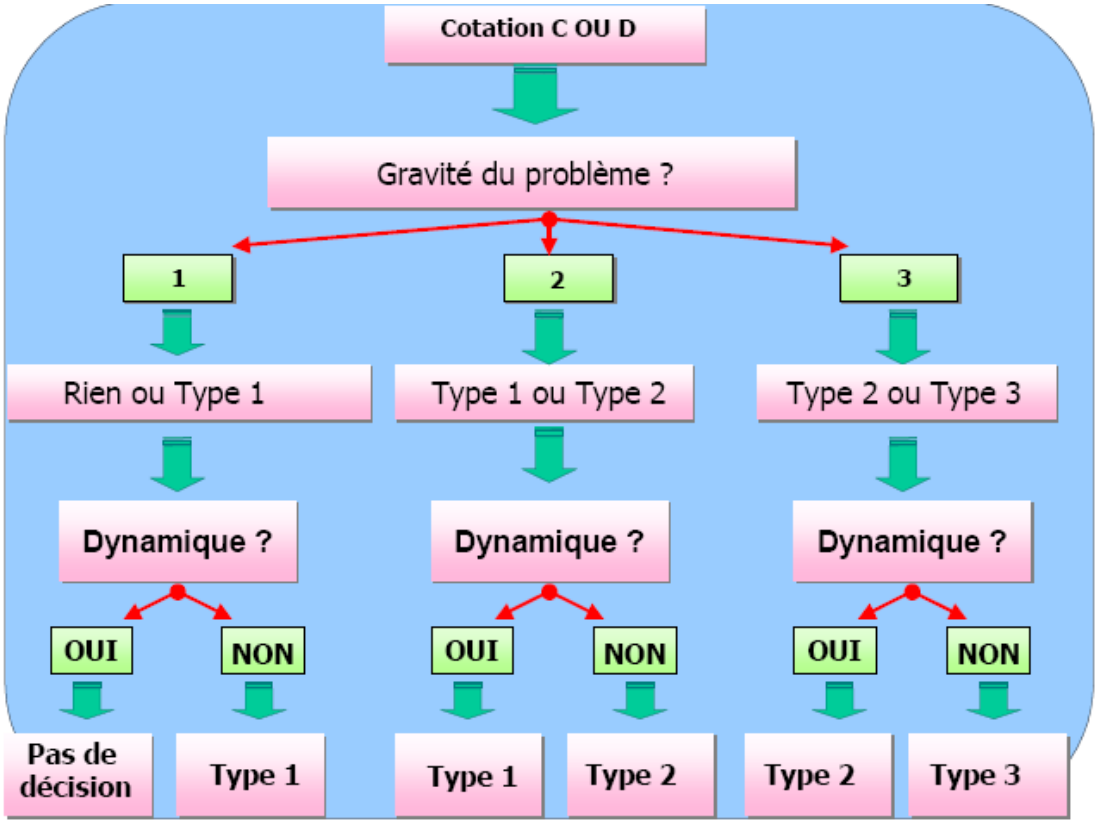
Table 37: HAS scoring system

	All Elements of appreciation	**Most of the elements of appreciation**	**Few Elements of appreciation**	**Too little of the significant elements of appreciation**
In all sectors and/or always	A	B	C	D
In most of the sectors and/or most of the time	B	C	C	
In some sectors and/or sometimes	C	C	D	
Nowhere and/or never				

The surveyors have to evaluate the results from the self-assessment round based on the current factual situation. For each criterion, they have to make a score from A to D. For the C and D levels, they have to propose a level of decision (Type 1 to 3 depending on the level of gravity and dynamics) and a synthesis of the comments (frequency and gravity, dynamics (have problems yet arises in the former accreditation round), context (for instance: fire hazard in establishment for people with reduced mobility) of the non satisfied criterion and the existence of the dynamics of the hospital to undertake measures to improve these points. The proposed decisions are harmonised by the project manager (member of the HAS guiding the hospital) and the coordinator responsible for the visit. A reviewing commission composed of experts in the different domains of health care votes on the decisions made by the experts. Afterwards these decisions are sent to the president of the HAS for validation. The decisions include 'certification', 'certification avec suivi', 'certification conditionnelle' or 'non certification'.

The non certification is a secondary decision that is taken if the conditional certification was not satisfying.

Figure 3: HAS C or D quotation steps



Source: http://www.has-sante.fr/portail/types/FileDocument/doXiti.jsp?id=c_569712

Surveyors recruitment and training

HAS had a pool of about 800 surveyors available to the programme at the end of 2006. 1/3 are physicians, 1/3 hospital managers and the others are nurses. Each new surveyor follows a 5-day induction training.

Change management

The certification agency provides 2 categories of services to the hospitals:

- Various tools as guidelines, and
- Training

Decision and appeal

The decision:

- is delivered in average 6 months after the external assessment,
- contains 4 levels, it is certification (the certification report does not include type 1), certification avec suivi (the certification report includes at least 1 type 2), certification conditionnelle (the certification report includes at least 1 type 3) and non certification[rr],
- is valid for 4 years, and

[rr] 7 % of the hospitals obtained the certification level, 40 % certification with recommendations, 44 % conditional certification and 9 % non certification

- can be appealed by the hospital

Results diffusion

The detailed report of the hospital results is available on the HAS website.

Funding mechanism & sources

The initial development of the programme was funded by the government. Its running is ensured partly by the health organisations and partly by the government, whose support has been essential for the rapid development of the process [41]. Hospitals participate to the programme under the form of fees paid per service, which represent about 15% of the HAS total income. The cost of accreditation for small hospitals can be estimated to 1% of their total budget, for big hospitals accreditation cost are higher[ss].

The HAS total expenditure on accreditation in 2006 was about 20 millions EUR. Surveyors are paid by professional fee per day of work and reimbursement of actual expenses.

Evaluation

According to HAS, it has data to quantify beneficial impacts of accreditation on hospitals, staff and patients, collected via satisfaction questionnaires sent to the surveyed hospitals, but no statistical indicators to evaluate the performance of the programme.

For example, results of a study on the domains modified by the V1 procedure according to the hospitals' staff presented at the Journée d'Etude sur l'Accréditation, Association Belge des Hopitaux in 2007 shows that 39,5% of the questioned people totally agree with the fact that this procedure modified the patient's information.

Besides, the programme's governing body organisation has formally agreed to work towards meeting the ISQua standards since 2002.

All the hospitals eligible to participate to the programme are currently enrolled. About 750 global surveys have been performed in 2006, while more than 100 follow-up visits were done.

The Netherlands

Policy

In The Netherlands, 2 voluntary schemes are available for health care providers:

- The Netherlands Institute for Accreditation of Hospitals (Nederlands Instituut voor Accreditatie van Ziekenhuizen – NIAZ) , and
- The Harmonisation of Quality Review in Health Care and Welfare (Harmonisatie Kwaliteitsbeoordeling in de Zorgsector – HKZ) [42]

The development of Quality Management systems was supported by the government. As a consequence, quality requirements for health care organizations were laid down in the Care Institutions Quality Act in 1996. 3 steps have to be followed according to this Act [43]:

- The quality of care should be measured,
- The results of such measurements have to be evaluated against explicit standards or goals, and
- Based on this evaluation, the organization is supposed to make the necessary changes in care processes or in its quality policy

The NIAZ, a not-for-profit organisation totally independent from the government, was founded in December 1998 by[tt]:

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ss Presentation of Ph. Burnel, former Directeur de l'accréditation – HAS at the « Journée d'étude sur l'accréditation » of the Association Belge des Hôpitaux – 2 mars 2007

tt www.niaz.nl

- The Netherlands Association of Hospitals (Nederlandse Vereniging van Ziekenhuizen - NVZ),
- The Netherlands Federation of Teaching medical centres (Nederlandse Federatie van Universitair medische centra - NFU),
- The Netherlands Association of Medical Specialists (Orde van Medisch Specialisten - OMS), and
- The Pilot Project Accreditation Foundation (Stichting Proefproject Accreditatie - PACE)

The NIAZ mission is to contribute to [44]

- The assurance and improvement of the quality of health care,
- A better and more informed choice by the health care consumer, and
- Increase the accountability of health care institutions by means of an independent assessment of the quality of health care organizations on the basis of publicly accessible standards and procedures in a way that encourages quality improvement

The programme, which focuses on the whole country, includes public and private facilities. The 1st health care organisation to receive the NIAZ accreditation certificate is the Teaching Hospital in Maastricht (academisch ziekenhuis Maastricht) in 1999

Contractual requirement by purchasers and desire for improvement are motivations for these establishments to participate.

Governance

The NIAZ is organised as follow[uu]:

The Board, which counts 11 members, is composed of:

- The Nederlandse Vereniging van Ziekenhuizen - NVZ,
- The Nederlandse Federatie van Universitair medische centra - NFU, and
- The Orde van Medisch Specialisten - OMS

In addition to the board, the NIAZ also has 3 committees:

- Committee of Experts, which acts as sparring partner for the board and it keeps them posted about developments and trends in the world of quality,
- Committee for Quality Declarations, which advises the NIAZ board about awarding accreditations, and
- The Committee of Appeal

Methods

Standards

The used standards:

- were inspired by the EFQM model and the Canadian accreditation programme[45],
- were submitted to an internal consultation,
- were approved in 2005,
- are the same for all hospitals, and

uu www.niaz.nl

- cover clinical, internal support and governance processes

NIAZ accreditation is carried out according to the General Quality Standards for Health Care Organisations and the 38 departmental quality standards[vv46].

The General Quality Standards contain quality criteria about the organisational conditions for quality health care which apply to the institution as a whole.

These standards focus on 9 related areas of attention:

- Leadership,
- Strategy and policy,
- Management of employees,
- Management of means,
- Management of processes,
- Appreciation by patient and clients,
- Appreciation by employees,
- Appreciation for society, and
- Final results

In addition, 38 departmental quality standards aim to develop a quality system on a departmental level. They are target standards, so departments do not have to meet all the criteria, but they can choose relevant standards for their own quality system.

The 38 standards are divided into the following sections:

- Policy and organisation,
- Process control,
- Means and materials,
- Knowledge and skills, and
- Assurance of the quality system

Measurement

Self-assessment, scheduled external assessment by surveyors and formal survey of patients' experience are the methods used for the assessment.

The NIAZ distinguishes 3 kinds of accreditation[ww]:

- Comprehensive accreditation, which concerns the institution as a whole,
- Initial accreditation, which focuses on the hospital departments which have high safety risks, and
- Partial accreditation, which pertains to individual departments, units, services and patient care processes

The steps of the 3 kinds of accreditation are nearly identical.

For comprehensive accreditation

The 1st step is a self-evaluation based on the General Quality Standards. A report draw by the organisation describes the actual situation in relation to all the criteria in the Standards as well as the state of affairs regarding the internal audit system. This report is submitted to the NIAZ, who decides whether or not the institution is ready for a formal survey.

vv www.niaz.nl
ww www.niaz.nl

If the institution is ready for survey, several departments and processes are selected for further investigation. The entire institution will next be visited by a team of surveyors with a special interest on the selected departments and processes. The survey team will then produce an accreditation report, which will be the basis for the surveyed organisation to draw up its action plan. The NIAZ's Quality Declaration Committee next decides on the basis of the accreditation report and the action plan whether the organisation meets the necessary conditions for accreditation.

1 year after the accreditation certificate has been awarded, the auditors monitor the implementation of the action plan on the basis of the organisation's latest proceedings and of a 1-day visit. This finally results in a follow-up accreditation report. On the basis of this report, the Quality Declaration Committee decides whether the institution is carrying out its action plan to a satisfactory level. The decision whether the accreditation certificate will be continued or not is then taken by The NIAZ board.

For a 100-bed hospital, the duration of self-assessment and preparation for external survey is usually 9 months. 4 days would usually be required for an external visit performed by a 5-person team composed of members of the Board of Directors or management, departmental heads, medical specialists, non-staff managers or quality officials and supervised by a chairman. All of them are thoroughly familiar with the working of health care organisations. The survey team report back key findings to the senior management of the hospital before leaving. The draft survey report is referred back to the hospital for factual confirmation before submission for accreditation award.

For Initial accreditation

The institution selects the processes which the auditors will examine during the site visit. It includes:

- At least 1 clinical process,
- 1 non-clinical process,
- All the departments with high safety risks,
- 1 nursing department, and
- 1 outpatient clinic

An institution can only apply for initial accreditation once and it has to apply for comprehensive accreditation within 4 years after completing the initial accreditation process in order to retain the accreditation certificate.

For partial accreditation

The organisation selects processes for accreditation which include, at the very least, the core departments of the institution.

Surveyors recruitment and training

170 trained surveyors were available for the programme at the end of 2006, and 45 of them were trained in 2006. The new surveyors are selected from people in the hospitals and follow an induction training of 2,5 days.

Change management

A handbook and scorebook were developed along with the General Quality Standards for Health Care Organisations.

The handbook is available to help health care organisations in carrying out their self-evaluation, whereas the scorebook is available to help the auditors during the auditing process[xx]. Besides, the NIAZ provides training services to the hospitals.

xx www.niaz.nl

Decision and appeal

The final report is delivered 60 days after the external survey. The decision taken is:

- binary, i.e. accredited/not accredited,
- valid for 4 years, and
- appealable by the hospital

Results diffusion

The names of the participating and accredited hospitals are available to the public on the internet.

Funding mechanism & sources

Professional associations funded the initial development of the accreditation programme. Hospitals pay the accreditation programme with an annual flat fee, which depends on the size of the hospital (small, medium or large). All hospitals are attributed to one of these categories[yy].

For a 100-bed hospital, the start fee payable for an accreditation survey in 2006 was 39.208 EUR excluding VAT and the annual contribution was 9.802 EUR excluding VAT. These fees include facilitation and preparation, expenses of survey team, accreditation decision and certificate. In 2006, they generate 95% of the NIAZ total income.

The surveyors are paid by professional fee per day of work and reimbursement of actual expenses.

Evaluation

There is no data to quantify beneficial impacts of accreditation on hospitals, staff or patients and the programme does not use statistical indicators to evaluate its performance. However, in 2006 the decision was taken it will work to meet ISQua standards.

65% of hospitals eligible to participate are currently enrolled in the programme. In 2006, 24 on-site visits were achieved.

United Kingdom[zz]

Policy

Inspired by experience in Canada and Australia, 2 separate hospital-wide programmes were set up without government funding, support or recognition in 1990 [27]:

- The 1st one developed into the Health Quality Services (HQS) providing accreditation across the spectrum of public and private services. HQS was the 1st programme in Europe to be awarded international recognition by the ALPHA Council.
- The 2nd, the Hospital Accreditation Programme covered independent and NHS facilities and changed its name to Healthcare Accreditation Programme (HAP). The HAP standards were accredited by ALPHA in 2003.

These 2 independent programmes have been combined into the Healthcare Accreditation & Quality Unit (HAQU), which belongs to the CHKS, a commercial provider of comparative information and quality improvement services. Participation in accreditation with the HAQU is voluntary.

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yy www.niaz.nl

zz For this study, given the 'own identity' of the Scottish programme we have separated the UK programmes from the Scottish which is treated further in the report.

The HAQU, whose aim is to improve the quality of care, is now an independent agency with government representation. Its governing body is determined by adopted constitution.

A 2nd accreditation programme, the Healthcare Commission, has been established in 2004, and focuses on independent healthcare providers in England (yet also includes public NHS providers) with a compulsory character. The Healthcare Commission has a legal status of government agency and is managed within the Ministry of Health. Enabling legislation determines the composition of its governing body.

Both programmes include private and public facilities. The HAQU focuses on UK while the Healthcare Commission focus on England, and Wales for some functions.

In terms of incentives, desire for improvement is mentioned as motivator to participate to the HAQU while statutory requirement represent the central element for Healthcare Commission.

Governance

Users and clinical professionals are stakeholders represented in the Healthcare Commission's governing body. Concerning the HAQU, the composition is different with mainly clinical professionals and academic institutions represented.

Methods

Standards

Both the standards for the Healthcare Commission and HAQU differ depending on the character of the hospital (e.g. private, mental health, etc.)

For the HAQU[aaa]

In 2006, 13 developmental standards that all healthcare organisations that treat NHS patients should be working towards achieving in the future were published by the Department of Health and approved by the governing body. These developmental standards are in addition to the 24 core standards that they should already be achieving.

The core standards cover 7 areas of activity:

- Safety,
- Care environment and amenities,
- Clinical and cost effectiveness,
- Governance,
- Patient focus,
- Accessible and responsive care, and
- Public health

For the Healthcare Commission[bbb]

The national minimum standards consist of 32 core standards, which must be met by all registered providers, as well as a range of service specific standards for different types of establishments such as acute hospitals, providers of mental health services, and organisations that use lasers for treatment.

The standards reflect statutory requirements and recognised best practice, with a focus on the patient's journey, clinical issues and include non-clinical factors that impact on the quality care.

aaa www.chks.co.uk
bbb www.healthcarecommission.org

Measurement

The Healthcare Commission has unannounced external surveys for the assessment, whereas the HAQU follows a more 'common' approach by conducting a planned external assessment after a self assessment has been completed and submitted by the hospital.

Concerning the HAQU programme, 12 months is the normal duration for self-assessment and preparation for external survey for a 100-bed hospital. 3 days are required for a full on-site survey performed by a 4-person team composed of experienced healthcare professionals drawn from acute, mental health, primary, secondary or tertiary services from both the NHS and independent sectors and include clinicians (consultants, GPs and nurses), managers (chief executives, directors, service and departmental managers) and allied health professionals. The survey lasts 1 day for the Healthcare Commission programme but the composition of the visiting team is not standardized.

All programmes conclude their assessment on site with a feedback to the hospital in terms of the results but the draft survey report is referred back to the hospital for factual confirmation only for the HAQU programme.

Surveyors recruitment and training

At the end of 2006, 420 surveyors were available for the HAQU programme whereas 180 were available for the Healthcare Commission. Concerning the induction training of new surveyors, 2 days are necessary for the HAQU programme while only 1 day is required for the Healthcare Commission.

Change management

The HAQU provides several services to the hospitals:

- Tools such as guidelines, checklists, methodologies, etc,
- Training, and
- Advice on implementation of the process but this is not consultancy to advice on meeting the standards

Decision and appeal

The accreditation decision for the HAQU programme accredited hospitals is binary. The accreditation validity is 3 years for the HAQU and 5 years for the Healthcare Commission. The establishment can appeal the decision in the 2 programmes.

Results diffusion

The HAQU does not publish survey reports on the internet while the Healthcare Commission diffuses following information for the public sector institutions only:

- Name of the participating hospital,
- Name of the accredited hospital,
- Summary report of the results of the hospital, and
- Detailed report of the results of the hospital

Funding mechanism & sources

The Healthcare Commission programme was initially funded by the central government. The HAQU was funded by voluntary sector.

Hospital pay the accreditation per service or product provided for HAQU. Accreditation for a 100-bed hospital undergoing the programme by HAQU cost 26.500`EUR in 2006, while the fee was about 37.000 EUR for the Healthcare Commission accreditation. These fees cover self-assessment documentation, facilitation and preparation, expenses of survey team and accreditation decision and certificate for both programmes. It covers also induction of hospital staff for the HAQU programme.

In 2006, 70% of the HAQU total income was generated by fees paid for accreditation surveys, whereas it was around 10% for the Healthcare Commission.

The total expenditure on accreditation in 2006 was 1.562.000 for the HAQU and about 60 millions EUR for the Healthcare Commission.

Surveyors are paid by reimbursement of actual expenses for the HAQU and by professional fee per day of work for the Healthcare Commission.

Evaluation

The HAQU does not have data available to quantify beneficial impacts of the accreditation programme. The Healthcare Commission has announced a full evaluation to be published during summer 2007.

On the 450 hospitals eligible to participate in the HAQU programme, 73 are currently enrolled to the programme. 68 on-site visits were performed in 2006. Concerning the Healthcare Commission, all eligible hospitals are already enrolled in the programme.

Ireland

Policy

The Irish accreditation programme is called "Irish Health Services Accreditation Board" (IHSAB) and functions on a voluntary basis. Initially, a 1-year project (1999-2001) was implemented to develop an Accreditation Scheme for the acute health services. It first involved the Major Academic Teaching Hospitals (MATHs) and was then rolled out by the Irish Health Services Accreditation Board throughout the acute healthcare sector with planned extension to all other healthcare entities [27]. Since May 2007, the Irish Health Services Accreditation Board is part of the new Health Information and Quality Authority (HIQA), which was established on a statutory basis in following the signing into law of the Health Act 2007[ccc].

HIQA is responsible for driving quality and safety in Ireland's health and social care services through:

- Setting Standards in Health and Social Services,
- Monitoring Healthcare Quality,
- Social Services Inspectorate,
- Health Technology Assessment, and
- Health Information

The accreditation organisation has now the status of an independent agency with government representation and the composition of its governing body is determined by enabling legislation.

Its aim is to improve the quality of health and patient safety and it is the desire of improvement which is identified as a motivation for the participation to the programme.

Governance

The stakeholders nominated as representatives on the governing body are:

- Users (e.g. patients, relatives, etc.),
- Clinical professionals (e.g. nurses, doctors, etc.),
- Hospital owners, and
- Academic/training institutions

[ccc] www.hiqa.ie

Methods

Standards

Accreditation schemes are currently provided in acute care[47] and palliative care[48]. A new hygiene standard was introduced in 2006.

The used standards:

- were inspired by the Canadian accreditation model,
- were submitted to the consultation of stakeholders' organisations and public at large,
- were approved in 2004 by the governing body,
- are generic for all types of hospitals, and
- cover clinical, internal support and governance processes, and more specifically Leadership and Partnership, Information Management, Human Resources Management, Environmental Management and Care / Service

2 revisions of the standards have already been published.

Measurement

The programme uses self-assessment, periodic statistical reporting, as well as scheduled external assessment by surveyors and formal survey of patients' experience to assess hospitals.

The 1st step is a self-assessment against a set of internationally recognised standards. For a 100-bed hospital, 6 months is the normal duration of self-assessment and preparation for external survey. Once this step is achieved, a survey aims to validate the self-assessment, to identify the organisation's strengths and to offer suggestions for improvement. It includes provision for documentation review, interviews with self-assessment teams, patients/clients, staff and tours of the relevant facilities[ddd.]

This external assessment:

- is held into 3-4 days for a 100-bed hospital,
- is performed by a team of 4-5 trained surveyors composed of doctors, nurses and managers accompanied by trainee surveyors and new staff members,
- ends with a verbal feedback from the team, and
- is followed by the submission of the draft report to the hospital for comments

Surveyors recruitment and training

At the end of 2006, 80 trained surveyors were available for the programme, which 30 of them completed the training in 2006. Each new surveyor receives an induction training of 2 days.

Change management

Training and tools such as guidelines, checklists, methodologies, etc. are services provided by the accreditation organisation to the hospitals.

Decision and appeal

The decision has the following characteristics:

- Delivery 1,5 month after the on-site survey,

ddd www.hiqa.ie

- Alternatives of an accreditation decision exist (pre-accreditation),
- Validity of 3 years, and
- Possibility to appeal the decision

Results diffusion

Reports are available to public on the website of the Health Information and Quality Authority.

Funding mechanism & sources

The programme was initially funded by the central government and does not charge users for its services.

In 2006, the total expenditure on accreditation was 3.500.000 EUR. Surveyors are reimbursed for their actual expenses.

Evaluation

A study to assess the effectiveness of accreditation is currently performed by an external party (3-year programme) but the results are not yet available. Besides, the accreditation programme agreed to work towards meeting the ISQua standards in 2004 and was in the process of getting ISQua accreditation in 2006[49].

51 hospitals are eligible to participate in the programme and 44 of them are currently enrolled in it. In 2006, 7 visits have been performed.

Scotland

Policy

The NHS Quality Improvement Scotland (NHS QIS) was established in 1999, integrating the Clinical Standards Board for Scotland and the Scottish Health Advisory Service. All NHS hospitals in Scotland are required to implement the standards produced by NHS QIS[eee].

The accreditation organisation is a not-for-profit organisation managed within the Ministry of Health. The composition of its governing body is determined by enabling legislation.

NHS QIS now focuses on all Scottish public and private facilities.

Statutory requirement, contractual requirement by purchasers and the desire to improve the quality of healthcare provided to the patients are motivations for hospitals to participate to the programme.

Governance

Users and clinical professionals are represented on the governing body.

Methods

Standards

The design of initial standards where inspired by the EFQM model.

The currently used standards:

- were submitted to the consultation of stakeholders' organisations and public at large,
- were approved in 2006,

eee www.nhsqis.org.uk

- are topic specific and apply within all hospitals providing the service (e.g. coronorary heart disease, stroke, clinical governance and risk management)

Measurement

The process involves NHS Boards completing a self-assessment and submitting this along with documentary evidence to support the assessment. This is then validated by peer review teams through on-site reviews and discussions with staff[fff].

For a 100-bed hospital, the self-assessment takes place over a 2 to 3 months period depending on the complexity of the standards being reviewed. NHS QIS reviews take place from 1 to 3 days, also depending on the topic being reviewed. Visiting teams vary from 6 to 15 members, are adapted in function of the topic being reviewed and are accompanied by observers such as new staff members as part of their induction or observers from other accreditation agencies (Health Inspectorate Wales, Northern Ireland Inspection & Regulation Authority as well as Audit Scotland, etc.). The team report back key findings to the senior management of the hospital before leaving and the draft report is referred back to the hospital for factual confirmation before submission for accreditation award.

Surveyors recruitment and training

In 2006, more than 700 trained surveyors were available to the programme. 90 of them achieved the training in 2006.

For new surveyors, half a day induction is provided which covers the role of the reviewer, the ethos of NHS QIS and background to the review process.

Change management

A range of tools (e.g. standards, audits, best practice statements, guidelines and health technology assessments to support the NHS in Scotland) is provided to the hospitals via the website.

Decision and appeal

The target turnaround time between the on-site visit and the delivery of the final survey report and recommendations is 8 weeks. NHS QIS bases its decision on a quality improvement rather than a "pass/fail" approach, has a range of assessment ratings which are specifically related to the topic being reviewed and gives the opportunity to the hospital to appeal the decision. It does not give awards.

Result diffusion

The summary reports of the results are available to the public on the web.

Funding mechanism & sources

NHS QIS programme was initially funded by the central government. The accreditation services provided by the Scottish programme are free of charge to the hospitals and the peer review is for free as well.

Evaluation

The NHS QIS states that it has recently undertaken an impact assessment of its work which will be published shortly. It has not agreed to work towards meeting ISQua standards.

All hospitals within NHS Scotland are currently enrolled in the programme.

fff www.nhsqis.org.uk

Spain

Policy

Responsibility for health care in Spain has been devolved to the 17 autonomous regions since 2002 (with some regions achieving autonomy much earlier), giving rise to 17 different policies on quality of care. This means that different quality concepts are adopted amongst which hospital accreditation by some regions. A total of 12 out of the 17 regions have introduced a Quality Plan as part of their strategic objectives. Prior to any regulation, in 1981, Catalonia engaged already in an accreditation programme which turned out to be the 1st in Europe. Next, in 1986 the Law on Consolidation of the National Health System formed the basis for accreditation to be developed within the autonomous regions [6]. For accreditation programme in itself there is no specific legislation [27].

It seems that a programme focusing on entire Spain, FADA - JCI, exists in parallel with regional accreditation programmes. This programme exists since 1996.

Currently there are 7 regions that do carry out accreditation programmes, yet in the context of this survey we received feedback from the following 3 regions:

- The region of Catalonia, since 1981,
- The region of Andalusia, since 2003, and
- The region of Valencia, since 2004, based on the corresponding legal text 'DECRETO 14/2002'

Spain does not have a national intention or policy, which has resulted in regions engaging or not in accreditation to their own definition and interpretation.

Whereas the Valencia region applies voluntary programme, for the public healthcare hospitals in Andalusia and Catalonia [42] accreditation is compulsory. Each of the programmes covers all hospitals in the region.

The FADA - JCI programme's accreditation body, a not-for-profit organization, is totally independent of the Ministry of Health.

In Catalonia there are no fully independent regulatory bodies. The regulatory functions are carried out through informal relationships between the Ministry of Health, the quasi-independent CatSalut and a mix of independent and state-owned providers. Quality accreditation of providers is the responsibility of a department within the Ministry of Health. The accrediting body is the Catalan Ministry of Health, which uses standards set by a commission of experts[42].

In Andalusia the Health Quality Agency is an independent organisation with government representatives which belongs to the Ministry of Health for the Andalusian Regional Government.

The Valencian Instituto para la Acreditación y Evaluación de la Prácticas Sanitaras (INA CEPS) is the health accreditation body in the Valencian Autonomous Region. It was founded in 2002 by the Valencian Government. The agency is independent in decision making, which is 'guaranteed' by the existence of 2 commissions:

- A sub commission comprised of members of scientific societies, patients and professional associations, and
- A Commission which approves the proposed decision regarding the accreditation

Governance

The FADA - JCI programme's governing body is represented by clinical professionals, regulators and academic institutions.

Methods

Standards

Apart from Valencia, the applied standards are generic for all hospitals. In Valencia there is a customization in function of the specialisation of the hospital to be accredited.

The standards in all programmes relate to clinical processes, internal support processes and governance processes and aim for performance targets.

Measurement

Self-assessments and external assessments are part of the accreditation process, with formal survey of patients' experience being part of the process as well for Andalusia and Valencia regions.

This external assessment will:

- Last about 3 days for a 100-bed hospital, with Valencia being an exception with 5-6 days,
- Be performed by a team composed of different profiles including management, nursing and doctors, and
- End with a verbal feedback from the surveyors, to the exception of Andalusia

Surveyors recruitment and training

14 trained surveyors were available to the FADA - JCI programme at the end of 2006 while Andalusia and Valencia respectively counted 32 and 83 surveyors.

Change management

Tools such as guidelines, checklists, methodologies, etc. and training are services provided by the all accreditation organisations to the hospitals. Valencia proposes also consultancy services.

Decision and appeal

The decision for the FADA - JCI programme is binary, whereas the regions of Andalusia and Valencia have different levels of accreditation with respectively 4 and 3 levels. For all programmes answered in the survey, there is an appeal mechanism allowing the hospital to question the taken decision. Accreditation is valid for a period of 3 years except for Andalusia, where a cycle of 5 years is applied.

Results diffusion

The final results of the national programme and Andalusia region are available to the public but this contains basically a listing of the names of the hospitals that have been accredited, and not detailed reports per hospital. For Valencia, the summaries for those hospitals for which the decision was positive are available as well. For Catalonia, the results are not public accessible [27].

Funding mechanism & sources

Whereas the FADA - JCI programme was initially funded by the sector, the different regional programmes were all financed by the local/regional governments. In all programmes, the accreditation is not free of charge to the hospitals i.e. the hospitals pay per products or service provided. For a 100-bed hospital for Andalusia the fee for participation in the accreditation amounted to 14.000 EUR in 2006 whereas this fee ranges between 8.000 – 12.000 EUR in Valencia.

The total expenditure for accreditation was 188.760 EUR in 2006 for the Andalusian accreditation organisation.

Evaluation

None of the Spanish programmes have data available to quantify the beneficial impacts of accreditation on hospitals staff or patients. Since 2005, the FADA - JCI programme

formally agrees to work towards the ISQua standards. Also Andalusian standards intend to comply with the ISQua standards whereas Valencia expressed in the survey their interest in it.

Portugal

Policy

Portugal is an exceptional country among the other European Member states in terms of the accreditation policy applied. It started a national accreditation programme in 1999 for hospitals with technical support from the UK Health Quality Service (UK - HQS) and funding from the Ministry of Health [27]. The initial idea was to leverage the UK – HQS experience for a limited duration, basically to get the programme started, yet until now Portugal still works with the 'outsourcing' mode. The Portuguese accreditation programme is voluntary and currently leaves the choice to the hospitals to either work with the UK - HQS[ggg], or with the Joint Commission programme (JCI). Until 2006, the accreditation programme was addressed to the public hospitals[50].

Portugal does not have a law specifically addressing accreditation, but there is enabling legislation for an agency fulfilling several functions, 1 of which is accreditation. To date this is the UK - HQS governing body [4].

In terms of incentives, additional funding and desire for improvement are specific incentives for hospitals to participate. Yet the fact that the National Health Service will contract only with those facilities that have been accredited will definitely play an important role in the participation of Portuguese hospital [50].

Governance

According to the survey response, although the services are currently outsourced, Portugal still has the intention to move away from the UK -HQS governing body and 'activate' its own government agency.

Methods

Standards

In the process of developing the initial set of standards professional associations, training institutions, the Department of Health and Consumer organisations were consulted. 3 revisions of the standards have been carried out so far. These standards are generic for all hospitals.

Measurement

Self-assessment and external assessment are the methods used to evaluate hospitals.

This external assessment will:

- Follow a self-assessment of 12-16 months,
- Last 3-4 days,
- Be performed by a 4-5 persons team composed of managers, doctors, nurses and technicians including peers as physiotherapists of pharmacists accompanied by trainee surveyors,
- End with a verbal feedback from the surveyors,
- Be followed by the submission of the draft report for comments before the decision

Surveyors recruitment and training

48 surveyors were available at the end of 2006. An induction training of 4 days is planned for the new surveyors.

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ggg UK – HQS is now part of CHKS Healthcare Accreditation & Quality Unit (HAQU)

Change management

Training, consultancy and tools such as guidelines, checklists, methodologies, etc. are services provided by the accreditation organisation to the hospitals.

Decision and appeal

Accreditation is valid for a period of 3 years. The decision can be appealed by the hospital according to the UK - HQS and JCI procedures.

Results diffusion

The results of the survey are not publicly published. The results are confidential to the organisation and the surveyors formulate recommendations on the report [50].

Funding mechanism & sources

The initial programme was partially funded by the Government [6] Hospitals do pay annual subscription for the UK - HQS programme and per service or product provided for the JCI. For a 100-bed hospital the participation in the UK - HQS accreditation programme cost about 50.000 EUR in 2006.

Evaluation

There is no data available in Portugal to quantify the beneficial impacts of accreditation on hospitals, staff, or patients. With the accreditation carried out by the UK HQS and JCI there is a commitment in Portugal to meet ISQua standards [27].

Germany

Policy

In 1999, an independent voluntary accreditation programme for hospitals, the Kooperation für Transparenz und Qualität im Krankenhaus - KTQ was established with the collaboration of federal medical chamber, insurers and the board of the German Hospital Federation. Because the programme expanded to include primary care, it changes its name in 2004 from Krankenhaus to Gesundheitswesen[hhh]. The Kooperation für Transparenz und Qualität im Gesundheitswesen - KTQ-GmbH is totally independent from the government and is an organization with limited liability, in conjunction with the appointment of a full-time chief executive, as illustrated on the schema.

This certification procedure, which is an active program without legislation, concerns[iii]:

- Hospitals,
- Doctors surgeries,
- Dental surgeries,
- Psychotherapy centres,
- Rehabilitation centres,
- In-patient (including partly in-patient) health care facilities,
- Ambulatory care services,
- Hospices, and
- Alternative residential arrangements

Laid down in the KTQ manual, it provides hospitals with the impetus for implementing new elements in quality management based on analysis and further development of existing structures and working processes (increased motivation).

hhh www.ktq.de
iii www.ktq.de

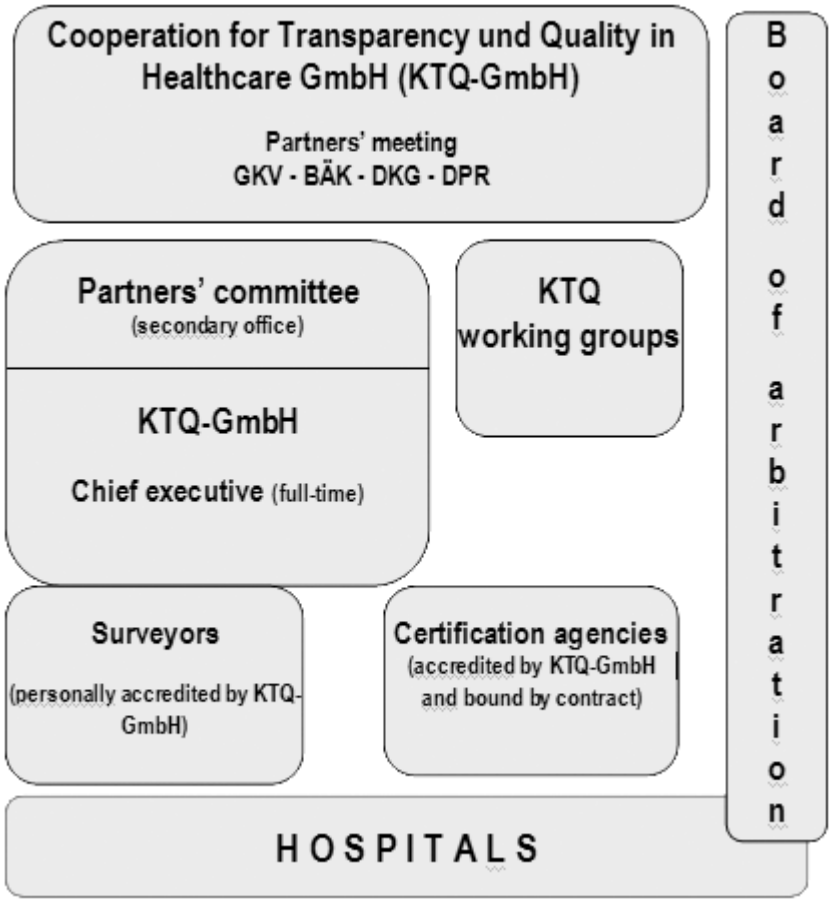
The aims of this certification procedure are:

- To motivate the management and the staff of the given facility, and
- To implement and constantly improve an internal quality management system focussed on the patient

Governance

The KTQ-GmbH is organised as follow:

Figure 4: Organization of KTQ-GmbH



Source: www.ktq.de

Methods

Standards

The KTQ certification procedure is based on proven international standards, the most important of which include the following[jjj]:

- Australian Council on Healthcare Standards,
- Joint Commission on Accreditation of Healthcare Organisations, and
- The Canadian Council on Health Services Accreditation

jjj www.ktq.de

Measurement

The evaluation process is composed of 3 steps: self assessment, external visit and reporting[kkk].

The self-assessment, which is an assessment of the situation of the hospital in term of a "present state" analysis, helps to get information about fulfilment of KTQ criteria in term of:

- Patient orientation,
- Employee orientation,
- Safety in the hospital,
- Information,
- Hospital management, and
- Quality management

After this self-evaluation, the hospital may apply for an external evaluation. It consists in a visit of the facility by professional visitors from the medical, financial and nursing care management sections, based on the self-assessment.

During this external assessment:

- Specific points in the self assessment are randomly selected for reviewing by external surveyors,
- Selected area of the hospital are inspected, and
- Some employees are invited to participate to interview

During this external assessment, the KTQ certification agency is responsible for administrative and organizational tasks. These include the following:

- Checking of application documents, self-assessment report including quality report in terms of fulfilling certification requirements,
- Assembling a survey team according to the guidelines of KTQ-GmbH,
- Coordinating the on-site visitation schedule,
- Provision of an on-site survey chairperson,
- Production of the KTQ survey report and KTQ quality report based on the KTQ surveyors' statements,
- Coordination of certification, and
- Monitoring the certification procedure schedule

To get the certification, the hospital has to:

- Attain at least 55 percent of the "adjusted" total point score per category,
- Demonstrate participation in external quality assurance procedures required by law, and
- Ensure publication of the KTQ quality report

Surveyors recruitment and training

The members of the survey team have to complete a KTQ surveyor training.

kkk www.ktq.de

Decision and appeal

3 different cases can occur[lll]:

- A certificate which is valid for 3 years is issued after a successful external evaluation,
- For hospitals whose score deviates by only a maximum of 5 % from the required percentage, an option is given of a follow-up survey to achieve the necessary score and thus fulfil requirements for certification. The criteria which must be improved in order to be eligible for certification should receive a measurably higher score during the follow-up survey than at the time of the first onsite visitation. Surveyors select especially those criteria which received less than 55% of the maximum score during the 1st survey. The hospital is given a maximum of 9 months to address the selected criteria and complete the KTQ external survey, and
- If the hospital and surveyors are unable to reach agreement during external assessment concerning the contents of the KTQ quality report or if the certification decision is appealed, the KTQ arbitration procedure is available

The board of arbitration is composed of 5 members:

- 1 person from the German Medical Association (Bundesärztekammer),
- 1 person from the German Hospital Federation (Deutsche Krankenhausgesellschaft),
- 1 person from the German Nursing Council (Deutscher Pflegerat),
- 1 person from the umbrella associations of statutory health insurers, and
- 1 non-partisan chairperson, who is a qualified judge

The decision of the board of arbitration is taken according to majority vote of those present and entitled to vote. In case of no majority, the deciding vote is cast by the chairman. The decision of the board of arbitration is final, there is no legal recourse.

Results diffusion

The KTQ quality report, which describes the concrete achievements and structural data of the hospital and the certificate are issued at the same time. The report is published by both the certified hospital and KTQ. Besides, the hospital decides whether it would like to make public its participation in the certification procedure during the assessment[mmm].

Funding mechanism & sources

Funding of the programme comes from professional associations [4].

Latvia

Policy

The programme called "Conformity assessment of health care organizations" began its 1st development in 1998 and is based on minimal standards. In Latvia, the 1997 Law on Medical Treatment defines mandatory conformity assessment of all health care organizations. The assessment, in accordance with national mandatory requirements for health care organizations, is mostly focused on structural criteria and quality system elements. The Health Statistics and Medical Technology Agency is authorized by the Cabinet of Ministers to provide it [27].

lll www.ktq.de
mmm www.ktq.de

At present, the Health Statistics and Medical Technologies State agency, which is structured in 6 departments, includes the department "Conformity assessment" which manages the accreditation programme. The composition of its governing body is determined by adopted constitution.

The aim of the programme is to improve the safety and quality of the healthcare services provided in the institutions[nnn]. It focuses on Latvia and includes public and private facilities.

Statutory requirement and contractual requirement by purchasers are key elements that motivate establishments to participate. Moreover, a positive evaluation implies obtaining money from the state, whereas a negative evaluation will generate the closure of the hospital.

Governance

There is no external representatives nominated at the governing body, but it is under discussion for changes.

Methods

Standards

The current standards:

- were submitted to the consultation of stakeholders' organisations,
- were approved in 2002 by the governing body,
- are generic for all hospitals, and
- cover internal support and governance processes

2 full revisions of the standards have been published.

Measurement

External assessment is the method used by the programme to evaluate hospitals.

This assessment:

- is preceded by a self-assessment which lasts in average 6 months for a 100-bed hospital,
- requires 1 day for the on-site visit,
- implies the participation of 4-person survey team composed of managers and doctors, and
- ends with the key findings reporting of the team to the hospital's senior management

Surveyors recruitment and training

120 trained surveyors were available to the programme at the end of 2006. 8 of them achieved the training in 2006. The classroom induction training of a new surveyor lasts 2 days.

Change management

Training is a service provided by the accreditation organisation to the hospitals.

Decision and appeal

The decision is:

- given 10 days after the external assessment,
- binary (accredited/not accredited),

nnn www.vsmtva.gov.lv

- valid for 5 years, and
- appealable

Results diffusion

The hospital results are diffused towards the public under the form of the accredited hospitals' names.

Funding mechanism & sources

The programme was initially funded by the Latvian government. Hospitals pay the accreditation programme per service or product provided. In 2006, 450 EUR was charged for an accreditation survey in a 100-bed hospital including survey team's expenses and accreditation decision and certificate. These fees represented 100% of the accreditation organisation's total income in 2006.

150.000 EUR was the total expenditure on accreditation in 2006. Surveyors are paid by professional fee per day of work.

Evaluation

The programme does not have any data to quantify beneficial impacts of accreditation on hospitals, staff or patients and does not use statistical indicators to evaluate the performance of the accreditation programme. Besides, It does not seek commitment with the ISQua standards.

105 hospitals are eligible to participate in the programme and are currently enrolled. In 2006, 30 full on-site visits were done.

Poland

Policy

Institutionalisation of quality improvement started in Poland when the National Centre for Quality Assessment in Health Care (NCQA) was created in 1995 with technical support from USAID and JCI. The voluntary "Program Akredytacji Szpitali" began his 1st development at this time.

The status of the accreditation organisation is a separate government agency and the composition of its governing body is determined by enabling legislation.

The Polish programme focuses on the whole country and includes public and private facilities.

The participation of the hospitals is motivated by contractual requirement by purchasers, desire for improvement and additional funding. Indeed, the lack of financial incentives has been a problem for a broader implementation of the accreditation programme, so 3 regions in Poland offered financial incentives to accredited hospitals. In Silesia, where this policy was the most developed, accredited hospitals received an increase of their overall budget comprised between 3 and 5% between 1999 and 2002 [41].

Governance

Clinical professionals (e.g. nurses, doctors), regulators (e.g. licensing authorities) and academic/training institutions are stakeholders nominated as representatives on the governing body.

Methods

Standards

Considering the program was supported by the United States, the initial standards were inspired by the JCAHO standards.

The currently used standards:

- were submitted to the consultation of stakeholders' organisations,

- were approved in 1998 by the governing body, and
- are standardised for all the hospitals

2 full revisions of the standards have been published.

Measurement

The programme uses external assessment by surveyors to evaluate the hospital.

This assessment:

- is preceded by a self-assessment which last in average 6 months for a 100-bed hospital,
- lasts usually 2 days,
- is performed by a 4-person team composed of managers, doctors and nurses accompanied by trainee surveyors and new staff members,
- ends with an oral feedback from the team, and
- is followed by the sending of the draft report to the hospital

Surveyors recruitment and training

22 trained surveyors were available to the programme at the end of 2006. 3 days are necessary for induction training of a new surveyor.

Decision and appeal

The decision:

- is taken 1 month after the external visit,
- is valid for 3 years, and
- can be appealed by the hospital

Results diffusion

Information is not available to the public.

Funding mechanism & sources

International aid and central government funded the initial development of the accreditation programme. Hospitals pay the accreditation programme with an annual subscription, which was about 4.000 EUR for a 100-bed hospital in 2006 and covered expenses of survey team and accreditation decision and certificate.

The total expenditure on accreditation for the accreditation organisation in 2006 was 141.538 EUR. Surveyors are paid with professional fee per day of work.

Evaluation

The programme does not have any data to quantify beneficial impacts of accreditation on hospitals, staff, or patients, and does not use statistical indicators to evaluate its performance. However, it agreed to work towards meeting the ISQua standards in 2005.

750 hospitals are eligible to participate in the programme, and 13% of them are enrolled in it. In 2006, 23 on-site visits were achieved.

Czech Republic

Policy

The "National accreditation programme for inpatient healthcare organizations" began his first development in 1998 in Czech Republic. Participation to this programme is voluntary.

The legal status of the accreditation organization is a commercial entity but it will change to a not-for-profit organisation in a near future. It is totally independent from the government and the composition of the governing body is determined by an adopted constitution.

The programme covers the entire Czech territory and now includes private and public facilities.

There are 2 main motivators for hospitals to participate:

- Marketing i.e. prestige;
- Anticipation of future government policies which might favour accredited organizations.

Governance

Delegates from the 2 Czech hospital associations are now nominated as representatives on the programme's governing body but this situation will change in a near future as all stakeholders (patients, payers, foreign experts, etc.) will join them.

Methods

Standards

The current edition of the standards:

- were inspired by the accreditation model, more precisely JCAHO standards,
- were submitted to the consultation of the stakeholders' organisations,
- were approved in 2005 by the governing body, and
- are generic for all the hospitals

2 full revisions of the standards have already been published.

Measurement

Czech Republic uses the external assessment to evaluate hospitals. This one:

- is preceded by a self-assessment which lasts in average 12 months for a 100-bed hospital,
- lasts usually 2 days,
- is led by a 3-person team composed of management representatives, doctors and nurses accompanied by trainee surveyors,
- is concluded by an oral feedback from the team, and
- does not include the submission of a draft report to the hospital for comments

Surveyors recruitment and training

In 2006, 7 trained surveyors were available to the programme and 3 of them completed the induction training. This training lasts 3 days and consists in observation of 2 surveys followed by the realization of a survey.

Decision and appeal

The hospital usually receives the final survey report 1 month after the on-site visit.

The decision:

- is valid for 3 years, and
- can be appealed by the hospital

Results diffusion

The names of the accredited hospitals are available to public upon agreement of the surveyed organisation.

Funding mechanism & sources

International aid funded the initial development of the accreditation programme but hospitals must pay a fee to the accreditation organization per product or service provided. This one was about 3.000 EUR for a 100-bed hospital in 2006 and includes facilitation and preparation, expenses of the survey team and accreditation decision and certificate. The totality of the fees generated about 70% of the accreditation organisation's income in 2006.

The total expenditure of this organisation on accreditation was 30.000 EUR in 2006. Surveyors are paid by professional fee per day of work and reimbursement of actual expenses.

Evaluation

The programme does not have data to measure the impact of accreditation and does not use statistical indicators to evaluate its performance. However it agreed to work towards meeting ISQua standards in 2005.

On the 200 hospitals eligible to participate to the programme, 62 are currently enrolled whose 12 accredited. In 2006, 5 on-site visits were performed.

Bulgaria

Policy

Bulgaria has a mandatory accreditation programme based on minimal standards since 2000, called "Accreditation of hospitals and diagnostic-consultative centers".

The Health Facilities Act of 1999 first mentions it, as it established hospitals as independent companies whose transformation and performance would in future be accredited. The accreditation modalities were laid down in Regulations for Accreditation of 2000, which were then updated and incorporated in the Public Health Act of 2002 [27]. The programme is currently run by an independent agency with government representation of the Ministry of Health. The composition of its governing body is determined by an enabling legislation.

It targeted all the hospitals of the Bulgarian territory at the beginning but is now restricted to the public hospitals only.

Academic recognition and statutory requirements are the 2 elements identified as motivators by the accreditation organization to participate to the programme.

Governance

Hospitals owners are nominated as representatives of the programme's governing body.

Methods

Standards

The initial standards were:

- inspired by the ISO model, and
- not submitted to any consultation

The currently used standards:

- were approved in 2001 by the governing body,
- are generic for all types of hospitals, and
- cover clinical processes only

Measurement

Bulgaria uses the external assessment to evaluate hospitals, which:

- is preceded by a self-assessment which lasts usually 6 months for a 100-bed hospital,
- lasts in average 5 days,
- is performed by a 5-person multidisciplinary team composed of doctors, nurses, lawyers and economists accompanied by trainee surveyors,
- ends with a verbal feedback from the team, and
- is followed by the sending of a draft report to the hospital for factual confirmation

Surveyors recruitment and training

The surveyors:

- were about 400 at the end of 2006, and
- follow a 14-day training after their recruitment

Decision and appeal

The target turnaround time between the on-site visit and the delivery of the final survey report is 2 months.

The decision has following characteristics:

- binary, it is accredited or not accredited,
- valid for 3 to 5 years, and
- not appealable by the hospital

Results diffusion

No information is diffused towards the public regarding the survey results.

Funding mechanism & sources

International aid funded the initial development of the accreditation programme. At present, the running of the programme is partially covered by the hospital fees, which was 526 EUR for a 100-bed hospital in 2006.

Surveyors are paid on the basis of a professional fee per day of work.

Evaluation

The Bulgarian accreditation organisation has no data to quantify beneficial impacts of accreditation on hospitals, staff and patients, nor uses statistical indicators to evaluate the performance of the programme. Besides, the organisation's governing body has not formally agreed to work towards meeting the ISQua standards.

80% of the eligible hospitals are currently enrolled in the programme.

Finland

Policy

Renamed in the beginning of 2004, the "Social and Health Quality Service" (SHQS) is the Finnish accreditation programme which functions on a voluntary basis. Besides, another organisation called Qualisan [ooo], offers certification and quality assessment services and measuring and qualification methods for organisations within social welfare and health care.

ooo www.qualisan.fi

In early 2003, Qualisan took over the classification and measuring system business of the Association of Finnish Local Authorities, including elderly care, rehabilitation, paediatric outcomes and nursing in hospitals [27].

SHQS is a commercial entity totally independent from the government and its governing body is determined by an adopted constitution.

It focuses on Finland and includes public and private facilities.

The hospitals are motivated to participate for marketing, contractual requirement by purchasers or desire for improvement reasons.

Governance

Clinical professionals e.g. nurses, doctors, etc. and hospital owners are the stakeholders nominated as representatives on the governing body.

Methods

Standards

The current standards of the accreditation programme:

- were inspired by all the accreditation models,
- were submitted to the consultation of stakeholders' organisations,
- were approved in 2005, and
- are generic for all the hospitals

As a lot of experts are implicated in the standards' modifications, 4 full revisions have already been published since their 1st version.

Measurement

Finland uses self-assessment and external survey to evaluate the participating hospitals.

After a period of 12-24 months necessary for the self-assessment and the preparation to the external survey for a 100 bed-hospital, the on-site visit:

- lasts in average 2 days,
- is performed by a 3-person multidisciplinary team composed of managers, doctors, and nurses accompanied by trainee surveyors,
- ends with a verbal feedback from the team, and
- is completed by the submission of the draft report to the hospital for comments

Surveyors recruitment and training

190 trained surveyors were available to the programme at the end of 2006, and 10 of them achieved the training in 2006. For a new surveyor, the induction training lasts 4 days and includes also an exercise in practise.

Decision and appeal - Results diffusion

The target turnaround time between the on-site survey and the delivery of the final survey report is 1 month.

The decision is:

- valid for 3 years,
- appealable by the hospital, and
- diffused towards the public under the form of participating hospitals and accredited hospitals' names

Funding mechanism & sources

The hospitals pay the accreditation programme per service or product provided. In 2006, the fee payable for a 100-bed hospital for an accreditation survey was 8000-10000 EUR and included accreditation and decision certificate. Their totality represented about 70% of the accreditation organisation's total income.

Surveyors are paid by professional fee per day of work.

Evaluation

The programme does not have data to quantify beneficial impacts of accreditation and does not use statistical indicators to evaluate its performance. Since the beginning, the programme's governing body agreed to work towards meeting ISQua standards.

13 hospitals are currently enrolled in the programme and 14 on-site visits were performed in 2006.

Luxemburg

Policy

Luxemburg has 2 accreditation programmes:

- "Autorisation d'exploitation des hôpitaux et de leurs services médicaux", which is a mandatory procedure managed within the Ministry of Health, and
- "Incitants Qualité", which is voluntary programme managed by an independent commission with the help of the Expertise Centre

Concerning the determination of the governing body, the "Autorisation d'exploitation" uses enabling legislation whereas the "Incitants Qualité" uses adopted constitution.

Both programmes cover the entire Luxemburg territory and apply to public and private hospitals.

The only motivation to participate to the "Autorisation d'exploitation" programme is statutory requirement. However, for the "Incitants Qualité", additional funding is a strong incentive as hospitals can receive 2% of their budget. Marketing and desire of improvement play also an important role.

Governance

Stakeholders nominated as representatives on the government body are regulators for the mandatory procedure. For the "Incitants Qualité", clinical professionals (e.g. nurses, doctors, etc.), health care insurers and academic/training institutions such as research centres are involved.

Methods

<u>Standards</u>

For the "Autorisation d'exploitation", the scope of consultation on the original draft standards was internal and stakeholders' organisations. The current edition of standards was approved in 2003 by the governing body.

For the "Incitants qualité, standards were based on the EFQM model and submitted to the consultation of internal and stakeholders' organisations, social insurance and research centres. The current edition of standards was approved in 1998 but they have changed during the years. 3 important revisions of the standards have already been published.

In both cases, those standards apply to all hospitals.

<u>Measurement</u>

For the "Autorisation d'exploitation", periodic statistical reporting and formal internal instructions of the hospitals are used to assess hospital. There is thus no survey but a declaration of honour by the hospital director and Governance Board is required.

For "Incitants qualité", the assessment method includes 3 different elements: self-assessment, periodic statistical reporting and external assessment by surveyors. Moreover, a national concept of formal survey of patients' experience is in preparation.

For a 100-bed hospital, 3 months are necessary to realise the self-assessment (preparation, report, action plan) and 3 other months are necessary to prepare the external survey. Generally, a committee is composed in each hospital for this step with management, doctors, nursing, administration and assessors.

Concerning the on-site survey, 14 days are required for report reading, visit preparation, on-site visit and report after the visit. It is performed by 2 surveyors, ends with the team's feedback to hospital's senior management and is followed by the submission of the draft report for comments before decision.

Surveyors recruitment and training

For "Incitants Qualité", approximately 60 assessors were available in the country at the end of 2006. 10 days is the duration of the induction training of a new surveyor.

Decision and appeal

For the "Autorisation d'exploitation", the validity period of the accreditation decision is 5 years.

For the "Incitants Qualité", the decision is valid 1 year as an external survey is realized each year: more and more difficulties have been introduced since 1998 and it is thus necessary to follow up the changes in the hospitals. The target turnaround time between the on-site visit and the delivery of the final survey report and recommendations is 3 months, but more time is necessary to receive money.

For both programmes it is possible for a hospital to contest the decision. For the "Incitants Qualité" a commission is available to examine the situation. This commission takes his decision after having heard the experts and the hospital. If the hospital continues to contest the decision of the commission, he has the opportunity to go in front of a conciliator.

Results diffusion

For both programmes, hospitals results are not available to the public but there is national discussion to choose a model for public reporting for "Incitants Qualité".

Funding mechanisms & sources

Central government funded the initial development of the "Autorisation d'exploitation", whereas the Social Insurance and the Hospital Association initially funded the "Incitants Qualité".

Hospitals do not have to pay their participation to the mandatory procedure, but the "Incitants qualité" charges hospitals per service or product provided in function of the hospital's size. For a 100-bed hospital, the fee was about 20.000 EUR for the external visit (half is paid from hospital and half from social insurance) in 2006.

In 2006, the total expenditure on accreditation was near 8 millions EUR including the costs of external surveys, quality coordinators, self-assessment, hospitals training and the maximum of 2 % of budget (incentive).

Evaluation

There is no data available to quantify the beneficial impacts of accreditation on hospitals, staff, or patients for the mandatory procedure. For "Incitants Qualité", there is a follow up of these impacts in 2 domains: nosocomial infections and pain. But now new performance indicators are used and there is hope that some changes could be demonstrated in 5 years.

None of these programmes use statistical indicators to evaluate its performance.

All the hospitals are eligible to participate in both programmes and they are all already enrolled. In 2006, 14 full on-site visits were done for "Incitants Qualité".

Italy

Policy

Although accreditation has been required by a national law since 1992, its implementation is delegated to the 21 regional governments with much freedom of interpretation which has resulted in a wide variety of differences between the regions. In 2004, Friuli, Venezia, Giulia, Lombardia, Piemonte, Emilia Romagna, Toscana, Marche, Molise, Sardegna, Calabria and Basilicata had set up an accreditation system or were in the process of doing so. The analysis underneath is limited to the Marche region, as this was the region with whom we established contacts.

These regional initiatives are monitored by the National Agency for Regional Health Services in Rome, which collaborates with the regions to support and survey health activity including accreditation, indicators, guidelines, etc [51]. Participation in the accreditation programme is mandatory for public and private institutions and represents a basic condition to be funded by the SSN (Servicio Sanitaris Nazionale).

Indeed, the national law states that:

- only accredited facilities can operate within the public system,
- standards and procedures for accreditation must be defined by regional governments, and
- at national level, minimum standards are defined for health care providers including private sector, and
- only facilities meeting minimum operating standards are eligible for accreditation, and
- only accredited facilities are eligible for contracts with (and payments from) the national health service [27]

Since only complete information of the Marche region could be obtained, this region will be focussed on. One of the currently implemented regional programme is the "Accreditation program of the Marche Region health care system", which focuses on public and private facilities of the Marche Region. It is now managed by a separate government agency and the composition of its governing body is determined by enabling legislation.

Governance

Regulators are the only stakeholders nominated as representatives on the Marche programme's governing body.

Methods

Standards

Piemonte and Lombardy, use ISO 9000 [52].

Liguria, Emilia-Romagna, Marche, Tuscany, Veneto and Puglia have introduced a model adapted from the Joint Commission International and the Canadian Quality Standards.

The system in the Marche region is accredited by the ALPHA Council of ISQua.

The system of Trentino uses the Joint Commission International model, along with the EFQM Excellence model application system.

Measurement

Self-assessment is the only method used for assessment of the hospitals in the Marche programme. While waiting for the political decisions to start the external visits, all hospitals have been self evaluated by their internal surveyors to review their compliance to regional standards and to plan and implement the most important structural and organisational changes.

Surveyors recruitment and training

In 2006, there were 50 trained external surveyors and 350 trained internal surveyors for the Marche programme, which usually come from scientific organisations on the field. 3 days are necessary for the classroom induction training of a new surveyor but it has been stopped in 2005.

Decision and appeal

The validity period of the accreditation award is 3 years according to the law for the Marche programme. The accreditation decision can be appealed.

Funding mechanism & sources

The Marche programme was initially funded by the local government. Hospitals pay accreditation with annual subscription.

Surveyors are reimbursed for their actual expenses.

Evaluation

The Marche programme has no data to quantify beneficial impacts of accreditation nor uses statistical indicators to evaluate its performance.

Countries with a programme in development

Denmark

Policy

In 2003, Denmark began to develop a mandatory accreditation programme based on target standards and named "The Danish Quality Model" (Den Danske KvalitetsModel) which is planned to start in 2008. The aim of this programme is to promote good patient pathways, so as to ensure that the patients experience improved quality.

The Danish Quality Model is built on the National Strategy on Quality Improvement in Health Care published in 2002 and originates from Economy Agreements between the Government, the Danish Regions and the Copenhagen Hospital Cooperation [27]. The development of the programme was at a 1st stage headed by a Steering Committee with the assistance of a project secretariat in charge of the development in cooperation with Danish and foreign expertise, but it was dissolved in 2004 following the decision to establish a new organisation to run the operation and further development of the programme[53]. It is consequently currently run by an independent agency with government representation of the Ministry of Health having a not-for-profit organisation status. The composition of the governing body is determined by adopted constitution.

The programme will cover in principle all providers of publicly financed healthcare services in Denmark. This includes private health care institutions treating patients with public funding.

Desire of improvement, marketing and staff recruitment are mentioned as main elements to motivate their participation to the programme.

Governance

The Board of Directors of the accreditation organisation includes hospital owners and regulators.

Methods

Standards

The developed standards:

- were inspired by other accreditation programmes,
- were submitted to the consultation of stakeholders' organisations,

- comprise general plus disease-specific pathway standards concerning clinical care activities for the individual patient pathway, and organisational standards concerning the underlying, transverse, organisational activities that are a precondition for good patient pathways[53],
- apply to all types of hospitals, and
- will normally be approved in 2007 by the governing body

Measurement

The programme will use self-assessment, periodic statistical reporting, scheduled external assessment and formal survey of patients' experience to assess the participating hospitals.

The planned duration of self-assessment and preparation for external review is 8 months for a 100-bed hospital but could be longer.

This external assessment will:

- be based on the results of the institutions' self-assessment,
- use qualitative and quantitative assessment methods[53],
- probably last 3-4 days,
- be performed by a 3-4 person interdisciplinary team composed of managers, doctors, nurses supplemented by other health professions when necessary and accompanied by trainee surveyors,
- end with a verbal feedback from the surveyors, and
- be followed by the submission of a draft report to the hospital before factual confirmation

Surveyors recruitment and training

There were still no surveyors available at the end of 2006 but the future ones will normally undergo a 5-day training programme.

Change management

Training, consultancy and tools such as guidelines, checklists, methodologies, etc. will be provided by the accreditation organisation to hospitals.

Decision and appeal – Results diffusion

The decision will:

- probably be valid for 3 years,
- be appealable by the hospital, and
- be published on the internet

The turnaround time between the end of the on-site survey and the delivery of the final survey report, the character of the decision, i.e. if it is binary or not, and the diffusion of results' modalities are currently under discussion.

Funding mechanism & sources

The initial development of the programme was funded by central and local governments. Besides, the individual hospitals will not have to participate financially to the programme but regions, which own several hospitals each, will have to pay.

On the accreditation organisation side, the total expenditure for accreditation was about 3.000.000 EUR in 2006. Surveyors will be paid by professional fee per day of work and reimbursement of actual expenses.

Evaluation

The Danish organisation has no data to quantify beneficial impacts of accreditation on hospitals, staff and patients, nor plans to use statistical indicators to evaluate the performance of the programme. Its development and maintenance have however been carried out in accordance with the Alpha Programme principles for the development of standards[53].

All public hospitals and all private hospitals treating patients with public funding are eligible to participate to this programme: this represents 100 to 125 hospitals.

Lithuania

Lithuania has no accreditation programme yet, only local licensing against minimal structure.

However, the Lithuanian Health Programme of 1997-2010 gives priority to health care quality, particularly to licensing, accreditation, certification of quality systems and audit [27].

The State Health Care Accreditation Agency under the Ministry of Health is currently preparing a national accreditation programme and expects its development will start in 2008.

Countries with a programme under discussion

Hungary

An accreditation programme has been planned in Hungary since 1993-1995. Various regulatory and legislative steps have been taken to create an infrastructure and environment for a national accreditation system, initially for hospitals, under the National Accreditation Council in Budapest (Nemzeti Akkreditáló Testület) but no programme yet exists [27].

However, the Hungarian Standards Institution (Magyar Szabványügyi Testület) carries out a certification procedure based on the Hospital Care Standards, which are an adaptation of Joint Commission's standards, initially published in 2001 by the Ministry of Health and reviewed in 2003 [54].

Slovakia

A national accreditation programme is still under discussion in Slovakia.

The Centre for Quality and Accreditation in Health Care was set up in 1999 by the Ministry of Health to prepare the launching of healthcare accreditation, and to develop accreditation standards [27].

Countries without programme

Cyprus

There is currently no accreditation programme in Cyprus.

Hospitals and private clinics are inspected by administrative medical staff, and assessed against certain criteria, which are defined by legislation and relate to infrastructure and equipment, and to minimal medical and paramedical competence.

Legislation for the introduction of a National Health Insurance Scheme has been passed by the Parliament which will enable the introduction of medical audit. Accreditation is applied to laboratories and has been suggested as 1 approach to clinical protocols and quality in general practice [27].

Austria

There is no accreditation programme at present for the Austrian hospitals.

However, the Federal Hospitals Act requires quality management in hospitals since 1993. This obliges hospital owners and managers to implement internal quality assurance but does not require accreditation other than governmental licensing in the federal counties.

Besides, the Federal Ministry of Social Security and Generations is developing proposals to link the reorganization of the health care sector's financing to a process of accreditation [27].

Malta

There is no national programme for accreditation and quality management in hospitals at the moment in Malta.

Hospitals do not require accreditation but legal provisions and subsidiary regulations (Medical and Kindred Professions Ordinance) stipulate the criteria for annual renewal by the Ministry of Health of a license to operate.

A project Quality Assurance in Maltese Hospitals covering nursing homes, secondary hospitals and the 900-bed teaching hospital in Valetta was launched in 2001 by the Ministry of Health[27].

Greece

In the absence of a national programme for hospital accreditation in Greece, there has been acceleration in the uptake of quality systems certification. In 2000, the Hellenic Organization for Standardization (ELOT) issued guidelines for the application of the ISO 9001 standard in healthcare.

Several private organizations have been certified as a whole or in part, but also the prestigious Onassis Cardiac Centre which is a public hospital. This certification helps hospitals to attract patients across borders [27].

Sweden

There is no national accreditation programme in Sweden.

Voluntary self-assessment methods are preferred to improve quality and safety. The legislation makes the county councils responsible for delivering and financing health care and it is up to them to decide what provider to use and how to select them [27].

Estonia

There is no accreditation programme yet in Estonia, only local licensing against minimal structure standards.

There is some interest among hospitals, and talk by senior officials of the need to standardise them more, but no prospects of funding for a standards programme [27].

Slovenia

In 2001, a WHO report recommended consideration of accreditation and re-accreditation of health care institutions using an appropriate model for development of quality systems [27]. Up to now however there is no accreditation system in Slovenia.

Yet, generic standards for hospitals, self-assessment programmes, and accreditation have been published at the Ministry of Health. At present, six indicators should be reported to the Ministry of Health: falls, decubitus ulcers, waiting time for CT scans, waiting for hospital discharge after treatment, percentage of unplanned readmissions (same hospital within 7 days due to the same illness), and presence of MRSA infection.

Countries without information

Romania

No information at our disposal.

APPENDIX 11. COMPARISON OF STANDARDS (CHAPTER 5.2)

1. UK-HQS

Information used for analysis was obtained from www.hqs.org.uk

The fourth edition of the manual (UK programme), describes 66 standards, in six sections covering:

- organisational management
- service delivery
- the patient's experience
- service specific standards for clinical and non-clinical departments.

The international standards used by HQS cover the following range of issues/services:

STANDARD 1 : ORGANISATIONAL AND SERVICE LEADERSHIP
STANDARD 2 : MANAGEMENT AND GOVERNANCE
STANDARD 3: RISK MANAGEMENT - GENERAL
STANDARD 4 : RISK MANAGEMENT - HEALTH AND SAFETY
STANDARD 5 : RISK MANAGEMENT - FIRE SAFETY
STANDARD 6 : RISK MANAGEMENT - INFECTION CONTROL
STANDARD 7 : RISK MANAGEMENT - WASTE MANAGEMENT
STANDARD 8 : RISK MANAGEMENT - SECURITY
STANDARD 9 : RISK MANAGEMENT - RESUSCITATION/REANIMATION
STANDARD 10 : HUMAN RESOURCES
STANDARD 11 : HUMAN RESOURCES - NURSING SERVICE
STANDARD 12 : HUMAN RESOURCES - MEDICAL SERVICE
STANDARD 13 : HUMAN RESOURCES - VOLUNTEER SERVICE
STANDARD 14: HUMAN RESOURCES - OCCUPATIONAL HEALTH
STANDARD 15 : INFORMATION MANAGEMENT AND TECHNOLOGY
STANDARD 16 : FINANCIAL MANAGEMENT
STANDARD 17 : BUYING AND SELLING GOODS AND SERVICES
STANDARD 18 : SERVICE OBJECTIVES AND PLANNING
STANDARD 19 : TEAMWORK, MANAGEMENT AND STAFFING
STANDARD 20 : STAFF DEVELOPMENT AND EDUCATION
STANDARD 21 : CLINICAL SERVICE DEVELOPMENT
STANDARD 22 : SERVICE ENVIRONMENT
STANDARD 23 : BUILDINGS MANAGEMENT
STANDARD 24 : CATERING SERVICE
STANDARD 25 : HOUSEKEEPING
STANDARD 26 : PORTERING SERVICE
STANDARD 27 : RECEPTION SERVICE
STANDARD 28 : THE PATIENT'S RIGHTS
STANDARD 29 : INFORMATION FOR PATIENTS
STANDARD 30 : THE PATIENT'S INDIVIDUAL NEED
STANDARD 31 : PARTNERSHIP WITH PATIENTS
STANDARD 32 : REFERRAL AND ADMISSION
STANDARD 33 : TREATMENT AND CARE
STANDARD 34 : LEAVING A SERVICE/DISCHARGE
STANDARD 35 : CLINICAL RECORDS
STANDARD 36 : OUTPATIENT SERVICE
STANDARD 37 : DIAGNOSTIC IMAGING SERVICE
STANDARD 38 : PATHOLOGY SERVICE
STANDARD 39 : PHARMACEUTICAL SERVICE

STANDARD 40 : PHYSIOTHERAPY SERVICE
STANDARD 41 : SURGICAL SERVICES
STANDARD 42 : STERILE SERVICES
STANDARD 43 : DAY CARE
STANDARD 44 : CARDIAC SURGERY
STANDARD 45 : TRANSPLANT SURGERY
STANDARD 46 : PAEDIATRICS
STANDARD 47 : CRITICAL CARE SERVICE
STANDARD 48 : CANCER SERVICES - CHEMOTHERAPY AND RADIOTHERAPY
STANDARD 49 : SPECIALIST PALLIATIVE CARE SERVICES
STANDARD 50 : FERTILITY SERVICES
STANDARD 51 : MATERNITY SERVICES
STANDARD 52 : EMERGENCY MEDICAL SERVICE
STANDARD 53 : MEDICAL PHYSICS AND BIOMEDICAL ENGINEERING SERVICES
STANDARD 54 : MENTAL HEALTH SERVICES
STANDARD 55: REHABILITATION

A detailed definition of standard 3: Risk Management – General:

There is a structured approach to the management of risk in the hospital which results in safer systems of work, safer practices, safer premises and a greater awareness danger and liability.

General

3.1 There are structures and accountabilities in place for the management of risk within the hospital, including clinical risk.

3.2 There is a dated, documented risk management strategy for the hospital, which includes the management of clinical risk. The strategy has been written/reviewed with the last three years.

3.3 The risk management strategy is communicated to all staff to ensure that they are aware of their responsibilities for the prevention and control of risks.

3.4 There is a multiprofessional risk management committee with documented terms of reference, which meets regularly and reports back to the executive management group on all aspects of risk and health and safety issues.

3.5 Meetings of the committee are documented.

3.6 There is a rolling programme of risk assessment in each service/department throughout the hospital, the results of which are documented.

3.7 Risk assessment findings and all other information about risk are collated and used to plan hospital-wide prioritisation and implementation of control measures.

3.8 Control measures (preventative and protective) are documented, prioritised and implemented.

3.9 There is an accident, adverse event, medication error and near miss reporting

system, which encompasses all types of adverse events and near misses.

3.10 There is a dated, documented policy and procedure, written and/or reviewed within the last three years, detailing how serious adverse events are reported, managed and investigated.

3.11 Records of all accidents, adverse events, medication errors and near misses are maintained, monitored and evaluated, in order that appropriate action can be taken in order to avoid recurrence.

3.12 Reports of all accidents, adverse events, medication errors and near misses are produced on a systematic basis and presented to the risk management committee for review and recommendations. The reports are also disseminated to senior managers as appropriate for review and action.

3.13 There is a designated individual responsible for processing legal claims against the hospital, and liaising with legal professionals, insurance companies and claimants.

3.14 Summary reports of legal claims and litigation in progress are produced and presented to the executive management group and the clinical governance implementation group.

Major Incident Plans (external and internal)

3.15 The hospital has a major incident, all-hazards plan written/reviewed within the last three years.

3.16 Where the hospital has a designated role in external major incident planning, the external major incident plan is developed in consultation with all relevant agencies.

3.17 There is a nominated senior person with overall responsibility for all aspects of response to a major incident, up-to date contact details for the nominated person (including out-ofhours) are accessible for staff working in the hospital.

3.18 All departments/services having a role in the response to a major incident (external or internal) are involved in the preparation of the action plans.

3.19 The hospital tests the major incident plan at least every three years to ensure the efficacy of the plan and staff awareness of it.

3.20 All major incidents are evaluated and a written report produced which the executive management group considers.

3.21 An annual risk management report is produced that covers all aspects of risk management.

2. Haute Autorité de Santé (HAS)

Information used for analysis was obtained from www.has-sante.fr.

The 2007 edition of the manual describes 44 standards, in five sections covering:

1. Politique et qualité du management

2. Ressources transversales

- Ressources humaines
- Fonctions hôtelières et logistiques
- Organisation de la qualité et de la gestion des risques
- Qualité et sécurité de l'environnement
- Système d'information

3. Prise en charge du patient.

- Droits du patient
- Parcours du patient

4. Évaluations et dynamiques d'amélioration

- Pratiques professionnelles
- Les usagers et les correspondants externes

5. Politiques et management

The standards used by HAS cover the following range of issues/services:

Politique et qualité du management

Référence 1 : Les orientations stratégiques de l'établissement.

Référence 2 : La place du patient et de son entourage.

Référence 3 : La politique des ressources humaines.

Référence 4 : La politique du système d'information et du dossier du patient.

Référence 5 : La politique de communication.

Référence 6 : La politique d'amélioration de la qualité et de gestion des risques.

Référence 7 : La politique d'optimisation des ressources et des moyens.

Ressources transversales

Référence 8 : La maîtrise des processus de gestion des ressources humaines.

Référence 9 : L'organisation et la maîtrise de la qualité des fonctions hôtelières et logistiques.

Référence 10 : Le management de la qualité.

Référence 11 : La gestion des risques.

Référence 12 : Le dispositif de veille sanitaire.

Référence 13 : Le programme de surveillance et de prévention du risque infectieux.

Référence 14 : La gestion des risques liés aux dispositifs médicaux.

Référence 15 : La gestion des risques liés à l'environnement.

Référence 16 : La sécurité et la maintenance des infrastructures et des équipements.

Référence 17 : La sécurité des biens et des personnes.

Référence 18 : Le système d'information.

Prise en charge du patient.

Référence 19 : L'information du patient.

Référence 20 : La recherche du consentement et des volontés du patient.

Référence 21 : La dignité du patient et la confidentialité.

Référence 22 : L 'accueil du patient et de son entourage.

Référence 23 : La prise en charge du patient se présentant pour une urgence.

Référence 24 : L'évaluation initiale de l'état de santé du patient et le projet thérapeutique personnalisé.

Référence 25 : Les situations nécessitant une prise en charge adaptée.

Référence 26 : La prise en charge de la douleur.

Référence 27 : La continuité des soins.

Référence 28 : Le dossier du patient.

Référence 29 : Le fonctionnement des laboratoires.

Référence 30 : Le fonctionnement des secteurs d'imagerie et d'exploration fonctionnelle.

Référence 31 : L'organisation du circuit du médicament.

Référence 32 : Le fonctionnement des secteurs d'activité interventionnelle.

Référence 33 : La radiothérapie.

Référence 34 : L'organisation du don d'organes ou de tissus à visée thérapeutique.

Référence 35 : Les activités de rééducation et/ou de soutien.

Référence 36 : L'éducation thérapeutique du patient.

Référence 37 : La sortie du patient.

Référence 38 : La prise en charge du patient en soins palliatifs.

Référence 39 : Le décès du patient.

Évaluations et dynamiques d'amélioration

Référence 40 : L'évaluation de la pertinence des pratiques des professionnels.

Référence 41 : L'évaluation des risques liés aux soins.

Référence 42 : L'évaluation de la prise en charge des pathologies et des problèmes de santé principaux.

Référence 43 : L'évaluation de la satisfaction du patient, de son entourage et des correspondants externes.

C. Politiques et management

Référence 44 : L'évaluation des politiques et du management.

Aspects that are related to risk are evaluated in standards 6, 11, 13, 14, 15 and 41.

Référence 6 : La politique d'amélioration de la qualité et de gestion des risques.

6a. La direction et les instances définissent les objectifs de l'établissement en matière d'amélioration de la qualité et de gestion des risques.

PRECISIONS

Cette politique intègre les différents domaines de risque, cliniques et non cliniques.

Cette politique vise l'amélioration du service médical rendu au patient, de la sécurité des personnes, de la satisfaction du patient et des autres parties prenantes, de la satisfaction des professionnels de l'établissement, de l'efficience de l'établissement, etc.

Ces objectifs résultent d'un consensus entre la direction, les instances et les responsables des secteurs d'activité/pôles.

ÉLEMENTS D'APPRECIATION

Politique formalisée d'amélioration de la qualité et de gestion des risques.

Implication de la direction, des instances et des professionnels de l'établissement dans la définition de cette politique.

Identification des responsables et définition de leurs missions (désignation, fiches de poste, coordination, etc.).

Références 1 à 7

6b. L'établissement définit et met en oeuvre une politique d'évaluation des pratiques professionnelles en cohérence avec la politique d'amélioration de la qualité et de gestion des risques.

PRECISIONS

Cette politique vise l'amélioration du service médical rendu au patient, de la sécurité des personnes et de l'efficience de l'établissement. Elle concerne les pratiques professionnelles des équipes de soins médicales et paramédicales.

ÉLEMENTS D'APPRECIATION

Définition par la direction et les instances (en particulier la CME) de la politique d'EPP dans le cadre de la politique qualité et gestion des risques.

Déclinaison de cette politique d'évaluation, selon les établissements, au niveau des projets de pôles ou de secteurs d'activité.

Promotion par la direction et les instances, du développement de l'EPP (formation, mise à disposition de moyens, etc.).

Suivi régulier par les instances du développement des programmes et des actions d'EPP.

Référence 11 : La gestion des risques.

11a. L'établissement recense et utilise toutes les sources d'information dont il dispose concernant les risques.

PRECISIONS

De nombreuses sources d'information préexistent à la mise en place d'une démarche globale de gestion des risques ; par exemple, celles en provenance du CLIN, de la commission du médicament et des dispositifs médicaux stériles (COMEDIMS), du comité de sécurité transfusionnelle et d'hémovigilance (CSTH), de la médecine du travail, du CHSCT et des réclamations ou plaintes (PV des visites de sécurité ou de conformité).

ÉLEMENTS D'APPRECIATION

Organisation du recensement des informations sur les risques.

Responsabilités définies pour le recensement des informations.

Veille réglementaire relative à la sécurité.

11b. La gestion des risques est organisée et coordonnée.

PRECISIONS

L'identification a priori des risques permet de gérer les risques prévisibles avant la survenue d'événements indésirables.

L'identification a posteriori concerne les événements indésirables : les accidents (risque patent), presque accidents et événements sentinelles qui témoignent de l'existence du risque.

La démarche structurée d'identification, de signalement et d'analyse des incidents et accidents survenus repose notamment sur un système et des outils mis en place pour signaler un événement indésirable et en analyser les causes, une formation des professionnels, une communication sur le dispositif mis en oeuvre à destination des professionnels, des plans d'actions et de retours d'expérience suite à un événement indésirable, etc.

Les événements sentinelles, prédéfinis, servent de signal d'alerte et déclenchent systématiquement une analyse poussée pour identifier et comprendre les points critiques qui requièrent une vigilance particulière des professionnels (par exemple : décès inattendus, reprises d'interventions chirurgicales, etc.).

ÉLEMENTS D'APPRECIATION

Structure de coordination des risques (COVIRIS, cellule de gestion des risques ou équivalent, etc.).

Responsabilités définies sur les domaines de risques (référents, vigilants, etc.).

Démarche structurée d'identification et d'analyse des risques a priori (secteurs à risque, risques professionnels, etc.).

Démarche structurée d'identification, de signalement et d'analyse des incidents et accidents survenus.

Définition d'un programme global de gestion des risques.

11c. Les résultats issus des analyses de risques permettent de hiérarchiser les risques et de les traiter.

ÉLEMENTS D'APPRECIATION

Hiérarchisation des risques (outils, grille de criticité, etc.).

Formalisation des conduites à tenir en cas d'incident ou accident.

Mise en oeuvre d'actions de réduction des risques.

Association des instances et professionnels à l'élaboration et à la mise en oeuvre du programme d'actions de réduction des risques.

11d. La gestion d'une éventuelle crise est organisée.

PRECISIONS

La crise correspond à une situation exceptionnelle qui vient perturber le fonctionnement habituel de l'établissement et aboutit à une situation instable.

Les conséquences de la crise sont dépendantes des modalités de réaction de l'établissement.

S'il n'est pas possible de prévoir la nature et la forme de la crise, il est possible de se préparer à vivre une crise (organisation, définition des circuits d'alerte et des modalités de communication, simulation de crise) et d'en limiter ainsi les conséquences.

ÉLEMENTS D'APPRECIATION

Identification d'une cellule de crise (responsables, rôles, etc.).

Définition des circuits d'alerte.

Information des professionnels.

11e. L'organisation des plans d'urgence pour faire face aux risques exceptionnels est en place.

PRECISIONS

Ces plans sont généraux (comme le plan blanc) ou spécifiques (plan canicule, pandémie grippale, etc.).

Les risques exceptionnels sont les risques nucléaires, radiologiques, biologiques, chimiques, les accidents ou événements majeurs (attentat, pandémie, etc.).

ÉLEMENTS D'APPRECIATION

Plan blanc formalisé et actualisé.

Plans spécifiques sur les risques exceptionnels pour lesquels l'établissement est concerné.

Formation des professionnels.

Exercices de simulation.

Modalités de communication interne et externe.

Référence 13: Le programme de surveillance et de prévention du risque infectieux.

13a. Les patients et les activités à risque infectieux sont identifiés et un programme de surveillance adapté est en place.

PRECISIONS

Tous les ES doivent développer un programme de maîtrise du risque infectieux, cependant le niveau d'exigence doit être adapté aux différentes structures et types de prise en charge.

ÉLEMENTS D'APPRECIATION

Identification des patients et des activités à risque infectieux.

Définition d'un programme de surveillance avec une stratégie particulière dans les secteurs à haut risque (secteurs interventionnels, réanimation, néonatalogie, etc.).

Mise en oeuvre du programme.

Suivi du programme.

13b. Des dispositions sont mises en oeuvre pour assurer la prévention et la maîtrise du risque infectieux.

PRECISIONS

Tous les ES doivent développer un programme de maîtrise du risque infectieux, cependant le niveau d'exigence doit être adapté aux différentes structures et types de prise en charge.

Les protocoles peuvent concerner les domaines suivants : hygiène des mains, usage des solutions hydroalcooliques, bonne utilisation des antiseptiques, prévention et gestion des accidents liés à l'exposition au sang, antibioprophylaxie, pose et gestion des dispositifs intravasculaires, de sonde urinaire, préparation cutanée de l'opéré, prévention des pneumopathies, isolement, etc.

Les précautions standard d'hygiène sont la désinfection des mains, du matériel et des surfaces souillées, le port de gants, des surblouses, des lunettes, des masques, etc.

Les situations particulières peuvent être : isolement géographique, renforcement du lavage des mains, limitation des déplacements, etc.

ÉLEMENTS D'APPRECIATION

Protocoles et procédures de maîtrise du risque infectieux actualisés et validés par le CLIN.

Diffusion des protocoles et procédures.

Mise en oeuvre des précautions standard d'hygiène.

Mise en oeuvre des précautions liées à des situations particulières.

Formation régulière à l'hygiène et à la prévention du risque infectieux de tous les professionnels (nouveaux arrivants, personnels temporaires et permanents.).

Suivi de l'utilisation des protocoles et procédures.

Association du CLIN et de l'EOH à tout projet pouvant avoir des conséquences en termes de risque infectieux.

13c. Le bon usage des antibiotiques, dont l'antibioprophylaxie, est organisé.

PRECISIONS

Le bon usage des antibiotiques vise l'efficacité pour le patient, la prévention des résistances et l'efficience. Il repose sur le respect des recommandations professionnelles, la formation, le conseil thérapeutique, le suivi des bactéries multirésistantes (BMR), la confrontation entre la consommation d'antibiotiques et les données bactériologiques.

Tous les ES doivent développer un programme de maîtrise du risque infectieux, cependant le niveau d'exigence doit être adapté aux différentes structures et types de prise en charge.

ÉLEMENTS D'APPRECIATION

Définition et mise en oeuvre des recommandations de bonnes pratiques de prescription des antibiotiques (réflexion collective au sein de l'établissement, COMEDIMS ou équivalent, etc.).

Définition et mise en oeuvre des règles de bonnes pratiques d'antibioprophylaxie.

Suivi de la consommation.

Surveillance de la résistance aux antibiotiques.

Information des professionnels.

13d. Le signalement des infections nosocomiales est organisé et opérationnel.

ÉLEMENTS D'APPRECIATION

Dispositif de signalement (responsable du signalement, processus défini, etc.).

Formation et information de tous les professionnels et des instances par le CLIN et les responsables d'hygiène, sur les dispositions relatives au signalement des infections nosocomiales.

Historique et analyse des signalements.

13e. Un dispositif permettant l'alerte, l'identification et la gestion d'un phénomène épidémique est en place.

ÉLEMENTS D'APPRECIATION

Identification préalable des événements anormaux pouvant entraîner une alerte.

Définition d'un circuit d'alerte.

Enquête en cas d'épidémie.

Communication au personnel des mesures déterminées par le CLIN.

Information des patients.

Mesures de prévention et de gestion communes en cas d'épidémie.

Référence 14 : La gestion des risques liés aux dispositifs médicaux.

14a. Le prétraitement et la désinfection des dispositifs médicaux non autoclavables font l'objet de dispositions connues et appliquées par les professionnels concernés.

PRECISIONS

On entend par dispositif médical tout instrument, appareil, équipement, matière, produit, à l'exception de produits d'origine humaine, ou autre article utilisé seul ou en association, y compris les accessoires et logiciels intervenant dans son fonctionnement, destiné par le fabricant à être utilisé chez l'homme à des fins médicales, et dont l'action principale voulue n'est pas obtenue par des moyens pharmacologiques ou immunologiques, ni par métabolisme, mais dont la fonction peut être assistée par de tels moyens.

Ces dispositions prennent en compte les règles d'hygiène et la sécurité des professionnels.

ÉLEMENTS D'APPRECIATION

Protocoles de prétraitement et de désinfection des dispositifs médicaux, validés par le CLIN.

Formation des professionnels concernés au prétraitement et à la désinfection des dispositifs médicaux.

Traçabilité du prétraitement et de la désinfection des dispositifs médicaux.

14b. Une organisation permettant d'assurer la qualité de la stérilisation est en place.

PRECISIONS

En cas de reconnaissance externe de la qualité par un organisme certifié, le secteur ainsi reconnu ne nécessite pas d'être visité par les experts-visiteurs. En revanche, les interfaces avec les autres secteurs non certifiés doivent être examinées.

ÉLEMENTS D'APPRECIATION

Certification externe ou démarche d'assurance qualité en stérilisation connue des professionnels.

- mise en oeuvre de protocoles et de procédures.

- formation régulière du personnel concerné.

Prise en compte des avis et recommandations des services d'inspection.

Interfaces organisées avec les secteurs d'activité utilisateurs.

14c. La maintenance préventive et curative des dispositifs médicaux est assurée.

PRECISIONS

L'organisation de la maintenance préventive et curative des dispositifs médicaux passe par l'identification de personnes-ressources, une organisation connue des professionnels, la gestion maintenance assistée par ordinateur (GMAO), un stock de matériel de dépannage, un classement à jour avec les recommandations des fournisseurs par type de matériel, un contrôle régulier du bon état des dispositifs médicaux, etc.

ÉLEMENTS D'APPRECIATION

Politique générale de maintenance préventive et curative des dispositifs médicaux.

Organisation définie et mise en oeuvre.

Procédures d'entretien, de remplacement et de réparation en urgence.

Formation et information régulières du personnel utilisateur.

Système de signalement des dysfonctionnements.

Référence 15 La gestion des risques liés à l'environnement.

15a. L'hygiène des locaux est assurée.

PRECISIONS

Il est indispensable de tenir compte des spécificités de certaines structures qui associent les patients à l'entretien et l'hygiène des locaux et des équipements (appartements thérapeutiques, etc.).

ÉLEMENTS D'APPRECIATION

Identification des zones à risque.

Nettoyage adapté des locaux (procédures, traçabilité, etc.).

Formation du personnel d'entretien et de nettoyage.

Contrôles périodiques organisés en concertation avec le CLIN et réajustements si nécessaire.

15b. La maintenance et le contrôle de la qualité de l'eau sont adaptés à ses différentes utilisations.

PRECISIONS

Ceci concerne l'eau alimentaire, l'eau sanitaire et l'eau à usage médical.

ÉLEMENTS D'APPRECIATION

Protocoles et procédures de maintenance et de contrôle de la qualité de l'eau.

Respect des normes de sécurité pour garantir la qualité de l'eau dans ses différentes utilisations.

Contrôles périodiques adaptés aux différentes utilisations de l'eau, notamment dans les secteurs à risque.

Recueil et analyse des dysfonctionnements.

Actions d'amélioration.

15c. La maintenance et le contrôle de la qualité de l'air sont adaptés aux secteurs d'activité et aux pratiques réalisées.

ÉLEMENTS D'APPRECIATION

Protocoles et procédures de maintenance et de contrôle de la qualité de l'air.

Respect des normes de sécurité pour garantir la qualité de l'air dans ses différentes utilisations.

Contrôles périodiques adaptés aux différentes utilisations de l'air, notamment dans les secteurs à risque.

Recueil et analyse des dysfonctionnements.

Actions d'amélioration.

15d. L'élimination des déchets, notamment d'activité de soins, est assurée.

ÉLEMENTS D'APPRECIATION

Organisation de l'élimination des déchets (classification des déchets, protocoles de tri, collecte, transport, stockage, traitement, etc.).

Formation et sensibilisation des professionnels.

Mesures de protection du personnel (déclaration d'accident, matériel sécurisé, etc.).

Recueil et analyse des dysfonctionnements.

Actions d'amélioration.

Référence 41 : Évaluations et dynamiques d'amélioration. L'évaluation des risques liés aux soins.

Les professionnels identifient a priori les actes, processus, pratiques à risque et/ou a posteriori les événements indésirables. Ils mettent en oeuvre les actions de prévention et d'amélioration correspondant à ces situations à risque et à ces événements indésirables.

PRECISIONS

Cette référence traite :

- des modalités d'évaluation et de maîtrise des risques ***a priori*** dans les secteurs d'activité clinique et médicotechnique. La mise en oeuvre par les professionnels de pratiques à risque s'accompagne de la nécessité de prévenir la survenue des risques évitables en réunissant les conditions de sécurité adaptées ;
- de l'analyse **d'événements indésirables**, c'est-à-dire de l'identification d'événements significatifs survenant dans les secteurs d'activité clinique. Cette approche a pour but d'éviter la récurrence de ces événements en exploitant le retour d'expérience. Elle est essentielle dans une démarche de gestion des risques. L'analyse concerne les événements indésirables soit prédéfinis comme des événements sentinelles soit identifiés par le système de signalement ou encore recensés dans le cadre de revues de mortalité et de morbidité. La démarche consiste à identifier les causes immédiates et latentes de survenue de ces événements puis à mettre en oeuvre des mesures de réduction des risques qui en découlent.

Les établissements de santé décriront succinctement l'ensemble des programmes et actions qu'ils conduisent en matière d'EPP. Parmi ces actions, il est demandé d'en mettre en exergue un certain nombre afin de permettre aux experts-visiteurs d'apprécier concrètement la qualité des actions et programmes menés.

Il est attendu, au titre de ce critère :

- 1 action pour les établissements de – de 60 lits
- 2 actions ou programmes pour les établissements de moins de 200 lits;
- 2 actions ou programmes, par type de prise en charge, pour les établissements de plus de 200 lits.

Si une prise en charge compte moins de 10 lits, il n'y a pas d'obligation de conduire une EPP spécifique.

Il est souhaité que l'établissement fasse au moins une démarche *a priori sur un domaine de risque* et une autre sur un événement indésirable significatif analysé *a posteriori*, mais ceci ne constitue pas une obligation. Toute latitude est offerte à l'établissement pour qu'il choisisse les thèmes qui lui paraissent les plus pertinents au regard de ses activités.

L'établissement présentera les actions ou programmes dans son auto-évaluation. Les appréciations des experts-visiteurs porteront sur la qualité des démarches entreprises et non sur les résultats obtenus.

Éléments d'appréciation

Choix d'une thématique porteuse de potentialités d'amélioration.

Analyse de l'organisation et des pratiques.

Positionnement par rapport à des références (recommandations, référentiels, pratiques d'autres équipes, etc.).

Définition d'objectifs d'amélioration.

Mise en oeuvre d'actions d'améliorations.

Mesure des résultats de ces améliorations (indicateurs ou toute autre modalité de suivi adaptée au cas de figure).

3. Nederlands Instituut voor Accreditatie van Ziekenhuizen (NIAZ)

Information used for analysis was obtained from www.niaz.nl.

Criteria are classified in 9 chapters, each chapter correlating with one domain of the EFQM model. A total of 73 standards is used.

Leadership

Strategy and policy

Management of employees

Management of means

Management of processes

Appreciation by patients and clients

Appreciation by employees

Appreciation for society

Final results

The standards used by NIAZ cover the following range of issues/services:

1. Leiderschap

1.1 De instelling heeft haar missie en visie geformuleerd.

1.2 De missie en visie van de instelling zijn in onderlinge samenhang vastgesteld. Hierin komen de kerntaken, de patiënt, de klanten, de medewerkers, de professionals, de samenwerkingspartners, alsmede de nagestreefde maatschappelijke positionering nadrukkelijk aan de orde.

1.3 De instelling maakt duidelijk hoe een balans wordt gevonden tussen de ontwikkelingen in de omgeving en de mogelijkheden van de instelling.

1.4 De instelling heeft haar visie vertaald in doelstellingen en concrete activiteiten.

1.5 Informatie is beschikbaar voor het managen van de primaire processen (patiëntenzorg, mogelijk ook onderzoek en opleiding) en de besturings- en ondersteunende processen (zoals het beleidsproces, de facilitaire en administratieve processen).

1.6 De instelling beheert strategische en beleidsdocumenten volgens vastgelegde

afspraken.

1.7 De instelling geeft aan hoe invulling wordt gegeven aan corporate governance.

1.8 Leidinggevenden creëren draagvlak voor de realisatie van de missie en de visie.

1.9 Leidinggevenden stimuleren en faciliteren medewerkers om bij te dragen aan, dan wel initiatieven te nemen tot acties welke leiden tot de verbetering van de processen, waarbij kwaliteitszorg een structurele plaats krijgt in de dagelijkse werkzaamheden.

1.10 Leidinggevenden onderhouden voor hun functie relevante relaties met belanghebbenden: (organisaties van) patiënten, klanten, medewerkers, professionals, samenwerkingspartners, bestuurders, zorgverzekeraars en financiers.

1.11 De instelling geeft aan hoe de invulling aan corporate governance wordt geëvalueerd.

1.12 Er is een open communicatie over de bereikte resultaten en ieders bijdrage daaraan.

2. Strategie en beleid

2.1 De instelling verzamelt informatie over de vier resultaatgebieden:

- waardering door patiënten en klanten;
- waardering door medewerkers;
- waardering door de maatschappij;
- eindresultaten.

2.2 Periodiek beoordeelt de instelling of de strategie en het beleid nog overeenstemmen met de visie. Bijstelling vindt plaats op basis van de behaalde resultaten en op basis van in- en externe ontwikkelingen (best practice). De frequentie waarmee bijstelling plaatsvindt is bekend. Er is sprake van continue kwaliteitsverbetering.

2.3 De instelling vertaalt de wettelijke kaders in doelstellingen en uitvoeringsplannen.

2.4 Strategie en beleid zijn aantoonbaar afgeleid van de missie en visie en vertaald in

concrete en, indien mogelijk, meetbare doelstellingen.

2.5 Relevante organisatieonderdelen binnen de instelling zijn betrokken bij de totstandkoming van beleid.

2.6 De instelling betrekt klanten, zoals patiënten, de patiëntenraad, samenwerkingspartners, verwijzers en zorgverzekeraars, bij de strategievorming en de concrete vertaling in doelstellingen.

2.7 Het beleid is gericht op continue verbetering van de processen binnen de instelling. Verbeterplannen zijn een regulier onderdeel van het beleid.

2.8 Er is een aanzet gegeven tot het formuleren van het gewenste serviceniveau van de diensten en producten.

2.9 De instelling beschikt over een beleid ter beheersing van de vitale risico's in de

bedrijfsvoering (risicomanagement). Dit heeft in ieder geval betrekking op

- de veiligheid van het primaire proces;

- de continuïteit van kritieke voorzieningen, zoals energie en ICT;
- de beheersing en het gebruik van risicovolle materialen;
- de integriteit van vertrouwenshandelingen, bijvoorbeeld ten aanzien van financiën en privacy;
- de beheersing van imagoschade.

2.10 Voor het bereiken van de doelstellingen zijn de beoogde resultaten, de benodigde middelen en de verantwoordelijkheden benoemd.

2.11 Strategie en beleid worden intern gecommuniceerd.

3. Management van medewerkers

3.1 Het personeelsbeleid is afgeleid van de missie, visie en het strategische beleid.

3.2 De aansturing van medewerkers is gericht op zorgverlening aan patiënten en dienstverlening aan verwijzers en overige klanten.

3.3 De instelling heeft vanuit haar beleid de taken, verantwoordelijkheden en bevoegdheden van functies vastgesteld en op elkaar afgestemd.

3.4 De instelling heeft afspraken over het inwerken van nieuwe medewerkers.

3.5 Jaargesprekken worden gehouden en vastgesteld is hoe de resultaten daarvan worden benut om het personeelsbeleid bij te stellen.

3.6 Bij de werving en selectie van leidinggevenden en medisch specialisten spelen de aspecten die worden genoemd in het organisatiegebied 'Leiderschap' een rol.

3.7 De instelling heeft beleid hoe om te gaan met leidinggevenden en medisch specialisten die disfunctioneren.

3.8 De instelling heeft beleid op het gebied van deskundigheidsbevordering. Hiervoor worden middelen ter beschikking gesteld.

3.9 De instelling heeft beleid op het gebied van loopbaanontwikkeling.

3.10 Afspraken zijn gemaakt over de wijze waarop medewerkers worden gewaardeerd.

3.11 De instelling beschikt over een laagdrempelige mogelijkheid voor medewerkers om klachten te kunnen uiten, waaronder in ieder geval een vertrouwensinstituut (procedure, commissie en/of persoon) inzake onheuse bejegening door andere medewerkers, leidinggevenden, bezoekers of patiënten.

3.12 De instelling geeft inhoud en uitvoering aan Arbo-beleid.

4. Management van middelen

4.1 De processen worden bestuurd met behulp van een planning- en controlecyclus. Zo realiseert de instelling een verdelingsmodel voor de financiële, personele en materiële middelen, faciliteiten en diensten.

4.2 Er is een effectief liquiditeitsbeheer.

4.3 De instelling beschikt over een door een externe accountant goedgekeurde jaarrekening, niet ouder dan het laatste of voorlaatste boekjaar voorafgaand aan de datum van het werkbezoek.

4.4 Elk niveau in de instelling beschikt over relevante sturingsinformatie.

4.5 De informatie is tijdig beschikbaar, toegankelijk, veilig en betrouwbaar.

4.6 Er is beleid ten aanzien van innovaties, op het gebied van zowel zorgvernieuwing als (medische) technologie.

4.7 Er is een systeem voor het beheer en de borging van kennis en kennisontwikkeling.

4.8 Afspraken zijn gemaakt over de wijze waarop het selecteren en beoordelen van leveranciers van materialen, diensten en faciliteiten plaatsvindt. Bijstelling van afspraken met leveranciers vindt indien nodig plaats.

4.9 Gebouwen, installaties en apparatuur worden planmatig ingezet en onderhouden.

4.10 De intramurale keten van omgang met gevaarlijke materialen en straling voldoet aan de vigerende wetgeving.

4.11 De instelling beschikt over beleid inzake het gebruik en de logistiek van in ieder geval de volgende materialen:

4.11.1 antibiotica;

4.11.2 oncolytica;

4.11.3 radioactieve stoffen;

4.11.4 geneesmiddelen (algemeen);

4.11.5 bloed(producten);

4.11.6 stralinggenererende apparatuur;

4.11.7 steriele hulpmiddelen.

4.12 Middelen die niet meer worden gebruikt, worden conform de wettelijke voorschriften afgevoerd.

4.13 Er is een actief milieubeleid.

5. Management van processen

5.1 De instelling heeft haar belangrijkste patiëntenprocessen en belangrijkste andere primaire processen benoemd. Ook zijn de ondersteunende processen die de organisatorische eenheden overstijgen benoemd en het is duidelijk wat hun relatie met de betreffende patiënten- of primaire processen is.

5.2 In de processen is expliciet aandacht voor de professionele relatie tussen de zorgverlener en de patiënt.

5.3 Voor professioneel handelen zijn afspraken gemaakt over de toepassing van professionele normen en richtlijnen.

5.4 De instelling beheert de aan processen gerelateerde documenten volgens vastgelegde afspraken.

5.5 De instelling heeft uitgewerkte en gecommuniceerde plannen voor de uitvoering van de patiëntenzorg in buitengewone omstandigheden. Dit betreft:

- de opvang van slachtoffers van een externe, grootschalige calamiteit (extern rampenplan);
- de gang van zaken in het geval van een interne calamiteit (intern rampenplan).De plannen geven tevens aan op welke wijze zij door oefening worden beproefd en geactualiseerd.

5.6 Afspraken zijn gemaakt hoe de processen worden beheerst (expliciet is aandacht voor de kritische punten in het patiëntenproces, en hoe taken, verantwoordelijkheden en bevoegdheden rondom deze kritische punten zijn vastgesteld).

5.7 Voor de processen zijn proceseigenaren benoemd.

5.8 Voor de processen zijn gewenste uitkomsten geformuleerd (in termen van effectiviteit, doelmatigheid, tijdigheid, veiligheid, patiëntgerichtheid van het proces).

5.9 De instelling verricht metingen ten aanzien van de veiligheid van patiënten, medewerkers en de omgeving.

5.10 De instelling heeft een operationeel intern auditsysteem.

5.11 De instelling licht de processen systematisch door om tot verbeteringen te komen.

5.12 De instelling investeert in de verbetering van processen.

5.13 De instelling geeft aan op welke wijze vernieuwingen tot stand komen.

6. Waardering door patiënten en klanten

6.1 De belangrijkste klantengroepen, leveranciers en samenwerkingsrelaties zijn benoemd.

6.2 Voor het vaststellen van de waardering door onderscheiden groepen worden resultaten gemeten. In ieder geval beschikt de instelling over

- een adequate opvang en behandeling van klachten van patiënten, alsook een meting daarvan;
- een vorm van meting van patiënttevredenheid;
- een georganiseerde manier waarop patiënten suggesties voor verbetering kunnen doen;
- een georganiseerde manier waarop incidenten in de patiëntenzorg ((bijna-) ongevallen, fouten) gemeld en geanalyseerd worden.

6.3 De resultaten van deze metingen worden afgezet tegen de geformuleerde doelstellingen en leiden onder andere tot maatregelen ter verbetering.

7. Waardering door medewerkers

7.1 De belangrijkste doelgroepen zijn benoemd.

7.2 Voor het vaststellen van de waardering door onderscheiden groepen worden resultaten gemeten. In ieder geval beschikt de instelling over

- metingen van medewerkerstevredenheid;
- metingen van het ziekteverzuim per relevante personeelscategorie;
- metingen van het verloop per relevante personeelscategorie;
- exit-interviews met medewerkers die ontslag nemen.

7.3 De resultaten van deze metingen worden afgezet tegen de geformuleerde doelstellingen en leiden onder andere tot maatregelen ter verbetering.

8. Waardering door de maatschappij

8.1 De belangrijkste doelgroepen zijn benoemd.

8.2 Voor het vaststellen van de waardering door onderscheiden groepen worden resultaten gemeten.

8.3 De resultaten van deze metingen worden afgezet tegen de geformuleerde doelstellingen en leiden onder andere tot maatregelen ter verbetering.

9. Eindresultaten

9.1 Voor de instelling zijn de belangrijkste resultaten benoemd en wordt gemeten of deze worden behaald. In elk geval worden indicatoren op het gebied van financiën, productie en kwaliteit benoemd. Minimaal zijn de volgende indicatoren vereist:

Financiën:

- meerjarige bedrijfsresultaten ten opzichte van de meerjarenplanning;
- vermogensopbouw

Productie:

- percentage productie volgens productieafspraken;
- marktpositie voor de instelling als geheel en voor de afzonderlijke specialismen.

Kwaliteit:

- veiligheid van zorg (onder andere het percentage infecties, decubitus en complicatieregistratie);

- toegankelijkheid.

9.2 De resultaten van deze metingen worden afgezet tegen de geformuleerde doelstellingen en leiden onder andere tot maatregelen ter verbetering.

9.3 De instelling presenteert de gegevens met betrekking tot de 'basisset prestatieindicatoren'.

Putting the standards related to risk management together:

2.9 De instelling beschikt over een beleid ter beheersing van de vitale risico's in de

bedrijfsvoering (risicomanagement). Dit heeft in ieder geval betrekking op

- de veiligheid van het primaire proces;
- de continuïteit van kritieke voorzieningen, zoals energie en ICT;
- de beheersing en het gebruik van risicovolle materialen;
- de integriteit van vertrouwenshandelingen, bijvoorbeeld ten aanzien van financiën en privacy;
- de beheersing van imagoschade.

4.10 De intramurale keten van omgang met gevaarlijke materialen en straling voldoet aan de vigerende wetgeving.

5.5 De instelling heeft uitgewerkte en gecommuniceerde plannen voor de uitvoering van de patiëntenzorg in buitengewone omstandigheden. Dit betreft:

- de opvang van slachtoffers van een externe, grootschalige calamiteit (extern rampenplan);
- de gang van zaken in het geval van een interne calamiteit (intern rampenplan).De plannen geven tevens aan op welke wijze zij door oefening worden beproefd en geactualiseerd.

5.8 Voor de processen zijn gewenste uitkomsten geformuleerd (in termen van effectiviteit, doelmatigheid, tijdigheid, veiligheid, patiëntgerichtheid van het proces).

5.9 De instelling verricht metingen ten aanzien van de veiligheid van patiënten, medewerkers en de omgeving.

5.10 De instelling heeft een operationeel intern auditsysteem.

6.2 Voor het vaststellen van de waardering door onderscheiden groepen worden resultaten gemeten. In ieder geval beschikt de instelling over

- een georganiseerde manier waarop incidenten in de patiëntenzorg ((bijna-) ongevallen, fouten) gemeld en geanalyseerd worden.

9.1 Voor de instelling zijn de belangrijkste resultaten benoemd en wordt gemeten of deze worden behaald. In elk geval worden indicatoren op het gebied van financiën, productie en kwaliteit benoemd.

Kwaliteit:

veiligheid van zorg (onder andere het percentage infecties, decubitus en complicatieregistratie);

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Wettelijk depot : D/2008/10.273/01

KCE reports

1. Effectiviteit en kosten-effectiviteit van behandelingen voor rookstop. D/2004/10.273/1.
2. Studie naar de mogelijke kosten van een eventuele wijziging van de rechtsregels inzake medische aansprakelijkheid (fase 1). D/2004/10.273/2.
3. Antibioticagebruik in ziekenhuizen bij acute pyelonefritis. D/2004/10.273/5.
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5. Het preoperatief onderzoek. D/2004/10.273/9.
6. Validatie van het rapport van de Onderzoekscommissie over de onderfinanciering van de ziekenhuizen. D/2004/10.273/11.
7. Nationale richtlijn prenatale zorg. Een basis voor een klinisch pad voor de opvolging van zwangerschappen. D/2004/10.273/13.
8. Financieringssystemen van ziekenhuisgeneesmiddelen: een beschrijvende studie van een aantal Europese landen en Canada. D/2004/10.273/15.
9. Feedback: onderzoek naar de impact en barrières bij implementatie – Onderzoeksrapport: deel 1. D/2005/10.273/01.
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19. Evaluatie van forfaitaire persoonlijk bijdrage op het gebruik van spoedgevallendienst. D/2005/10.273/21.
20. HTA Moleculaire Diagnostiek in België. D/2005/10.273/23, D/2005/10.273/25.
21. HTA Stomamateriaal in België. D/2005/10.273/27.
22. HTA Positronen Emissie Tomografie in België. D/2005/10.273/29.
23. HTA De electieve endovasculaire behandeling van het abdominale aorta aneurysma (AAA). D/2005/10.273/32.
24. Het gebruik van natriuretische peptides in de diagnostische aanpak van patiënten met vermoeden van hartfalen. D/2005/10.273/34.
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28. Voorlopige richtlijnen voor farmaco-economisch onderzoek in België. D2006/10.273/10.
29. Nationale Richtlijnen College voor Oncologie: A. algemeen kader oncologisch kwaliteitshandboek B. wetenschappelijke basis voor klinische paden voor diagnose en behandeling colorectale kanker en testiskanker. D2006/10.273/12.
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50. Eigen betalingen in de Belgische gezondheidszorg. De impact van supplementen. D/2006/10.273/68.
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60. Longfunctie testen bij volwassenen. D/2007/10.273/27.
61. Vacuümgeassisteerde Wondbehandeling: een Rapid Assessment. D/2007/10.273/30
62. Intensiteitsgemoduleerde Radiotherapie (IMRT). D/2007/10.273/32.
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68. Vergoeding van schade als gevolg van gezondheidszorg – Fase IV : Verdeelsleutel tussen het Fonds en de verzekeraars. D/2007/10.273/52.
69. Kwaliteit van rectale kankerzorg – Fase 1: een praktijkrichtlijn voor rectale kanker D/2007/10.273/54.
70. Vergelijkende studie van ziekenhuisaccrediteringsprogramma's in Europa D/2008/10.273/01.