Developments in professional quality assurance towards quality improvement: some examples of peer review in the Netherlands and the United Kingdom

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Abstract

This study will explore new developments in three clinical peer review programmes in the UK and the visitatie programme in The Netherlands and how these programmes can be linked, in the future, with other quality systems. The information about the English peer review programmes was gathered by conducting four structured interviews with the programme co-ordinators (see Acknowledgements). Information about the Dutch visitatie programme was gathered by the author working with different visitatie programmes at the Dutch National Institute for Quality Improvement. Comparing new developments in the models of the Institute for Standardization of Organizations and the European Foundation for Quality Management, common changes are identified which seem to reflect elements viewed internationally as necessary in quality improvement. This study will examine if and how these elements are or will be included in the clinical peer review programmes in the UK and in visitatie in The Netherlands.

Keywords: audit, clinical peer review, quality assessment, quality improvement, quality system, visitatie

Clinical peer review programmes

Peer review of clinical departments in Europe can be defined as ‘standards based on on-site surveys conducted by health care professionals in order to assess the organization of the care processes and its results aimed at improving the quality of patient care’.

Typical features of these peer review programmes are that they are initiated and co-ordinated by the relevant professional bodies or scientific associations. They focus on improvement of care and on exchanging ideas. To get the doctors’ support and active participation the reports and recommendations resulting from a peer review visit are confidential to the departments visited. Other interested parties such as the hospital administration, hospital medical staff or financiers will only be informed by the surveyed department itself.

Peer review takes place periodically. Most of the scientific associations in The Netherlands and the UK choose a 5-year cycle at the moment. Peer review is a formalized event: it is planned and organized in line with explicit predetermined procedures, questionnaires and standards for reports. Information is obtained from documentation, observation and verbal information. Standards of good quality care or best practice are used when available. Where scientific bodies have not yet produced standards, relevant guidelines are being developed gradually during the course of the programme.

The scope of the review is the care process and its organizational aspects: care delivered, staffing levels, education, facilities, procedures etc.

Context and policy

A great deal of attention is currently directed at systems for peer review, quality assurance and improvement in health care in the UK and The Netherlands. There is a general tendency to demand more transparency from professionals. Until now the peer review and visitatie projects of doctors and nurses have taken place somewhat isolated from other quality activities. Now doctors, nurses and other health care professionals are expected to take part in total quality management activities such as streamlining production processes, working on multi-professional teams, learning how to benchmark processes and results, and taking part in the
strategic improvement plan of the hospitals [1]. There is a need for the integration of the hitherto independent activities such as clinical audits, risk management, education and personnel, research and development. Clinicians should increase their role and responsibility into a larger perspective and doing so would re-empower them with an essential role in medical planning and commissioning [2].

In The Netherlands it was decided to use an approach with an emphasis on professional self-regulation within a framework of agreements with other stakeholders in health care: the patient organizations, the government, and the financiers. In the UK the publication of the White Paper The New NHS: Modern, Dependable [3] and the subsequent consultation document A First Class Service [4] have laid down specific recommendations for the implementation of clinical governance. In this framework the Royal College of Physicians has developed the following plan:

- every physician should have an annual interview with his senior officer in the hospital;
- Continuing Medical Education (CME) will be compulsory;
- every physician has to participate in audits to demonstrate compliance with the standards;
- every physician may have to participate in external peer review.

Until now there is no uniform British system. There is a series of experimental peer review systems that is continually evolving with time. This goes for surgeons as well as physicians and pathologists.

Method

This study will explore new developments in three clinical peer review programmes in the UK and the visitaties programme in The Netherlands and how these programmes in future can be linked with other quality systems.

The three British programmes described were selected with the support of Charles Shaw, Director of ExPeRT and of CASPE’s Hospital Accreditation Programme [5–9] the programmes chosen were examples of some of the most structured and developed schemes in the UK; most programmes in the UK are less structured.

In The Netherlands all clinical specialists are taking part in visitatie. In 1995, the Dutch medical association developed a very structured visitatie-programme in terms of level of participation, way of administration and level of formalization. This visitatie-programme has become the model for other health care professionals in The Netherlands to develop their own programme.

The information about the English peer review programme was gathered by conducting four structured interviews in July 1999 with the programme co-ordinators. The author then made use of the documentation [10] provided.

Firstly, the way in which the programmes were structured was explored. The operational issues addressed were: expertise of the auditors, protocols, programme management, the use of standard documents, sources of information for the auditors, criteria used, content of the report etc.

Within the context of the ExPeRT project the new developments in the models of the Institute for Standardization of Organizations (ISO) and the European Foundation for Quality Management (EFQM) were studied. Common changes were analysed. In the interviews it was explored how these common changes are also being adopted in peer review and visitatie programmes. The changes studied were: the use of self-evaluation, continuous improvement and standards of excellence, the Plan-Do-Study-Act (PDSA) cycle and the focus on results and the patient in the visitatie and peer review programmes. After that the linking of the peer review and visitatie with other quality activities was explored.

Information about the Dutch visitatie programme was gathered by the author working with different visitatie programmes at the Dutch National Institute for Quality Improvement (CBO).

Analyses of the operational issues in clinical peer review

Most of the operational aspects were comparable or are being developed in the same direction. There were a few interesting findings however.

Much of the success of the review depends on the expertise and attitude of the reviewers. It is necessary that they have an up-to-date knowledge of the professional standards, they have to be open-minded, have a broad view and in general have a constructive attitude. In most of the Dutch visitation programmes the selection criteria for reviewers are more elaborated than those in the UK. In the UK training the reviewers is not common at this time. Written instructions appear to be enough guidance for the volunteers to make the peer review visits a success. In most of the Dutch visitation schemes the written report is first discussed in a plenary committee to ensure that the conclusions and recommendations stated by the reviewers are in line with other reports.

A second interesting difference is that whereas the peer review schemes in the UK and the visitatie project in The Netherlands use the same information sources, the main method of gathering information differs: in the Dutch schemes the main sources of information are the questionnaires and the structured interviews; the British schemes gather most of their information through observation and ad hoc interviews. The Dutch approach is more formally structured; in the British scheme the review process is structured in a more implicit way by following the workflow of the department. The advantage of the Dutch approach is that the visits take only 1 day whereas the British approach lasts 2 days but is probably more attractive for the participants. For the Dutch approach training in interview technique is necessary.
All of the schemes in this study are being evaluated frequently and participants are asked to give suggestions for improvements. Furthermore, in some peer review programmes and visitatie programmes an analysis of the recommendations and the implementation of recommendations is made.

Analyses of quality improvement issues in peer review

Both the EFQM and the ISO 9000 have made several common changes, which seem to reflect issues that are internationally supported as necessary elements in quality improvement. The question is how some of these elements are part of or will be adopted by the different professional peer review programmes.

Self evaluation

It is implicit that systematic self-evaluation is part of both peer review schemes and visitatie – when the clinician is filling in the questionnaire for the reviewers. In several visitatie schemes self-evaluation is explicitly encouraged by the layout of the questionnaire. The clinician has to grade his department on certain aspects.

In the Diabetic Scheme in the north-west region of the UK self-evaluation is even more important. Each year the departments receive feedback about their performance together with an analysis of the quality indicators. An annual self-evaluation is required and each department is visited once every 5 years.

Standards of Excellence and continuous improvement

The main focus of all the peer review and visitatie programmes is stated as health care improvement. By adding the need for accountability to others the pitfall of limiting the audit to inspection of minimal norms is mentioned in the UK as well as in The Netherlands.

PDSA cycle: A focus on goal setting, analysis of data and information and outcome

In most of the Dutch visitatie schemes there is a gradual shift taking place from the structure elements to the processes of care, the policy, its outcomes and its evaluation. Questions are asked, for example, about the registration of complication rates, rates of unplanned re-admission, what has been done about the complaints received etc.

Some Dutch scientific societies have shown interest in developing quality indicators like that the Diabetic society in the UK is already doing. CBO will try to develop, in the future, these indicators together with the evidence-based guideline programme.

In most of the programmes emphasis still seems to be on the structural aspects of the department. A systematic approach during the audits to focus on setting goals, comparing results, analysing the processes of care and how to plan systematically for improvement is not yet explicitly built into the programmes.

Customer focus

Only in very few visitatie programmes the patient actually takes part. At this moment only the Diabetic scheme mentioned an active role for the patient in their programme.

Integration of professional peer review schemes with other quality schemes

The general idea is that the Dutch visitatie schemes are linked to other medical quality assurance activities. Moreover visitatie should incorporate evidence-based guidelines and indicators as well as prerequisites for CME. Some societies have set out to integrate their peer review project with other surveys with different goals. Currently there are projects to integrate visitatie with accreditation surveys for teaching departments, with schemes similar to ISO certification for health care etc. There will be an understanding with the Dutch hospital accreditation scheme (NIAZ) to avoid unnecessary overlap between peer review of departments and accreditation. Another development is that some hospitals are setting up an internal, multi-professional visitation programme between their different departments [11].

The British peer review projects will be linked with the annual report and job plan programme for senior officers in the hospital, with compulsory CME, and incorporating audits into the ‘clinical governance’ framework. The performance framework of the National Health Service will, in future, provide performance standards and quality indicators that can be used in the peer review schemes. The Diabetic project can be seen as a systematic approach to linking peer review and the development of standards.

Currently there is not yet a systematic approach linking peer review to quality systems for hospital organization in place (e.g. TQM, accreditation) either in the UK or The Netherlands. The only link is that the physicians present their review reports on a voluntary basis to the hospital management. It may be that EFQM can provide the common platform for management and doctors. This approach is currently being tested in the Diabetic project. In The Netherlands CBO has started a programme for developing quality systems in hospitals. Within this programme (BEREIK) the question arises how visitatie fits into the quality systems of the hospital. If this question can be answered the different systems will be able to reinforce their effects by co-operating.

Discussion and conclusions

First some comments about the operational issues that differed between the British and the Dutch programmes:

- When accountability will get more emphasis in the
It will be a challenge to test which combination of information sources used during the audits will have the best results, and how the sources can be used as systematically as possible without losing their attractiveness for the participants.

In future it is possible that evaluation has to meet specified criteria. It would be helpful then to have a standard method for evaluation for visitatie and external peer review programmes.

Comments about the new developments:

- It will be interesting to test whether explicit, systematic self-evaluation might be linked or integrated into more Peer Review/visitatie schemes. With the use of quality indicators in particular, it will probably enhance the effectiveness of the instrument of peer review.

- It is necessary to find and keep a good balance in the set up of the peer review schemes between the accountability to minimal norms and the attractive and challenging aim of continuous improvement by exchanging ideas and suggestions.

- It seems that the British peer review schemes are pushed by the very tight time schedule of the ‘Clinical governance-scheme’ to swiftly adopt a more process- and outcome-oriented approach. This will be a real challenge and can be very attractive for the physicians – at least when the pitfall of creating a lot of paperwork without any further uses than accountability can be avoided. It can be attractive to the physicians if they can use the goal-setting and indicators themselves as an instrument to get more grip on the coordination of the processes of care in their own department.

- It is clear that patients’ and other stakeholders’ perspectives are and should be more involved in the British as well as in the Dutch schemes. It’s not yet clear, however, what is the most effective way: an advisory board, satisfaction inventories, being interviewed or being on the review team etc. More pilots are needed.

- It is clear that if we could succeed in linking the clinical peer review and visitatie programmes with the total quality management systems in the hospitals, without losing all the effort, experience and commitment that doctors and other health care professionals put into these programmes, this could really accelerate quality improvement.

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References

5. More information about the ExPeRT project: http://www.expert-caspe.demon.co.uk

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