Assessing the value of accreditation systems

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Unlikely the USA, Canada and Australia, the UK National Health Service has no single dominant accreditation system. The Department of Health commissioned Keele University to study the organization and processes of accreditation and the potential impact of the introduction of a national accreditation system into the NHS. The paper discusses the policy issues involved in considering the value of accreditation systems and alternative approaches to evaluating them.

Key words: accreditation, evaluation, indicators, health service performance

What is accreditation?

As this paper will show, there is no clear, single view of the definition, scope or purpose of accreditation. However, it is useful to assess different types of systems in terms of their deviation from an ideal type. For the purposes of this paper the 'ideal type' of accreditation system would have the characteristics of voluntary participation, standards against which compliance is assessed, assessors who are external to and independent of the participating health care organization and a single measure which denotes the degree of compliance with the standards.

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Participation in most accreditation processes is voluntary and results in the award of a grading or score which denotes the degree of compliance with standards. The grading is normally denoted in a number of years before the next survey for example, 4 years for high levels of compliance and one or less for low levels of compliance.

Accreditation bodies are self-funding and each participating organization pays a fee.

FOCUS OF THE ACCREDITATION SYSTEM

Precisely which aspects of health care or the health care delivery system are addressed by the standards and therefore by the accreditation system, vary according to the interests of those who developed the system. Some systems concentrate on the organization of institutions, some on the service delivery process and some on the conduct of professional practice. In some cases the standards are written to reflect patient concerns, in others,
professional concerns. Recent developments, such as the Patients' Charter, demonstrate a move towards standards which are oriented towards measures of system output rather than the simple process measures of the past.

**Organizational**

The accreditation process focuses on the nature of the organization in which health care is delivered. In many cases therefore, the standards concentrate on such things as the meeting of health and safety regulations, the correctness of administrative procedures, staffing and training policies, the existence of policies and procedures and the processes used to create them. A distinction needs to be drawn between 'creating the right standard' and 'creating the standard rightly'. It is the latter which is considered important in an organizationally based audit. There is a generally held view that the contents of policies and procedures, for example, are not questioned. It is their existence and use which is of importance for the audit. This focus raises the inevitable question of whether organization contributes directly to patient care. On the one hand, organization is something which operates outside the relevance for patient care. Alternatively, organizational processes create the environment in which care is provided. This model suggests that patient care depends not only upon individual professionals but also the integration of systems.

**Service standards**

In the UK there is a growing concern that the current structure of health services needs to change. Policy is directed at altering the boundaries between primary and secondary care and the future of the traditional hospital is in doubt. Therefore, it is felt that accreditation processes should, at least, not stultify the development of new methods of providing care and, at best, should promote changes. The focus of the accreditation process should, therefore, be more on the processes of service delivery and less on the organization. Standards are therefore being written to reflect service structures and the delivery of care. In many cases the aspiration of the accreditation system is to track the standards of care provided to individual patients as they travel through the system.

**Professional practice**

The professional bodies exist to ensure that standards are met. Much of their work therefore is involved in setting and assessing professional standards of care. Their questions are concerned with issues such as, is the right treatment being provided in the right way at an appropriate time? To assess compliance with standards so constructed requires professional judgement. This therefore suggests that professionals are required to act as assessors and even if lay assessors are acceptable, demands that the accreditation system is operated within the control of professional bodies.

**Clinical indicators**

An alternative approach to setting standards is that of focusing on clinical indicators, which suggest problems in the process of care. According to the JCAHO, a clinical indicator is "a quantitative measure that can be used as a guide to monitor and evaluate the quality of important patient care and support service activities". Indicators tend to be classified into 2 general types: sentinel event and rate-based. A sentinel event shows a serious and frequently avoidable process or outcome, e.g. maternal death. A rate-based indicator measures trends over time. Indicators may measure an outcome (what happens to a patient after something is done) or process of care (activities performed on patients). The indicators could be used to support where surveyors may look to investigate processes further or may be used comparatively to make judgements on the level of care provided.

**CRITERIA FOR EVALUATION**

There is no single view about the purpose of an accreditation system. The success of an accreditation system will be dependent upon the believed purpose of the system which is in turn affected by the perspective of those who are selecting the criteria.

- **Standards**
  First, accreditation systems provide standards against which organizations can be measured. These may be perceived as the most important part of the accreditation system. The existence of standards offers guidelines for staff to match themselves against. They may also encourage staff to achieve them, reorganizing their work and reassessing their methods of practice.

- **Check on standards**
  Second, the presence of the surveyors creates an external check on standards which can encourage staff to improve their practices. Our research suggests the motivation is fostered by the attitude of managers towards the accreditation process. The visit by surveyors can be interpreted to staff as a process of professional development or threatened as an inspection. In some cases, surveyors may perceive their role as reassuring staff that they are well on the way to achieving the necessary standards.

- **Help achieve standards**
  Third, the surveyors can act in a management development capacity, helping organizations achieve standards or higher standards, by advising them of the existence of good practice and highlighting the existence of poor practices.

- **Risk management**
  Fourth, standards with interpretation from surveyors can help managers to detect areas of potential risk. Risk can fall into a number of categories, for example clinical, financial and physical. Here the surveyors can use the standards to diagnose problems in organizational structures and processes which may put the organization at risk.

- **Organizational change and the development of innovation**
  A number of chief executives have felt that examination by external agents such as surveyors can motivate staff to change their behaviours. Simply being reviewed by outsiders signals the need to take the exercise of quality assessment seriously. How this is perceived by the staff is
dependent upon the attitude of the manager towards the accreditation process. Presented threateningly, the staff perceive a need to change for their personal or the institution's survival. Presented supportively, staff can see it as a vehicle for developing their own solutions to quality issues.

APPROACHES TO EVALUATION
Each of the individual components of accreditation, the standards, the survey and the assessment process can be scrutinized to see if they have any effect upon the processes of delivery of health care and the outcomes of health care. There are 2 broad approaches to evaluation which can be adopted.

- The experience or perception approach, in which perceptions of participants are elicited after the experience of participation and their reflections enable a considered view of the benefits and disbenefits of the process to be discussed.
- The objective indicator approach, in which objective measures of success are posited before the introduction of accreditation and statistical indicators are produced, change in which will confirm the impact of the accreditation system upon the organization.

PERCEPTIONS
The perceptions of benefits approach allows individuals to suggest their own interpretations of improvements in the quality of service, changes in practices and their satisfaction with the process. This has been the most commonly used approach to evaluating accreditation systems. However, our research identified that different groups will have different interests.

Providers
The history of accreditation systems suggests that accreditation arose from the interest of provider groups, frequently the medical profession, to assess whether institutions are providing appropriate environments in which to practice. Over time, a managerial interest in accreditation has been added to the professional interest. Managers wish to know whether their management is leading to compliance with standards and whether there are problems they need to address. In the UK, there are few rules defining a well-run hospital. Because of this, there has been a growing interest in developing standards which lay out the parameters of a 'good' institution or service. In addition, there is a desire to develop peer review to gain commendations from peers for good work, and to turn to peers for advice on where problems may exist. This would make accreditation part of the internal management process, offering a series of checks and support for managers. A different view which providers can hold is that accreditation processes reassure purchasers, the professionals and the public that the infrastructure of the health service delivery systems is at an appropriate level to promote the best possible care. Again this may provide reassurance to the institution, but some perceive this as part of a wider marketing process. In the NHS this may be used to attract purchasers and patients. But criticism can be successfully used in campaigns to argue for more resources from the government resource allocation processes.

Purchasers
Purchasers in the UK have been slow to take an interest in accreditation as a tool which may help in informing purchasing decisions. Insurance companies are reported as being interested in a process of accreditation to identify poorly run institutions. By refusing to contract with such organizations, they can restrict the available pool of health service organizations with which they need to deal. Purchasers may wish to use accreditation to reduce their internal requirements for assessing quality. The outcome of the accreditation system prevents them from having to develop quality assessment processes and also saves having to undertake inspections and reviews themselves.

Consumers
Patients or potential patients and their families may want to know that the consumer of health care will be safe in the hands of the health service. Although most people assume that safety is paramount in the minds of those who run the institutions and provide care, reassurance on this fact will doubtless be perceived as valuable. Probably more significantly, patients will want to know that they are being referred to a 'good' hospital, that is one recognized for high standards of care. And, finally, if consumers are able to choose the institution at which they are treated, they may want information to help them make what for them feels like an informed choice.

Public
In an state-funded health service, frequently exposed to the carping of political parties about the standards of services being delivered, taxpayers wish to be reassured that standards are as high as can be expected and are not slipping.

Policy makers locally and nationally
Policy makers are likely to be concerned about the maintenance or improvement in standards. Furthermore, they may be concerned about equity in access to services across the country or ensuring comparable standards of care across the country.

Perceptions of the standards are also important. Standards are the core of an accreditation system and the choice of standards, their focus and the level at which they are set is crucially important in determining the tone, acceptability and nature of the system. It has turned out to be almost impossible to devise workable standards without reference to the availability of resources. Whether staff feel it is reasonable to be asked to implement the standards will depend on an extent upon their views of acceptable practice within the resource constraints of the service. Furthermore, there are problems in validating some of the standards in that it is not clear that they in fact relate to clinical outcomes at all. In many cases the standards are
derived from collective perceptions of good practice and rarely are or can be directly related to outcomes. Assessment against the standards can be undertaken by a variety of agents. Those working within the organization, outsiders from within the health service or outsiders acting on behalf of an external body. Again, the tone and nature of the accreditation scheme will be affected by 2 questions. On whose behalf are the external agents acting and what decisions hang upon their findings? A number of managers have suggested that the main criterion for assessing the effectiveness of an accreditation system is the satisfaction of the staff with the process. There are a number of additional influences which need to be taken into account in any evaluation. The degree of success of accreditation, however defined, will be affected by, for example, the credibility of the surveyors. If staff feel that the surveyors are not being fair in their judgements, their perceptions of the process will be affected. Furthermore, the use of accreditation as a means of comparing organizational or service behaviour will be highly dependent upon the degree of consistency across the surveyors in applying their judgement. Any such comparisons will be compounded by the difference in external, physical and managerial environments in the institutions studied.

Although perceived benefits are important in determining the acceptability of the accreditation process they do not show categorically that any change has taken place in the delivery of health care or its outcome. However, the search for objective proof must be approached with caution. In our review of accreditation systems, we asked managers with experience of organizational accreditation systems whether it was realistic that they would be able to record any changes detectable by indicators or measures. They all reported that the accreditation system was not designed to achieve this. Its impact was only to be expected in terms of attitudes towards quality or cultural change within the organization.

However, given the emphasis of health care systems upon the need for statistical indicators to demonstrate change, there is a view that more quantitative approaches are called for to establish tangible benefits. If this is the case, what sorts of indicators might be felt to be able to demonstrate the impact of accreditation systems?

INDICATORS

The search for objective criteria presents a number of challenges. Which part of the health care delivery system would the process of accreditation be expected to affect? Should the search for evidence be addressing the impact of accreditation on organization, on professional practice or on patient health? Does an accreditation system impact upon the inputs, processes or outputs of the health care system?

If the standards of the accreditation process are focused on structural inputs, then changes in the inputs will be the most obvious outcome. And, as pointed out earlier, there are many who would argue little more could be expected from an accreditation system. It is merely a precursor to organizational change and can only be assessed in terms of an organization’s readiness to accommodate the search for quality. The accreditation processes which focus on organizational design, for example, all demand the existence of policies and procedures and the most readily accessible measure of impact is the existence of documents.

More difficult to identify are the process measures which result from the introduction of the standards. Where the accreditation process asks for evidence of the existence of, for example, knowledge of policies and procedures, this again becomes a self-fulfilling aspect of the evaluation. If the accreditation process produces evidence of existence, then the knowledge must be deemed to exist. Where the accreditation process does not focus on this, the evaluation process has to address this issue independently. And the outputs of the accreditation process, improvements in the smooth running of the organization and service delivery system require more complex indicators still. In all the interviews we have conducted, managers have failed to find any evidence of anything other than changes in inputs. For most of them, this was enough.

The highest aspiration, change in the outcome of patient care, is even more problematic to measure. There is a paradox in the evaluation of accreditation systems, alluded to earlier. If the accreditation system is supposed to have an impact upon patient health, the outcome measures which reflected the impact of the health care delivery system would also reflect the impact of the accreditation system. Therefore, the impact of an accreditation system whose primary purpose was to indicate the quality of hospital care would be contained within the outcome measures.

The measures that might be used will depend upon whether perceptions, indicators or outcome measures are considered appropriate evaluative tools. For each orientation of the accreditation system therefore, there are 3 possible evaluation measures: organizational, professional and patient orientation.

The indicators are applied to the organization after (and possibly compared with a previous or prior state) accreditation. These are not to be confused with indicators which may become part of the accreditation process itself. They are selected to suggest measurable changes which could be expected after an organization has gone through the accreditation process.

INPUT INDICATORS

These, for the most part, are simple counts and reports of activities which have been developed as a result of an organization going through an accreditation system. Organizational indicators are limited to expected adoption of the standards such as the writing of policies and procedures. But do staff understand and use the policies or do the policies simply sit on shelves gathering dust whilst practice moves ahead? How do we measure whether staff have changed their practices in order to conform to the agreed policies? It often transpires that the examination of policy documents results in rewriting the policy to conform with current practice rather than changing prac-
I approach dealing with the problems faced by managers.

CONCLUSION

OUTPUT INDICATORS

PROCESS INDICATORS

These are indicators which may well suggest changes in the processes of the delivery of care, being simple audit tools for assessing the functioning of the organization. If the purpose of the accreditation system is perceived as creating the right environment in which staff can deliver high-quality services, proxy indicators may be staff turnover and staff morale. A happy stable work-force, which feels well managed, may well be an indicator of an environment conducive to quality.

Other organizational indicators such as those which relate to the smooth running of the health care facility, stemming from well-ordered organizational processes, e.g. financial stability and appropriate levels of patient throughput and turnover, may again be indicators of successful organizational development.

Many clinical indicators are designed to demonstrate the smooth running of health care processes. By comparing rates of, for example, discharge and readmission, questions about the quality of care can be raised. The incidence of bed sores suggests how well the nursing process is working for example.

OUTPUT INDICATORS

Organizational outputs suggest changes in organizational processes. The more sophisticated challenges are those which address the outputs of the clinical process. Here there is an attempt to find changes which have occurred as a direct result of the organization going through the accreditation process. Outputs, however, being indicators which rarely relate directly to the process under study, require a causal or linking logic to suggest why they might demonstrate change. There are few satisfactory indicators which could be categorically related to the introduction of accreditation systems. However, patient satisfaction with aspects of care which the accreditation system addresses may be important.

CONCLUSION

There are many possible permutations in the development of an accreditation system. The UK faces the challenge of deciding whether it wishes to pursue the accreditation option or look for other means of assessing health care. The ability to ascertain the impact of an accreditation system depends upon the measurement techniques available for measuring the impact of health services. Accreditation, therefore, is an imprecise science. It is perhaps best to view it as a management consultancy approach to dealing with the problems faced by managers rather than a tool for measuring the performance of health services. The value of accreditation therefore is more in its ability to generate discussion about the health care system and to this extent it acts as a tool of public accountability. It can never be the sole solution to assessing or monitoring quality in a health care system.

Where the accreditation process will go in the future is not clear. In all countries there is growing public interest in the measurement and demonstration of quality of care. This is leading all accreditation systems to consider indicators which offer more proof of quality than the review of processes and procedures. The demands of public accountability appear to be changing and creating pressures for more clinically oriented review systems. If these are based on statistical indicators, which all the evidence to date suggests is the preferred future, review processes using surveys which characterize accreditation systems may no longer be relevant. It would seem that the peer review and self-improvement model is becoming less attractive in a world in which consumers are more educated, where information is needed to make choices about health care and where public agencies are expected to guarantee public safety and the best use of public funds.

The anglo- phone experience would appear to indicate that accreditation will become less about professional education and more about surveillance, protecting the public interest. The motif, 'regulate yourselves or be regulated' will lead inexorably to more policing and public scrutiny than the internal motivations of personal excellence.

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REFERENCES


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