European Accreditation Network (EAN)

University of Durham, UK, Grey College Conference Centre

Minutes of meeting, 24-25 September 2012

Welcome and introductions

Charles Shaw[1] welcomes the participants (Appendix 2), who represent a variety of national and international organisations. He explains the background and purpose of the meeting, highlights the opportunities for networking, exchange of experiences and ideas, and forwards the apologies of those who could not come. Basia Kutryba[2] facilitates the introduction of the participants, who briefly present themselves and their organisations.

Session 1 External assessment of healthcare providers

Robin Burgess[3] chairs session 1, which consists of four presentations and subsequent discussions.

Presentation 1: Standards for improvement in healthcare: supervision, certification and accreditation in Europe - Charles Shaw

The presentation refers to Kieran Walshe's study fashions and trends in terminology of quality improvement in literature published between 1998 and 2007[1]. While publications on 'medical /clinical audit' and 'clinical governance' passed their peaks in the early 1990s and early 2000s, 'accreditation' and particularly 'patient safety' became increasingly popular during the recent years. Regulation and accreditation can complement each other: while regulation primarily aims at securing safety and competence of provider organisation through the compliance with essential (minimum) & developmental standards, accreditation with its more ambitious standards has the potential to enhance the service delivery from a competence level to excellence. The common model of quality systems consists of three components: standards (setting), measurement (of actual performance against standards) and (quality) improvement. He comments on the weaknesses in setting standards, notably organisational standards which often lack the level of evidence and rigour which is expected of clinical standards.. He outlines the similarities and the differences between accreditation and ISO-certification. During the last two decades the number of accreditation bodies - independent, governmental or mixed status - increased. However, the percentage of hospitals covered by accreditation schemes ('saturation') varies significantly within Europe: with Denmark and France at the top-end and countries like Spain, Poland, and UK at the bottom end. Critical for the successful development of accreditation are factors such as policy environment, healthcare financing, stakeholder participation, public information and a critical mass, i.e. size. He concludes by commenting on the climate change regarding external assessment, illustrated by the convergence between regulation and accreditation (particularly in Canada and Australia, where voluntary accreditation is combined with regulatory supervision), the collaboration and sometimes competition

[1] chairman of EAN, Executive Board of the European Society for Quality in Healthcare (ESQH)
[2] Chairperson of EU Working group on Patient Safety and Quality of Care; Fellow of Executive Board of ESQH; Head of WHO Collaborating Center for Developing Quality and Patient Safety in Health Systems, Krakow
[3] CEO, Healthcare Quality Improvement Partnership, London, Executive Board of ESQH

between ISO-certification and accreditation, increasing demand for cross-border healthcare provision to be externally assessed and the need for cross-border standards.

Discussion:

Of particular interest is the fact that hospital accreditation is uncommon in the UK, although the King's Fund accreditation initiative started in the 1980s. Robin Burgess, the chairman of session 1, suspects that the very nature of the state-run National Health Service may have inhibited the development of accreditation in the UK.

A comment is made that the compliance with standards does not guarantee that (excellent) outcomes will be achieved.

Presentation 2: Certification of healthcare facility, European Partnership for Accreditation (EA) - Paul Stennett[4]

At the beginning of his presentation, Paul Stennett depicts the accreditation infrastructure in Europe, as mandated by the European Union, which consists

- at the national level of accreditation bodies like the UK Accreditation Service (UKAS),
- at the regional level of the European Partnership for Accreditation (EA) and relates
- at the international level to the International Laboratory Cooperation ("ILAC) and the International Accreditation Forum ("IAF")

In 1995 UKAS itself converted from a governmental body into a private, "not for profit" company, required by the UK Government to work in the public interest. Paul Stennett defines and outlines the particulars of accreditation and certification, which are occasionally confused in healthcare quality systems. UKAS currently accredits all medical laboratories in the UK on behalf of the Royal College of Pathologists, and has recently started accreditation of the UK's diagnostic imaging services and physiological diagnostic services for the Royal College of Radiologists and Royal College of Physicians , respectively. The standards in the aforementioned schemes use ISO9000 as the basis for the Quality Management System, however he then demonstrated how ISO9000 was developed to meet the requirements of the Royal College of Pathologists to become the globally accepted standard for medical laboratories, "ISO15189" . ISO has its roots in the standardisation of the production of goods, which often creates the fear of inflexibility amongst service providers like hospitals, however, the previous example shows how it can be adapted. Paul Stennett concludes his presentation with a list of essential requirements of assessments, which include (i) impartiality/integrity and independence of the accreditation body, (ii) ensuring the competence of the assessors,(and in healthcare UKAS uses clinically qualified Peers), (iii) appropriate resources and facilities, (iv)actual performance and the evaluator's capability of sustaining the required level of performance.

[4] CEO UK Accreditation Service (UKAS)

Presentation 3: European Standards: role of national standards bodies (NSB) and Comité Européen de Normalisation (CEN) - Rob Turpin[5]

Rob Turpin briefly describes the relationship between Comité Européen de Normalisation **(**CEN)[2] and its 30 members and 17 affiliate states. At the international level, CEN and ISO formed an agreement to avoid duplication of work. While the global ISO-standards are not automatically transposed into national standards, EN-standards are within the CEN member states. The development of a new EN standard entails a consensus-driven approach with a public enquiry (consultation) and national votes. The consensus-approach does not, however, necessarily imply 'unanimity'. European standards in healthcare serve a variety of purposes: they provide patients with confidence and protection, support legislation and set required levels of healthcare service, can be used to measure staff competence and service quality and thus provide a framework for certification of healthcare providers and ultimately contribute to more equal healthcare provision across Europe. Several EN standards in the area of healthcare have been recently developed, including prEN 15224 – *Healthcare services QMS (2012).* Rob Turpin concludes his presentation with three recommendations:

- Use existing specifications or guidelines as base documents for CEN standards;
- For new standards ideas, CEN should use professional networks and NSBs to create a better common understanding from the outset;
- CEN should work closely with European organisations to establish their strategy for health service standards.

Discussion:

Basia Kutryba refers to the experience in Poland, where healthcare professionals expressed their dissatisfaction with the application of healthcare standards, which they perceived as a 'bureaucratic burden'. Basia Kutryba assumes that an inquiry amongst health professionals in other European countries might reveal similar perceptions.

A further topic in the discussion is the distinction between 'certification' and 'accreditation'. For healthcare professionals, accreditation means recognition of training, services or providers; in the regulated ISO system it means recognition of the auditors or certification agency – healthcare accreditation would be regarded as "certification". (A paper comparing the systems has been submitted for publication[3].)

Presentation 4: Role of healthcare supervisory organisations and of the European Partnership of Supervisory Organisations (EPSO) - Jooske Vos[6]

EPSO was founded in 1996. The current objective of EPSO is to improve quality and safety of healthcare and social care in Europe. As a voluntary cooperation network, it conducts biannual meetings amongst the partner organisations and provides a platform to voluntary exchange, discuss and learn from experiences, ideas and knowledge, and in particular to identify best and bad practices in inspection, regulation and monitoring. The partner organisations vary very much as to their national legislation, mandates and competences in direction, inspection and enforcement, their assessment methods and standards. A particular focus in Jooske's presentation forms the peer review approach applied in 2011 in the evaluation of the Norwegian Board of Health with the aim to

[5] Sector Content manager, Healthcare – BSI Standards
[6] EPSO secretariat, Director EURinSPECT

identify areas for improvement and further standard setting. The approach combined document review, observation and interviews. A set of norms were established prior to the evaluation. 13 key areas were assessed, including internal quality systems, personnel, inspection methods and procedures and impact assessment. Jooske Vos highlights that the Norwegian case can serve as a model for future peer evaluations amongst the partner organisations. Further peer evaluation and research by third parties will be instrumental in the validation and development of the norms. Her vision for EPSO is to develop towards a more quality oriented network of professional supervisory organisations.

Discussion:

Specific questions are raised about the peer review evaluation conducted in Norway and parallels with the beginning of the ISQua peer review for healthcare accreditation in New Zealand.

The common threads of the further discussion of session 1 are:

- Certification and accreditation – similarities between ISO-certification and accreditation
- Relationship between accreditation and regulation – differences and common purposes
- Importance of patient engagement and public information

The experiences from different countries in Europe, represented within the audience, include:

Private hospitals in Denmark have two types of inspections, one through regulation and one from accreditation. The purposes of the two are different. Regulators focus on patient safety, accreditors on quality improvement. All evaluation accreditation reports are public. The accreditation organisation informs the regulators in case of poor, safety-compromising hospitals. This is different in the Netherlands. Yet, the healthcare inspectorate (IGZ) can consult the Netherlands Institute for Accreditation in Healthcare (NIAZ) website to find out if a hospital has not been accredited.

In the United Kingdom, the relationship between accreditation schemes and regulators is evolving. UK moved back from accreditation. The NHS hospitals are regulated by Healthcare regulators and became less aspirational concerning quality improvement.

Wales: The practice of regulation in Wales is very different from Care Quality Commission (CQC) in England. The Healthcare Inspectorate in Wales (HIW) is considered to be one of the most ambitious regulators. It is a small country only, which has no national accreditation system.

England: there are incentives for good organisational performance, but these are independent from accreditation and regulation.

Poland: There is no relation between the accreditation and regulators and no incentives are in place for hospitals to become accredited.

Session 2 European activities in quality in safety

Charles Shaw chairs session 2, which consists of four presentations and two discussion blocks.

Presentation 5: European Policy, organisation, research and activities for healthcare improvement - Basia Kutryba

At the beginning, Basia Kutryba sensitises the audience about patient safety by stating that '8 - 12% of patients admitted to hospital in the EU suffer from adverse events whilst receiving healthcare'. She explains that although the primary responsibility for healthcare lies with the member states, the European Commission supports the cooperation across the EU and with the Commission through legislation and specific activities in healthcare quality**.** The EU-activities include the establishment of a working group on patient safety and quality of healthcare, projects & research, the *Council recommendation on patient safety* and collaboration like the *Joint Action on patient safety and quality of healthcare*. Amongst the projects & research that the EU has been co-funding are COMAC (1990-93), ExPeRT (1996-99), ENQuaL (2003-05), MARQuIS (2005-08), SIMPATIE (2005-07),EUNeTPaS (2007–10) and the ongoing research projects DUQue and *Handover*. At Senior EU Level the issues of 'which areas of quality should and could be addressed at EU level' and 'how to ensure patient empowerment and involvement of health professionals' have been discussed. Here, Basia Kutryba refers to the *Directive 2011/24/EU on the application of patients' rights in cross-border healthcare* and outlines the related challenges of patient empowerment and involvement of professional organisations. Her presentation concludes with the description of the *Joint Action on Patient Safety and Quality of Healthcare*, a special EU-initiative aiming at sustainable cooperation between its member states.

The chairman of session 2 thanks Basia Kutryba for her subtle, diplomatic presentation, which pointed out the quandary of the situation: although healthcare quality is a public issue that requires a joint action across the EU, the member states do not appreciate interference referring to principle of 'subsidiarity'.

Presentation 6: Safety standards European hospitals: rational and reality - Charles Shaw

The Self Assessment for Patient Safety in Hospitals (SANITAS) project incorporates advice from numerous European and national sources into a tool for assessing quality and patients & staff safety in European hospitals[4].

The rationales for the SANITAS project are, as Charles explains at the beginning, the lack of a research/evidence-based approach in healthcare policy and practice, fragmented certification, accreditation and regulation across borders and the absence of a central clearing house and formal mechanisms to establish and share best practice on hospital organisation. European quality and safety standards can provide guidance for managers and clinicians to introduce systems that reduce unacceptable variation. Unified standards would also allow for a consistent assessment of hospitals and patients, public and payers. Based on existing research and guidance from various sources, the SANITAS project designed a self-assessment tool and further improved it through a voluntary field-test in ten Italian hospitals. The tool covers the areas of patient/staff and environment safety, patient rights, workforce and clinical practice. The next steps will entail validating the tool, identifying training needs and evaluating the assessment procedure and compliance.

Discussion:

Carlo Ramponi, JCI, points to the diversity of countries and the different levels of healthcare achievements in the European member states. He considers it unrealistic to expect the same performance level in every country and prefers a step-wise approach, starting with basic standards

for those countries that are less advanced. In his reply, Charles Shaw stresses the need for incentives to stimulate the hospitals advancing to the next level of standards such as by "graded recognition" in South Africa.. There could be one set of worldwide standards (requirements such as JCI , but different levels of compliance with individual criteria.. Jooske Vos further elaborates, proposing that there could be different levels of achievement in one country, such as with academic hospitals at the top and some 'regional' hospitals at the bottom end.

A further discussion builds on this idea. Charles Shaw stresses on the importance of equality of services as a principle, taking the divide between Northern and Southern Italy as an example. Giovanni Caracci finds it appealing to have basic patient safety for every hospital as a starting point. Harmonised European standards and regulation for healthcare could play an important role within the context of a decentralised healthcare system within a country like Italy.

Jörg Pruckner, CPME, points to the financial/economic aspects. He raises concerns whether quality in healthcare can be improved in the context of economic crises and scarce funding. Charles Shaw highlights that poor quality often results from bad management of existing resources rather than the need for more staff, equipment or money; quality improvement therefore does not necessarily lead to high costs.

Being asked about the purpose of the SANITAS the project, Charles Shaw states that the MARQuIS and DUQuE projects showed that basic safety practices are missing in many European hospitals. but the EC does not have the legal competence to enforce EU guidelines. Several participants shared concern at the lack of information in the public domain about the safety levels in hospitals.

Jan Vesseur expresses the importance of systems that control hospital quality in every country. A government should not be concerned with one particular hospital, but ensure that an effective quality assurance/improvement system is in place at the various levels in the country, which can be based on accreditation and/or regulation/inspection. Further expanding this idea, Charles Shaw proposes that all regulators should themselves be independently assessed, not necessarily by the government, but by peer review, like EPSO conducted in Norway.

Presentation 7: Professional association views on health service standards - Jörg Pruckner[7]

At the beginning, Jörg Pruckner introduces the Comité Permanent des Médicins Européens (CPME) to the audience, whose activities amongst others include professional practice, patient safety and patient centred healthcare[5]. CPME considers European standardisation as beneficial in many respects. Standardisation needs to respect that healthcare services are complex and of specific nature. Therefore, regulations on healthcare services are to be developed with the best possible expertise and should form an integral part of the healthcare system. He refers to the draft CEN standard on aesthetic surgery services as a negative example, which shows the conflicts with existing competences at national level, particularly when those standards are drafted outside the structures that ensure profession's expertise. Jörg Pruckner concludes that no standards should be developed in contradiction to European or national legislation. This is to ensure legal clarity for patients and to avoid parallel framework of reference for professionals.

[7] CPME Vice president and rapporteur on standardisation. Comité permanent des médicins Européens. Standing committee of European Doctors

In summary, it can be stated that

- CPME not satisfied with certain developments in the standardisation process,
- The healthcare professions need to be involved in the process of standardisation.

Presentation 8: Anaesthesia Clinical Services Accreditation (ACSA) - Charlie McLaughlan[8]

Charlie McLaughlan gives a brief ad-hoc presentation about the development of standards for anaesthesia clinical service accreditation. He explains that the initiative is still in a pilot phase. The activities entailed a survey on how standards were applied, which yielded a return rate of 100 per cent. So far 168 standards have been developed through the involvement and consultation of specialists, employers, patients and others. Neither, regulators nor governmental bodies were involved, though, the Care Quality Commission has adopted the standards and applies the guidelines in their assessment of healthcare services. The standards are meant to be supplementary and not replacing the expertise of the senior anaesthetists.

Discussion:

Llively discussion follows on issues of 'revalidation' of individual doctors, and potential conflicts with other specialties in overlapping areas of standards. This leads to the questions, 'how much freedom should be given to those who develop the standards? And which stakeholders to involve? Dr McLaughlan reports that there were not many overlaps between ACSA and other specialties or existing guidelines. Jörg Pruckner states that there is a harmonising process within the CPME to reconcile different standards within each EU country, but rules are needed to harmonise overlapping areas between different professions.

Asked whether the Royal College of Anaesthetists also conducts audit compliance, Charlie McLaughlan clarifies that it does not, but leaves the standards to be used in 4 year cycle of self-audit and self-check, and CQC in their inspections. Further discussion highlights the complementary roles that various bodies ideally play in setting and enforcing standards, directing and inspecting hospitals. The audience agreed that self-assessment alone is insufficient to ensure healthcare quality and safety. Quality checks should also include unannounced inspections. Reference is made to the experience of the healthcare inspectorate IGZ the Netherlands. Jan Vesseurs, IGZ, and Jorien Soethout, NIAZ (the national accreditation programme), provide more details about the *visitatie*, which is a longstanding professionally based peer-review system that started in teaching hospitals. In the past, the results of the peer-audit were shared with the doctors only, which formed an image of secrecy. Nowadays *visitatie* reports are shared with the particular hospitals boards. Jan Vesseur points to the responsibility of the boards of hospital directors to assess and ensure that their hospital departments comply with the guidelines and standards. Although IGZ and NIAZ do not directly forward their assessments to each other, IGZ receives NIAZ accreditation reports often from the hospitals upon request, and NIAZ indicates the status of the accreditation process on its website.

Session 3 Clinical service standards

Session 3 is chaired by Jan Vesseur, IGZ, and consists of three presentations and discussion

[8] Director of Professional Standards, Royal College of Anaesthetists Quality Management of Service Committee

Presentation 9: Opportunities for intercollegial and cross-border accreditation of clinical services - Roland Valori[9]

Roland Valori describes the accreditation scheme that is offered for Gastrointestinal endoscopy in the UK by the Royal College of Physicians (RCP)[6], the opportunities this entails for service providers and the future role of the RCP in accreditation. He starts by exploring clinical service accreditation as a framework of purpose, policy and priorities, emphasising the particular challenge to bring the priorities of the key stakeholders together. The accreditation scheme has been developed by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG), representing various professions, organisations and patients (www.thejag.org.uk). Initially the patient-centred standards of the so called endoscopy Global Rating Scale (GRS) related to the domains of (i) clinical quality and (ii) quality of the patient experience only. Two more domains, (iii) Workforce and (iv) training were added later. The grading system consists of four levels (excellent, good, basic and inadequate), each of which is defined by one to four measures. GRS functions as an on-line check list, comprising approximately 200 measures in 21 items in the four above mentioned domains. Although it remains a challenge to convince the medical professionals, GRS has shown a high compliance with self-rating. Yet, the self-assessment needs to be validated. The validation is part of the accreditation visits which are conducted by a team of three peer assessors. The preparation for the accreditation usually requires many efforts from the healthcare provider, yet there are various levers which reward those efforts and support accreditation in the long run. Several countries have adopted the endoscopy GRS or adapted them, such as Canada and Austria. The accreditation scheme in endoscopy is one amongst several others that the Royal College of Physicians runs. This raises the issue of the future role of RCP in accreditation, (i) leading: the medical specialities, linking with other colleges and lobbying amongst commissioners. There are still a number of questions concerning the methodology, particularly

- What should be accredited: pathway, speciality, service, ward, hospital
- What are the boundaries: quality, safety and patient experience
- What about training, workforce, innovation, research, prevention, productivity
- Should it inform professional revalidation?

Roland Valori concludes his presentation with an illustration, which depicts the opportunities that GRS either as standards framework or in combination with accreditation provides for healthcare organisations. Some will fly, some will drift and some will crash. The crucial factor for success seems to be leadership.

Presentation 10: Audit, enquiry and registry data as part of accreditation of clinical services - Robin Burgess[10]

Robin Burgess outlines the potential for clinical standard development, accreditation and quality improvement arising from the evidence collected by HQuIP in clinical audits and inquiries. He commences by providing background information about the Healthcare Quality Improvement Partnership (HQuIP), its status as a non-for-profit organisation and its particular role in national audits, confidential enquiries in clinical and social services in England. Through its involvement in

[9] Gastroenterologist, National Clinical Director for Endoscopy, Clinical Director for Accreditation, Royal College of Physicians (RCP), London

[10] Chief Executive Officer, Healthcare Quality Improvement Partnership (HQuIP)

national audits, it has access to a large range of high quality clinical data. For further information viz. http://www.hqip.org.uk/national-clinical-audits-including-ncapop-and-corp/ There is a limited range of clinical accreditation schemes in England. The regulation system in England sets minimum standards only, and aspiration to excellence is not a requirement for NHS hospitals. There is a great potential for the use of audit findings: the data collected in the clinical audits and confidential enquiries in the UK could be used to inform the development of accreditation standards in the UK and across Europe, if pooled with data sets from replicated audits in other European countries. This could be especially interesting for smaller countries with fewer data sets. Robin Burgess concludes his presentation with the following suggestions:

- To articulate more forcefully the vision of what clinically led accreditation schemes of clinical services could provide
- To work towards a common way of working for such schemes
- Where possible, to integrate audit data as a major source of evidence
- Potential discussion with those outside of the UK about audit

Discussion:

The first question concerns the different rules about data protection, anonymisation, pseudonimisation in European member states that might be in conflict with the suggested pooling of data. Asked about the cooperation with CQC and NHS organisations, Dr Valori confirms that there is a rapid turnover of data and information which HQuIP passes to the CQC as a result of their audits. NHS organisations are obliged to participate in HQuIP audits.

Contribution made by Roland Valori, UK, and Carsten Engel from Denmark suggest bringing regulation and accreditation audits together to (i) avoid duplication in data collection and (ii) yield a scientifically more powerful data sets.

Presentation 11: Models for harmonising health services standards in Europe - Charles Shaw

Charles Shaw lists the various steps through which clinical practice guidelines(CPG) are developed according to the Scottish intercollegiate Guidelines Network (SIGN) – published in 'The guidelines developer's handbook'[7], which includes amongst others a systematic literature review, involvement of patients, consultation and peer review, but 'not piloting'. Similar activities are formulated concerning the process and criteria that the Appraisal of Guidelines for Research and Evaluation (AGREE)[8 9] entails. AGREE however does explicitly include field testing. While a systematic literature review is also applied in the USA by the Agency for Healthcare Research and Quality (AHRQ) [10]for the inclusion of CPGs in the national database, it neither envisages an explicit role for patients nor field-testing[11]. Other procedures for standards development include::

- National quality standards by NICE[12]
- Standards for external assessment by International Society for Quality in Healthcare (ISQua)[13]
- CEN (viz. presentation by Rob Turpin)

Charles Shaw critically comments on approaches which exclusively rely on internal committee negotiations rather than drawing conclusions from hard evidence and data. He concludes that health-service standards must include Systematic review of scientific literature, and must involve stakeholders including patients and NGOs.

Discussion:

Training is mentioned as an important factor for successful assessment, alongside clear rules of how to do assessments. The content and duration of training would differ depending whether the training is about how to assess a primary healthcare centre or a highly specialised healthcare complex.

Robert Turpin suggests that standards development projects could be articulated better at the beginning and reported to the widest public to ensure sufficient time for participation. Stephen McAdam agreed it is advisable not to rush, but spend sufficient time to get to a point of starting, so that stakeholders do not feel excluded.

A further strand of the discussion deals with the advantages and disadvantages of (unified) European standards. While some of the audience emphasise the opportunities that common European standards would have especially for smaller or weaker member states in terms of saving efforts and time (i.e. efficiency) ('there are probably a number of European specialty organisations working on common standards'), quality improvement, harmonisation and equality, other participants refer to the diversity and contextual differences amongst the EU member states ('we need to recognise that things are done differently in different countries'). Acknowledging such differences and difficulties, Charles Shaw suggests codifying the process for standards development. Concerning his area, i.e. gastrointestinal endoscopy, Roland Valori considers a further European-wide harmonisation of standards advantageous, and points to the role of European specialties organisations and cross-country cooperation. In further discussion, it is suggested to map the relevant national and European specialty groups, yet it remains open who could lead or host the harmonisation process. Jan Vesseur, chairperson of session 3, asks the audience whether there is any process or group that looks for gaps where guidelines are needed but not yet developed. The audience confirms that there is much variation even within a country.

Recommendations and next steps

Charles Shaw invites the participants to flag up issues and ideas for activities 'that would add value'. He refers to questions which emerged from the conference presentations such as 'how a standard should be expressed', and 'how the valuable data from Danish and Swedish registries could be utilised'. The audience then engages in a discussion on the following topics/issues:

- **Use of scientific evidence in standard setting**: as it became evident during the meeting, not all standards are based on scientific evidence, many are historical only. A requirement therefore should be that those organisations that generate or employ criteria, standards or statements, reference the origin. Accreditation Canada International and the West Midlands Quality Review Service were cited as positive examples. Charles Shaw explains that electronic links can be easily embedded in digital quality manuals without obscuring the standards and criteria. As a wider approach, it has been suggested to define principles for development of service standards. This in particular concerns the CEN standards.

- **Harmonising standards amongst the specialties and across Europe**: the quandary between coherence across Europe on one side and the freedom (subsidiarity) of EU member states on the other became evident in the previous session. Overlaps and redundancies also exist amongst the various specialties. A comparative mapping could be the starting point for identifying and harmonising standards that are similar (but not identical) amongst the

various specialties. Standardising the standards development is a rather delicate, political issue, which is likely to collide with professional freedom.

- Roland Valori has been encouraged to embark on the harmonisation process with the specialties and across Europe concerning the gastro-endoscopy accreditation standards as a pilot case. The process may start by identifying who the stakeholders are, and which would be particularly interested. This could be organised as a model / pilot project to disseminate a specialty-based assessment programme from one national NGO, via a European counterpart.

- **Generic set of standards**: further elaborating on the above, the suggestion is discussed to group – analogously to the Joint Commission - all general, i.e. cross-cutting or core, standards together as common chapters of a quality management manual, while standards that refer to specialist areas could remain as separate chapters. General issues like recruitment could be allocated in a general human resources chapter. A core set of procedures and structure would help to link the specialities.

- **Assessing the assessing organisations**: a lively discussion builds on the question of how to ensure the quality of organisations that conduct quality assessments, i.e. regulators/inspectors or accreditors. While the ISO procedures clearly define who assesses the assessors, this question is not settled for many accreditation schemes and regulators/inspectorates. The peer-evaluation conducted by EPSO in Norway and the support EPSO received from France in designing the review are regarded a positive example that could develop into a model for other countries. If EPSO was to continue such evaluations on a broader scale, it would require substantially more resources. The suggestion is made to strengthen the links between ISQua and EPSO, since both organisations have similar goals. Jan Vesseur adds that the cross-border directive could set such inspections in other countries as a requirement, however the peer review seems to be a more practical and independent approach, from which especially smaller states could benefit.

- **Accreditation data – confidentiality rules over transparency**: Charles Shaw points to the divide between accreditors and regulators/inspectorates in sharing information with the public about hospital assessments. The latter are typically, but not in every country, found to be more generous with publishing data. A lively discussion commences amongst the audience concerning the necessity for accreditation schemes to treat information about their clients confidentially and the interest of the regulators and the public to receive valid information about quality and safety in hospitals. Several participants such as CASPE Health Knowledge System (CHKS), IGZ, RGP express their reservations about free exchange of information between regulators and accreditation schemes. Yet, some organisations do exchange assessment data in case by case cooperation, particularly when patient safety is threatened.

- **Separation between accreditation/standard setting and assessment**: Charles Shaw refers to Australia as an example where standards are laid down by one body, but the actual auditing contracted out to independent organisations. The same applies to the ISO system where standards development and assessments are separated. Such a separation could also be considered for accreditation programmes so as to avoid a conflict of interest. A further discussion concerns the question on whether an approach which utilises generic assessors

undermines the peer-review which is considered to be an essential part of accreditation. At this point, Robin Burgess points to the differences in the standard setting for hospital based accreditation, and specialty based accreditation, a topic which has not been sufficiently discussed during this meeting.

Basia Kutryba concludes referring to the many different countries and experiences in Europe and the need to equalise the standards of treatment within European healthcare. The time however needs to be right until a critical mass has gathered. Probably 'some of the players need to marinate'. She encourages the participants to come up with new ideas and conclusions, inviting them to look at the website of the DUQuE project and relevant articles published in peer reviewed journals. It is expected that the EC "cross-border" Directive will come into force early next year. She closes the conference by thanking the organisers and audience and referring to the conference presentations which can be downloaded from the website www.tpj.pl

Minutes of Meeting taken by Anne Christine Hanser

Appendix 1 List of Acronyms

ACSA	Anaesthesia Clinical Services Accreditation
AGREE	Appraisal of Guidelines for Research & Evaluation
AHRQ	Agency for Healthcare Research and Quality
BSI	British Standards Institution
CQC	Care Quality Commission
CEN	Comité Européen de Normalisation
CEO	Chief Executive Officer
CHKS	Comparative Health Knowledge System
COMAC	Concerted action programme on quality assurance in hospitals (EC research)
CPME	Comité permanent des médicins Européens
DUQuE	Deepening our understating of quality improvement in Europe (EC research)
EA	European Partnership for Accreditation
EAN	European Accreditation Network
EC	European Commission
ENQuaL	European research Network on Quality management in health care
EPSO	European Partnership of Supervisory Organisations
ESQH	European Society for Quality in Healthcare
EU	European Union
ExPeRT	External Peer Review Technique
GRS	Global Rating Scale
HIW	Healthcare Inspectorate Wales
HQuIP	Healthcare Quality Improvement Partnership
IAF	International Accreditation Forum
ILAC	International Laboratory Accreditation Cooperation
IGZ	Health Care Inspectorate of the Netherlands
JAG	Joint Advisory Group
MARQuIS	Methods of Assessing Response to Quality Improvement Strategies (EC research)
NIAZ	Netherlands Institute for Accreditation in Healthcare
NICE	National Institute for Health and Clinical Excellence
RCP	Royal College of Physicians
SIMPATIE	Safety Improvement for Patients in Europe
UKAS	United Kingdom Accreditation Service

Appendix 2 Participants of EAN conference, Durham, September 2012

First	Surname	Organisation	Base
Moyra	Amess	CASPE Health Knowledge Systems (CHKS)	UK
Robin	Burgess	Healthcare Quality Improvement Partnership (HQIP)	UK
Giovanni	Caracci	National agency for healthcare regional services (AgeNAS)	Italy
Sally	Coomber	Royal College of Physicians, London	UK
Jacques	Douchamps	Free University of Brussels	Belgium
Carsten	Engel	Institute for Quality and Accreditation in Healthcare (IKAS)	Denmark
Anne Christine	Hanser	University of Bath	Germany
Iuliana	Iacob	National Commission for Hospital Accreditation (CoNAS)	Romania
Basia	Kutryba	Centrum Monitorowania Jakosci (CMJ)	Poland
Judit	Lám	National Health Fund Administration	Hungary
Jan	Mackereth-Hill	International Society for Quality in Healthcare (ISQua)	Ireland
Stephen	McAdam	Det Norske Veritas (DNV)	Norway
Charlie	McLaughlan	Royal College of Anaesthetists	UK
Nicola	Malbon	DNV	
Jasna	Mesarić	Agency for Quality and Accreditation in Health Care	Croatia
John	Powell	Healthcare Inspectorate Wales	Wales
Jörg	Pruckner	Comité Permanent des Médecins Européens (CPME)	Austria
Carlo	Ramponi	Joint Commission International (JCI)	Italy
Tim	Reynolds	Royal College of Pathologists	UK
Charles	Shaw	European Accreditation Network	UK
Biserka	Simčič	Ministry of Health	Slovenia
Jorien	Soethout	Nederlands Instituut voor Accreditatie in de Zorg (NIAZ)	Netherlands
Paul	Stennett	United Kingdom Accreditation Service (UKAS)	UK
Robert	Turpin	British Standards Institution (BSI)	UK
Roland	Valori	University of Bath	UK
Jan	Vesseur	Dutch Healthcare Inspectorate	Netherlands
Jooske	Vos	European Partnership for Supervisory Organisations (EPSO)	Netherlands

References

[1] Walshe K. Pseudoinnovation: the development and spread of healthcare quality improvement methodologies. Int J Quality in Health Care 2009; 3: 153–

[2] Comité Européen de Normalisation (CEN) http://esearch.cen.eu/esearch/extendedsearch.aspx

[3] Shaw CD, Stennett P. Certification, accreditation and regulation of healthcare in Europe: a case for treatment. Submitted to Health Policy 2012

[4] Shaw CD, Jelfs E, Franklin P. Implementing recommendations for safer hospitals in Europe: the SANITAS project. *Eurohealth,* 2012, 2:26-8

[5] CPME position on the legislative proposal for a Regulation on European Standardisation (COM (2011) 315 final). CPME/AD/Brd/26112011/147_final/EN November 2011

[6] Valori R. Quality Improvements in Endoscopy in England Techniques in Gastrointestinal Endoscopy (2012) 14, 63-72

[7] Scottish Intercollegiate Guidelines Network . SIGN 50: A guideline developer's handbook http://www.sign.ac.uk/guidelines/fulltext/50/index.html

[8] AGREE Collaboration [Cluzeau FA, Burgers JS, Brouwers M et al]. Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: the AGREE project. Qual Saf Health Care. 2003 Feb;12(1):18-23.

[9] AGREE Next Steps Consortium (2009). The AGREE II Instrument [Electronic version] www.agreetrust.org

[10] Agency for Healthcare Research and Quality (AHRQ) http://www.ahrq.gov/

[11] Criteria for Inclusion of Clinical Practice Guidelines in NGC. http://www.guideline.gov/about/inclusion-criteria.aspx

[12] National Institute for Health and Clinical Excellence. Healthcare quality standards. Process guide . Jan 2012 http://www.nice.org.uk/media/6E3/84/NICE_quality_standards_interim_process_guide_in_Spring_2012.pdf

[13] International Society for Quality in Health Care. International Principles for Healthcare Standards http://www.isqua.org/accreditations.htm