Practice accreditation:

the European perspective

INTRODUCTION

Accreditation has different meanings in different healthcare settings.[1] A complex picture emerges from reviews of healthcare accreditation schemes worldwide but two key features are common — promoting change and professional development.[2] Accreditation in primary care settings is generally seen as a way of assessing and benchmarking the performance of general practice care across a broad range of clinical and organisational domains.[3] It describes a formal process of self-assessment and external and independent peer review to encourage best practice and can result in recommendations for continuous quality improvement of safety and quality.[4]

Buetow and Wellingham have suggested five ways in which accreditation may be used.[3] These are quality control (mandatory, externally set, minimum predetermined acceptable standards), mandatory regulation (legal or safety standards), continuous quality improvement (to demonstrate excellence above a minimum standard), information giving (to enable comparison between providers by patients and policy makers), and marketing (to showcase services available).

WHAT IS THE VALUE OF PRACTICE ACCREDITATION?

Compared with hospital environments, which have a long history of accreditation, general practices have been considered more difficult and less important to accredit.[5] However quality problems, caused in part by system failures[6] rather than individuals,[7] have led to a growing emphasis on the team or organisation as the unit of analysis in quality improvement initiatives. Despite this, with notable exceptions such as the evidence base underpinning the use of the European Practice Assessment (EPA) programme[8] there is still a relatively limited evidence base demonstrating the effectiveness, cost effectiveness, and appropriateness of accreditation.[9,10,11]

THE EUROPEAN PICTURE

A representative from each member country of the European Association of Quality in General Practice (EQuiP) was asked to complete a detailed survey in December 2011 about their country's health system, and practice accreditation scheme, achieving a 100% response rate.

Nine countries have practice accreditation schemes (Czech Republic, Estonia, Germany, the Netherlands, Poland, Portugal, Romania, Turkey, and the UK) (Table 1).

Five countries are piloting a practice accreditation scheme (Belgium, Croatia, Denmark, Slovenia, and Spain). Ten countries have no current plans to develop a practice accreditation scheme (Austria, Finland, France, Greece, Ireland, Israel, Italy, Norway, Sweden, and Switzerland).

COMPARISONS BETWEEN ACCREDITATION SCHEMES

In six of the nine countries with accreditation, group practices rather than single-handed GPs are the norm. Most schemes have been implemented since 2009 and almost all are voluntary in nature

Table 1. Summary of key features of the accreditation schemes

	Czech Republic	Estonia	Germany	Netherlands	Poland	Portugal	Romania	Turkey	UK[a]
Scheme developer	National College + University	Estonian Society of Family Doctors	AQUA Institute + University	Dutch College of GPs	Ministry of Health	Andalusian Agency for Quality in Health	National Insurance House	Ministry of Health	RCGP + University
Year of introduction	2009	2009	2003	2005	2004	2009	2006	2010	2011
Compulsory	No	No	No	No	No	No	Yes	Yes	No
Organisational issues	No	No	No	No	No	No	Yes	Yes	Yes
Organisational/clinical/patient experience	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Number of criteria	120	18	220	187	123	112	45	38	78
Duration of scheme	3 years	1 year	3 years	3 years	3 years	5 years	2 years	1 year	3 years
Cost of the scheme to the organisation, €	1000	Free	2500	6240	800	<3500	250	Free	2362
Initial pilot stage	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
Inclusion of an improvement plan	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Digital or paper assessment	Both	Digital	Both	Both	Paper	Digital	Paper	Paper	Digital
Self-assessment or face to face	Face to face	Both	Both	Face to face	Face to face	Both	Both	Face to face	Self
Includes a practice visit	Yes	Yes[b]	Yes	Yes	Yes	Yes	Yes	Yes	No
Benchmarking against other practices	No	No	Yes	Yes	No	Yes	No	Yes	No
Publically reported	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Practices completed accreditation, %	≤1	22.4	3	30	≤1	≤1	100	100	0

[a]UK data refers to the Practice Accreditation scheme only and not the Quality Practice Award. [b]Yes for A grade practices.

"... implementation remains slow and the evidence base underpinning the value of accreditation for patients, practices, and policy makers remains limited."

(except for Romania and Turkey). While all schemes except Turkey and Estonia have a cost attached to registering, only Turkey pays practices on completion.

Three schemes were devised by a national non-medical body. Most were the product of collaboration between GPs and a quality group. The majority of schemes included a range of organisational, clinical care, and patient experience criteria. Almost all schemes include a face-to-face assessment through an external visit and a quality improvement plan. Public reporting is more common than benchmarking between practices. The UK data in Table 1 suggest it is an outlier, but is based on the Practice Accreditation (PA) scheme rather than the more established Quality Practice Award (QPA), reflecting the move towards a quality journey is in response to the relatively low uptake of the QPA. This problem is encountered in most countries, with the notable exceptions of Germany, the Netherlands, and Estonia. It is also important to note that only the EPA in Germany was able to provide evidence of the benefit of the scheme to practice development or patient care.

CASE STUDIES FROM POLAND, THE UK, AND ESTONIA

Poland is a post-communist country with a population of 38.3 million. Family medicine was introduced 15 years ago. In 2008, the Polish parliament approved an accreditation scheme centrally organised by the National Centre For Quality Assessment in Health Care. Accreditation is voluntary and paper-based. Assessors rate the level of practice performance in relation to 123 criteria and each is categorised as completed, partially completed, or not completed. A minimum requirement for accreditation is 75% of points. By the end of 2011, 13 primary care practices had been accredited by the Minister of Health. Important barriers are the time and money (€800) required to participate, the top down nature of the scheme, a greater focus on assurance than quality improvement, and the lack of financial benefits for accredited practices.

The UK has a population of 62.6 million and over 40 000 family doctors. There are two voluntary practice accreditation initiatives. QPA has been available for over a decade and is a UK-wide award of excellence covering both clinical and organisational domains. The PA scheme was introduced in 2011 to recognise good practice in organisational areas and will help English practices with forthcoming regulation by the Care Quality Commission. PA has 78 criteria in six domains, all focused on organisational issues and includes a mixture of quality assurance and quality improvement criteria. All data are uploaded onto an online webtool and assessed remotely. PA costs €2362 and is valid for 3 years. QPA, a larger scheme, also incorporates clinical issues and patient experience and includes a face-to-face site assessment of paper-based evidence. QPA costs €4690 and is valid for 5 years. Only about 1.5% of practices have registered for PA and fewer than 1% have completed QPA. This may be related to the cost, the fact that practices are not financially rewarded for achieving either award, and the general sense of political uncertainty created by the recent NHS Health and Social Care Bill.

Estonia is the most northerly of the three former Soviet Baltic republics and gained its independence in 1991. It has a population of 1.3 million with approximately 800 family doctors and introduced practice accreditation in 2009. The voluntary scheme was developed and piloted by the Estonian Society of Family Doctors. Practices do not pay to participate. Data are uploaded by the practice onto a centrally-held website and self-assessed from grades C to A. Practices who score an A grade are externally audited to verify scores and discuss a quality improvement plan. In 2010/11, 22% of practices took part and 27% achieved grade A. Practices are not financially rewarded for completion — the main motivation is positive media attention. They also receive a specially-designed wall pennant and in 2011 the president of the Estonian Republic invited all the A-grade practices for tea.

WHY HAVE COUNTRIES NOT INTRODUCED PRACTICE ACCREDITATION?

In half of the 10 countries without practice accreditation, single-handed practice is the norm. While this does not prevent the development of a scheme, in France, there are no practices nurses and managers, creating a number of barriers in terms of practice culture and workload. There were three recurring reasons why countries had not introduced practice accreditation: a professional culture of autonomy that is strongly resistant to regulation initiatives; a lack of political will; and a lack of funding to develop a scheme in primary care. In Greece, for example, the culture did begin to change in 2006, with the possibility of adopting EPA as a national accreditation scheme, but the recent financial crisis means there is no money to implement any form of accreditation. The different ways in which primary care health services are organised within countries created additional problems for Israel and Sweden. Israel has 4500 family doctors and four separate health funds that appear to be disinterested in initiating a single accreditation scheme. Sweden has 4800 family doctors working in 21 regions, where each is enabled to organise health care autonomously but the lack of national linkage makes the adoption and implementation of a single accreditation scheme problematic.

WHAT DOES THE FUTURE HOLD FOR PRACTICE ACCREDITATION ACROSS EUROPE?

This analysis provides useful information for practitioners and policy makers hoping to develop practice accreditation systems in primary care. There is no one ideal European practice accreditation scheme, and a rather mixed picture of established schemes which share a number of common features emerges.

Variation in accreditation schemes between countries is linked to the historical context of the locus of clinical and policy decision making, for example, how centralised the health system is, insurance coverage, purchasing behaviour, and the status of the medical profession.[12] To this we would add political and financial stability and also the maturity of practice team development. It is noticeable, but perhaps not surprising, that countries with large numbers of single-handed practitioners are less likely to have developed a scheme. However, piloting of PA in the UK demonstrated its feasibility in single-

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handed practices and no differences in achievement between practices of different sizes.[13] Barriers to implementation, particularly concerns over costs, environmental factors such as the political climate, and the limited evidence base, also echo previous work on critical success factors for spread and sustainability of innovations in health care.

Finally, we found a reassuring balance of quality improvement versus assurance in most countries[15,16] and no strong evidence that former Eastern Bloc countries are more likely to use accreditation as a regulatory activity in a primary care context.[17] Indeed, Estonia in particular has not only created an accreditation scheme that is largely developmental in nature but has also broken free of traditional systems ways of thinking.[18]

The overall picture is of an increasing number of countries taking up the challenge of developing and implementing country specific and locally-owned accreditation schemes. However, implementation remains slow and the evidence base underpinning the value of accreditation for patients, practices, and policy makers remains limited. While the greater move towards piloting is encouraging, one way to convince policy makers and practitioners of the value of accreditation is to ensure that continuous data collection is built into practice systems, providing a much needed evidence base on the value of accreditation.

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