KING's FUND CENTRE

Quality Improvement Programme

THE QUALITY QUESTION

A Report on the First Year of the Organisational Audit Project

THE KING'S FUND CENTRE QUALITY IMPROVEMENT PROGRAMME was set up to promote a greater understanding of quality in health care; it does so by encouraging innovation and good practice in this field as well as providing a resource for the exchange of information.

Over the past two years the Quality Improvement Programme has concentrated on helping managers and health care professionals to work together towards achieving a quality culture in the NHS, one in which services are provided in a genuinely customer focused way and the delivery of a high quality service is viewed as the first concern of everyone in the organisation.

Important elements in any quality approach must be the definition of service to be provided, the translation of this definition into quantifiable standards and the measurement of performance against these standards.

The Quality Improvement Programme is particularly concerned with the definition of standards for the organisation of health care.

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SETTING THE SCENE

The origins of the exercise you will read about in this report go back to late 1988 when the Quality Improvement Programme hosted a workshop for an invited audience of senior health personnel and representatives of professional bodies, to consider whether a national approach to the setting and monitoring of standards for the organisation of health care (accreditation) was applicable to the UK.

The workshop caught the growing mood of concern about the variation which exists, not only in the standard of clinical care, but also in the organisational capability of some acute hospitals to support that care.

The day concluded with a number of district health authorities volunteering to pilot some form of accreditation system if the King's Fund was prepared to organise the necessary work.

We were prepared to do the ground work and the timing appeared to be right.

Within a couple of months, the White Paper 'Working for Patients' was published, which detailed new management arrangements for the NHS. Central to these proposals was the negotiation of agreements between commissioners and providers of health care which had to include a clear specification of the quality of service to be provided. Accreditation, or what we term organisational audit, can make an important contribution to such a specification.

The NHS has a long way to travel if it is to become a 'quality organisation', but our work over the past year has demonstrated to those involved, and we hope to a much wider audience, that the will and the energy are there in abundance to make this goal a reality.

This publication marks the end of Phase 1 of the organisational audit project, but we are pleased to say that this is only an interim report – our work is to be extended and we are currently scheduling more pilot sites into 1992.

ACKNOWLEDGEMENTS

Our thanks to:

The pilot sites – Brighton, East Dorset, North Derbyshire, North West Hertfordshire, Nottingham and West Dorset Health Authorities, AMI Chiltern and The Hospital of St John and St Elizabeth, all the staff working in these organisations. A special thanks to the local coordinators who so successfully organised the survey visits.

The survey team members:

David Bowden, DGM, Brighton Health Authority.

Dr David Burnett, Consultant Biochemist, North West Hertfordshire Health Authority.

Dr Richard Burwood, Consultant Radiologist, Brighton Health Authority.

Ian Carruthers, DGM, West Dorset Health Authority.

Elizabeth Davies, Director, Clinical Services, Nuffield Hospital Trust.

Dr Steven McDonald, Consultant Physician, East Dorset Health Authority.

John Newton, DGM, North Derbyshire Health Authority.

Philip Nye, Director of Quality Assurance, North West Hertfordshire Health Authority.

Diana Sale, District Nurse Advisor, West Dorset Health Authority (now Management Consultant with Peat Marwick, McLintock)

Mr Hugh Thelwall-Jones, Consultant Obstetrician and Gynaecologist, West Dorset Health Authority. (now Chief Medical Officer for BUPA.)

Finally we would also like to thank The Gatsby Foundation, one of the Sainsbury Charitable Trusts, for their financial support to the project.

THE EXERCISE

The Organisational Audit (Accreditation) Project

Phase 1 – Spring 1989 to Spring 1990

In Spring 1989, the Quality Improvement Programme at the King's Fund Centre set up a project to test the applicability of an 'accreditation' type approach to the UK health care system. The aims of the project were threefold:

6 the foundations of the project were laid in early 1989... six NHS acute units and two independent hospitals had volunteered and been signed up... 9

1. To develop a comprehensive framework of organisational standards for an acute hospital which could be applied nationally.

2. To look at the process of assessing a hospital's progress towards meeting those standards.

3. To assess the level of acceptance for a national programme of organisational audit.

The foundations of the project were laid in early 1989. By May, seven NHS acute units and two independent hospitals had volunteered and been signed up to take part in the exercise. They were:

Bournemouth General	(East Dorset HA)
Chesterfield and Derbyshire Royal	(North Derbyshire HA)
City Hospital	(Nottingham HA)
Hemel Hempstead	(N W Hertfordshire HA)
Queen's Medical Centre	(Nottingham HA)
Royal Sussex County	(Brighton HA)
West Dorset	(West Dorset HA)
AMI Chiltern	(Independent)
St John and St Elizabeth's	(Independent)

The criteria for selection included the following:

- **Size**

We looked for a range of hospital sizes (71 bed AMI Chiltern to 1,282 bed Queen's Medical Centre, Nottingham).

■ **Type**

We wished primarily to test the process in an average district general hospital but did include one teaching hospital.

■ **Public/Independent mix**

We wanted to examine the applicability of the process and the standards in both the public and independent sectors.

■ **Commitment**

This was the most important criterion. Each unit nominated a consultant, a senior manager (from district or unit) and a senior nursing representative to the steering group.

6 evident commitment from senior management was the most important criterion for selection as a pilot site 9

The steering group considered the North American and Australian accreditation models (appendix 1) and decided that the Australian system provided the most appropriate base on which to build our own approach.

In addition, the full time Project Officer appointed to the programme travelled to the USA, Canada and Australia to look at these models.

This enabled us to learn from the experience of others and, using our own expertise and experience, to develop a system which more closely reflected the health care needs of this country. We termed this system organisational audit.

The timetable we set was very tight, just one year from inception to completion of the survey process. The reason for this was simple – those who were taking part in the project wanted to use the preparatory period both as a way of preparing for the survey and for the introduction of the new management arrangements in 1991.

6 over 80% of professional and consumer organisations consulted about the standards responded positively 9

They viewed the exercise as offering both an organisational diagnosis and an action plan for this purpose.

Developing the standards

A first draft manual of standards covering the range of services offered by an acute unit (appendix II) was

produced in June 1989. Each section within the manual followed the same internal format (appendix III).

While using the Australian accreditation document as its basis, the manual included references to guidelines issued by the various professional organisations and the Department of Health, as well as detailed organisational guidelines already developed in a separate King's Fund Project.

The draft was subject to significant revision by a multi-disciplinary editorial panel and went out for consultation to professional and consumer organisations in September 1989.

Over 80 per cent of those consulted responded positively, and there was a strong call for some form of national approach to the setting and monitoring of organisational standards.

The staff of the pilot sites were also involved in a practical evaluation of the document, to determine which standards could be implemented and the impact these would have on the service provided to the patient, as well as the working environment for staff.

Preparation for the survey

By autumn 1989, each of the participating organisations had established its own local steering group with responsibility for the distribution of information, ensuring that all staff understood the process and that the applicable standards would be met. We worked closely with these groups.

Each steering group consisted of staff who could effectively represent the various services within the hospital and were of a seniority to demonstrate to hospital staff the management's commitment to the project.

A typical group consisted of:

- UGM/chief executive

6 each hospital established its own local steering group which could effectively represent the various services within the hospital and were of a seniority to demonstrate the management's commitment to the project 9

- two consultants (medical/surgical representatives, chairman of the medical audit committee)
- senior nurse (director of nursing or equivalent)
- paramedical representative
- support services manager
- head of personnel

Each group nominated a survey coordinator as its spokesperson. The coordinator liaised with us at the King's Fund and, with the support of the group, coordinated the survey preparation programme (appendix IV).

In most of the pilot sites, this role was assumed by staff with other responsibilities, such as a consultant biochemist, consultant in public health, quality assurance manager or the UGM.

Two hospitals appointed an individual (for six months) to work full time on the programme.

Pre-survey documentation

One of the key tasks for the group, (which usually fell to the coordinators), was to distribute and coordinate the completion of the pre-survey documentation.

This consisted of:

- **A hospital profile form** – a 60 page document providing information on the hospital – the range and size of services, number of beds, population served, staffing levels and organisation. The main purpose of this form was to build up a picture of the hospital for the survey team.
- **Self assessment forms** – consisting of the standards manual divided into individual service sections, adapted to allow compliance with standards to be indicated and comments to be made. This gave hospital staff the opportunity to assess their own progress towards meeting the standards, to expand or explain responses and to comment on the validity of the standards themselves. The completed forms were returned to the King's Fund one month prior to the survey date and were checked and circulated to the survey team.

6 the pre-survey documentation served to build up a picture of the hospital for the survey team 9

The survey timetable

The coordinator was also responsible for putting together a timetable for the survey, covering meetings with staff on wards, in departments and other services included in the standards manual.

6 putting together a timetable for the survey proved to be a major undertaking involving the coordination of numerous diaries 9

This proved to be a major undertaking as it involved the coordination of numerous diaries, while ensuring the continuation of the hospital's normal routine.

The intention had been for the survey team, which met one week prior to the survey, to compile a comprehensive list of areas to visit and staff to interview, based on the questions arising from the pre-survey documentation completed by the hospital.

The North Derbyshire and Chesterfield Royal Hospital, the first site to be visited, had less than a week in which to organise a timetable – a daunting challenge.

It succeeded, much to its credit, but only just. It was apparent that the timescale for drawing up the timetable was unrealistic. The revised Chesterfield timetable (appendix V) was used subsequently as a 'model' and circulated to the remaining pilot sites, which aided the timetable process considerably.

The mock survey

A number of the pilot sites elected to do a 'mock' survey which offered an opportunity to check the accuracy of the completed pre-survey documentation, to explain the process and to alleviate any anxieties among the staff.

The approach taken varied from using a team of three (doctor, nurse and manager) – or 10 (the local steering group), which carried out a full survey or targeted discrete areas. Alternatively the survey coordinator checked the completed documentation with individual heads of departments.

The survey team

6 a group of nine health care professionals was formed to carry out the surveys... All gave their services free of charge... 9

A group of nine health care professionals was formed to carry out the surveys. Each of the participating hospitals was invited to nominate senior members of staff to act in this capacity and from these nominations, three consultants, three directors of nursing or equivalent and three DGMs/UGMs were selected.

All were volunteers who gave their services free of charge to the project and each devoted approximately 15 days to the task, which included a three day training programme.

This training took place during October 1989 and covered the following areas:

- The background to accreditation
- The standards
  - how and why they had been developed.
  - guidance on interpretation.
  - identification of the key areas.
- The survey process – practical guidance on the process including time management, interview skills and report writing.
- Discussion and workshops with the executive director of the Australian programme.

In future, individuals will observe one or perhaps two surveys before becoming active survey team members.

The survey process

6 ... the survey structure did not vary 9

A three to four day survey of each hospital was conducted by a team consisting of a consultant, a DGM, a nurse and a King's Fund observer, between February and April 1990.

While the survey team spent two and a half days in the smaller independent hospitals and three and a half days in the larger NHS hospitals, the structure of each survey did not vary (appendix VI).

The first meeting

When the team arrived at the hospital, it met with the management executive which usually consisted of the

UGM, a consultant, director of nursing, head of personnel, head of finance and estates manager.

The object of this first meeting was to introduce the team members, outline the process, identify any areas of sensitivity to which their attention should be drawn and discuss points arising from the pre-survey documentation which required clarification.

The meeting, while tending to be quite informal, set the scene for the survey and was important in terms of establishing a relationship between the hospital and the survey team.

In most of the visits, the survey team also met the heads of departments before assembling in the work room which had been set aside for them.

Documentation

The work room, apart from being a meeting place for the team, housed the documentation which had been compiled by the hospital.

This included:

- policy and procedure manuals
- district/unit annual and financial reports
- consumer feedback studies
- patient information packs
- leaflets
- complaints files
- quality assurance programme packs
- management consultant reports
- staff rotas
- organisation charts
- maps of the hospital

This documentation served two main purposes:

1. It assisted in building up a picture of the hospital for the survey team.

2. It provided evidence to support compliance with standards which could be tested out with staff.

The volume of documentation varied from hospital to hospital and formed an essential part of the team's bedtime reading.

It was an important reference source and together with the pre-survey documentation served to alert the team to the potential areas of focus and ensured a working knowledge of each department or service.

Team interaction

Each team member covered his or her own areas of expertise, interviewing staff on a one to one basis.

6 all team members visited certain core areas – wards, A&E, outpatients – which enabled standards to be monitored from different perspectives... 9

However, all the team members visited certain core areas such as the wards, A&E and outpatients and in most instances did so separately.

This enabled standards to be monitored from different perspectives and provided a means of cross-checking findings. Those occasions on which the team visited a ward or individual collectively proved to be, quite understandably, the most intimidating and the least successful.

The survey team met at regular intervals during each day to compare notes, to test points of view and alert one another to perceived problems or areas which appeared to demonstrate good compliance with standards.

This interaction served to build up an accurate picture of the hospital's progress towards meeting the standards over the survey period.

The team also interviewed users – staff, patients and visitors – about the services which they received from departments such as catering, pharmacy, radiology and pathology. Other hospital-wide concerns such as infection control, fire safety, cleanliness and methods of communication were also explored in this way.

The routine of the hospital continued as normally as possible during the survey; indeed it was an important

element of the task of the survey team to be unobtrusive and sensitive to the demands placed on staff.

If a ward or department was particularly busy, the team member would return to talk to the staff, where possible, when the situation became less hectic.

The survey process involved discussion with all levels of staff throughout the hospital and included a night visit.

Team members frequently returned to departments to check findings and the afternoon of day three was set aside for return visits (appendix V).

On the evening of day three, the team compiled its report. This involved further discussion between members to ensure that all were in agreement with the conclusions reached and the recommendations which each would make.

On day four these findings were presented to the management executive in the form of an overview of general themes and individual reports by each team member on their respective sections.

A further presentation was then made to the heads of department. This proved to be the least successful aspect of the survey process and will be dealt with in the next chapter. The feedback from the team was compiled into a confidential report which was returned to the unit within a month of the survey.

ASSESSMENT

This section is not intended to provide a formal evaluation of the organisational audit programme, rather we hope that it will answer some of the many questions which we have been asked about the programme and help those interested in our work to gain a better understanding of the steps within the process.

We have made general comments about standards and activities. While these do not apply in every instance to each of the participating hospitals, there was a remarkable level of commonality between the units.

It is important to bear in mind that the aim of the project was to examine the process of organisational audit (accreditation) and not to make specific statements about the quality of the hospitals we surveyed, although each hospital has received feedback on its progress towards meeting standards.

Assessment of the project has therefore concentrated on the process and has involved discussion with the King's Fund steering group, local steering groups, the survey coordinators and the survey team.

These discussions covered each stage of the process:

1. Survey preparation.
2. Pre-survey documentation.
3. The survey and the timetable.
4. The survey team.
5. The report.
6. The standards.

The impact of the process – and what changes resulted – will be evaluated in 18 months time when each of the pilot sites will be resurveyed.

6 the aim of the project was to examine the process of organisational audit ... not to make specific statements about the quality of hospitals we surveyed 9

Standards

By the time the first survey took place in February 1990, there had been feedback on the standards from three sources:

- Each of the participating hospitals had been part of the original review process.
- Comment had been received from those professional and consumer organisations to which the manual had been sent for consultation.
- Perhaps most importantly for the purpose of the survey, the completed self-assessment forms from the hospitals had been returned, which offered a real insight into the standards. These correlated closely with the findings of the survey team, reflecting positively on the realism of those completing the forms, helped no doubt by the encouragement of the survey coordinators.

6 ...the standards had stood up to close scrutiny. 9

The survey teams were therefore able to use the manual with confidence, knowing that the standards had stood up to close scrutiny. In addition, the team members were themselves very familiar with these standards as each had been involved in the project since its beginnings.

By and large, the standards worked well, but there were a number of areas in which it became clear that further work would be needed to improve them and make them more user friendly.

1. Applicability

There were a few standards which were inapplicable and a somewhat larger number which were open to misinterpretation. These points have been addressed in the revision of the manual of standards.

2. Layout

In constructing the manual, much discussion had surrounded the desirability or otherwise of incorporating core sections such as staffing and direction in each chapter (appendix III) as opposed to producing a single 'core' chapter. The former approach was adopted with the resultant element of repetition. However, this format has the advantage of ensuring that each department or service

addresses all relevant standards and it is likely that the next edition of the manual will retain the same layout.

3. Design

The design of the manual will be amended to allow for easier distribution of the sections.

4. Sections in content

Two sections of the manual – Management and Environmental Services – did not work well. These were both umbrella sections covering a range of sometimes loosely related services (appendix III) for which the management member of the survey team had responsibility. Experience of using the standards suggests that these sections could be redesigned and certain subsections more appropriately located.

5. Tracking the patient

In adopting the Australian standards as our blueprint, we acknowledged the real limitation that the standards were not patient focused. Use of the standards confirmed this limitation and it became an important task for each team member and in particular the nurse to ensure that the patient focus was built in at all stages, not least by interviewing patients in relation to services. The next draft of the standards[1] will include a patient care section, which will build upon the patient-focused standards in each of the chapters and tie these together by means of the patient's natural progress through a hospital stay from admission to discharge.

6. Link with professional standards and local standards for the delivery of service

A concern frequently expressed by critics of the accreditation approach is that the standards are top down and cannot command ownership. Our own experience is contrary to this. There were instances where existing local standards were different from, though rarely in conflict with, our own. More commonly, staff expressed the view that the organisational standards provided a useful framework within which local and professional standards could sit and on occasions acted as a stimulus to their development.

1. Organisational Audit (Accreditation UK) – standards for an acute hospital (A King's Fund Centre publication, to be published October 1990).

6 organisational standards provided a useful framework within which local and professional standards could sit 9

Survey preparation

The hospitals taking part in the project had six months to prepare for the survey, less than would normally be allocated. This did not appear to be a major handicap, and one of the most powerful messages from the project was that it was this preparatory phase which proved of greatest value to participating hospitals in terms of self review, attitude change and planning for the future. The survey provided the icing on the cake!

■ A systematic review of services

The preparatory phase provided an opportunity to undertake a systematic review of services across all groups and levels of staff: "It was a time to question what you do, how and why you do it".

■ Change in attitude

During this period, a significant shift in staff attitudes took place from an initial concern at the apparent size of the challenge to meet the standards, through to a recognition that: "we actually achieve many of the standards but have no formal means of demonstrating this". With this change came a growing confidence that the process offered a means of validating actual practice.

This in turn led to a documentation of that practice, an identification of the gaps and the development of timetabled action plans.

It was also the experience of some hospitals that there was a shift in certain groups of staff from a position of disdain and distance from the project – "What can we possibly learn from an Australian bush hospital" – to a growing sense of humility and willingness to participate.

■ Multidisciplinary mode of working

The necessity to develop a multi-disciplinary mode of working as a means of approaching the standards was clearly a very positive by-product of the programme which: "offered an opportunity to work together across professional boundaries in a context in which competition was absent", sometimes for the very first time.

6 it was a time to question what you do, how and why you do it 9

■ **The value of a survey coordinator**

A frequently expressed attitude which the steering group and coordinators had to confront was one of scepticism – "We're too busy". "What's in it for us?" "Why should we take on more work?" or "What has the DGM/UGM volunteered us for this time?"

The survey coordinators played an essential role in responding to this anxiety. They had to be well informed and, in the words of one coordinator, "inventive and lateral thinkers, anticipating questions and allaying early anxieties".

It is a tribute to the survey coordinators and the local steering groups that hospitals were well prepared and staff open and honest in discussions about their compliance with the standards.

The coordinators also had to be 'persuaders'; where there was resistance, they, together with the steering group, had to overcome this.

Further key elements in the success of this phase of the project were:

6 hospitals were well prepared and staff open and honest in discussion about their compliance with the standards 9

■ **Senior management commitment**

It was essential to gain the involvement and commitment of all staff and in particular medical staff to the process. This could only be achieved if senior management demonstrated its backing for the exercise. While those working at departmental level had the responsibility for implementing the standards, they had to feel supported both by their peers and senior management.

■ **Communication**

Over a period of time, the project assumed an importance for all staff within units as a result of good communication. Organisational audit was included on everyone's agenda – heads of department meetings, meetings of the medical advisory committee, nursing advisory committee, unit management boards and unit team briefings.

While hospitals adopted different approaches to

communicating the progress of the project, they all had consistent and regular feedback in common. Examples of communication included regular organisational audit meetings and the inclusion of items about the project in staff newsletters and on bulletin boards.

The survey process

6 an independent objective hospital wide assessment 9

While the survey itself has already been described in this report as "the icing on the cake", its value was nonetheless considerable.

It was the affirmation of many months of hard work on the part of the hospitals, and provided the necessary focus for that activity. It ensured that standards were worked towards, drew the attention of management and professional groups to the need to document their working practices and helped staff to formulate plans to implement standards which could not be complied with by the survey date.

It also provided an external reference point – an independent, objective hospital-wide assessment.

Those hospitals which had undertaken a 'mock' survey generally thought that they had identified all the problem and 'good' areas. Some openly admitted that they did not expect the survey team to glean much additional information in what was considered to be the very short length of time of the survey visit, principally because the team would be unfamiliar with the hospital.

Contrary to expectation however, the survey team was able to gather significant additional information about the hospital, some of which was known, some of which had not been anticipated.

As outsiders, the survey team members are detached from the day to day politics and personalities of the organisation. They are able to offer a wide angled and objective assessment of whether the systems and processes are in place and working effectively for a service or department and its users.

The success of this part of the process served to convert many of the sceptics, particularly amongst the medical staff who had been doubtful about what the survey team could realistically achieve.

6 morale booster 9

There is a natural tendency to assume that external monitoring bodies will focus on negative aspects of a service and there was understandable anxiety within hospitals as the survey date approached.

The survey however did provide an important opportunity to commend staff for their work and proved in many instances to be a morale booster.

Many examples of good practice were highlighted by the survey team and, as the members of the team gained experience, they were able to point staff with a particular problem to a hospital which had succeeded in overcoming a similar difficulty.

This exchange of information was an important aspect of the survey process and proved educative for both the hospital and the team members.

It is the King's Fund's intention, with the agreement of the hospitals involved, to gather this information on a database for wider circulation.

6 the timetable was extremely tight 9

The survey timetable was extremely tight and the team members had to be both physically and mentally fit. There was a keen sense of disappointment among staff who had not been visited by the team, or who felt that insufficient time had been allocated to them. This was reflected in the sense of anticlimax during the final feedback session. This sense of disappointment was also shared by team members when they were unable to speak to all the staff they wished to.

Logistics proved an additional problem – Queen's Medical Centre has some 20 miles of corridors to negotiate, whilst West Dorset is made up of three quite separate acute units located some distance apart.

The latter proved to be one of the most difficult surveys, not simply because of distance between units but also because of duplication of services. In future we feel the length of time for each survey should be more flexible, the time allocated to a unit being determined by the number of beds and range of complexity of services offered.

For this reason, sites will be visited by us in advance to determine the survey length and hospitals will then be charged on a per diem basis.

Feedback

6 anticlimax of the feedback session 9

The purpose of the survey is to provide feedback to the hospital on its progress towards meeting the standards. It is clearly important for the hospital to have an opportunity to have a full discussion of the process and recommendations with the survey team.

We had given hospitals the opportunity to determine the form of feedback they wanted, but had suggested that a detailed verbal report should be given to the unit executive, followed by a general themes feedback to heads of departments.

In the event, insufficient time (one and half hours) was allowed for the first feedback session at Chesterfield Hospital.

Subsequent feedback sessions to the management executive were extended but the appropriate length of time for this activity needs review.

The sense of anticlimax at the end of the survey was something which we had not anticipated.

In general, the final meeting with the heads of department(s) and other hospital staff was not a success – everyone who attended wanted to know about their own department and was disappointed at the lack of specific department comment.

The themes which had been pulled out were valuable but

were summaries and therefore tended to be bland and depersonalised and staff found, quite understandably, that it was difficult to relate to them.

The survey team tried to build in some time to return to each head of department to discuss recommendations but this was not always practicable. Often, the 'completed' picture of a service / department / ward did not emerge until the very end of a survey.

Future surveys will need to ensure that this important element is built into the timetable.

Whatever arrangements are made, some sense of anticlimax will remain because staff will have worked hard to meet the standards and their anticipation and anxiety will build up as the survey dates draw near.

It must ultimately be the responsibility of the hospital management to deal with this and the survey feedback process, to ensure that staff feel rewarded for their efforts and are enthusiastic about the next step.

Report

6 forming the basis for action agendas 9

The management executive of each hospital has now received a confidential report on its progress towards meeting the standards, which details recommendations for action and areas meriting commendation. This report is not available to anyone within the DHA without the express permission of the unit. The hospitals are agreed that the report and the organisational audit process have greatly assisted in setting priorities for action, confirmed where they are on the right track and identified when an input or action is not having the desired or expected effect. (These reports will form the basis for action agendas for the next year).

The production of the reports proved a considerable task both for the survey team and for us at the King's Fund.

The bulk of the report had to be completed prior to the feedback session, which entailed working into the small

hours, particularly on day three.

Following the completion of the survey, the King's Fund observer translated what were often mere notes into a comprehensive document.

The report offers a brief overview of each department followed by recommendations for action against standards and commendations.

Survey team members (and the King's Fund) undoubtedly improved with practice, but in future, team members will be issued with a booklet to guide them through the construction of reports, and report writing will become an important feature of future training programmes.

Survey team members

6 high calibre individuals 9

Critical to the success of the survey process was the credibility and acceptability of the team members.

Feedback from the hospitals suggests that the effort which was put into training them, together with our good fortune in working with high calibre individuals – all generously endowed with a sense of humour – paid dividends.

As far as possible, no two teams contained the same combination of people, as we wished to avoid the development of a shared view.

The average working day was long, running from 9am to 11pm, and team members needed to be fit.

They also needed to be able to extract information, often in non-specialist areas, very quickly and with sensitivity, to be well informed, and able to put anxious staff at ease.

Many staff and hospitals wanted the team to fulfil the role of consultants. This clearly posed a difficult dilemma to individuals trying to demonstrate empathy while retaining detachment.

The development of a good practice database, which has

been referred to earlier, will prove invaluable in this respect, enabling team members to refer individuals to the work of other hospitals without making value judgements themselves.

An issue which has yet to be resolved is that of the appropriate makeup of the survey team.

For Phase 1 of the project, we used a team of three – nurse, consultant and general manager.

We did this to achieve maximum acceptability within the unit surveyed, but are aware that by doing so we have excluded major areas of expertise, such as that of paramedical staff.

CONCLUSIONS

It would be premature to predict the outcome of this exercise at this early stage; we must wait until a future date to do this.

We are fortunate in being allowed the opportunity through the extension of the programme to revisit the original pilot sites and assess the change which has taken place in relation to the standards as well as to survey a wider range of hospitals from which we shall learn more lessons.

It may be helpful however to recap our findings to date in relation to the three tasks which we set ourselves.

1. To develop a comprehensive framework of organisational standards for an acute hospital which could be applied nationally.

- We are confident that we have created a robust framework of standards for the organisation of health care and one which is applicable in very large part to both the public and independent health care sectors. Applicability has less to do with the market status of a unit than its size and the range of services which it provides.
- While the standards are robust and comprehensive, they will require considerable work over a period of time to become more closely suited to the working of an acute hospital and in particular to become more genuinely patient focused.
- The standards must be developed alongside and be complementary to professional standards, and those for the delivery of service. They provide a useful framework within which other standards can sit, but their value is limited if they stand alone.
- Preliminary research suggests that the standards, while framed for an acute hospital, could be used in adapted form by primary, community care and other services.

■ The frequently expressed concern that explicit standards will constrain rather than encourage good practice has not been borne out by this exercise. In many cases, a department's performance exceeded the level of the standards and it was justifiably proud of this. The standards must be constantly reviewed and updated in response to changing requirements. They must be in the vanguard of good practice – ahead, but not so far ahead as to be unachievable.

2. To look at the process of assessing a hospital's progress towards meeting these standards.

■ The process, and in particular, the pre-survey preparation, provides an excellent opportunity for self review and development.

■ The survey process itself offers a powerful lever for change, particularly in those areas lagging behind.

■ While the amount of work involved in survey preparation is clearly considerable (particularly for the coordinator and steering group members) much of this work needs to be done in preparation for the new management arrangements in order to draw up contract specifications. The evidence from hospitals suggests that preparation for the survey helps units to make explicit the quality components of these contract specifications.

■ The process brings staff together for a common purpose and encourages multi-disciplinary working.

■ Our own concern that lack of resources would be a focal issue during the surveys was not borne out.

■ Most importantly, the process of organisational audit does appear to provide a framework for encouraging the systematic review of hospital organisation and of the systems and processes which must be in place in order to provide an effective and efficient service.

■ It provides a real focus for the improvement of patient care. For example, in our pilot a number of initiatives were developed in the area of professional standards. There were also examples of groups of staff, such as the paramedics, getting together on a regular basis as a result of the process

to develop common objectives and support mechanisms. This has also been the experience of accreditation in other countries (see appendix 1).

3. To asess the level of acceptance for a national programme of organisational audit.

In many ways this was a by-product of our work. The interest in the programme and the demand to participate suggests that the level of support for the development of a national programme is considerable. More acute units than could realistically be assessed wished to participate in the King's Fund initiative and the number of volunteers continues to increase.

Already, 18 hospitals have been selected to be surveyed in the next phase of the programme planned for 1991 and these hospitals are currently in the preparatory stage. They will obviously benefit from the experience gained in the first phase of the project but will also be assisting in the development of the process and standards. A further 25 will be scheduled for survey in 1992.

Alongside this, an advisory council comprising membership from the major professional bodies and consumer interests has been set up to guide the future work of the programme. This body will also give serious consideration to the long term management of the programme.

Considerations for the future

- **Status of exercise**

In looking at the process of organisational audit, it was clearly important that we should not make judgements upon the hospitals taking part.

We were not in the business of pass or fail. However, in embarking on the programme, we assumed that in the long term such status would be accorded to hospitals participating in the programme.

Phase 1 of the project suggests that notions of self-development and self-regulation may not sit comfortably alongside the 'plaque on the wall' approach of accreditation and this will clearly need to be thought through. Nonetheless, if a pass/fail system is not to be introduced, then the public must be clearly protected from those hospitals which fall below an acceptable standard.

- **Status of survey team**

The credibility of the survey team is key to the success of this exercise and will require the commitment of individuals and professional organisations to release the most able managers and professionals for significant periods of time.

- **Confidentiality**

It is our view that confidentiality should be maintained between the monitoring organisation and the client. However it is recognised that within the commissioner/provider arrangements planned for heath care, purchasers (commissioners) may wish to negotiate access to organisational audit reports as part of the contract or agreement.

- **The consumer**

We must ensure that the patient – the consumer – is the focus of both the standards and the survey process.

- **Bureaucracy**

There will be an increasing need to prevent the process becoming mechanistic and bureaucratic.

- **Outcomes**

An inevitable criticism of a programme such as this is that it is structure and process and not outcome based. It is our view that at this point in time no one system could encompass all three elements of the quality equation, but it is clearly essential that work continues in parallel along these three dimensions.

CONCLUSION

Organisational audit alone cannot provide an assurance of quality, but must form part of a managed approach to the provision of healthcare.

Nonetheless, while it cannot provide all the answers to quality, it does offer a sound starting point.

It offers a framework within which professionals can look critically at their own processes for the delivery of health care and should provide a real opportunity to include an effective consumer input into the development and monitoring of standards.

While organisational audit cannot guarantee the quality of healthcare offered, it is a good measure of the hospital's ability to sustain a quality clinical service. This will have considerable significance in the proposed purchaser/provider system of healthcare planned for this country.

APPENDICES

APPENDIX I

Accreditation Models – An Overview

The starting point for the design of the King's Fund organisational audit model was a study of existing accreditation models in the United States, Canada and Australia. The following description offers a brief outline of the history, structure and working of these models. For a fuller account readers should refer to the King's Fund publication **Health Service Accreditation – An International Overview** by Ingrid Sketris (ISBN 0903060175) including observations on the potential benefits and drawbacks.

Definition

Accreditation is:
A framework of organisational standards which are concerned with the systems and processes for the delivery of health care. It also involves the evaluation of compliance with those standards by means of a survey conducted by a team of health care professionals.

Accreditation offers a national approach to setting and monitoring standards. The standards relate to the structure of hospital organisation and to the systems and processes which must exist in order to provide an effective and efficient service to patients and a good working environment for staff. In meeting them, a hospital demonstrates that it has the necessary mechanisms in place to support a high quality of patient care.

History

The process of accreditation is one which has been developed and implemented in the United States, Canada and Australia over a number of years. Its history dates back to the early 1900s. In 1919, the American College of Surgeons introduced what was then called a 'hospital standardisation programme'. The resulting standards were widely publicised and hospitals participated in the programme on a voluntary basis. The surgeons were joined in 1951 by representatives of other professional organisations (physicians, nurses, management) to form what is now known as the Joint Commission on Accreditation of Healthcare Organisations. The Canadians, who had collaborated with the American programme from the start, established their own standards and accreditation programme in 1959, under the auspices of the Canadian Council on Health Facilities Accreditation.

In 1974 the Australians developed an accreditation programme, establishing the Australian Council on Healthcare Standards as its governing body, and in 1989, New Zealand embarked upon a similar programme.

The standards, the organisations and the process of accreditation are broadly similar in each country:

a) The standards relate to hospital organisation, systems and processes.

b) The organisations running the programme are:
- professionally led
- independent of central and local government
- non-profit making
- educational (produce supporting literature and guidance on interpretation of standards; organise workshops and seminars; (provide consultancy service)
- include limited consumer representation (with the exception of Canada).

Process

Participation in the accreditation process is voluntary. To gain accreditation status, a hospital undergoes an assessment of compliance with standards, known as the survey. The steps involved are as follows:

1. **Pre-survey:**
   - The hospital applies for accreditation.
   - The hospital receives copies of the standards manual and may request guidance on interpretation.
   - The date of the survey is agreed.
   - The hospital prepares for the survey (approximately 12 month preparation period).

Pre-survey documentation:
The hospital is required to complete a questionnaire which provides details on the size, complexity and range of services. This information is used as a basis for the selection of an appropriate team to conduct the

survey. The questionnaire is sent to this team in advance of the survey to provide it with background information about the hospital. The hospital may be asked to complete a self-assessment form; their own assessment of progress towards meeting the standards. This information is also sent to the survey team.

1. **The Survey:**
   - The team (with the exception of the US) is comprised of senior practising healthcare professionals – consultant, manager, nurse.
   - The survey is conducted over a 3–5 day period.
   - The team (with the exception of the US) recommends accreditation status (for 3, 2 or 1 years). The council or commission vote on accreditation status of the hospital, based on the surveyors' report.
   - The hospital receives the report and the accreditation award.

The results of the survey are confidential, although whether or not a hospital is accredited is made public.

The various accreditation programmes originally developed standards for acute hospitals but have now expanded to encompass all health care facilities – long stay elderly, mentally handicapped, mentally ill, community – both public and private. Comprehensive standards have been written which reflect the special needs of each facility. These are national standards which have been developed through extensive consultation with professional and consumer organisations. They are subject to rigorous testing in the field before they are included in the standards manual as a requirement which must be met in order to gain accreditation status. The standards document itself is subject to regular review to ensure that it reflects current health care needs, since regular evaluation is regarded as an essential requirement of any standards programme if it is to retain credibility and make a significant impact on quality.

The success of the accreditation programme is dependent upon the credibility of the surveyors. Surveyors can put themselves forward but are more usually nominated by their professional organisations or peers and they are selected on the basis of seniority, experience and personality. They are then subject to a training and orientation programme.

It is important to note that there are significant points of difference between the models outlined, most noticeably between the United States and the rest. For example in relation to surveyors, the Joint Commission employs full-time surveyors who are not current practising professionals. Survey teams are comprised of a doctor, nurse and administrator, but members are frequently retired professionals.

The benefits of an organisational audit programme are:

1. It is based upon explicit national standards developed with input from professionals and the consumer.
2. The standards can be applied to public and private sector health care.
3. It is seen as a means of improving quality rather than being punitive.
4. It is independent of local or central government.
5. It encourages a systematic review of quality.
6. It builds upon the concept of peer review.
7. It includes consumer representation.
8. Support and guidance is provided to hospitals participating in the programme.
9. Training, support and guidance is provided to those acting as surveyors.

It is not without its drawbacks:

1. The approach is mechanistic and must constantly guard against becoming an overly bureaucratic tier of inspection.
2. The process can rapidly lose credibility if the standards are not constantly reviewed and updated (the US, Canada and Australia are now looking at outcome-based standards which will be assessed in tandem with the systems and processes).
3. The process can also lose credibility if those selected to act as surveyors are not equal to the task. (In the US, most of the surveyors are full-time, salaried members of staff which has led to problems of credibility).
4. The programmes (with the exception of the US) rely on professionals acting as surveyors on a voluntary (no payment) basis (as do the HAS) which can lead to problems of availability.

APPENDIX II

SERVICES*

Accident and Emergency

Acute Day Care

Catering

Environmental Services
- **Estates Management**
- **Fire Safety**
- **Health and Safety**
- **Housekeeping**
- **Infection Control**
- **Linen**
- **Sterilisation and Disinfection**

Professions Allied to Medicine

- **Finance**
- **Patients' Rights and Special Needs**
- **Personnel**

Laboratory Services

Library

Medical

Medical Records

Nursing

Operating Theatre

Out-Patients

Pharmacy

Hospital Management

Radiology

Special Care

APPENDIX III

STANDARD HEADINGS*

1. **Philosphy and objectives**
2. **Organisation and administration**
3. **Policies and procedures**
4. **Staffing and direction**
5. **Staff development and education**
6. **Facilities and equipment**
7. **Evaluation**

* These headings appeared in the first draft of the standards manual which has now been subject to revision (see Organisation Audit (Accreditation UK) – Standards for an acute hospital. A King's Fund publication to be published October 1990).

APPENDIX IV

SURVEY PREPARATION TIMETABLE

Timescale: 9 months – 1 year

1. **Establish local steering group**
   * **Identify co-ordinator**

2. **Education**

3. **Distribute standards**

4. **Develop standards implementation programme**
   * **Identify areas for action**

5. **Pre-survey documentation issued**
   (3 months prior to survey)
   * **Self-assessment questionnaire**
   * **Hospital profile form**

6. **Return pre-survey documentation**
   (1 month prior to survey)
   * **Survey timetable**

7. **Survey team meeting (3 weeks prior to survey)**

8. **Survey**

APPENDIX V

TUESDAY 13th FEBRUARY 1990

	Director of Nursing Services	Consultant Physician	District General Manager
09.00	Meet Unit Executive, Committee Room		
09.30	Meet Heads of Departments, Staff Coffee Lounge		
10.00	Visit to Surveyors Room		
10.30	Patient Care Manager	Pathology Service	Visit Laundry Manager
11.00	Outpatients	Director/Chairman of Division	
12.00			Fire Precautions
13.00	Lunch Team Meeting		
14.00	A and E Services	CSSD	
15.00	Occupational Therapy	Medical Records	
	Diatetics		
16.00	Speech Therapy		
	Chiropody		
17.00	Team Meeting		
21.00	Night Visit	Wards Security A and E On Call Facilities Pharmacy	

WEDNESDAY 14th FEBRUARY

<table>
<tr><td></td><td>Director of
Nursing Services</td><td>Consultant
Physician</td><td>District General
Manager</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>07.00</td><td colspan="3">Shift Hand Over</td></tr>
<tr><td>08.30</td><td>Physiotherapy</td><td>Chairman Med. Div.</td><td rowspan="2">Works Department

Health & Safety</td></tr>
<tr><td>0900</td><td colspan="2">Infection Control</td></tr>
<tr><td>1000</td><td colspan="2">Day Care</td><td rowspan="2">Catering Department
including Ward
Visit</td></tr>
<tr><td>1100</td><td colspan="2">Operating Theatre</td></tr>
<tr><td>1300</td><td colspan="3">L U N C H</td></tr>
<tr><td>1330

1430</td><td>Intensive Therapy

Coronary Care Unit</td><td>Pharmacy</td><td rowspan="2">Porters

Domestic Department</td></tr>
<tr><td>1530</td><td>Special Care Baby Unit</td><td rowspan="2">Radiology</td></tr>
<tr><td>

1700</td><td>Maternity & Gyn Wards</td><td>Library</td></tr>
</table>

THURSDAY 15th FEBRUARY 1990

	Director of Nursing Services	Consultant Physician	District General Manager	
0800		Chairman Midwifery Division		0815
0830		Chairman Psychiatric Division	Patient Care Manager	0900
0900	Ward Visits	Chairman, Paediatric Division	Unit Medical Officer	0930
0930		Unit Medical Officer/Chairman	Unit General Manager	1030
1030		Anaesthetic Division Vice-Chairman, Radiology Division	Personnel Manager	1115
1100		Ward Visit	General Services Manager	1200
1200			Unit Finance and Planning Manager	
1300	Lunch			
1400	Follow Up Visits			

APPENDIX VI

Evening – team assemble at hotel
– team meeting to plan day 1

Day 1

09.00 am – Surveyors meet unit management team

09.30 am – Surveyor team introduced to heads of department and other staff

10.00 am – Surveyors assemble in work room
Team separates to visit their respective areas

Lunch – Team meeting
Team separates to visit their respective areas

Evening – Team meeting to discuss findings and plan day 2

Day 2

Team separates to visit their respective areas

Lunch – Team meeting
Team separates to visit their respective areas

Evening – Team meeting to discuss findings and plan day 3

Day 3

AM – Team separates to visit their respective areas

Lunch – Team meeting

PM – Afternoon set aside for re-visits to check and feedback findings

Evening – Team meeting to discuss and write the report

Day 4

AM – Surveyors present their findings to the unit management team followed by discussion (approximately 2.5 hours)

– Surveyors present general themes (overview of survey findings) to the heads of department and other staff (approximately 1 hour)

Surveyors depart

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