Do we need standards and accreditation?

Introduction

"Perhaps the biggest challenges facing the practitioner when considering how to assist claimants with the rehabilitation process is to identify an appropriately qualified provider. Presently, there are no national standards laid down for the providers of rehabilitation. Accordingly, when a rehabilitation provider becomes involved, it is necessary to ensure that they are suitable for the work that they will be asked to do" [1]

"Employers, insurers and groups representing individuals all identified the need for providers of VR (Vocational Rehabilitation) to adopt agreed VR standards where they exist and develop standards when they do not. Stakeholders have also expressed the need for the accreditation of providers" [2]

These two statements are unequivocal. There is an undoubted mood amongst those involved in rehabilitation, that those providing rehabilitation services should adhere to agreed standards and against which they should be monitored. Initiatives have already been taken by organisations but as yet there is no accepted set of standards with universal application. Examples of initiatives are the work done by CMSUK, Health Quality Service, the Vocational Rehabilitation Association's Working Party on Standards and the ABI/IUA Working Group on Rehabilitation.

In the present climate, organisations are striving to improve their services and work to known and accepted benchmarks which will establish their credentials but the problem they all face is, there is no universally accepted body of standards against which they are independently assessed and accredited.

This article asks, can universal standards be set for rehabilitation providers in the UK, can they be independently monitored and can the providers who meet the standards be accredited and suggests that there is a way forward based on the experience of other countries,

Standards

There has, over the last couple of years, been a gradual movement towards the setting of standards for providers because all those involved in rehabilitation, funders and consumers, want consistency in the delivery of care across the country. Regardless of who is paying, people want value for money and in this environment, the value of universally accepted standards becomes even more important. The days when a funder and consumer get a different response to the same request are rapidly disappearing and the application of universal standards will provide one solution and assure

1 C Ettinger; [2005] *Journal of Personal Injury Law* p49

2 DWP: *Building Capacity for Work: A UK Framework for Vocational Reh*abilitation 2004 p32

consistency across the country.

Standards do not mean regulation. Standards will change with experience, knowledge and, in the area of treatment, with clinical evidence. Professional bodies will also reflect the increasing demands made on them to maintain the highest professional standards. Legislation will have a dynamic impact on the organisation's responsibilities for access, discrimination, employment practices, health and safety issues, working practices and financial conformance.

Standards should therefore be prepared for organisation management, leadership, governance, financial management, quality improvements, the process of service delivery and are customer focused. They should help providers measure and improve the quality, value and outcomes of their service. The preparation of standards will involve a wide number of bodies and organisations including consumers (i.e. patients and relatives)

In the non clinical areas, standards will, to a large extent, be defined by legislation, custom and widely accepted practices. There is however a little more difficulty when setting and assessing standards in treatment. Although it is now accepted that rehabilitation is no longer based on a medical model it is nonetheless imperative that treatment is evidence based and outcomes are measurable. This has the potential for being the most difficult area. A recent search of the Cochrane Collaboration using the search words "*rehabilitation: standards*" revealed no hits for rehabilitation and 105 for standards. A review of those relating to standards showed that it is a complex issue. A study to examine the extent to which differences in the interpretation of published results influence the definition of standards [3] concluded that the assessment of the quality of reported trials should be standardised and the results will improve in three dimensions; the quality of standards, the quality of scientific support and in the agreement of those standards.

A further example of how systematic reviews help in the setting of standards was that carried out in Holland [4] This was the first time systematic reviews were specifically conducted to support a Dutch College of General Practitioners standard. It concluded that systematic reviews are a prerequisite for treatment standards and that when recent well conducted reviews are not available, the performance of such reviews covering the most relevant topics should precede the standard setting procedure.

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3 *Delphi's twin: a method to improve the quality of standards in medicine*. Porzsolt F. and Gauz W. Dept Medicine111, University of Ulm, Germany 1996 Adelaide p1.08

4 *Systematic reviews as a basis for a treatment standard for tennis elbow in general practice*. Assendelft et al Oslo 1995 08

Similarly two abstracts from Cochrane Reviews [5] [6] indicated that there was little scientific evidence to support biopsychosocial rehabilitation for upper limb repetitive strain injury and multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain treatment, whereas another review [7] which focused on chronic low back pain concluded that this combination of skills in treatment worked. The important point here is that the universal application of a known successful form of treatment for a specific condition or group of patients to other conditions is not necessarily the most appropriate. This behoves those who are involved in setting standards to be constantly vigilant to the latest trials and reviews. Without this vigilance standards will not improve. This argument is supported by the Department of Work & Pensions [8] which states "*Stakeholders should be encouraged to contribute and to develop robust evidence on what works*" and "*it is clear that we need more evidence of what works*".

Standards do not know boundaries and have universal application. An example of the universality of standards is the work done by the Commission on Accreditation of Rehabilitation Facilities (CARF). This organisation, which is a private, not for profit organisation has been setting standards in America since its foundation in 1966. Since then it has expanded into Canada, Sweden, Denmark, Ireland, Netherlands and the UK (Northern Ireland and Scotland) and its standards are accepted and applied in over 4,800 facilities and organisations in those countries. The variety of delivery systems in places other than the USA has not necessitated any changes because the system reflects good practice, not a particular payment system. The only changes that have occurred have been to recognise the different bodies which licence or register individuals. The universality of CARF standards is that rehabilitation is a product that focuses on the individual receiving the services and they are part of the team. The team can be one other individual or many but it is an interdisciplinary approach to the delivery of services. Rehabilitation is a process which produces outcomes (direct results of services). If there is no system to measure what rehabilitation does, the efficiency of that delivery and the access to necessary services when people need them, then money will be spent for service delivery with little or no affect on the person or the ability to return people to function. But what is consistent, is that consumers and funders have confidence in a system that is internationally applied and tested with access to measurements of outcome across the globe. The standards require that treatments are based on evidence of effectiveness

[5] Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. *Biopsychosocial rehabilitation for upper limb repetitive strain injuries in working age adults*. The Cochrane Database of Systematic Reviews 2000, Issue 3

[6] Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. *Multidisciplinary biopsychosocial rehabilitaion for neck and shoulder pain among working age adults.* The Cochrane Database of Systematic Reviews 2001, Issue 3.

[7] Guzman J, Esmail R, Karjalainen K, Malmivaara A, Irvin E, Bombardier C. *Multidisciplinary biopsychosocial rehabilitation for chronic low back pain. (Cochrane Review).* In Cochrane Library, Issue 2 2004

[8] DWP: *Building Capacity for the Future: A UK Framework for Vocational Rehabilitation* 2004 p26

and market place acceptance. They are not prescriptive; e.g. they don't stipulate how many ultra sound sessions or which splint to use. These remain clinical decisions to be taken locally. But the standards demand that those local providers measure the results of their particular choice of services delivered and, more importantly, they disclose the information on their performance to interested parties. It is because they are 'field driven' standards that they so applicable and universally accepted.

The following quote from Marcelo Rivano-Fischer, Head of Department of the Rehabcentrum Lund – Orup, Sweden confirms how universal standards are:

"You may quote me saying that CARF standards are international and that the same arguments about Americanization were heard here in Sweden. In reality, with its emphasis on interdisciplinary teamwork, the central role of those who need our services, and the emphasis on analysis of results as well as transparency and accountability, CARF is an excellent way to put your operation together and to keep it in touch with the latest in quality improvement, thanks to the limitation included in the 3 years accreditation system. It is important to note that CARF is less and less normative, not telling you how to do it, but telling you what are the areas to cover. You put your systems together in your own manner as long as they answer to the topics in questions"

CARF now has a presence in the UK and has accredited 2 NHS Hospitals [9] with a third in the process [10]. A number of organisations, both within the NHS and the private sector, are also in varying stages of discussion about accreditation.[11] The two NHS Trusts already accredited and the third, currently underway, have all stated that the process of seeking accreditation made them think about all their policies and procedures, many of which had to be rewritten for the better, and how they interfaced with organisations and people outside their own immediate environs. They also found it required a great deal of time, effort and commitment, not only from the senior management but also from all personnel involved. It was this "coming together" to provide a completely joined up service which they thought had been the most beneficial aspect accreditation – for the first time the organisation pulled together as a team to achieve its goal. Having achieved a 3 year accreditation, they are now gearing themselves up for re-evaluation and accreditation but note that "the bar has been raised". The only implication from this statement is that standards never remain static; they are constantly being raised and that, surely, must be in everyone's best interests.

9 Downs Lisburn Health NHS Trust (Thompson House) and Fife Healthcare NHS Trust (Cameron Hospital)

10 National Spine Injuries Centre, Stoke Mandeville Hospital NHS Trust

11 There are 6 organisations, (I NHS Trust and 5 private or charitable organisations, one of which has 19 facilities)

In this discussion we must never lose sight of the fact that we are talking about people who have been injured and, by offering rehabilitation, we are offering them the opportunity of being put in the same position as they would have been had they not been injured. Rehabilitation must be paid for and the payment will come from any damages awarded. The court's view on damages for personal injury can be traced back to 1880 [12] where it was stated:

"Where any injury is to be compensated by damages, in settling the sum of money to be given for reparation or damages you should, as nearly as possible, get that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been if he had not sustained the wrong for which he is now getting his compensation or reparation."

It follows, then, that the person paying for rehabilitation is the claimant, i.e. the injured party. If the injured claimant establishes that the third party is at fault, then either the third party or their insurers will pay compensation. Part of that compensation will include the cost of rehabilitation. By reminding ourselves that we are dealing with injured fellow human beings and not some huge conglomerate, we bring into sharper focus the obligation to work to universally accepted standards of treatment and provision of rehabilitation.

Accreditation

Accreditation involves a demonstrated commitment to standards of quality in the provision of programmes and services as evidenced through observable practices, verifiable results over time and comprehensive demonstration of practices and, if required, supporting documentation. It must not be confused with the professional registration or certification of a practitioner to practice or with good practice guidelines issued by professional bodies.

It will only be accepted as having meaning and relevance if the accrediting body is independent of any organisation or body involved in rehabilitation. It must, however, include those who are involved in rehabilitation and who will contribute to raising standards. Patients and relatives must have a voice on the accrediting body. This is an increasing and successful practice in the UK where the medical Royal Colleges have Patient Liaison Groups to represent the patient's voice in the clinical arena.

CARF has identified that the persons served shall be its moral owners and thus it is not tied to any one organisation or body. Persons served are the primary consumers of services; they may be classified as clients, participants or residents. When these persons are unable to exercise self representation at any point in the decision making process, persons served is interpreted to refer also to those persons willing and able to make decisions on behalf of the primary consumer.

12 Lord Blackburn *Livingstone v Rawyards Coal Company* (1880) 5 A.C . 25

CARF clearly is not driven by the self interests of those providing rehabilitation services but by those for whom the service is provided.

CARF

CARF's core beliefs are that;

i. all people have the right to be treated with dignity and respect
ii. all people should have access to needed services and achieve optimal outcomes
iii. all people should be empowered to exercise informed choice

Accreditation, research and educational activities carried out by CARF are conducted in accordance with the beliefs described above and in addition it is committed to;

i. the continuous improvement of both organisational management and service delivery
ii. diversity and cultural competence activities and associations
iii. enhancing the involvement of persons served in all of its activities
iv. having persons served be active participants in the development and application of standards for accreditation
v. enhancing the meaning, value and relevance of accreditation to persons served.

CARF is a private, non profit organisation that is financed by fees from accreditation surveys, sales of publications, grants from public bodies, fees from workshops and conferences and contributions from sponsoring and associate members. It has about 32 sponsoring organisations, all are national and with an interest in rehabilitation and 15 associate members. Since its inception in 1966 it has benefited from national organisations joining together in support of the goals of accreditation. These organisations, representing a broad range of experience are divided into two categories, sponsoring and associate as described above, with the sponsoring organisations having seats on the Board of Trustees. The associate members attend as observers.

It is this broad range of organisations with their individual interests, skills and experience coming together with one common aim and purpose that makes CARF so effective, responsive and credible.

A CARF type structure the UK might, for example, have representation from the following organisations:

- insurers
- employers
- TUC
- consumers (persons served)
- NHS
- DWP

- case managers
- rehabilitation providers
- professional and medical colleges
- lawyers eg APIL and FOIL
- international representatives expert in the process

The benefits of accreditation will include:

- being identified as an organisation that meets robust and recognised standards in the provision of quality services
- confidence on the part of the consumer and funder seeking such services
- guidance to the organisation in the form of standards which have been recognised by others as providing high quality services, implementing strategies for improvement in performance and developing specific policies and procedures in all areas from the organisational structure to daily routines
- objective programme expectations and guidelines that are common to all accredited organisations and are free from inappropriate influences such as political pressure or individual bias
- evidence through outcomes and auditable documentation that money is being used effectively
- documentation that demonstrates accountability, positive outcomes, a person centred and inter disciplinary approach to service delivery, teamwork within the organisation, concern for the ongoing professional development of personnel, networking with other providers and resources, comprehensive financial management and an overall focus on service to the patient.
- access for management to new and innovative ideas in treatment models, organisation and financial management
- transparency of the organisation in sharing its performance as it relates to the persons served (results achieved, access, input from person served etc.)
- continuing support from the accrediting body as new research and evidence becomes available.

With its 40 years experience and accreditation of 4800 facilities world wide CARF is in a unique position to bring its knowledge and skills to the UK. Evidence from its world wide operations show that it does not impose an “American” model but goes to great lengths to adapt to the host country’s cultural and social differences. It has done this successfully in Canada, Sweden, Denmark, Ireland, the Netherlands and has recently demonstrated that it can bring its unique experience and knowledge base to the UK. The time is now appropriate to move forward in this country by involving CARF with its many years of international experience in the standards setting and accreditation process. The wheel has been invented and works. Why try to re-invent it?

But possibly the biggest benefit will be the recognition that rehabilitation can make a major contribution to health provision in this country. Rehabilitation can change lives for the better.

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