



Public Consultation Response

Many thanks to all of you that took the time to respond to the IQIPS standards consultation. The public consultation ran for 12 weeks and closed on 7 October 2011. Over 80 bodies were contacted to inform their members of the consultation. During the consultation the following materials were made available:

- IQIPS standards and criteria
- A letter explaining the consultation process and how to respond
- The consultation questions
- IQIPS fact sheet explaining the scope of the programme

Responses were received from a variety of stakeholders; 12 from Audiology, 3 from vascular science, 2 from cardiology, 2 from respiratory & sleep, 1 from neurophysiology and 4 from other national organisations. To date IQIPS pilots have been completed in vascular science, GI physiology and clinical neurophysiology and are currently ongoing in Audiology, Cardiac physiology and respiratory & sleep science. Feedback from pilots is not included in this report, but will be included in an overall review of the IQIPS material.

It is important to note that quality improvement is a journey and IQIPS is an iterative process that will develop over the years to include more agreed outcome measures and other aspirational markers of quality.

All comments regarding individual standards and criteria are currently being considered and a report will follow shortly. Some of the general responses and action taken is detailed below for your information.

The vast majority of responses received suggested that the meaning and purpose of the standards were clear. However a large number of responders noted that it was difficult to fully determine this without seeing the detail below the standards. The IQIPS team recognise the need to understand the detail; once a service registers for accreditation they will have access to all of the detail beneath the standards. There will then be the opportunity to continually feedback any further comments on the standards as part of an ongoing review process by the Accreditation Clinical Advisory Group (ACAG).

The majority of responses said that the standards were relevant, extensive and manage to maintain generality. Some concern was raised regarding the generic nature of the standards. The standards and criteria are high level statements in order to be generic across all 8 specialisms within physiological science services. This allows for small services contributing to healthcare pathways to be presented as integrated scientific specialisms to stakeholders such as Trust boards and commissioners. However, the specialism specific detail will not be lost; there will be explicit guidance and indicative evidence which will give specialism specific information.

One respondent suggested a pruning exercise to reduce the number of standards another suggested that they are not comprehensive enough and further standards are needed. However the majority appeared to agree with the number of standards proposed, although there was a comment that there are gaps around facilities and standard of equipment, staff training and patient feedback. These will be reviewed by the ACAG in 2012.

One common theme raised was the lack of focus on children's services, patients with learning difficulties and a family friendly approach. The IQIPS team acknowledge these omissions and will investigate further with the pilot sites. We will also ask the ACAG to review the standards with regards to children's services and patients with learning difficulties as a priority in 2012.

The systems and process nature of the standards led to some respondents suggesting that IQIPS could be seen as a "tick box" exercise and not evidence based or outcome focussed. The IQIPS team have endeavoured to deliver an evidence based accreditation programme and so far the pilot sites have supported this view. It is hoped that once all the guidance, example evidence and references including the National Service Frameworks are available professionals will not view IQIPS as a tick box exercise. The IQIPS accreditation process encourages the systematic and comprehensive collection and analysis of data to provide

evidence that quality standards are being achieved and they are outcome based. For example, to demonstrate that an audiological intervention has been conducted to a quality standard it will be expected that outcome data will have been collected and analysed. Audiology service improvement programmes such as Modernising Hearing Aid Services and Transforming Audiology Services have recommended the use of a validated outcome measure pre and post hearing aid fitting as a marker of quality. This is most likely to be the Glasgow Hearing Aid Benefit Profile (GHABP) although other validated tools are available. These programmes have also promoted the use of real ear measurements (REM) in hearing aid fitting and verification to demonstrate that the aid has been programmed correctly to maximise hearing benefit for a patient. Hearing benefit outcomes are considered validated when they are measured using evidence based and objective tools such as GHABP and REM. Services will need to demonstrate that they are providing a validated and objective measure of hearing benefit through their use of these evidence based tools.

It was reported that the specific accreditation requirements of an audiology service are not fully covered including the habilitative/rehabilitative audiology services. There seems to be some misinterpretation that the clinical section of IQIPS is heavily biased to diagnosis. In fact, the eight sections of the clinical domain work through a systematic and step by step approach to the whole patient pathway, including pathway management, quality of diagnostic test, quality of test results, quality of treatments and outcomes, safe use of drugs, minimisation of risks, effective use of clinical records and promotion of best practice. The service seeking accreditation is asked to provide evidence of meeting these quality standards at each step along the patient pathway, from initial referral to final outcome.

One respondent stated that CL4 (Interventional Procedures) and CL5 (Drugs and Contrast Media) and not relevant to many physiological diagnostic services. This is acknowledged by the IQIPS team and there will be a “not applicable” option when registering your service which will ensure that inappropriate standards are not ‘switched on’.

The standards have been mapped to NHSLA and have been shown to align. **One respondent was concerned regarding this and thought there may be duplication.** The clinical advisory group will be asked to consider this during the ongoing review process.

One question raised by several respondents was; “How will IQIPS link with other accreditation schemes that have been developed?” There is ongoing work to align with other schemes to avoid conflict, reduce duplication and ensure we are not adding burden to service. This includes the British Society of Echocardiography accreditation programme, the Heart Rhythm UK standards and the British Sleep Society accreditation system. The IQIPS

team acknowledge that there remains significant work to be done in this area but key stakeholders are engaged in this process.

Reassurance was sought regarding the peer review selection and training process. The accreditation preferred provider is very experienced in delivering assessor training and ensuring fair selection. All peer reviewers will be thoroughly trained on a three day residential peer review training event and subsequent refresher training courses. Training will include using the guidance written by the experts in order to assess service against the standards, confidentiality and impartiality.

A number of respondents stated that a guide at the start of the process would be helpful. This is being developed.

There were questions raised regarding Any Qualified Provider and the cost of accreditation to service. These are out of the scope of this consultation but further information and relevant links will be posted on the IQIPS web site.