Continuing fitness to practise Professional Liaison Group (PLG)
11 March 2008

Existing models and good practice

Executive summary and recommendations

Introduction

At the last meeting, the group considered a paper which looked at models of revalidation outside of the UK.

This paper follows up on some of the UK-based models identified at the group's previous meetings, in particular the wider discussion meeting on 13 November 2007.

Decision

The group is invited to discuss the attached paper.

Background information

The General Medical Council (GMC) and General Dental Council (GDC) will be attending this meeting to present on their current work/ proposals.

Resource implications

None

Financial implications

None

Appendices

Appendix one: A short note on the quality of health care organizations in the Netherlands

Date of paper

27 February 2008

Existing models and good practice

Introduction

One of the aims of the group's work is to explore the ways in which employers, health professionals and others can be supportive of continuing fitness to practise, with particular reference to the professions regulated by HPC.

This paper looks at the some of the specific models and practices discussed at the previous meetings. The paper is divided into the following six areas, followed by an overall summary:

- Supervision
- Periodic assessment
- Mentorship / induction
- Professional body activity
- Other regulators and industries outside of healthcare
- Self-certification and exception reporting

Under each area, a model or models are detailed, together with a brief summary of any salient points in relation to those models. The models detailed are those which the group has specifically identified at previous meetings and are not intended as an exhaustive list.

1. Supervision

At the group's meeting on 13 November 2007, supervision was mentioned as a way in which any risk in the isolation of practitioners who worked alone could be mitigated.

The term 'supervision' can have different meanings. In this context 'supervision' often does not infer that the person being supervised is newly qualified or learning new skills; instead supervision by a colleague or peer which monitors the relationship between practitioner and client is seen as a central part of good professional practice.

- British Association of Dramatherapists (BADth)

The British Association of Dramatherapists sees supervision (sometimes referred to as 'clinical supervision') as a central part of dramatherapy practice, holds a register of qualified supervisors and publishes standards for supervision. The Association says:

'Dramatherapy Supervision is a formal and mutually agreed arrangement. BADth recommends that Dramatherapists discuss their work regularly with someone who is an experienced and competent Dramatherapist and familiar with the process of Dramatherapy supervision. The task is to work together to ensure and develop the efficacy of the supervisee's Dramatherapy practice. It is also aimed at the development of a critical reflective practitioner, who is committed to on-going professional development as a dramatherapist and the continued development and practice of the profession.'[1]

Supervision is seen as distinct from managerial supervision and can be delivered in a variety of different modes and methods, including differential supervision (supervision by a more experienced dramatherapist) and peer supervision.

- British Association for Counselling and Psychotherapy (BACP)

The British Association for Counselling and Psychotherapy is a professional body which holds a voluntary register of counsellors and psychotherapists who have met its standards for their education and training.

BACP similarly sees supervision as an essential part of good practice.

Accreditation or renewal of accreditation with the BACP requires that counsellors or psychotherapists have a contract for supervision for a minimum of one and a half hours per month for each month in which practice is undertaken. The BACP ethical framework for good practice in counselling and psychotherapy says that: 'All counsellors, psychotherapists, trainers and supervisors are required to have

[1] British Association of Dramatherapists, Standards of Ethical Practice for Registered Supervisors of Dramatherapy, www.badth.org.uk

regular and on-going formal supervision/consultative support for their work in accordance with professional requirements.'[2]

From time to time, supervision has raised concern about the practice of the supervisee or supervisor and has led to a referral to BACP's fitness to practise processes.

- Statutory supervision of midwives

Statutory supervision of midwives has been in place since 1902. Supervision is separate from managerial supervision and aims to be a peer-oriented process which maintains and improves standards, identifying any problems and acting quickly to remedy them in a supportive manner.

The supervision system is supervised by a Local Supervising Authority (normally a Strategic Health Authority or health board) which appoints a local supervising authority midwifery officer who is responsible for managing supervisors of midwives.

The Nursing and Midwifery Council (NMC) sets standards and approves the training for midwives to become supervisors and annotates this on their Register. To become a supervisor a midwife must be in practise and have at least three years of experience.

The NMC says that: '…statutory supervision of midwives supports protection of the public by promoting best practice and excellence in care; preventing poor practice; and intervening in unacceptable practice. Effective use of the supervisory framework leads to improvements in the standards of midwifery care and better outcomes for women.'[3]

Summary, comments, observations

- In art therapy, music therapy and dramatherapy (existing HPC regulated professions), supervision is 'led' by the professional bodies, individual practitioners and supported by most employers. The importance of 'professional buy-in' can be seen here.

- Supervision monitors the therapeutic relationship between practitioner and client and the focus is on the safety of the client.

- In all the models, supervision is separate from managerial supervision and is undertaken by colleagues and peers.

- Supervision is supportive of ongoing fitness to practise and acts to achieve an early resolution of any difficulties before they become problematic.

[2] British Association for Counselling and Psychotherapy, Ethical Framework for Good Practice in Counselling and Psychotherapy, April 2007, www.bacp.co.uk

[3] Nursing and Midwifery Council, Standards for the preparation and practice of supervisors of midwives, October 2006, www.nmc-uk.org

- In terms of thinking about revalidation as periodic assessment of fitness to practise, there may not be a direct link between participation in supervision and fitness to practise (i.e. competence, performance, good character).

2. Periodic assessment

- **Recertification of paramedics**

Recertification is a process by which paramedics working for NHS Ambulance Trusts are required to undertake training and assessment in order to demonstrate their continuing competence.

In the past, paramedic training has been delivered by the IHCD (part of the examinations board, Edexcel) at ambulance training centres attached to NHS Trusts. Whilst university programmes have now been developed, a significant proportion of training is still delivered via the IHCD.

Certificates issued by the IHCD have an expiry date; hence the 'requirement' to recertify. IHCD says: 'Paramedics are required to undertake one day Paramedic refresher every year, and every three years, 5 days Paramedic refresher, 3 days of which should be spent in-Hospital refreshing their invasive skills.'[4]

However, the IHCD does not reissue certificates to paramedics who have undergone recertification, and holds no central register of those who have recertified. In addition, those paramedics who have qualified having following a university programme may still be required to recertify by their employer, even though they do not hold a qualification from the IHCD. Recertification is not a requirement made by the HPC for renewal of registration as a paramedic.

The exact format of recertification varies between NHS trusts, however, it often includes:

- a period of observed practice to identify personal development needs;
- a short period of CPD courses (around 5 days), including training in areas and competencies key to paramedic practice; and
- assessment of those areas against relevant standards.

If the recertification is failed, the practitioner may be required to spend time in supervised practice, sometimes at a lower grade, and is offered remedial training.

Summary, comments, observations

- Recertification is regular periodic assessment, usually against threshold standards (i.e. covers core areas learnt in initial training). The outcome is a pass/fail, with remediation for those who fail.

- Anecdotally, recertification may not always be delivered because of financial constraints.

- The format of recertification can vary between individual employers.

- As there is variation in way in which recertification is delivered, there is a lack of evidence as to pass/fail rates, and a lack of evidence of efficacy.

[4] http://www.edexcel.org.uk/subjects/a-z/ihcd/

- Anecdotally, one criticism of recertification is that it only tests the ability to recite previously learnt information; there may not be a direct relationship between passing recertification and fitness to practise.

- A failure to successfully recertify has occasionally been included in the terms of an allegation against a registrant via the fitness to practise process. However, the majority of cases concerning paramedics (as for most other professions) are about conduct, rather than competence.

- In 2006-07, paramedics accounted for 25.2% of complaints received, and made up 7.4% of the total number of registrants on the Register.[5]

- In terms of thinking about revalidation, we might question whether such a model could be applied to other professions, where there might be less focus on a range of technical skills, and less homogeneity of environment/ employer context.

[5] Fitness to Practise Annual Report 2007, p. 9. www.hpc-uk.org/publications.

3. Mentorship and Induction

The flying start programme was highlighted to the group at its first meeting as an area which might be of interest. The programme is briefly summarised below, alongside a scheme developed by the Royal College of Speech and Language Therapists to help manage the transition from student to newly qualified practitioner.

- NHS Scotland flying start programme

NHS Scotland has a development programme for newly qualified nurses, midwives and allied health professionals to support the transition from student to qualified practitioner.

The programme involves a number of different learning activities, with support available from workplace mentors. Learning covers areas such as communication, clinical skills, teamwork and safe practice.[6]

- Royal College of Speech and Language Therapists (RCSLT)

The RCSLT has developed a competency framework to guide transition to certified RCSLT membership.

Newly qualified practitioners from UK approved courses are entered into the supervised membership category of RCSLT membership. RCSLT requires that the individual completes approximately one year in a clinical setting before being given full, certified membership.

The framework sets out a number of competencies such as communication, health and safety and equality and diversity which newly qualified practitioners need to meet and evidence. Once the standards have been met, the practitioner's manager is asked to confirm this by filling in a form and sending it to RCSLT.[7]

Summary, comments and observations

- Both these models provide a framework of clear standards, with structured support and assessment against those standards. The focus is ongoing support of fitness to practise, and fitness for purpose in the employment context.

- Both theses models are led by the profession or an employer and are complementary to the aims of regulation.

- In terms of thinking about revalidation, both these schemes might provide information which could contribution towards a demonstration of fitness in a particular role.

[6] www.flyingstart.scot.nhs.uk

[7] Royal College of Speech and Language Therapy, Speech and Language Therapy Competency Framework to Guide Transition to Certified RCSLT membership, June 2007

- The schemes are employer-based and required by a specific employer (in the case of flying start) and voluntary (in the case of the RCSLT scheme). There may therefore be variation between employers; these schemes would therefore not apply to registrants who work in other areas or who do not work in an employed environment.

4. Professional body activity

Professional bodies are often involved in work which is supportive of continuing fitness to practise. This includes producing standards or frameworks for higher or advanced levels of practice, guidance, CPD schemes and courses, and other opportunities for sharing of good practice.

At the meeting on 13 November 2007, the post-qualifying framework produced by the College of Occupational Therapists was specifically referred to. This framework lists graded statements that identify capabilities expected to be demonstrated at different levels of practice – including management, education and research.

Summary, comments, observations

- At the meeting on 13 November 2007, the discussion group noted that not all registrants were members of their professional body and that take-up of professional body membership varied between professions. The services offered by professional bodies also vary between professions.

- In our response to the Review of the Regulation of the Non-Medical Healthcare Professions ("the Foster review"), we noted how professional input would be required in the development of revalidation, in particular if standards were required for discrete areas of practice, and highlighted the variation in the size, resources and finances available to the professional bodies representing the professions we regulate.

5. Other regulators in sectors outside of healthcare

At the group's last meeting, there was some discussion around whether there were any useful models in areas outside of healthcare. This section briefly outlines some practice in other areas.

- **Civil Aviation Authority (CAA) – Pilots and Air Traffic Controllers**

In the 2006 report by the Chief Medical Officer, 'Good Doctors, Safer Patients', the regulatory requirements for a number of roles in 'high risk' industries was discussed. In particular, aviation is a much cited area.[8]

The Civil Aviation Authority is the UK regulator of the civil aviation industry. The CAA sets standards and issues operating licenses to airlines, which are required to meet certain standards. It also runs a licensing system for pilots.

Pilots undergo a variety of tests to ensure that they remain fit to fly. They include:

- A twice yearly assessment by the airline including testing in a simulator and examination of non-technical skills (e.g. communication).
- A yearly assessment by a trained and approved supervisor who travels on the flight deck during a normal flight.
- Annual licence revalidation undertaken in an aircraft or simulator.
- Fitness to fly certification involving medical assessment.

A licensing system is also in place for air traffic controllers who undergo an annual oral assessment by a trained assessor. Specific licensing requirements are also in place so that licensees undergo a period of supervision if they change job role or location.

- **Health and Safety Executive (HSE) – Nuclear Power Unit Desk Engineers and Offshore Installation Managers**

The Chief Medical Officer's report also outlines the Health and Safety Executive's (HSE) role in overseeing a system of regular checks for engineers who work in the control rooms of nuclear power plants, and offshore installation managers who work on offshore oil rigs.

For both of these roles, the HSE licences the operators, not the individual staff. The HSE sets goals rather than prescriptive requirements.

After qualification and appointment as a unit desk engineer, revalidation takes the form of annual simulator training, annual appraisal, 360 degree feedback, occupational stress questionnaire and a formal assessment and panel interview every two years.

[8] Department of Health, Good Doctors, Safer Patients (July 2006). www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137232

Following appointment as an offshore installation manager, competency assurance schemes are used. They include peer assessment, regular training, and simulator exercises.

The HSE employs inspectors who ensure that the licensee (i.e. the company rather than the individual) complies with its requirements.

- **Royal College of Veterinary Surgeons (RCVS)**

The RCVS is the statutory regulator of veterinary surgeons and veterinary nurses.

A revalidation or recertification scheme is not currently in place. Continuing Professional Development (CPD) is not currently compulsory. The College recommends a minimum of 105 hours of CPD every three years. The College's website indicates that CPD and recertification for veterinary surgeons may become requirements in the future.

The College accredits veterinary practices and hospitals against standards, and offers a scheme for assisting newly qualified veterinary surgeons in their first year of practice.

- **Barristers / Solicitors**

In January 2006, the Bar Council, the professional body for barristers, separated its regulatory and representative functions and created the Bar Standards Board.

The Bar Standards Board requires barristers to undertake compulsory CPD. Newly qualified practitioners are required to undertake, in their first three years, 45 hours of CPD, including at least 9 hours of advocacy training and 3 hours of ethics training. After that, barristers are required to undertake 12 hours of CPD each year.

The Bar Standards Board does not have in place revalidation or recertification arrangements. However, this is something their quality assurance committee is currently looking into. This includes examining whether a revalidation system and peer review are necessary for all barristers.[9]

For solicitors, the Solicitors Regulatory Authority (SRA) has been created by the separation of the representative and regulatory functions previously performed together by the Law Society. The SRA requires solicitors to undertake 16 hours of CPD in one year, 25% of which must consist of accredited training courses. The SRA does not have any revalidation or recertification requirements.

Summary, comments, observations

- Where it takes place, revalidation is carried out on a frequent basis and takes into account information from a variety of different sources. Technical skills, as well as non-technical skills (e.g. communication) are covered.

[9] www.barstandardsboard.org.uk

- In commenting on the transferability of the CAA and HSE models to medical revalidation, the CMO highlighted the scale of the task; there are 17,000 pilots compared to 177,000 doctors, therefore the cost and burden of revalidation would be greater in the medical profession. HPC currently regulates over 182,000 professionals.

- We might argue that the CAA and HSE requirements work in part because of a great degree of homogeneity of working environment, and homogeneity of practice.

- We might also observe that in these models the burden of revalidation / recertification falls on the employer, which is normally a profit-making, private sector organisation.

- Revalidation or quality assurance is something that is being looked at in areas beyond healthcare.

6. Self-certification and exception reporting

At the last two meetings, the group has highlighted the effectiveness of the existing processes of self certification and exception reporting.

The summary below focuses on self-certification and does not describe the existing fitness to practise process in any detail.

- **Health Professions Council (HPC)**

HPC currently runs a process of self-certification on application to the Register, and on renewal. Complaints are considered via the fitness to practise process and appropriate action taken, if necessary, to protect members of the public.

Applicants for registration are currently required to sign a declaration in the following terms:

- I declare that I have read, understood and will comply with the HPC's standards of conduct, performance and ethics.
- I understand that fraudulently procuring an entry in the HPC Register is a criminal offence under article 39 of the Health Professions Order 2001.
- I declare that I have read, understood and will comply with the HPC's requirements for continuing professional development (CPD).[10]

Applicants are required to declare any convictions or cautions or determinations of other regulators responsible for licensing a health or social care profession as part of the application form.

On renewal (every two years), registrants are required to sign a declaration confirmed that they have:

- continued to practise their profession since their last registration; or
- not practised their profession since their last registration but have met the HPC's return to practice requirements.

Registrants also confirm that:

- they continue to meet the HPC's standards of proficiency for the safe and effective practice of their profession;
- there have been no changes to their health or relating to their good character which they have not advised HPC about and which would affect the safe and effective practice of their profession; and
- they continue to meet the HPC's standards for continuing professional development.[11]

From July 2008, a random sample of registrants will be audited and asked to demonstrate that they meet the CPD standards, each time a profession renews its registration.

[10] www.hpc-uk.org/apply

[11] www.hpc-uk.org/registrants/renew

The standards of conduct, performance and ethics also place a responsibility on registrants to disclose any relevant information about their conduct and performance. If a registrant makes a disclosure, this is referred to as a self-referral.

The self-certification process is supported by the health and character process.

If a registrant declares an issue relevant to their good character on application or renewal (e.g. a caution or conviction) a health reference raises possible concern, or a registrant makes a self-referral during their registration cycle, this will be considered by a health and character panel. The panel determines whether the applicant should be admitted to the Register / whether the registrant should be able to renew their registration. In the case of a self-referral, the panel decides whether the matter referred raises any concern regarding the fitness to practise of the registrant, and therefore whether the matter should be referred into the fitness to practise process.

Summary, comments and observations

- Self-certification on application and renewal is supported by the health and character process, fitness to practise process and, from 2008, random audits to check compliance with the standards for continuing professional development.

- Analysis of the outcomes of the CPD audits may provide useful information at a future point.

- At both of the last two meetings, it was suggested that the low percentage of fitness to practise cases was evidence that the existing system was working. In 2006-2007, 0.18% of the total number of registrants on the Register was subject to a complaint.

7. European regulation

At the last meeting, the group asked whether there were any European models which might be of interest. The regulation of health professionals in the Netherlands is outlined below. However, further information about regulation in Europe may be brought to the group at future meetings.

- Netherlands

In the Netherlands, RBIZ (translates as Healthcare Providers Registration and Information), holds a statutory register of healthcare professionals. It is a division of the CIBG, an agency of the Ministry of Health, Welfare and Sport.

RBIZ regulates around 350,000 professionals from the following professions: dentists, doctors, healthcare psychologists, midwives, nurses, pharmacists, physiotherapists and psychotherapists. Other professions have voluntay or compulosry registration requirements, sometimes with the body 'Kwaliteitsregister Paramedici'.

Holders of a dutch diploma are eligible to be registered with RBIZ. International applicants can apply for a statement of competence which allows them to apply for registration; certain conditions such as supervision may be applied to their registration before they are able to work independently. Regulation works via protected professional titles, and, in some professions, reserved acts.

RBIZ do not run a revalidation system; at present, registrants are registered for life and do not need to regularly renew. However, the RBIZ website says that re-registration requirements will be brought in from 2009. Every five year registrants will be required to demonstrate their competence, either by demonstrating that they have continued to practice their profession (thereby qualifying by work experience) or that they have met training requirements which RBIZ will prescribe.

Appendix one is a brief summary of the regulation of healthcare providers in the Netherlands.

Summary, comments, observations

- The Dutch system was suggested by one participant at a recent listening event as a model which was 'half-way between' the existing HPC model and revalidation as figured in the white paper. Although detail about the proposals isn't yet available, we could suggest that these two elements are already covered by HPC in its defintion of practise and in the returners to practice requirements.

- HPC defines practising a profession very broadly. We say that someone practises their profession when they draw on their professional skills and experience in some way during the course of their two year registration cycle. It is therefore an individual professional decision for the individual registrant as to whether they continue to practise their profession. This could include considering whether registration is an employer requirement

for the role they are performing and whether they are using a protected title.

- Registrants are asked on renewal to confirm that they have continued to practise their profession since their last renewal. Registrants who have been out of practise for two years or more, are required to undertake an updating period in line with the returners to practice requirements before they can come back on to the Register.[12]

[12] Returning to practice brochure
www.hpc-uk.org/assets/documents/10001364returning_to_practice.pdf

Overall summary and observations

- At its broader discussion meeting on 13 November 2007, the group identified a number of existing areas or models which were supportive of registrants continuing to be fit to practise. One group identified a number of broad areas including:
    - Complaints/ disciplinary systems
    - Performance targets
    - CPD audits
    - Accreditation schemes
    - Membership of professional bodies
    - Appraisal processes, including the NHS KSF
    - Mentoring
    - Clinical Audit
    - Risk Management
    - Insurance Schemes
    - Service regulation (e.g. Healthcare Inspectorate Wales)
    - Professional Networking
    - Peer Review

- The specific areas outlined in this paper, and the broader areas listed above, might be sub-divided as to whether they are led by the employer, individual, profession/ professional body, or required by a regulator. However, many models may involve 'leadership' from more than one group (e.g. CPD is individually led, professional body led and led by regulatory bodies).

- In the existing professions regulated by HPC, most of the models outlined are voluntary and depend on professional buy-in, or are required by an employer. The model is led by the profession and/or employer rather than being imposed by a regulator or outside authority.

- The models which are not required by a regulatory body are often complementary to the purpose of regulation, but have a slightly different aim. For example, professional body activity is often aimed at promoting the profession through encouraging good practice; employers are often concerned with ensuring good service delivery and fitness for purpose.

- We might conclude that the models outlined in this paper are supportive of continuing fitness to practise but alone could not form the basis of revalidation (as figured in the white paper recommendations).

- We might further conclude that professional regulation is only one part of the area of continuing fitness to practise, existing in an environment which includes service regulation and clinical governance.

A short note on the quality of health care organizations in the Netherlands
Marlieke Bosman, NIAZ

In the Netherlands most health care is publicly financed, partly by a system of national insurance executed by private insurance companies, partly by governmental subsidies. Health care organizations, like community health services, hospitals, elderly care, psychiatric care, etc., and health care workers, like general practitioners, are privately organized. In the Netherlands there is no such thing like 'state health care'; all health care is delivered by private legal corporations. Still, most of those health care organizations are not-for-profit foundations. In future this probably will chance due to the new governmental policy on 'health care market'.
The Department of Health Care has recently developed new ambitions on the quality of health care. Their policy is to focus on transparency of achievements of health care organizations, reinforcement of the influence of patient on health care and safety of health care.

To provide good health care for every citizen and to distribute collective means fairly, there's a system of laws on health care including themes as admission to the health market, financial rules, supervision and the quality of health care organizations and workers. On the issue of quality the most important laws are the Law on Quality of Health Care Organizations (Kwaliteitswet Zorginstellingen, in short 'KZI'), the Law on Individual Health Care Workers (Wet beroepen individuele gezondheidszorg, in short 'Wet BIG') and the Law on the agreement of medical treatment (Wet geneeskundige behandelovereenkomst, in short Wgbo). Patients rights are distributed over a series of laws, like the Law on Shared Control by Patients of Health Care Organizations (Wet medezeggenschap cliënten zorginstellingen).

The laws on quality of health care organizations and individual health care workers are supervised by the Dutch Healthcare Inspectorate (Inspectie voor de Gezondheidszorg, IGZ, www.igz.nl, with English homepage). This is a governmental organization that belongs to the Department of Health Care (Ministerie van VWS, www.minvws.nl) of the Netherlands. The IGZ supervises on 24 laws. Offenses can be punished by instructions, in some case by fines, by a disciplinary court, by criminal law and by private law.

Performance indicators are one of the supervising methods the IGZ uses. Performance indicators are measurable aspects of care which give an indication of quality, safety, efficiency and accessibility of healthcare. In cooperation with the Dutch association of Hospitals (NVZ), the Dutch Federation of academic hospitals (NFU), and the Order of Medical Scientists, IGZ developed a set of performance indicators for Dutch hospitals. These indicators are questions about hospital healthcare which must be answered before the 1st of June. The questions are revised annually, therefore it is of utmost importance to compare questions and answers of the same year. The questions are sent to the hospitals in a booklet which is called: Base set of Hospital Perfomance indicators.
In case of problems of calamities in health care organizations, the IGZ will conduct an in-depth investigation into the causes of the problem, its consequences for the quality of care and ways of avoiding recurrence of the incident.

In the main quality law, the KZI, the provider of health care is obliged to deliver ‘justifiable care’, which means ‘care of a good level, that is effective, efficient and patient-directed and adjusted to the realistic needs of patients’ (art. 2 KZI). Therefore the provider of health care has to obtain a quality health care system to guard, control and improve the quality of health care systematically (art. 4 KZI). As to *how* to carry out these obligations, the provider of health care is free of choice. The past 10 years a lot of health care organizations implemented and were certified on quality management systems, based on for example ISO 9000:2001 and INK (which is based on the EFQM Excellence Model). Various specialized institutes developed TQM systems and schemes especially for health care organizations. Examples are HKZ (which means ‘Harmonization of quality review in health care and welfare’, www.hkz.nl with English summary), NIAZ (which means Netherlands Institute for Accreditation of Hospitals, www.niaz.nl, with English homepage) and Perspekt (www.perspektkeurmerk.nl).

HKZ produces ISO 9001 compatible certification schemes for various types of health care and welfare institutions (except hospitals). HKZ doesn’t certificate itself; commercial certification institutes provide certification based on HKZ-schemes.

The NIAZ has developed an accreditation standard ‘Kwaliteitsnorm Zorginstelling’ (General Quality Standard for Health Care Organisations, based on the INK-model), 38 departmental quality standards and accreditation guides. NIAZ performs accreditation itself by means of audit through peer review. Even though the ‘Z’ in NIAZ stands for hospitals (ziekenhuizen), it is also possible for other health care organizations to participate in the NIAZ accreditation program, for instance, mental health care institutions, nursing and retirement homes, dialysis centres, physiotherapy practices, GP practices and private clinics. The English version of the NIAZ homepage (www.niaz.nl) provides a lot of information about the accreditation process, as well as an English version of the General Quality Standard for Health Care Organisations. Perspekt audits nursing and retirement homes based on the ‘gold or silver hallmark’ of the ‘bronze hallmark’.

There is no legal obligation for health care organizations to get certified based on one of the mentioned standards above, but health insurance companies ask for it more and more. Certification / accreditation is also an issue for the national health inspection (IGZ) in its role as supervisor of health care organizations.

The quality of the individual health care workers (being employed or working freelance) is defined by the Wet BIG. Everybody is allowed to perform medical treatment, except for the ‘reserved actions’ as described by the law. Those are reserved to specific health workers like doctors, nurses, etc. To become, be and stay competent and capable, health care workers have to be educated and registered in the ‘BIG register’.

In the Netherlands there are a lot of (knowledge-) institutions working on the issue of quality of health care organizations and health care workers. There are of course the educational institutes like universities and colleges. Health care workers as well as health care organizations are united in (an innumerable amount of) associations that more or less provide quality projects for there members. Besides that, there are a number of national knowledge institutes working on the issue of quality of health

care. One of those, the Dutch Institute for Healthcare Improvement CBO (www.cbo.nl, with English website), is completely devoted to improve the quality of patient care. CBO was founded in 1979 by the Dutch Association of Medical Specialists and by the Dutch Association of Chief Medical Officers, as an independent, not-for-profit foundation. Originally CBO aimed for the improvement of professional care, working with medical specialists, nurses and allied health professionals. Over the years the scope has been expanded to include quality management in health care organizations.