

Accreditation – From Past to Future

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Honoured guests, esteemed colleagues and friends,

It is a great pleasure for me to be here with you today to celebrate the beginning of the second phase of the Veneto Region's accreditation program. I thank you very much for inviting me to share this important occasion with you. I do remember well the very beginnings of this project and I am extremely gratified to see how it has evolved. I compliment and congratulate all those who have worked so hard, and with such diligence, to bring the program to its current state of development. Your strong belief in the accreditation process in the past, if continued, will most certainly now carry the program forward into a successful and gratifying future.

As you are aware, I am here today representing the International Society for Quality in Healthcare (ISQua) and I am very pleased on behalf of the ISQua Board and Staff, as well as ISQua's International Accreditation Program participants, to extend congratulations to you for your past work and wish you every success for Phase 2. ISQua will look forward to a strong future relationship with your program,

Your conference organizers have asked that I provide for you a brief introduction to accreditation and a capsule view of its world wide development and where it might be going in future. They have also asked that I acquaint you with how national/regional accrediting bodies are,

themselves, monitored by an international program offered by the International Society for Quality in Health Care. A tall order for a short period of time! - so, let us begin.

Introduction to Accreditation

a. Definition

Any introduction to accreditation begins, of necessity, with some definition of terms. The first of these is “accreditation”. The International Society for Quality in Health Care has published what it refers to as its “toolkit” for accreditation¹ and within this document some definitions of accreditation are provided, two of which we will look at today:

“a voluntary program, sponsored by a non-governmental agency, in which trained external peer reviewers evaluate a health care organization’s compliance with pre-established performance standards.”

“a public recognition of the achievement of accreditation standards by a health care organization, demonstrated through an independent external peer assessment of that organization’s level of performance in relation to the standards.”

The difference between these two definitions rests with who it is that actually delivers the accreditation program. The first definition is specific on this (a non-governmental agency) while the second definition leaves this open. This difference in definitions, as we will see shortly, is significant in

¹ Shaw, C.D. (2004), “Toolkit for accreditation programs, some issues in the design and redesign of external health care assessment and improvement systems”, The International Society for Quality in Health Care

the evolution of accreditation. Both definitions are similar, however, in their descriptions of an external or independent review of a health care organization's performance (often referred to as the "accreditation survey") based on a set of standards.

For our purposes today, let us summarize the four main components of accreditation. The first of these is the standards which will be used to evaluate an organization's or program's performance. Without these there could be no accreditation.

The second component is the review process. This may be comprised of one or two parts. There will always be a review by external evaluators (surveyors), those who offer an objective assessment of the organization's or program's performance against standards. The review by external evaluators, however, may be accompanied by an internal review, often called self-assessment, in which the organization or program assesses its own performance against the accreditation standards prior to the assessment performed by external evaluators.

The third component of accreditation is the accreditation report which is provided to the organization or program following the external review. The report gives the findings from the review and provides both commendations about what is done well and recommendations for areas of improvement. Organizations and programs can use the recommendations from the accreditation report as a key basis for their internal quality improvement activities.

Some accreditation programs are now able to aggregate the findings from all their accreditation reports to be able to provide high level views of accreditation findings nationally or regionally. Using accreditation results in such a way helps to identify major problem areas common to the health care system as a whole and which, in turn, may allow for more focused attention for their resolution. Similarly, major achievements across the system can also be highlighted and used to support public confidence in the quality of the system.

The final component of accreditation is follow up, which occurs after the survey report has been provided and before the next accreditation visit. During this period, many accreditation programs require some evidence that action is being taken by the organization/program to address the recommendations that have been made. Such follow up may include: submission of progress reports and/or interim visits by external assessors.

b. Accreditation and other forms of evaluation in health care

But, what makes the accreditation standard and the accreditation review different from other health care evaluation processes, such as licensing and certification? For this we draw on a very useful table prepared in 2002 by Dr. Charles Shaw from the UK.²

² Shaw, C.D., Kalu, I. (2002), "A background for national quality policies in health systems", World Health Organization

Table 10. Definitions of accreditation, licensure and certification

Process	Issuing Organization	Object of Evaluation	Components/Requirements	Standards
Accreditation (voluntary)	Recognized tools, usually an NGO	Organization	Compliance with published standards, on-site evaluation, compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Licensure (mandatory)	Governmental authority	Individual	Regulations to ensure minimum standards, exam, or proof of education/ competence	Set at a minimum level to ensure an environment with minimum risk to health and safety
		Organization	Regulations to ensure minimum standards, on-site inspection	
Certification (voluntary)	Authorized body, either government or NGO	Individual	Evaluation of predetermined requirements, additional education/training, demonstrated competence in speciality area	Set by national professional or speciality boards
		Organization or component	Demonstration that the organization has additional services, technology, or capacity	Industry standards (e.g. ISO 9000 standards) evaluate conformance to design specifications

While this table is useful in establishing the basic differences between accreditation, licensing and certification we have seen that there are variations to this basic schema which have evolved over time. We can also see the similarities amongst the three and why they are easily confused.

c. Goals of accreditation

We cannot leave this introduction to accreditation without some discussion of the goals of accreditation, or more simply put: why accreditation? There may be many goals, or purposes, but I suggest to you that seven are most evident:

- ***Ensure safety:*** The first target for accreditation is to ensure that the care delivered by health care organizations is safe, preventing unnecessary harm to both patients and staff of health care organizations. Safety standards are often a central component of the accreditation standards

- ***Maintain and improve quality:*** Accreditation always promotes maintaining and improving quality of patient care and within other services provided. Most standard require that programs for quality improvement be implemented throughout the health care organization.
- ***Promote effective delivery of care and service:*** The accreditation standards and the accreditation survey focus on how the health care organization achieves the desired results for care and other services.
- ***Promote efficient delivery of care and service:*** The accreditation standards and the accreditation survey focus on the best use of resources (human, financial, equipment and facilities) to achieve the desired results.
- ***Create uniformity of care and service across the health care system:*** Accreditation standards provide a “blueprint” for care and service within health care organizations. If standards are met by all health organizations within a health system, uniformity of service for the population will result.
- ***Promote the development of the health care system:*** Through the standards and accreditation process new directions for the health care system can be introduced and their implementation monitored across the system over time.
- ***Help to create public confidence in the health care system:*** Ensuring that there is external, objective evaluation of the health care system will give the general public confidence that health services are being monitored on a regular basis and that problems are being addressed and improvement made.

In an accreditation system the prominence or priorities of these goals is influenced by local social, political, economic and historical conditions. However, when beginning an accreditation program it is imperative that goals be clearly articulated and made widely known to participating health care organizations as well as across the health care system. It should be noted that these goals are important for funders, providers and consumers, alike.

World-wide Development of Accreditation

I want now to turn to the development of accreditation which spans a period of nearly 100 years. I have elected to examine this development in terms of the main lessons we have learned over time.

Lesson 1: There must be a compelling reason for accreditation. The compelling reason must be continuous

The first lesson that we have learned, and that we keep learning over and over again, is a simple and rather obvious one, that there must be a compelling reason for accreditation and that this compelling reason must be continuous. Let us go back to the early history of accreditation for the “compelling reason,” or driving force, which was the impetus for its beginnings.

Accreditation, as many of you will know, began in North America around 1910.³ Dr. Ernest Codman is credited with the original kernel of an idea, not only for accreditation but also for looking at the end-results of the care that was given in hospitals at the time. His espousal of end-results of care involved the implementation of a system that would enable a hospital to track every patient it treated long enough to determine if the treatment provided was effective. If treatment were not effective, the hospital would try to find out how to prevent such failure in future. It should be noted that

³ Davis L: *Fellowship of Surgeons: A History of the American College of Surgeons*. Chicago, American College of Surgeons, 1973. As referenced by: Roberts J. et al, *A History of the Joint Commission on Accreditation of Hospitals*, JAMA, Vol 258, No 7, Aug.1987.

hospitals at the time were primarily boarding houses for the poor and sick. They were, in fact, an embarrassment to the medical profession of the time.

This system proposed by Dr. Codman was the first suggestion that hospital care could be standardized. He further proposed that hospital standardization would also be best undertaken through the formation of an American College of Surgeons that would not only screen and approve medical credentials but would also seek to standardize hospital care. To make a long story short, the American College of Surgeons was founded in 1913. Much to Dr. Codman's chagrin, however, his ideas for looking at the end results of care did not find enthusiastic acceptance in the new College. In fact, they were not to receive prominence until much later in the evolution of quality monitoring – but that is for discussion later in this presentation.

As the new College was being founded, however, interest was confirmed to pursue hospital standardization. One of the first resolutions of the College's founding group was “. . .that some system of standardization of hospital equipment and work should be developed. . .” This resolution ultimately resulted in the formulation of the first set of minimum standards for hospital. There were five standards that covered the following:

- physicians and surgeons are organized as a staff
- membership on staff requires competency in a field and worthiness in character and ethics
- staff develop rules, regulations and policies
- accurate records be kept for all patients

- diagnostic and therapeutic facilities, under competent supervision are available to diagnose and treat patients, at least laboratory and x-ray

Lesson 2: Standards are the core of accreditation and must target those things that make a difference to quality of care.

From these standards we learned our second important lesson, that standards are the core of accreditation and must target key elements for quality of care. As we can all appreciate, the early fathers of accreditation targeted the five basic things that they felt would make a real difference to hospital care. And we can also appreciate that these early standards are still relevant today and still incorporated into the standards used by many accreditation programs around the globe. Today, accreditation standards around the world may be much more comprehensive and complex but they are still the core of any accreditation program and they still seek to cover those areas which will have the greatest effect or impact on quality of care. While early standards were primarily focused on assessing the structures of an organization, today we tend to see a combination of standards related to structure, process and outcome. Outcome standards are still a challenge and will, no doubt receive more attention in future.

But, back to our story of early accreditation. . .

These initial minimum standards formed by the American College of Surgeons were field tested in 692 hospitals of 100 beds or more. Only 89 hospitals met the standards. These results were so appalling that those who reviewed the data decided to burn them at midnight in the furnace of the

Waldorf Astoria Hotel, New York City, where they were meeting, in order to keep them from the press.

Lesson 3: Performance must be assessed against standards and action taken based on results.

What happened next brings us to the third lesson we learned and that is that if standard are to be useful, performance against them must be assessed and action must be taken on any deficiencies which are found.

With the results of the field test, a compelling reason for action was evident, and act the College of Surgeons did. The Hospital Standardization Program was firmly established by the College. There was a demonstrated need for such a program and there was widespread support for it, from the viewpoints of both patients receiving care in hospitals and physicians who were practicing, or learning to practice, in the hospital setting. This compelling reason continued until the 1950s when well over 3300 hospitals had obtained approval through the Program. As result the quality of care in hospitals over the years improved dramatically.

In the 1950s, the Hospital Standardization Program had grown so much that the College of Surgeons felt it could no longer support it. Hospitals were becoming more and more complex and medical care was becoming increasingly sophisticated, especially with the emergence of more non-surgical specialties. Thus, the College solicited support from other national professional organizations for the continuation of the program. Ultimately, four other groups, including the Canadian Medical Association (and, thus the Canadian entry into the world of accreditation), joined the College to

create in 1951 the Joint Commission on Accreditation of Hospitals. The first beginnings of the Canadian accreditation program occurred in 1958 when the Canadian Medical Association withdrew from the Joint Commission in order to form our own unique program. These two programs existed on their own until the 1970s when Australia moved accreditation beyond North American borders.

Lesson 4: Each country has its own unique characteristics that must be taken into consideration for an accreditation program. Transplantation of programs from one country to another without such considerations will not be successful.

And, this brings me to our fourth lesson in accreditation, that is, that each country or region has its own unique characteristics that must be considered when creating an accreditation program. Transplantation of programs from one country to another without consideration for these unique characteristics will result in programs which will either not be successful or will be less successful than they could be.

New Zealand developed an accreditation program shortly after Australia and in the 1980s, the UK, through work of the King's Fund, began to explore accreditation and, as well, the Hospital Accreditation Program (HAP) was developed by Dr. Charles Shaw, based on his experience with accreditation in Canada. Europe's major interest in accreditation did not begin to occur until the mid-late 90s when Finland, the Catalunya region of Spain, the Czech Republic, Poland and Switzerland began to implement accreditation.

When accreditation emerged in Europe, three important variations in implementation began to occur. In the late 1990s France introduced compulsory accreditation for hospitals which was mandated by federal law. As well, accreditation in France was to be government supported and funded, although its operation was to be overseen by an “arms length” organization of government. Thus began in Europe a trend which has increased over time. It is now estimated that approximately 24 accreditation programs exist in Europe with the majority of them being government initiated and government supported.

In Europe as well, we began to see another important deviation in national accreditation. In Spain and here in Italy accreditation was mandated at the national level but its implementation was left to individual regions within the country. While this method of implementation detracted somewhat from the uniformity of accreditation across a county, it did allow regions to implement accreditation in ways they felt would best suit their own local situations and systems.

A third variation, again witnessed in France and Ireland, but also right here in your region, was the incorporation of accreditation into agencies with a larger, more comprehensive role and responsibility for quality.

Growth of interest in accreditation also began to occur in the 1990s in other parts of the world and today the International Accreditation Program of the International Society for Quality in Health Care estimates that there are accreditation programs being created or currently operating in over 70 countries around the world.

Lesson 5: Hospital accreditation alone does not create a quality health care system. Accreditation must be applied to other sectors as well.

Our next lesson in accreditation involves the scope of health care organizations for which accreditation has been created. In its early days accreditation rested almost exclusively in acute care hospital and still today that is the case for many of the newer or developing program.

However, for the older programs the 1960s, 70s and 80s were periods of expansion for accreditation beyond hospitals. There was a dawning recognition that accreditation of hospitals alone does not create a quality care system for institutional health care. In my country of Canada, for example, psychiatric hospitals began to be accredited in the 1960s, long term care (chronic hospitals and nursing homes) in the 1970s and the rehabilitation sector (rehabilitation hospitals and community based rehab programs) in the 1980s. The 1990s saw the inclusion of outpatient and community based services in accreditation thus ensuring accreditation coverage for the entire continuum of care. A similar application of accreditation has been experienced in other of the older programs around the world. While most accreditation programs around the world have started with acute care hospital accreditation, there has quickly been a recognition that a health care system needs to have accreditation programs for all its sectors if the full force of its impact is to be realized, especially its ability to provide quality as part of continuity of care across the system.

However, before looking further ahead in time we need to look at another development that began in the 1980s, that being more rigorous attention to

precisely how quality was monitored within accredited health care organizations.

Lesson 6: Quality monitoring requires a rigorous approach. It cannot be done haphazardly.

As accreditation was maturing and being implemented around the world, so too, was our way of monitoring quality. We began to understand that simply creating accreditation standards did not insure that our desired levels of quality were being achieved. If you will recall, this was the message of Dr. Ernest Codman in 1910, a message we were not then ready to hear. He advocated for looking at the end-results of care, which involved tracking the results of treatment; if treatment was not effective (which was seen as failure) then changes needed to be made (prevention of future failure). The message that was not heard or accepted in 1910 was now, in the 1980s to become a major focus for health care and we had learned another lesson, that quality monitoring needed to be rigorous if it was to make a difference.

Our response to this need for better monitoring was to embrace the concept of quality assurance and older accreditation program as well as those newly emerging began to incorporate into our standards the requirement for all departments in all accredited organizations to carry out quality assurance activities. Quality assurance generally involved setting a standard for performance and then working to achieve this standard. Once the standard was achieved, then the task was to maintain the standard.

This move by accreditation was, over the next few years, to foster widespread development of quality assurance programs in the institutional

sector of health care. While this development was certainly an improvement on how quality was being monitored, it did have its down side. Most organizations either appointed quality assurance coordinators or, in larger organizations, created quality assurance departments. As result, the coordinators and departments became the custodians of quality and it was more or less removed as a responsibility of front line, direct care providers. Thus, quality assurance came to be associated with an inspection mentality. The attitude of the front line providers became “Let them do it, it’s their job!” As well, quality assurance, rightly or wrongly, resulted in a focus on finding problem people and making them pay for the problems they created. As a response, health care workers became defensive and avoided participation in quality assurance activities. Quality assurance as the dominant focus of quality monitoring continued, however, until the late 1980s when a new and dramatic idea was presented and a new lesson was to be learned.

Lesson 7: Quality monitoring must focus on constantly improving.

Our sixth lesson is that the focus of quality monitoring in health care must be on continuously improving the care and service that we offer to those we serve. The move away from quality assurance to quality improvement began in the late 1980s and one of its major proponents was Dr. Donald Berwick, then from the Harvard Community Health Plan. Dr. Berwick’s seminal article in January 1989 in the *New England Journal of Medicine*⁴ presented a compelling case for a new way of thinking about quality monitoring. It argued against the currently used inspection “Theory of the

⁴ Berwick, Donald M., MD, MPP, *Continuous Improvement as an Ideal in Health Care*, *New England Journal of Medicine*, 320:53-56 (January 5), 1989.

Bad Apples:” (If there were one bad apple in a barrel it was to be sought, found, and eliminated from the barrel, thus ensuring that the rest of the apples in the barrel would be fine.) This theory involved an “I will find you out if you’re deficient” mentality, with a response from the other side being for each individual to strive to prove he is not deficient.

Lesson 8: Reestablish trust in health care workers who deliver front line care/service.

Lesson 9: Use more sophisticated tools to analyze and evaluate quality.

We learned many important things from Berwick’s work but perhaps the two most important lessons were that we had to reestablish trust in health care workers who delivered front line care /service and that we had to use more sophisticated tools to analyze and evaluate quality.

What did this mean for accreditation? In fact, it was to mean the significant redesign of accreditation, both the standards and the process used for evaluating compliance with standards. At the risk of oversimplifying the results of this redesign, I suggest to you that they included four major changes to standards:

- 1. Standards were changed to be “client-focused”**
- 2. Standards were built around the patient care process.**
- 3. Standards were to be used by the multidisciplinary group of caregivers.**

4. Those involved in delivering care/service should be directly involved in its evaluation and improvement.

5. Quality Improvement was to be the basis for accreditation.

These changes which were finding themselves in accreditation standards also began to be reflected in how accreditation assessments were carried out, that is, how they were organized and what things external assessors began to look at and how they did this. In short, quality improvement principles became firmly imbedded in all aspects of most accreditation programs.

One of the firm principles of quality improvement is the need to measure what is done so as to be able to determine whether improvements have been made and, if made, whether they have been sustained over time.

Accreditation programs, themselves took this principle to heart. There was a strong need emerging for accreditation programs to be able, through the accreditation process, to assist health care organizations to measure their progress over time as well as to compare their performance with other similar organizations at particular points in time. This, in turn, created the need for easily accessible and highly rigorous data from accreditation surveys, especially data on compliance with standards and performance on required indicators. And this requirement, of course, led to the need to automate the accreditation process, a difficult and resource intensive undertaking. While most accreditation programs around the world are only in the beginning stages of this daunting task, it is clear to all that automation and the production of good and valid data is what must be done if accreditation is to play its important role in health care systems of the future.

And, this brings us to our tenth lesson, that is, accreditation is a living and dynamic process and must change with the changing needs of the times.

Lesson 10: Accreditation is a living and dynamic process and must change with the changing needs of the times.

Well, when I look into my accreditation crystal ball to see the future I can predict five things with some certainty.

1. The focus of accreditation will expand.

The focus of accreditation is now primarily on quality improvement and that focus will remain into the future. However, it will be coupled with an equally important focus on patient safety. This second focus is now emerging in many of the accreditation programs around the world. Caution will need to be exercised to insure that quality improvement does not become overshadowed by the urgency to act which patient safety is now presenting in many countries.

2. Measurement within accreditation will become more rigorous

The need for more rigorous measurement with accreditation encompasses several specific future activities. As mentioned previously, the data from accreditation surveys will need to be made more accessible and easy to use by accredited organizations themselves but also by external users. Its validity and reliability, as well as its comparability will need to be insured. As well, most accreditation organizations are now anticipating, or at least exploring, the incorporation of required performance indicators, both clinical and non-clinical, which will need to be monitored by accredited health care

organizations. Many of the early (i.e. since the 1990s) indicator requirements have been focused on selected clinical indicators and their monitoring was often optional. More recent efforts have seen required indicator monitoring in specific areas related to patient safety. This trend can be expected to continue. As well, the importance of monitoring indicators in non-clinical areas of the health care organization is also now being recognized. However, the collection of indicator data through accreditation will require reliable and appropriate data systems.

3. The domains for accreditation will expand.

The trend to expand accreditation beyond the hospital will continue and intensify. The importance of accrediting out-patient and community based services will increase. As well, there is growing interest in the accreditation of clinical programs (which are often “disease focused” such as diabetes, stroke, breast and other forms of cancer), either as adjunct parts of an organization’s accreditation survey or as separate surveys altogether. Clinical programs often are delivered in several different inpatient, outpatient and community settings and thus continuity of care as well as clinical practice guideline which govern the care in the various settings become the focus for accreditation.

4. Patient/consumer involvement in accreditation will increase.

Most accreditation programs existing today believe in the need for participation of the patient and/or the consumer in accreditation and this belief is likely to get stronger and evolve as we move into the future. Options which are now being considered or implemented in various of the accreditation programs include participation in the following:

- Planning and reviewing the accreditation program
- Assisting to develop accreditation standards
- Governing accreditation agencies, as members of board of directors
- Carrying out the accreditation survey visit (participation in the organization's self-assessment, being interviewed by surveyors, participation in patient focus groups, patient surveyors (example, Ireland)

5. Accreditation will use new and improved methodologies

Accreditation agencies around the world are exploring new methods for delivering all parts of the accreditation process. Some of these new methods focus on easing the burden of accreditation for health care organizations while others are focused on ensuring that accreditation helps health care organizations to continually and effectively monitor and improve quality and safety. For example, the tracer methodology of surveying enhances the patient centeredness of accreditation while at the same time creating a more focused survey. Accreditation standard are being streamline in an effort to ease the burden for the health care organization while at the same time capturing those elements which are truly important for assessing quality and patient safety.

Accountability for Accreditation

Talking about the future also leads me to a final trend for the future, this trend being for accrediting organizations themselves. It is my belief that as accreditation becomes more and more prominent in health care evaluation so

too must it become more and more accountable for what it does and how and for whether or not accreditation is effective. This, of course raises the question of: *who accredits the accreditor?*

I am pleased to be able to tell you that there is assistance for accrediting organization from the International Society for Quality in Health Care (ISQua). ISQua's International Accreditation Program (IAP) offers and accreditation program for accreditation and evaluation organizations. This program will assess:

- Accreditation standards (using internationally established principles)
- Accreditation organization performance (using internationally established standards)
- Surveyor/assessor training programs.

As well, the IAP program, through the leadership of the Canadian Council on Health Services Accreditation (CCHSA) is now preparing a website for information and research findings on the effectiveness of accreditation.

But, why should accreditation organizations seek this kind of international recognition? There are many reasons but perhaps three stand out:

- It provides confidence and credibility through worldwide recognition
- It involves an impartial and independent review system
- It provides reassurance to governments, funders, clients, the public and the accreditation organization itself that international performance standards are being met.

In short, when accreditors allow themselves to be externally assessed they send a signal that they are open and accountable and will go through the same evaluation as they require of their client health care organizations.

ISQua's IAP program continues to grow as more and more accrediting agencies recognize the need for, and usefulness of external evaluation. Currently, 15 organizations have had their standards accredited and 7 organization have submitted their standards to ISQua for assessment prior to seeking accreditation for them. Ten organizations have to date completed both standards accreditation and the accreditation of their organizations.

The IAP program is governed by a Council of 15 member organizations who provide guidance for standards and organization accreditation as well as oversee the business of delivering the IAP programs. The ISQua website provides considerably more information on the Accreditation Program than I am able to provide today.

Conclusion: Continue to establish the compelling reason for accreditation

Which brings me to my last point. You will recall that the first lesson learned that I described to you in the beginning of this presentation, was that there must be a compelling reason for accreditation. I suggest to you that this is a lesson we continue to have to learn today. We continue to have to ask ourselves the question: "why would anyone want to do this?" or "what is the benefit one gets from going through this process?" Not only to we have to ask ourselves the questions BUT we also have to have the answers. In the early days answering the questions was easy. Health care was poor and

there was very little, if any, monitoring going on. Today, we have a different set of circumstances, a different set of achievements, different players, and it, therefore stands to reason that we will have different answers. However, two things are still abundantly clear to me and that is, first, that accreditation is still about monitoring quality and end results of care, as Ernest Codman encouraged us to do from the early days of the 20th century, and, second, that accreditation is not an isolated activity but must be an integral part of any health care system. It must work in partnership with providers, funders and consumers. It must help to achieve the goals and aspirations of that system as they change over time and it must be scrutinized and advised by that system as well as provide advice to it. It must learn its lessons well and be at all times responsive. It must lead for quality by being an example of quality.

Thank for interest and attention. And, may I again extend to all of you here in the Veneto Region who are involved in accreditation, or who will be, my best wishes for every future success as the second phase of work begins.