

Denne version er opdateret med et afsnit om de praktiserende speciallægers 2. runde.



Accreditation of general practices and specialist private practices in Denmark: who performs better and why?

Findings from surveys and outcomes after the opportunity to improve shortcomings

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1. Introduction

The Danish healthcare system is universal and based on the principles of free and equal access to healthcare for all citizens. The healthcare system is financed by general taxes.

The healthcare system operates across three political and administrative levels: the state, the regions and the municipalities (national, regional and local levels). The state holds the overall regulatory and supervisory functions for health and elderly care. The five regions are primarily responsible for the hospitals, the general practitioners, specialist private practitioners, and for psychiatric care. The 98 municipalities are responsible for a number of primary healthcare services as well as for elderly care.

Accreditation of specialist private practice and general practice

As part of the collective agreement for general practice and specialist private practice in Denmark, specialist private practitioners (SPs) and general practitioners (GPs) were accredited according to the Danish Healthcare Quality Programme. Between October 2015 and October 2018, 885 specialist private practices were accredited and between January 2016 and January 2019, a total of 1607 practices were accredited. That equals about 93 % of all specialist private practitioners and about 92 % of general practitioners in Denmark.

In general, this study shows that both the SPs and the GPs perform really well. What we focus on in this study are the relatively few clinics where shortcomings have been identified.

Specialist private practice

Specialist private practice consists of the following 16 specialities. All 16 specialities have been surveyed and will be presented in this study:

| Medical specialities | Surgical specialities |
|---------------------------------|-----------------------|
| Child and adolescent psychiatry | Anaesthesiology |
| Dermatology | Gynaecology |
| Internal medicine | Ophthalmology |
| Neurology | Orthopaedic surgery |
| Paediatrics | Otolaryngology |
| Pathology | Plastic surgery |
| Psychiatry | Surgery |
| Radiology | |
| Rheumatology | |

Specialist private practices are privately owned but are funded by the regions on the basis of the collective agreement and the treatment provided.



General practice

In Denmark, we generally distinguish between three different types of general practices; single-handed practice, cooperation practice and partnership practice.

General practices are privately owned but are funded by the regions on the basis of the collective agreement and the treatment provided.

Accreditation

Accreditation is a procedure where a recognised body, in this case IKAS, the Danish Institute for Quality and Accreditation in Healthcare¹, assesses whether specialist private practice and general practice meets a set of common standards which prescribe quality standards for specialist private practitioners and general practitioners. The assessment is done by a half-day survey, conducted by a team consisting of one GP or SP and one surveyor from a similar profession (e.g. a nurse or GP/SP receptionist).

The standards for the SPs and the GPs consist mostly of legal requirements such as patient identification and the patient health record, and requirements based on the collective agreement such as vulnerable patient groups, drug statistics and patient involvement.

The standards are developed through negotiation with the respective region (the employer) and each respective trade union (one for the GPs and one for the SPs) and IKAS. The standards primarily contain legal and contractual requirements and therefore indicate an oversimplification of the quality level in the two sectors.

Shortcomings in these areas are, in fact, an expression of non-compliance with legislation and contractual obligations.

The standards could be set higher which would mean that the results for the large group that are already accredited would be more nuanced; the results reflect a huge difference in quality which we don't cover in this study.

The standards developed for the SPs include 16 overall standards containing 69 indicators². The standards for the GP's also include 16 standards, but only 64 indicators.

¹ IKAS develops, plans and runs the Danish accreditation programme for healthcare providers. This is called the Danish Healthcare Quality Programme (abbreviated: DDKM, which refers to the name of the programme in Danish).

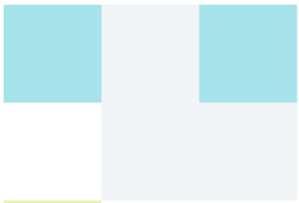
² An indicator is a measurable element. The indicators are qualitative and describe how we will evaluate the client's effort to achieve this aim.

The themes of the standards cover essential work processes in the clinic, from referral and visitation to treatment and handling of paraclinical tests, and also include management, recruitment, the introduction of personnel, hygiene, equipment, handling of utensils, and medicinal products as shown in the table below:

Table 1

| Specialist private practice | General practice |
|---|--|
| Standard title | Standard title |
| 1. Management quality and operation | 1. The professional quality |
| 2. Use of guiding documents on diagnostics and treatment | 2. Use of good clinical practice |
| 3. Patient safety | 3. Adverse events |
| 4. Adverse events | 4. Patient evaluations |
| 5. Sedation of patients without anaesthesiologic assistance | 5. Prevention of confusion of patient's identity |
| 6. The patient's health record | 6. Prescription of medicine and renewal of prescriptions |
| 7. Patient identification | 7. Paraclinical tests |
| 8. Paraclinical tests | 8. Emergency response and cardiac arrest |
| 9. Basic cardio-pulmonary life support | 9. The patient's health record, data safety and confidentiality |
| 10. Triage and referral | 10. Availability |
| 11. Hygiene | 11. Referral |
| 12. Equipment for diagnosis and treatment | 12. Coordination of patient care |
| 13. Personal data and confidentiality | 13. Acquisition, storage and disposal of clinical utensils and medicine/vaccines |
| 14. Handling of utensils and medicine | 14. Hygiene |
| 15. Hiring, introduction and competence development | 15. Management and operational activities |
| 16. Patients' perception of quality | 16. Hiring, introduction and competency development |

The indicators are assessed according to the four-point scale below. If all indicators are rated at one of the two upper levels (4 and 3), accreditation is awarded immediately. If not, the practice has the opportunity, within 3-6 months, to demonstrate improved compliance before a final decision on accreditation is made. If there are still low-rated indicators, an independent committee will decide, based on a risk assessment, whether or not accreditation can be awarded.



| | | |
|---|-----------------------|---|
| 4 | Met: | All indicator requirements have been met |
| 3 | Largely met: | Some indicator requirements from the standard have not been met but the non-compliances do not constitute a significant part of the requirement |
| 2 | Partially met: | Some indicator requirements from the standard have not been met and the non-compliance does constitute a significant part of the requirement |
| 1 | Not met: | No indicator requirements have been met or only plans exist |

2. The objectives of this study

- 1) To assess and analyse the extent to which standards are not sufficiently met, and to assess the improvements achieved at the follow-up survey, that is, basically, to assess the effect of the accreditation model.
- 2) To examine which indicators have the most ratings on the two lower levels.
- 3) To examine the influence of the variations across gender, age and geographical location of the practices (the five regions) for both sectors. In addition to these objectives, we examined practice types and the time of the survey in relation to the general practitioners and specialties in relation to the specialist private practices.

3. Objective one

By January 2019, 885 special private practices and 1607 general practices had been surveyed and this is what we discovered:

Specialist private practitioners

In 22.3% of the 885 specialist private practices, the surveyor team found one or more conditions that did not meet the minimal requirements in an indicator (including legal requirements). These practices had the opportunity to improve the fulfilment of the indicators within 3-6 months. After the opportunity to improve, 98.5% of the practices (equivalent to 872 special private practices) were accredited without remarks. Of the remaining 1.5%, 1% was accredited with remarks and 0.5% was not accredited.

General practitioners

In 33.4% of the 1607 general practices, the surveyor team found one or more conditions that did not meet the minimal requirements in an indicator (including legal requirements). These practices had the opportunity to improve the fulfilment of the indicators within 3-6 months. By September 2019, five of the practices that didn't meet the minimal requirements still need to have their follow-up completed. After the opportunity to improve, 96.7% of the practices (equivalent to 1550 general practices) were accredited without comments. Of the remaining 3.3%, 2.1% were accredited with remarks and 1.1% was not accredited.

Fig. 1

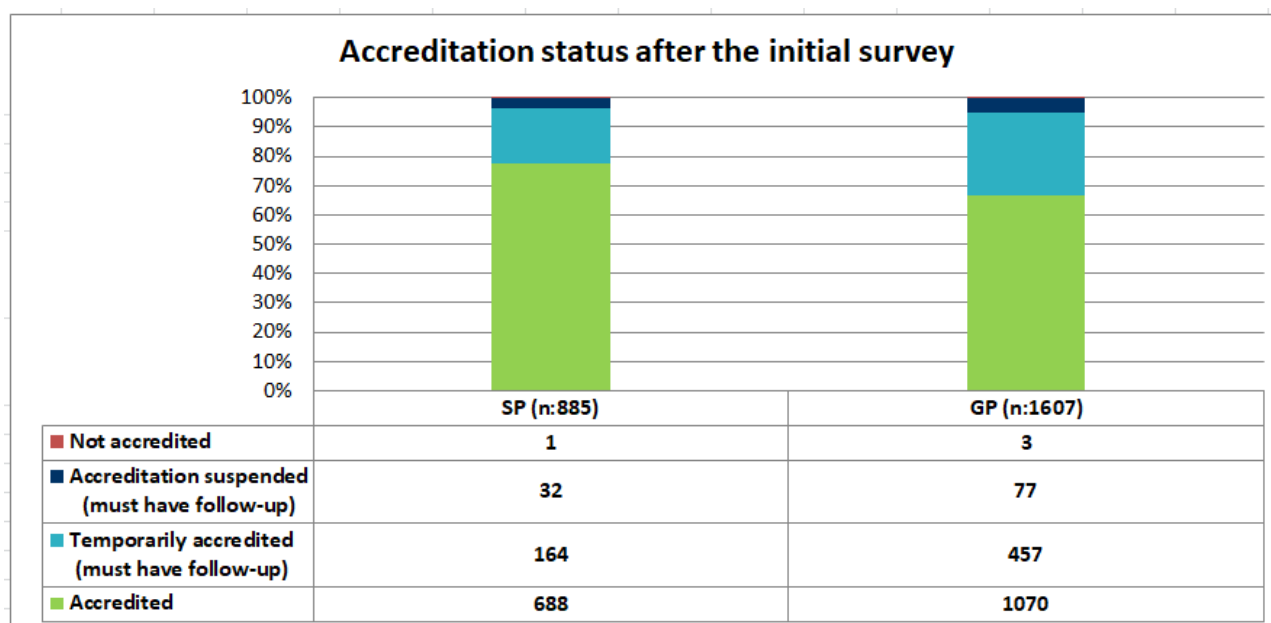
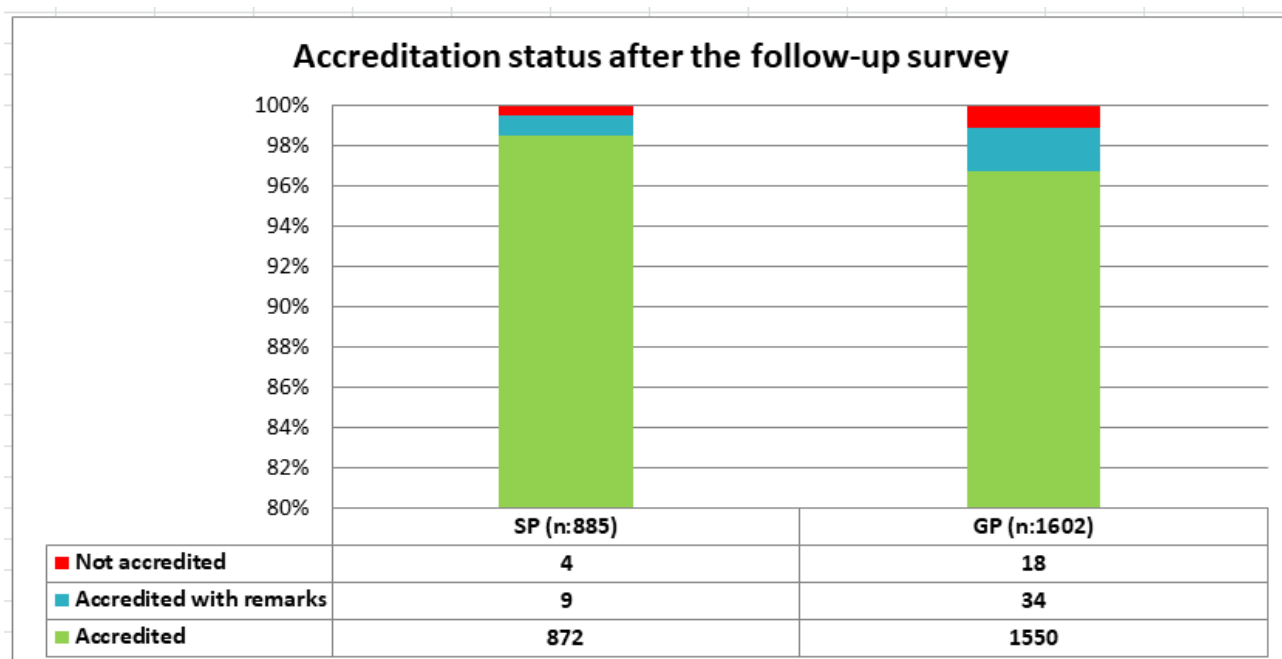


Fig. 2



Results

Accreditation works!

This can be deduced by the results of the first objective of the study. We can conclude that when defining requirements in the form of standards and surveying the practices based on these standards, the compliance increases. If the SPs and GPs do not fulfil the requirements when the survey starts, they do by the time the accreditation process is finished. Therefore, it can be deduced that if requirements are to be met, regarding for example quality or legal requirements, accreditation is an efficient way of implementing them.

The strength of accreditation is indicated both by the large proportion of GPs and SPs that improve during the accreditation process, as well as with the improvements which must occur during the preparation for the initial survey.

4. Objective two

In the study we selected the following indicators that seem to have the greatest consequences for patients:

- Procedure for sterilisation of medical equipment for re-use
- Systems to ensure follow-up on paraclinical tests
- Audit of patient health records
- Procedure for identification of patients

In general practice it turns out that these indicators are also the indicators with the most negative findings i.e. the most findings on the two lower levels (Partially Met and Not Met). Within specialist private practice there were other indicators with more negative findings than the selected indicators, but for the sake of comparability, we have chosen to include indicators similar to those selected for general practice.

Within specialist private practice areas concerning hygiene, adverse events and the patient health record were the most difficult areas to fulfil for the practices. The indicator concerning management of infectious patients had the most negative findings followed by the indicator concerning information to patients and relatives about their possibility to report adverse events and then the indicator concerning audit of patient health records.

See the percentage of negative findings for these indicators in the table below:

Table 2

| Specialist private practice | | | General practice | | |
|---|---|------------------------|--|---|------------------------|
| Standard | Indicator | Number of clinics in % | Standard | Indicator | Number of clinics in % |
| 07 To ensure that: • the right tests, examinations and treatments are provided for the right patient. • the right prescriptions, test results, etc., are recorded for the right patient. | 1- Procedure for identification of patients | 2.0 | 2.1 To ensure that: • the right tests, examinations and treatments are provided for the right patient. • the right prescriptions, test results, etc., are recorded for the right patient. | 1 - Procedure for identification of patients | 6.1 |
| 08 To provide the basis for: • correct and valid results from paraclinical tests. • that no patients suffer any injuries or endure unnecessary harm due to lack of a timely reaction to paraclinical tests. | 2 - Systems to ensure follow-up on paraclinical tests | 2.3 | 2.3 To provide the basis for: • correct and valid results from paraclinical tests. • that no patients suffer any injuries or endure unnecessary harm due to lack of a timely reaction to paraclinical tests. | 3 - Systems to ensure follow-up on paraclinical tests | 7.9 |
| | 3 - Lacking test results are identified, and the clinic follows up on these results | 0.1 | | | |

| | | | | | |
|---|--|------------|---|---|------------|
| 06 | 2 - Audit of patient health records to check whether they include the data required in accordance with applicable laws | 4.6 | 2.5 | 5 - Audit of patient health records to check whether they include the data required in accordance with applicable law | 7.7 |
| That the patient health record is kept in accordance with current statutory provisions to ensure good, safe and continuous patient treatment. | | | That the patient health record is kept in accordance with current statutory provisions to ensure good, safe and continuous patient treatment. | | |
| 11 | 2 - Procedure for sterilisation of medical equipment for re-use | 5.6 | 4.1 | 2 - Procedure for sterilisation of medical equipment for re-use | 8.5 |
| To prevent transfer of infection in the clinic. | | | To prevent patients, relatives and staff from contracting infections in the clinic and by re-using medical equipment and materials | | |

The table below illustrates the distribution of the number of indicators assessed as partially met and not met.

Table 3

| | Specialist private practice | | General practice | |
|--|------------------------------------|------------------------|-------------------------|------------------------|
| Number of indicators partially met/not met | Number of clinics | Number of clinics in % | Number of clinics | Number of clinics in % |
| 0 | 688 | 77.7 | 1070 | 66.6 |
| 1 | 73 | 8.2 | 212 | 13.2 |
| 2-5 | 78 | 8.8 | 246 | 15.3 |
| 6-10 | 33 | 3.7 | 49 | 3.0 |
| 11-20 | 7 | 0.8 | 13 | 0.8 |
| 21-40 | 5 | 0.6 | 17 | 1.1 |
| >40 | 1 | 0.1 | 0 | 0 |
| Total | 885 | 100.0 | 1607 | 100.0 |

Results

The second objective to examine which indicators have most ratings on the two lower levels show that the areas regarding hygiene, paraclinical tests, the patient health record and prevention of confusion of patient's identity are the most difficult areas for GPs to fulfil. For the SPs, it is the areas concerning infectious patients, the patient health record and adverse events.

Note that there are much fewer negative findings within the SPs.

5. Objective three

Can intermediate variables explain the observations?

Even though two different sets of standards and two different organisations were used, there is still so much convergence that it makes sense to compare the significance of a number of the intermediate variables. These variables are gender, age, type of practice (GPs only), time of survey and distribution of specialties (SP only).

Intermediate variables

| | General practices | Specialist private practices |
|--|-------------------|------------------------------|
| Gender | x | x |
| Age | x | x |
| Type of practice | x | |
| Geographical location of the practices (five regions) | x | x |
| Time of completion of the survey | x | x |
| Specialties | | x |

The analysis thus looks at whether these variables can affect the individual clinic's scores according to the selected indicators, specifically in the form of testing the durability of the following hypotheses:

Hypotheses

- **Gender**

We expected that due to, among other things, an AKIAP research project and the article 'Almost half of Danish GPs have negative a priori attitudes towards a mandatory accreditation programme³, that there would be a difference in compliance of the indicators based on gender. For GP's this analysis is based on data from doctors in single-handed practices.

- **Age**

Correspondingly, on the basis of the knowledge already provided in the AKIAP research project, we expected that there would be a difference in the compliance of the indicators based on age, that is: younger general practitioners are expected to perform better than their older colleagues.

- **Type of practice**

We expected to find a difference regarding compliance between the group of doctors in single-handed practice (as they are characterised as not engaging in a close, daily collegial cooperation) and the group of doctors in cooperation practices and partnership practices, where opportunities for sparring, knowledge sharing and learning are obviously greater.

- **Geographical location of the practices (five regions)**

As far as GPs are concerned, the advisory responsibility is based in the five regions and we expected that the differences in method selection etc. might have influenced the advice given, and therefore differences in the effects of the advice afterwards.

As far as SPs are concerned, advisory responsibility is centrally placed with eKVIS ("Unit for quality improvement in specialist private practice") and therefore one expects a uniform advisory practice for all SPs.

- **Time of completion of the survey**

It is anticipated that clinics speak to and learn from each other during the process, so that clinics that are surveyed later in the process are expected to perform better than the earlier surveyed ones.

- **Distribution of specialties**

We expected that there would be a difference in compliance of the indicators across the 16 specialties and across the categorisation of medical specialties and surgical specialties.

Statistical methods

Chi square test has been applied where the sample sizes allow it and p-value is shown in the figures where relevant. However, the study does not solely focus on providing statistical evidence, and therefore we have selected a number of figures based on their visual information value.

³ Waldorff FB, Nicolaisdóttir DS, Kousgaard MB et. al. Dan Med J 2016;63(9):A5266, where it is, among other things, proven that a negative opinion correlates with being older, being a man and working in a single-handed practice.

Results

In order to illustrate the significance and the variables Gender and Age, we have constructed a measure that we have called 'Average Score', where each individual practice has been scored according to their results in the four (GP) and five (SP) selected indicators. The score is based on a pre-determined goal, where Not Met = 0 points, Partially Met = 6 points, Largely Met = 14 points and Met = 20 points. Therefore, if all indicators have been scored Met, the practices will receive, respectively, 80 points (GP) or 100 points (SP). The value of each individual graph indicates the average score for the total of the indicators.

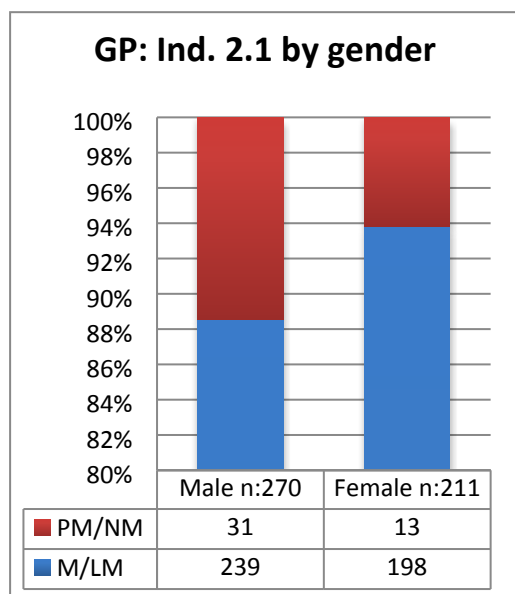
The scatter plot diagrams illustrate the spread of the individual specialties, including whether a high or low average is due to an individual practice with an extreme score.

We have chosen to limit the analysis to data from the selected indicators (ref. p. 6), rather than using total scores, in order to avoid confounding data levels across the analysis.

Concerning gender:

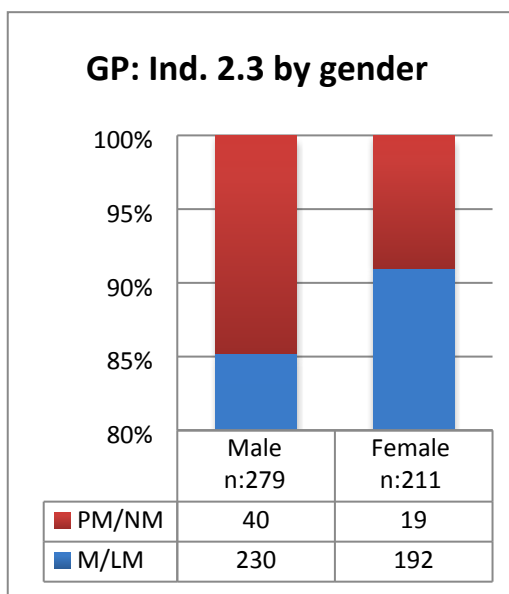
For the doctors in a single-handed practice, female doctors perform significantly better than their male counterparts. There is a significant difference ($\chi^2 p < 0.05$) for all the relevant analysed indicators.

Fig. 3



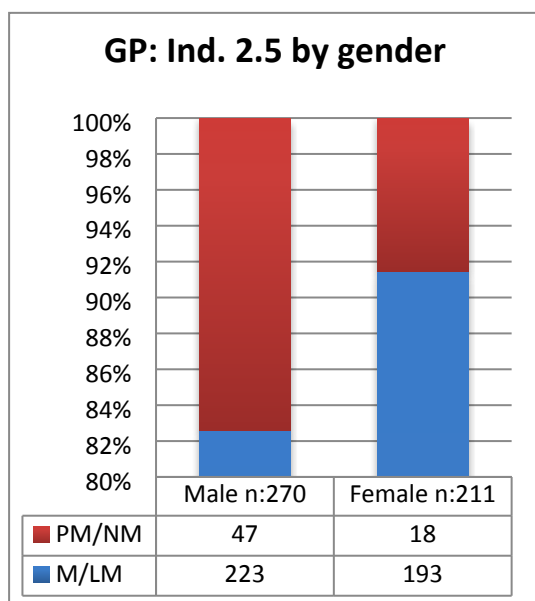
$p: 0.045$

Fig. 4



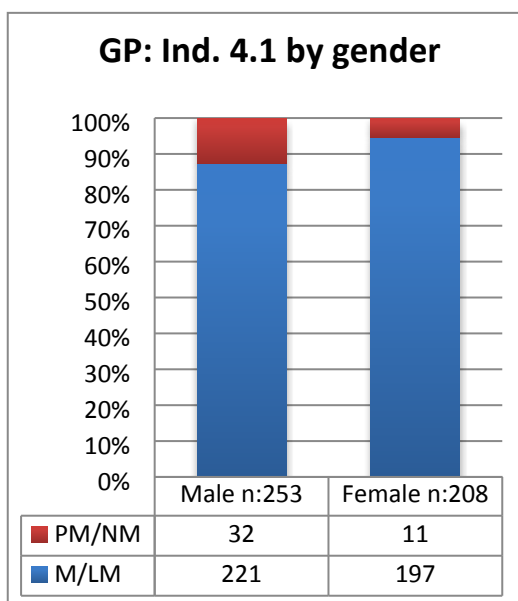
$p: 0.054$

Fig. 5



p: 0.005

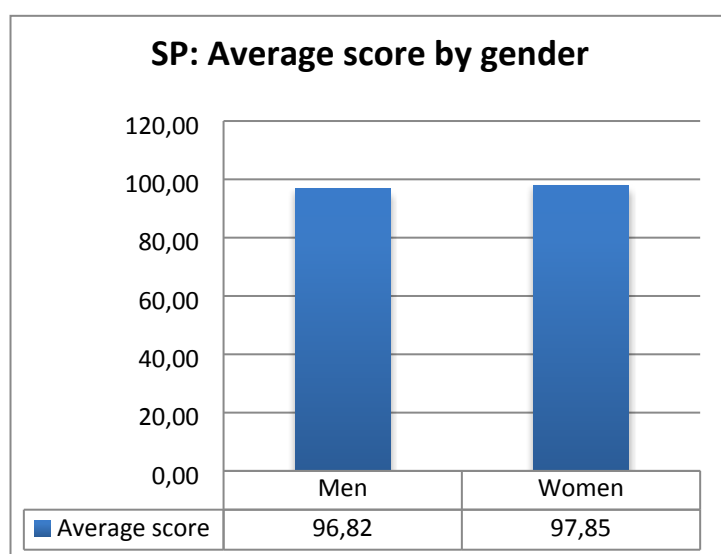
Fig. 6



p: 0.007

There is no significant difference in performance pertaining to gender in SPs.

Fig. 7



Concerning age:

At first glance, the bar chart tends to suggest that junior SPs have a higher degree of compliance than older colleagues. However, when one studies the bubble chart (fig. 9) it can be seen that 39 SPs who are located in the oldest age group, represent a relatively large spread, and thus the trend seen in the bar chart must be interpreted with caution.

Fig. 8

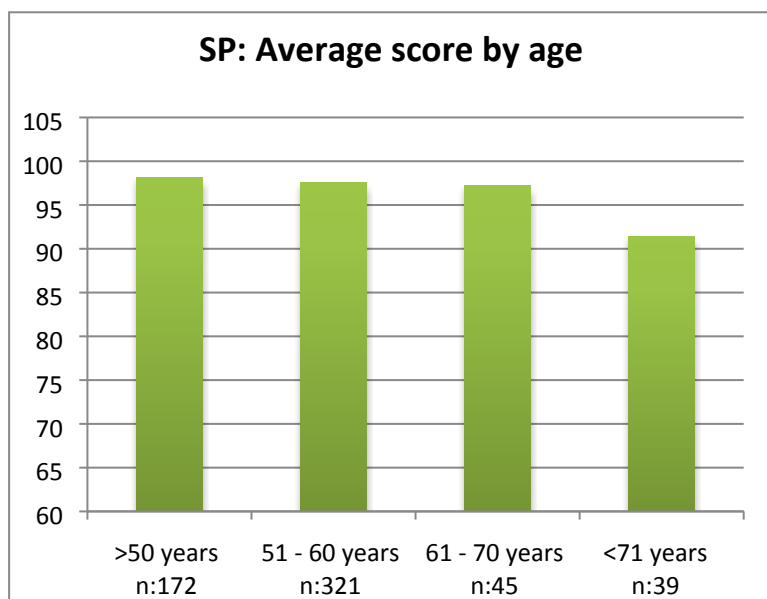
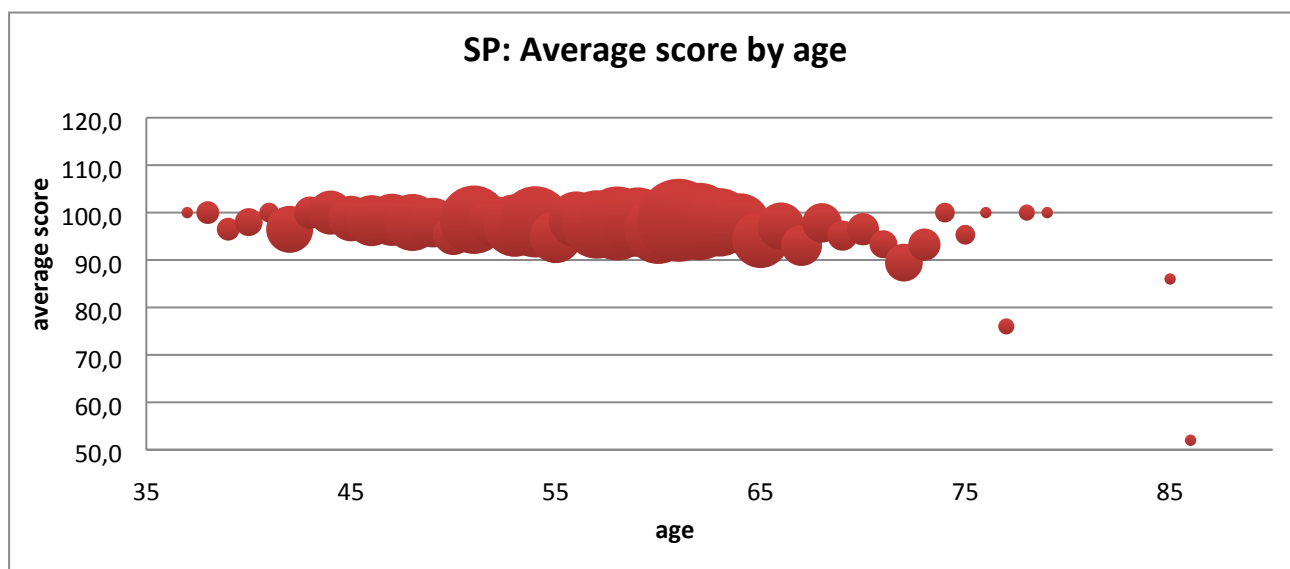


Fig. 9



The bubble chart is 3-dimensional where the location of the bubble illustrates the average score by age, and the size of the bubble illustrates the number of observations.

A similar pattern is seen with the single-handed practice GPs. For both groups, a somewhat larger spread for doctors in the 65+ age group can be noted, but the hypothesis of 'grumpy old men' cannot be clearly confirmed for either GPs or SPs.

Fig. 10

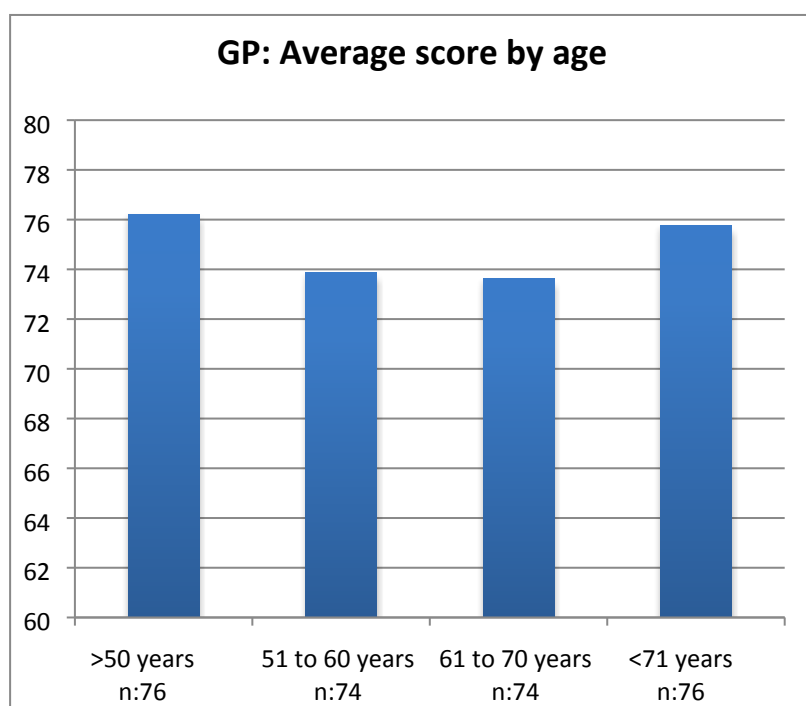
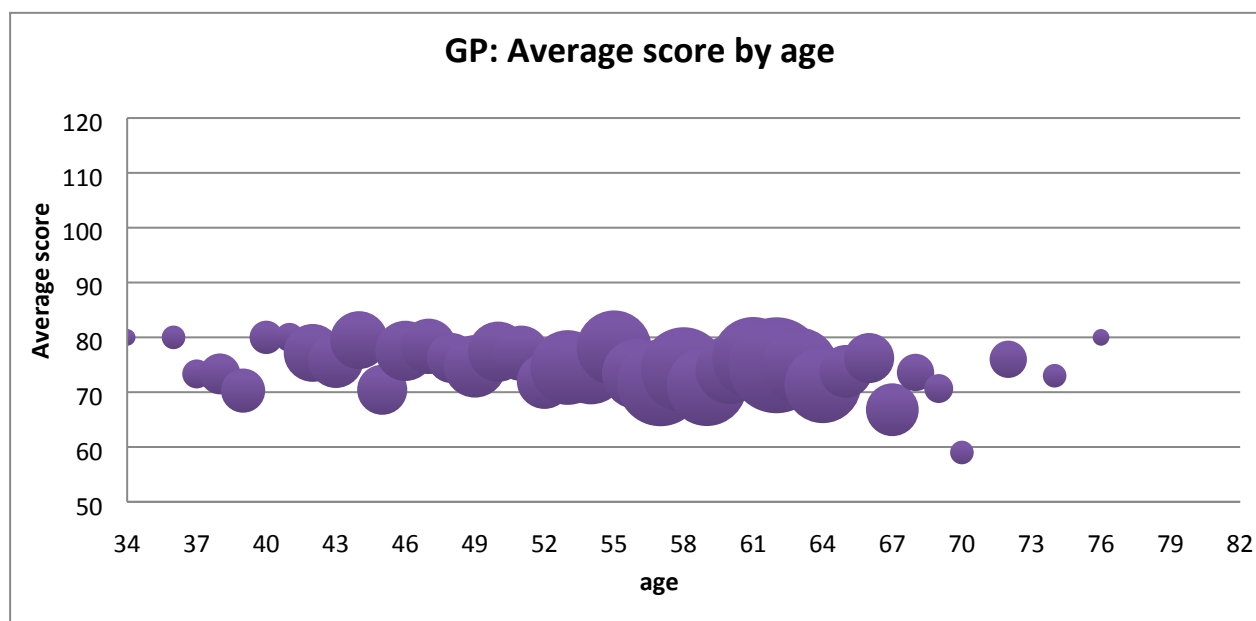


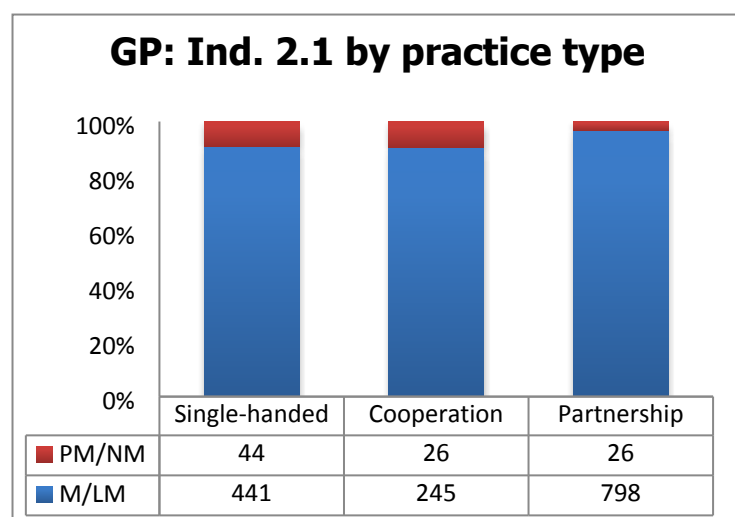
Fig. 11



Concerning type of practice:

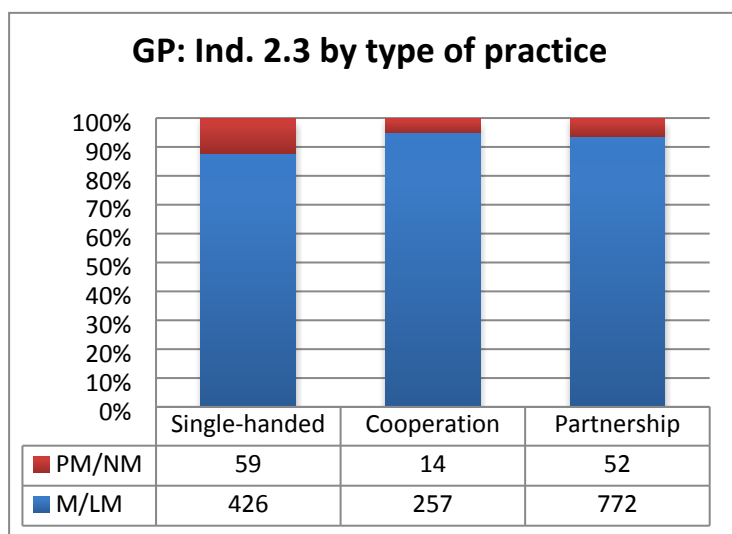
The effect of this variable was investigated for GPs. In Denmark, we generally distinguish between three different types of general practices based on the degree of cooperation in the practice: single-handed practice, cooperation practice and partnership practice.

Fig. 12



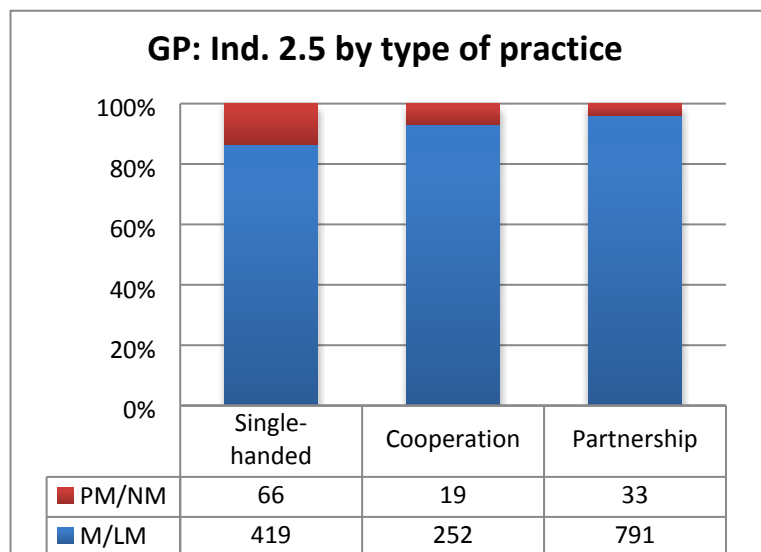
p: 0.00

Fig. 13



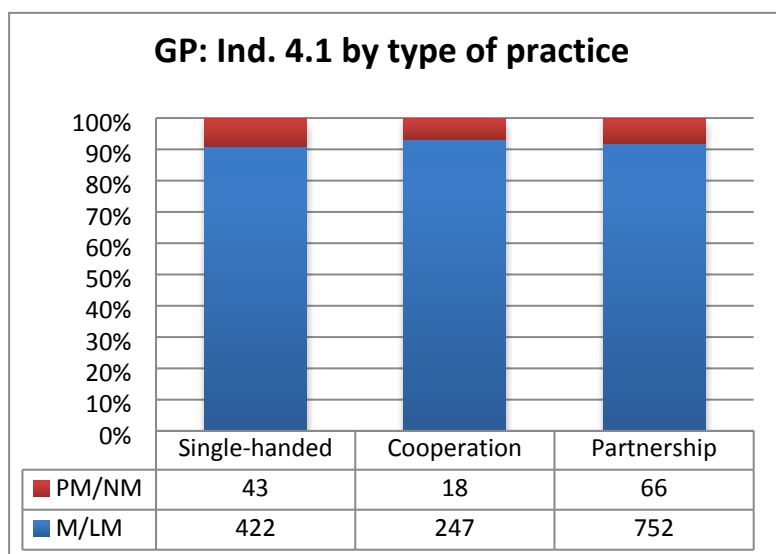
p: 0.00

Fig. 14



p: 0.00

Fig. 15



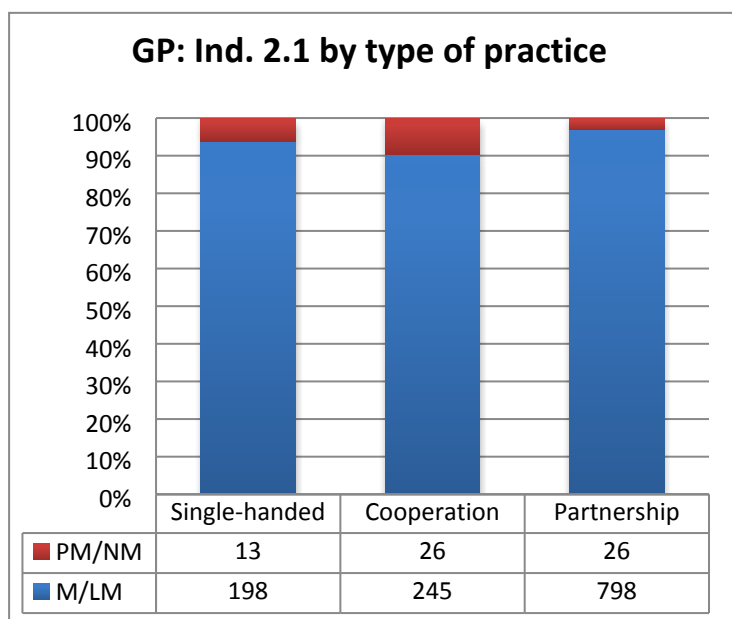
p: 0.5

There is a clear tendency that single-handed practices meet the goals to a lesser extent than the other two groups where several doctors work together. Data thus supports the hypothesis that clinics with several cooperating doctors have better opportunities for sparring, knowledge sharing and learning and therefore perform better than doctors in a single-handed practice.

We have shown above that gender is an explanatory factor regarding performance in a single-handed practice, where women perform significantly better than men.

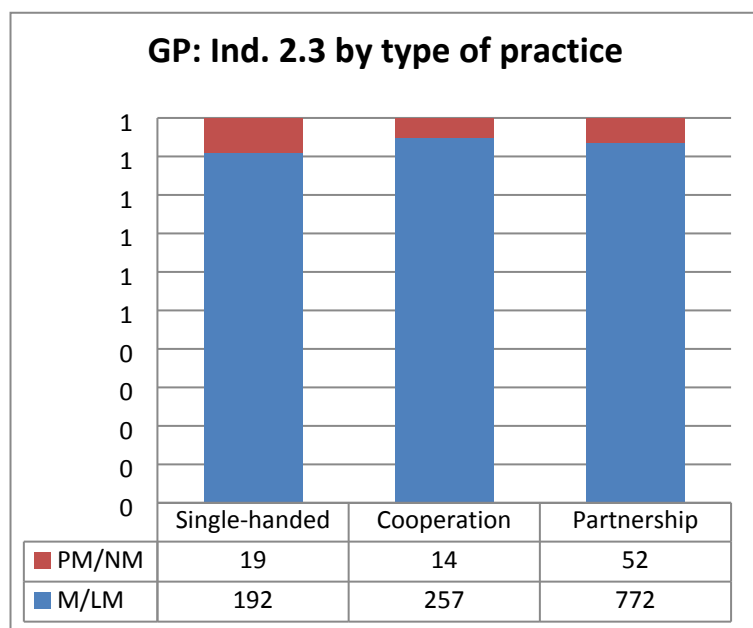
In order to evaluate the importance of the gender variable in terms of the performance of the different types of practice, we have tested for gender as an intermediate variable. The analysis is thus carried out with a data set for the single-handed practice group where male doctors have been removed.

Fig. 16



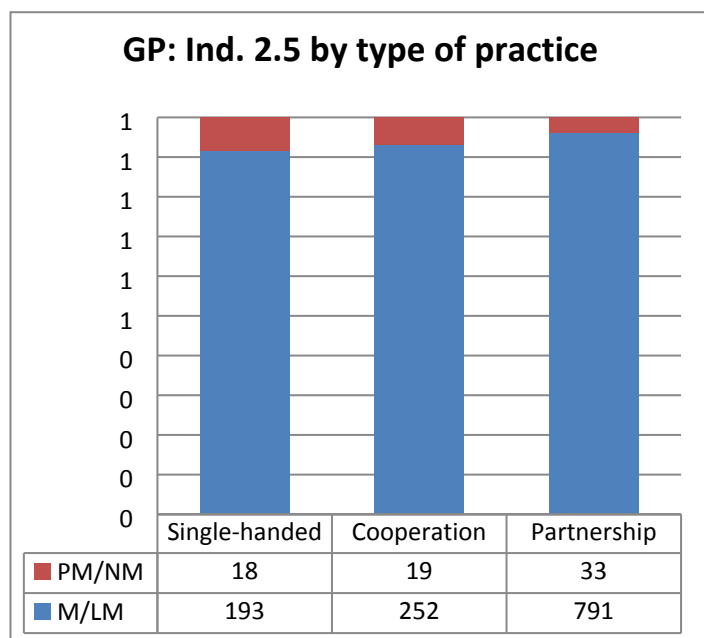
P. 0.00

Fig. 17



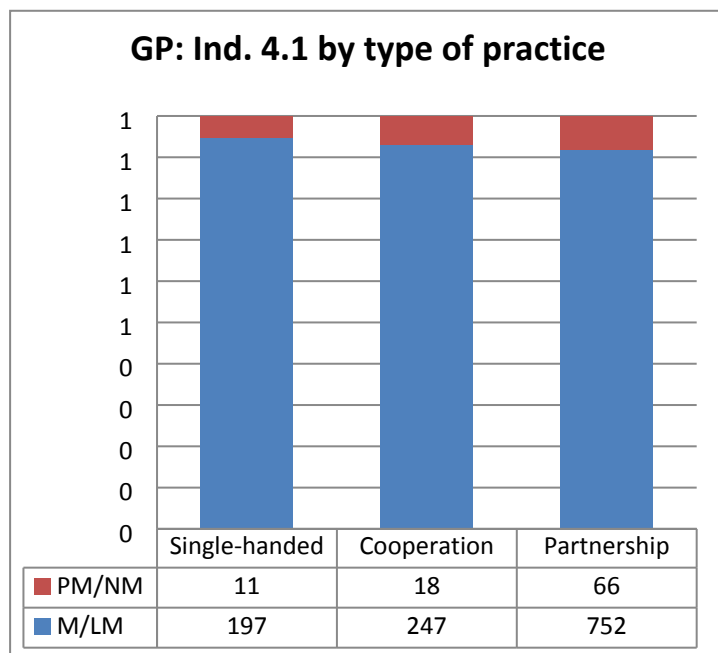
p: 0.22

Fig. 18



$p: 0.01$

Fig. 19



$p: 0.36$

This shows that gender is of importance, see in particular the results for the indicators 2.1 and 4.1. However, gender cannot explain all the differences.

Concerning geographic location:

The advice GP clinics get prior to accreditation is carried out by the quality offices in the respective regions, while advice to SPs is carried out by one organisation that is responsible for all tasks relating to general quality development for the country's SPs (eKVIS).

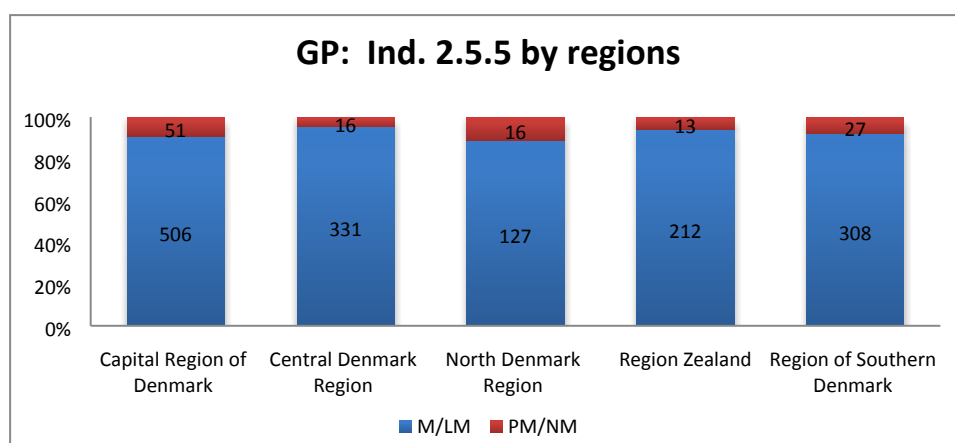
We therefore expected that differences would be observed in the different GP regions as the advice was likely to have a different effect since it is fundamentally organised and implemented in five different ways.

However, data does not support this assumption, and only indicator 2.5.5 regarding patient health record keeping showed a significant difference.

Thus, GPs in the Central Denmark Region have a significantly higher compliance rate for this indicator than is the case for the other regions.

For the other indicators, no significant difference can be seen.

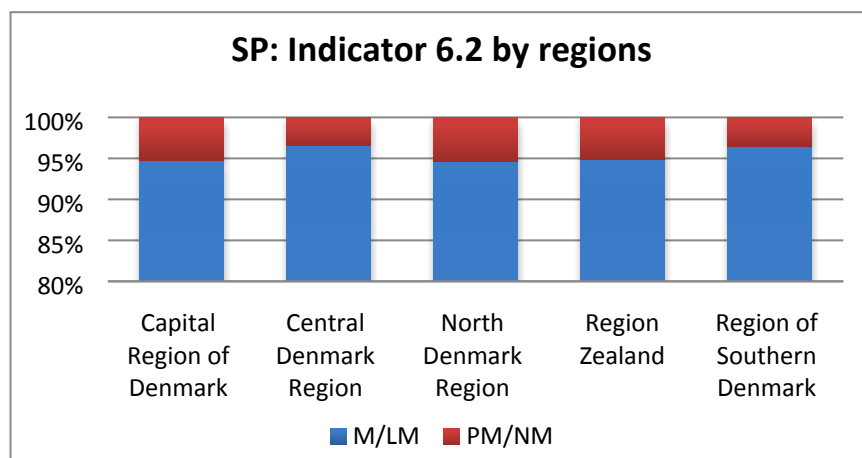
Fig. 20



$p: 0.04$ $n: 1607$

Looking at the corresponding indicators for the SPs, we see no significant difference in average scores for clinics in the different regions. We would not expect this as the advice is basically the same to all clinics.

Fig. 21

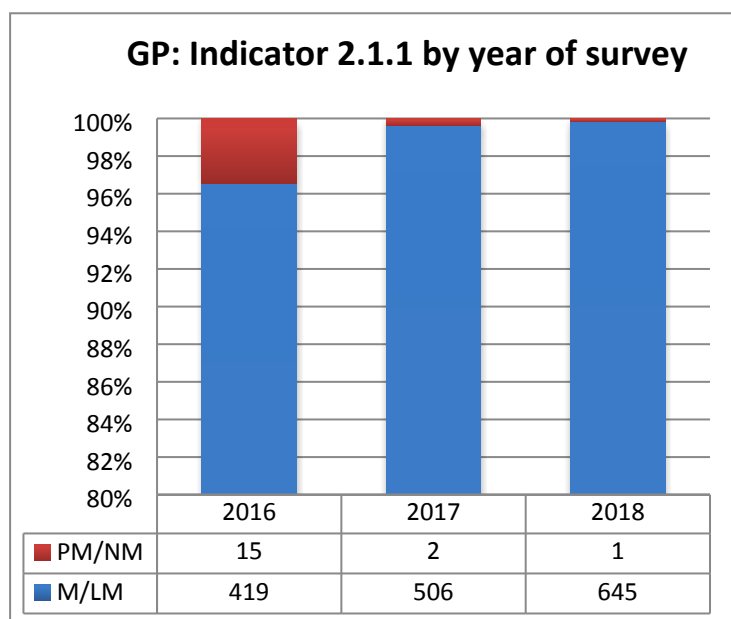


p: 0.86 n: 884

Concerning time of survey:

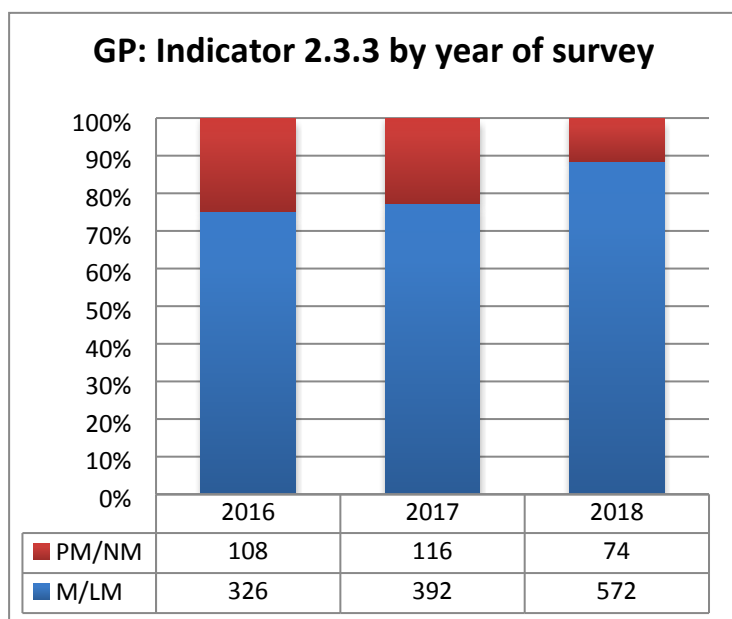
We expected that the fulfilment of goals would increase over time, considering that knowledge sharing through social media, professional forums etc. and more qualified experience-based advice would mean that the clinics that were accredited later in the process would do better.

Fig. 22



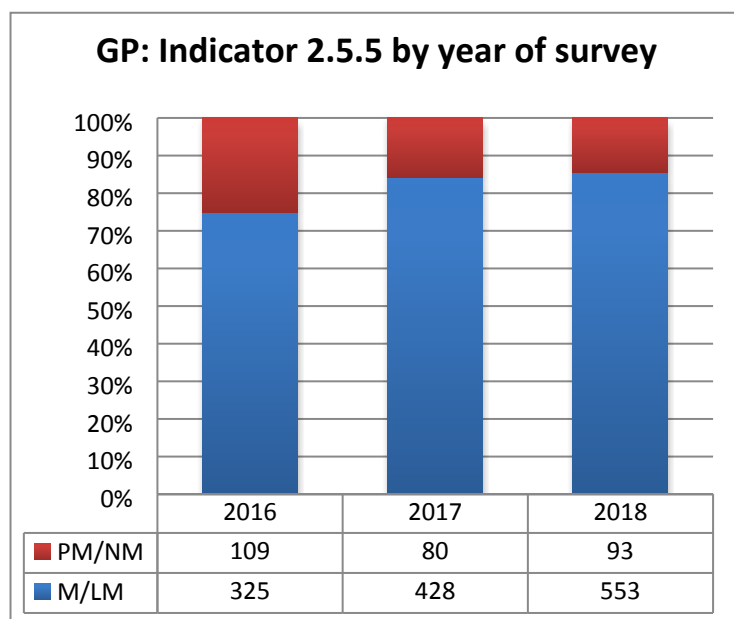
p: na

Fig. 23



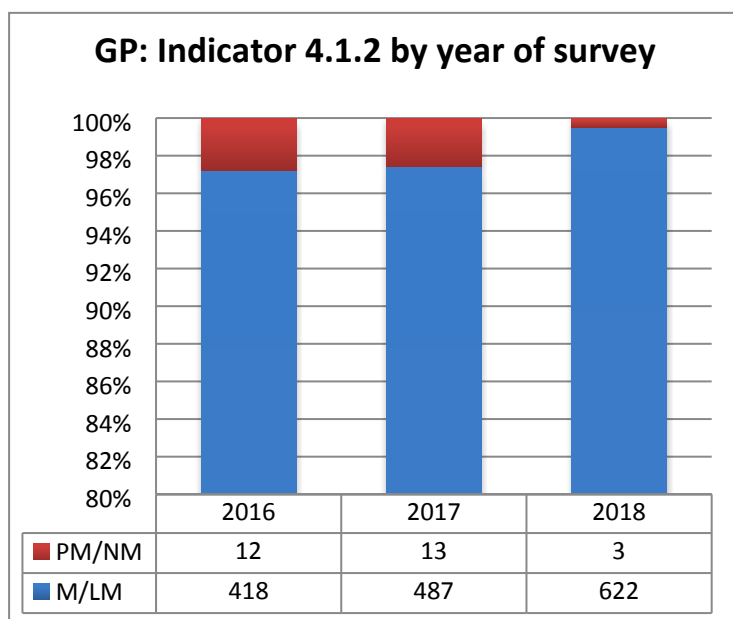
$p: 0.00$

Fig. 24



$p: 0.01$

Fig. 25



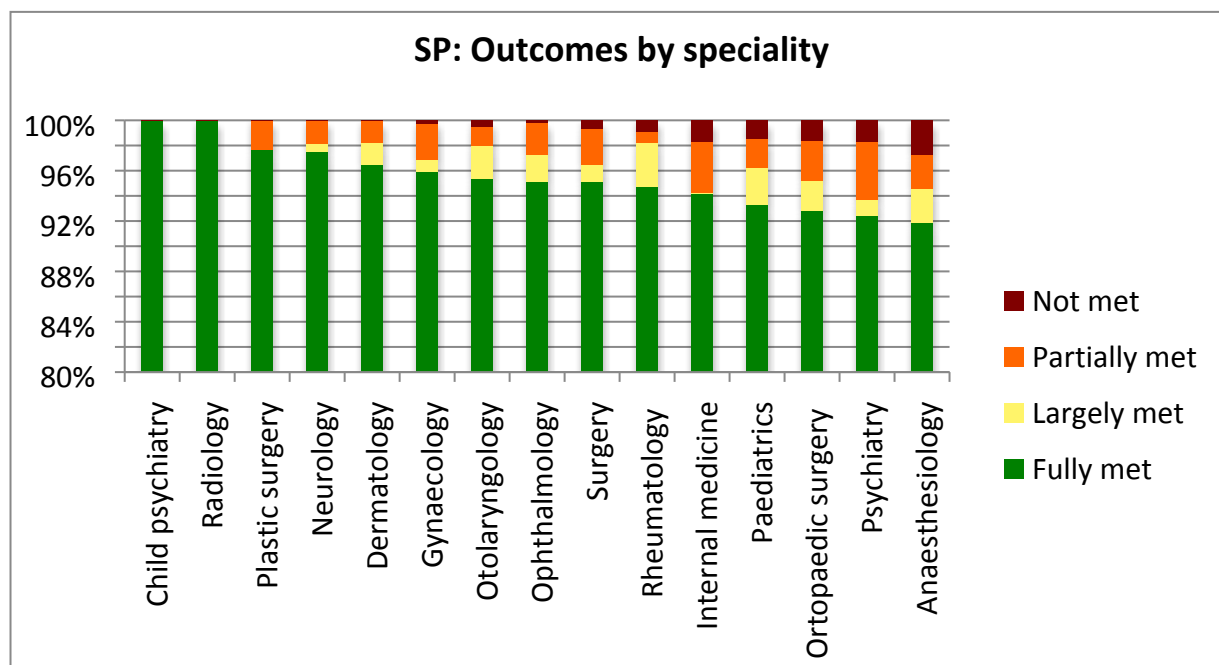
p: na

In the GP area, there is a significant tendency that the fulfilment of goals does increase over time. Thus, the data appears to confirm the hypothesis.

For SPs, no comparable analysis can be made as the clinics were accredited in order of specialities. For example, otologists were accredited first, followed by rheumatologists etc.

However, it is possible to see whether there are differences between the specialities and whether these differences can be attributed to a time factor.

Fig. 26



We anticipated that differences between the individual specialities would emerge when one investigated the degree of goal fulfilment in relation to the five indicators.

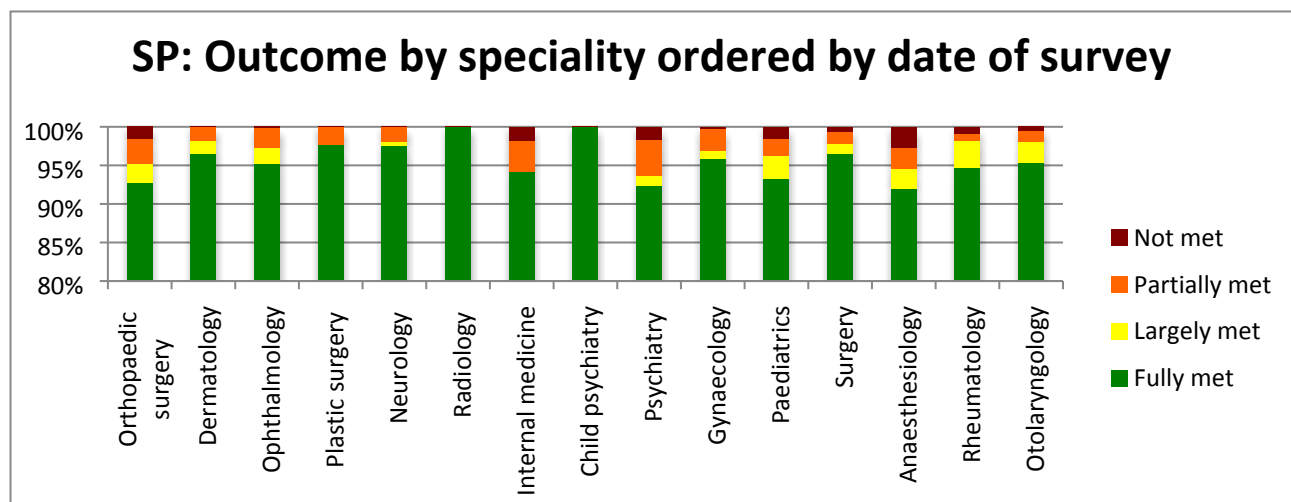
The figure above shows that there are differences, but it is difficult to see any pattern in these differences.

In order to investigate other possible explanations, we looked into the variables' geographical location, time of survey and differences related to a surgical/medical split-up.

We have previously shown (fig. 21) that there is no correlation between SPs performance and geographical location

If we include the time of survey factor, we get an idea of whether later surveys will increase the likelihood of a good result, since these specialties have had the opportunity to learn from the specialties that have had an earlier survey.

Fig. 27



There is no indication that the order of the surveys has had any impact on performance. Finally, we looked into whether a split-up in surgical and medical specialties can explain the observed variations. The following figures show the performance of the two groups - surgical and medical specialties - for the selected indicators.

Fig. 28

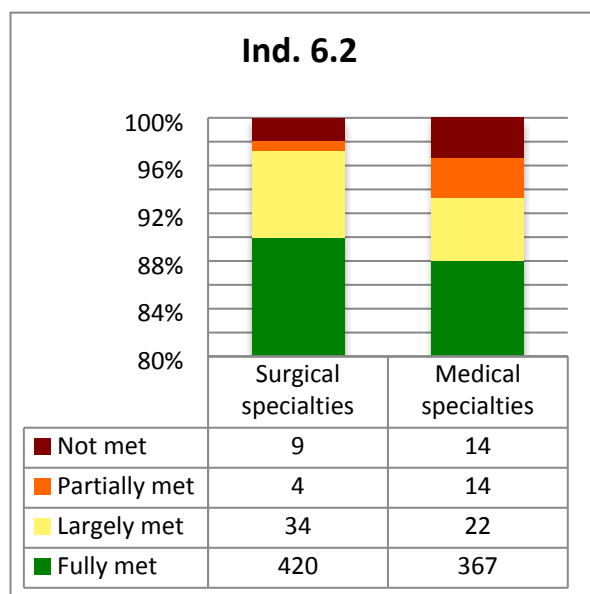


Fig. 29

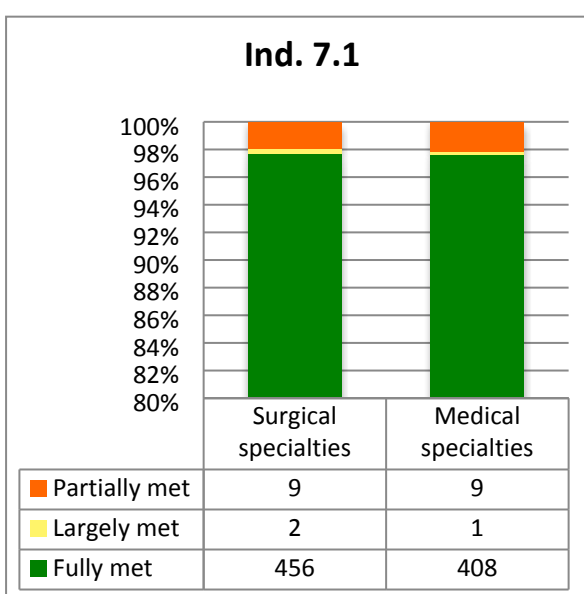


Fig. 30

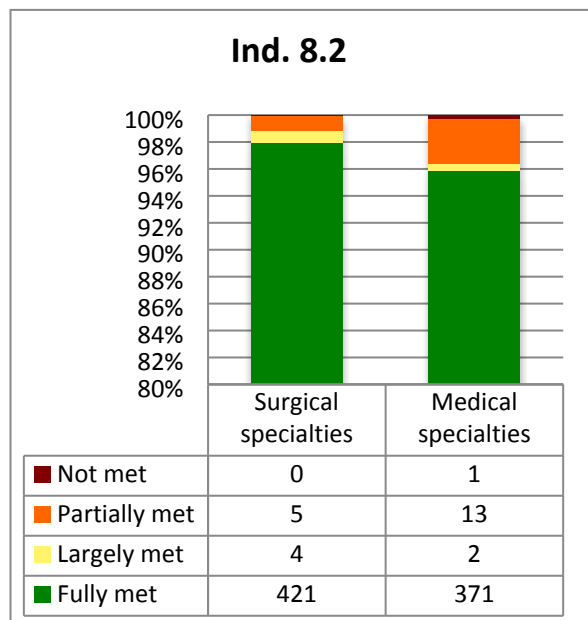


Fig. 31

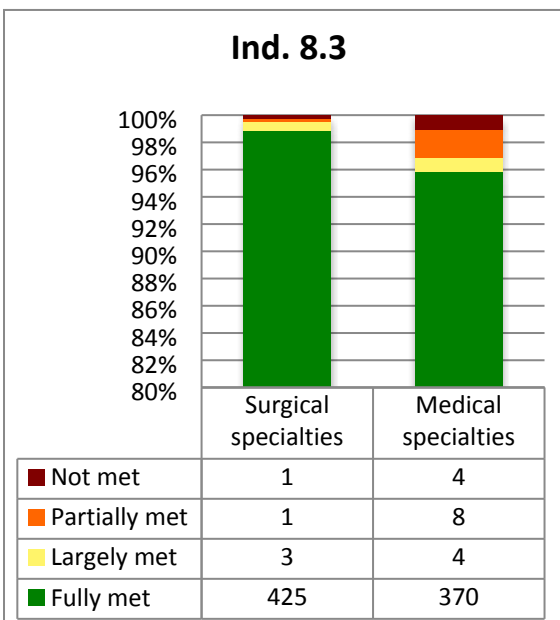
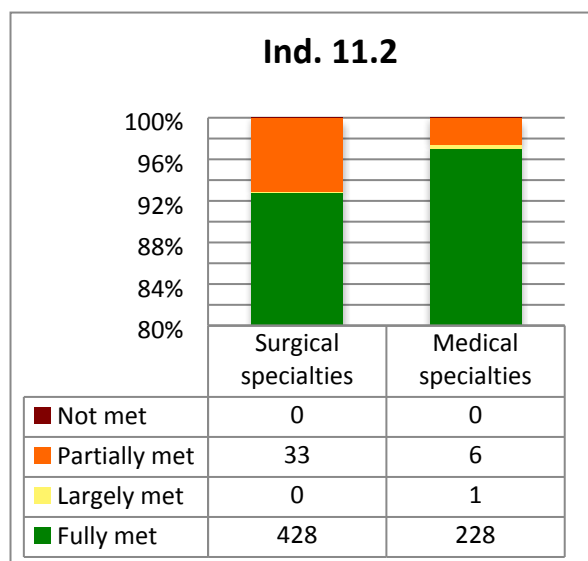


Fig. 32



The results are not clear, and the observed variations between the specialties cannot be explained by these variables.

6. Conclusions

Accreditation works!

This can be concluded based on the results of the first objective of the study, which was to assess and analyse the extent to which standards are not sufficiently met, and to assess the improvements achieved at the follow-up survey. We can conclude that when defining requirements in the form of standards and assessing the practices based on these standards, their compliance increases. The work performed by the clinics in the period until the survey is of substantial value, and if the SPs and GPs - despite their preparations - do not fulfil the requirements when the survey starts, they do when the accreditation process is finished. Therefore, we have shown that if requirements are to be met, for instance regarding quality or legal requirements, accreditation is an efficient way to implement them.

The second objective: to examine which indicators have most ratings on the two lower levels, shows that the areas regarding hygiene, paraclinical tests, the patient health record and prevention of confusion of patient's identity are the most difficult areas to fulfil for the GPs. Within the SPs the areas are a bit different and include the areas of hygiene, adverse events and recording patient health.

The third objective was to determine whether a number of variables could explain - fully or partly - the patterns shown by the data. Thus, we tested the validity of several hypotheses regarding the variables gender, age, type of practice, order of survey, geography and distribution of specialties.

Our data only allows us to test gender in single-handed practices in GPs. It is clear that gender is a significant factor: female doctors in single-handed practices perform significantly better than their male colleagues. Turning to SPs, it is not possible to identify a similar correlation.

Only a weak correlation between age and performance can be indicated, but it is evident that the group of doctors over 65 indicate a relatively large spread for both GPs and SPs. It is in this group that the worst results are found.

For GPs, we have examined whether the type of practice can explain differences in performance, anticipating that there would be a correlation between performance in a single-handed practice with the scepticism of accreditation that is demonstrated in this group.

There was a clear tendency for single-handed practices to perform worse than the cooperation and partnership practices where conditions for knowledge sharing, learning and sparring are better. As indicated, gender contributed to part of this correlation as the female doctors in single-handed practice performed better than their male counterparts. However, this could only partially explain the observed differences in the types of practices.

The geographical location of the clinics is only to a limited degree correlated with performance. For GPs, the standard for patient health record keeping indicated a significant correlation, and clinics in the Central Denmark Region performed better than clinics in other regions. The same tendency cannot be seen regarding the corresponding standard for SPs.

This could possibly support the assumption that the regional advice provided to the GPs is of some importance, in contrast to the SPs, where all the advice is supplied by one organisation.

We expected that the time of survey could have an impact on performance, since the practices that were surveyed last would have had the opportunity to learn from the others. Data supports this hypothesis for GPs, whereas no evidence can be found for this for SPs.

For SPs, it seems that the degree of difference between the individual specialties affects the performance more. We have not been able to identify variables that can explain this observation. Geographical location, time of survey or differences related to surgical/medical specialties cannot explain the observations. Therefore, it is more likely that the observed differences can be explained by cultural and professional differences between the specialties.

7. De praktiserende speciallægers anden akkrediteringsrunde.

I perioden april 2019 – december 2021 gennemførtes anden akkrediteringsrunde hos de praktiserende speciallæger. Akkrediteringen skete på baggrund af et standardsæt, der var lettere justeret i forhold til de standarder, der var anvendt ved første runde. Denne revision skete på grundlag af erfaringerne fra første runde, men der var lagt vægt på, at klinikkerne i høj grad skulle genkende kravene fra første standardsæt. Processen omkring survey og akkreditering var i øvrigt identisk med det, der var kendt fra første runde. Det var således samme surveyorkorps, der besøgte klinikkerne, ligesom tilbud vedr. rådgivning var uændret.

Det er oplagt at se på, hvorvidt der kan konstateres ændringer i forhold til de fund og mønstre, der kunne ses efter første akkrediteringsrunde. I dette afsnit findes således en kortfattet beskrivelse af

1. i hvilket omfang klinikkerne lever op til kravene i standardsættet, og i hvilket omfang klinikkerne er i stand til at rette op på de mangler, der konstateres i forbindelse med det første besøg
2. hvilke indikatorer, der udgør grundlaget for de foretagne analyser
3. hvorvidt der i anden runde kan konstateres andre sammenhænge, end dem der blev konstateret efter den første akkrediteringsrunde. Altså hvorvidt der kan konstateres at faktorer som alder, køn og geografisk placering har betydning for resultaterne, ligesom det undersøges om specialetilhørsforhold kan have betydning.

Ad 1:

Status på akkreditering af speciallægepraksis

I perioden 1. april 2019 til 27. april 2022 har Akkrediteringsnævnet behandlet 885 sager efter eksternt survey hos privatpraktiserende speciallæger.

| | | |
|---|--|---|
| Surveys forelagt til 1. behandling i Akkrediteringsnævnet (885) | | Surveys færdigbehandlet af Akkrediteringsnævnet (885) |
| Direkte Akkrediteret 73,4 % (650/885) | | Akkrediteret 98,9 % (875/885) |
| Til opfølgning 26,6 % (235/885) | Efter opfølgning | |
| | Surveys forelagt til 2. behandling i Akkrediteringsnævnet (235) Akkrediteret 95,7 % (225/235) | |

| | | |
|---|--|---|
| | Akkrediteret med bemærkninger 3,4 % (8/235) | Akkrediteret med bemærkninger 0,9 % (8/885) |
| | IKKE Akkrediteret 0,9 % (2/235) | IKKE Akkrediteret 0,2 % (2/885) |
| Direkte IKKE akkrediteret 0 % (0/885) | | |

(Tallene i parentes er antal vurderede surveyrapporter. Der udarbejdes en surveyrapport pr. ydernummer.)

I forhold til første runde ses en mindre stigning i andelen af klinikker, der blev henvist til opfølgning, nemlig 26,6 procent mod 22,3 procent i første runde. Efter opfølgningen i anden runde var 98,9 procent akkrediteret mens det tilsvarende tal for første runde var 98,5 procent.

Selvom der kan ses en lidt større andel i anden runde, der blev henvist til opfølgning, tyder noget på, at der har været tale om relativt få fund i de enkelte sager. Således var der i første runde i alt 756 fund, der blev vurderet som værende Ikke Opfyldt/I Nogen Grad opfyldt, mens det tilsvarende til for anden runde var 573.

Vi har set på, hvorledes de klinikker, der har gennemgået begge akkrediteringsrunder, har klaret sig. Konkret har vi set på de 235 klinikker, der har fået forskellig akkrediteringsstatus i de to runder. 133 af disse klinikker har klaret sig dårligere i anden runde sammenlignet med første runde, mens 102 klinikker har klaret sig bedre i anden runde. Man kunne måske have forventet, at klinikkerne generelt ville have klaret sig bedre i anden runde, men dette bekræfter tallene tilsyneladende ikke. Der er tilsyneladende ikke tale om, at fundene grupperer sig på særlige indikatorer – faktisk er der en stor spredning af fundene på hele standardsættet.

Ad 2:

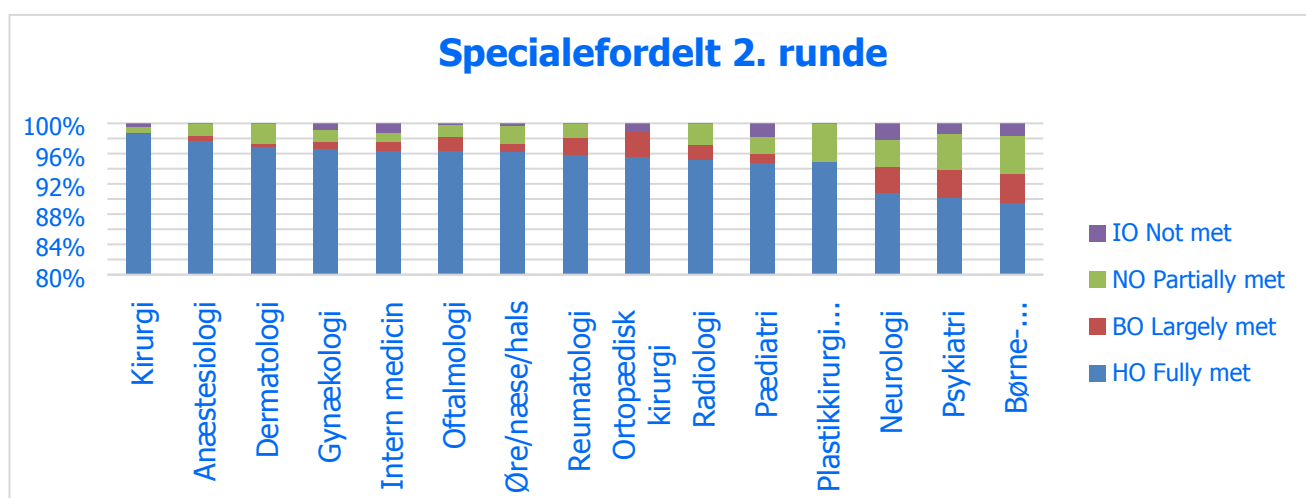
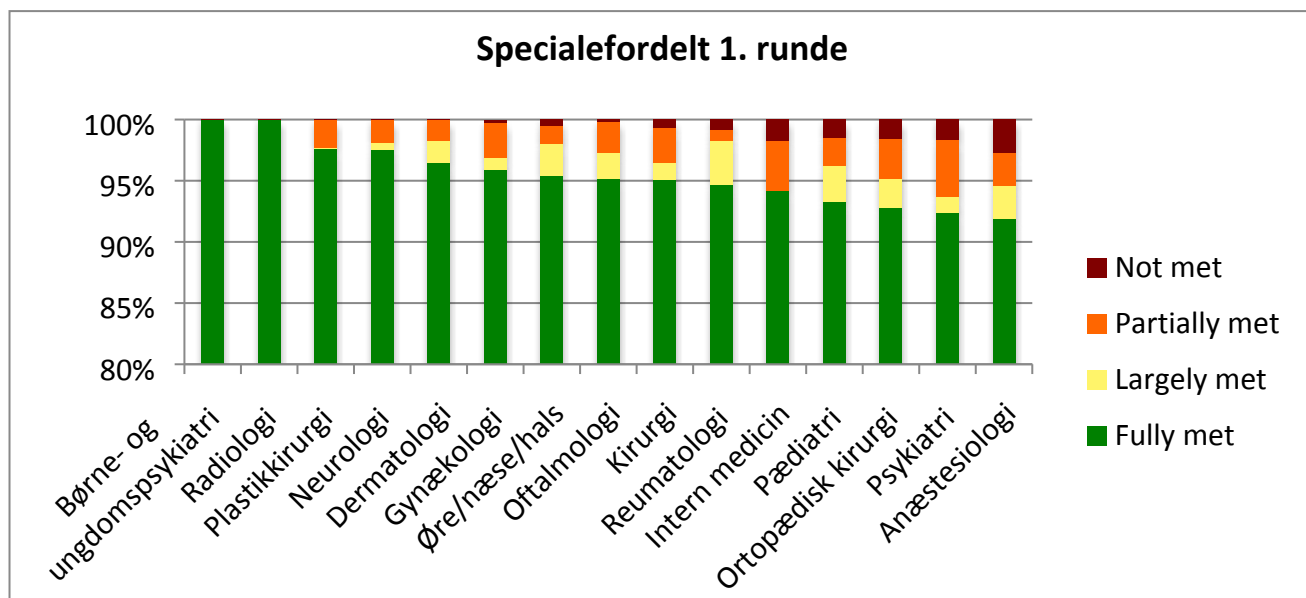
Af hensyn til at kunne sammenligne i forhold til første akkrediteringsrunde, har vi valgt at se på klinikernes performance i forhold til de standarder, der blev analyseret i forbindelse med første runde. Standarderne har andre numre, men kravene, der er udmøntet i indikatorer vedr. følgende områder, er uændrede:

1. kvaliteten af journalføring
2. patientidentifikation
3. opfølgning på parakliniske undersøgelser
4. rengøring og opbevaring af medicinsk udstyr til flergangsbrug

Ad 3.

Som det kunne forventes, viser analysen af data fra anden runde ikke nye sammenhænge, når det gælder køn, alder og geografi. Der kan ikke påvises nogen klar sammenhæng mellem nogen af disse faktorer og de konstaterede mangler, således som det heller ikke var tilfældet efter første runde.

Ser vi på, hvorvidt de forskellige specialer performer forskelligt, gentages mønstret fra første runde, hvor der blev fundet relativt store forskelle specialerne imellem – blot med den forskel, at specialernes rækkefølge er noget anderledes, således som det kan ses af figurerne:



Som nævnt ovenfor, har det ikke været muligt for os at finde baggrundsvariable, der kan forklare denne variation, og det forekommer derfor nærliggende, at forskellene skyldes forskelligheder i specialernes faglige kultur. Der er naturligvis tale om relativt små forskelle, men det er ikke desto mindre bemærkelsesværdigt, hvorledes anæstesi og børne- og ungepsykiatri skifter position fra første til anden runde.