ISQuaEEA

International Society for Quality in Health Care
External Evaluation Association

Guidelines and Standards for External Evaluation Organisations

5th Edition Version 1.1, March 2022

Contents

Foreword and Acknowledgements

In 2018, the International Society for Quality in Health Care External Evaluation Association (ISQua EEA) was established, as a separate legal entity, by the International Society for Quality in Health Care to deliver external evaluation services. ISQua EEA commenced operations on 1st January 2019. This version of the 5th edition of the Standards (v1.1) has been updated to reflect that the International Accreditation Programme (IAP) is now delivered by ISQua EEA.

This, the 5th Edition of the Guidelines and Standards for External Evaluation Organisations (the Standards) is the result of an extensive review which commenced in March 2017. A literature review was undertaken at the outset by the IAP team to identify any new themes or changes in each of the Standard areas which should be considered in the revision of the Standards. Client and surveyor evaluations of the Standards were also collated and analysed and these together with the literature review were used to guide the revision of the Standards.

The Accreditation Council, on behalf of the ISQua EEA Board, is responsible for advising on all standards developed by ISQua EEA. ISQua EEA would like to thank the following Accreditation Council members who worked closely with the IAP team to revise the Standards: Lena Low, Australia; Moyra Amess, United Kingdom; and Salma Jaouni, Jordan. With the guidance of the working group a draft set of Standards was developed. We would also like to thank the following ISQua EEA surveyors who participated in a focus group on the draft standards in April 2018: Ann Wunsch, Australia; Jan Mackereth-Hill, United Kingdom; and Paul van Ostenberg, United States of America. The draft standards were circulated to stakeholders including client organisations and surveyors for consultation in May 2018.

Using the RUMBA principles these standards were then pilot tested by HDAA, Australia, and by one of our peer review surveyors Danielle Dorschner, Canada, in June - July 2018. RUMBA principles ensure the criteria are relevant, understandable, measurable, beneficial and achievable.

A change log outlining the differences between this, the 5th Edition and the 4th Edition can be found at the end of this document. A total of four new criteria have been introduced. These address the organisation's approach to corporate social responsibility, the management of ethical concerns, knowledge dissemination and the assessment of surveyor intra and inter-rater reliability. The 4-point rating scale has also been revised based on feedback received through the IAP evaluation process to ensure that there is clearer differentiation between each numerical rating. The same rating scale will be used for all services within the International Accreditation Programme.

I would also like to acknowledge the work of the IAP team Nicola McCauley-Conlan, Gillian Conway and Caitrona Curran. A special word of thanks to Nicola McCauley-Conlan who project managed the Standards revision process to produce Standards which will support external evaluation organisations to continuously improve what they do.

I would also like to thank our client organisations and surveyors who complete the post-survey evaluations and who contributed to the consultation process for the draft Standards. Your feedback and ongoing support has helped us to revise the Standards ensuring that they remain fit-for-purpose and a resource for external evaluation organisations around the world.

This is Version 1.1 of the 5th Edition and will be available from March 2022. Minor changes have been made to the Guidelines but no changes have been made to the Standards.

Elaine O' Connor
Head of Operations
March 2022

Glossary

Accountability	Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and should be transparent to all stakeholders.
Accreditation	A self-assessment and external peer review process used by health and social care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health or social care system.
Audit	A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.
Best Practice	An approach that has been shown to produce superior results, selected by systematic process and judged as exemplary, or demonstrated as successful. It is then adapted to fit a particular organisation.
Certification	Formal recognition of compliance with set standards validated by external evaluation.
Chief executive	The person appointed to act on behalf of a governing body of an organisation in the overall management of the organisation. A range of other titles may be used including general manager, executive director or manager.
Client	Individuals or organisations being served by the organisation.
Code of Conduct	Documented set of agreed principles that informs all parties of responsibilities and expectations under the code.
Community	Individuals, families, groups and organisations that usually reside in the same locality.
Competency	The knowledge, skills, abilities, behaviours, experience and expertise to be able to perform a particular task and activity.
Complaint	Expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing.
Confidentiality	The right of individuals to keep information about themselves from being disclosed.
Contract	Formal agreement that stipulates the terms and conditions for services that are obtained from, or provided to, another organisation.
Culture	The shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.
Data	Numbers, symbols, words, images, graphics that have yet to be organised or analysed.
Document Control System	A planned system for controlling the release, change and use of important documents within the organisation, particularly policies and procedures.
Education	Systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills.
Effectiveness	The degree to which resources are brought together to achieve desired results most cost effectively, with minimal waste, re-work and effort.

Equity	The absence of avoidable, unfair or remediable differences in health among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means. Health equity is achieved when everyone can attain their full potential for health and well-being.
Ethics/Ethical	Acknowledged set of principles which guide professional and moral conduct.
Evaluation	A formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.
External Evaluation Organisation	A recognised body that evaluates through independent peer assessment the performance of organisations in relation to quality standards for organisational functions.
Goals	Broad statements that describe the outcomes an organisation is seeking and provide direction for day-to-day decisions and activities. The goals support the mission of the organisation.
Governance	The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.
Governing Body	Individuals or group with ultimate authority and accountability for the overall strategic directions and modes of operation of the organisation.
Human resources	The personnel requirements of the organisation.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on clients, groups, staff or the organisation.
Indicator	Performance measurement tool that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process and outcomes and are rate based, i.e. have a numerator and denominator so that they can be compared and benchmarked.
Information	Data that is organised, interpreted and used. Information may be paper-based or electronic.
Information Management	The collection, management and distribution of information.
Mission	A broad written statement that articulates the organisation's purpose and scope.
Objective	A target that must be reached if the organisation is to achieve its goal.
Operating/Operational plan	A plan which clearly defines the actions that the organisation will take within a defined timeframe to deliver its stated objectives and enable the organisation to meet its longer-term strategic objectives. The operational plan provides detailed information about how the organisation will achieve its stated objectives and identifies what activities must be undertaken; who has responsibility for undertaking each of the stated activities; the timeframes in which the activities must be completed; and the resources (financial, human and other) required to achieve the identified activities.
Orientation	The process by which staff are introduced to a new role and work environment.
Performance evaluation	The continuous process by which a manager and a staff member review the staff member's performance, set performance goals, and evaluate progress towards these goals.

Policy	A written operational statement that formalises the approach to tasks that is consistent with the organisational objectives.
Procedure	A written set of instructions conveying the approved and recommended steps for a particular act or series of acts.
Process	A series of actions or steps taken in order to achieve a particular end.
Quality	The degree of excellence, or extent to which an organisation meets identified needs or objectives and exceeds expectations.
Quality improvement plan	A plan that outlines quality improvement initiatives including the proposed actions, timelines and responsible individual(s).
Research	Contribution to an existing body of knowledge through investigation, aimed at the discovery and interpretation of facts.
Risk	The probability of danger, loss or injury.
Risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organisation.
Risk management framework	A set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organisation.
Safety	The degree to which the potential risk and unintended results are avoided or minimised.
Scope	The range and type of services offered and any conditions or limits to service coverage.
Service user	A person who uses health or social care services.
Staff	Employees of the organisation including temporary and permanent staff.
Stakeholder	A person, group or organisation that has interest or concern in an organisation. Stakeholders can affect or be affected by the organisation's actions, objectives and policies. Internal stakeholders are individuals who are already committed to serving the organisation such as board members, staff and volunteers, including surveyors. External stakeholders are individuals who are impacted by the work of the organisation such as clients and community partners.
Strategic plan	A formalised plan that establishes the organisation's overall goals.
Survey	External peer review, which measures the performance of the organisation against an agreed set of standards.
Surveyor	An external peer reviewer of organisational performance against agreed standards.
Values	Principles, beliefs or statements of philosophy that guide behaviour, which may include social or ethical issues.
Vision	A declaration of an organisation's objectives, intended to guide its internal decision-making.

Part A – The Guide

Section 1
About ISQua EEA

1.0 Introduction

Part A of this document is a guide for organisations and surveyors using the ISQua EEA Standards for External Evaluation Organisations, 5th Edition. It describes the survey process; the different roles and responsibilities; how to complete the self-assessment tool; the rating scale; and how to achieve and maintain ISQua EEA accreditation.

1.1 The International Accreditation Programme (IAP)

The International Society for Quality in Health Care External Evaluation Association (ISQua EEA) provides third-party external evaluation services to health and social care external evaluation organisations and standards developing bodies around the world. ISQua EEA's primary programme is the International Accreditation Programme (IAP). The IAP delivers a unique global accreditation service to external evaluation organisations and standards developing bodies.

Since 1999, the IAP has provided these organisations with an independent third-party assessment process to validate existing systems and drive continuous quality improvement.

Operating in over 60 countries, the IAP offers three separate peer review assessment options:

- **Accreditation of Health and Social Care Standards;**
- **Accreditation of External Evaluation Organisations; and**
- **Accreditation of Surveyor Training Programmes.**

The survey process includes:

- self-assessment;
- peer review evaluation;
- written report with recommendations;
- award; and
- continuous assessment.

The IAP is a voluntary process and is entered by application via the ISQua EEA website (www.ieea.ch).

Evaluation services are provided on a voluntary basis by international surveyors.

1.1.1 Code of Conduct

ISQua EEA personnel, including surveyors will:

- act ethically;
- be responsive to the needs and interests of clients;
- avoid conflicts of interest;
- act professionally;
- respect confidentiality;
- be competent to undertake the work they are assigned; and
- ensure complaints about any of ISQua EEA's personnel or services are investigated promptly and fairly and resolved wherever possible.

1.1.2 Principles underlying the ISQua EEA Standards for External Evaluation Organisations

The ISQua EEA Standards for External Evaluation Organisations have been developed for the assessment and accreditation of external evaluation organisations (including accreditation, certification and inspection), which focus on the following areas:

- Leadership through effective planning, governance and management.
- Organisational performance through the management of processes and outcomes and the transparency of decision-making.
- Continuous quality improvement based on innovation, evidence, best practice and evaluation to better meet the needs of clients.
- Valuing people by appropriately selecting, training and appraising personnel and maintaining good relationships.
- Safety by providing safe work environments and complying with statutory requirements.
- Quality service for both potential and existing clients.

1.2 Roles and responsibilities

1.2.1 Governance of the IAP

ISQua EEA is governed by a Board of Directors elected by and from its members. The External Evaluation Award Committee (EEAC) governs the IAP on behalf of the Board. The Board has delegated responsibility to the EEAC to approve accreditation awards. The EEAC makes the final award decisions.

1.2.2 Validation Reviewer

The Accreditation Council delegates its accreditation recommendation to a Validation Reviewer who will be either an experienced surveyor or a Council member with no conflict of interest. The Validation Reviewer is responsible for:

- reviewing the report to ensure it is clear and the comments will provide the organisation with the direction needed to continually improve in meeting the Standards;
- ensuring that the comments reflect that the appropriate rating has been applied;
- ensuring the report findings support any recommendations and/or opportunities for improvement;
- ensuring that the report supports the survey team's accreditation decision recommendation; and
- completing the Validation Review Form and submitting it to ISQua EEA.

The Validation Reviewer's recommendation goes to the External Evaluation Award Committee (EEAC), which makes the final decision regarding accreditation.

1.2.3 ISQua EEA accreditation staff

ISQua EEA staff work with each participating organisation and:

- train and allocate surveyors and Validation Reviewers;
- schedule the surveys and manage the critical path;
- complete technical reviews;
- perform quality assurance reviews of survey reports.

1.2.4 Participating organisations

All participating organisations should agree to abide by the terms and conditions of the IAP and adhere to the timescales as set in the critical path (see 2.1). As part of the application process they should nominate a contact for all correspondence with ISQua EEA. ISQua EEA should be updated with any changes to these details.

1.3 Surveyors

ISQua EEA has a consortium of experienced international professionals who work with health and social care external evaluation organisations in over 18 countries around the world. The ISQua EEA surveyors are recruited and trained to validate an organisation's self-assessment and assess their level of achievement against the ISQua EEA Principles and Standards.

1.3.1 Survey team composition

The survey team consists of three peer review surveyors, chosen by ISQua EEA, one of whom is appointed as the team leader. The role of the survey team is to validate the organisation's self-assessment and provide detailed feedback on whether compliance to each criterion is achieved.

The organisation is provided with the surveyors' biographies and has the opportunity to object to any surveyors who they consider to have a conflict of interest. The Accreditation Manager should be informed of reasons for the objection within 5 working days of the organisation receiving the biographies. ISQua EEA will review the reasons for the objection and make the final decision to remove or retain the surveyor on the team.

1.3.2 Survey team responsibilities

All team members are responsible for preparing for survey including:

- ensuring endorsement from their organisation for participating in the survey;
- reading pre-survey materials;
- leading on the Standards allocated;
- completing their section(s) of the report; and
- answering any queries that ISQua EEA may have.

1.3.3 Team leader responsibilities

The team leader is responsible for coordinating the survey; collating the findings; ensuring that there is a consensus of agreement on the ratings; and writing the executive summary. The team leader submits the report, rating matrix and award recommendation to ISQua EEA.

Section 2
Overview of the Process

2.1 Entry into the Programme

To be eligible for assessment against these standards, an organisation must be an external evaluation organisation within the health or social care sector. Before an organisation can apply for accreditation of their organisation, ISQua EEA should first have accredited at least one set of their standards (see ISQua EEA Guidelines and Principles for the Development of Health and Social Care Standards). In certain circumstances, external evaluation organisations such as government bodies or designated auditing agencies that use standards developed by another body can apply for ISQua EEA accreditation of their organisation.

If an organisation has previously had their surveyor training programme accredited by ISQua EEA they may be eligible for the combined onsite organisational and surveyor training programme survey.

All organisations must complete an application form prior to entry into the programme. Once this has been received and payment made to ISQua EEA for access to the survey resources, ISQua EEA will assign a critical path which includes dates for the following;

- submission of the completed self-assessment and supporting evidence for technical review;
- submission of the final self-assessment and supporting evidence for survey;
- onsite organisational survey;
- review of the survey report by the organisation for factual errors;
- informal notification of assessment by Validation Reviewer;
- award decision ratification at the next External Evaluation Award Committee meeting.

For organisations undergoing re-accreditation, the next survey will be scheduled at least two months prior to the current expiry date to prevent any lapses in accreditation.

Section 3
Working with the Standards

3.0 Introduction

The ISQua EEA international accreditation process is a mechanism for external evaluation organisations to assure themselves that their organisation meets international best practice requirements and to demonstrate this to their clients, funders and other stakeholders. Organisations can guide development of their systems and processes through the implementation of the ISQua EEA Standards for External Evaluation Organisations.

3.1 Framework of the Standards

The ISQua EEA Standards for External Evaluation Organisations address governance, operational and risk management, support services, surveyor management and service delivery as follows:

Governance	The external evaluation organisation is responsibly governed to meet its defined purpose and objectives.
Strategic, Operational and Financial Management	The external evaluation organisation is effectively managed to meet its strategic, operational and financial objectives.
Risk Management and Quality Improvement	Risks and improvement opportunities are identified and managed to deliver safe quality services.
Human Resource Management	Staff planning and management support the external evaluation organisation's objectives, and staff are supported to deliver quality services.
Information Management	Information is managed to support the external evaluation organisation to meet its business objectives.
Surveyor Management	Surveyor planning and management support the delivery of a high-quality survey service to participating organisations.
Survey and Client Management	The external evaluation programmes are consistent with the organisational objectives and meet the needs of participating organisations and other stakeholders.
Accreditation or Certification Awards	The processes for awarding and maintaining accreditation or certification are objective and consistently implemented.

A comparative table of the extent to which criteria in the 4th edition Standards have been incorporated into the 5th edition is included in this document (page 70).

3.2 Structure of a Standard

1 **The external evaluation organisation is responsibly governed to meet its defined purpose and objectives.**

2 **Criterion 1.1**

The external evaluation organisation has a clear vision and mission which are:
a) developed by the governing body with staff input
b) communicated to stakeholders
c) regularly reviewed

3 **Guidance**

This could include:

i. communication with stakeholders such as policy, professional, funding and service user groups and participating organisations

ii. reviews taking place at defined intervals, or when there is a significant change in the external evaluation organisation's mandate

See also criterion 1.14.

4 **Suggested Evidence**

- Written mission and vision or evidence to support existence (may be in plans, brochures)
- Evidence of how these are made available to stakeholders
- Evidence of how reviews are planned and take place

1 **Overall standard statement** – this describes the high-level outcome for the Standard.

2 **Criterion** – this is mandatory, and organisations are required to self-assess against the criterion. If there are multiple elements within each criterion (e.g. a) to c)), these have equal weighting. Therefore, organisations are required to consider each of these when formulating their written response and the overall rating for the criterion and to outline how they are meeting each of the elements.

Surveyors will assess and report on whether each element has been met.

3 **Guidance** – this explains and expands on the concepts contained within the criterion. It provides guidance for organisations on factors to be considered when formulating their written response and overall rating for the criterion. The guidance is provided for explanatory purposes only and is not mandatory. They may demonstrate their compliance with the criterion in ways other than those outlined.

4 **Suggested evidence** – these are illustrative examples of the type of evidence which organisations can provide to demonstrate their compliance with the criterion. Organisations may demonstrate their compliance with the criterion in various ways and may provide alternative or additional evidence other than that listed.

3.3 Completing the self-assessment tool

The first task for the organisation is to complete an initial self-assessment of their organisation using the self-assessment tool (SAT). It is recommended that a small team is tasked with working through the self-assessment process. They will be responsible for collating all the evidence, checking details and identifying any areas for particular attention. If the team has any problems with interpreting the Standards or deciding what, or how much evidence should be provided, ISQua EEA accreditation staff are available to provide advice. They can also assist with any questions that organisations may have about the survey process. At the end of this exercise, a gap analysis should be completed with identified actions where further work is required.

When completing the self-assessment tool, organisations are required to self-assess each criterion, including both a numerical rating and written response. If there are multiple elements within a criterion, care should be taken to ensure that these are all assessed. Many of the criteria have additional guidance to assist organisations when completing the self-assessment. This guidance is not mandatory. There is also suggested evidence included for each criterion. Please note that this is suggested evidence only and organisations may decide to present other evidence that demonstrates their compliance. Evidence should be provided for each criterion and must be in English. If any actions are required to achieve better compliance, these should be clearly documented.

The overall rating for each Standard is calculated by adding the ratings and then dividing by the number of criteria. This overall rating should be rounded up or down. For example, Standard 8 has 10 criteria; if they are rated as a 4, 3, 4, 4, 4, 3, 3, 4, 2 and 2, the total combined score is 33, this is divided by 10 (number of criteria) = 3.3, which is rounded down to 3 to give the overall score. An overarching statement regarding the level of compliance should be added for each Standard when each overall rating score has been calculated.

The SAT, including the text, is copyrighted and the property of ISQua EEA. It is designed for self-assessment and external surveyor reporting. The SAT must be completed in English, in Arial 10 font, should be focused and not excessive. Automatic numbering, bullet point systems or any type of additional formatting of the document should be avoided. This also applies to information that has been copied and imported from any other documents. Extra formatted headings, borders, graphics and colour elements should be avoided.

3.4 Rating scale

When applying a rating, use the following rationale and guidance to determine the level of compliance. If necessary, add details of the improvements that are required to achieve a higher rating.

Rating	Rationale	Guidance
4	Full achievement All elements addressed and no gaps in compliance (100%) No recommendation (but can have an opportunity for improvement)	If the organisation has exceeded the requirements this should be noted in the surveyor finding.
3	Good achievement Majority of the criterion elements addressed (more than 60%) Recommendation or opportunity for improvement required	The rationale for the recommendation or opportunity for improvement should be included in the surveyor finding.
2	Fair achievement Some of the criterion elements addressed (between 30 - 60%) Recommendation required Risk assessment required	The rationale for the recommendation and the risk assessment should be included in the surveyor finding.
1	Poor achievement Few or none of the criterion elements addressed (under 30%) Recommendation required Risk assessment required	The rationale for the recommendation and the risk assessment should be included in the surveyor finding.

If there are multiple elements within each criterion, please consider these to have equal weighting. For some criteria with only one measurable element, it may only be possible to have full or poor achievement (i.e. there is no option for partial achievement).

Recommendations must be provided when one or more elements of the criterion have not been met i.e. where there is a gap in compliance. Recommendations are mandatory and must be addressed by the organisation. They are required to submit progress reports 12 and 30 months post award demonstrating how the recommendations have or will be addressed. Recommendations should only relate to elements of the criterion which have not been met (i.e. gaps in compliance).

Opportunities for Improvement (OFIs) identifying areas that organisations could consider improving or strengthening can also be provided. They can be provided with any rating and are not considered mandatory.

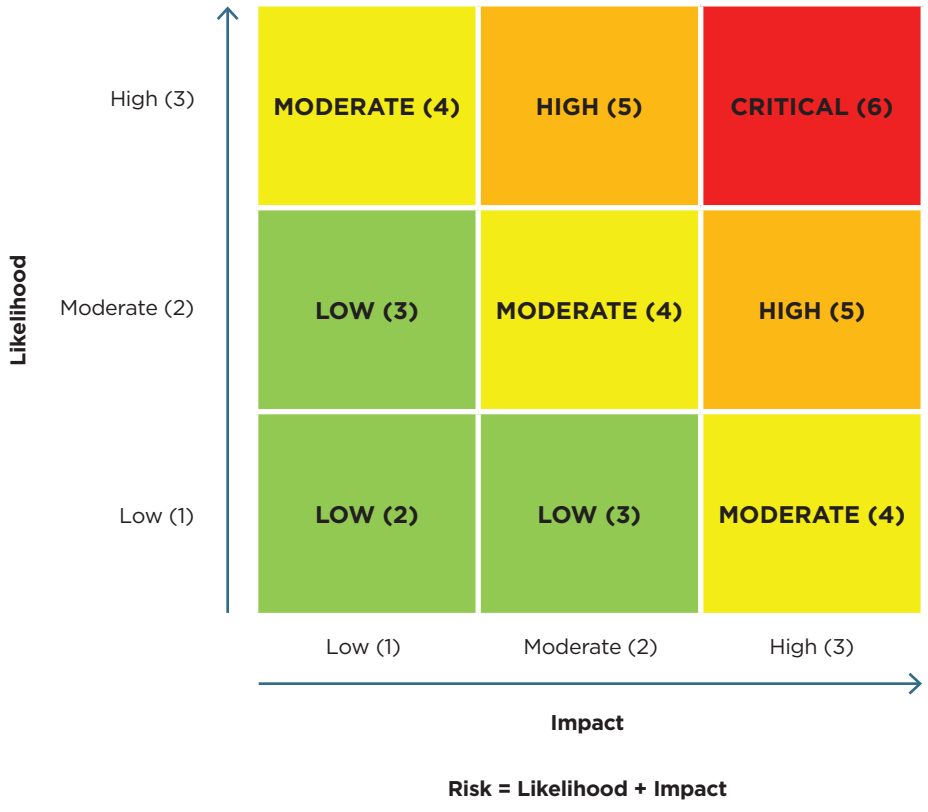
3.5 Risk assessment

When a rating of 1 or 2 is given to any criterion during self-assessment, or by the survey team, a risk assessment must be carried out.

With a rating of 1 or 2, there is a potential risk for the organisation as some or many of the specific criterion elements are not in place. A risk assessment involves describing what the risk is in relation to the missing elements of the criterion and then quantifying this risk by assigning a numerical score using the following risk matrix.

The risk matrix allows one to determine how likely it is that the identified risk will actually happen or materialise (the likelihood) and the impact on the organisation if the risk does materialise or happen (the impact).

The numerical risk assessment score (the overall score) is calculated by adding the score for the likelihood of the risk occurring with the score for the impact of the risk if it did occur. Or more simply, Risk = Likelihood + Impact.



Risk = Likelihood + Impact

3.6 Core criteria

A number of criteria have been identified as core to the Standards; they relate to leadership, financial management, risk management, quality improvement, staff health and safety, control of information, data protection, surveyor planning and skills development, and accreditation award decision making.

Core criteria should achieve a rating 3 or higher for the Standard to reach compliance. However, a core criterion rating of 2 may be acceptable, if the risk associated with the criterion is low or moderate as calculated using the ISQua EEA risk matrix and the necessary action can be achieved within 3-6 months post award.

Core Criteria							
Standard 1	Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Standard 7	Standard 8
1.6	2.1	3.3	4.4	5.3	6.1	7.4	8.1
1.10	2.2	3.4	4.7	5.5	6.2	7.7	8.5
1.11	2.4	3.5		5.6	6.7		8.6
1.12	2.5	3.7			6.8		
	2.6	3.8					
		3.11					

In total, there should be no more than **four core criteria achieving a rating of 2 or lower**, and the risk associated with these criteria must be low or moderate.

3.7 Not applicable criteria

It is recognised that not all criteria may be applicable for all external evaluation organisations. For some criteria, the guidance identifies when a criterion should be considered not applicable. Any further criteria which organisations consider to be not applicable should be discussed with ISQua EEA accreditation staff in advance of the technical review. If agreed, the self-assessment should clearly state the date of the agreement with ISQua EEA and the reason the specific criterion, or elements of it, are not applicable. For example, a criterion may not apply due to national, legal, environmental or cultural factors. If the survey team determine that the criterion should be applicable, this will be noted in the report and a rating will be provided.

3.8 Technical Review

The self-assessment tool must be fully completed in English and all supporting evidence translated into English and submitted to ISQua EEA for technical review eight weeks in advance of the survey start date. The date for the technical review submission is included in the critical path. An ISQua EEA Accreditation Manager then reviews the draft self-assessment tool and supporting evidence to ensure that the self-assessment has been completed in accordance with ISQua EEA requirements and that relevant evidence has been provided for each criterion. A report is sent to the organisation commenting on any areas which may need to be addressed; no comments are made on compliance. The organisation then has time to make any necessary changes to the self-assessment tool prior to submission to the survey team. This process ensures that the self-assessment tool is suitable for assessment and helps streamline the survey. The technical review report is also made available to the survey team.

3.9 Submitting the final self-assessment tool and required documentation

The completed self-assessment tool and any remaining supporting evidence must be submitted in English to ISQua EEA four weeks in advance of the survey start date.

Section 4
Organisational Survey

4.1 Survey arrangements

4.1.1 ISQua EEA responsibilities

ISQua EEA is responsible for:

- scheduling the onsite organisational survey
- allocating the survey team
- managing the logistical arrangements and ensuring that the survey team have all the required information
- ensuring the timeframes are adhered to.

4.1.2 Survey duration

The survey team, consisting of three international peer review surveyors, will be onsite for three to five days depending on whether this is the organisation's first survey or a re-accreditation survey and whether the survey incorporates assessment of the surveyor training programme. Time is allocated within the timetable for the surveyors to complete the first draft of their report.

4.1.3 Travel

The organisation is responsible for paying for the survey team's travel. Travel to the organisation is booked in one of two ways:

- Surveyors purchase their own flexible economy flights. The surveyors are required to submit quotes for approval prior to booking. Surveyors must be reimbursed for the flight costs within one month of booking.
- Surveyors will obtain flexible economy flight quotes and once approved, the organisation will make the travel bookings directly.

From an ISQua EEA perspective, flexible economy flights are those which are fully refundable; changes are permitted; and upgrades to business class are possible.

4.1.4 Accommodation and expenses

The organisation is responsible for booking the hotel. This should take into account the surveyors' travel plans, as well as time to acclimatise to any time differences. The hotel should be of a good standard, with facilities for surveyors to work in the evenings (a desk, good lighting, Wi-Fi or internet access). If a meeting room is required by the surveyors on the evening prior to the commencement of the survey, this will be agreed in advance. The organisation should pay the hotel directly so that surveyors do not have to pay for their accommodation and meals.

A working lunch must be provided each day for the survey team. As the surveyors will not be familiar with the area, the organisation may wish to advise them on local restaurants for dinner.

The organisation is responsible for reimbursing surveyors' expenses incurred during the survey, including all travel, accommodation and meals at the end of the onsite survey if possible, or within one month of the onsite survey. Arrangements for reimbursement should be discussed and agreed prior to survey.

4.2 Logistics

The following arrangements should be made prior to the survey:

- travel information for each day of the survey;
- a nominated individual(s) to meet the team upon arrival at the organisation, answer queries, provide additional information and documentation as required and to receive and provide feedback on the progress of the survey;
- Wi-Fi connection;

- a secure base room set aside for the survey team to work in, with all relevant evidence to support the self-assessment. This may need to be made available after working hours; and;
- interview rooms (separate to the above base room).

4.3 Staff involvement

It is important that as many staff as possible are involved in the survey process. The organisation should allocate staff that have been working with the standards to the appropriate interviews and include their names and job titles in the survey timetable. The organisation should also invite as many staff as possible to meet the surveyors and to attend the summation meeting at the end of the survey.

4.4 Timetable

A timetable of daily scheduled interviews and meetings will be prepared by ISQua EEA and the team leader, which is sent in advance of the survey to the organisation for their input and agreement. The timetable includes:

- an introductory briefing by the senior management team on the environment, the organisation and issues it has been or is facing and any improvements and/or changes made since the self-assessment was completed;
- an orientation tour of the premises;
- documentation review and instructions on how to access files, including electronic files, staff, client and surveyor records (the organisation must acquire prior approval, in line with their own data protection and confidentiality policy);
- meetings with the organisation's teams who have completed or are involved in each of the ISQua EEA standards;
- a meeting or teleconference with a selection of surveyors; and
- a meeting or teleconference with a selection of their stakeholder organisations including clients, government agencies and any other relevant professional bodies.

4.5 Summation meeting

An hour is allowed for the summation meeting. The purpose of the summation meeting is to give an overview of the survey, provide feedback to the organisation on main findings and provide an opportunity to clarify any misunderstandings. The team will have already briefed the chief executive or senior manager on the main findings and any areas of sensitivity that have been identified.

The summation meeting is led by the team leader and summarises the main findings relating to each standard, emphasising areas of excellence and areas for improvement. The team will not comment on the award recommendation.

4.6 Survey of non-English speaking organisations

All ISQua EEA survey processes are in English but every effort will be made to reduce the burden to non-English speaking organisations. It may be necessary for the organisation to provide interpreters to assist both the organisation and the survey team with interviews and the documentation review. Two interpreters may be required to assist with documentation review and interviews. It is recommended that as much documentary evidence as possible is translated into English.

Section 5
Post Survey - Award and Maintenance of Accreditation

5.1 Achievement of Accreditation

For an organisation to achieve ISQua EEA accreditation, an overall compliance rate of 70% must be achieved. Each individual Standard must also achieve a 70% compliance rate and the following rules must be met:

- there should be no more than two criteria within each Standard rated as a 2 or lower, and the risk associated with these criteria must be low or moderate;
- there should be no more than four core criteria in total with ratings of 2 or lower, and the risk associated with these criteria must be low or moderate;
- there should be no high or critical risk ratings for any criteria; and
- recommendations from previous accreditation cycles (if applicable) must have been considered and/or implemented.

Award with consideration: If **one Standard** does not meet the above rules, but the surveyors' recommendations can be achieved within 3 or 6 months, accreditation can be recommended, with the completion of an Action Plan within 3 or 6 months of award outlining how and when the specific report recommendations will be addressed, or have been addressed (the survey team will specify the timeframe i.e. 3 or 6 months). Failure to address the recommendations may result in an award being revoked.

Deferred award: If **two Standards** do not meet the above rules, depending on the scenario, a recommendation on the individual report can be made to defer an award for 3 or 6 months, subject to the submission of an action plan from the organisation. If the survey team feel that an action plan is not sufficient, it can be recommended that surveyor(s) go back out to the organisation in order to determine whether the high-risk areas have been adequately addressed i.e. defer an award subject to a resurvey.

Overall compliance rate = 266/380 = 70%							
Standard 1 42/60 = 70%	Standard 2 25.2/36 = 70%	Standard 3 30.8/44 = 70%	Standard 4 33.6/48 = 70%	Standard 5 30.8/44= 70%	Standard 6 30.8/44 = 70%	Standard 7 44.8/64 = 70%	Standard 8 28/40 = 70%
1.1	2.1 (Core)	3.1	4.1	5.1	6.1 (Core)	7.1	8.1 (Core)
1.2	2.2 (Core)	3.2	4.2	5.2	6.2 (Core)	7.2	8.2
1.3	2.3	3.3 (Core)	4.3	5.3 (Core)	6.3	7.3	8.3
1.4	2.4 (Core)	3.4 (Core)	4.4 (Core)	5.4	6.4	7.4 (Core)	8.4
1.5	2.5 (Core)	3.5 (Core)	4.5	5.5 (Core)	6.5	7.5	8.5 (Core)
1.6 (Core)	2.6 (Core)	3.6	4.6	5.6 (Core)	6.6	7.6	8.6 (Core)
1.7	2.7	3.7 (Core)	4.7 (Core)	5.7	6.7 (Core)	7.7 (Core)	8.7
1.8	2.8	3.8 (Core)	4.8	5.8	6.8 (Core)	7.8	8.8
1.9	2.9	3.9	4.9	5.9	6.9	7.9	8.9
1.10 (Core)		3.10	4.10	5.10	6.10	7.10	8.10
1.11 (Core)		3.11 (Core)	4.11	5.11	6.11	7.11	
1.12 (Core)			4.12			7.12	
1.13						7.13	
1.14						7.14	
1.15						7.15	
						7.16	

5.2 Decision process

Following the survey, the survey team submits the draft report and the ratings matrix with award recommendation to ISQua EEA. To ensure fairness and consistency of the process, the following steps occur:

- ISQua EEA staff perform a quality assurance review of the survey report;
- the survey team reviews any queries from ISQua EEA and submits their final report and award recommendation to ISQua EEA;
- the organisation undertakes a factual review of the report to ensure that the surveyors have not misinterpreted evidence or missed information. Any comments raised from the factual accuracy review are discussed with the survey team and the report finalised as appropriate;
- the final report is sent to a Validation Reviewer with the survey team award recommendation; and
- the final report, including any changes suggested by the Validation Reviewer and agreed by the survey team, and the completed Validation Review Form are sent to the External Evaluation Award Committee (EEAC) which makes the final award decision.

5.3 The award

In making their decision the EEAC considers the achievement of accreditation guidelines as outlined in 5.1 and the recommendations of the survey team and the Validation Reviewer. They also consider the organisation's overall performance across all Standards and the overall number of recommendations recorded as part of the survey.

It is the right of the EEAC to confer a different award than that recommended by the survey team and the Validation Reviewer if they consider it appropriate in light of the overall performance and number of recommendations recorded.

Following the EEAC meeting, ISQua EEA will advise of the accreditation award decision. If the organisation is successfully accredited, it will be accredited for four years with effect from the date of the EEAC meeting at which the decision was made. The award will be issued once confirmation is received from the ISQua EEA Finance Department that all accreditation-related fees have been paid.

5.4 Post-survey evaluation

ISQua EEA is committed to improving its services and each organisation and survey team are asked to complete an online questionnaire on their experience of the survey. The summation of the evaluation results is published in an annual report which is distributed to stakeholders.

5.5 Maintaining the award

Continuing accreditation status will be subject to the completion of a Progress Report within 12 months of award outlining how and when the report recommendations will be addressed or have already been addressed. A second Progress Report showing these changes is required 30 months post award.

In order to maintain ISQua EEA accreditation, an organisation must report any significant changes to the organisation. If there are any concerns about lack of progress, the External Evaluation Award Committee (EEAC) will be informed and may request an independent review. The independent review will be undertaken by a senior ISQua EEA surveyor who will review the progress report and evidence provided and will make a recommendation to the EEAC regarding the appropriateness of the action undertaken and any further action required by the organisation. An ISQua EEA accreditation award can be removed by the EEAC, depending on the result of this review.

5.6 Appeal

If there is dissatisfaction with the accreditation decision, the organisation has the right to appeal within 28 days of receiving their final accreditation decision, clearly outlining the grounds on which they disagree with the decision. The appeal will be independent of any other process.

Grounds for appeal are that:

- relevant and significant evidence was not properly considered, or was incorrectly interpreted;
- inappropriate weighting was given to the evidence; or
- the original decision-making process was inconsistent with the published criteria for accreditation.

The appeal will be considered within one month of the written request being received by the ISQua EEA Chief Executive Officer. The appeal panel will consist of three members:

- A member of the Board who will chair the appeal panel;
- Two independent experts, not involved in the survey.
- The CEO and Chair of the appeal panel shall decide on a fourth member of the panel, if required.

The appeal panel's decision is reviewed and communicated to the Board.

If the appeal results in a recommended change in accreditation status, the decision must be endorsed by the External Evaluation Award Committee (EEAC).

Part B – The Standards

Standard 1
Governance

The external evaluation organisation is responsibly governed to meet its defined purpose and objectives.

Criterion 1.1

The external evaluation organisation is a legal entity, or a defined part of one, such that it can be held legally responsible for all its external evaluation activities.

Guidance

A governmental external evaluation body is deemed to be a legal entity on the basis of its governmental status.

Suggested Evidence

- Deed, constitution or articles of association which define the structure, powers and authority of the organisation
- Governing legislation (if appropriate)

Criterion 1.2

The external evaluation organisation has a clear vision and mission which are:

a) developed by the governing body with staff input

b) communicated to stakeholders

c) regularly reviewed

Guidance

This could include:

i. communication with stakeholders such as policy, professional, funding and service user groups and participating organisations

ii. reviews taking place at defined intervals, or when there is a significant change in the external evaluation organisation's mandate

See also criterion 1.14.

Suggested Evidence

- Written mission and vision or evidence to support existence (may be in plans, brochures)
- Evidence of how these are made available to stakeholders
- Evidence of how reviews are planned and take place

Criterion 1.3

The external evaluation organisation is guided by a defined set of values that are:

a) shared with staff

b) made publicly available

c) evident in all services and activities

Guidance

The organisational values could be on websites, and promotional and information materials.

See also criterion 4.4.

Suggested Evidence

- Written set of values (may be in plans, brochures, displayed on walls and on website)
- How the values are implemented in all services and activities

Criterion 1.4

The organisation documents its approach to corporate social responsibility and this is used to guide ethical decision making in the organisation.

Guidance

Social responsibility relates to the duty of an organisation to act for the benefit of society. This could include the protection and promotion of public health and safety (e.g. through research, public health campaigns, standards development) and the environment (e.g. resource conservation, waste reduction).

The organisation's approach to corporate social responsibility may be documented in a statement or policy.

Strategic planning (particularly capital planning) and operational planning reflect the organisation's approach to corporate social responsibility and this is also reflected in the organisation's policies and procedures (e.g. procurement, waste management, human resource management).

Suggested Evidence

- Statement / policy on corporate social responsibility
- Examples of policies and procedures that reflect the organisation's corporate social responsibility
- Minutes of meetings

Criterion 1.5

A defined process is in place for the management of ethical concerns which is communicated to all staff.

Guidance

Ethical concerns may relate to the operation of the external evaluation organisation and/or their clients.

The organisation may establish a committee to specifically address ethical concerns.

Suggested Evidence

- Process for addressing ethical concerns
- Examples of how this process is communicated to staff
- Organisational chart outlining role of relevant committees

Criterion 1.6

CORE

Policies are in place to ensure that:

a) accreditation or certification award decisions are independent and objective

b) conflicts of interest are avoided

c) the award decisions are based on the surveyors' findings in relation to compliance with the standards

Suggested Evidence

- Policy on how accreditation or certification award decisions are made to ensure impartiality
- Conflict of interest policy

Criterion 1.7

There is a defined separation between the external evaluation activities and any consultancy services offered and this is communicated to all staff, clients and other stakeholders.

Guidance

Examples of consultancy include preparing or producing documentation or procedures, and giving specific advice, instructions or solutions towards achieving compliance with the standards.

Advising on understanding of standards or the external evaluation process, arranging training and participating as a trainer is not considered consultancy, provided that, where the advice or course relates to standards or external evaluation, this is confined to the provision of generic information that is freely available in the public domain; i.e. the trainer or consultant should not provide client specific solutions.

This criterion would be considered not applicable for any organisation that does not provide consultancy services as described above.

Suggested Evidence

- Statement on consultancy
- Evidence of how this is communicated to staff e.g. orientation training materials

Criterion 1.8

There is a policy for maintaining the confidentiality of information obtained from, or about, all stakeholders in the course of the external evaluation process.

The policy ensures that stakeholders are fully informed about disclosed information.

Guidance

The policy may include how the information including research data is used and shared without breaking confidentiality; this may be achieved by limiting information made publicly available from the survey report except when required by law.

Suggested Evidence

- Relevant policy e.g. Confidentiality policy
- How stakeholders are made aware of any information which may be made publicly available

Criterion 1.9

A code of conduct, endorsed by the governing body, guides the interaction of staff and surveyors with clients, other stakeholders, and the general public.

Suggested Evidence

- Code of Conduct
- Evidence of how this is made available to staff and surveyors
- Evidence of governing body endorsement

Criterion 1.10 CORE

The external evaluation organisation has documented its governance arrangements including:

a) the composition of the governing body

b) the tenure of the appointed members

c) how new members are appointed

d) terms of reference including any subcommittees

e) lines of accountability incorporating stakeholders external to the legal entity

Guidance

Lines of accountability external to the legal entity may relate to relationships with external bodies including governmental bodies or agencies (e.g. Ministry of Health).

Suggested Evidence

- Constitution of the governing body
- Terms of reference for the governing body and any subcommittees
- Documented lines of accountability

Criterion 1.11 CORE

The governing body defines and documents overall authority and responsibility for:

a) overseeing the strategic planning process

b) developing and approving accreditation / certification standards used by the organisation

c) making decisions on accreditation or certification, including appeals

d) ensuring the organisation meets legal and regulatory requirements

e) approving the organisation's corporate policies and ensuring the policies are followed

Suggested Evidence

- Annual plan
- Strategic documents
- Job descriptions
- Organisation chart
- Rules/guides for accreditation or certification decisions

Criterion 1.12 CORE

The governing body is accountable for the sustainability of the organisation and defines and documents authority and responsibility for financial activities including:

a) approving the organisation's capital and operating budgets

b) ensuring the organisation is adequately resourced to meet its objectives

c) approving major transactions such as capital investments or major equipment purchases

Guidance

Responsibility may be delegated to the chief executive or equivalent or to a chief financial officer. See also criteria 2.6 - 2.8.

Suggested Evidence

- Terms of reference
- Budget approval
- Financial reports
- Job description

Criterion 1.13

Members of the governing body are supported through:

a) a planned orientation programme to ensure they understand their responsibilities and duties, confidentiality and the external evaluation organisation's standards and services, and

b) provision or facilitation of on-going information and/or education to assist them in fulfilling their role

Guidance

The orientation programme may include induction to any of the sub-committees that the individual is appointed to.

Suggested Evidence

- Documented and completed orientation programme
- On-going education programme

Criterion 1.14

The governing body:

a) defines the external evaluation organisation's stakeholders

b) delegates authority for managing communications and stakeholder engagement

c) ensures that appropriate communication plans and strategies are in place

Guidance

Stakeholders may include but not be limited to clients, professional bodies, policy and funding authorities, and patient/service user groups.

Activities may include the external evaluation organisation:

i. actively seeking the opinions of their stakeholders on the development, evaluation and improvement of services

ii. contributing to projects, committees and networks aligned with its strategic direction

Suggested Evidence

- Communication plan(s) and strategies
- Stakeholder surveys and results (not post-assessment evaluations)
- Lists of memberships of committees, projects, etc.

Criterion 1.15

The effectiveness of the governance of the external evaluation organisation is evaluated using indicators and other measures of performance.

The data are used to assist with improving the governance arrangements.

Guidance

Certain governance functions could be delegated to the chief executive and evaluation of the chief executive's performance in relation to these functions may be included.

Suggested Evidence

- Defined performance measures
- Results of annual evaluation of governing body performance
- Results of performance of defined governance indicators
- Examples of how the data have been used to make improvements

Standard 2
Strategic, Operational and Financial Management

The external evaluation organisation is effectively managed to meet its strategic, operational and financial objectives.

Criterion 2.1 CORE

The governing body:

a) delegates responsibility for the operational management of the external evaluation organisation to a chief executive or equivalent

b) defines the chief executive's role and authority in a job description

c) sets and evaluates annual performance objectives for the chief executive

Suggested Evidence

- Chief executive's job description
- Current performance objectives and evidence of evaluation

Criterion 2.2 CORE

The lines of accountabilities and responsibilities within the external evaluation organisation:

a) are clearly defined

b) are made known to staff

c) ensure staff and surveyors are free from influence by those who have a direct interest in the accreditation/certification decisions

Guidance

The lines of accountabilities and responsibilities may be outlined in an organisational chart. This may be made known to staff at orientation and whenever there is a change of responsibilities.

Suggested Evidence

- Organisational chart
- Orientation programme
- Job descriptions

Criterion 2.3

The external evaluation organisation:

a) defines key suppliers and services

b) defines the requirements for these key suppliers and services in documented agreements

c) makes contractual decisions on the basis of competency and cost effectiveness

d) monitors the contracted work

Guidance

Key suppliers provide goods or services that are critical for the external evaluation organisation's ability to perform its external survey activities at the required performance level.

Key suppliers and services could include:

i. IT services, equipment and programmes

ii. bookkeeping and accountancy services

iii. human resource administration

Contracts may include key performance indicators to enable detailed monitoring.

Suggested Evidence

- Examples of contracts
- Decision making process
- Monitoring of contracts

Criterion 2.4 CORE

A strategic plan, developed through a defined process including stakeholder engagement, contains achievable and measurable goals (or directions) and objectives.

Guidance

The aim of a strategic plan is to direct the external evaluation organisation's services, programmes and activities and guide decision-making and resource allocation.

The strategic plan could:

i. be based on an analysis of the external evaluation organisation's strengths, weaknesses, opportunities and threats

ii. use information from research, performance measurement and risk analysis

iii. provide direction for a specified number of years, e.g. four years

Suggested Evidence

- Strategic plan
- Evidence of stakeholder engagement

Criterion 2.5 CORE

An annual operating plan defines the external evaluation organisation's objectives, and the timelines and resources required to achieve them. The plan is developed in accordance with the strategic plan.

Guidance

The operating plan may be integrated with the financial plan and/or the budget.

Suggested Evidence

- Annual operating plan

Criterion 2.6 CORE

The external evaluation organisation has processes for financial planning and budgeting.

Guidance

Financial planning is delegated by the governing body (see criterion 1.12). This could include:

i. a financial and resource plan developed and used to prioritise the strategic and operational objectives, strategies and activities
ii. budgets being used to monitor and report regularly on financial performance
iii. financial reports being shared with the governing body

Suggested Evidence

- Finance plans
- Financial policies and procedures
- Financial reports
- Budgets

Criterion 2.7

An effective financial system is used to:

a) record and track income and expenditure

b) monitor past, current and projected financial positions

c) generate financial reports as required

Suggested Evidence

- Financial reports

Criterion 2.8

Internal and independent systems of financial and asset control protect the external evaluation organisation's assets.

Guidance

Systems could include:

i. documentation of delegated authority and accountability for purchasing

ii. an effective system of asset control with controls for cash, debtors, inventory and equipment

iii. a comprehensive insurance programme that protects financial assets, buildings, contents, physical assets and staff and surveyors when travelling

iv. an independent and comprehensive annual financial audit undertaken by appropriately qualified persons with results reported to the governing body.

Suggested Evidence

- Policies and procedures
- Asset register
- Details of insurance policies held
- External financial audit

Criterion 2.9

Progress in achieving strategic and annual objectives, including financial and, if appropriate, research objectives, is measured regularly and achievement is evaluated.

Guidance

Progress is monitored and could include:

i. the strategic and annual plan being reviewed and revised in accordance with a planned schedule and progress results

ii. financial effectiveness being measured by achievement of budget and other defined targets, e.g. financial ratios

iii. if the organisation's mission includes research there may be a research plan to define the external evaluation organisation's annual research objectives, strategies and activities and the resources required to achieve them.

Suggested Evidence

- Evidence of monitoring of all planned objectives
- Financial indicators

Standard 3
Risk Management and Quality Improvement

Risks and improvement opportunities are identified and managed to deliver safe quality services.

Criterion 3.1

Policies and procedures (electronic or paper-based) are in place for all aspects of the external evaluation organisation's operations and are developed, implemented and cyclically reviewed in consultation with stakeholders.

Guidance

See also criterion 3.2.

Suggested Evidence

- Examples of policies and procedures

Criterion 3.2

A document control system is in place for both electronic and paper-based documents/records that ensures the appropriate versions are available to staff, clients, and other stakeholders.

Guidance

The document control system could include:

i. a document control policy and/or procedure

ii. a register (electronic or paper-based) being maintained of all documents with the respective issue or amendment status, the authorising person and the distribution list/procedure

iii. new or revised documents being reviewed and approved by authorised personnel prior to them being implemented

iv. systems to prevent the unintended use of obsolete documents

Suggested Evidence

- Evidence of document control

Criterion 3.3 CORE

A risk management framework endorsed by the governing body is used to identify and manage, through reactive and proactive strategies, all risks to the external evaluation organisation, including (but not limited to):

a) service provision

b) financial

c) human resources

d) environmental

e) information management

Guidance

The risk management framework outlines how risks are identified and managed throughout the organisation.

The framework is endorsed by the governing body and includes roles and responsibilities.

The risks associated with service provision could include failure to maintain firewalls between units, failure to retain appropriate numbers and types of competent surveyors, inter or intra surveyor reliability issues and poor client relationships.

See also criteria 1.6, 1.7 and 6.1.

Suggested Evidence

- Risk framework endorsed by the governing body

Criterion 3.4 CORE

The risk management framework is supported by a risk management plan, policies, procedures and a risk register.

Guidance

The risk management plan includes reporting, reviewing and monitoring of risks.

The risk management plan could be linked to the strategic plan.

The procedure(s) detail how risks are identified, managed, reported and acted upon together with the process used to record them.

A risk register is a live record of all risks and is updated on a regular basis. The identified risks may be rated in accordance with their severity, probability and/or potential impact to the organisation.

Suggested Evidence

- Documented risk management plan(s), policies and procedures
- Risk register

Criterion 3.5 CORE

Risks are identified, analysed, reported and acted upon.

Guidance

This may include:

i. analyses of information from a variety of sources

ii. identification of potential consequences

iii. assessment of the significance of the risk in terms of likelihood, consequences and outcomes

iv identification and implementation of risk management strategies e.g. how risk can be avoided, reduced, transferred, shared, retained and planned for

v. how staff are kept appraised of identified risks

Suggested Evidence

- Risk reports
- Minutes of risk management meetings

Criterion 3.6

The governing body receives at least two reports per year, and more frequently if necessary, about the management of risks.

Guidance

Reports to the governing body could include:

i. review of the frequency and severity of damages and losses incurred

ii. analysing incident and adverse event trends

iii. reviewing policies and procedures that might prevent or minimise risk

iv. assessing new or increased risk (risk register)

v. assessing the effectiveness of risk management education and communication strategies

Suggested Evidence

- Reports to the governing body

Criterion 3.7 CORE

A quality improvement framework is used to identify and manage opportunities for improvement.

Guidance

The framework could include:

i. a designated person or committee with responsibility for promoting and coordinating quality improvement
ii. quality improvement policies and/or procedures
iii. audits and reviews
iv. setting and review of quality indicators
v. staff training on quality improvement

Suggested Evidence

- Quality improvement framework
- Job descriptions
- Committee terms of reference
- Quality improvement policy
- Audit schedule

Criterion 3.8 CORE

A quality improvement plan is implemented which includes processes for:

a) identifying, recording and analysing improvement opportunities
b) developing solutions to address opportunities for improvement
c) implementing improvements
d) monitoring and evaluating improvements

Guidance

There may be more than one plan for different activities, but each plan includes:

i. timelines
ii. responsibilities
iii. monitoring processes

The quality improvement plan could be linked to the strategic plan.

Suggested Evidence

- Quality improvement plan(s)
- Minutes of meetings that show quality improvement process in action
- Evidence of improvement

Criterion 3.9

The governing body receives at least two reports per year on the outcome of quality improvement activities and the revision of the quality improvement plan.

Guidance

Reports may include:

i. quality improvement projects planned and completed
ii. processes or practices changed as a result of improvement activities
iii. complaints received and resolved within the timeframes

Suggested Evidence

- Quality improvement reports
- Updated quality improvement plans

Criterion 3.10

The external evaluation organisation identifies key performance indicators, monitors performance against them and communicates results to the relevant stakeholders.

Guidance

Performance measures could include:

i. assessment against accepted standards
ii. assessment against defined indicators and other relevant measures
iii. level of compliance with policies, procedures and guidelines
iv. progress against the quality improvement plan

Suggested Evidence

- Examples of key performance indicators and results
- Internal audit activities
- Minutes of meetings

Criterion 3.11 CORE

A complaints management process is in place which:

a) is communicated to client organisations, surveyors and other stakeholders

b) has defined timeframes and responsibilities

c) provides those who are complained about with an opportunity to respond

d) includes feedback to the complainant

e) uses findings from complaints for continuous quality improvement

Guidance

The complaints management process could be supported by a:

i. policy and/or procedure

ii. complaints register

It is recognised that the complaints management process may be based on regional and/or national legislation.

Complaints may relate to accredited or certified organisations or staff and surveyors from the external evaluation organisation.

Suggested Evidence

- Complaints policy and/or procedure
- Complaints register

Standard 4
Human Resource Management

Staff planning and management support the external evaluation organisation's objectives, and staff are supported to deliver quality services.

Criterion 4.1

There is a human resources management framework that is supported by policies and/or procedures relating to:

a) conditions of service

b) disciplinary procedures

c) grievances

d) appeals

e) end of service and retirement

Guidance

Policies and procedures are developed in accordance with local law and legislation and cover all aspects from recruitment to end of service. Where appropriate, documents take into account staff rights.

Suggested Evidence

- Human resources policies and/or procedures

Criterion 4.2

Human resource planning includes the determination of the numbers and competencies of staff needed for the type and level of activity, and, for changes in workload.

Guidance

The planning process may include:

i. a separate human resource plan or human resource component within the operational plan and budget

ii. desired training, qualifications and experience being considered as part of the planning process

iii. succession planning

See also criterion 6.1.

Suggested Evidence

- Human resource plan
- Skills gap analysis
- Competency mapping
- Operational plan

Criterion 4.3

Staff are recruited and selected:

a) in accordance with policies and/or procedures, and regional and/or national legislation

b) with the required qualifications, competencies, experience and responsibilities described in a job description

c) with defined terms of employment outlined in a contract

Guidance

Staff includes both temporary and permanent employees.

An employment contract could include:

i. reporting relationships and relationships with other positions

ii. documented conditions of employment including remuneration, working hours and leave entitlements

Suggested Evidence

- Job advertisements
- Examples of job descriptions
- Employment contracts

Criterion 4.4 CORE

An induction/orientation programme is provided for new staff and is regularly reviewed and improved.

The programme includes as a minimum:

a) the organisation's services and structures

b) the current strategy, mission and values

c) health and safety procedures

d) the employee's roles and responsibilities

Suggested Evidence

- Documented induction/orientation programme
- Orientation webinars/trainings
- New staff welcome kit
- Orientation checklist with sign-off
- Evidence of sign-offs of induction/orientation programme in personnel file

Criterion 4.5

Temporary staff, including independent consultants, have tailored orientation/induction programmes and training appropriate to their role. Health and safety and confidentiality are included as a minimum.

Suggested Evidence

- Tailored orientation programmes and training

Criterion 4.6

All staff upon completion of a satisfactory induction/orientation sign a confidentiality statement and agree to abide by the terms of the external evaluation organisation.

Guidance

The organisation could have a register of confidentiality statements for all staff.

Suggested Evidence

- Confidentiality statements

Criterion 4.7

CORE

There is a documented health and safety programme that is systematically implemented, in accordance with the regional and/or national legislation, which is reported, assessed and reviewed periodically.

Guidance

The health and safety programme could include:

i. health and safety education programme for staff
ii. staff having access to first aid and rehabilitation after injury or illness
iii. buildings and facilities that provide a comfortable, functional, secure and safe work environment
iv. information from health and safety related risks communicated to staff
v. workloads being monitored and managed to limit work-related stress
vi. workplace assessments being undertaken to ensure staff have ergonomically safe workspaces, furniture and equipment

Suggested Evidence

- Health and safety programme and policies necessary to comply with regulations/legislation
- Results of health and safety assessments with evidence of action and review
- Health and safety minutes
- Health and safety incident reports
- Attendance records of health and safety training/webinars/presentations to staff

Criterion 4.8

Staff are supported through:

a) work procedures to promote staff well-being

b) mechanisms to identify and recognise best practices and individual work contributions

c) the resolution of workplace issues

Guidance

The promotion of staff well-being may involve:

i. procedures to promote well-being, e.g. stress management, workload monitoring, management of work-life balance, healthy lifestyle programme

ii. staff being provided with appropriate supervision, support and advice

iii. access to an external employee assistance programme

Mechanisms to recognise work contributions could include peer to peer recognition, long service awards, promotion and social activities.

The resolution of workplace issues may involve:

i. promotion of a culture of openness and accountability

ii. clear procedures for the effective management of complaints and underperformance

iii. measures to protect staff against violence, bullying and harassment

Suggested Evidence

- Documented policies and/or procedures
- Staff recognition programme

Criterion 4.9

There is a programme for staff training, which includes continuous education and development to ensure a competent workforce.

Guidance

Staff training could include:

i. in-house training provided on service delivery and workplace issues and developments

ii. staff given opportunities to attend off-site workshops, seminars and conferences

iii. staff training attendance being monitored and documented

iv. staff supported to undertake further education and research as relevant to the work of the external evaluation organisation

v. observing surveys

Suggested Evidence

- Staff training programmes
- Attendance records
- Staff development plan
- Leadership development programme
- Professional development policy
- Observational survey policy and guidelines

Criterion 4.10

Staff records are:

a) current, complete and accurate

b) confidential and secure

c) accessible to the individual member of staff

d) retained and/or destroyed in accordance with any relevant legislation

Suggested Evidence

- Staff records
- Staff record policy

Criterion 4.11

There is a process to regularly evaluate the ongoing performance and competency of all staff in line with their job descriptions.

Guidance

The staff performance assessment process could include:

i. assessment of achievement against defined objectives

ii. identification of additional training, education and support requirements to enhance the staff member's performance

Suggested Evidence

- Performance evaluation process/policy
- Evidence of staff performance evaluation
- Evidence of performance improvement plans
- Individual development plans

Criterion 4.12

Human resource management is evaluated on a regular basis and action is taken to address identified issues and make improvements.

Guidance

The evaluation could include:

i. the review of gaps or issues with service provision at defined intervals to identify and address the cause

ii. assessment of staff satisfaction on a regular basis, e.g. annually, and action being taken on issues identified

iii. the use of performance measurements and indicators such as staff satisfaction, staff turnover, absenteeism, staff injuries or work-related conditions and the results of exit interviews on retirement or resignation

iv. the results being shared with staff who are encouraged to contribute to the solution of problems and improvements

Suggested Evidence

- Evidence of review and actions taken
- Performance indicators
- Staff satisfaction survey results
- Evidence of de-briefing and action plan for staff satisfaction results
- Exit interview reports

Standard 5
Information Management

Information is managed to support the external evaluation organisation to meet its business objectives.

Criterion 5.1

There is an approved information management framework, supported by a policy, plan and/or procedures which describes how and why information is generated, collected and used.

The framework addresses the following as a minimum:

a) collection of data including consent

b) confidentiality

c) accessibility

d) responsibilities

e) storage and back-up

Guidance

The information may be electronic or paper-based.

The information management policy may specify the national and/or regional legislation which guides the generation, collection and use of data.

Consent may be required for the collection, storage and use of personal data in line with national and/or regional legislation.

Suggested Evidence

- Information management policy, plan and/or procedures

Criterion 5.2

The information management plan is reviewed and updated at defined intervals, and progress reports are provided to the governing body.

Suggested Evidence

- Reports from review of information management plan
- Updated information management plan
- Minutes of governing body meeting(s)

Criterion 5.3 CORE

There are processes to ensure that all information is:

a) accurate

b) reliable

c) accessible in line with relevant legislation

d) confidential and secure

Guidance

The information may be electronic or paper-based. It includes all information collected, stored and published.

Suggested Evidence

- Policies and procedures

Criterion 5.4

Knowledge is disseminated to all relevant internal and external stakeholders to promote learning and continuous quality improvement.

Guidance

Knowledge shared could include project outcomes, lessons learned, procedural changes, quality improvement initiatives and good practice examples.

The knowledge could be disseminated via newsletters, webinars, conferences, meetings, the organisation's website or social media channels.

See also criterion 1.14.

Suggested Evidence

- Communication plans
- Newsletters
- Webinars
- Conference programmes
- Minutes of meetings

Criterion 5.5

Information Technology (IT) systems are maintained and updated, and there are security mechanisms in place.

Guidance

IT system management could include the management of software licences.

IT support may be outsourced.

Security mechanisms could include firewalls and antivirus software.

Suggested Evidence

- Information management plan and/or policy
- IT support contracts

Criterion 5.6 CORE

Safe data/information storage, back-up and recovery are ensured. Mechanisms are in place to support all organisational functions in case of unexpected failure or emergency.

Guidance

This could include:

i. policies and procedures on information storage, retention and recovery including procedures for data/information recovery in case of malfunctions or disaster including when surveyors are on surveys

ii. a contingency plan on information management if not included in the information management plan or policy

Suggested Evidence

- Details of data/information storage, back-up and recovery processes
- Information management plan or policy or contingency plan

Criterion 5.7

Data/information are available and accessible to those who need it and are used to inform decision making.

Suggested Evidence

- Information management plan and/or policy

Criterion 5.8

The information management system is audited on a defined schedule to enable identification of key risks and to determine any corrective and/or preventative actions required.

Guidance

The information management system may be electronic or paper-based.

Suggested Evidence

- Audit plan
- Audit reports
- Evidence of corrective actions

Criterion 5.9

All staff are trained in how to use information management systems correctly, including security mechanisms.

Guidance

Training could include:

i. individual information security responsibilities including use of passwords
ii. storage, retention and destruction of records
iii. appropriate use of software and social media channels
iv. electronic communication guidelines
v. data protection

Suggested Evidence

- Training plan
- Staff records
- Guidelines for use of social media

Criterion 5.10

All information and educational resources are produced to defined standards of use and consistency. Contents are accurate and meet stakeholder requirements.

Guidance

This could include:

i. resource materials being prepared by people with experience and credibility in the subject area

ii. stakeholder requirements being determined from mechanisms such as feedback, surveys, complaints and queries

iii. stakeholder requirements being considered when the website, newsletters and education and other information resources are being designed

iv. a style guide covering such items as colours, font and the use of names and logos to encourage consistency

See also criterion 7.8.

Suggested Evidence

- Examples of information and education materials
- Documented style guide
- Evidence of stakeholder feedback

Criterion 5.11

All written material is reviewed and edited before being published to ensure information is accurate and in line with copyright requirements. Contents are reviewed periodically to ensure they are current.

Guidance

This criterion relates to all written material which may be published online or in hard copy.

This could include use of a:

i. documented procedure for the review of material publicly available

ii. version control policy

Suggested Evidence

- Evidence of review
- Policies and procedures
- Marketing materials

Standard 6
Surveyor Management

Surveyor planning and management support the delivery of a high-quality survey service to participating organisations.

Criterion 6.1

CORE

There is a plan to ensure that there are the number and skill mix of surveyors to deliver quality survey services.

Guidance

The plan may be separate to, or included in, the annual operating plan. It may include planning for the overall surveyor numbers, numbers of paid/employed or volunteer surveyors, types and numbers of healthcare professionals and the skill mix required.

See also criterion 4.2.

Suggested Evidence

- Surveyor management plan

Criterion 6.2

CORE

Surveyors are selected and appointed through a rigorous and transparent process in accordance with competency-based selection criteria and the external evaluation programme's requirements.

Guidance

The competencies could include:

i. personal attributes, including the ability to communicate effectively
ii. professional qualifications and experience
iii. contemporary knowledge of the health and/or social care sector
iv. substantial skills in at least one area relevant to the survey areas
v. specialised knowledge and experience in a particular area (e.g. indigenous health, patient/service user engagement, mental health)

Suggested Evidence

- Surveyor selection procedure
- Surveyor competencies

Criterion 6.3

The responsibilities and expectations of surveyors are clearly defined, and surveyors sign a contract or agreement to signify their acceptance of these.

Guidance

Surveyor contracts or agreements could include:

i. responsibilities and expectations
ii. any responsibility for tax, personal accident insurance and/or professional indemnity insurance
iii. financial remuneration arrangements
iv. period of appointment
v. required availability
vi. support for the external evaluation organisation's objectives
vii. commitment to comply with the external evaluation organisation's rules
viii. maintenance of confidentiality and independence
ix. declaration of known and potential conflicts of interest
x. performance review – see also criterion 6.8

The surveyor responsibilities could also be defined in a code of a conduct - see also criterion 1.9.

Suggested Evidence

- Surveyor contracts/agreements

Criterion 6.4

All surveyors undergo a formal initial training programme which includes evaluation of performance as part of the process.

Guidance

The training programme could include:

i. mock survey processes
ii. legal and survey requirements
iii. external evaluation standards and their interpretation
iv. survey techniques
v. negotiating skills
vi. performance expectations and evaluation systems
vii. a process for dispute resolution

Suggested Evidence

- Surveyor training programme
- Surveyor evaluation criteria

Criterion 6.5

Upon successful completion of the surveyor training programme a planned programme of orientation into the surveyor role is undertaken.

Guidance

The orientation programme could be incorporated into the surveyor training programme and could include:

i. how they are allocated to surveys
ii. their role in the survey
iii. what insurances they might require
iv. how to claim expenses
v. survey logistics
vi. performance expectations

Suggested Evidence

- Surveyor orientation programme

Criterion 6.6

New surveyors are supported to survey effectively against the external evaluation organisation's programmes they are selected for.

Guidance

Support for new surveyors may include:

i. manuals and resources being provided to guide surveyors to perform their work consistently
ii. new surveyors being supported and mentored by more experienced surveyors and staff
iii. further training provided if evaluation indicates this is required

Suggested Evidence

- Surveyor manual/guide
- New surveyor evaluation criteria

Criterion 6.7 CORE

There is on-going development of surveyors' skills with sessions being held on a regular basis.

Guidance

On-going development could include:

i. surveyors being assisted with the interpretation of standards and with assessment techniques

ii. development sessions being held at least annually, addressing identified training needs and covering problematic standards and new or revised standards or methodologies

iii. specific training being provided for those taking team leader roles

iv. sharing the learning from difficult scenarios which may have arisen during a survey

Suggested Evidence

- Examples of surveyor training/development sessions and programmes

Criterion 6.8 CORE

The performance and on-going competence of surveyors is evaluated regularly.

Guidance

This could involve:

i. evaluation feedback being collected after each survey by those involved in the survey, e.g. clients, members of the survey team, and other individuals such as client managers and report editors

ii. evaluation results being shared with surveyors and used to identify training needs and assist with performance improvement

iii. on-going competence of surveyors being reviewed over a period of time, e.g. annually, by reviewing results of evaluations, participation in training, professional development and any change in role to determine whether appointment should continue or if new roles can be assigned

Suggested Evidence

- Tools used for evaluation
- Evidence of competence review

Criterion 6.9

The external evaluation organisation assesses intra and inter surveyor reliability and addresses any issues which emerge from assessments.

Guidance

Inter-surveyor reliability relates to the consistency between surveyors.

Intra-surveyor reliability relates to the consistency of an individual surveyor from survey to survey.

Suggested Evidence

- Review of evaluation forms and verbal feedback (e.g. from survey team members, client organisations)
- Ratings analyses
- Surveyor training agendas

Criterion 6.10

The relevant competencies, experience and performance of surveyors are documented in an individual record and are used to allocate roles.

Guidance

The information in each individual record could include qualifications, training, experience, professional status, affiliation, position, survey history, participation in training and development, performance evaluation results and contact details.

Suggested Evidence

- Surveyor records

Criterion 6.11

The effectiveness of the surveyor selection, orientation, training and development programme is evaluated, and results are used to make improvements to the management and development of surveyors.

Suggested Evidence

- Measures to evaluate effectiveness of the management of surveyors
- Examples of how evaluation has been used to make improvements

Standard 7
Survey and Client Management

The external evaluation programmes are consistent with the organisational objectives and meet the needs of participating organisations and other stakeholders.

Criterion 7.1

The external evaluation programmes provided by the organisation are developed in response to a defined needs identification process.

Guidance

External evaluation programmes could include accreditation or certification (or a combination of both).

The development could take account of:

i. the expectations of government

ii. the community and other key stakeholders

iii. any national or international health priority areas focused on safety and quality in health care delivery systems, e.g. WHO guidelines

iv. whether programmes can be achieved and whether they are financially feasible

The governing body delegates responsibility for the development of programmes and standards, see criterion 1.11.

Suggested Evidence

- Development plan
- Strategic plan
- Operational plan
- Minutes of meetings

Criterion 7.2

The external evaluation organisation takes responsibility for any external evaluation activities outsourced to another organisation by:

a) defining its requirements for the outsourced external evaluation work in documented agreements

b) making decisions to award contract based on the outsourced organisation's competency, ability to meet quality and health and safety requirements, cost effectiveness

c) monitoring outsourced work

Guidance

This criterion may be rated as not applicable if no external evaluation activities are outsourced to another organisation.

This criterion is not relevant to contracts with individual surveyors as this is included in criterion 6.3. It applies to, for example, technical experts, educators and where evaluation activities are carried out on behalf of the organisation by another body.

Suggested Evidence

- Examples of contracts/tenders for services outsourced
- Contractual decision-making process
- Monitoring of outsourced work

Criterion 7.3

Applicants for the external evaluation programme are assessed for suitability before entering into the programme.

Guidance

Where programmes are voluntary, applicants could be assessed for suitability through an application process. This may be carried out through a screening process, questionnaire or formal application review.

Suggested Evidence

- Process for assessment for suitability
- Application form or equivalent for entry into the external evaluation programme

Criterion 7.4 CORE

Actual and potential clients are provided with full information on the external evaluation programme.

Clients formally agree to comply with the requirements of the programme and to abide by the defined responsibilities of an accredited or certified organisation.

Guidance

This could involve:

i. applicants signing an agreement to comply with the requirements of the programme, supplying any information needed and making all necessary arrangements for the survey, including provision for examining documentation and access to all areas, records and personnel

ii. applicants accepting publication of survey findings and awards of certification/accreditation as required by law, statutory requirements or by the programme itself

Client responsibilities could include:

i. only claiming accreditation or certification for services which have been granted accreditation or certification

ii. not bringing accreditation or certification into disrepute or making any misleading statement regarding their accreditation or certification status

iii. ensuring that no certificate, logo or report is used in a misleading manner

Suggested Evidence

- Information for clients on the survey process
- Client agreement

Criterion 7.5

The external evaluation organisation defines its clients and keeps a register of clients.

Guidance

Clients may be defined as health and/or social care provider organisations who have signed a contract with the external evaluation organisation. The organisation may define specific eligibility requirements for their different programmes.

Alternatively, if the external evaluation programme is mandatory, clients may be defined as all health and/or social care providers falling within the scope of the programme.

Suggested Evidence

- Eligibility requirements for the external evaluation programme(s)
- Contracts with specific eligibility requirements
- Client register

Criterion 7.6

The relationships with clients recognise their specific needs.

Guidance

Relationships could include:

i. defined contact points in the client organisation and the external evaluation organisation being identified

ii. on-going communication and non-prescriptive advice assisting clients in their preparation for survey and continuous improvement activities

iii. networking and education opportunities

These could be documented in a client service plan.

Suggested Evidence

- Client service plan
- Examples of client communication

Criterion 7.7 CORE

Arrangements are in place to ensure impartiality and avoidance of conflicts of interest in client relationships.

Guidance

Policies and structures are in place to assure that all clients have equitable access to information.

Separation of consultancy and evaluation services is an important prerequisite for impartiality but does not exclude the external evaluation organisation from providing education or advice to clients (see also criterion 1.7).

Suggested Evidence

- Impartiality policy

Criterion 7.8

Education and information materials are available for clients which support the programme objectives and meet their needs. Needs are met in ways that are consistent with the requirements for impartiality.

Guidance

This could include:

i. the client education needs being assessed, and programmes being designed to meet these needs

ii. clients being assisted to prepare for the survey, e.g. by the provision of on-site or off-site education, self-assessment assistance or pre-survey reviews

See also criteria 5.10 - 5.11.

Suggested Evidence

- Examples of education and information materials

Criterion 7.9

Feedback on information and education materials used in the accreditation process is obtained from users and used to make improvements.

Guidance

This could include user feedback being sought on resources such as information materials, resources used at education sessions, manuals and reports.

Suggested Evidence

- Examples of feedback
- Examples of improvements made

Criterion 7.10

The team for the survey of an organisation is selected to provide a balance of skills and experience and to match the needs and characteristics of the participating organisation.

Guidance

This could include:

i. a selection process for survey teams that ensures that appropriate skills, expertise and experience are provided for each survey

ii. prevention of conflicts of interest of survey team members, e.g. by checking if they have relationships with competing or contracting agencies or with key people in the participating organisation, have had previous employment with the organisation or have provided consultancy services to it

Suggested Evidence

- Documented process for selecting survey teams

Criterion 7.11

The planning of the survey is transparent and timely.

Guidance

The survey planning process could include:

i. the survey team biographies being sent to the client and accepted by them

ii. the organisation being made aware of any observers or translators

iii. pre-survey documentation being provided in a timely and comprehensive manner by relevant parties

iv. the survey process being clearly defined and covering the nature of, and timelines for, the provision of documentation and the survey timetable

Suggested Evidence

- Documented survey plan and/or planning process

Criterion 7.12

The survey is conducted according to a timetable and is agreed in sufficient time to make necessary arrangements.

Guidance

The timetable:

i. outlines the activities to take place each day

ii. enables each member of the survey team to be clear about his/her individual responsibilities

iii. includes locations for activities as appropriate, especially where sampling takes place or the client has multi-sites

iv. indicates which staff from the client organisations are expected to participate

Suggested Evidence

- Examples of survey timetables

Criterion 7.13

The survey is conducted using appropriate tools and guidelines and a transparent, valid and consistent process.

Guidance

Supporting documentation could include:

i. guidelines and survey tools that are used by surveyors in the survey of performance against the standards or their agreed equivalent

ii. guidelines and survey tools assisting the application of rating scales

iii. debriefing template to support the provision of feedback on key findings by the survey team to the participating organisation at the end of the survey

Suggested Evidence

- Examples of survey tools and guides

Criterion 7.14

A written report outlines the findings from the survey and the ratings of achievement against the standards assessed.

Guidance

The report could include:

an executive summary which includes the dates of the survey, the names of the surveyors, the services and sites assessed, the scope of the survey, the standards used, the findings of the team, and recommendations on areas of insufficient achievement/compliance.

Suggested Evidence

- Report writing guidelines
- Examples of reports

Criterion 7.15

Documented review processes and guidelines are followed to ensure the report is complete and accurate.

Suggested Evidence

- Processes and guidelines for report writing

Criterion 7.16

The relationships with clients, and the support offered to them, are reviewed regularly and improvements made based on the evaluation and feedback provided.

Guidance

Improvements may include:

i. updating policies and procedures
ii. developing or revising client education materials
iii. revising processes
iv. revising standards

Suggested Evidence

- Evaluation and feedback evidence
- Examples of improvements

Standard 8
Accreditation or Certification Awards

The processes for awarding and maintaining accreditation or certification are objective and consistently implemented.

Criterion 8.1

CORE

The external evaluation organisation defines:

a) who is responsible for determining the outcome of the survey

b) the criteria for the awarding of accreditation or certification

c) the timeframes within which the award decisions are made

Guidance

The criteria for the award of accreditation or certification could include:

i. achievement on all compulsory standards

ii. a defined level of achievement of all standards

iii. no standard being rated below a defined level

See also criterion 1.6.

Suggested Evidence

- Defined process and criteria for making accreditation/certification decisions

Criterion 8.2

The certificate awarded to the participating organisation details the name of the organisation, the scope and effective date of the accreditation or certification and the term for which it is valid.

Guidance

Depending on the external evaluation body the scope may not always be necessary, as the whole organisation is being evaluated. Some external evaluation programmes only award a certain department or programme and the certificate must clearly state this.

Suggested Evidence

- Example of certificate

Criterion 8.3

A documented appeals process is in place for when the outcome of the survey is in dispute which:

a) is communicated to client organisations, surveyors and other stakeholders

b) has defined timeframes and responsibilities

c) is led by individuals independent of the original survey process

Suggested Evidence

- Documented appeals process

Criterion 8.4

The external evaluation organisation has processes to:

a) monitor that the award decisions are consistent with the criteria for awarding accreditation/certification

b) take action if deviations are identified

Guidance

Award decisions may be monitored as part of an internal audit process or by an external party.

Suggested Evidence

- Accreditation/certification award criteria
- Results of monitoring
- Evidence of any actions taken

Criterion 8.5 CORE

The external evaluation organisation monitors its clients' continued compliance with standards and their actions for improvement.

Guidance

Monitoring could include:

i. submission by the accredited or certified organisation of a plan of the specific actions and timeframes in which they will make any improvements recommended in the survey report

ii. processes for validating the implementation of these actions

iii. review of specified documentation

iv. a system of periodic self-assessments, annual or mid-term reviews, or unannounced reviews

Suggested Evidence

- Documented monitoring process
- Examples of monitoring reports

Criterion 8.6 CORE

There are processes for following up any concerns or issues raised about an accredited/certified client.

Guidance

Processes could include:

i. Client organisations against whom a concern/issue is raised being required to make available, when requested, its records of complaints and subsequent action(s) taken

ii. A defined system for following up with client organisations when a sentinel event occurs

iii. A re-survey if required after the issue has been evaluated

iv. A re-survey if the client organisation has undergone significant changes

Suggested Evidence

- Documented process for following up any concerns/issues

Criterion 8.7

The external evaluation organisation protects the integrity of its accreditation/certification awards by having:

a) documented rules for the use and display of the accreditation or certification award logo

b) a process for taking suitable action to deal with incorrect claims about accreditation or certification status

Suggested Evidence

- Rules for the display of accreditation or certification status
- Process for dealing with incorrect references/claims

Criterion 8.8

The public has access to information about which organisations have been accredited or certified, including information about when an award has been suspended or withdrawn.

Suggested Evidence

- Evidence of published lists of accredited or certified organisations
- Evidence of how suspended or withdrawn awards are handled

Criterion 8.9

A record for each survey is managed, stored and disposed in accordance with any relevant regional or national legislation.

Guidance

Records may be kept for at least one full accreditation or certification cycle (see also criterion 3.2).

Suggested Evidence

- Accreditation or certification records

Criterion 8.10

The accreditation or certification processes and outcomes are evaluated, and the results used to make improvements.

Guidance

Evaluation may include:

i. participating organisation satisfaction
ii. outcomes from the appeals process
iii. audits of documentation
iv. analysis of the outcomes of accreditation or certification surveys

Suggested Evidence

- Evaluation process
- Evaluation results
- Examples of improvements

Comparative Table

5th Edition to 4th Edition

The table below shows the current criterion number and its comparative in the 4th Edition. Where the criterion is new to the 5th Edition the reference to the 4th is noted as New.

Standard/Criterion 5th Edition	5th Edition Reference	4th Edition Reference
Standard 1 – Governance		
Legal entity	1.1	1.4
Vision and mission	1.2	1.1
Values	1.3	1.2
Social responsibility	1.4	**New**
Management of ethical concerns	1.5	**New**
Conflicts of interest	1.6 (Core)	1.3 (Core)
Consultancy services	1.7	1.3
Confidentiality of stakeholder information	1.8	1.5
Code of conduct	1.9	1.7
Governance arrangements	1.10 (Core)	1.8
Governing body authority and responsibility	1.11 (Core)	1.10 (Core)
Financial activities	1.12 (Core)	1.11 (Core)
Governing body orientation and education	1.13	1.12
Relationship with stakeholders	1.14	1.13
Governance evaluation	1.15	1.14
Standard 2 - Strategic, Operational and Financial Management		
Chief executive responsibilities and objectives	2.1 (Core)	2.1 (Core)
Management and responsibilities	2.2 (Core)	2.2 (Core)
Contracting and outsourcing of suppliers	2.3	2.4
Strategic planning	2.4 (Core)	2.5 (Core)
Operating plan	2.5 (Core)	2.6 (Core)
Financial planning and budgeting	2.6 (Core)	2.7 (Core)
Financial systems	2.7	2.8
Financial and asset control	2.8	2.9
Evaluation	2.9	2.10
Standard 3 - Risk Management and Quality Improvement		
Policies and procedures	3.1	3.10
Document control system	3.2	3.11
Risk management framework	3.3 (Core)	3.1 (Core)
Risk management plan, policies, procedure and register	3.4 (Core)	3.2 (Core)
Risk identification	3.5 (Core)	3.3 (Core)
Risk reports	3.6	3.4
Quality improvement framework	3.7 (Core)	3.5, 3.6
Quality improvement plan	3.8 (Core)	3.7
Quality improvement reporting	3.9	3.8
Key performance indicators	3.10	3.9
Complaints management	3.11 (Core)	3.12 (Core)

Standard/Criterion 5th Edition	5th Edition Reference	4th Edition Reference
Standard 4: Human Resource Management		
Human resources management framework	4.1	4.1
Staff planning	4.2	4.2
Recruitment and selection	4.3	4.3
Induction/orientation programme	4.4 (Core)	4.4 (Core)
Temporary staff	4.5	4.7
Confidentiality statement	4.6	4.8
Health and safety programme	4.7 (Core)	4.5 (Core)
Staff support	4.8	4.6
Continuous education	4.9	4.9
Staff records	4.10	4.10
Performance appraisal	4.11	4.11
Evaluation	4.12	4.12
Standard 5: Information Management		
Information management framework	5.1	5.1
Review of information management	5.2	5.2
Accuracy and confidentiality of information	5.3 (Core)	5.3 (Core)
Knowledge dissemination	5.4	**New**
IT systems	5.5 (Core)	5.4 (Core)
Safe storage	5.6 (Core)	5.6 (Core)
Availability of information	5.7	5.7
Information management system audit	5.8	5.8
Staff training	5.9	5.9
Resource material accuracy	5.10	5.10
Review of all material	5.11	5.11
Standard 6: Surveyor Management		
Surveyor planning	6.1 (Core)	6.1 (Core)
Selection and appointment	6.2 (Core)	6.2 (Core)
Surveyor contract or agreement	6.3	6.3
Initial training	6.4	6.4
Orientation	6.5	6.5
New surveyor support	6.6	6.6
Skill development	6.7 (Core)	6.7 (Core)
Performance review	6.8 (Core)	6.8 (Core)
Inter and intra-rater reliability	6.9	**New**
Surveyor records	6.10	6.9
Evaluation	6.11	6.10

Standard/Criterion 5th Edition	5th Edition Reference	4th Edition Reference
Standard 7: Survey and Client Management		
Programme development	7.1	7.1
Outsourcing	7.2	2.3
Suitability for the programme	7.3	7.2
Entry into the programme	7.4 (Core)	7.3 (Core)
Client register	7.5	7.4
Client relationships	7.6	7.5
Impartiality and conflicts of interest	7.7 (Core)	7.6 (Core)
Client education and information	7.8	7.7
Feedback on education materials	7.9	7.8
Selection of survey team	7.10	7.9
Survey planning	7.11	7.10
Timetable	7.12	7.11
Survey tools and guides	7.13	7.12
Survey reporting	7.14	7.13
Report review	7.15	7.14
Evaluation	7.16	7.15
Standard 8: Accreditation or Certification Awards		
Responsibilities for awarding accreditation	8.1 (Core)	8.1 (Core)
Award certificate	8.2	8.2
Appeals process	8.3	8.3
Monitoring outcomes	8.4	8.4
Monitoring continued compliance	8.5 (Core)	8.5 (Core)
Follow up of concerns	8.6 (Core)	8.6 (Core)
Certificate and logo	8.7	8.7
Public information	8.8	8.8
Survey records	8.9	8.9
Evaluation	8.10	8.10

Change in Scale

	5th Edition	4th Edition
Standard	8	8
Criteria	95	94

Review Committee

Salma Jaouni (HCAC), Lena Low (ACHS), Moyra Amess (CHKS), Elaine O' Connor (ISQua EEA), Gillian Conway (ISQua EEA) and Nicola McCauley-Conlan (ISQua EEA)

Change Log

Date	Vers #	Summary of changes made
March 2022	1.1	■ International Society for Quality in Health Care (ISQua) replaced with International Society for Quality in Health Care External Evaluation Association (IEEA). ■ Board Accreditation Committee (BAC) replaced with External Evaluation Award Committee (EEAC). ■ Glossary – new definition of equity added ■ Section 5.3 The Award – additional text added regarding role of the EEAC

ISQua EEA

International Society for Quality in Health Care
External Evaluation Association

International Society for Quality in Health Care
External Evaluation Association (ISQua EEA),
Multifiduciaire Genève,
Carrefour de Rive 1,
Case postale 3369,
1211 Genève 3
Switzerland

www.ieea.ch