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**Assessing the Impact of Healthcare Accreditation from the
Perspective of Professionals' in Primary Healthcare Centres: A
Mixed Methods Case Study from Kuwait**

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MBBS, MPH

**Submitted in fulfilment of the requirements for the Degree of Doctor of
Philosophy**

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Institute of Health and Wellbeing
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Abstract

Objective: Although a modest body of literature exists on accreditation, little research has been conducted on the impact of accreditation on primary healthcare organizations in the Middle East. This study aimed to assess the impact of accreditation on primary healthcare centres in Kuwait, from the perspective of healthcare professionals. The study also aimed to develop an understanding of the impact of implementing an international programme of accreditation in the country's developing primary care system and to identify the facilitators and barriers resulting from the introduction of such a programme in the primary healthcare setting.

Context: A range of methods were used in order to evaluate the impact of accreditation on primary healthcare centres in Kuwait following an accreditation programme implementation in selected public PHC centres. This included a systematic review, followed by fieldwork in Kuwait. Fieldwork comprised a quantitative survey based on Primary Healthcare (PHC) centres and qualitative interviews conducted with key healthcare professionals. The PHC centres were divided into early adopters and late adopters in order to explore possible differences in the perceptions of the health professionals in each setting.

Subjects and Methods: The work employed a mixed methods approach, with three inter-linked studies in order to answer the research questions. The first study was a systematic review of the international literature published between 2003 and 2013. The results were analysed and guided using Normalization Process Theory which is often used to understand the implementation of complex interventions such as accreditation. The second study was a self-administered anonymous questionnaire distributed to 520 employees in three PHC centres defined as early adopters conducted in summer 2015. The return was 375 questionnaires achieving a 72 % response rate. Analysis included Pearson's Chi-squared tests to test for significance, Kruskal-Wallis tests and multiple regression models. The third study was qualitative semi-structured interviews with 18 key stakeholders in the Kuwaiti Ministry of Health, including the Quality and Accreditation department, local surveyors and heads of PHC centres. The interviews were conducted between October 2015 and June 2016. Finally the key results from each study were compared and synthesised using Normalization Process Theory to fully understand the 'work' underpinning the implementation of accreditation.

Results: Results from all the research methods were analysed and synthesised using Normalization Process Theory. While policies and those involved in the strategic planning of accreditation may have a clear idea of what accreditation was trying to achieve, this was

not always clear to those on the ground. Becoming involved in the accreditation process and doing the work required by accreditation enabled individuals to develop a clearer view, and understanding of what accreditation was about. Taking part also helped individuals see the value and benefits of being an accredited organisation. Employee engagement and participation in the accreditation programme helped break down professional barriers, created a sense of teamwork, and increased confidence in the process and what accreditation was aiming to achieve. The systematic review identified several strategies that promoted staff engagement in the accreditation process, including selecting key facilitators or ‘champions’, assigning credible leaders that champion continuous quality improvement, and explaining the ethos behind the accreditation process. The qualitative interviews suggested that staff awareness and involvement had increased, and that this may have empowered employees within the workplace and allowed them to voice their opinions more freely. The data across the three studies suggest that the more staff participated in the tasks associated with accreditation work, the more confident they tend to be about the positive impact that accreditation plays on quality improvement and the role they have to play in the process. Financial support for accreditation came up in all three studies, but particularly in the review and the interviews. Financial support was a major barrier which has affected several different aspects of the accreditation programme, including staffing issues, information dissemination, and training. Staff shortages and turnover were another issue that impacted the sustainability of the programme. An important facilitator during the accreditation process was the provision of training and documentation, including guidelines and clear standards. Finally accreditation was seen to improve the quality of services delivered, in particular through standardising delivery of services, improving the local healthcare culture and improving teamwork and collaboration across the PHCCs.

Conclusion: The suggested findings show that while professionals project a positive attitude towards accreditation, their views are not built on substantial information and not supported by evidence based research or monitoring plans that could determine and quantify the exact benefits to accreditation when it comes to quality.

While evaluating such quality improvement programmes can be difficult, it is not impossible. While this study contributed to the knowledge of how professionals perceive the outcomes of accreditation, there was no opportunity to assess patient views. Patient views of accreditation remains an under researched area and, again, a programme of research would be beneficial to the long-term implementation of accreditation programmes.

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Dedication

I grant this achievement to my lovely family especially my awesome mother, who taught me that nothing is impossible, provided me the buoyancy to believe in myself and her prayers have enlightened my way all along; to my father, who has guided my path from the very start and encouraged me to continue this journey despite his sickness and his need to have me by his side; to my loving sisters, Eng. Haifa, Amina and Hana for their never ending support and encouragement and for being there for me throughout the entire doctorate programme; to my beautiful brothers and friends who have supported me throughout the process, especially my exquisite friend Mrs. Daniah Turjman for her endless support and believe in me-if it was without your support, I would have never been able to embark on this journey; to my best friend Dr. Mariam Al- Failkawy who always believed in me and have been with me in every step of the way through the good and the bad; to the joy of the family my nieces Amar and junior Lamia as well as my nephews; Hamad, Bader, and Rakan for being patient and understanding when I did not have enough time for them because of my studies and whose smiles gave me positivity and assurance.

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Limya Alaradi

Glasgow, August 2017.

Declaration

I, Limya Alaradi, confirm that I as the named author conducted the research study detailed in this thesis. The research was carried out at General Practice and Primary Health Care, Institute of Health and Wellbeing, University of Glasgow, under the supervision of Prof. Kate O'Donnell and Prof. Graham Watt. I declare that all the material presented in this thesis is my own work unless specifically stated otherwise.

Limya Alaradi

Glasgow, August 2017.

List of Abbreviation

ACI: Accreditation Canada International
ACS: American College of Surgeons
CCHSA: Council on Health Services Accreditation
CDs: Communicable Diseases
CI: Confidence Intervals
CVD: Cardio Vascular Disease
DALYS: Disability-Adjusted Life Years
EMR: Eastern Mediterranean region
EMRO: Eastern Mediterranean regional Office
ENT: Ear, Nose, and throat
GBD: Global Burden of Disease
GCC: Gulf Cooperation Council
GDP: Gross Domestic Product
GPs: General Practitioners
HACA: Higher Advisory Committee on Accreditation
HR: Human Resources
HSRP: Health Sector Reform Programme
ISO: International Standards Organization.
IT: Information Technology
JCAHO: Joint commission on Accreditation of Healthcare Organizations
JCI: Joint commission International
KIMS: Kuwait Institute for Medical Specialization
KSE: Kuwait Stock Exchange
MDGs: Millennium Development Goals
MESH: Medical Subject Headings
MOH: Ministry of Health
MPH: Ministry of Public Health
NCDs: Non Communicable Diseases
NGOs: Non-Governmental Organizations
NPT: Normalization Process Theory
OECD: Organization for Economic Co-operation and Development
PCO: Primary Care Officer
PCT: Primary Care Trust
PHC: Primary Health Care

PHCC: Primary Health Care Centre
PIS: Participant Information Sheet
PMCPA: Primary Medical Care Provider Accreditation
Q&A: Quality and Accreditation
QI: Quality Improvement
QPA: Quality Practice Awards
QTD: Quality Team Development
RCGP: Royal College of General Practitioners
SR: Systematic Review
TQM: Total Quality Management
UAE: United Arab of Emirates
UK: United Kingdom
US: United States
WHO: World Health Organization
YLD: Year Lived With Disability

Definition of Key Terms

- **Patient safety:** A culture adopted in a healthcare environment which revolves around the prevention of harm to patients and learning from errors which take place for future prevention.
- **Quality improvement:** The formal approach to analysing performance in a healthcare organization and what systematic and continuous efforts are required from concerned parties to further improve services in terms of enhanced patient outcomes, system performance, as well as professional development (Batalden et al., 2002).
- **Self-assessment:** The Process of assessing an organization in terms of performance against pre-set standards (ACI, 2008).
- **Early adopter PHCs:** Those PHCs that have implemented the accreditation process before others and have undergone the pilot-surveying phase in the presence of the Accreditation Canada International (ACI).
- **Late adopter PHCs:** Those PHCs that have been introduced to the accreditation concept relatively recently, and although they have received local training, lectures, and local surveying by MOH, they still have not been surveyed by the accrediting agency (ACI). They considered not having enough knowledge and experience in dealing with all the related issues of accreditation.
- **Stakeholders:** Individuals or parties who can affect or be affected, directly or indirectly, by an organization's activities. In this study, some stakeholders included directors, local surveyors, several heads of PHC centres and coordinators at the MOH (Thomas and Poister, 2009).
- **Accreditation Body:** An organization delegated to make decisions about the status, legitimacy, and appropriateness of an institution or programme (UNESCO, 2007).
- **Quality Management System:** Set of policies, processes, and procedures required for planning and execution, and which defines how an organization will deliver the service to the end user (Mark, no date).
- **Quality Indicators:** Measures of healthcare quality which utilize existing internal data to gauge performance.

"Unilaterally cutting cost won't eliminate the inefficiencies, unnecessary procedures and avoidable burdens on the system. But if we work together with fresh thinking and strategically-smarter spending, we can recast into a more and humane and efficient health care system and the lower overall costs to governments will follow. "

DR. LOUIS HUGO FRANCESCUTTI

CHAPTER 1: Introduction and overview of the study

1.1. Introduction

This chapter will provide a general introduction to this PhD, describing accreditation and the need to develop such programmes in the primary healthcare sector. It will also detail the purpose of this study, the research questions, theoretical framework, assumptions and the significance of the study.

The drive for quality healthcare has made the accreditation process an increasingly popular subject in the field of healthcare. Ensuring that desired health outcomes are consistent with current professional knowledge is a major factor in providing effective and efficient healthcare services.

The Accreditation Commission for Health Care (ACHC) defines accreditation as

“A process of review that healthcare organizations participate in to demonstrate the ability to meet regulatory requirements and accreditation standards established by a recognized accreditation organization”

Thus, accreditation schemes allow organizations, such as hospitals, to compare their health services against nationally or internationally agreed benchmarks. This enables them to measure their performance against pre-established standards, with the aim of providing high standard quality services in an effective and efficient manner. However, whether these accreditation programmes are actually affecting the quality of healthcare, and to what extent, is yet to be further explored and measured.

Accreditation schemes in the Middle East are quickly picking up pace, and many hospitals are becoming involved in improving their health standards by implementing such schemes to gain the status of reliability and to show their commitment to improving health standards. There is, however, very little parallel work in primary care. This study was undertaken to fill this knowledge gap in one country's primary healthcare system – Kuwait - exploring the effects of accreditation on the delivery of primary care services, and in particular to understand professionals' perspectives towards accreditation in primary healthcare. Such a programme can be rigorous and demanding, not to mention time and resource consuming, and thus being able to measure its value and reliability is imperative. The results of this study will, therefore, offer a more in depth understanding about the

impact of implementing an international programme of accreditation in one country's developing primary care system.

1.2. Background

Accreditation is a benchmarking and assessment process used in almost every industry whereby organizations develop standards against which performance is measured. These standards are usually developed by an international or national organization, and then applied to more local organizations. Such measures should provide a basis to build upon and develop initiatives for improvement. It is also recognized that receiving the status of being accredited can offer a mark of distinction and status among competing organizations.

Healthcare institutions are under immense pressure to demonstrate improvement in order to cope with the economic pressure (Olsson et al., 2003; Pomey et al., 2010), with quality standards continually being developed to improve healthcare quality and delivery. Coupled with increased expectations to provide quality care, it is no wonder we are observing an increased interest in international healthcare accreditation (Lovern, 2000).

Accreditation in healthcare dates back to the early 20th century, with the formation of the Minimum Standards for Hospitals in the United States by the American College of Surgeons in Chicago. After establishing these standards, the College then began to monitor hospitals in order to identify which of the hospitals were meeting these standards. This eventually evolved into the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) (Wright, 2017).

Established in 1951, the JCAHO is a not for profit organization which seeks to continuously improve health care for the public. It is one of several internationally recognized accreditation, setting standards and accrediting health care organizations worldwide. In recognition of its expanding role and remit from the hospital sector to health care more widely, it re-branded to become the Joint Commission in 1994, with its international work overseen by the Joint Commission International (JCI). Another well recognised international accreditation body – and key in this thesis – is Accreditation Canada. Established in 1958, it has similar aims to the Joint Commission and a growing international role under the banner of Accreditation Canada International (ACI) (Patients beyond Borders, 2011).

History, society, economy and politics together affect the priorities identified in national accreditation programs (Shaw et al., 2003). Developed countries, such as the US and

Canada, were pioneers in implementing and introducing accreditation in healthcare. In developing countries, accreditation has focused on building capacity and expanding access to care, often in settings where there may be a lack of resources for the recruitment of personnel, equipment or even infrastructure, such as buildings (Shaw et al., 2003). Therefore, each country has to evaluate and measure the effects of accreditation within its own setting (Shaw, 2003).

In the Middle East, the practices adopted in the delivery and assessment of healthcare quality stem from either the JCI or the ACI, which introduced accreditation processes to the Middle East Region in 2000 (Hojjati and Vahdani, 2010). Accreditation is seen as a means to recognize high-performing organizations and departments integrating quality improvement into their normal daily work, and aiming to improve efficiency and effectiveness (Bender and Halverson, 2010). However, as quality is considered to be the responsibility of everyone in a healthcare organization, it is vital that all staff members are engaged in the process (American Society for Quality, 2011).

Research has been conducted into the impact of accreditation on healthcare organizations, especially in the hospital sector. A systematic review, conducted in 2008, identified 66 studies which explored the impact of accreditation. These studies focused on 10 areas: the attitude of professionals towards accreditation, promotion of change, the impact on the organization itself, the economic impact, determinants of quality, programme evaluation, patient satisfaction, public opinion, development of skills, and surveyor problems (Greenfield and Braithwaite, 2008). The review found that two categories - change promotion and development of skills - were fairly consistent, with significant improvements in accredited hospitals. The evidence was inconsistent across five other categories, namely the attitude of professionals towards accreditation, the impact on the organization, the economic impact, quality and programme assessments (Greenfield and Braithwaite, 2008). Finally, there was not enough research conducted to draw conclusions about the impact of accreditation on patient and public views or surveyor roles (Greenfield and Braithwaite, 2008).

Several studies tried to compare performance between accredited and non-accredited organizations. According to Schmaltz, JCI accredited hospitals demonstrated greater improvements in their performance from 2004 to 2008 compared to non-accredited hospitals (Schmaltz et al, 2011). This finding was supported by Alkhenizan and Shaw (2011) who found that clinical outcomes improved in accredited hospitals, including

trauma care, pain management and infection control (Alkhenizan and Shaw, 2011). However others found no difference in performance between accredited and non-accredited hospitals (Bogh et al., 2015).

1.2.1. Accreditation in the Middle East

In the Eastern Mediterranean Region, Lebanon was the first country to establish and implement an accreditation system in its hospitals (El Jardali et al., 2008). El Jardali et al studied the impact of this accreditation, technically and interpersonally, on the quality of care provided by hospitals, from the nurses' point of view. The results revealed that nurses judged accreditation to have a positive impact on improving quality, with this impact more significant in small and medium hospitals than in relatively larger ones (El Jardali et al., 2008). Another study by Al Awa et al (2011) surveyed nursing staff in King Abdul-Aziz University Hospital in Saudi Arabia, on the quality of care before and after the implementation of accreditation. Overall, nurses were positive about the impact, with a statistically significant improvement in perceived quality of patient care and safety after the implementation of the accreditation process (Al Awa et al., 2011). Accreditation in the Middle East will be discussed further in chapter 4.

1.3. Context

In Kuwait, the Ministry of Health (MOH) is leading a national comprehensive action plan targeted at quality improvement, both in the hospital and primary care settings (Shaw et al., 2003). To support this, the MOH chose Accreditation Canada to develop an accreditation programme for Kuwait (Accreditation Canada, 2008). Consequently, a contract between Kuwait MOH and Accreditation Canada International (ACI) was signed to cover both hospital and primary healthcare accreditation programmes (Ministry of Health, 2012). This will be described in more detail in Chapter 4.

1.4. Outline of the thesis topic

As will be described later, the focus of this thesis is primary healthcare in Kuwait. In Kuwait there are 92 Primary Healthcare Centres (PHCCs) distributed among five medical regions. At the initial phase of accreditation, a pilot for the overall accreditation process was conducted in 5 PHCCs under the supervision of ACI in affiliation with the MOH. Subsequently, 15 PHCCs started on the accreditation journey under local supervision, with the remaining 72 centres to follow later. However, as will be discussed in a chapter 4, most

of the current international literature on the impact of accreditation focuses on hospital-based care. The purpose of this work, therefore, was to explore the process of implementing accreditation in primary care in Kuwait, with a particular focus on the views of both PHCC professionals and MOH personnel involved in accreditation.

This research is the first study to be conducted into accreditation in primary care in Kuwait. Thus, this is an important opportunity to explore the impact of accreditation on staff and those implementing it and to increase awareness among policy makers in Kuwait and how accreditation is being implemented. Also, to identify opportunities to amend or modify the accreditation process in the future.

1.5. Aim and objectives

The overall aim of this study was to examine the implementation of accreditation in primary healthcare in Kuwait from the perspectives of the different professional groups involved, namely policy-makers, Heads of PHCCs, surveyors and staff.

The research objectives were:

- To better understand the barriers, facilitators, and impacts of accreditation in the primary care setting on practitioners.
- To assess the professionals' attitudes towards accreditation and to explore how practitioners perceived and evaluated the impact that accreditation has on health care services.
- To develop a more detailed understanding of the impact of accreditation standards at PHCCs level.
- To compare and contrast key stakeholders' attitudes, beliefs, and perceptions about the accreditation programme between those who were early adopters and those who were late adopters.
- To identify the drivers, barriers, and impact of the accreditation process, and identify future strategies for better implementation.

1.6. Methodological approach

This was a mixed methods study, comprising three related studies. Firstly, a systematic review of the available international literature was conducted, focused on accreditation in primary health care. Secondly, the views of health care professionals working in a sample

of PHCCs which participated in the accreditation programme were sought through administration of a questionnaire. Thirdly, a qualitative study was conducted, to seek the views of key stakeholders with regards to the current and potential roles of the accreditation programme, and its impact on primary health care services.

1.7. Thesis structure

The thesis consists of 10 chapters. The first introductory chapter gives an overview of the study and defines the main purpose of the study.

The second chapter gives an overview of the State of Kuwait's profile in terms of its geography, demographics, and educational system, in order to understand the population characteristics and consequently lead to a better understanding of the major health problems and challenges facing the healthcare system in Kuwait. Throughout this chapter, a comparison between Kuwait and other Gulf Cooperation Council (GCC) countries is presented, to examine Kuwait's status and development among GCC countries which share a similar cultural and political profile. The healthcare system of Kuwait is briefly discussed in this chapter with a general overview on the health profile of the population in Kuwait, and the major challenges that face healthcare system reform.

Chapter three discusses primary health care as a concept and progresses into the development of accreditation within primary care. It begins with a definition of primary care, its place in wider health systems and its key components, drawing in particular on the work of Starfield and, later, Kringos. The chapter ends with highlighting the importance of investing and strengthening primary care through accreditation.

Chapter four focuses on accreditation and addresses the different accreditation schemes existing in a variety of country programmes or systems. It provides an overview of the advantages and drawbacks of accreditation in general and in the Eastern Mediterranean Region (EMR) in particular. The chapter will end with a discussion of the development of accreditation in Kuwait.

Chapter 5 explains the methodological and theoretical frameworks used for this study. As such, this chapter presents a layout of the methodological approaches selected for the current research. In addition, it discusses the importance of adopting a theoretical framework for data collection and analysis. The theoretical framework underpinning this

work is Normalisation Process Theory (NPT); the reasons for selecting this framework are described here as is the rationale behind choosing the case study design and mixed method approach.

Chapters 6 to 9 present the main findings of each of the studies that make up this thesis. Chapter 6 is a systematic review of the international literature addressing the impact of accreditation in primary healthcare, which answers the first research question. Chapter 7 is a short contextual chapter describing the study sites in Kuwait, including the six health regions and the primary care settings where fieldwork was conducted. It describes the distinction between early and late adopters of accreditation and the basis on which they were chosen to participate in the quantitative and qualitative research.

Chapter 8 presents the findings from a quantitative survey of primary care staff who participated in the accreditation of three primary care centres. Chapter 9 presents the results of the qualitative semi-structured interviews with key stakeholders.

Finally, Chapter 10 discusses the findings from all three studies, along with consideration of the implications of the findings for professional practice and further research. It will end with recommendations for the future development of primary care accreditation in Kuwait, and internationally.

CHAPTER 2: The history and characteristics of the state of Kuwait

2.1. Introduction

This chapter gives an overview of the State of Kuwait. The geography, demographics, and education system are presented to understand the population characteristics and lead to a better understanding of the major problems and challenges facing Kuwait. The economy and welfare regime of Kuwait are discussed, as are the main industries and employment rates in the State of Kuwait among Kuwaitis and non-Kuwaitis. Throughout this chapter comparison between Kuwait and other Gulf Cooperation Council (GCC) countries is presented, including economic and health indicators to examine Kuwait's status and development among GCC countries which share a similar cultural and political profile. Finally, the healthcare system of Kuwait is briefly discussed, with a general overview on the health profile of the population in Kuwait, the main health delivery systems and the major challenges that face healthcare system reform.

In writing this chapter, several sources of literature and data were used. In describing the economic and educational development of Kuwait, local reports and data from the International Labour Organization Regional Office, 2013; United Nations Development Programme, 2016; and United Nations Educational Scientific Cultural Organization, 2016 reports were used. Several sources of data were selected to describe Kuwait's health profile, selected from international organisations and projects with recognised and comparable methods of data collection and analysis, in order to facilitate comparison both across the region and internationally. These include: the Global Burden of Disease project and its related publications, and the WHO World Health Statistics report for 2015 as well as data from the World Bank, 2015 report. Local data were obtained from Al Diwan Al Amiri, 2014 and the Ministry of Health, Kuwait, 2012.

2.2. Overview of Kuwait governance

Kuwait is an Arab country located in the north east of the Arabian/Persian Gulf (Fig. 2.1). The country covers an area of 18,000 square kilometres and is bordered by Iraq to the north and west, by the Kingdom of Saudi Arabia to the south and west, and on the east by the Arabian/Persian Gulf. Kuwait City is the capital of the State of Kuwait and it is located on its eastern coast. Since Kuwait is located in a desert region, the climate is distinguished by long hot dry summers and warm short winters with occasional rainfall. Sandstorms

often occur during the summer months. The country's per capita income (USD 85,819) is one of the highest in the world (UNDP, 2016). Arabic is the official language of the country, but English is widely understood and used (CIA, 2010).

Figure 2. 1 Arabian Gulf Map



The State of Kuwait is divided into six governorates (akin to regions), which are the Capital (Kuwait), Hawalli, Al Farwaniya, Al Ahmedi, Mubarak Al Kabir and Al Jahra (Fig.2.2). The country is ruled by a monarchy system. The executive authority lies in the hands of the Amir who assigns the ministerial cabinet, comprised of 15-16 ministers upon the request of the Prime Minister. In addition to the Cabinet of Ministers, a National Assembly exists. The National Assembly consists of fifty members who are elected by Kuwaiti citizens in accordance with the provisions of the election law (Al Diwan Al Amiri, 2014). No law may be passed unless it is approved by the National Assembly and signed by the Amir. The term of the National Assembly is four years, starting from the date of its first meeting (Al Diwan Al Amiri, 2014).

Figure 2. 2: Kuwait Governorates Map



2.2.1. Kuwait as part of the Gulf Cooperation Council

The Gulf Cooperation Council (GCC) is a union among some Arab countries of the Persian Gulf which are viewed as sharing political and economic unity. Kuwait, together with Bahrain, Oman, Qatar, Saudi Arabia and the United Arab Emirates constitute the GCC countries and meet regularly (Qureshi, 1982). All of the GCC countries are considered high income countries (Appendix A).

2.3. Characteristics of the population in Kuwait

2.3.1. Population size

Data from the World Bank predicts population growth in the state of Kuwait, with the population increasing from 3.8 million in 2014 to 4.7 million in 2025 (World Bank, 2015).

The population is made up of Kuwaitis, who are citizens of the State of Kuwait, and non-Kuwaitis, who are only residents of the State of Kuwait. In 2009, Kuwaitis constituted around 30% of the total population, and non-Kuwaitis around 70% (World Health Survey in Kuwait, 2013) (Table 2.1).

Table 2. 1: Distribution of Population in Kuwait by Gender and Nationality

Kuwaitis		Non-Kuwaitis		Total	
Males	Females	Males	Females	Males	Females
571,076	593,369	1,612,590	854,971	2,183,666	1,448,340
1,164,445		2,467,561		3,632,006	

*(Public authority of civil information)

2.3.2. Population distribution

The majority of the population is aged between 15 and 64 years constituting 75% of the total population, whereas only 2% are 65 or older (Table 2.2). This high percentage of working age adults can be attributed to the presence of high number of non-Kuwaitis who come to Kuwait for work, as seen when the population pyramids of non-Kuwaitis and Kuwaitis are compared (Figures 2.3 and 2.4).

Table 2. 2: Population Distribution by age in % of the total in the State of Kuwait

Population distribution by Age (% of total)				
	2011	2012	2013	2014
0-14	23	23	23	22
15-64	75	75	75	76
65+	2	2	2	2
Population Total (Millions)	-	3.4	3.6	3.8

Source: World Bank, 2015

Figure 2. 3: Population Pyramids of non-Kuwaitis in 2009 (World Health Survey in Kuwait 2013)

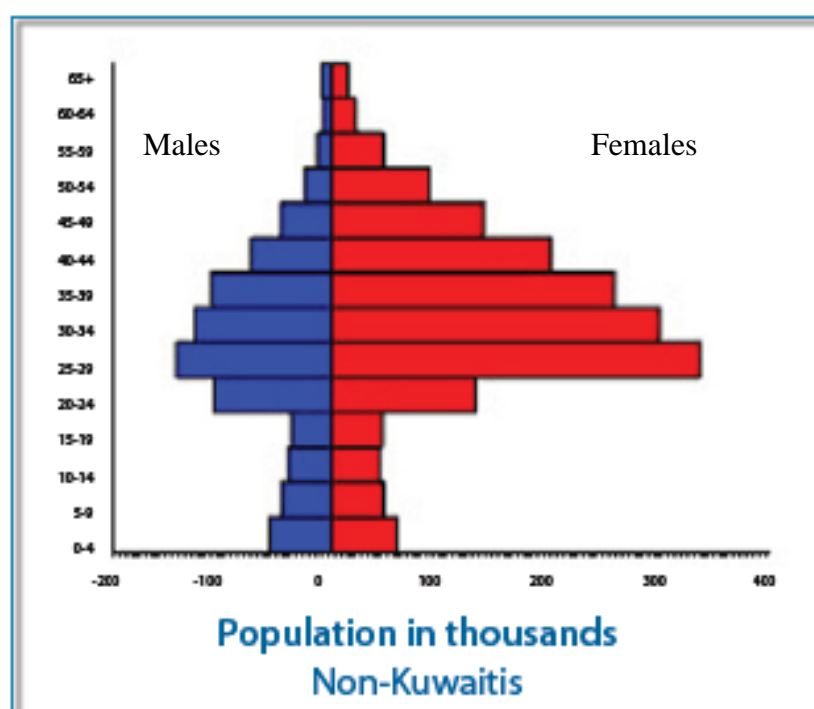
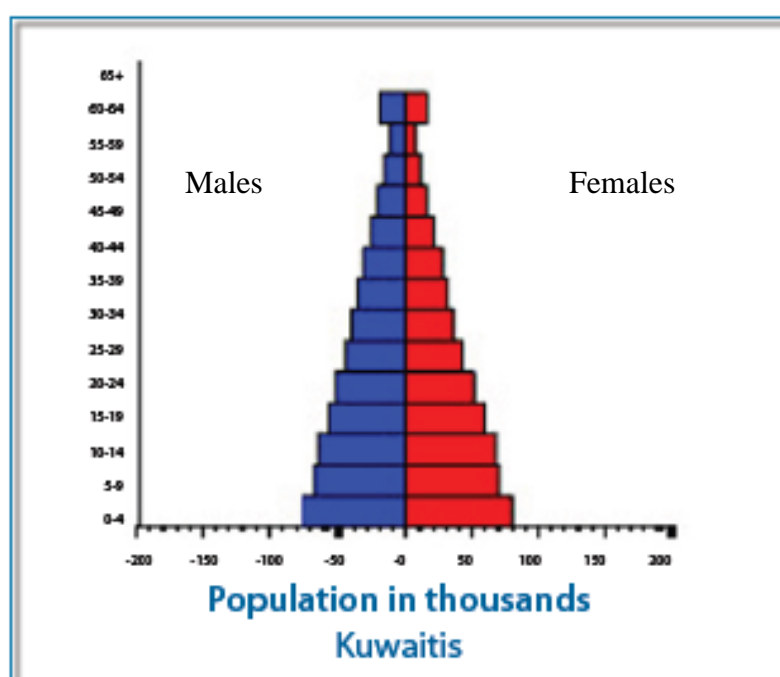


Figure 2. 4: Population Pyramids of Kuwaitis in 2009 (World Health Survey in Kuwait, 2013)



The high number of non-Kuwaiti workers is due, in part, to the discovery of oil in 1952 which made Kuwait one of the largest oil producing countries worldwide. Since then, Kuwait has been a destination for numerous foreign workers from all around the world.

Most foreign nationals in Kuwait come from Asia and the North African Arab countries (62% of the total population). Indians and Egyptians are also large groups, comprising 30% and 21% of the foreign population respectively. Foreign labourers are generally confined to services and “blue collar” occupations. In contrast, Arab expatriates often fill the upper level occupations (32% of Arab workers are in managerial, professional and clerical positions), although Egyptian expatriates are also found in manual and service jobs as well (Gulf Labour Markets and Migration, 2013).

2.4. Education

In Kuwait, pre-university education is divided into three levels: elementary, intermediate, and secondary. Education is free from elementary school to university for Kuwaitis. It is also compulsory for Kuwaitis from the age 6-14 (UNICEF, 2003; Oxford Business Group, 2010). Saad Akashah, a senior adviser at the Arab Fund for Economic and Social Development said:

“We have been financing health and education longer than anywhere in the region. This is the foundation on which the country was built”.

This has allowed Kuwait to have strong indicators of educational achievement (Oxford Business Group, 2010: p.180). In 2015, the adult literacy rates for those aged 15 was 96% (World Bank Data, 2015), one of the highest in the GCC region (WHO, 2013).

The Ministry of Education supervises and regulates the Education sector including public and private schools. In 2007, there were 703 Government schools providing education to 340,000 students. However, admission to state schools is restricted to those who fit the following categories: Kuwaiti children, the children of teachers who work for the Ministry of Education, and non-Kuwaiti children whose parents obtained Kuwaiti residency prior to 1960 (Oxford Business Group, 2010). In 2007, 65.6% of students were educated in state schools, although private education is now becoming more popular, especially for non-Kuwaitis (Oxford Business Group, 2010). In 2006, around 4% of Kuwait's GDP was spent on education (UNESCO, 2016). This figure is in line with the trends of high income countries for expenditure on education. This has allowed Kuwait to achieve one of the Millennium Development Goals (MDGs) in the area of education, namely that of enhancing female education. The percentage of females enrolled in schools for primary education increased to 99.9% in 2005 and girls also had higher secondary school enrolment rates than boys (UNESCO, 2008).

2.5. Economy

2.5.1. Distribution and contribution of industries to the economy

Although Kuwait is small geographically, it is considered a high income country and contributes high oil rents as a percentage of GDP among GCC (Table 2.3).

The economy of Kuwait, like the majority of the GCC countries is an oil-based growth model economy. Aside from petroleum, which accounts for more than 6% of the world's reserve of crude oil, Kuwait's other natural resources include shrimp, fish and natural gas (CIA, 2014). Industrialization is thus crucial for the development and progression of Kuwait's economy since the country is mainly dependent on oil production and exports. According to Forbes Magazine in 2012, Kuwait ranked 15th in terms of the wealthiest countries around the world. Qatar ranked first followed by UAE in 6th place (Forbes, 2012).

Table 2. 3: Oil rents (% of GDP) in GCC

Country	2011	2012	2013
Kuwait	58.6	57.7	57.5
Bahrain	21.2	17.9	17.1
Oman	40.1	36.1	34.5
Qatar	29.9	26.0	23.4
Saudi Arabia	48.1	45.8	43.6
United Arab Emirates	25.1	24.1	21.6

* “Oil rents (% of GDP): Oil rents are the difference between the value of crude oil production at world prices and total costs of production.” (World Bank, 2015)

Although oil production is the main industry within Kuwait, the diversification of its production base has always been an important issue for the government of Kuwait. The government has been struggling to reduce the country’s dependence on the oil sector and has been continuously seeking to expand its national income sources such as the production of other goods. In 2010, a five-year economic development plan was passed that aimed to diversify the economy away from oil, incentivize more investment, support national products and boost both private and national industries, though much of these funds are yet to be allocated (Central Intelligence Agency, 2014). With the 2015-2016 oil crises affecting the oil rich countries, Kuwait continues to invest and strengthen industries that are not related to non-renewable resources such as oil and natural gas. Many promising medium to large scale manufacturing plants have been established producing food and beverages, textiles, clothing and leather, wood and wood products, paper and paper products, chemicals, coal, rubber, plastic, non-metallic minerals, machinery, and equipment.

2.5.2. Employment status

Kuwait ranks second lowest in terms of unemployment among the GCC countries after Qatar. However, unemployment has doubled from the year 2010 to 2012 (Table 2.4). This may be due partly to youth unemployment. In addition, the fact that non-Kuwaitis accept work as labourers with low wages whereas Kuwaitis do not, has also offered an advantage to recruit non-Kuwaiti labourers over Kuwaitis in certain industries.

Table 2. 4: Unemployment, total (%of total labour force) in GCC

*Unemployment, Total (% of total labour force)					
Country	2006	2008	2010	2012	2014
Kuwait	1.3	1.8	1.8	3.4	3.0
Bahrain	4.1	3.7	3.6	3.7	3.9
Oman	7.8	7.7	7.6	7.4	7.2
Qatar	0.9	0.3	0.4	0.5	0.3
Saudi Arabia	6.3	5.1	5.4	5.6	5.6
United Arab Emirates	3.3	4.0	4.2	4.0	3.6

**"Unemployment refers to the share of the labour force that is without work but available for and seeking employment." (World Bank Data, 2015)*

Although unemployment in Kuwait increased from 2006 to 2014, the percentage of women in employment and the labour force has increased since 2005 (25.2%) to reach 33.2% in 2011 (ILO, 2013). Among women, a substantial increase in percentage of employment among Kuwaiti women specifically was observed. Empowering women's role in the society may have played a crucial role in increasing the number of women employment in Kuwait (UNDP, 2016).

2.6. Welfare regime

The Kuwaiti Government provides Kuwaiti citizens with a number of services that come in the form of welfare support. Those services include: free health services, employment services, the provision of public housing, subsidised mortgages and household utility costs to encourage home ownership, providing family allowances according to the number of family members to increase the population (Merza, 2007), and giving out marriage allowances for couples and for every child born (Al-Bustan and Batistella, 1988). In addition to that, the State of Kuwait subsidises utilities such as water, gas, electricity and telecommunication.

There is also support for Kuwaitis from other sources, in particular from the Kuwaiti tribes, clans and extensive family networks. Those groups provide additional support for the elderly, divorced women, and orphans. As a result, poverty among Kuwaitis is very low (Stiftung, 2009). Although the government does not provide free health services for the non-Kuwaiti population, the state is putting in efforts to enhance the healthcare system's

performance to accommodate the high percentage of the non-Kuwaiti population seeking healthcare. This is discussed in greater detail in the next section.

2.7. The healthcare system in Kuwait

2.7.1. Introduction

The healthcare system in Kuwait has improved in the last few years, with a vision of focusing on improving the quality of healthcare delivery and on providing preventive services. As such, primary healthcare delivery is getting more attention from policy makers who are willing to invest in improving the quality of primary care in Kuwait.

This section discusses the healthcare system of Kuwait in terms of its distribution, accessibility and healthcare delivery. It also provides a general overview on the health profile of the population in Kuwait and the indicators that could serve as evidence to strengthen the governance and monitoring of the healthcare system. Also it depicts the three levels of health care as well as the health information system in Kuwait.

2.7.2. Role of Kuwait's Ministry of Health

2.7.2.1. Stewardship of the healthcare system

The Ministry of Health (MOH) was established in 1936. It is one of the largest ministries in Kuwait after the Ministries of Education and the Interior, and is responsible for the provision of 80% of healthcare services to the population. Other organisations also have some responsibility for providing healthcare, for example, the Ministry of Defence provides care for its entire staff. The Kuwait Oil Company has developed its own hospitals for their employees and the Ministry of Social Affairs provides care targeted at the disabled and elderly (WHO, 2006). The main role of the MOH is to regulate, control, evaluate, finance, allocate resources, and deliver care services. The strength of the Ministry lies in the provision of healthcare and the ability to prioritize reforms for an improved health system. The MOH's structure involves twelve functional divisions embracing 42 central departments and offices at the central level (Ministry of Health Kuwait, 2012).

2.7.2.2. Healthcare system governance

Kuwait's national health plan 2010-2014 aimed to increase accessibility of healthcare services across the regions in Kuwait by providing a strong infrastructure of health centres, skilled healthcare professionals and advanced technological advances in the health sector. Around 80% of deaths in Kuwait are due to non-communicable diseases, which are

discussed further in section 2.7.6. Reasons for this might include a weak primary care system (WHO, 2014), where the emphasis on health promotion and prevention is traditionally found, and a lack of policy reform that prioritizes preventive care. Currently Kuwait is still behind other high income countries with regard to the monitoring and supervision of the healthcare sector. There are no recognised standards for maintaining privacy and confidentiality of medical records, licensing of health care professionals, liability, or suitable payment mechanisms for healthcare services (Al Mutairi, 2011). Moreover, there are no methods to assure ethical standards in the health system. In order to address this, it has been suggested that there needs to be an independent and formal body that sets appropriate and clear regulations (Shukri, 2009).

2.7.3. Health expenditure

According to the World Development Indicators from the World Bank, the Government percentage spend of total health expenditure in 2013 for Kuwait was 82.6%, which was higher than the global mean (59.6%), and higher than in most of the GCC countries (World Bank, 2015).

Table 2. 5 : Health spending from a range of sources, averaged over 1995 to 2014: Kuwait comparison (from Global Burden of Disease Health Financing Collaborator Network, 2017)(For details on high, middle and low income countries see appendix A)

Note: Data in brackets are the range for that category.

Region/Country	Total health pending per capita (US\$)	Total health expenditure per GDP (%)	Government health spending per total health spending (%)	Prepaid private spending per total health spending (%)	Out-of-pocket spending per total health spending (%)	Development assistance for health per total health spending (%)	Annual rate of change in total health spend per capita, 1995 – 2014 (%)
Income Group							
High	5221 (853 to 9237)	11.7 (2.2 to 16.6)	63.4 (4204 to 93.9)	22.7 (0.0 to 38.8)	13.9 (2.4 to 55.7)	0 (0.0 to 0.1)	3.0 (-1.1 to 7.6)
Upper-middle	914 (228 to 1980)	5.9 (2.3 to 17.2)	57.2 (19.4 to 95.5)	8.7 (0.0 to 44.2)	33.8 (4.4 to 74.2)	0.3 (0.0 to 23.2)	5.9 (-3.0 to 17.0)
Lower-middle	267 (92 to 791)	4.3 (1.9 to 16.1)	35.9 (0.0 to 87.2)	3.1 (0.0 to 10.2)	58.0 (2.8 to 76.6)	3.0 (0.2 to 92.3)	5.0 (-1.4 to 9.4)
Low	120 (33 to 347)	7.3 (3.6 to 39.3)	18.0 (0.0 to 48.5)	17.2 (0.0 to 64.8)	29.1 (7.8 to 54.1)	35.7 (12.9 to 92.2)	4.6 (-3.0 to 19.7)
Global Burden of Disease Super Region							
North Africa and Middle East	870 (159 to 2663)	5.2 (2.2 to 9.7)	60.1 (14.3 to 91.8)	4.3 (0.0 to 14.9)	34.9 (5.9 to 76.6)	0.7 (0.0 to 30.9)	4.9 (-1.4 to 9.0)
GCC Countries							
Kuwait	2075	3.0	85.9	1.3	12.7	0.0	-1.1
Bahrain	2258	4.8	65.3	10.6	24.1	0.0	2.2
Oman	1467	3.5	91.8	2.3	5.9	0.0	1.6
Qatar	2663	2.2	85.7	7.4	6.9	0.0	0.7
Saudi Arabia	2320	4.4	78.7	6.2	15.1	0.0	5.0
UAE	2561	3.6	72.3	9.9	17.8	0.0	-0.4

Recent data from the Global Burden of Disease project (GBD)(<http://www.healthdata.org/>) confirm that this is still the case (Table 2.5). Over the period 1995 to 2014, Kuwait, like the other GCC countries, had a higher per capita health spend than the average for countries in the upper-middle income group and much higher than the GBD North Africa and Middle East region. Kuwait spends 3.0% of its GDP on health, with the Government accounting for 85.9% of the total, higher than most of the other GCC countries (Table 2.5). Private and out-of-pocket expenditure was lower; however, the annual rate of spend in Kuwait slowed over 1995 to 2014, and was currently -1.1%. Moreover, an 11-year average mean (2001–11) of total health and government health expenditure as a proportion of GDP for selected Arab countries, Turkey, Iran, and the world for comparison, Kuwait has one of the lowest percentages in terms of health expenditures (El Zein et al., 2014).

2.7.4. Healthcare manpower distribution

Between 2007 and 2014, the healthcare workforce in Kuwait was broadly similar to that of upper-middle income countries and, like the other countries of the GCC, is higher than the average for the WHO Eastern Mediterranean Region (Table 2.6) (WHO, 2015). The number of doctors increased from 362 in 1962 to 2641 in 1988, although as Table 2.6 demonstrates the increasing population means that the doctor to population ratio is now increasing relatively slowly. The overall healthcare workforce has increased since 2001 to 2014.

Table 2. 6: Health care workforce comparisons: Density per 10,000 population for 2007-2013 (WHO,2014; 2015)

	2007 - 2013				2014			
Region/Country	Physicians	Nursing and Midwifery	Dentistry	Pharmacists & Pharmacy technicians	Physicians	Nursing and Midwifery	Dentistry	Pharmacists
Income Group*								
High	28.7	88.2	6.5	10.1	-	-	-	-
Upper-middle	16.1	26.3	-	3.4	-	-	-	-
Lower-middle	7.9	18.0	1.2	4.2	-	-	-	-
Low	2.5	5.3	0.3	0.4	-	-	-	-
WHO Eastern Mediterranean Region*	12.7	18.0	1.9	6.5	-	-	-	-
GCC Countries								
Kuwait	17.9	45.5	3.5	3.0	19.5	47.3	6.0	4.8
Bahrain	9.2	23.7	2.4	1.5	9.4	24.5	2.5	1.6
Oman	24.3	53.8	2.8	18.8	15.4	33.5	18.5	3.5
Qatar	77.4	118.7	-	-	19.6	57.0	5.7	9.3
Saudi Arabia	24.9	48.7	0.9	5.4	25.7	52.1	4.0	7.0
UAE	25.3	31.6	4.3	5.9	15.6	30.6	3.1	3.7

For full details of included countries, see Appendix A(<http://apps.who.int/gho/data/node.main.A1444?lang=en>).

Table 2.7 shows the breakdown of the healthcare workforce in Kuwait. The Kuwaiti healthcare system has physician and nurse ratios comparable to that of OECD upper-middle income countries. While there is no comparable data for dentists, Kuwait appears to be reasonably well supplied with respect to dentists and also for pharmacists and pharmacy technicians. While managerial and technical staffs were predominantly Kuwaiti, the medical, nursing and other support staff were dominated by non-Kuwaitis. To address this, Kuwait's government has implemented a national approach of Kuwaitization mentioned earlier to increase the number of the Kuwaiti medical staff in the health sector and reduce the demand gap among certain healthcare professions (WHO, 2006).

Table 2. 7: Health care workforce by year in Kuwait: Density per 10,000 population
From (<http://apps.who.int/gho/data/node.main.A1444?lang=en>)

Workforce	2001	2006	2009	2014
Physicians	-	14.45	18.53	19.49
Nursing and Midwifery	46.22	41.26	47.04	47.29
Dentistry	3.38	3.11	3.66	5.96
Pharmacists & Pharmacy technicians	3.63	3.00	3.08	4.83
Other health care workers ^a	-	27.62	26.13	-
Health management and support workers ^b	-	49.06	42.73	-

a. Health care workers excluding those listed above and other community health workers.

b. Includes managers, administrators, support staff, ambulance drives, estates and buildings staff.

2.7.5. Health regions

Kuwait is divided into 6 health areas/regions namely: Capital, Hawali, Ahmadi, Jahra, Farwania and Al Sabah. As depicted in the WHO's health system observatory report on Kuwait's health care system each region is an "independent decentralized administrative unit" (WHO, 2006). Further details are contained in chapter 7.

2.7.6. The three levels of healthcare

Kuwait provides Kuwaiti nationals with free medical services, while non-Kuwaitis pay a symbolic amount of money approximately 3 USD for a regular consultation and extra charges for procedures such as X-rays. These charges are lower than private hospital

(Harper, 2013). In the public health care services, Kuwaitis can visit outpatient clinics at any time, whereas non-Kuwaitis can only visit such clinics during their afternoon shift. There are no restrictions on non-Kuwaitis using private health care services and the waiting time is shorter. However private practice fees are expensive (Globe Media Ltd, 2014). Non-Kuwaitis access to health care, compared to that of Kuwaitis, has been a particular issue in Kuwait for several years. In a country where non-Kuwaitis outnumber Kuwaitis 2 to 1, numerous complaints were received by the Kuwait parliament regarding the local citizens having long waiting times in public health care centres, due to the large number of non-Kuwaitis being treated (Harper, 2013; Globe Media Ltd, 2014). As a result, talks have been circulating regarding the government creating separate hospitals for non-Kuwaitis (Globe Media Ltd, 2014).

Primary healthcare (PHC): Kuwait has a long history of PHC development, especially since its independence in 1961. Kuwait's achievements in the field of PHC have been and are still comparable to those of industrialized countries (WHO, 2006). There are 92 primary health care centres (PHCCs) spread over the country. These provide services for approximately 34,000 inhabitants per catchment area who are registered through the national health registration system, which indicates the officially registered users of the healthcare services in Kuwait. The focus of the primary healthcare service is on immunization, providing family physician services, dental services, pharmacy, laboratory services and radiology (alazmi, Mohammad, & Hanafi, 2006). Patients can be referred to secondary or tertiary level care when necessary. The total number of visits to primary health care centres in 2013 exceeded 15 million, the majority being for Kuwaitis (WHO, 2013). The topic of primary health care in Kuwait will be addressed in more detail in Chapter 3.

Secondary healthcare: Kuwait provides secondary care through six general hospitals that have an emergency department, inpatient and outpatient services. Hospitals in Kuwait cover the following services: Internal medicine, ENT (Ear, Nose, and throat), ophthalmology, general surgery, trauma, paediatrics, orthopaedics, physical medicine, psychiatry, dental services and dermatology. The World Health Survey in Kuwait showed that the occupancy rate of hospitals is 65% with an average length of stay of around 5 days (WHO, 2013). These hospitals consume the largest proportion of the health budget, despite moderate bed occupancy and high pressure on primary care services (WHO, 2013).

Tertiary healthcare: is the third level in healthcare in Kuwait. It includes specialized hospitals and centres. These centres provide all citizens and residents with specialized

health care services including: obstetric care; specialized chest care; psychiatric care; neurosurgery; cancer care; transplantation and a specialist burns treatment centre. These services are provided free of charge for Kuwaiti citizens. However, non-Kuwaitis are charged one Kuwaiti Dinar (3 USD) for visiting the primary health centre, and two Kuwaiti Dinars (6 USD) for visiting clinics of hospitals and specialized health centre.

2.7.7. Health information system (HIS)

A centralized national HIS for Kuwait based on a population-wide patient database, including Kuwaitis and non-Kuwaitis was first launched and successfully implemented in 2001. Afya Net was developed to ensure that all clinics and hospitals in Kuwait would be fully computerised and linked together to form an integrated HIS. It consists of three, related initiatives: (i) The primary healthcare information system, successfully installed and operating in PHC clinics; (ii) The health insurance system to facilitate the registration of patients and healthcare institutions, issue their cards, and maintain a contact database of all registered patients and institutions; and (iii) The hospital management information system, operating from admission to discharge and including patient transfers (AlMutairi, 2011). This creates an integrated electronic communication network to link all sectors and departments of the MOH including clinics, hospitals, and medical centres. This has a potential to create and maintain a central patient database that can be used by all stakeholders for service planning, providing, evaluating, and quality monitoring (AlMutairi, 2011).

2.8. Health indicators

2.8.1. International comparisons

Kuwait has experienced a steady improvement in health in terms of general mortality and infant mortality. This change was observed in Kuwaiti population's health after the government introduced a comprehensive health care system for its entire population in the 1950s (WHO, 2006).

Life expectancy at birth in Kuwait improved from 75 years in 1990 to 82 in 2013; this is broadly similar to both the other countries of the GCC and to high income countries (Table 2.8). It is higher than the average for the WHO Eastern Mediterranean region; however that is a wider region which includes much poorer countries such as Yemen and Somalia. As is the case internationally, life expectancy is better for women than for men.

Table 2. 8: Life expectancy at birth (years) (World Health Organization, 2015)

	Both sexes		Male		Female	
	1990	2013	1990	2013	1990	2013
WHO Income Groups						
High	75	79	71	76	78	82
Upper-middle	68	74	66	72	71	76
Lower-middle	59	66	58	64	60	68
Low	53	62	51	61	54	64
WHO Eastern Mediterranean Region*	62	68	61	67	63	70
GCC Countries						
Kuwait	73	78	73	78	74	79
Bahrain	73	77	72	76	74	78
Oman	68	76	66	74	70	79
Qatar	75	79	74	79	76	80
Saudi Arabia	69	76	67	74	71	78
United Arab Emirates	72	77	71	76	73	78

Health improvements in the Middle East Region (both in terms of the WHO Eastern Mediterranean Region and the GCC countries) have been significant, especially in indicators such as infant, child and adult mortality rates (Table 2.9). According to the Human Development ratings, high income countries ranked also the highest in life expectancy indicators when compared to low income countries such as Yemen and Sudan (Boutayeb et al., 2006).

Table 2. 9: Neonatal, child and adult mortality rates, by year (WHO, 2015)

a. Neonatal mortality per 1000 live births, by year				
	1990	2013		
Income Group				
High	7.5	3.5		
Upper-middle	24.1	9.7		
Lower-middle	44.0	27.1		
Low	47.4	28.2		
WHO Eastern	40.0	25.8		

Mediterranean Region				
GCC Countries				
Kuwait	9.3	4.7		
Bahrain	8.1	2.3		
Oman	18.7	6.6		
Qatar	10.0	4.3		
Saudi Arabia	20.7	8.8		
United Arab Emirates	9.3	4.8		
b. Under-5s mortality rate per 1000 live births, by year				
	1990	2000	2013	
Income Group				
High	14.3	9.7	6.3	
Upper-middle	54.4	38.5	19.6	
Lower-middle	118.9	93.4	59.0	
Low	166.6	134.9	76.3	
WHO Eastern Mediterranean Region	100.6	80.4	55.2	
GCC Countries				
Kuwait	16.7	12.7	9.5	
Bahrain	23.0	12.7	6.1	
Oman	39.3	16.5	11.4	
Qatar	20.8	12.4	8.2	
Saudi Arabia	44.1	22.8	15.5	
United Arab Emirates	16.5	11.2	8.2	
c. Adult mortality rate (aged between 15 and 60) per 1000 population, by gender and year				
	Male		Female	
	1990	2013	1990	2013
Income Group				
High	182	135	83	66
Upper-middle	199	139	133	89
Lower-middle	286	236	222	160
Low	343	264	294	219
WHO Eastern Mediterranean Region	239	181	196	135
GCC Countries				
Kuwait	128	59	81	42
Bahrain	117	70	103	54
Oman	215	116	151	73
Qatar	94	72	82	50
Saudi Arabia	178	89	131	67
United Arab Emirates	150	84	121	59

For neonatal mortality rate, Kuwaitis similar to most of the GCC countries and high income countries and showed improvement from 9.3 per 1000 live births in 2009 to 4.7 per 1000 live births in 2013 (Table 2.9). Under-5s mortality rate decreased from 16.7 per 1000 live births in 1990 to 9.5 per 1000 live births in 2013. As for adults mortality rate, Kuwait's rates decreased since 1990 among males and females to reach in 2013, 9 per 1000 population in males and 42 per 1000 population in females. The numbers show better rates compared to higher income countries as well as in other GCC countries (WHO, 2015).

2.8.2. Kuwait's health profile

As outlined in the previous section, Kuwait has a comparable health profile with other high income countries. Table 2.10 highlights some other key health data in relation to both high and upper-middle income countries and with the WHO Eastern Mediterranean region.

Table 2. 10: Health profile of Kuwait, compared to high and upper-middle income countries and to the WHO Eastern Mediterranean Region(WHO, 2015, p.6788).

Indicator	WHO High Income Group	WHO Upper-middle Income Group	WHO Eastern Mediterranean Region	Kuwait
Cause-specific mortality per 100,000 population				
Communicable diseases	34	75	214	82
Non-communicable diseases	397	558	654	406
Injuries	44	59	91	25
Crude birth rate per 1000 population	11.6	15.3	25.0	20.6
Total fertility rate per woman	1.7	1.9	3.1	2.6
Antenatal care coverage, 2007-2014 (%)				
At least 1 visit	-	94	78	100
Immunization coverage for measles for 1 year olds (%)				

In 1990	84	90	67	66
In 2013	94	95	78	99

The mortality pattern in Kuwait resembles those of high and upper–middle income countries, with a much higher death rate from non-communicable diseases (NCDs) compared to communicable diseases (CDs) and injuries (Table 2.11). This is markedly different to the pattern seen in the wider Eastern Mediterranean region, again due to the inclusion of countries such as Afghanistan, Somalia and Yemen. Other indicators, such as antenatal coverage and immunization rates also indicate a system representative of a high income country; birth and fertility rates remain higher than in other high income countries.

Table 2. 11: Age standardised mortality for communicable and non-communicable diseases and injuries for 2012 (rate per 100,000 population) (WHO, 2015)

	Communicable Diseases	Non-communicable Diseases	Injuries
Income Group			
High	34	397	44
Upper-middle	75	558	59
Lower-middle	272	673	99
Low	502	625	104
WHO Eastern Mediterranean Region	214	654	91
GCC Countries			
Kuwait	82	406	25
Bahrain	48	506	34
Oman	84	478	53
Qatar	28	407	41
Saudi Arabia	71	549	41
United Arab Emirates	36	547	32

2.8.3. Trends in cause-specific mortality

The Global Burden of Diseases Study, established by WHO and the World Bank, has identified a clear global shift since 1991 from deaths predominately due to CDs to deaths mainly due NCDs (Mokdad et al., 2014). Two thirds of the world’s deaths is due to NCDs and this is no different in the Arab world where in high income countries like Kuwait and

other GCC countries, ischemic heart disease and other NCDs are the highest causes of death (Mokdad et al., 2014).

Among the Arab population, high income countries, which constitute mainly the GCC countries, show a similar pattern of change from 1990 till 2010 in relation to the most common causes of death, with ischemic heart disease the top cause of death (Abdul Rahim et al., 2014). Other common causes include cardiovascular disease (CVD), road injuries and congenital anomalies.

Cardiovascular disease (CVD) is the leading cause of death in Kuwait, where 39.5% of deaths are due to CVD; however there has been a decrease in mortality between 2005 and 2015. The second and third most common causes of death remained unchanged, with road injuries second and CVD third (IHME, 2015).

2.8.4. Health-related lifestyle behaviours.

Risky health-related behaviours are known to lead to poor health and increased likelihood of diseases that could be prevented. Smoking, poor dietary habits and inadequate physical exercise are the main risk factors associated with the development of NCDs such as diabetes, CVDs, cancer, respiratory diseases and other NCDs.

Table 2.12 shows that the prevalence of raised fasting blood glucose (FBG) and raised blood pressure is higher in Kuwait than in WHO high and upper-middle income countries and is also higher than the WHO Eastern Mediterranean region – this is particularly true for raised blood glucose. One reason is likely to be the high levels of obesity in Kuwaiti adults, with 35% of men and 46% of women obese. The prevalence of smoking is very low amongst Kuwaiti women and alcohol consumption is negligible.

More than 80% of adults in Kuwait and other Arab countries reported eating less than the WHO recommended level of five servings of fruits and vegetables per day. Obesity is alarmingly prevalent in Kuwait and high levels of physical inactivity are reported (Abdul-Rahim et al., 2014). A recent paper from the GBD study showed that the contribution of obesity, hypertension, high cholesterol and raised fasting plasma glucose levels to disability-adjusted life years (DALYS) has increased between 1990 and 2013 (Mokdad et al., 2014).

Although the healthcare system in Kuwait is improving, as discussed earlier, the population in Kuwait suffers from serious health problems and growing prevalence of

NCDs (World Health Survey, 2013). However, what threatens this improvement; like in most high income countries is the rising threat of chronic diseases, as well as associated risk factors in particular obesity (Mokdad et al., 2014). Kuwait ranks poor with respect to these factors with high smoking rates among youth and men, high diabetes prevalence and high obesity and inactivity rates among women.

According to the GBD study, 2013 in Kuwait, around 8% of total DALYS could be attributed to high FBG and round 6% to high systolic pressure, both of which are risk factors for CVD and diabetes (IHME, 2013). The prevalence of diabetes is currently 14.6% among Kuwaitis (WHO, 2015) and according to Dr. Kazem Behbehani, Director General of Dasman Diabetes Institute, this can be attributed to poor lifestyle choices of diet and physical inactivity among the population. Kuwait is ranked the third highest in the number of diabetic patients worldwide according to the International Federation on Diabetes, suggest that the Kuwaiti lifestyle is far from healthy (Macropolis, 2012).

Table 2. 12: Prevalence of selected risk factors in Kuwait in adults aged 18 and over, compared to high and upper-middle income countries and to the WHO Eastern Mediterranean Region (WHO, 2015a,p.#6788; WHO, 2015b)

Indicator	WHO High Income Group	WHO Upper-middle Income Group	WHO Eastern Mediterranean Region	Kuwait
Raised fasting blood glucose (%)				
Male	9.2	10.6	13.4	21.0
Female	6.9	9.0	13.8	18.9
Raised blood pressure (%)				
Male	22.3	22.4	27.5	29.1
Female	15.1	18.7	26.4	22.6
Obesity (%)				
Male	22.6	10.5	14.6	35.5
Female	24.3	15.8	23.6	45.9
Alcohol per capita consumption (litres pure alcohol)	10.3	6.7	0.7	0.1
Smoking any tobacco product, aged over 15 (%)				

Male	32.8	32.8	36.2	35.0
Female	17.8	17.8	2.9	4.0
Physically inactive (%)				
Male				56.9
Female				72.1

The percentage of obese adults in Kuwait is greater than in other Arab countries and high income countries (Table 2.12) (El Zein et al., 2014). Kuwaiti males and females rank higher in overweight percentages and obesity than non-Kuwaitis in most age groups (Table 2.13).

Thus more attention should be given to health promotion messages focused on nutrition and health, physical activity awareness and education. There is an increased likelihood of developing NCDs in Kuwait, thus emphasizing the importance of prevention services, indicating that primary care should be strengthened to meet these population needs.

Table 2. 13: Percentage distribution of Kuwaiti and Non-Kuwaiti respondents by BMI: Overweight and obese

	Kuwaitis		Non-Kuwaitis	
	Male	Female	Male	Female
Overweight				
18-29	33.0	37.9	23.1	44.1
30-44	42.1	43.4	42.9	39.5
45-59	44.1	29.4	43.3	36.5
60-69	47.4	23.8	44.4	11.8
Obese				
18-29	23.4	22.7	22.0	13.3
30-44	37.1	38.9	24.8	37.9
45-59	38.3	61.3	38.0	53.1
60-69	38.6	68.3	30.3	53.5

Source: World Health Survey, 2013

In Kuwait, around 4% of total DALYS is attributed to smoking, which is a recognised risk factor for cancer, CVD, and lower respiratory diseases (IHME, 2013). Kuwait has a higher percentage of smokers than either Qatar or UAE. Kuwait also ranks high among GCC countries in terms of physical inactivity (IHME, 2013). Thus healthy lifestyle promotion is needed. Preventing and treating NCDs and their related risk factors requires lifestyle change by healthcare professionals and public health practitioners and a health system that can support practitioners and patients (The Lancet, 2014). To lower the % of DALYS caused by these risk factors, a new road map is required for the health sector in Kuwait. The threat behind NCDs is embedded in the fact that people are admitted to secondary care after experiencing acute symptoms and complications for a long time.

2.9. Kuwait health care system challenges and barriers

2.9.1. Related to demographics

In 2009 a conference held by Dr. Khalid Shukri, the Chairman of the International Pan-Arab Critical Care Medicine Society (IPACCMS), discussed the challenges facing the healthcare system in Kuwait and made recommendations for improvement. This section relies on information from that conference as no other source has covered it as comprehensively. In spite of the progress that Kuwait has achieved in the past decade towards a better public health care sector, it still faces many challenges. The population in Kuwait is increasing and so is the public demand for high quality healthcare services. Moreover, with an aging population and the shift from CDs to NCDs, Kuwait, like any other country, needs to be prepared to face the persistent demands to services that such diseases bring. This has created major challenges for health policy makers and will require radical strategic funding and priority decisions to cater for such demographic changes (Shukri, 2009). New healthcare policies also need to take into account the high percentage of non-Kuwaitis who constitute a large percentage of the population (WHO, 2006).

2.9.2. Related to the health system

Over 70% of the population is receiving care from the healthcare system in Kuwait; some care is provided by providers from the private sector whereas others by governmental sector. Public hospitals are the most accessed services; private care is used more by Kuwaitis, women and the young (World Health Survey, Kuwait 2013). There are high levels of patient satisfaction with the care provided however complaints about

responsiveness and accessibility have been raised (World Health Survey, Kuwait 2013). Although a large budget is allocated for health care every year, particularly on costly hospital development programmes, many hospitals are old and underdeveloped. A lot of them do not have enough space; have underdeveloped information technology and inappropriate transport facilities. Thus, to be comparable with world class medical facilities there are a lot of renovation challenges ahead (Shukri, 2009). Other complains concern medicine availability. Patients are obliged to buy medications from private pharmacies on many occasions due to shortages of vital medicines in the state-run community clinics and hospitals (Shukri, 2009).

Another challenge facing the improvement of the healthcare sector in Kuwait concerns health human resources. Currently the health workforce is dominated by non-Kuwaiti professionals. As they come from various backgrounds and have studied or worked under different systems, there may be a problem when it comes to standardization of care. Any expansion of the health system will require commitment from its citizens and practitioners to raise the sector and its practices perhaps through the development of additional medical schools and residency programmes (Shukri, 2009).

Moreover, the MOH needs to recognize that investment in quality will help reduce costs in the medium and long term. Although the MOH is keen on organizing training programmes, there is a need to invest in capacity building and leadership empowerment. It has been suggested that this lack of investment has led to poor strategic direction and ineffective utilization of resources due to deficiency in knowledge of the health needs of the population (Shukri, 2009).

With medical advance, increased health care expenditure and increases in population, Kuwaiti's leaders have identified the importance of achieving an efficient healthcare system. To achieve this, the system has to emphasize the importance and quality of preventive care. As such, the significance of PHC accreditation is on the top priority of the political agenda in Kuwait. This will be discussed in more detail in Chapter 4.

2.10. Summary

This chapter has outlined the history and development of Kuwait, before focussing on the structure of the Kuwaiti health system and the challenges it faces in terms of the demographics and health profile of the population. Addressing the rise of non-communicable diseases and their underpinning risk factors has been placed on the global

agenda; therefore the focus on preventive services and primary care is being strengthened worldwide and seen as a priority (Mokdad et al., 2014). This is also a priority for Kuwait. The next chapter will consider the place of primary care – both internationally and in Kuwait – to address this priority.

CHAPTER 3: Primary healthcare system

3.1. Introduction

This chapter discusses primary health care as a concept and the development of accreditation within primary care. It begins with a definition of primary care, its place in wider health systems and its key components, drawing in particular on the work of Starfield and, later, Kringos. The chapter ends with highlighting the importance of investing and strengthening primary care through accreditation.

3.2. What is primary healthcare?

3.2.1. Definitions of primary healthcare

There are different definitions of primary care in the literature. One of the earliest accepted definitions came from the International Conference on Primary Healthcare held in Alma-Ata in 1978. The Declaration of Alma-Ata, discussed further below, defined primary healthcare as:

“essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”(WHO, 1978).

While the Alma Ata definition was very broad, another commonly referred to definition comes from Barbara Starfield's seminal 1994 paper, in which she states:

“Primary care is first-contact, continuous, comprehensive, and coordinated care provided in populations undifferentiated by gender, disease, or organ system.”(Starfield, 1994).

Each of these contain aspects that primary care in Kuwait aspires to, including making primary care the first point of contact within the wider health system and accessible to all.

3.2.2. Alma Ata declaration and the move towards “health for all”

While hospital-based care focuses on curing illnesses and alleviating conditions by providing medical care to patients for a specific defined period, primary care focuses on the wider health needs of the individual and the community as a whole to achieve better health outcomes. The “Alma-Ata” conference of 1978 saw primary care as addressing health problems in communities through the provision of ‘promotive, preventive, curative and rehabilitative services’ (WHO, 1978).

The Alma Ata Declaration provided a very broad definition of primary healthcare that was synonymous with public health. It asserted the right to health and the role of the government in developing healthcare which would provide this (WHO, 1978). It identified PHC as “essential healthcare” aimed at attaining better health through addressing the physical, social and psychological aspects of the individual and community being served. The Declaration also stressed the need to pay attention to increasing accessibility of services to reach equitable distribution and to ensure health care services reached as wide a range of the community as possible, regardless of their social or economic disadvantage (WHO, 2008^b).

While public health interventions target the major risk factors of diseases in a community, they are often not prioritized by governments despite their cost effectiveness (WHO, 2008b). Public health interventions address risk behaviours of diseases, prevention strategies, health promotion and education and public health policies (WHO, 2008b). Some interventions have been used across different population groups and sub-groups (for example, young adults, low educational level, low socio-economic status) as such increased the health inequalities. Public health policies though came to place to reduce these inequalities (WHO, 2008^b).

Much of the activity stemming from the Alma Ata Declaration was considered to be of a wider public health nature, for example vertical programmes of population-based immunisation programmes, rather than the more horizontal integrative approach required of primary care (Rawaf et al., 2008).

As a result, its implementation was not successful in many countries. To address this, the World Health Organization reconvened in Almaty (as Alma Ata was now called) in 2008 to address the gaps of the earlier 1978 Alma Ata Declaration. Before that, however, there was important supportive work from Barbara Starfield and her team. The approach in primary care is often defined by the practitioner who delivers it, particularly in higher income countries. For example, in the UK and Europe this is the General Practitioner (GP), while it is broader in the US system where the practitioner delivering primary care could be a paediatrician or a GP/family physician (Starfield, 1994). Starfield, however, did not consider who delivered care as much. According to Starfield, primary care is a philosophy of care delivery not merely a set of specific services, with the providers competent through training and following this philosophy. However, Starfield also acknowledged that many other things impact on, and can improve health, for example via education, environment, the economy as well as the health system (Starfield, 1994).

Starfield suggested that the definition of primary care is measured across four elements, which are: first-contact care; comprehensiveness; coordination of care; and continuity and accountability (Starfield, 1994). These elements will be discussed in further detail in this chapter.

3.3. Montevideo Declaration: “PHC is the basis of a health care system” and the "Now More Than Ever report"

Several initiatives and documents built on the Alma Ata declaration. Countries in North and South America came together in 2005 to express their commitment to primary healthcare in the Declaration of Montevideo 2005 (WHO PAHO, 2005). This also viewed primary care as integral to the development of a healthcare system and not separated from it. However, arguably, the most important recent document was the WHO report "*Primary Care: Now More Than Ever*" which arose out of a meeting in Almaty Kazakhstan in 2008, aimed to both celebrate the 1978 Declaration and to renew its commitment to primary care. The most important difference between 2008 and 1978 however, is that today there is more evidence about the effectiveness and efficiency of primary health care with more available data. This evidence may inspire action at different levels with greater safety, effectiveness, efficiency, patient-orientation, timeliness, and equity of the health services (WHO, 2008^a). In addition to that, the economic and political challenges of the current world have consequences for the financing of primary care. The health system is often under resourced in terms of both financial resources and human resources (WHO, 2008^a).

The WHO report, *Now More Than Ever* identified four major components on which PHC should be built to achieve high quality and equitable care. These components are patient centred care, universal coverage, development of public health policies to support health and leadership (WHO, 2008^a). Again these will be discussed further in this section.

3.3.1. Accessibility to primary care services

An increase in investment towards primary care has been observed, especially in countries where the systems did not recognize primary care's importance previously such as in many Arab countries (Abdul-Rahim et al., 2014). Many countries are now considering moving towards universal health coverage and improving cost effectiveness by incorporating mixed capitation, removing co-payment and investing in improving quality of care. Thailand and Oman are success stories in a system that shifted to strengthening primary care through investing in a healthcare system led by primary healthcare. There, system changes increased the public's accessibility to healthcare, improved cost effectiveness and rendered better health indicators (Rawaf et al., 2008). Despite the fact that primary care has been expanding in several countries, many countries are still behind and lack systems to monitor and report the data needed to monitor health inequities (WHO, 2008b).

3.3.2. The need to move to patient-centred continuous care

Now More Than Ever encourages the trend of primary care to shift towards a patient-centred approach. This moves the focus from curative medical care, to preventive care that responds to the health needs of the population. This moves primary care towards the Starfield model described above and also promoted greater involvement of patients and the public in the development of health care (Table 3.1). Primary healthcare has tried to accommodate the changing needs of societies by providing evidence-based care which takes account of the health needs and expectations of the people (WHO, 2008b). With globalization and ageing of populations, the health needs are changing rapidly and creating complex diseases which are harder to manage. This emphasizes the need for comprehensive and continuous care.

Table 3. 1: Dimensions of Care that compares people-centred primary care with other conventional healthcare

Conventional ambulatory medical care in clinics or out patients departments	Disease control programmes	People-centred primary care
Focus on illness and cure	Focus on priority diseases	Focus on health needs
Relationship limited to the moment of consultation	Relationship limited to programmes implementation	Enduring personal relationship
Episodic curative care	Programmes defined disease control interventions	Comprehensive, continuous and person centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility disease control targets among the target population	Responsibility for the health for all in the community along the life cycle; Responsibility for tackling determinants of ill health
Users are consumers of the care they purchase	Population groups are targets of disease control interventions	People are partners in managing their own health and that for their community

Source: * Taken from WHO Report, "*Now More than Ever*", 2008

Despite the fact that the Alma Ata declaration articulated specific goals for primary care, this remains a challenge specifically in developing countries, where the money spent in the health system is failing to provide the aimed at health outcomes in the community (WHO, 2008^b). Health systems are often hospital-based and fall into the trend of providing short term curative care or overlap with specialized care. The current challenges facing specifically the developing world is the inequitable access to health services, high cost of health care and loss of trust in the health care system. This jeopardizes the definition of primary care that aims at increasing accessibility, comprehensiveness, accountability and continuity of care (WHO, 2008^b).

3.4. What is good primary healthcare (PHC)?

Primary care is the first level of structured healthcare in a health system by which people's health problems, whether acute, chronic or relating to underlying risk factors, can be addressed (Kringos et al., 2013). It focuses on empowering people in the community and to help them make healthy lifestyle choices (WHO, 2008^b). Primary care is not provided in a hospital setting, but in communities, and aims to cover health problems that are most common in a community. Moreover, primary care has been studied in contexts with reference to family medicine or general practitioners, which are not applicable in low-income countries as they are not utilized efficiently for the several reasons.

Firstly, primary care by definition has to get into the health system a wide coverage of health services to cover a wide range of health problems; however, in developing countries, it often focuses on government's priorities rather than needs of the population. Second, primary care in low-income countries is considered as a distinctive separate entity in the health system rather than an integrated pillar in the health system. Third, primary care in low-income countries often still lacks a good patient-health provider relationship. This rapport is usually built when patients become involved in decision making of their own health services and health problems and as such the approach would be patient-centred. Fourth, primary care is for early detection and managements of illnesses through health promotion and education; often, that is not the case in low-income countries, where primary care is only providing services for treating common illnesses (priorities). Fifth, in low income countries, primary care is associated with poor monetary and human resources and poor quality care and coverage; whereas it has to a system that functions with a team of multi-skilled health providers. Finally, primary care has to be provisioned under strong leadership and stewardship that plans and manages the financial and human resources to provide efficient use of resources for the best quality of care; in low-income countries, it is often financed from out-of- pocket sources through which people in these countries usually are the least able to afford (WHO, 2008^b).

3.5. Comprehensive care and the new definitions of primary care

Primary care systems can deliver several specialized care services such as maternal health, child health, dental care and other specializations. This would be determined by the needs assessment of the community the primary care system serves. In that sense, primary care aims to reduce morbidity and mortality from preventable diseases. It is also supposed to ensure an equal distribution of healthcare services and meet the needs of the majority of the population's health problems and demands (Kringos et al., 2013).

From that perspective, the elements of person-centred approach, comprehensive care, continuity of care and coordinated care discuss Starfield's definition, while universal health coverage and quality have been added by the *Now More Than Ever* to cover or extend Starfield's work. As such Starfield and the WHO's definition on primary care have identified several major elements of primary care:

- 1- *Person-centred approach*: The priority is the patient. The healthcare provider builds rapport with the patient; the patient becomes more responsive and committed to follow the provider's advice. In primary care, the patient is the key person in the

planning of his/her own care. Also about addressing the needs that are most important to the patient at that point in time.

- 2- *Comprehensive Care*: Integrating the emotional, psychological, physical and social context of the patient enhances the development of a preventive approach that addresses the needs of the patient and facilitates responsiveness to many health problems in early stages. Comprehensiveness also refers to the range of services available to meet a patient's needs which implies an unconditional approach to patients' problems.
- 3- *Continuity or long term care*: Primary care is not limited to an episodic consultation for the patient but rather a continuous one. It involves awareness, management and follows up with the patient to ensure that the patient is well informed and empowered; thus co-ordination depends on the development of good long-term relationships. This allows the building of shared knowledge, experience, confidence and trust with all of which can be achieved within the relatively short encounters that occur in primary care.
- 4- *Coordinated care*: Coordinates care across the community-hospital interface and within the community care by utilizing a system of referrals to specialties and other organisations, such as social care, and ensuring that the scope and the rate of which the information is being exchanged is recognized.
- 5- *Universal Coverage (NMTE Report)*: The concept of universal health coverage has gained importance recently, as an approach towards health equity. Universal health coverage encompasses universal access to health services and social health services and the devolution of funds to make sure that the services are available and accessible to everyone, providing a good quality of care. (WHO, 2008^b). Universal coverage is a step forward towards health equity. To reach universal coverage, advocacy, governance and support has to be built from the governments, health insurance companies, financial experts and the communities. Some developed countries, specifically in Europe, started an initiative of including social health protection schemes as part of the health coverage and as a step forward towards universal health coverage that is comprehensive. Some low and middle-income countries are moving fast towards working on universal health coverage, such countries are: Turkey, Mexico, Thailand, and Costa Rica. The challenge in implementing universal health coverage is that it embraces three pillars, the comprehensiveness of the coverage of social health protection schemes (breadth of coverage), expectations and people's health demands and needs and meeting

financial expectations of fund pooling to reduce the reliance on out of pocket payments (WHO, 2008^b).

- 6- *Quality*: One of the pillars of primary care which characterised by benchmarking the outcome of care with standards to evaluate the appropriateness of interventions (Starfield, 2000). Although policy documents such as *Now More Than Ever* Report did not mention a lot about quality of care as an element in their definition of primary care, we should expose this information in this research. In particular, it presents a main challenge to primary care with the increasing challenges of a person-centred approach and the increasing demands and expectations of people.

3.6. Benefits of a strong primary care system

The overall assessment of a healthcare system is not determined by the GDP of the country or by the number of healthcare providers. A good healthcare system is determined by strong primary care which is under the stewardship of a government that prioritizes strong health policies (Starfield, 2011). A good primary care system is, therefore, one that provides universal health coverage under the government's stewardship, with equitable distribution of resources to the population, providing primary care services for common health problems while maintaining the quality and continuity of care through the efficient use of resources and enhancing its affordability with little or no co-payments. This is provided by a well-trained and skilled workforce, patient centred care, and wide range of services to meet the needs of the population and better coordination of care among the primary care personnel and among the levels of healthcare as well (Kringos et al., 2013; Starfield, 2009).

With the emphasis on primary healthcare, the healthcare system of the country shifts to a more cost-effective one (Starfield, 1994). The general practitioner becomes the first patient encounter, thus a gatekeeper against using the services of secondary care when unnecessary. Thailand and Cuba, two countries that implemented universal primary care, have experienced improvement in health indicators because of that reform. In Thailand, under five mortality rate indicator decreased significantly after providing compressive primary care and providing the accessibility of primary care in rural areas. In Cuba, similar improvements in indicators were shown, especially related to a reduction in infant mortality rate (Macinko and Sattrfield, 2009). The reform in both systems showed that investing in primary care reform could lead to a better health care system and improvement in healthcare indicators. The benefit of primary care is not only on improving the health

outcomes of the community but also in improving the health outcomes at a lower total cost, especially when the number of primary care physicians is sufficient relative to the population ratio (Starfield et al., 2005). For example, pneumonia care was more cost effective when delivered by a generalist rather than a specialist. This is consistent with studies that show that weak primary care is associated with higher cost of health services (Starfield et al., 2005).

A stronger PHC system may also narrow the gap between socioeconomic classes. The major advantage in prioritizing PHC in resources and development is with achievable efficiency. This is achieved by reducing unnecessary procedures and focusing on health education and prevention which in turn lowers the healthcare cost and better health outcomes resulting in a healthier population (El Jardali et al., 2014). PHC at the community level is an education and preventive tool that has improved early detection and management of diseases and lowered premature mortality and morbidity from preventable diseases (Shi et al., 2012).

Therefore, the advantages of primary care can be summarized as firstly, the population benefits from strong primary care by having early detection and management of health risks of the population, which is the vital preventive role of primary care. Second, strong primary care systems benefit the population by providing greater accessibility to care and better quality of care. This being said, primary care would reduce the use of specialist care in health services and as such reduce the cost of health services (Starfield et al., 2005).

However, primary care still faces many challenges, such as managing co morbidity, prevention of side effects of medical interventions, widening accessibility and coverage, and improving health equity in health services for populations, while maintaining high quality care (Starfield, 2009). Because primary care can be based on either where, what or who, it can include quite different activities, ranging from the unconditional clinical care provided by doctors and to lesser extent nurses, to programmes of preventing care for mothers and children, delivered mostly by nurses and/or lay people. There is also a distinction between contacts initiated by patients who have problems they want to sort out which, once done, provides opportunities for other issues to be addressed, and contacts initiated by professionals driving a public health programme (Starfield et al., 2005). The challenges are global, such as an ageing population, health inequities, increased demand of health services by patients, higher health expenditures, an increase in the life-style risk

factors and coping with technological advancements (Kringos et al., 2013; Starfield et al., 1994).

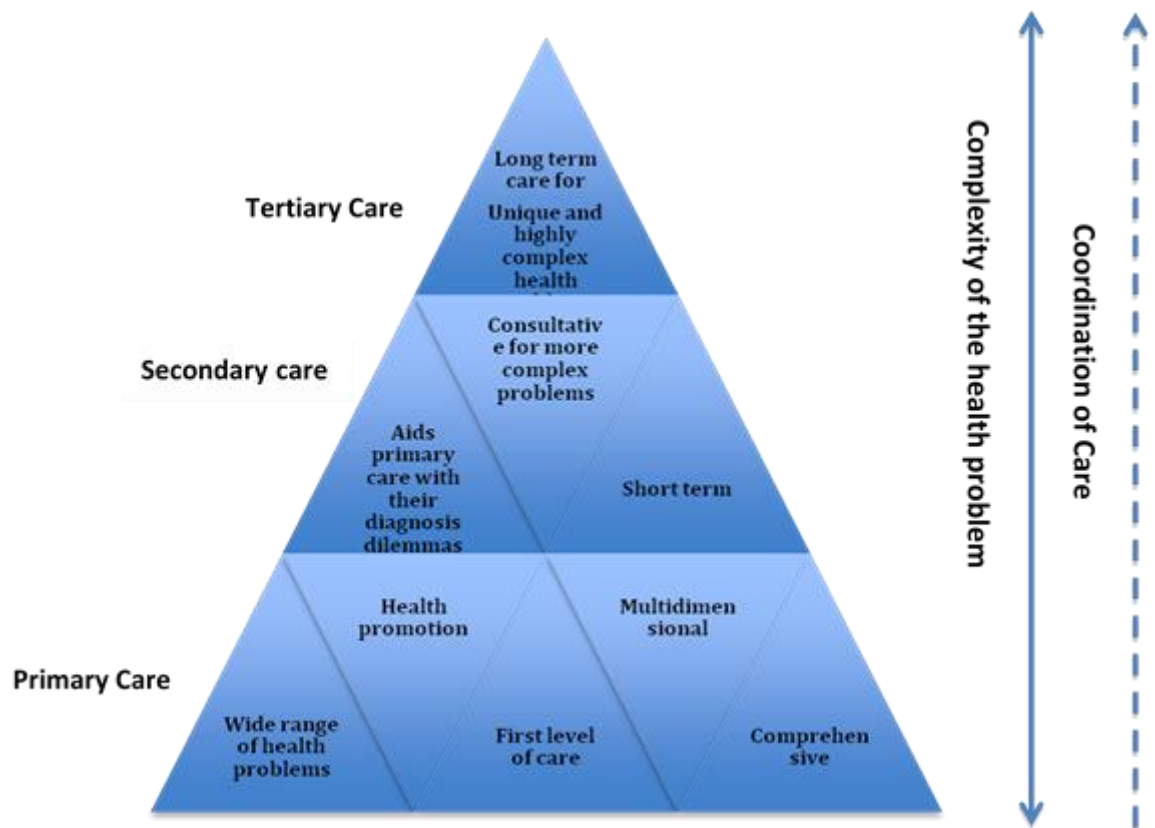
3.7. Contribution of primary care to the wider healthcare system

3.7.1. The role of primary care in healthcare systems

As outlined above, primary care is the first point of contact in a healthcare system. It is distinguished from the other levels of care, secondary and tertiary care by the wide range of services it provides, the duration of care, the providers providing the care and the generalist approach.

While primary care is the first contact for care in a healthcare system that provides a wide range of health services to the community, secondary care plays a consultative role for more complex problem and provides short to long term care, whereas tertiary care provides care for complex, specialist health issues (Figure 3.1). However, the three levels of care are interlinked and should be balanced to maintain a strong healthcare system. Strengthening primary care is vital to maintain a strong healthcare system. Despite the distinction among the levels, a certain level of collaboration is needed. Patient management, especially on health problems with lifestyle change in behaviour such as cardiovascular and diabetes needs good communication and cooperation between secondary care physicians and primary care physicians. Providers in secondary and tertiary care also need to work together with primary care personnel to make sure patients receive continuous and appropriate care (Starfield, 1994).

Figure 3. 1: The three levels of care and the level of coordination among them.



Weak primary care systems may result in the “preventable not being prevented”, so problems and complications of problems occur earlier with patients accessing various forms of scheduled appointments (out of hours, Accident and Emergency (A&E), hospital admission). The importance of having a GP as a first contact in healthcare care reduces on hospitals admissions and hospitalization cost. Patients who usually visit A or E departments in the Emergency unit could be seen by GP; however, due being unable to book an appointment with GPs caused higher number of visits to the A&E department (Cowling et al., 2015). This dilemma between access to GP and A&E in the UK remains unresolved.

3.7.2. Role of primary healthcare in non-communicable diseases management

As mentioned in Chapter 2, there is a basket of modifiable risk factors that could be preventable such as smoking, obesity and lack of physical activity worldwide (WHO, 2008^b; AbdulRahim et al., 2014; IHME, 2017).

Weak primary care systems are associated with increased mortality, increased prevalence of morbidities and increased healthcare expenditure (Mackinko et al., 2003); while a strong

primary care system helps to meet the challenges faced by a health system (Kringos et al., 2013). The health promotion role of primary care plays a crucial role in reducing the prevalence of non-communicable diseases. It improves the health of the population, reduces unnecessary hospitalization and lowers mortality numbers (Lee et al., 2007). Prevention and health promotion is needed to curb NCDs; this might require more investments to be placed in primary care settings to help in disease management and in public health services. In a weak primary care system, NCDs might be diagnosed at later stages due to a deficient primary care resources and management and thus increases hospitalization and cost of care.

Primary care in this situation can complement the role in a healthcare system to help in spreading awareness of risky lifestyle behaviours and as such avoid preventable hospitalizations and cost. The collaboration and integration of primary care with other levels of care is crucial to ensure a comprehensive, continuous and specialized care is being given to the population (AbdulRahim et al., 2014). Thus the integration of vertical programmes which are highly specialized and have high levels of expertise to horizontal systems which focus more on prevention and have centralized medical records for patients is recommended (Wilson, 2016).

In Kuwait, the prevalence of tobacco smoking and obesity is high. Smoking has been recorded as exceeding 25% and obesity is very prevalent, especially among Kuwaiti women. In addition to that, Kuwait is also known as one of the countries with the highest prevalence of diabetes (AbdulRahim et al., 2014). As discussed in the previous chapter, around 80% of the causes of death in Kuwait are due to NCDs. Reasons for this might include a weak primary care system (WHO, 2014). The government's strategies in reinforcing the balance between primary care and other levels of care and prioritising primary care policies to lower the prevalence and prevent NCDs is crucial. Strengthening the primary care system in Kuwait, as discussed in the previous chapter, needs to be on several dimensions, such as increasing the available workforce who are trained for primary care, enhancing the public health and health promotion side of primary care, and enhancing its coverage and accessibility.

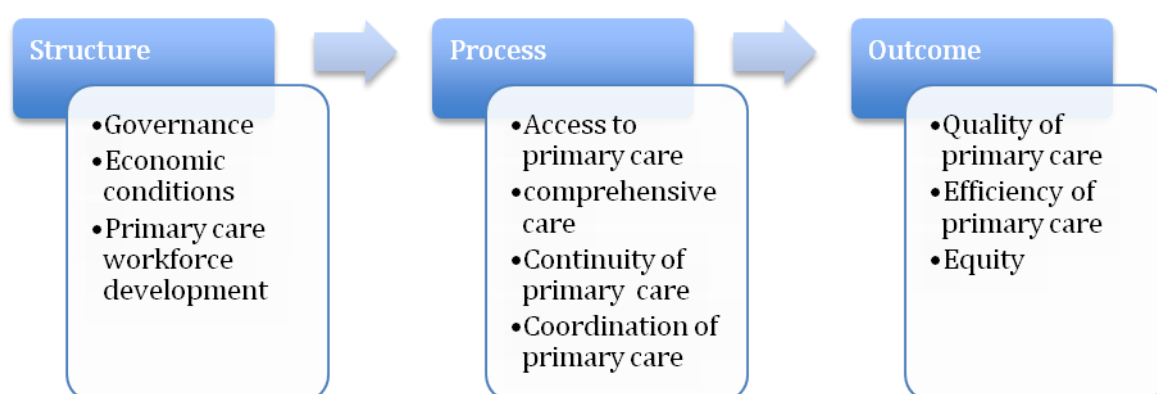
3.8. Multi-dimensional system

As mentioned earlier, primary care is the first contact care in the health system that provides generalist care which aims at curing and preventing illnesses. This system has to

be accessible to all and responds to the health needs of the population. Primary care is characterized in being a multi-dimensional system. Key dimensions have been developed by the Donabedian model to evaluate and monitor the quality of primary care at the levels of structure, process and outcome (Donabedian, 1980). The dimensions are further explained in the diagram below (Figure 3.2).

The strength of a primary care system can be evaluated by examining the strength of care in each of the dimensions' indicators (Starfield, 2012).

Figure 3. 2: Dimensions of Primary Care (Kringos et al., 2010, 2013)



3.8.1. Structure

Three dimensions contribute to the structure of a primary care system. First, governance of primary care must provide adequate stewardship in identifying the goals and priorities of the system and determine the level of provision in the primary health care system. In other words, whether the governance and the management of primary care will be centralized or decentralized in a certain community (Kringos et al., 2010). In addition to that, indicators such as the level of patient advocacy and collaboration policies of the primary care with other levels in a healthcare system are also taken into consideration in assessing the governance of a primary care system. The economic indicators take into account the primary care expenditures and coverage. It considers the system of payment of income to providers, whether they are employed by the healthcare system or are independent contractors. The third dimension contributing to structure is the extent of primary care workforce development, including the profile of primary care workforce, their academic status and professional associations (Kringos et al., 2010).

3.8.2. Process (Components)

Access to primary care is determined by the geographic distribution of primary care, and ways in which patients can access practices, for example through telephone, emails, practice-based consultations and home visits. This indicator also looks at patient satisfaction. Comprehensiveness of the primary care services considers whether the services provided are meeting the needs of the population. Measures include the extent to which there is first contact care with a GP; referral systems to secondary care; availability of medical equipment in primary care; the provision of medical procedures, preventive care and health promotion in primary care.

Continuity of care is measured by longitudinal continuity which is a long term relationship between the provider and the patient, and the quality of this relationship, whether the provider is meeting the needs and preferences of the patient. It is also determined by what is known as the informational continuity which is the quality of medical records and referrals. Coordination of primary care is determined by the gate keeping system and the collaboration of primary care with other levels of care, referral systems and providers' skills mix (Kringos et al., 2013).

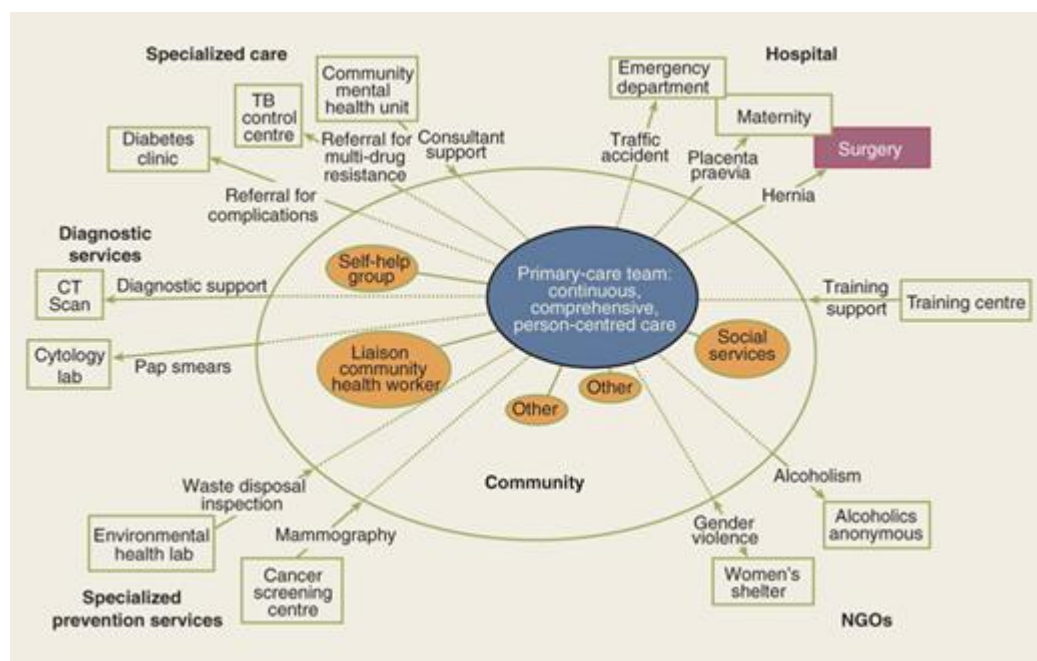
3.8.3. Outcome

Initially, the outcome dimension as per Kringos et al., 2010, comprised of quality, efficiency and equity. Quality is assessed by the prescribing frequency of primary care providers, cases of avoidable hospitalizations, the quality of diagnosis and treatment, quality of management of diseases such as prevalence and treatments, quality of health promotion and preventive care services provided. It also assesses the level of patient centeredness. Efficiency of care is another determinant of outcome; it measures the balance in resources for each outcome. In other words, it is the use of the minimum resources to achieve the best outcome without compromising on the quality of care. Finally, equity measures the level by which the health services are available for all and the centres are widely distributed in different areas of the country (Kringos et al., 2010). Later, the outcome measures of primary healthcare were developed to include indicators that show the impact of primary care on the health status of a population, measured by morbidity and mortality rates, and the levels of patient and employee satisfaction (Macinko et al., 2003). In other words, a strong primary care system was inversely related to the indicators of mortality, morbidity and premature deaths in a country (Macinko et al., 2003).

There is no specific recommendation on the number of primary care personnel required for primary care. However, the number and skills of the primary care personnel have to meet the demands of the population and the health care needed. It is estimated that on a yearly basis, around 80% of a population seek primary care (Starfield, 1994). The higher the number of health providers the better coverage of the health needs of the population (Starfield, 1994). The availability of the primary care work force is essential to meet the standards and quality of care provided. The role of a gate keeper is that is the first contact, its role is not distinct of other primary care personnel. Primary care personnel should be collaborating among each other to maintain a longitudinal, coordinated care. The level of training personnel in primary care receive, the availability of resources, the payment methods whether as a fixed income or entrepreneurial, and their skills are important to look at while assessing the work force availability and shortage. The number and calibre of primary care personnel should match with needs assessment of the primary care setting and the population and service it is providing (Hysong et al., 2007). The proper management in a primary care setting needs to ensure the communication and collaboration among different personnel and to make sure that everyone's skills are being utilized well.

While the number of healthcare providers is essential, a multi-skilled team is also vital to ensure the delivery of a comprehensive care that is responsive to the needs of the population it is serving (WHO, 2008^a). As such, primary care physicians, nurses have to collaborate with specialists in different levels of the healthcare system (WHO, 2008^a). This will also enable the primary care system a wider coverage on the range of care it is providing. Not only across levels, but also, primary care providers are specialized in different services such as technicians, pharmacies, screening services, emergency services and more. This skill mix and level of collaboration within the different levels of the primary care team with other services jeopardize the hierarchy approach of a healthcare system (WHO, 2008^b). The gate keeping role of primary care and the primary care team become effective tools of communication and liaison between the community and the institutions that provide the health services (Figure 3.3) (WHO, 2008^a).

Figure 3.3: Primary care the centre of communication and collaboration with other services and institutions in the community



* Source: WHO Report *Now More than Ever*, 2008

3.9. Primary health care in Kuwait: current situation and trends

The MOH in Kuwait manages the majority of healthcare services, by providing rigorous governance and a primary care infrastructure has been established (MOH, 2013; Badawi et al., 2015). PHC services in Kuwait cover dental care, maternal and child care, prevention and vaccination, diabetes and family medicine. The primary care system in Kuwait operates as a gatekeeper in the overall healthcare system (Badawi et al., 2015). Primary care centres in Kuwait are based in the community, so they meet a geographical definition of primary care and comprise a range of services such as maternal and child health (as in Alma Ata), general practitioner or family medicine and specialist services based in the community such as diabetic clinics and radiology.

The strength of primary care in Kuwait could be accessed through several dimensions, one of which is patient satisfaction, which reflects on the quality of care provided (Al-Otaibi et al., 2015). In a study by Al-Doghaither et al., 2001, the overall mean score of patient satisfaction was more than 60% in a sample of 301 patients from five primary healthcare centres in different geographic areas in Kuwait (Al-Doghaither et al., 2001).

Nevertheless, when examining the prevalence of certain NCDs in Kuwait, the rates are alarming. Kuwait has been ranked the third highest for prevalence of diabetes patients

worldwide, according to the International Diabetes Federation. Dr.Kazem Behbehani, Director General of Dasman Diabetes Institute mentioned in an article that:

“Kuwait’s healthcare, consisting of 6 general hospitals and over 94 primary healthcare centres, focuses on cancer and other highly prevalent diseases. However chronic diseases, such as diabetes, are growing at a rapid rate”(MarcoPolis, 2012).

Since 2009, there has been a substantial increase in primary healthcare visits in Kuwait. Table 3.2 shows the increase in the patients’ visit to PHC between 2009-2013 in general healthcare clinics and child care among Kuwaiti and Non-Kuwaiti patients (Ministry of Health Kuwait, 2013).

Table 3. 2: Number of patient visits between 2009-2013

PHC clinics	Year 2009 (visitor)	Year 2013 (visitor)
General Healthcare Clinics	9.0 million	13.2 million
Childcare Clinics	3.6 million	4.5 million

In 2013, Kuwaitis comprised 64% of the visit to PHCCs, whereas non Kuwaitis comprised 36%. Data from the same year show that 66 diabetic clinics existed and welcomed an average of 730 patients daily. Non Kuwaitis constituted the higher percentage of visits to these clinics with Al-Farwaniya PHC attracting the highest number of patient visits and the Capital region the least (MOH, 2013). In Kuwait, patients cannot access specialist care without a referral from primary care. This adds to the strength of the primary care system in Kuwait (MOH Kuwait, 2014).

While the Kuwait government has the capacity to expand the number of primary healthcare centres with the availability of financial resources for that cause, the major challenge that faces primary healthcare systems in Kuwait is attributed to the high prevalence of non-communicable diseases as mentioned earlier. This high number of patients suffering from diabetes or any other NCD renders an increased number of patients seeking primary healthcare. This has resulted in long waiting hours and an overburden of workload on healthcare providers (WHO, 2014). This has put the Ministry of Health in Kuwait under an obligation to prioritise investing to strengthening primary care and placing it a national top priority, as such the primary role of primary care in Kuwait is to invest in health promotion to lower the prevalence of NCDs and their risk factors, specifically obesity and diabetes.

3.10. Primary healthcare accreditation

To cope with the challenges facing primary healthcare globally, strengthening primary care is required. Accreditation plays an important role in strengthening primary care to provide best quality care with the minimum use of resources, thus making it more affordable and continuous (Kringos et al., 2013).

3.10.1 The status of accreditation in primary care globally

The demand for accreditation in primary healthcare is increasing; placing accredited PHCs in an advantageous image compared to the non-accredited centres. Accreditation of PHC aims not only at improving the quality of health services but also the work environment of healthcare workers and enhancing patient satisfaction (El Jardali et al., 2014). The healthcare system that focuses on improving quality in PHC is strengthening the role of PHC and placing a greater importance on better management of care, improving efficiency of healthcare system, focusing on risk management, patient safety and employee satisfaction (El Jardali et al., 2014).

In the WHO report on “Quality and Accreditation in Healthcare Services” 2003, several vital points regarding the partnership among countries towards improving quality in primary healthcare settings were addressed. The report emphasized the importance of a health information system at the PHC level that renders a cost effective run of services. In addition to that, EMRO commenced the initiation of accreditation auditing and consultations systems for primary health care systems.

Many countries emphasised the development of primary healthcare and advocated for accreditation and partnerships. For example, the African Development Bank assisted in financing primary health services such as maternal and child care, family planning and disease control in the African Region; whereas in the Asian region, the Asian Development Bank helped Mongolia in reforming its healthcare system by focusing on primary healthcare and its accreditation. The latter also advocated for creating collaborations between the private and public sector in Mongolia to improve efficiency, accessibility and quality of the health services. In Canada, the Canadian International Development Agency focused on enhancing cost effectiveness of services by emphasizing the implementation of technologies in the health system. In that sense, WHO member states should partner and collaborate among each other to achieve better quality of health services through focusing on accreditation in primary health care systems to achieve a cost effective, responsive and accessible care (WHO, 2003).

Primary care empowers primary care physicians and staff. By emphasizing their importance, healthcare providers in primary care become the liaison between the community and the advanced healthcare system that helps people make better informed health decisions (WHO, 2008^b). Studies have confirmed that healthcare workers including providers and administrative staff in an accredited PHC are more satisfied than those in non-accredited centres. This is attributed to the fact that they work in a well structured environment with clear policies and procedures. The enhanced communication and team spirit in accredited PHCs among healthcare providers, directors and staff are also main features of the positive impact of accreditation in PHCs on staff satisfaction (Gadallah et al., 2010). Directors' satisfaction is aligned with that of staff, especially attributed to clear documentation and applied theory into practice (El Jardali et al., 2014).

By placing the people as the centre of care, primary care services render better health outcomes on the patient (WHO, 2008^b). Patient satisfaction proved to be an indirect advantage of accreditation in PHC. Patients may trust and show higher levels of satisfaction in accredited PHCs. Their voice being heard and the fact that an accredited PHC allows patients to raise their complaints have placed accredited PHCs in an accountable and reliable status according to patients. Moreover, the fact that the patient builds rapport with the healthcare provider and trusts the care giver, allowed them to better follow the medical prescriptions and advise (Gadallah et al., 2010).

There are, however, challenges to implementing accreditation programmes. Financial limitations can hinder the proper implementation of high quality PHC services required by the accredited institutions. It requires financial resources to run required services, purchase required equipment, and improves infrastructure, continuous monitoring and follow up (El Jardali et al., 2014). Resistance to change is possibly another challenge especially if staff do not recognize the added value of accreditation in their practices. It is hard to convince a healthcare provider who has been practicing for few decades to comply with specific guidelines and follow on certain procedures and documentations' requirements (El Jardali et al., 2014). In addition to that, high workload and stress on PHC staff and healthcare workers especially at the initial stages is also a key obstacle for implementing accreditation in PHC (El Jardali et al., 2014).

Finally, political commitment and leadership that prioritize and direct resources to invest in primary care services remain the key factor in overcoming the challenges facing

implementing accreditation in PHC. Primary care services that in turn respond to the rising health needs of the population (WHO, 2008^b). As an initiative towards developing the healthcare system in Kuwait, Kuwait's health system is working towards obtaining accreditation, of which is primary healthcare accreditation. Accreditation in a healthcare setting is a crucial step towards efficiency in a health system, which leads to improved quality of health services provided while reducing costs.

3.11. Summary

The chapter highlights the importance of strengthening primary care by focusing on improving the dimensions of the system (Structure process and outcome). Accreditation is an important tool that aims at improving the quality of care through better performance in all dimensions. The next chapter will focus more on the importance of accreditation on health care personnel, patients and the healthcare system which in turn will lead to improvement in performance and better health outcomes.

CHAPTER 4: Accreditation

4.1. Introduction

This chapter provides a background to the definition of accreditation and its progress as a quality improvement tool. The chapter provides some definitions of key terms in accreditation and quality as well as summarising key evidence on the impact of accreditation on personnel satisfaction, patient satisfaction, outcomes of care and the sustainability of healthcare organizations. Moreover, in this chapter a brief overview on the status of accreditation in the Eastern Mediterranean Region (EMR) and Kuwait in the hospital sector as well as the primary care sector is provided.

For the accreditation chapter, a standardized search of the literature was followed. To identify literature on the history and background of accreditation, seven databases were searched (EMBASE, EBSCO, SCOPUS, MEDLINE, BRITISH NURSING INDEX, HEALTH MANAGEMENT IMPROVEMENT CONSORTIUM and OVID) as well as websites of the Ministry of Health, Kuwait, Ministry of Public Health Qatar, The JCI webpage, WHO webpage and US Department of Health and Human Services. The literature identified provided definitions of accreditation, dimensions, key concepts and the history of the development of accreditation, the different accreditation schemes, as well as some advantages and disadvantages.

Articles identified from the systematic review, but then excluded as they were not focused on PHC, were also used. After evaluating the articles collected, I ended up using around 22 articles related to accreditation history, definition and dimensions, 4 books and toolkits on accreditation as well as 8 reports from official websites such as the JCI, WHO, MOH Kuwait and MOH Qatar.

4.2. Background

Accreditation in healthcare is an internationally recognized process used to assess and improve the quality of healthcare services provided as well as improve the efficiency, and effectiveness of resource use in health care organizations for better health outcomes (WHO, 2003; Alkhenizan and Shaw, 2011; Nicklin, 2015). It is also a way to publicly recognize that a health care organization has met national quality benchmarks and standards (Nicklin, 2015).

There is a long history to the development of the definition of accreditation, with much of it originating in the United States. This is covered in more detail in Section 4.3.

Accreditation is now seen as one approach to help standardize the quality of care delivered within a health care system, sitting alongside with other quality improvement and patient safety approaches. Accreditation has been updated from the previous traditional practice which was driven by medical professions and aimed only at quality assurance and safety (Shaw, 2004). Nowadays accreditation goes beyond quality assurance; it aims at achieving highest standards in quality and quality improvement on a continuous basis (Shaw, 2004). Hence, accreditation has become one part of a continuous quality improvement system with global recognition and demand of improving quality of care (WHO, 2003; Shaw, 2004). The US Department of Health and Human Services defined healthcare quality as getting the *“right care to the right patient at the right time-every time, with the focus on three dimensions: structure, process and outcome”* (US Department of Health and Human Services, 2013). Ideally, to achieve effective accreditation programs that are affordable and sustainable, factors such as a robust political system, organisational structure, implementation and sufficient resources have to be met (Shaw, 2004).

As part of accreditation program, the World Health Organization (WHO) addressed six dimensions of quality (WHO, 2004). Accreditation programmes have to be “effective” and “efficient”. Effectiveness aims at providing evidence-based healthcare treatment and efficiency ensures providing healthcare in a way that maximizes the use and benefit with the minimum resource use or waste generated. “Accessibility” and embracing a “patient-centred approach” are also important dimensions to consider as part of accreditation programmes. Accessibility and patient focused dimensions are crucial to deliver healthcare services in a timely manner, geographically accessible to different groups and subgroups of the population as well as taking a patient centred approach that is responsive to the medical needs, demands and expectations of the community. Moreover, accreditation programs have to be “equitable”, that is not compromising quality or service delivery for any reason of gender, ethnicity, economic status, race, etc. and “safe”, that is providing healthcare in a manner that minimizes the risk and harm to users (WHO, 2004).

4.3. Definitions

While the below definitions of accreditation cover its purpose and principles (Table 4.1), the definition provided by Shaw, 2004 is the one I am adopting in this study as it is comprehensive in terms of defining accreditation by purpose, responsibilities, principles as well as highlighting the importance of continuity for quality improvement (Shaw, 2004).

Table 4.1: Different definitions of accreditation

Organisation/Citation	Definition
(World Health Organization, 2003)	<p>‘Accreditation is usually performed by a multidisciplinary team of health professionals and is assessed against published standards for the environment in which clinical care is delivered’.</p> <p>On page 58, it is made clear that accreditation, in this context, applies to organizations rather than to speciality clinical training.</p>
(Shaw, 2004)	<p>‘Accreditation is usually a voluntary program, sponsored by a non-governmental agency (NGO), in which trained external peer reviewers evaluate a health care organization’s compliance with pre-established performance standards. Accreditation addresses organizational, rather than individual practitioner, capability or performance..... accreditation focuses on continuous improvement strategies and achievement of optimal quality standards’</p>
(Pomey et al., 2004)	<p>Quote the National Agency for Healthcare Accreditation and Evaluation (1999) definition:</p> <p>‘... an evaluation process carried out by independent professionals external to the health care organization and its governing bodies, focusing on its functioning and practices as a whole. It aims to ensure that conditions regarding the safety, quality of care and treatment of patients are taken into account by the health care organization’.</p>
(Hinchcliff et al., 2012)	<p>‘The purpose of accreditation programmes is to monitor and promote, via self and external assessment, healthcare organisation performance against predetermined optimal standards.’</p>
(Nicklin, 2015)	<p>‘Accreditation is an internationally recognized evaluation process use to assess and improve the quality, efficiency and effectiveness of health care organizations. Based on the premise that adherence to evidence-based standards will produce higher quality health care services in an increasingly safe environment. A way to publicly recognize that a health care organization has met national quality standards.’</p>

Accreditation is generally voluntary and involves the assessment of performance to targets and standards usually through external teams of reviewers (WHO, 2003; Shaw, 2004; Nicklin, 2015). This considers the process of accreditation as voluntary and aims at evaluating the services provided by the healthcare organization by an external body. The assessment is done by evaluating the data on the current status and operation of the services against international standards, and is completed by a visit from the external expert to discuss the results and outcomes of the self-assessment and provide recommendations for improvement (Shaw, 2004; Sicotte and Champagne, 2008).

Organizations which participate in accreditation programmes often, perceive it as a reliable and important tool for improving the quality of health services they provide. Simply put, accreditation is based on the premise that adherence to evidence-based standards will improve the quality of health care services provided in an increasingly safe environment and in a sustainable way (WHO, 2003; Nicklin, 2013).

4.4. Historical overview of accreditation development

The term accreditation was first coined in the US in 1917 for recognition of surgery training posts; this included the development of a set of minimum standards for hospitals and hospital inspections carried out by the American College of Surgeons (The Joint Commission, 2016). The oldest accrediting body is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), created in 1951 (Shaw et al., 2003). Originally called the Joint Commission on Accreditation of Hospitals, it was a joint venture between the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and Canadian Medical Association (Ratcliffe, 2009). In 1966, Donabedian published his now seminal paper on the evaluation of quality in medical care (Donabedian, 2005). This paper established a new focused attention on three areas. First is structure, namely the physical and staffing characteristics of health systems. Second is process, the activities that have to take place to provide care and third is the outcome, the results of care. In response to this, accreditation approaches in hospitals began to focus heavily on structure and related it to quality. For example, questions in surveys mainly revolved around the presence of adequate infrastructure of a healthcare organisation such as organized staff, management plans, monitoring plans and evaluation strategies to assess the quality of care provided (Ratcliffe, 2009). Disseminating the findings, discussing the actions that were put into place, and highlighting the impact of clinical outcomes were also of significance to assess the structure of healthcare organisations and assess their preparedness (Ratcliffe, 2009). Accrediting programmes can

also target different aspects of a healthcare system. For example, some may target the entire health care institution, while others focus on individual private or public services such as cardiac or endoscopy services (Shaw et al., 2003).

In 1986, among many major changes taking place, the Joint Commission Standards along with the Medicare Conditions of Participation expanded their work to address a wider array of process and outcome activities and other health care sectors, including home care organizations. At this point performance standards such as “reviews of infection control, surgical and anaesthesia services, and quality assurance (QA)” became incorporated into accreditation standards (Shaw et al., 2003; Ratcliffe, 2009) and the organisation changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). There was also a steady expansion of accreditation programmes in other countries. Unlike other quality assurance schemes such as the International Organisation for Standardization (ISO), licensing and peer review, accreditation became a unified national coordination programme (Shaw, 2004). What started as a voluntary programme has also, in some countries, developed to involve government programmes as well, some of them becoming mandatory particularly as an extension of statutory licensing (Shaw et al., 2003). For example, compared to accreditation in Canada, where it is optional, accreditation in France is compulsory. This has led to further interest in evaluating the level to which the accreditation process acts as a tool for bureaucratic coercion as opposed to a tool of continuous improvement and learning. This however, showed that accreditation has positive impact whether it was implemented on a compulsory or voluntary basis. Other studies have shown that mixed model of compulsory and voluntary standards is favourable in which some aspects of the system become more coercive and other become more flexible and open to be a learning tool (Pomey, 2010). Comparison of the two approaches however, shows that current trends in the evolution of accreditation could threaten the purpose of the accreditation process. Countries like Canada have made healthcare accreditations obligatory by the government for all public and private healthcare institutions in several provinces in Canada and in others the government have made recommendations to place it as a mandatory approach for healthcare bodies (Nicklin, 2015). As such, different countries are choosing to develop accreditation programmes in slightly different ways. In some countries, quality assurance in health care has been left to professional organizations and provider associations with little specific regulation (Tabrizi et al., 2011). Different accreditation schemes therefore exist with a variety of programmes or target different areas of a health care system. This is summarised in Table 4.2, drawing

on the work of Tabrizi et al and the 2003 WHO report which defines the current state of accreditation systems by country (Tabrizi et al., 2011), showing that different countries chose to develop accreditation in slightly different ways. However, the Canadian, Australian, French, and New Zealand's systems, as reported by WHO reports, are considered to be the most influential on the development of global accreditation standards. This is a crucial point to the study as it will be taken into consideration when thinking about the accreditation system in Kuwait that has been imported from Canada and its advantages and drawbacks (Tabrizi et al., 2011).

Table 4.2: Countries different accreditation schemes

Country	Type of accreditation	Accreditation characteristic
Australia	The Australian Council on health care standards (ACHS)	Focuses especially on the improvement of clinical care
Canada	Canadian Council on Health Services Accreditation (CCHSA)	The second largest established program in the world; emphasizes the continuous improvement of quality and patient safety
France	A gency Nationale d'Accréditation et d'Evaluation en Santé (ANAES)	A government agency, which established the accreditation of colleges, and which must accredit all public and private health services in France including more than 3250 hospitals. Unlike other countries, this accreditation programme is mandatory.
India		Health care in this country is considered the responsibility of individual states therefore it is considered impractical to have a national accreditation programme. However state and central governments may implement a voluntary accreditation system, through peer review
Ireland	Irish Health System Accreditation Scheme (IHSAS)	The accreditation project, which initially started for the acute health services began in 1999 and was completed by 2001. The IHSAS is now being implemented mostly in the acute health care sector but plans to extend to all other health care entities
New Zealand	Quality Health New Zealand (QHNZ)	QHNZ emphasizes mostly on the evidence-based decision making through efficient information management
USA	Joint Commission on Accreditation of Healthcare Organizations (JCHAO)	JCHAO, from which all subsequent national programmes have been derived, mainly focuses on "best practices" in the organization and the design of standards that work towards preventing injury in health care.
UK	The Royal College of General Practitioners'(RCGP)	UK's RCGP has three quality accreditation schemes for general practice teams, including Quality Practice Award (QPA), as well as

		Quality Team Development (QTD) and Practice Accreditation.
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As outlined above, countries have different definitions and foci when it comes to accreditation programmes. With respect to the UK, accreditation for general practices is overseen by the Royal College of General Practitioners' (RCGP), which is "a professional membership body for family doctors in the UK and overseas" focusing on patient care improvement and training of general practitioners. The RCGP has achieved considerable expertise in the professional development and education of GPs and setting minimum standards for the General Practice field. RCGP has established three accreditation schemes for the quality of general practice teams, developing frameworks, processes, and plans to support the improvement of all general practices throughout the whole process (RCGP, 2013).

The schemes are the Quality Practice Award (QPA), the Quality Team Development (QTD), and Practice Accreditation. Only QPA applies across the UK, and is a voluntary process to which primary care teams can apply to; it is a multidisciplinary initiative involving all health professionals in a practice, including primary care nurses, health visitors and midwives (Ring et al., 2003; RCGP, 2013).

The basic principles underlying the QPA are working through multi-professional teams, meeting all pre-set quality criteria based on 17 categories (practice profile, availability, clinical care, communication, continuity of care, equipment, health and safety, health promotion, information technology, medical records, nursing and midwifery, practice management, other professional staff, patient issues, premises, prescribing and repeat prescribing, and the practice as a learning organization), practice based on evidence, the use of accreditation to improve quality of care, and encouraging the development of practice personnel (RCGP, 2013). The QPA is the highest accreditation award from the RCGP, and recognizes that practice teams which have shown both organizational and clinical excellence in the delivery of primary care (RCGP, 2013).

Practice Accreditation (PA) recognizes practices who have demonstrated good practice from an organizational point of view while delivering primary care. Practices that complete the PA award can continue the process to achieve the QPA award (RCGP, 2013). Both awards share a common goal of improving quality of care of patients. Practices that complete the PA can be ready to continue throughout the process to achieve the QPA award.

The Quality Team Development (QTD) award was launched in 2000 and designed to provide a formative framework that would enable GP practices and the wider primary care team to assess the quality of the services they provide for patients and the way their team functioned, and also provided benchmarking standards for use by Primary Care Organizations in England and Wales (PCOs—district level organizations responsible for overseeing the work of GP practices).

Accreditation Canada International (ACI), was launched to support clients outside Canada in 2000 as the international service division under CCHSA which later became ACI. It is known to involve patients, families, staff, board members, directors, and community partners within an accreditation cycle which ultimately aims to enhance health outcomes, efficiency, and quality and safety, as well as decrease risks. This accreditation body now works with over 7,000 health care organizations including primary, secondary and tertiary care settings, dental care and emergency medical services, and independent health facilities (ACI, 2017). It has a team of more than 500 surveyors with varied backgrounds which allowed them to assemble an accreditation survey team that is tailored to different levels of health care organizations. ACI aims to improve health care outcomes, and patient safety, as well as healthcare ethics.

The UK programme differs from the Canadian programme by focusing primarily on process rather than outcomes, and on education for improvement. In addition, the UK programmes focus only on primary care, involving only GPs and healthcare professionals working with general practices. The ACI programme has a broader remit, which involves all healthcare professionals working in different sectors, as well as patients, social workers and the public. Patients and families are full partners in what ACI does.

In Kuwait, ACI was chosen as the accreditation agency over other internationally known accreditation bodies to survey primary health care centres. This was due to the size of primary health care centres in Kuwait, and the number and type of health services provided which was more closely aligned to the types surveyed and accredited by the ACI model. Moreover, the aims of Kuwaiti's MOH was aligned with that of ACI, including a broader perspective of improving PHC by involving a greater range of services and professional groups. This made the ACI scheme a better fit with the Kuwaiti model. ACI was also chosen by other countries in the Middle East and GCC countries such as Lebanon, UAE, Qatar and Saudi Arabia to implement accreditation standards at their healthcare facilities

across all health system levels (primary, secondary and tertiary) under one contract. Therefore, ACI was chosen by Kuwait rather than for example schemes available in the UK, which cater only for primary health care centres in small model practices that is different from the Kuwaiti model.

4.5. Accreditation

Given the extent of the literature on the impact of accreditation, this section and the next draws principally on a number of systematic reviews, supplemented with primary data studies. The aim of accreditation is to guide organizations towards delivering better quality healthcare (Sicotte and Champagne, 2008).

Accreditation programmes can promote change in health organisations by standardising the organising and decision making of care rather than producing care outcomes. This is now discussed.

4.5.1. Key principles of Accreditation

4.5.1.1. Outcomes of care

Accreditation provides a framework to help create and implement systems and processes that improve operational effectiveness and advance positive health outcomes (Nicklin, 2015). Accreditation is essential in empowering systems and processes in the health care institution improve the quality of care and subsequently health care outcomes (Nicklin, 2015). Yet, it is also essential to highlight that there remains inconclusive evidence regarding accredited health care institutions' ability to improve and provide high quality health care (El Jardali et al., 2008) or to improve the delivery of patient care (Duckett, 1983; Nicklin, 2015).

4.5.1.2. Practitioner satisfaction

Literature has agreed on several benefits of accreditation for healthcare personnel. Healthcare institutions that are accredited have shown better staff involvement and dedication, better teamwork, better awareness on patient safety, more quality assurance projects, trained staff, better accessibility to care, improved care processes and quality of care (El Jardali et al., 2008; Hinchcliff et al., 2012; El Jardali et al., 2014). For example, nurses from 59 hospitals in a Lebanese study stated that they felt a tangible improvement in the delivery of quality care as a result of accreditation (El Jardali et al., 2008). An older study that compared the impact of accreditation in accredited versus non-accredited

hospitals showed that nurses from accredited hospitals had high positive opinion about accreditation (Duckett, 1983). Moreover, accreditation not only improved the communication among the staff, but also between the staff and external stakeholders. This was through establishing a communication culture through defined communication schemes, decision making schemes and clear vision, mission and organisational structure (O'Daniel, 2008). Such effective communication does not only improve staff satisfaction but may also have an impact on reducing medical errors that happen as a result of lack of communication. Creating a learning environment is another benefit from accreditation for staff, where variation in practice is reduced, a healthy environment for achieving the goals and visions of the institution are established and a culture of striving for excellence and continuous training creates a sustainable healthcare organisation (Hinchcliff et al., 2012; Nicklin, 2015).

The systems and processes previously adopted may need to change to fit the requirements of the accreditation system and ensure that their performance is improving with the support of trained staff (Montagu, 2003; World Development Group Incorporated, 2006).

However, for the management and senior staff employees, accreditation might cause more work and stress. Health care professionals support accreditation programmes but there are concerns including: difficulties with using and interpreting programmes; programmes perceived to add little to patient care; direct and indirect costs and perceived inconsistency amongst surveyors (Greenfield et al., 2008; Greenfield et al., 2007; Alkhenizan and Shaw, 2012).

4.5.1.3. Patient satisfaction

Accreditation has been found to impact on patient satisfaction, at least in hospitals. Accredited organisations have better patient safety outcomes and quality of health outcomes. Equitable health outcomes among all population groups may also result from accreditation; with better distribution of good quality services and cost-effective use of resources have been shown to have increased, which may offer the most disadvantaged equitable opportunities to access good quality care (El Jardali et al., 2013).

4.5.1.4. Costs/Resources

Accreditation also positively impacts the financial outcomes of an organization. It decreases liability costs, supports effective investment and use of health care services resources, and pinpoints areas that need funding instead of distributing budgets in a random matter (Nicklin, 2015). Accreditation can aid health care institutions in

participating in reimbursement programs (Nicklin, 2015). Yet, on the other hand accreditation demands a huge budget and sustainable funding; as was the case in Zambia where a review highlighted that accreditation costs are usually not covered by government resources alone, and need external donors (Bukonda, 2003). Institutions that are short of funding prefer to use their resources to run their services rather than spend it on accreditation (El Jardali et al., 2014), suggesting that there is work to do in communicating the long-term benefit of accreditation to healthcare organizations.

4.5.1.5. Sustainability/ Continuous performance Improvement

Accreditation demonstrates an institution accountable and credible for quality of healthcare (Nicklin, 2015) and enhances the sustainability of a healthcare quality improvement approach by supporting the efficient and effective use of resources and ongoing self-evaluation against standards (Hinchcliff et al., 2012; Nicklin, 2015). As such, it is a process of continuous quality improvement, in which new challenges arise that healthcare organisations need to address in order to continuously meet international standards (Pomey et al., 2010). It is stated that accreditation by itself is not necessarily the agent of change, but rather the process of accreditation is an effective tool of continuous learning, planning and improvement to achieve better outcomes (Braithwaite et al., 2010; Pomey et al., 2010).

In addition to that, the existing national policies and governmental support, sufficient and stable funding is also crucial for the sustainability of accreditation programmes that are effective and tailored towards the needs of the population and healthcare institutions (Braithwaite et al., 2012).

4.6. Accreditation in primary health care

To date, much of the work on healthcare accreditation has focused on the hospital sector. Accreditation is now very much linked to quality improvement (Shaw, 2004). However, the shift from treatment to prevention and the movement of care from hospital-based settings to primary care are key drivers for striving to implement accreditation in PHC.

PHC faces several obstacles in this journey, including staffing constraints, minimal resources, and lack of support (El Jardali, 2013). To understand the background of the existing literature about accreditation in primary healthcare the rest of this chapter will focus on describing accreditation in the WHO Eastern Mediterranean Region (EMR) in general and Kuwait in particular.

4.7. Accreditation status in the EMR region

Healthcare accreditation has been an important activity in many of the WHO EMR member States. After the success of hospital accreditations systems in several EMR countries, member states started focusing on primary care accreditation (Ammar, 2009; WHO, 2010; El Jardali et al., 2013). Strengthening primary care in these countries became a priority and as such accreditation of primary care services was placed on the agendas of policy makers (WHO, 2008). More recently, assessing and improving the quality of PHC has become a high priority in many of these countries. For example, Lebanon launched a primary care accreditation system in 2009 as a means to strengthen primary care (Ammar, 2009; WHO, 2010). Similarly, Bahrain, Qatar and Dubai, after successful implementation of hospital accreditation, launched accreditation for their primary care services (Bahrain News Agency, 2014; Ministry of Public Health Qatar, 2015). In Qatar for example, the Healthcare Facilities Accreditation Section was established in 2009 as a part of Healthcare Quality and Patient Safety Department, at the Supreme Council of Health. This department is responsible for supporting the healthcare sector in Qatar by setting up a regulatory framework that aims to improve the existing quality performance measures to promote patient safety and best practice (Supreme Council of Health Qatar, 2015). In Dubai, the Joint Commission International (JCI) was appointed by Dubai Health Care City to accredit healthcare organizations which are located and operating within the premises of the city. The fact that evidence shows that countries with strong primary care systems show better health outcomes and cost efficiency; Kuwait is following the same roadmap of other EMR countries in improving quality of care in primary care services by implementing the primary care accreditation system.

4.8. Accreditation in Kuwait

Accreditation provides the means to identify performance improvement opportunities from strengthening the relationship with the customer to enhancing management. Accreditation is a rigorous external evaluation process that comprises self-assessment against a given set of standards, an on-site survey followed by a report with or without recommendations, and the award or refusal of accreditation status (Pomey, 2010).

In the WHO Eastern Mediterranean Region, particularly in Kuwait, numerous efforts towards accreditation by the MOH are underway such as developing a national comprehensive action plan targeted at quality improvement in the PHC setting (Shaw, 2003). In light of this, great attention is made with regard to accreditation and how PHC

can meet the minimum standards set. This programme focuses on the 92 PHC centres (PHCCs) distributed among five of the six health regions. (One health region has no PHCCs). The MOH chose Accreditation Canada to develop an accreditation programme from 2011 till 2016 (Accreditation Canada, 2008). Consequently, a contract agreement between Kuwait's MOH and ACI was signed on 19th of June, 2011 to cover both hospitals and PHC accreditation programme (Ministry of Health, 2012). The overall outcome of this contract agreement is to develop and finalize PHC standards, and provide the health care centres, through education and training, with the capacity to successfully implement those standards and training up to 40 Kuwaiti PHC surveyors recruited by the MOH.

4.9. The MOH pilot accreditation phase

The initial phase of accreditation included a pilot testing for the overall accreditation process. The aim of this pilot test was to examine the PHC standards developed by Accreditation Canada in the Kuwaiti setting. The pilot test consisted of survey visits conducted by external surveyors from ACI accompanied by eight local surveyors from Kuwait who have been trained by Accreditation Canada. In addition, the surveys were also attended by a representative from the MOH who was considered to be the facilitator or coordinator. The role of the MOH representative was to clarify unclear terminology for staff undergoing the survey as well as ensuring the transparency of the process. Five primary care centres representing five of the Kuwait's health regions were chosen for the pilot study which was conducted in December, 2012. The pilot sites were assessed according to their compliance against the required standards through the establishment of self-assessment teams and completing self-assessment questionnaires. Each pilot site was expected to form approximately four to six self-assessment teams depending on the services provided (Ministry of Health, 2012). After the completion of the assessment surveys, external surveyors would check the validity of the presented data and fulfilment of the required standards through site visits. Following this, 15 PHCCs started following similar procedures except that only locals and in-house surveyors were involved. The remaining 72 centres will join the accreditation programme eventually. In this study, the aforementioned PHCCs that have implemented the accreditation process before others and went through pilot are considered "early adopters" especially that their initial surveys have been monitored by ACI. The 15 PHCCs that started following similar procedure but involving local and in house surveyors only are considered "late adopters". Late adopter PHCCs, are those that have been introduced to the accreditation concept, and although they have received local training, lectures, and local surveying by MOH, they still have not

been surveyed by the accrediting agency (ACI), nor are they considered to have enough knowledge and experience to deal with all that relates to accreditation.

PHCCs are divided to three categories: large, medium and small. Large centres provide all types of medical services including PHC, ambulatory care, dental care, pharmacy, obstetrics/gynaecology, mental care and home care. In addition to diagnostic imaging, lab services, medical devices sterilization, specialized clinic such as chronic disease clinic. Large PHC centres also provide public health services such as: health surveillance, health education, community health assessment, health protection, and disease injury and prevention. Medium centres provide all the essential medical services excluding diagnostic imaging. In addition to essential medical services like primary health care, pharmacy, lab services, dental care, medical devices sterilization, home care and specialized clinic such as chronic disease clinic. Small centres provide limited but essential services like those provided by the medium centres excluding diagnostic imaging and laboratory services.

4.10. Summary

Previous studies on accreditation have stated it as a quality improvement tool to improve health outcomes in an efficient and equitable way in a healthcare setting. Accreditation in hospitals has been studied more than accreditation in primary care. Where the focus of care is becoming more towards preventive care, accreditation in primary care settings is gaining further attention and investment. Having outlined both primary care as a system (Chapter 3) and accreditation (Chapter 4), the next chapter will focus on the methodological and theoretical approach which have underpinned the studies reported in this thesis.

CHAPTER 5: Research design and theoretical framework

5.1. Introduction

A research study is as strong as the methodology chosen to conduct the research, the theoretical framework used for data collection and analysis, and the appropriateness of both to answer the intended research questions. As such this chapter presents a discussion of the methodological approaches selected for the current research. In addition, it discusses the importance of adopting a theoretical framework to inform data collection and analysis, explains the selected framework, and justifies the choice. In this chapter, I will explain the ethos behind choosing a case study design for the research approach, the rationale behind using mixed methods for the data collection and Normalization Process Theory to inform the work.

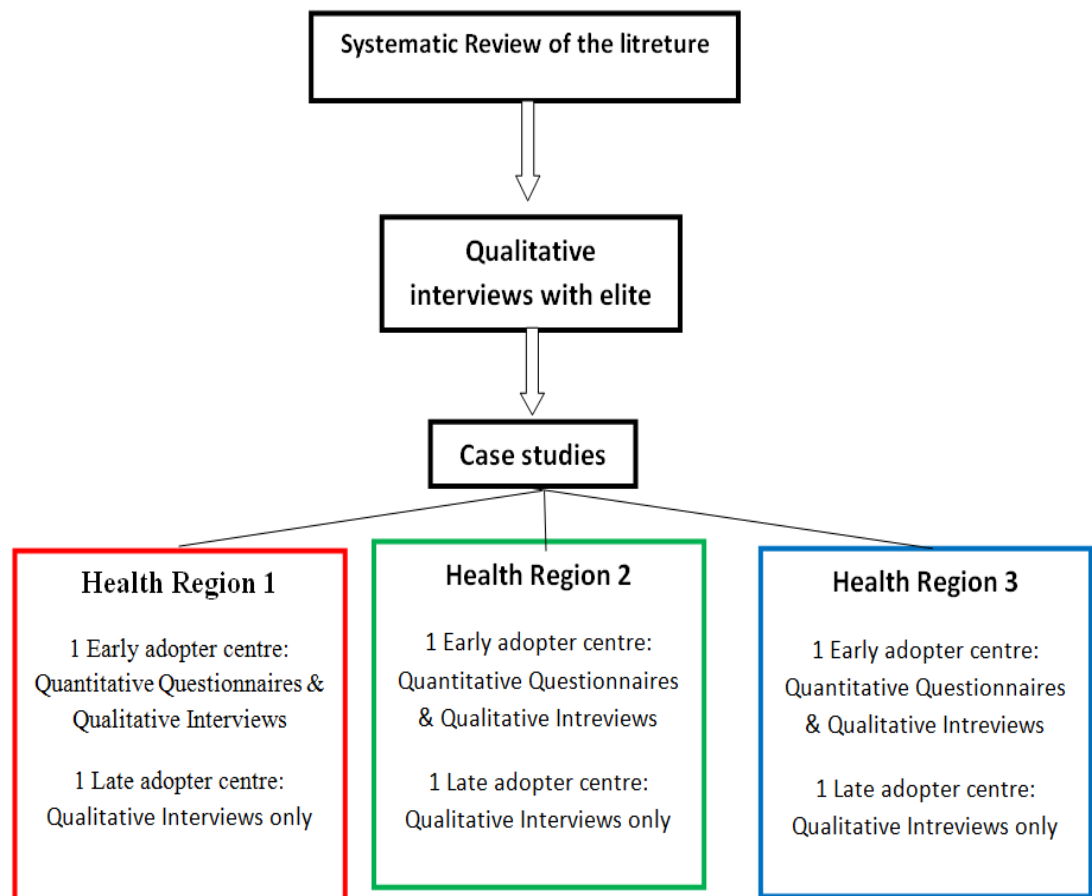
This research used three main research methodologies. The first consisted of a systematic review of the international literature focused on accreditation in primary care. The second approach was a quantitative survey carried out with staff in three PHCCs which had completed the pilot phase of accreditation – termed the early adopting PHCCs. The third approach was qualitative interviews with a range of key stakeholders operating at three levels within the healthcare system of Kuwait: the Ministry of Health (MOH); Heads of the PHCCs (both early and later adopters); and MOH surveyors working in the PHCCs with staff.

The order and structure of these approaches is outlined in Figure 5.1. The three health regions in which the participating PHCCs were located are considered as three case studies, with two types of data collection – the quantitative survey and the interviews with stakeholders. Although the interviews are all reported in the one chapter (Chapter 9), the interviews with stakeholders in the MOH were partially conducted within these case study areas and the remains were taken place in different sites within the MOH. In addition, these individuals operate at a higher level than PHCCs in the health care systems.

Therefore, in Figure 5.1, they are depicted between the systematic review and the case studies and described as ‘elite interviews’. Each results chapter will contain a description of the methods used. In addition, Chapter 7 is a short bridging chapter, describing the case study sites in more detail.

The purpose of this chapter is to discuss first the case study methodology, then the mixed methods approach with a focus on mixing quantitative and qualitative methods, and finally the theoretical framework used in my research.

Figure 5.1: A figure demonstrating the different research methodologies and approaches



5.2. Case study design

As outlined in chapter 1, the overall aim of this study was to explore and understand the implementation of accreditation in Kuwaiti PHC from the perspective of the different professionals involved. For this, a mixed methods study was developed, collecting data in PHCCs located in three different health regions. In order to explore the context in which accreditation was situated in each setting, and to facilitate the use of mixed methods approaches, a case study approach was used.

With the increase in innovation and new technologies that aim to improve the quality of care offered in the healthcare settings, concerns have been raised about how to study the effectiveness of such innovations (Baker, 2011), especially when approaches such as randomised controlled trials are not feasible, as was the case with the introduction of accreditation to Kuwaiti primary care. In his paper *"The contribution of case study research to knowledge of how to improve quality of care"* Baker argues that researching strategies and approaches that facilitate the implementation of change is as important as

understanding the change itself. He went on to suggest that case study research can play a vital role in acquiring an in depth understanding of ways of improving care, and taking account of the different contexts in which implementation occurs (Baker, 2011).

Yin defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined" (Yin, 2014). Case study research designs often entail collecting qualitative and/or quantitative data from several sources to explore systems, or part of them, and their characteristics in a particular context (Baker, 2011; Yin, 2014). This also means that case studies can collect data on different levels, paying attention to both the meso-level (e.g. the department, hospital or, in this research, the Primary Healthcare Centre) and the macro-level (e.g. the wider health care system) contexts. They are thus a powerful tool of research since they are able to cope with situations having more variables of interest than data points (Yin, 2014). This characteristic, along with its ability to utilise multiple sources of evidence makes case study design a particularly appropriate approach to conduct this current research. An additional advantage was that using both quantitative and qualitative methods for data collection with an integrated approach to analysis helped to produce a fuller picture of the phenomenon of interest; i.e. the impact of accreditation in Kuwaiti primary health care. When using a case study approach, however, thought must be given to the type of case study design being applied. This is important, as some argue that with their lack of controls and small sample size case studies cannot be generalised (Fitzgerald, 2009). Critics of the method state that the selection of cases can be unsystematic in the sense that the design and content of case studies can look very varied and there is often not enough justification for the selection of cases (Flyvbjerg, 2006). While these criticisms can be true, researchers tend to miss the advantages that case study design offers in exploring the relationship of organisational processes and the determinants of their success or failure (Baker, 2011; Yin, 2014).

A case study design can be exploratory, descriptive, or explanatory, dependent on the type of questions the research is aiming to address. The objectives of this study could be framed as research questions beginning predominantly with "what" (e.g. What are the barriers, facilitators and impacts of accreditation in the primary care setting on practitioners?). This made the case studies here broadly exploratory (Yin, 2014). An exploratory case study is defined as one which "investigates distinct phenomena characterized by a lack of detailed preliminary research, especially formulated hypotheses that can be tested, and/or by a specific research environment that limits the choice of methodology". This also seemed to

fit the current setting, namely an already defined roll-out of accreditation in Kuwaiti primary care.

The research aimed to develop a deeper understanding of how professionals perceived the impact of accreditation on certain indicators such as management and leadership, human resource utilization, quality management, quality results and patient satisfaction and was located in a real life setting, namely primary healthcare of Kuwait.

Yin has also differentiated between two types of case study research, single or multiple case studies. The difference between a single case study and a multiple case study is that in the latter, the researcher studies multiple cases to understand the differences and the similarities between the cases (Baxter & Jack, 2008; Stake, 1995). Another difference is that the researcher is able to analyse the data both within each situation and across situations (Yin, 2003). Multiple case studies can be used to either compare contrasting results for expected reasons or to identify similar results in different settings (Gustafsson, 2017). In my study, multiple case studies in three different health regions were chosen. This was used for the purpose of replication and verification of the results.

5.2.1. Advantages and challenges of the case study approach

Case study research offers several challenges particularly in ensuring methodological rigour. Rigour can be demonstrated by clearly showing how the data were collected, the analytical procedure and the used theory. It is also helpful to demonstrate how testable or logical any theory emerging from the research is (Baker, 2011). For example, the more the theory or framework of analysis is explained and robust, the more valid the results are. A disadvantage for case study design that many critics raise is how information and findings can be extrapolated to wider settings and thus enrich our understanding of complex processes such as improving healthcare delivery (Baker, 2011). Finally, it offers an in depth data collection and understanding of the context, in addition to paying more attention to the details of the context.

5.2.2. Case study approach in our current research

In the work presented here, there were three case study sites selected – these were three predominantly urban health regions. These health regions were regarded as a specific case by itself, with the research process replicated across all the selected centres. Within each case study, two PHCCs were selected – one which had taken part in the pilot process (an early adopting PHCC) and one still to go through accreditation (late adopting PHCC). Data collection consisted of a cross-sectional questionnaire to health care professionals working

the early adopting PHCCs and qualitative interviews with key stakeholders in both types of PHCCs. More details are given in Chapter 7 on the chosen centres.

The rationale for this mixed methods approach is discussed next. Finally, I will discuss the underpinning theoretical rationale for the overall study and the selection of Normalisation Process Theory to guide data collection and analysis.

5.3. Mixed methods research (MMR) design

5.3.1. Definition

Case studies can include a wide array of data, both qualitative and quantitative. Data sources may include interviews, documents, observation, and surveys. After a thorough review of studies defining mixed methods research, Johnson et. al concluded that “mixed methods research is an intellectual and practical synthesis based on qualitative and quantitative research; it is the third methodological or research paradigm (along with qualitative and quantitative research)”. This kind of research can often provide more “informative, complete, balanced, and useful research results” (Johnson et al., 2007). Furthermore, it underscores the strength of each separate approach (Ostlund et al., 2011). The broad range of perspectives that mixed methods approaches offer makes it appropriate to deal with the complexity of healthcare phenomena such as those being studied here (Ostlund et al., 2011). One of the most important characteristics of mixed methods approach is the ability to integrate findings at one stage of the research or another (Kroll and Neri, 2009).

There are different underlying paradigms and approaches to the research process. While quantitative research seeks to produce objective, reproducible, and generalizable results, qualitative research is concerned with understanding the complex and subjective meanings that emerge for different individuals and groups in particular social contexts and over time (Creswell, Fetters, & Ivankova, 2004). Quantitative methods have long dominated the health sciences, represented by the randomized control trial (RCT) and its focus on hypothesis testing. Health researchers, especially those from a social science background, have also utilized qualitative methods. These include research tools such as observational methods, in-depth interviews, case study evaluations, and focus groups. Many scholars argue, however, that the demands of an increasingly complex health care system and the needs of both practitioners and patients require new and more inclusive approaches to health services research (Curry et al., 2013). The incorporation of mixed research methods is more and more seen to be a valuable and necessary component of research aimed at

improving health services (O’Cathain et al., 2007). Conceptually, the value of combining qualitative and quantitative approaches is the opportunity it brings for diverse perspectives to be brought together. This raises issues, however, about the order in which different types of data are collected and how they are integrated (Wisdom et al., 2012).

5.3.2. Major types of mixed method designs

The main issues in relation to combining qualitative and quantitative methods are priority (the relative importance given to the quantitative and qualitative data collection) and sequence (the order in which they are carried out), depending on the aims of the study (Creswell, Fetters, and Ivankova, 2004). Some limitations of such an approach include the time and complexity of the method and dealing with discrepancies in the case of conflicting findings (Moffat et al., 2006).

Researchers have identified three major analytical approaches of mixed method designs, the parallel, sequential, and concurrent approach. Each is classified depending on the stage of integration of data. In the parallel design, the collection and analysis of both data sets (the quantitative and the qualitative) is carried out separately and the findings are not compared or consolidated until data are brought together and the findings are being interpreted. The concurrent data analysis approach is when each data set is integrated during analysis, after the data have been analysed quantitatively or qualitatively. This merging helps to develop a more complete picture (Onwuegbuzie and Teddlie, 2003). In the sequential data analysis, data are analysed in a particular sequence with the purpose of informing, rather than being integrated with, the other method (Onwuegbuzie and Teddlie, 2003). In some cases, one data set can then lead the investigation using the other method, e.g. qualitative interviews to better understand the findings from a questionnaire (Östlund et al., 2011).

The second major methodological issue to consider is the priority, or weighting, given to the two data collection approaches. The first approach is where the quantitative and qualitative approaches have equal status in the research. These mixed methods researchers are likely to believe that qualitative and quantitative data approaches will add insights as one considers most, if not all, research questions. The other two types are one which is “qualitative dominant” and the other which is “quantitative dominant”. In these two types the researcher relies on either one of the two approaches as a primary approach while recognizing that an additional approach is likely to benefit the research and add to its comprehensibility (Johnson et al., 2007).

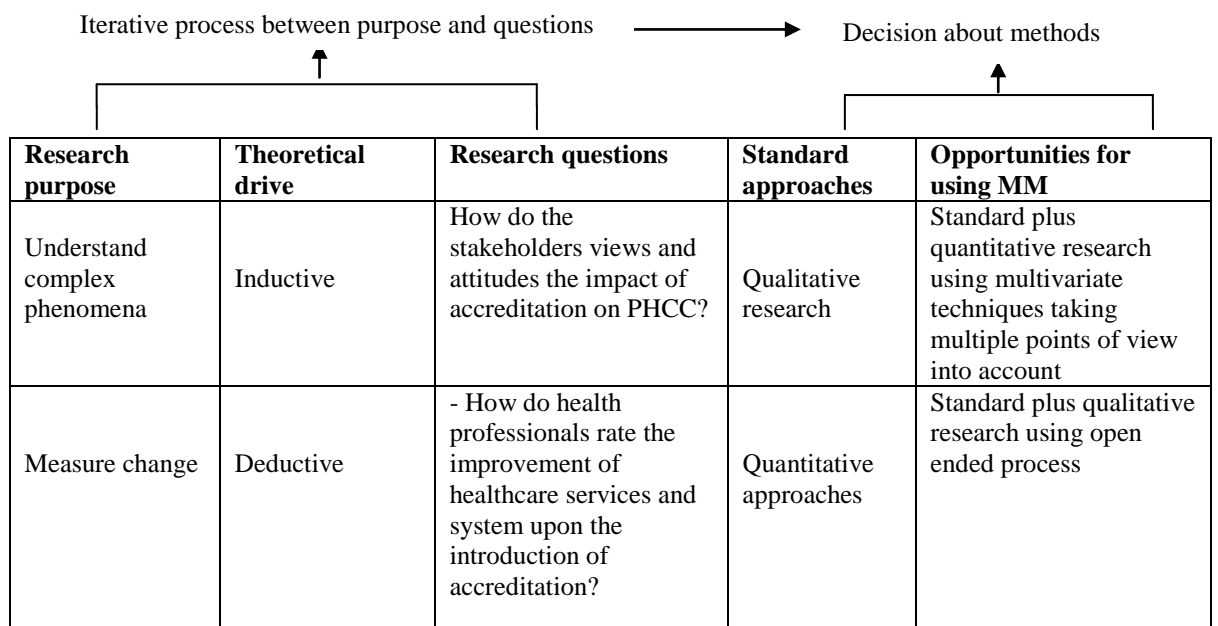
5.4. Rational behind choosing MMR for this study

The different data sources employed in this research necessitated a study design that could accommodate different types of research approaches to data collection were used. First, there was a systematic review of the published literature to inform our understanding of the wider issues in relation to accreditation. Then, in the selected case studies, qualitative data were generated in the form of interviews with senior managers and surveyors in the PHCC centres, as well as in the Kuwaiti MOH. A quantitative study incorporating self-administered questionnaires with a rating scale was also conducted with staff in those centres that had taken part in the pilot. The differentiation between quantitative and qualitative data began from the data collection phase. However, as both the survey and the interviews were conducted at around the same time, the approach was a parallel mixed method approach. In addition, the approaches were each given equal weighting in the final analysis.

At the analysis stage, each set of data was first analysed separately, as described in chapters 6 (systematic review), 8 (survey) and 9 (interviews). In chapter 10, the key findings from each study were then brought together in order to identify commonalities and differences across the different data sources.

Figure 5.2 (below) inspired from Pommier et al, 2010 depicts the mixing process and describes the relationships and iterative process between the qualitative and quantitative approaches, the different datasets and the project phases.

Figure 5.2: Mixing Process and relationships and iterative process between the quantitative and qualitative approaches



5.5. Theoretical Framework

5.5.1. Integrated theoretical framework for research

Since the main purpose of research in healthcare delivery is to improve patients' care, it is not enough that the findings are disseminated to individuals. The science of healthcare delivery takes a systems view in order to achieve outcomes at the population level (Pronovost, 2011). The difficulties and barriers of moving from basic biomedical research, through clinical research into implementation research means that researchers have to address the gap between developing new treatments and knowledge and implementing these in practice for the patient or population groups. This is often referred to as the T2 translational gap (Woolf, 2008; Pronovost, 2011). This need to consider implementation has driven healthcare research to look for theories that have the ability to inform researchers, and policy makers about the implementation of interventions in every day settings.

Research in the healthcare setting strives to provide findings that could improve the effectiveness and efficiency of patient care. However, as discussed above, there is often a gap in the translation of research to practice, or between the findings of research and their actual implementation in the healthcare setting (Woolf, 2008; Pronovost, 2011; Eccles et al., 2009). This could be attributed to either the absence of clear methodologies that can guide such implementation or to the poor applicability of the findings. Through discussing the framework proposed by the UK Medical Research Council for the development and evaluation of complex interventions (Craig et al., 2008), Eccles et al shed light on the importance of using theory to help guide and understand the development and implementation of interventions, particularly complex multifaceted interventions such as accreditation (Eccles et al., 2005).

The advantages of using theory include: it provides a framework that is generalizable across settings and across individuals; it offers an opportunity to develop and add to knowledge in the field; and it can guide data collection and analysis (Eccles et al., 2005; Davidoff et al., 2015; O'Donnell, 2017). Indeed, Kleinman and Dougherty described much of quality improvement work in healthcare as a 'black box' and suggested that one way was to use theory to help 'unpack' what is taking place (Kleinman & Dougherty, 2013). In order to do, it is helpful to understand what theory is. Theory has been defined as "a coherent and non-contradictory set of statements, concepts or ideas that organises, predicts and explains phenomena, events, behaviour" (Bem & De Jong, 2013). An example of how theories may shape the implementation of change is the social cognition theories. These

theories state that audit and feedback (as interventions) can only produce change in motivated populations, and may not work in populations lacking such motivation (Eccles et al., 2005). There are generally three recognised levels of theory, as outlined in O'Donnell et al., 2017.

- Grand theory: abstract and broadly applicable across different areas and subject.
- Mid-range or 'big' theory: addresses specific phenomena or concepts and can be developed into testable questions and used to inform intervention development.
- Programme theory: specifies particular components on an intervention in a logic model, usually linking a programme's processes and inputs to its intended outcomes.

As identified by Ferlie and Shortell, 2001, an intervention needs to operate at one, or more, of the following levels: individual health professional, health care groups, health care organizations, larger health care systems. The relevant theory used thus depends on the level which the intervention is intended to operate in. In order to be able to translate the research findings into routine practice, a full exploration of the theories relevant to the directed intervention should be carried out (Eccles et al., 2005). Having a rationale behind choosing a theory is a key in the success of choosing the theory.

As outlined earlier, case study research usually generates large quantities of data making analysis a complex and critical issue. Thus the need for a robust theory or method to help organise and sort the data is clear (Baker, 2011). The theory intended to be used in this research needed to consider interventions implemented at the level of health care organizations since accreditation is targeted at the level of primary healthcare centres. In 2009, Damschroder et al published a study that scrutinized the currently available theories that promote effective implementation of interventions. The study concluded in developing the Consolidated Framework for Implementation Research (CFIR) which offers an "over arching typology to promote the implementation of theory development and verification about what works, where and why in multiple contexts" (Damschroder et al., 2009). Since then the CFIR has been used in a range of implementation settings, mainly in hospitals (Kirk et al., 2016). However, it is not the only theory of implementation research with other common frameworks including the RE-AIM Framework; Promoting Action on Research Implementation in Health Services (PARIHS), and Normalization Process Theory (NPT). These are included in a high level review by Tabak et al, 2012. While all are concerned with furthering our understanding of the process of implementing complex

interventions, Tabak's review identified differences in the health system level at which each operated. Thus, while all operated at the level of individuals, organizations and communities, only NPT also offered a lens to consider the health system. This, therefore, was a particular reason to select NPT as the theoretical framework to guide this project. Normalization Process Theory is a middle range sociological theory concerned with the work that people and organizations have to do to embed a new intervention or way of working into routine practice (May et al., 2009; May and Finch, 2009). Thus it provides a robust and replicable theoretical framework for analysing the concepts involved in the implementation of complex interventions. NPT is intended to explain and dissect the elements of an intervention in a specific setting and addresses the work that both individuals and groups have to do (May and Finch, 2009). As a mid-range theory, it is possible to develop testable questions, e.g. in the form of interview questions, in order to further our understanding of the implementation process and its impact on those involved. This is described in more detail in the following sections.

5.5.2. Understanding implementation using NPT

As described above, NPT is a sociological theory of implementation that focuses on the work that individuals and groups have to do in order to embed or 'normalize' new ways of working into everyday practice (May and Finch, 2009; May et al, 2009; Murray et al, 2010). NPT proposes that material practices become routinely embedded in the healthcare contexts as the result of people working, individually and collectively, to implement them. So, to understand the embedding of a practice or new way of working, one must look at what people actually do and how they work, both individually and collectively. Work, in these terms, is described as "purposive social action that involves the investment of personal and group resources to achieve goals" (May and Finch, 2009), so NPT is particularly concerned about what people do.

NPT, and its predecessor the Normalization Process Model, were originally developed from empirical work seeking to understand why e-health interventions were, or were not, embedded into routine practice (May et al., 2007). It has, however, quickly developed and has now been applied to a wide range of complex interventions implemented in health care systems, including for example chronic kidney disease care in primary care (Blakeman et al., 2012), work undertaken by patients living with chronic heart failure (Gallacher et al., 2011), maternity care (Forster et al., 2011), speech and language therapy (James, 2011), diabetes (Furler et al., 2011) and process evaluation for complex interventions in primary care (May et al., 2007). A recent systematic review conducted by McEvoy et al, 2014

identified 29 papers reporting the use of NPT in a variety of settings. In analysing the use of NPT, McEvoy concluded that there was stability in the use of theoretical constructs across different settings and that NPT was a “*beneficial heuristic device to explain and guide implementation processes*” (McEvoy et al., 2014).

NPT focuses on the work that individuals and groups do to enable an intervention to become normalised. There are four main components or constructs to NPT: coherence (the work to understand or make sense of a new intervention); cognitive participation (the work of engagement); collective action (the work done to enable the intervention to happen); and reflexive monitoring (formal and informal appraisal of the benefits and costs of the intervention). Each construct has its own underpinning 4 sub-constructs, each of which can be developed into its own question appropriate to the study, in order to guide data collection (e.g. in interview schedules) and/or analysis (O'Donnell et al., 2017). These are laid out in Table 5.1

Table 5.1: NPT constructs and sub-constructs from (O'Donnell et al., 2017).

<u>Coherence (sense-making):</u> Can stakeholders make sense of the intervention?	<u>Cognitive Participation (Relationship Work):</u> Can stakeholders get others involved in implementing the intervention?	<u>Collective Action (Enacting Work):</u> What needs to be done to make the intervention work in practice?	<u>Reflexive Monitoring (Appraisal Work):</u> Can the intervention be monitored and evaluated?
Differentiation: Do stakeholders see this as a new way working?	Enrolment: Do the stakeholders believe they are the correct people to drive forward the implementation?	Skill set workability: Do those implementing the intervention have the correct skills and training for the job? Who is doing what job?	Reconfiguration: Will stakeholders be able to modify the intervention based on evaluation and experience?
Communal specification: Do all those involved agree about the purpose and aims of the intervention?	Activation: Can stakeholders identify what tasks and activities are required to sustain the intervention?	Contextual integration: Do local and national resources and policies support the implementation?	Communal appraisal: How will stakeholders collectively judge the effectiveness of the intervention?

Individual specification: Do individuals understand what tasks the intervention requires of them?	Initiation: Are they willing and able to engage others in the implementation?	Interactional workability: Does the intervention make it easier or harder to complete the routine tasks?	Individual appraisal: How will individuals judge the effectiveness of the intervention?
Internalization: Do all the stakeholders grasp the potential benefits and value of the intervention?	Legitimation: Do they believe it is appropriate for them to be involved in the intervention?	Relational integration: Do those involved in the implementation have confidence in the new way of working?	Systematization: Will stakeholders be able to judge the effectiveness of the intervention?

It is important to note, however, that although papers lay out the constructs in a linear way, they are not, but are in dynamic relationships with each other and with the wider context of the intervention, such as organisational context, structures, social norms, group processes and conventions (May and Finch, 2009). This will become important later in the analysis and synthesis of the findings of this study.

5.5.3. Purpose behind choosing NPT

As a theory which conceptualises the factors that play a role in the success of an implementation, NPT seemed to be an apt model for describing the process of accreditation in Kuwaiti primary healthcare centres. The purpose of this study was to examine the implementation of accreditation in Kuwaiti primary care in order to better understand the barriers, facilitators and its impact on primary care. Thus NPT provides the framework to identify those factors that promote or inhibit accreditation's normalization into every day practice (May and Finch, 2009). An additional advantage to selecting NPT for this work was that it has been used to guide different types of study design in particular qualitative research, as it the case in the aforementioned studies. However, NPT has also been used in guide data extraction and coding in several systematic reviews, including one which explored the impact of living with chronic disease (Gallacher et al., 2013) and another which reported on the implementation of e-health initiatives (Mair et al., 2012).

5.6 Summary

This chapter presented the 3 main research methodologies that were adopted in this research. In order to explore the professionals' attitude towards the accreditation of PHC centres in Kuwait a case study design was used. Three health regions were selected and

centres were chosen from each region. For data collection a mixed method approach was followed whereby parallel quantitative and qualitative questionnaires and interviews were conducted. Finally while highlighting the importance of a theory to guide the data analysis, the rationale for selecting Normalization Process Theory to guide data collection and analysis was outlined. The next chapter presents the first of the three studies, the systematic review of the literature. This review is not only a research by itself, but also constitutes an important data base on which the discussion of the findings will be based on.

CHAPTER 6: Systematic review of the literature

6.1. Introduction

This chapter answers the first research objective, described in Chapter 1, namely, what are the barriers, facilitators and impacts of accreditation in the primary care setting on practitioners.

First a background to the approach of the systematic review and its purpose is explained, and then the stages of the review process and their application in my current research are elaborated. However, in order to develop our understanding of the implementation of accreditation, the identified literature was then analysed using NPT; these results are also presented here. The chapter concludes with key messages and the limitations of this study.

6.2. The purpose of the systematic review

Conducting a systematic review is increasingly becoming an essential tool for researchers in healthcare research (Bambra, 2011). The advantages of such reviews include saving time and labour, providing a clear overview of an area in an unbiased manner (Bambra, 2011). Although there were several systematic reviews on health care accreditation, these were mostly descriptive, with no underpinning theoretical framework, and there was no review that dealt particularly with primary health care accreditation (Greenfield et al., 2008).

Thus, the research questions aimed to:

1. Assess the impact of accreditation in PHCCs on the quality of health care services, particularly as perceived by practitioner.
2. Identify the barriers and facilitators of implementation in PHCCs.
3. Map these barriers and facilitators to the theoretical framework of NPT.

A systematic review usually consists of a series of defined steps, including the development of a search strategy, defining exclusion and inclusion criteria, screening identified studies, quality assessment and extraction of data, analysis and interpretation. A protocol was thus developed and registered on PROSPERO, the International prospective register of systematic reviews

(https://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42015014398) in February 2015. A copy is presented in Appendix C.

6.3. Methods

6.3.1. Search strategy

A substantive literature search was developed in early 2014, in discussion with both supervisors and a librarian at the University of Glasgow. The main key words included in the search strategy were “accreditation” and “primary health care”. These terms were mainly chosen after a series of attempts to find the best terminologies that would give the most relevant results. Quality improvement (QI) and total quality management (TQM) are often discussed alongside accreditation; however adding quality management and improvement terminologies affected the search results dramatically, identifying a large number of papers which were not about accreditation, but focused more on QI and quality criteria for health care management.

The search strategy finally developed was based on that published by Greenfield and Braithwaite in 2008 in their review on health sector accreditation (Greenfield and Braithwaite, 2008). However, while their search focused on health care accreditation in general, my search focused only on primary care accreditation. As well as the search terms “accreditation”, “primary health care” and “primary health care services”, terms related to “Accreditation or Joint Commission on Accreditation of Healthcare Organizations” were also used.

Additional MESH (Medical Subject Headings) and keyword terms used in the search included: “accredit*”, “audit*”, “authorize*”, “certif.*”, “primary health care”, “health care quality”, and “patient satisfaction”.

Five databases were searched: Scopus, Medline, Embase, Cochrane Library, and Science Direct. The same search terms and procedure were used in all databases, as far as possible, to ensure no bias was introduced. The search was limited to papers published between 2003 to 2013. 2003 was selected as the start year as the Kuwaiti MOH launched its agenda for change then, with the aim of creating a modern and sophisticated accreditation process in primary and secondary care. This was also the year that the Canadian Council on Health Services Accreditation (CCHSA) published their first report titled “National Health Accreditation Report”. Given the restrictions of time and finance, a further limit on searching was a restriction on papers published in the English language.

The results of the searches in two databases are shown in Appendix B. The searches identified 5497 papers, of which 4225 were duplicates and removed in Endnote. The

remaining 1272 papers were imported into DistillerSR for screening and data extraction – described in the following sections.

6.3.2. Inclusion and exclusion criteria

The review included papers that discussed the implementation of accreditation in primary care process and the various accreditation systems. Papers focused on accreditation and patient satisfaction, accreditation and safety, or accreditation and patient experience, were included as long as they were set in primary care. There was no exclusion based on study type, but papers had to contain quantitative or qualitative data. Papers discussing accreditation in hospital settings were excluded. A full description is contained in table 6.1.

Table 6.1: Inclusion and exclusion criteria

Inclusion criteria
Focus on the impact of accreditation
Focus on professional views of accreditation
Focus on safety and accreditation
Set in primary care
Any study design reporting data
Exclusion criteria
Not about accreditation
Focus on development of accreditation standards or guidelines
Focus on accreditation of educational or professional training programmes
Focus on accreditation of medical, surgical or diagnostic procedures
Focus on accreditation of a single professional discipline e.g. pharmacy or a single setting e.g. cancer care centre
Not data driven e.g. editorial, letter, opinion piece or commentary
Not English language
Full paper not available

6.3.3. Screening of papers

The results of each search were imported into the bibliographic software package Endnote, where duplicates were removed. The full dataset of 1272 papers was then imported into DistillerSR, an on-line software package designed for the screening and data extraction of papers for systematic reviews (see Figure 6.1).

Article screening was performed at 2 levels.

Level 1 (Title and abstract screening): Titles and abstracts were double screened by myself and either my primary supervisor or another PhD student (Azari Alhaleel),

with conflicts resolved by discussion. Screening questions were based on the inclusion and exclusion criteria described in Table 6.1.

1. Is this about accreditation at all? Yes/No/Can't tell Exclude if No.

For those papers where the response to Q1 was Yes or Can't tell, the following questions were applied:

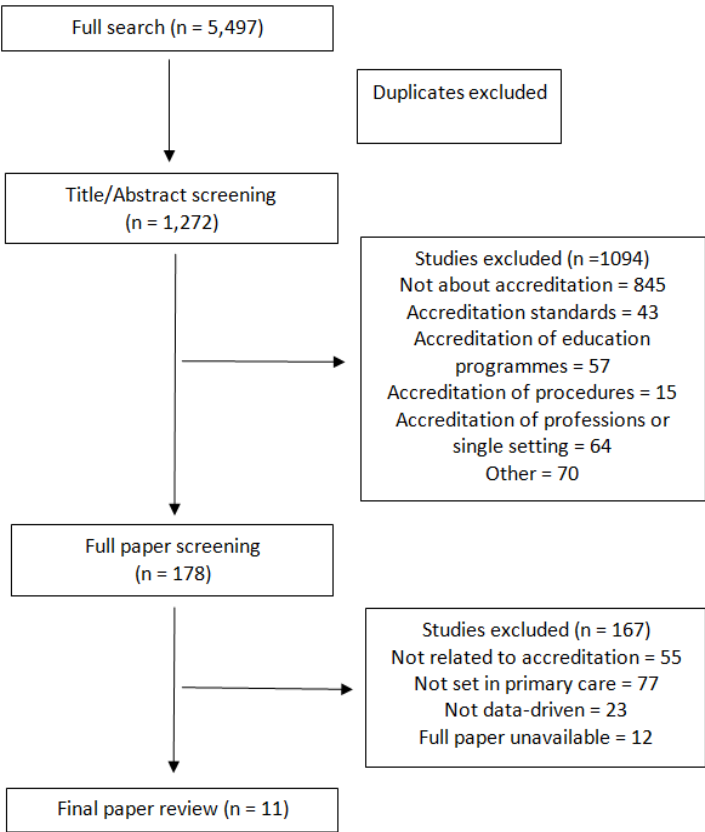
2. Is this about the impact of accreditation systems? Yes/No/Can't tell Exclude if No
3. Is this about accreditation of surgical or medical procedure? Yes/No/Can't tell
Exclude if Yes
4. Is this about the development of accreditation standards or guidelines?
Yes/No/Can't tell Exclude if Yes
5. Is this about the accreditation of an educational or professional training
programme? Yes/No/Can't tell Exclude if Yes
6. Is this about the accreditation of a surgical, medical or diagnostic procedure?
Yes/No/Can't tell Exclude if Yes
7. Is this about the accreditation of a single discipline or profession or a single setting
e.g. pharmacy, cancer care centre, nursing home? Yes/No/Can't tell Exclude if Yes

Level 2 (Full paper screening): Again, this was carried out by myself and my primary supervisor. Full papers were reviewed and a decision made to include or exclude them made on the basis of two questions.

1. Include or exclude.
2. If exclude, reason for exclusion:
 - Not related to accreditation.
 - Not set in primary care.
 - Not data driven study e.g. editorial, commentary, opinion piece, letter.
 - Couldn't find the full paper.

The results of the screening are shown in the PRISMA diagram in Figure 6.1. Level 1 and 2 screening resulted in 11 papers being included in the review, where the next stages were initial data extraction and quality appraisal.

Figure 6. 1: PRISMA diagram of the resulting number of articles from each screening level and reasons for exclusion



6.3.4. Initial data extraction

In order to develop an understanding of the type and range of studies identified, initial data extraction focused on the following criteria: setting, study design, duration of study, number of participants, health professionals involved, aims of the study, outcomes, and key findings. A pro-forma was completed for each included article (Appendix D).

6.3.5. Quality assessment of studies

A key task in a systematic review is to assess the quality of the included studies (Ryan et al, 2013). The purpose of this is not to further exclude studies, but to gain some knowledge as to the methodological quality of the published literature. As this review included a range of study designs, several recognised appraisal checklists were used. There are many appraisal checklists available. For this work, I used the checklists published by the Critical Appraisal Skills Programme (CASP <http://www.casp-uk.net/>), which were also used in the Scottish Evidence-Based Practice Course and now stored online at the University of

Glasgow(<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/ebp/checklists/#d.en.19536>). Each of these focuses on key aspects of the study design, including sampling and recruitment, data collection and analysis. Appraisal of observational studies, was informed by using a form that has been adopted from multiple studies previously (Moher et al., 2009). Copies of the checklists can be found in (Appendix E).

For each of the 11 included articles I and my primary supervisor read and scored the papers against a scoring sheet depending on the type of study design. This process was completed on DistillerSR.

Scores were assigned to criteria in each checklist, based on the information given in each paper. For systematic review papers, if the answer of the question was “yes” the criterion was given a score of 1. If the answer was a “no” or “can’t tell” the criterion was given a score of 0. At the end the scores were summed up and each paper was given a final score. A score of 0-3 meant the paper has a “poor” quality, a score from 4-5 meant the paper has a fair quality, and a score of 6-8 meant the paper is of good quality.

For qualitative research and descriptive studies, a slightly different approach was followed. Each criterion was given either a poor (0) a fair (1) or a good (2) score. However, the global score of the paper was determined according to the number of poor scores it received. If the paper received no poor scores on any of its criteria, it was considered to be of good quality. If the paper received one poor score on one of its criteria only, it was considered of fair quality. Finally if the paper received 2 or more poor scores on its criteria, it was considered of overall poor quality. Descriptive studies were: surveys, cross-sectional studies, cohort studies, and before & after studies.

Quality appraisal was conducted in DistillerSR by myself and my primary supervisor. Discrepancies in scores were discussed and consensus reached.

6.3.6. Coding of papers to NPT

Given the focus on understanding the implementation of accreditation and its impact on professionals in primary care, the next stage of the work involved coding the included papers to NPT. Analysis of the papers included in the SR using NPT allowed a more detailed understanding of the process of implementing accreditation and its relation to professionals’ experience. The analysis was guided by the four constructs of the NPT and

their respective sub constructs and was informed by the work of Mair et al, who used NPT to analyse the international literature on the implementation of e-health systems (Mair et al., 2012).

The first step for the analysis was to develop a coding framework using the four constructs of NPT, along with its sub-constructs. Using the framework reported in Mair et al (Mair et al., 2012), as well as other NPT papers in particular (Murray et al., 2010 and McEvoy et al., 2014), a preliminary coding framework was developed. This was revised following discussions with the primary supervisor (who has extensive experience of applying NPT to implementation research) and then tested against 2 included papers. The framework took the form of 16 questions to apply to the included papers, for example: *Do stakeholders see accreditation as a new way of working?* This was coded under Coherence, Differentiation. Table 6.4 shows the NPT coding framework to which the articles were coded.

Once the framework was developed, it was used to code the 11 included papers. Each paper was viewed as a piece of qualitative data; coding focused primarily on the results and discussion of each paper. Reading the paper, codes were applied to pieces of text thought to map to the NPT framework; this coding was carried out by myself and the primary supervisor. Regular coding clinics were held to discuss the application of the codes and discrepancies in coding, where they occurred. Pieces of text thought to relate to the process of implementing accreditation, but not codeable to NPT were still coded, in order to capture anything that might fall outside the NPT framework. This work was carried out in Word by myself and in NVIVO by my supervisor, allowing the generation of coding reports in which all the codes to one construct could be gathered from across the review papers to facilitate analysis and interpretation.

6.4. Results

6.4.1. Overall characteristics of the included papers

Table 6.2 provides the main characteristics of the included papers. The years of publication were concentrated from 2008 onward, with 8 out of the 11 articles from then. Most were set in high income countries, with only 1 in another setting (Egypt); Studies designs were literature reviews, although none were systematic reviews; qualitative studies, using mainly semi-structured interviews and/or focus groups; or mixed methods, combining quantitative data with qualitative interviews. Methodological quality was mainly fair or good. It is worth mentioning here that all the 11 papers were based in the PHC setting but

tended to look at it from different perspectives and settings. For example, three looked at quality team development in individual general practices in UK setting (Ring et al., 2003; Macfarlane et al., 2004; Campbell et al., 2010). However, other studies examined larger primary care organizations, for example in Canada and the US (Paccioni et al., 2008; Braun et al., 2008) which shows the diversity of the primary care models involved in accreditation.

Table 6. 2: Characteristics of the included papers

Characteristic	Number of papers (n = 11)
Year of publication	
2003 - 2007	3
2008 - 2013	8
Country setting	
UK	3
Australia/New Zealand	2
US	1
Canada	1
Europe (Spain)	1
Egypt	1
International	2
Study design	
Literature review	3
Qualitative	3
Mixed methods	3
Cross-sectional survey	1
Observational	1
Quality assessment	
Good	4
Fair	4
Poor	3

6.4.2. Key findings of the included papers

Table 6.3 summarises the aims and key findings of each of the included papers. Across the studies, the main stakeholders and practitioners included general practitioners (GPs), nurses, administrative and other healthcare practitioners from various disciplines. The aims of the identified papers fell into two main themes: exploring the challenges and facilitators of accreditation from the perception of healthcare practitioners, and studying the impact of accreditation on certain organisational characteristics such as organisational support,

employee culture, and leadership. Two studies aimed at deepening the knowledge of the accreditation concept itself and defining it primarily by conducting literature reviews(O'Beirne et al.,2013 and Hinchcliff et al., 2012). Finally, two studies aimed at evaluating accreditation schemes through engaging health practitioners either in assessing the accreditation manuals and schemes or in developing them(Alcázar et al., 2011 and Ringer al., 2003).

Thematic analysis of the findings in each paper found there wasno common agreement about the effectiveness of accreditation as a quality of care improvement tool. However, there were some common themes addressed in these papers, namely:

- Barriers for accreditation
- Facilitators for accreditation
- Positive impact ofaccreditation on professionals and organisations
- Negative impact ofaccreditation on professionals and organisations

Barriers and facilitators were identified from the papers. Facilitators included credible leaders; ownership and involvement of professionals, availability of data on systems for data sharing, good collaboration between professionals and teams. Barriers included a lack of financial resources, scepticism about accreditation and perceived threats to professional autonomy. Facilitators and barriers are outlined in Table 6.5.

Table 6. 3: Aim and key findings of included papers

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
10	Buetow and Wellingham (2003). Accreditation of general practices: challenges and lessons. <i>QualSaf Health Care</i> . (12),129-135.	Non-systematic review based on personal files & knowledge, electronic searches, conversations with colleagues.	General practice; Empirical work in Australia and New Zealand. Conducted during 2001-2003	<ul style="list-style-type: none"> To discern lessons about experiences of accreditation in general practices, with a particular focus on Australia and New Zealand. 	<ul style="list-style-type: none"> Practice accreditation may pose a threat to professional autonomy; GP should share its control of accreditation with other stakeholder groups. Involving patients in the development of practice accreditation increases its success. There is a need to reward quality practices, loosen professional control over accreditation, trade some consistency of standards for validity, develop standards that acknowledge cultural diversity, and be transparent. Separate quality control from quality improvement within a coordinated systems based framework, with practices being helped to pay for accreditation and quality improvement.
11	Hinchcliff et al.(2013). Stakeholder perspectives on implementing accreditation programmes: a qualitative study of enabling factors. <i>BMC Health Services Research</i> , (13), 1-9.	Qualitative study involving 39 focus groups and eight interviews. Semi structured interviews, followed by thematic analysis.	Conducted in 2011 and 2012, involving 258 diverse healthcare stakeholders from every Australian State and Territory	To gather views of key Australian healthcare stakeholders' regarding the range of factors influencing the implementation of three Australian accreditation programmes in primary care, aged and acute sectors.	<ul style="list-style-type: none"> Implementation is more likely to be successful when accreditation programmes and their standards are suitable and reliable, positively received by healthcare professionals and organisations, and supported by regulatory initiatives. Alignment of accreditation with other regulatory initiatives and incentives also supportive.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
32	Braun et al.(2008). Quality-related activities in federally supported health centres. Do they differ by organization characteristics? <i>Journal of Ambulatory Care Manage,31(4)</i> , 303 -318.	A cross-sectional assessment (quantitative) of quality related activities in Health Resources and Services Administration related activities in using a mailed questionnaire.	Health Resources and Services Administration–funded health centres in US Sample size N=290.	To examine relationship between extent and frequency of quality-related activities and organizational characteristics, comparing health centres by urban/rural location, size and whether or not accredited.	<ul style="list-style-type: none"> • The frequency and type of most quality-related activities did not vary greatly by size and location, but differed by accreditation status. • This might partly be explained by the on-going accreditation initiative of the Health Resources and Administration Bureau.
90	Macfarlane et al.(2004). RCGP quality team development programme: An illuminative evaluation. <i>Qual Saf Healthcare, 13</i> , 356-362.	Qualitative study, Semi structured interviews.	Semi structured interviews were conducted with 34 key stakeholders in practices from 4 PCOs in England .	To evaluate the RCGP Quality Team Development (QTD) from the perspective of participants and assessors. To evaluate the design of the programme, the experience of participating practices and PCOs, and its perceived impact on patient care and team-work.	<ul style="list-style-type: none"> • There appeared to be positive benefits for participants and the organizations participating in the QTD programme. • Practice based respondents perceived it as acceptable and feasible, reporting positive changes in teamwork and patients services, especially as it is as participative and multi professional nature. • QTD was seen as a way of delivering on national policies of clinical quality and modernisation. • Main concerns were workload, especially for assessors, and sustainability of the programme. • Participating practices are a self selecting innovative minority.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
718	O'Beirne et al.(2013).The status of accreditation in primary care. <i>Quality in Primary Care</i> , 21, 23–31.	Systematic literature review and Qualitative study- interviews.	62 papers were used in this review in addition to 72 sources from grey literature. Eight semi-structured interviews were also held with key informants. Databases- Primary care settings. International	To explore the current state of primary care accreditation. To identify jurisdictions where primary care (PC) accreditation processes are in place, determine the nature and uptake of accreditation, and lastly examine how accreditation processes in PC have affected outcomes of care, care utilisation and costs, and asses the perceptions of PC providers and patients towards accreditations.	<ul style="list-style-type: none"> • Accreditation in primary care is generally non-government funded and voluntary with some countries offering financial incentives. • It was evident that there is a dearth of research on the nature and uptake of accreditation in this sector, along with how accreditation affects outcomes of care, whether it is an effective method to improve quality, perceptions of care, healthcare utilisation and costs. • These findings imply that further research is required to examine the possible impact accreditation may have on health care within primary care.
741	Hinchcliff et al.(2012). Narrative synthesis of health service accreditation literature. <i>BMJ QualSaf</i> , 21, 979-991.	Systematic identification and narrative synthesis of health service accreditation literature. Identified 129 papers from 29 countries.	Range of settings including hospitals (79/122 papers) and general practices (11/122 papers). International	To systematically identify and synthesize health service accreditation literature.	<ul style="list-style-type: none"> • The majority of studies (n=67) were published since 2006, occurred in the USA (n=60) and focused on acute care (n=79). • Two thematic categories, 'organisational impacts' and 'relationship to quality measures', were addressed 60 or more times in the literature. • The literature was limited in terms of the level of evidence and quality of studies, but highlighted potential relationships among accreditation programmes, high quality organisational processes and safe clinical care.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
					<ul style="list-style-type: none"> Implementation of accreditation is more likely to be successful when accreditation programmes and their standards are suitable and reliable, positively received by healthcare professionals and organizations, and supported by regulatory initiatives.
770	Alcázar et al.(2011) Professional involvement in the design of accreditation manuals. <i>International Journal of Healthcare Quality Assurance</i> , 24,611-620.	Qualitative case study-semi structured interview.	439 healthcare professionals from 58 disciplines between March 2005 and January 2008 Spain	To describe the participation of health professionals as key agents for the successful definition of skills manuals supporting professional accreditation in Andalusia (Spain).	<ul style="list-style-type: none"> The main facilitators to the participation of health professionals in preparing manuals for accreditations are: Involving managing authority from the start point; involvement of stakeholders (medical societies, professional associations and clinical leaders); inclusiveness; use of scientific evidence to support manual development; and use of workgroups and committee co-ordinators to support use of on-line tools. The most significant barriers to this participative process were: Initial scepticism about participating; informal leaders emerging on some committees that biased the outcome; variability across Committees; excessive effort required by some participants.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
854	Paccioni et al.(2008). Accreditation: a cultural control. <i>International Journal of Healthcare Quality Assurance</i> , 21, 146-158.	A multiple-case longitudinal study was conducted taking a mixed qualitative/quantitative approach study that provides a theoretical model for understanding organizational changes brought about by accreditation of primary services.	2 Quebec Primary care Health organizations. Canada N= 328	To describe and understand the effects of the accreditation process on organizational control and quality management practices	<ul style="list-style-type: none"> • Accreditation process has a significant impact on participants' perceptions of their organizations. • Employees not directly involved in the accreditation process have perceptions that are significantly different from administrators. • The accreditation process does not have a significant effect on employees' perceptions of the values promoted in the organization. This indicates that the basis of the accreditation process and its final outcome are not necessarily understood or absorbed by most of the staff, who are left out of the process. • The accreditation process has fostered the implementation of consultation mechanisms in self-assessment teams. • As long as not all staff members have integrated the basis for accreditation and its outcomes, the accreditation process appears to remain an external, bureaucratic control instrument.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
1024	Ring et al.(2003). The RCGP quality practice award (QPA) for primary care teams. <i>British Journal of Community Nursing</i> , 8,112-115.	General literature review	UK	To highlight the importance of Royal College of General Practitioners' Quality Practice Award (QPA) for primary care teams	<ul style="list-style-type: none"> • Although initially an RCGP initiative, by integrating processes such as evidence- based and reflective practice, continuing professional development and team working, QPA reflects the philosophy of current nursing practice. • It is therefore essential that nurses and midwives who are members of practice teams working towards QPA actively and collaboratively participate in all phases of this process. • While QPA accreditation requires time and commitment from busy primary care teams, there are benefits to the individual members of staff, their teams and patients, from such participation.
1082	Gadallah et al.(2010). Are patients and healthcare providers satisfied with health sector reform implemented in family health centres? <i>Qual Saf Healthcare</i> , 19, 1-5.	Mixed method approach with quantitative assessment using statistical analysis of questionnaire and qualitative approach using focus groups.	<ul style="list-style-type: none"> • The study included eight PHC units/centres; four reformed and four non-reformed in Egypt. • 14 months from 16 April 2005 to 15 June 2006. • N= 380 	To assess satisfaction of patients and providers to services and working in family health centres affiliated to the Health Sector Reform Programme (HSRP)	<ul style="list-style-type: none"> • Patient satisfaction was higher in accredited family health units compared to non-accredited units in all aspects: cleanness, doctors and nurses, waiting area and waiting time. • Providers in accredited centres were more satisfied than providers in non-accredited centres regarding availability of equipment, job satisfaction and income satisfaction.

Code	Citation	Study design	Setting and participants	Aims of the study	Outcome measures and Key findings
1089	Campbell et al.(2010). Primary medical care provider accreditation (PMCPA): pilot evaluation. <i>British Journal of General Practice</i> , 295-304.	Qualitative-interviews and thematic analysis.	Thirty-six nationally representative practices (GPs, practice managers, nurses and other relevant staff). England , June and December 2008.	The aims of the pilot were to evaluate the experiences of a representative sample of general practices across England in implementing PMCPA, and to analyse the uptake and achievement of the core criteria in each.	<ul style="list-style-type: none"> • All practices felt that PMCPA was relevant to and aligned with family practice priorities, reflected quality in primary care, and was a worthwhile use of practice time. • While externally imposed standards could be seen as a ‘tick-box’ exercise, with organisations seeking to meet the target without necessarily reflecting on how the issues contained within the standard affect their own setting. PMCPA was not seen as just a tick-box exercise by most practices but as an opportunity to change and benefit the practice.

Table 6.5: Summary of the facilitators and barriers of the accreditation implementation

Barriers/ Challenges	Facilitators
Lack of financial resources	Legal requirements, policies and procedures, incentives and support
Raises a threat for professional autonomy	Credible leaders
Employees not directly involved in the accreditation process thus they do not understand the basis of the accreditation process and its final outcome	Ownership and participation among professionals
Initial scepticism about participating	Online tools for sharing information
Embedding accreditation related work into daily tasks may results in redundant issues i.e.: work load	Involve patients in the development of practice accreditation
Difficulty of actively involve the general practitioners in the accreditation process	The availability of a key personnel who coordinated the accreditation team, and acted as catalysts for the communication among professionals, as well as accreditation agencies and other stakeholders
	Collaboration between the accreditation team during the accreditation process
	Availability of key statistics and data
	Teamwork: combining teams of clinical, and administrative staff

However, identifying barriers and facilitators is not enough to help inform what needs to be done to ensure the implementation and sustainability of accreditation in primary care settings. For that, an analysis using NPT as an analytical lens was carried out.

6.4.3. NPT analysis of included papers

As outlined in Chapter 5, NPT is a theoretical framework that focuses on the work required by individuals and organisations to embed new ways of working into routine practice (Murray et al., 2010 and McEvoy et al., 2014). Analysis of the papers included in thisSR using NPT led to a more detailed understanding of the work required to embed accreditation and where that work was focused. The analysis was guided by the four constructs of NPT and their respective sub-constructs. Table 6.4 shows the NPT coding framework to which the articles were coded

Table 6. 4: Normalization Process Theory Coding Frame for the Impact of Accreditation in Primary Health Care Centres

Coherence (Sense-Making Work)	Cognitive Participation (Relationship Work)	Collective Action (Enacting Work)	Reflexive Monitoring (Appraisal Work)
<p>Differentiation: knowledge and understanding of the accreditation process, its significance, scope and aims</p> <p><i>Do stakeholders see accreditation as new way of working? Is it different to current practice?</i></p>	<p>Enrolment: engaging with colleagues, facilitators, accreditation focal persons, and heads of relevant departments for support on accreditation</p> <p><i>Are stakeholders able to organize themselves, and others, to drive forward the implementation? Will they invest/spend time and effort on it? Do they think they are the right people to be involved?</i></p>	<p>Skill set workability: laying down a strategy to ensure that accreditation standards are entailed within the daily scope of work in primary health care centres – <i>this is more action-oriented than laying down a strategy.</i></p> <p><i>How does it fit with existing work practices? Do those implementing the accreditation have the correct skills and training? Does it impact on the division of labour?</i></p>	<p>Reconfiguration: revisiting accreditation standards to make them more context sensitive and applicable to the reality of existing primary health care settings</p> <p><i>Will stakeholders be able to modify the intervention based on evaluation and experience?</i></p>
<p>Communal specification: attaining information about accreditation from colleagues, MOH facilitators, accreditation focal persons, accreditation and quality directorate, and heads of accreditation departments.</p> <p><i>Do all those involved have a shared understanding of the aims, objectives and expected benefits of accreditation?</i></p>	<p>Activation: managing to receive support from accreditation specialists and focal persons</p> <p><i>Are those involved able to define the activities and procedures needed to take forward and sustain implementation activity? This is “thinking” about it, rather than actually doing it.</i></p>	<p>Contextual integration: ensuring that financial and human resources are in place to enable the implementation of accreditation</p> <p><i>Does it fit with organizational goals and policy – this can be at local, regional and/or national level? This can refer to human, financial, social resources.</i></p>	<p>Communal appraisal: evaluating the required alteration of initiated accreditation standards and procedures for context sensitivity purposes, along with colleagues and accreditation focal persons</p> <p><i>How will stakeholders collectively judge the effectiveness of the accreditation process?</i></p>

<p>Individual specification: seeking to understand more about accreditation through relevant readings and research, and through one's own experience with accreditation</p> <p><i>Do they understand their own specific tasks and responsibilities in the accreditation process? Does it make sense to them?</i></p>	<p>Initiation: using given professional knowledge and skills to manage one's own contribution to the accreditation process, such as following standards as set by accrediting bodies</p> <p><i>In particular, are key stakeholders willing and able to drive forward implementation? Can they engage others in the implementation?</i></p>	<p>Interactional workability: implementing accreditation standards and procedures, attending relevant meetings, seeking quality improvement measures in daily practice</p> <p><i>Does accreditation process make it easier or harder to complete routine tasks or do the routine “day job”?</i></p>	<p>Individual appraisal: personally assessing whether or not to continue abiding by standards and procedures as required by accrediting bodies</p> <p><i>How will they individually judge the effectiveness of the accreditation process?</i></p>
<p>Internalization: having and understanding of your experience vis a vis accreditation, realizing its implications, knowing when and where to get support</p> <p><i>Do all stakeholders understand the potential benefits and values of the accreditation process?</i></p>	<p>Legitimizing: pursuing feedback from accreditation focal persons to ensure that work is aligned with accreditation standards and procedures</p> <p><i>Do those involved think they are the right people to be involved? Do they “buy into” accreditation? Are they seeking reassurance from others about the appropriateness of the implementation plan?</i></p>	<p>Relational integration: establishing relationships with accreditation focal persons, and ensuring access to accreditation-related information when needed— <i>establishing relationships more in the CP domains.</i></p> <p><i>Do those involved have confidence in the accreditation process and in others implementing it?</i></p>	<p>Systematization: developing means to stay informed about the most recent information on accreditation – <i>this is more about how they are evaluating the impact.</i></p> <p><i>How will stakeholders evaluate the impact and benefit of accreditation? This may use formal and/or informal methods.</i></p>

Although qualitative analysis of text does not usually focus on the number and distribution of codes, in this case it did help to show where the focus of attention lay in the included papers. Thus, 342 pieces of text were coded to NPT; of these, two-fifths addressed the actual work of accreditation – i.e. the construct of collective action. Monitoring and appraisal codes (reflexive monitoring) were next most common, followed by codes addressing understanding and sense-making (coherence). The least addressed area was that cognitive participation, the construct focusing on the work of engagement and participation. These are now discussed in turn. This helps us to understand where there is currently a lot of data and where there are gaps in knowledge.

Making sense of and understanding accreditation (Coherence)

Coherence addresses how participants understand, or make sense of, accreditation. It focuses attention on whether accreditation is seen as a new activity, whether individuals and groups have a shared understanding of accreditation and whether participants can identify any benefits associated with accreditation. Most of the papers contained at least some data relating to the work of understanding accreditation, describing knowledge and understanding of the accreditation process, its significance, scope and aims. Some papers also reported on subjects' experiences with accreditation, how they viewed their responsibilities, and the implications of implementing accreditation programmes.

The reviewed papers showed that while healthcare professionals understood accreditation as a concept, they did not have a clear understanding about its aims or impacts. Whereby Buetow and Willingham, 2003, reported that

“There are several barriers to GP acceptance of practice accreditation. Compared with hospital environments which have a long history of accreditation, general practices have been considered more difficult and less important to accredit” (Buetow & Willingham, 2003).

Another paper highlighted that “*Accreditation in PHC is relatively new in comparison with its acute care counterpart*” (O'Beirne et al., 2013).

Two papers by Hinchcliff reported that professionals who were directly involved in the accreditation process demonstrated a better understanding of it than those who simply worked at an accredited centre or were never exposed to accreditation. Thus, accreditation in general practice and PHC was still fairly new for many practitioners. There was also a strong sense of confusion among primary care professionals between certification, inspection, and accreditation. However, at least one paper reported that accreditation improved professionals' understanding of their organization, for example Paccioni et al., 2008 reported that *"administrators admitted that they had developed a better understanding of the organization through the accreditation process."*

Individuals, departments and organizations need to understand their role in accreditation, as well as the aims and objectives of the organisation (individual and communal specification). Most of the included papers contained data relating to shared views and understanding, but almost nothing about the views of individuals in relation to their roles and responsibilities. One reason, as described above, might be the different understandings of accreditation held by those involved. For example Hinchcliff et al., 2013; p 2) reported that

"In addition, health professionals were commonly found to conceptualise accreditation differently (e.g. variously as a regulatory obligation, method to obtain financial incentives, or tool to validate local quality improvement efforts), resulting in organisations enacting programmes in diverse ways."

This confusion in understanding was also reported by Campbell et al., 2010:

"Some practices fed back that the role of accreditation is to show adherence to an acceptable standard in terms of compliance or conformance with an accepted set of standards. Others explicitly emphasised focusing on formative practice-specific quality improvement as a reflective exercise rather than a box-ticking exercise..."

This confusion may well make it difficult to ensure that all those in a primary care centre have a shared understanding of the aims and potential benefits of accreditation. Only one paper had data relating to individual consideration of one's role in accreditation. In their article Buetow and Wellingham, 2003, found that the benefits and risks of accreditation were unclear for

individual practitioners and that “*accreditation programmes [should] include the need to tell potential participants clearly from the outset which type of accreditation is being used, for what purpose(s), and with what benefits and risks to themselves*” (p:133). None of the articles contained information about how or if participants sought information about accreditation or reflected on their own role in it.

The last component of sense-making and understanding is internalisation, namely whether or not those involved acknowledged the potential benefits and values of the accreditation process. This aspect was not well reported, with 3 papers discussing it. Practitioners appeared to have a generally positive attitude about accreditation where they valued it as a tool; however, they presented different interpretations about its actual role and benefits. In general practitioners admitted that accreditation increases the trust of external parties. One risk was when accreditation was viewed as a

“externally imposed standards that could be seen as a ‘tick-box’ exercise, with organisations seeking to meet the target without necessarily reflecting on how the issues contained within the standard affect their own setting” (Campbell et al., 2010).

Participation and relationship work in accreditation (Cognitive Participation).

A key part in the implementation of any new programme or way of working is involving the right people and, in turn, sustaining their ability to involve others. In NPT terms, this is referred to as cognitive participation. It included the support participants received during accreditation, the time and effort invested in the process, and how much they were actively involved in it.

Engaging the ‘right’ professional groups (enrolment) was referred to in many of the papers. One of the main challenges for the accreditation process in PHC was to actively involve general practitioners in the accreditation process. The importance of key figures, who coordinated the accreditation team, and acted as catalysts for the communication among professionals, accreditation agencies and other stakeholders was identified. For example:

“A team of external assessors is then allocated to the practice team by the RCGP. The assessment team is multiprofessional, with representatives from general practice, practice management and nursing. Lay representatives are also included. The assessors individually, and as a team, assess the supporting documentation against the quality criteria.” (Ring et al., 2003).

Collaboration during the accreditation process helped to break down professional barriers, creating and improving teamwork. Quoting Paccioni et al., 2008; p:151, *“the participation mechanisms implemented as part of the [accreditation] process contributed to a better organizational climate among departments and professional groups”*.

Activation, considers how those involved in the accreditation process defined the activities and procedures needed to sustain implementation activity. This was not well reported in the included papers. Hinchcliff et al., 2012 reported that surveyors or assessors were the key players in the accreditation process and that they were valued by all staff especially in the matters of support for the activities and procedures. However, there was little research and consensus on the features and *“activities of surveyors that facilitate the process of accreditation”* (Hinchcliff et al., 2012, p: 987).

Key stakeholders must also be willing to drive the implementation of accreditation and to involve others – in NPT terms, initiation. Most of the papers commented on such activities. Factors which contributed to this involvement included incorporating their perspective into the process of implementation, choosing facilitators, distributing staff responsibility, assigning credible leaders that championed continuous quality improvement, and explaining the ethos behind the accreditation process. Employee participation and engagement created a sense of ownership towards the process which in turn reflected positively on their commitment to accreditation. This involvement included all staff:

“Effective team working is a key to successful QPA accreditation. For the purposes of QPA, the team is considered to include practice employed and practice attached staff, clinical and non-clinical personnel.” (Ring, 2003).

“While most of the workload was undertaken by managers within practices, both doctor and team engagement at some level were critical to success, and those practices that did not complete PMCP [accreditation] were usually those where only the manager was truly engaged in the scheme.” (Campbell et al., 2010).

This involvement was also important in the production of materials such as accreditation manuals where Alcázar et al., 2011, found that

"The Committees were not solely composed of representatives from corresponding Scientific Associations, they included other [clinical] opinion leaders. Setting up processes without these groups would have been incomplete and significantly reduced its chances of success. Including other professionals enriched each Committee's composition and demonstrated the Agency's commitment to plurality and diversity."

This willingness to be involved arguable comes from the concept of 'buying into' accreditation – the sub-construct of legitimation. This included whether those involved think they are the right people to be involved, and the extent to which they sought reassurance from others about the appropriateness of the implementation plan. Several papers commented on this, both negatively and positively. Some papers, professionals reflected either scepticism or resistance to change towards the accreditation process. Alcázar et al., 2011; p: 617, mentioned that *"some participants expressed their doubts about the project's chances of success. Their attitude spread somewhat to others who had previously participated in unsuccessful collaboration experiences"*. However, two papers emphasized the importance of communication that accreditation had introduced among the staff members. Paccioni et al., 2008; P:154 concluded that:

"Results demonstrate that the accreditation process reinforced cohesiveness in the self-assessment teams. Formulating expectations and exchanges with administrators contributed to improved communication in the institutions."

Thus, team work and leadership were vital for the success of the accreditation process, particularly where it could influence the views of participating doctors.

Work involved in implementing accreditation (Collective Action)

The actual work involved in implementing accreditation programmes was the best reported area across all the included papers. This included consideration of information about incorporating the accreditation into the daily scope of work, the type of work needed, and the financial and human resources required.

Skill set/workability considered how new accreditation processes fitted with existing work practices and if those implementing accreditation had the correct skills and training. It also

considered who did what work. Several papers reflected that accreditation had a positive impact on the activities carried out in a primary health care setting. These impacts ranged from attention given to infection control, activities supporting quality control, carrying out audits, fostering team work and participation through embedding quality objectives within their departments. Braun et al., 2008, p:316 stated that

“[The] study found many differences between accredited and non-accredited health centres. This was most notable in regard to the frequency of QI projects, staff training and education, competency verification, infection control, and environment of care activities, and to a lesser extent in risk management and diagnostic studies follow-up.”

Challenges embedding the work into daily tasks were also reported. Professionals saw that this process created a burden of extra paper work for them. Campbell et al., 2010, p: 301 found out that *“The workload was higher than expected in most practices, although almost all practices emphasised that this reflected the 15-week duration of the pilot...”*. This paper also reported that most of the accreditation workload fell to practice managers, with GPs remaining largely *“hands-off”*.

In order to become embedded, accreditation must not make the routine day job harder (interactional workability) and those involved must have confidence in both accreditation and those implementing it (relational integration). Both issues were addressed in the identified papers. Coding to interactional workability identified three major issues. The first reflected a negative perception of accreditation where it was seen as a restriction of autonomy and flexibility for the general practitioners. Accreditation was perceived as requiring substantial organizational effort, and moved the focus of clinical care from the patient to quality and safety, requiring more time, effort and workload from healthcare staff. Hinchcliff et al.'s paper, 2013, p5, quoted

“Professionals were characterised as often harbouring doubts about the ability of accreditation to promote organisational and health system improvements. Such views were linked to broader questions regarding the allocation of time and

attention to quality improvement practices, as opposed to patient- centred clinical care, within healthcare organisations”. (Hinchcliff et al., 2013, p5).

This might have contributed to the mixed views reported in terms of professionals’ confidence in accreditation (relational integration). While some papers reflected poor trust in the outcomes of the accreditation process, for example *“professionals were characterised as often harbouring doubts about the ability of accreditation to promote organisational and health system improvements”* (Hinchcliff et al., 2013). Other papers showed that accreditation helped built trust among the healthcare staff. Macfarlane et al., 2004, p358, reported *“Respondents felt positive about inviting colleagues in for the assessment visit and valued the feedback given”*. Finally, this was one of the few areas where patient and public views were also considered: *“Quality control seeks to assure or, even better, improve the trust of external parties such as patients, financiers and government and other stakeholder groups”* (Buetow and Wellingham, 2003).

The role of organisational goals and policies and external resources to support, or not, the implementation of accreditation is considered under the sub-construct of contextual integration. These external goals and resources could operate at local, regional and/or national level, with resources referring to human, financial, or social resources. This sub-construct was addressed in all of the papers reviewed and had the most pieces of text coded to it, indicating that the literature, at least up until 2014, had focused most on these external resources. Three issues were identified: incentives for implementing accreditation, financial resources, and human resources.

The primary driver for compliance with accreditation was regulation, often linked to funding. Buetow and Wellingham, 2003, p130 stated that

“Regulation - compliance with accreditation requirements (e.g. legal, safety) defines a gateway to additional funding”.

However, such policy environments will push practice accreditation from a voluntary activity to a statutory activity. Hinchcliff et al., 2013, p6, concluded that

“The results of this study suggest that systems-level factors (that is, regulatory initiatives and financial incentives) can affect the ethos underlying accreditation programmes, which affects their standards and surveying practices.”

Financial resources were viewed as a barrier for implementing accreditation, coupled with a lack of research into the cost effectiveness of accreditation. Thus, accreditation was still considered a costly process, requiring a lot of resources. Accreditation also required substantial human resources including recognition that the amount of extra effort required from the participants for the implementation [or accreditation] often incurred stress in staff (Macfarlane et al., 2004).

Monitoring and appraisal work (Reflexive monitoring).

This construct focuses attention on activities following the attainment of the accreditation. Such activities include revisiting accreditation standards to make sure they are well compatible and applicable to the setting, collecting data on impact, evaluating the process among the involved healthcare professionals, and assessing whether those involved can make changes to the system.

Reconfiguration considers the extent to which stakeholders can modify the accreditation process for the future, based on evaluation and experience. Eight papers contained information on this. The main finding was the importance of external audits as a tool to develop and revisit the standards. Accreditation is inherently a tool of continuous improvement, and thus it is essential that modifications are enacted, especially with regards to testing the standards. As reported by Braun et al., 2008, P.316:

"In addition to the standards, the differences by accreditation status are likely influenced by a health centre's process of preparation, self-assessment, and monitoring compliance with the standards, as well as the external assessment of performance by independent experienced surveyors".

As well as changing systems, accreditation may also change behaviour:

“Information may available by practice accreditation may also change behaviour by individuals, practices and the health system, as demonstrated by the use and public disclosure of performance indicators and other comparative data” (Buetow & Wellingham, 2003).

How teams, organisations and individuals judge the effectiveness of accreditation are considered under communal and individual appraisal. However, a lack of data on outcomes and effectiveness or feedback to participants often hampered this process. Feedback was generally tasked to the assessors and was often verbal, with written reports. There was, however, a lack of robust evidence on whether accreditation impacted on quality or safety of care. There was also "uncertainty over whether the benefits outweigh potentially significant costs. Unfortunately, data on the costs of accreditation are limited" (O'Beirne et al., 2013). There was little on the views of individual practitioners, although Macfarlane et al reported that:

"Although respondents generally felt that their practice would have 'passed' if QTD had taken a summative approach, all felt that the strengths of a formative process far outweighed the benefits of formal 'accreditation'". (Macfarlane et al., 2004).

Finally, systemization focused attention on how stakeholders evaluated the impact and benefit of accreditation and the methods used. Effective communication was seen as a fundamental strategy for the evaluation of performance. For example, in relation to the UK'S Quality Practice Award, feedback from QPA assessors was crucial to judging how well accreditation had gone. Again, data on patient care was one method of assessing the impact, but other methods included practice self-reflection and client satisfaction. Paccioni et al., 2008, p154 reported that: *"Throughout the accreditation process, making better assessments of client satisfaction was identified as one of the main objectives."* This could be through group discussions or surveys as studied by Gadallah et al., 2004.

6.5. Discussion

Coherence (Sense-Making Work): The reviewed papers showed that while the healthcare professionals understand what accreditation is as a concept, they do not have a clear understanding about its aims or impacts. Hinchcliff et al., 2012 and 2013, reflected in two papers that professionals who were directly involved in the accreditation process demonstrated a better understanding than those who simply worked at an accredited centre or were never exposed to accreditation. Thus these findings suggest that while the coherence and sense making of accreditation clearly reaches the professionals directly involved in the process, heads still fail to distribute this knowledge to all the employees. Although the accreditation

usually is encompassed within the organizations' visions and policy, employees are not always properly informed. The literature still needs to explore that area specifically with regards to exploring staff views on the significance and scope of accreditation. There was also a lack of information in the most effective way to deliver information on accreditation to the healthcare professionals and the best way to make them aware of such a process. This is important especially that in the differentiation sub construct the NPT analysis showed that the awareness of health professionals on accreditation is still weak. The individual specification construct emphasized the lack of literature in the area of seeking information. There is an obvious lack of research in how healthcare professionals learned about accreditation or reflected about their own experience in it. Noting that only 3 out of the 11 coded articles listed information that fall under internalization, the available information to this end is still not very abundant or clear, indicating a lack of information on the perceived benefits and implications of accreditation by professionals. These findings emphasize the need to further explore the professionals' view on accreditation and how they perceive its benefits.

Cognitive participation: Findings showed that the involvement of the practitioners in the accreditation process is a main challenge and barrier for its implementation. What could facilitate the involvement is the presence of a catalyst or a key figure that would coordinate the process and drive it forward, be it a manager or a healthcare professional. When present, the employee engagement and participation in the accreditation helped breaking down professional barriers, creating a sense of teamwork, improved teamwork, access to care, and consequently increased awareness of patient safety. On the other hand, an evident deficiency in the literature was observed in the area of activation, or how healthcare professionals managed to receive support from others. Among the three articles which listed different information pertaining to professionals' activation in the accreditation process there were inconsistent findings. While some suggested that professional bodies (such as the Royal College of General Practitioners in the UK) were the main driver for such initiatives, others valued the assessors as the key players to the accreditation process. On a different note one paper reported that the proper received training was a contributor to the process of activation. In all cases, this literature review found out that information on the activation of the accreditation process is still an area waiting to be explored.

The main contributors to the initiation of the accreditation process were found to be participation/ engagement, ownership, leadership (commitment), teamwork, and combined efforts of clinical and administrative staff. Many papers described accreditation as a way that

encourages continuous professional development for its staff, especially those involved in the accreditation process. Yet, the findings were conflicting as to whether accreditation hindered professional autonomy or encouraged professional development.

It is important to note that although the literature identified several actors who played a role in facilitating the accreditation process, studies have also observed that this relationship is a two-way process. Paccioni et al., 2008, P152, stated that: *“We also observed that the accreditation process fostered the implementation of consultation mechanisms in the teams and reinforced participation by representatives from the different professional boards.”* While employee engagement fostered the implementation of the accreditation process, sustaining the accreditation in return helped maintain such relationships within the organisational culture. As highlighted by O'Beirne et al., 2013, P25: *“In a cross-sectional study, Braun et al., found accredited centres were more likely to have staff dedicated to risk management, environmental safety and QI.”*

In legitimisation, the results showed conflicting information regarding professionals' legitimisation of the accreditation process. It is still unclear how professionals perceive the real outcomes of accreditation or if they believe it to incur legitimate impacts. No consensus could be reached as to how professionals reflect on the appropriateness of the implementation plan. While some studies showed that professionals reflected their encouragement towards the accreditation and demonstrated a positive attitude towards this process, others expressed doubts and scepticism about its success and believed it to be a threat to the physicians' professional autonomy. Others were simply resistant to change. Therefore, from the reviewed literature, there is not enough evidence to conclude whether the professionals had a positive or a negative attitude towards the accreditation process. No paper reported the mechanism of seeking feedback from focal points or checking if the standards are aligned with the procedure. Thus this area is yet to be explored in the future studies.

Collective Action: Much of the data was coded to skill set workability. While accreditation carried the burden of extra paper work and effort, it also focused attention on infection control, activities related to QA/QC and self-monitoring, audits and clinical records, fostering team work and participation through embedding quality objectives within their departments. When it comes to the set of tasks and scope of work required from accreditation, the reviewed literature had conflicting results. Some saw that the process required a significant amount of paper work and extra burden on documentation and others overlooked this to highlight the areas that accreditation projected improvement to. As to whether the extra effort put through

accreditation was worth the positive change, this is a grey area which the literature did not explore yet.

All papers contained data coded to contextual integration. The emerging findings from this sub constructs were the following:

- 1- The main promoter for accreditation was the presence of legal requirement or policies that supported accreditation. The body of literature to this end presented better information in the developed nations rather than other parts of the world. This presents a need to explore policies and regulations to promote accreditation of PHC in the developing world as well as in Kuwait.
- 2- A major barrier to implementing accreditation and sustaining it was the availability of financial resources. The cost effectiveness and the economy of investing in accreditation were still unknown and no information was present in the literature to this regard.
- 3- Last but not least, human resource building was a major driver to the accreditation process. The literature reported information on the role of leaders, engagement, and organisational culture in driving accreditation forward.

For Interactional workability while professionals still doubt the benefits of accreditation, all the coded papers reported at least one challenge in incorporating the standards into their routine work. The body of literature studied the healthcare professionals' challenges however; no study quantified the amount of time or effort needed for accreditation related activities, not even on the pilot testing phase.

Although much information was coded under the relational integration sub-construct, it was difficult to draw firm conclusions, with conflicting findings. Thus more information is needed to explore this area especially with regards to the role of the leaders in the application of the accreditation standards.

Although an abundant information were exist under the collective action construct, this construct still lacks fundamental information, particularly about the relation between the accreditation and financial resources and a gap in exploring the economic outcome of accreditation.

In the *reflexive monitoring* construct, the importance of external audits and assessors as a tool for revisiting standards was highlighted. However, the information was poor in discovering other methods for scrutinizing context sensitive standards (lack of details related to a certain context or setting). The information provided in communal appraisal showed that the literature has focused on studying subjective improvement perceptions of the healthcare professionals

rather than looking for objective indicators for quality improvement. There was also little on the effectiveness of the accreditation especially when considering the expensive financial investment required.

While several studies reflected the professionals' view on accreditation, no research reported on the views of patients.

6.6. Strengths and limitations

This is the first work to use a theory of implementation – NPT – to better understand the process and impact of implementing accreditation in a primary care setting. The use of a recognised theoretical framework meant that the findings could move beyond a description of the barriers and facilitators, to understanding how these are enacted in a health care setting.

Limitations of the work included:

- Time frame: this literature review covered article published from 2003 till 2013. It is likely that other, pertinent work has since been published and which could add to, or refute, the findings here.
- Data analysis drew only on NPT. While this is widely used and accepted theory of implementation, the use of another theoretical framework may have identified other areas of interest.
- Attributive (descriptive) data falling out with NPT were not identified. This may mean that we were not fully attuned to such data; however other studies have also found that most of the data is coded within NPT (e.g. Mair's studies of ehealth; Macfarlane's work on the use of interpreters in primary care).
- While only 5 databases were searched, these do represent the largest health and health care delivery databases, so it is unlikely that pertinent articles were overlooked.
- Grey literature was not considered.

6.7. Summary

A systematic review of the published international literature has indicated that most of the focus of current accreditation literature has been on the work needed to implement accreditation and on the use of formal and informal data to monitor its impact. However, much less attention was paid to ensuring that those involved understood the aims of the accreditation

process and why they were doing it, nor to the need to ensure that the correct people were involved and able to sustain their involvement.

In addition, these findings came from a range of studies conducted in different international settings. What is thus needed is a more detailed study of the impact of implementing an accreditation programme in one primary care setting. Chapters 8 and 9 will present the findings from such work in Kuwait; first, however, chapter 7 will briefly describe the setting in which this work took place.

CHAPTER 7: Methodological approach and description of case studies

7.1. Introduction

This chapter outlines the setting which the Kuwaiti fieldwork took place. This chapter describes the six health regions outlined in chapter 2 in more detail, gives a detailed description of the PHCCs and the basis on which they were chosen to participate in the quantitative and qualitative research. It finally addressed the relationship between the main stakeholders involved in the accreditation of PHC in Kuwait.

As outlined in Chapter 5, the qualitative and the quantitative components of the fieldwork were located in three out of 6 health regions in Kuwait (referred to as Region 1, Region 2, and Region 3). The reasons for the choices of health regions and PHCCs will be described here; quantitative results will be reported in Chapter 8 and qualitative findings in Chapter 9.

7.2. Description of the six health regions

As mentioned previously Kuwait is divided into 6 health regions, with each region considered an independent decentralized administrative unit. The regions are responsible for the administration and delivery of all health and support services, as well as strategic direction (WHO, 2006). The regions are also responsible for IT support and staff training.

PHC is delivered through a series of health centres, with general or family health clinics, maternal and child care clinics, diabetic clinics, dental clinics, and preventive care clinics, school health services, and ambulance services. In the following brief descriptors, data related to the number of staff in each piloted centre was taken from the human resources department in each centre.

7.2.1. Health region one

The first health region has an area of 200 km² and a population of 534,964. It is dominated by senior citizens and home for 23 PHCs out of which two centres were chosen to be part of this study. It was recorded by the World Health Organisation as a healthy city in 2014 (Arab Times, 2017; Globe Media Ltd, 2014).

7.2.2. Health region two

This health region has an area of 82 km² with a total population of 890,000. It has a total of 15 PHCCs out of which two centres were chosen to represent the early and late adopters respectively. Middle and young aged citizens dominate this modern city which is characterised by quality services (Kuwait E Gate, 2017).

7.2.3. Health region three

This region has an area of 5,120 km² and a total population of 809,353. It has a total of 20 PHCCs out of which two centres were chosen to represent the early and late adopters respectively. Middle and old aged citizens dominate this city which is characterised by greenery areas (Kuwait E Gate, 2017).

7.2.4. Health region four

This region has an area of 11,230 km² and a total population of 491,392. And considered as the largest governorate in Kuwait; the region occupies most of Kuwait's arable land (Kuwait E Gate, 2017). The PHCCX was chosen by the MOH to participate in the pilot survey. However, it was not included in this research due to its relatively small size, providing only six kinds of services: primary care, pharmacy, dental care, medical devices sterilization services, and specialized clinics for chronic disease such as diabetes.

7.2.5. Health region five

This health region has an area of 190 km² and the largest population with around 1,077,377 residents. It is considered as the Kuwait's main residential area (Kuwait E Gate, 2017). Although the PHCC Y was included by the MOH in the pilot survey, it was not recruited into this study due to difficulties in reaching this region.

7.2.6. Health region six

This health region has secondary care facilities providing general secondary care services and specialized clinical services provided by specialized tertiary health care centres. However, it has no PHC facilities. Therefore, it was not included in this study.

While listing the characteristics of each of the health regions above, we may draw some key demographic similarities and differences amongst them.

In terms of the area covered by each region, they range from 82 Km² to 11,230 Km², with the smallest health region 2 and the largest health region 4. There are also important differences in the size of the populations in each health regions, from health region 4 with a population of 491,392, to other regions covering more than a million citizens, in particular health region 5 with a population of 1,077,377. Regarding the age range of citizens in these health regions, while some regions include mainly senior citizens such as health region 1, others are mainly inhabited by young to middle aged citizens, for example health region 2. Finally there are those which have populations of middle to old age citizens such as health region 3.

Kuwaiti health regions, both urban and rural, are also unique in that some of them are characterized as modern cities, some are known for their arable land, , while others are considered to be mainly residential areas. For example, health region 1 has been entitled a “healthy city” by the World Health Organization in 2014.

In terms of PHCCs, Kuwaiti health regions differ in that some of them included a greater number of PHCCs in comparison to others, while of course ensuring that the number of PHCCs and the services provided by them are adequate for the number and age profile of the population living in each of the regions. Also, the health regions include PHCCs that have completed the MOH accreditation pilot (considered in this thesis as early adopters of accreditation standards), whereas others have not yet completed the accreditation cycle (considered here as late adopters of those standards).

The types of services provided by each region also vary, for example: one region includes a piloted PHCC with a relatively small scope of services (i.e. health region 4), whereas another region does not have any PHC coverage, but does provide its population with secondary and tertiary health care services (health region 6). Health region 5 does include a PHC which was locally piloted by the MOH, however the region was left out of the study due to difficulties travelling to this region.

This variation in the size and demographics of the population that each centre serves affects the number of visits to each PHCC. For example PHCC A received 850 patients per month whereas PHCC C received 30,000- 35,000. Although the latter is considered a large centre and

A is a medium centre, this significant difference in the number of visits is related partly to the age of the population that the aforementioned centres were served. PHCC A located in health region 2 which occupied by young - middle aged citizens, so it might be expected that the number of visits were less as younger citizens probably have less diseases than the senior citizen population in health region 3 (PHCC C). Young citizens are also likely to be more educated, have better awareness and better socioeconomic status thus have less diseases and less complications.

7.3. Choice of health regions

As described, I chose to conduct the fieldwork surveys in 3 regions in order to examine the perceptions of healthcare professionals and MOH accreditation personnel in Kuwait on the accreditation process – these were predominantly urban settings. The remaining 2 rural health, which were regions of rural character, were excluded due to difficulties accessing them, with the distance to them challenging for the researcher's availability to conduct the surveys on regular bases. Moreover, the rural lifestyle in these regions did not encourage a single female researcher staying alone for consecutive nights. The final health region was ineligible as it did not have any PHCCs. The sample of the 3 chosen regions was also broadly representative of all the health care regions in Kuwait. Region 1 contained a total of 15 PHCCs, region 2 has 23 PHCCs, and region 3 has 29 PHCCs.

7.4. Choice of PHCCs

Due to time and resource constraints, preference was given to studying only few centres distributed among three regions but in a more in-depth manner. The study did not involve any small PHCCs, but rather focused on medium and large size PHCCs only, in order to include a wider number of departments and services within each centre.

As outlined in Chapter 5, two PHCCs were recruited in each health region. In each region, an early adopting centre was selected, which had implemented the accreditation process before others, and had undergone the pilot-surveying phase in the presence of the ACI auditors in December 2012. In early adopting centres, fieldwork consisted of both a quantitative survey of staff and qualitative interviews with key stakeholders.

A second centre, referred to as late adopter, was also selected in each region. Late adopters had not yet been introduced to the process of accreditation concept and had not been surveyed

by the accrediting agency (ACI). As a result, a quantitative survey of staff about the process of accreditation was not appropriate. Thus, in these later adopter centres, data collection was confined to qualitative interviews with key stakeholders. These were broadly similar to the early adopting PHCCs, in terms of size and services offered,

7.5. Description of participating PHCCs.

7.5.1. Early adopting centres

Centre A

PHCC A is located in health region 2 in the centre of area X; it serves a population of 9,854 of predominantly middle-aged and young citizens (Kuwait E Gate, 2017). PHCC A is a medium sized centre that started operating in 2010 and provides a range of services such as: primary care, pharmacy, laboratory services, dental care, maternity care, home care, and specialized clinics for chronic diseases such as diabetes. The number of staff in this centre is 125 distributed across departments with a total of 31 physicians (one family physician, 17 general practitioners, 3 diabetologists, and 10 dentists), 24 technicians (17 lab and 7 haematology technicians), 15 pharmacists and 32 nurses, with a total of 23 administrative staff. The average number of patient visits is 850 per month.

Centre B

PHCC B is located in health region 1 in area Y and serves a population of 20,211 mainly seniors. PHCC B is considered a large size centre according to the services provided: primary care, pharmacy, laboratory services, dental care, home care, specialized clinics for chronic diseases including diabetes and hypertension. Other services include maternity services, school health, preventive medicine, an X-ray department and paediatrics. The centre has a total staff number of 171: 43 physicians (2 family physician, 13 general practitioners, 3 diabetologists, 14 dentists, 2 ENT specialists, 6 maternity and 3 preventive physician), 21 lab technicians, 9 pharmacists, 60 nurses and 38 administrative staff. The average number of patient visits per month ranges between 24,000 and 30,000.

Centre C

PHCC C is located in the centre of area Z in health region 3. It serves a population of 30,411 citizens. The centre was launched in 2002 and is considered large. Like Centre B, it provides a wide range of services such as: primary care, pharmacy, laboratory services, dental care, home care, and chronic disease clinics. It also has ENT clinics, maternity services, school health, preventive medicine, an X- ray department, and paediatrics, as well as ophthalmology, and occupational therapy.

The centre has a total of 224 staff members among them there are 59 physicians distributed as such: 4 family physicians, 16 general practitioners, 5 diabetologists, 14 dentists, 2 ENT, and 6 maternity physicians, 4 preventive physician, 3 paediatricians, 2 surgeons, and 3 ophthalmologists. The number of technicians is 30 distributed as 21 lab technicians and 9 X- ray technicians. They also have 20 pharmacists, 70 nurses and 45 administrative staff. The average number of patient visits per month ranges between a minimum of 30,000 and a maximum of 35,000.

7.5.2. Late adopting centres

PHCC Ai

The Ai PHC centre is a medium centre that started working in 2012, located in area X which is belong to health region 2. It has a population of 8665 of predominantly middle-aged and young citizens. PHCC Aiprovides a range of services such as: primary care, pharmacy, laboratory services, dental care, maternity care, home care, and specialized clinics for chronic diseases such as diabetes. The number of staff in this centre is 130 distributed across departments with a total of 32 physicians (two family physician, 17 general practitioners, 3 diabetologists, and 10 dentists), 25 technicians (18 lab and 7 haematology technicians), 16 pharmacists and 33 nurses, with a total of 24 administrative staff. The average number of patient visits is 900 per month.

PHCC Bi

The Bi PHC centre is categorized as large centre located in area Y in health region 1. Its population is estimated to be 20,746 predominantly of middle aged and senior citizens. As other large size centres, it provided primary care services, pharmacy, laboratory, dental care, home care, specialized clinics for chronic diseases including diabetes and hypertension. And other services included maternity care, school health, preventive medicine, an X- ray department and paediatrics. The centre has a total staff number of 182: 49 physicians (3 family

physician, 14 general practitioners, 3 diabetologists, 14 dentists, 4 ENT specialists, 8 maternity and 3 preventive physician), 22 lab technicians, 11 pharmacists, 61 nurses and 39 administrative staff. The average number of patient visits per month ranges between 26,000 and 32,000.

PHCC Ci

The Ci family medicine PHCC is located in area Z which was launched in 1989 and belongs to health region 3 having a population of 30,000, the large PHCC was launched in 2008 (Kuwait E Gate, 2017). It provides a wide range of services such as: primary care, pharmacy, laboratory services, dental care, home care, and chronic disease clinics. It also has ENT clinics, maternity care, school health, preventive medicine, an X-ray department, and paediatrics, as well as ophthalmology, occupational therapy, and mini operation theatre. The centre has a total of 217 staff members among them there are 58 physicians distributed as such: 4 family physicians, 15 general practitioners, 5 diabetologists, 14 dentists, 2 ENT, and 6 maternity physicians, 4 preventive physician, 3 paediatricians, 2 surgeons, and 3 ophthalmologists. The number of technicians is 28 distributed as 20 lab technicians and 8 X-ray technicians. They also have 19 pharmacists, 68 nurses and 44 administrative staff. The average number of patient visits per month ranges between a minimum of 28,000 and a maximum of 34,000.

7.6. Activities during accreditation

The WHO report in 2003 *"Quality and accreditation in health care services: A global review"* had supported the introduction and implementation of quality assurance and accreditation among different countries. This report highlighted the most important quality interventions which are usually undertaken in conjunction with international agencies and explained the activities which are undertaken to prepare health care institutions before and during the accreditation process (WHO, 2003). The following section will explain the activities that were taken during accreditation as highlighted from the aforementioned report as well as from the experience of the researcher who was directly involved in the process as an accreditation facilitator in the Q&A Directorate.

According to the WHO report, preparation is an integral part in the process of accreditation, the more prepared the centre was the faster it could gain accreditation. Preparation is best

facilitated in the centres where a group of employees is responsible for the process. These groups must understand and be able to communicate the process and standards to other staff members, delegate responsibility, conduct effective meetings, create lists of needed policies, evidence, and forms. They must also create forms that provide evidence of compliance with standards, and most importantly motivate and build confidence in staff (WHO, 2003). Preparation is essential to ensure successful accreditation; therefore PHCCs A, B and C initiated a set of activities to pave the road to earning the accreditation. The centres had several staff meetings across departments involving all staff in order to educate them on the standards and the method by which the centre hoped to meet them. Administration and medical teams were created to identify existing examples of evidence and areas of partial or non-compliance with standards. These meetings encouraged members to share their observations and findings in each category which later was going to serve as the basis for developing plans to achieve compliance. Moreover, the centres held lectures and seminars about accreditation where staff got information on how to incorporate the standards in day-to-day work. Usually one employee was responsible from each department to follow up on the meetings; however, all employees were involved in preparation activities. In principle, the health care centre needs to review its existing policies and medical procedures to adjust and change what has to be changed. The health care centres also developed documentation forms and quality templates for each department to be later used by the staff serving as a guideline for executing each task. The three PHCCs held lectures to raise awareness for both the patients and employees, organized meetings at multiple departmental levels and also engaged the higher authorities such as the heads of the regions. Moreover, the centres organized meetings with NGOs and other societies to get funding, and with Quality and Accreditation Directorate of the MOH to address their inquiries regarding unclear terminologies and standards. In addition, they provided motivational programmes for employees to encourage them to participate in the accreditation process.

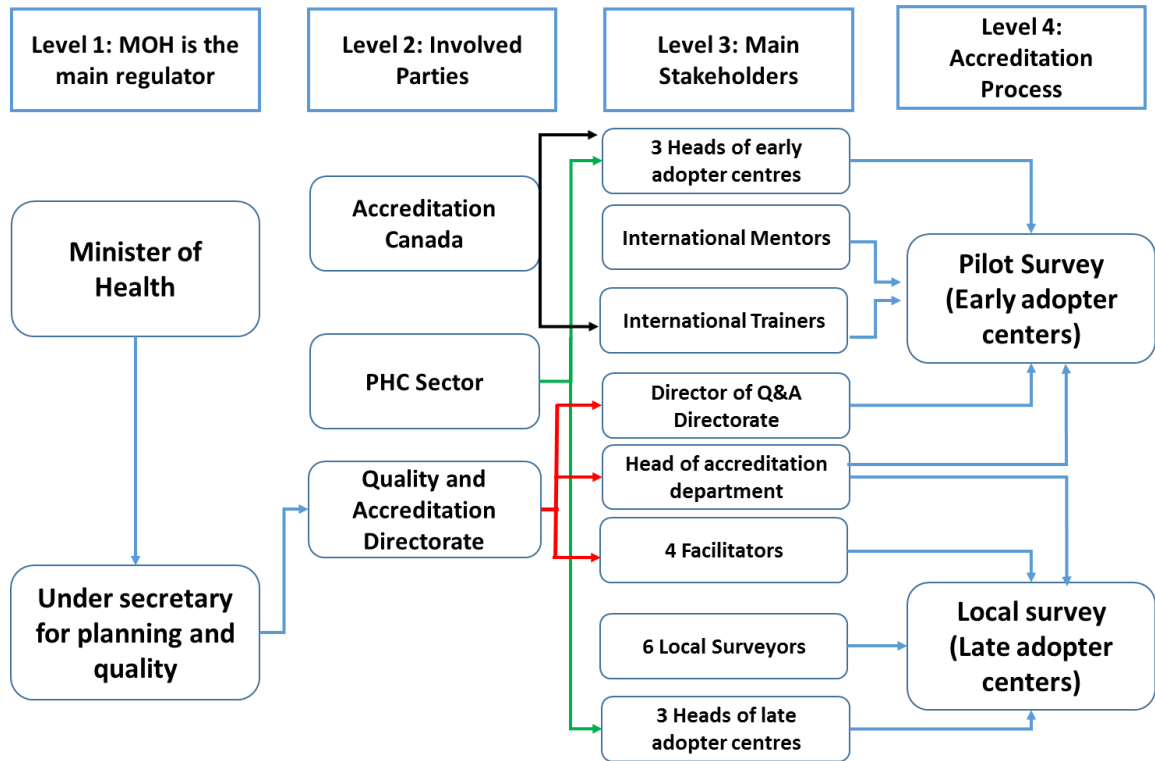
At the PHCC A, the staff was engaged in teamwork that included the director and the heads of departments. They held several meetings weekly with the group leaders of each self-assessment team and regular meetings with the head of departments every two weeks. Communication was enhanced among staff through technology, for example using the ‘‘What's App’’ mobile application where each assessment group created a group on the aforementioned programme to inform each other on meetings and required tasks and

assignments. Finally, they received lectures from the MOH which they disseminated to their employees and carried out workshops on patient safety.

PHCC B provided lectures for patients and their families to enhance their knowledge about accreditation and answer questions about accreditation, since the accreditation aims at providing better services to patients (Ferlie and Shortell, 2001). Since the patients knew the centre's mission, vision, and values, they also took part in the activities that took place at the health care centre for example the marathon, and the evacuation training inside the clinic. For PHCC B the pilot survey had good consequences on both the patients and the employees. It is worth to mention that PHCC C provided very similar activities as A and B.

Although these activities started 5 years ago, accreditation approach is maintained and supervised by Q&A Directorate. Figure 7.1 illustrates all the stakeholders involved in the accreditation of PHC and the relationship between them.

Figure 7. 1: The relationship between all the stakeholders involved in the accreditation of PHC in Kuwait



7.7. Summary

This chapter described the setting in which the fieldwork took place. The next two chapters describe the actual studies conducted. The detailed methodology, procedures, results, and discussions for each study are described within each chapter. Finally the closing chapter provides a general discussion that integrates the key messages from each study, as well as recommendations and conclusions.

CHAPTER 8: Professionals' views of the impact of accreditation: A quantitative survey

8.1. Introduction

As described in Chapter 1, a key research question was to understand the beliefs and perceptions of healthcare professionals involved in the accreditation process at PHC level in Kuwait. Thus, we aimed to identify their views on the impact of accreditation on the institution as a whole and on the quality of care.

This chapter reports on that study, including a detailed description of the study's quantitative approach. It describes the research setting, study population, sampling and data collection methods, the questionnaire, and ethical considerations. It also describes the data analysis and statistical procedures used, before going on to present the results.

The discussion section discusses the overall and detailed findings of the study, with comparison to the literature. It also considers the strengths and limitations of this work.

8.2. Design and Setting

This study was a descriptive, cross sectional survey of healthcare personnel working in three PHCCs, each located in a different health region in Kuwait, using a self-completion questionnaire. The 3 PHCCs were selected on the basis that they had already participated in the accreditation process, completing the pilot survey phase initiated by ACI. As previously described, these three centres were the early adopters of the accreditation process and so they were particularly valuable to understanding professionals' view on the accreditation process.

8.2.1. Study population

As outlined in chapter 7 three health regions were chosen for the study: region 1, region 2 and region 3. The remaining three regions were excluded because of difficulties in accessing 2 regions, including the issue of distance and one region did not host any PHCCs. The total number of PHC centres in each region was 23, 15 and 20, respectively.

Three PHCCs were selected for this study, each from a health region. Two of them were large sized, and one, medium sized. All 3 centres had undergone the preparation for accreditation and had been chosen for the pilot survey phase by external surveyors from ACI to represent their respective health regions as previously described. Given the importance of exploring the

impact of accreditation on all staff, there were no exclusions on the type of staff eligible to participate in the survey. Thus, staff included both management and front line employees: directors, physicians, nurses, administrative staff including unit assistants, secretaries and clerks, pharmacists, dentists, and technicians. The total number of employees targeted for this study across these three centres was 520. All the staff of the selected PHCCs were given the self-administered questionnaire to complete, excluding employees who have worked for less than two years and those who were not present before and after the accreditation process. Such arrangements were made with the HR department in each centre.

8.2.2. The questionnaire

The survey utilised in this quantitative phase of the thesis was a self-administered anonymous questionnaire previously used twice by El-Jardali et al in Lebanon. It was first used in 2008 to assess the impact of hospital accreditation on quality of care as perceived by Lebanese nurses (El Jardali et al., 2008). It was then used in 2013 to measure the impact of accreditation on PHCCs, including assessing the successes, challenges and policy implications as perceived by healthcare providers and directors in Lebanon (El Jardali et al., 2014). Although originally developed in English, the questionnaire had been translated into Arabic by a professional translator. Two members of their research team then conducted back translation to ensure that the correct wording and phrasing of questions were used throughout the survey. Finally, the survey was piloted and validated with health care professionals working for the Ministry of Public Health (MPH) in Lebanon.

8.2.2.1. Questionnaire structure and content

The questionnaire was made of five sections covering: quality of care, impact of accreditation, the accreditation process in retrospect, the awareness of the respondents to the overall accreditation process, and demographic information of respondents. A copy is contained in Appendix F. In total, it consisted of nine scales each including several items. The respondents were asked to rate each question as either: 1 - Strongly disagree, 2 - Disagree, 3 - Neither disagree nor agree, 4 - Agree, 5 - Strongly agree, or 9 - Don't know. At the end of the questionnaire, respondents were given the opportunity to add any further general and/or specific comments regarding the accreditation process.

The following is a brief description of the different sub-scales of the questionnaire:

- i. **Management and leadership:** Nine items asking the participants to rate the efforts put by the management personnel and senior executives to improve quality of care through the accreditation process. Respondents were asked if they felt that senior management provided an environment to support QI, for example by providing resources and the vision to support change.
- ii. **Strategic quality planning:** Seven questions examining the centres' activities in sharing specific plans to improve quality and involving departments and staff members in setting QI goals and priorities.
- iii. **Human resource utilization:** Examined if the centres invested in training and rewarded their staff to improve quality.
- iv. **Quality management:** the participants were asked six questions to evaluate the management efforts and methods to meet quality standards, with a particular focus on designing quality into new services.
- v. **Quality results:** Five questions examined the opinions of the participants regarding the improvement in quality services of the centres at different levels, including direct patient care and care provided by support services such as pharmacy and radiology.
- vi. **Customer/patient satisfaction:** Seven questions examining the process of assessing and meeting patient needs, expectations and complaints.
- vii. **Accreditation Impact:** 14 questions assessing whether the accreditation process had a positive impact on the centres and on the participants. These questions focused on the impact of accreditation across a range of processes and on patient care. This section also addressed dissemination of recommendations to staff and their role in the implementation of any changes.
- viii. **Staff Involvement:** This addressed the level of involvement of individual participants in the centres. They were asked if they received sufficient encouragement to participate in the process together with the appropriate training and support.
- ix. **Accreditation Awareness:** Five questions assessing if staff members were aware of the accreditation process, its aims and objectives, and if they valued it.
- x. **Demographic information of the participants:** gender, age, years of experience and the work position (occupational category) at the centre.

8.2.3. Questionnaire distribution and data collection

After obtaining the necessary ethical approvals, data collection commenced first at Centre A - the medium-sized centre. The rationale for this was that, as the large-sized centres had more services and employees, they would require more time, effort and experience than the medium-sized one. However, the contact process was the same for each site.

First, the directors of the PHCCs were contacted by phone and a meeting was requested in order to explain the study and seek permission to carry it out in their PHCC. Following the director's agreement to participate, subsequent meetings were conducted with the head of the HR department and heads of each clinical/non clinical department to discuss the logistics of data collection. At this stage statistics and data regarding the number of employees in each department were provided. A meeting was also held with the head of each centre's self-assessment team, who were directly involved in the accreditation process in 2012 at the pilot stage. This was followed by several presentations to staff in each department to explain the research study, its purpose and to introduce the questionnaire to potential participants. At this point, the process of data collection was explained. The employees were assured that their participation was voluntary, their choice to participate would not affect their employment and that directors would not view their responses.

Prior to data collection, codes were assigned to each centre, department and respondent. Each centre, department and individual had a code. For example: Centre A code: 001, Administration department code: 01, Individual: 01. For my own identification purposes, the centres were coded, 001, 002, and 003. The departments in each centre were coded in chronology of the distribution of the questionnaire. Only the number of individuals was a cumulative code where the numbers added up to the total number of questionnaires distributed. At no point, could an individual employee be identified on the basis of their ID code.

For each department, a pack was delivered by me who contained the exact number of questionnaires equal to the number of employees within that department. This information was obtained upon the first visit to the HR department. In this way, all employees in the selected PHCCs received a copy from the questionnaire, a participant information sheet (PIS), a copy of the consent form and an empty envelope for returning the completed questionnaire. Thus the consent form and the questionnaire were both attached inside a sealed envelope and collected together. It is important to note that all the distributed questionnaires were returned back me, even those that were not completed or contained missing data.

Participants were requested to complete the survey at a time and setting of their choice and to return it in a sealed envelope within one week of receiving it. Site visits to collect data ensued in two different time periods (morning and afternoon) to ensure that all employees in the department returned their questionnaire (whether completed or not). Although there was great interest among the participants, it took more than one week for the questionnaires to be returned. Thus, multiple visits to the centres were conducted to encourage and remind them about completing and returning the questionnaires. This was also accompanied by sending gentle reminders through emails and text messages to the heads of departments. The aforementioned steps were repeated similarly in the 3 participating centres to avoid bias and to ensure reliability. Data collection lasted about 8 weeks for each centre.

Once questionnaires were returned, data were entered onto a Microsoft (MS) Excel sheet from the questionnaires by myself. It was double checked by two colleagues for accuracy, quality and consistency. Then, it was exported to STATA for analysis.

8.2.4. Enhancing the response rate

Several strategies were used to increase the response rate:

1. The survey was conducted and distributed in collaboration with the Q&A Directorate at the MOH of Kuwait, who provided me with a written letter to encourage the staff members to participate in this study and explained its benefits.
2. The questionnaire was printed out on high quality paper to increase its visibility (VanGeest et al., 2007).
3. A free envelope was included for anonymise return of the questionnaire.
4. I took the responsibility to distribute, explain, and collect the questionnaires. Moreover, I met all the participating staff members personally and promised to share the final results with them.
5. I held a good position at the Q&A Directorate of the MOH, which allowed me to have good relations with the directors of the centres as well as all staff members.

8.2.5. Data Analysis Plan

Similar to the questionnaire and the research methodology, data analysis followed that performed by El Jardali et al., 2008 and El Jardali et al., 2014. Data generated from the

questionnaires were coded, entered, and analysed using MS Excel (Office 2010) and STATA/IC 11.2. P value of equal to or less than 0.05 was considered significant. Incomplete and/or missing data were identified and coded as missing. This allowed missing values to be identified and removed from analyses.

Categorical variables, for example demographic variables, professional group, were summarised using numbers and percentages. The characteristics and demographics of the respondents according to the PHCCs were further analysed using cross tabulations, with Pearson's Chi-squared tests used to test for significance.

Many of the questions had a scale response from 1 to 5. To measure the internal consistency and reliability of the scales, Cronbach's alpha was used. This is a measure of internal consistency and identifies how closely related a set of items are as a group. All values were above 0.80 thus indicating good reliability and internal consistency.

For all scale items, scores were created by summation of the responses within the scale and dividing by the number of response with non-missing values (El Jardali et al., 2008) (Appendix G). This produced a score that varied between 1 and 5 for each scale with higher scores indicating higher agreement with the question (Warmbrod, 2014 and Shortell et al., 1995). Univariate analyses of all these scores were computed for all the scales and subscales and the results presented as: mean, standard deviation (SD), median and the quantiles including the minimum and maximum for each scale. In order to analyse the findings of these scales according to the demographics variables, the means of the scores created above for each scale were compared across the categories of each demographic variable using the Kruskal-Wallis test. This was used instead of ANOVA because the distributions of the scores in all the scales were found to be non-parametric.

A correlation analysis was performed to assess the relationship between the Quality Results scale and the perception of the respondents regarding the other scales: Management and Leadership, Strategic Quality Planning, Quality Management, Human Resource Utilisation, Customer Satisfaction, and Accreditation including Accreditation Impact, Staff involvement, and Accreditation Awareness. Analysis was done by using the scores calculated as described above for the aforementioned scales.

Linear regression models were then used to further examine the findings in the above correlation analyses. Taking Quality Results as the dependent variable, linear regression models were used to understand the relationship between Quality Results and the other scales. The independent variables included in these models were the scores for the scales produced

above measuring Management and Leadership, Strategic Quality Planning, Quality Management, Human Resource Utilisation, Customer Satisfaction, and Accreditation including Accreditation Impact, Staff involvement, and Accreditation Awareness. In order to control for any confounding/effect modification and further analyse the effects of these independent variables on Quality Results, a multivariate regression model was run between the dependant variable and independent variables, together with the demographic variables. Thus, the model was controlled for age, gender, experience, professional group and PHC size.

8.2.6. Ethical approval procedure

Ethical approval to conduct this study was sought and obtained from the relevant committees at both the academic and governmental levels (Appendix L). These were the College of MVLS Ethics Committee at the University Of Glasgow (UOG) and the Medical Research Ethics Committee at the Kuwait Institute for Medical Specialization (KIMS) of the MOH. At the institutional level, approval of the centres was secured by acquiring oral informed consent, in the presence of a witness, from the directors of the involved PHCCs, after meeting with them and in depth discussion about the research project and its methodology. Participants received a consent form with the questionnaire, both in English and Arabic, stating the purpose of the study and their freedom to participate in it or decline to do so. Confidentiality of respondents and their respective centres were maintained by using serial numbers and codes instead of actual names. Participants were told that all the questionnaires were to be kept securely, under locked conditions, and available only to the researcher throughout the whole period of the research project. Finally, it was also mentioned to them that the information gained through this study, will not, in any way, be used against any party involved in this study, rather it will only be used to develop a better understanding of accreditation and its impacts at PHC level.

8.3. Results

8.3.1. Questionnaire distribution and response rates

Of the 520 questionnaires distributed over 3 PHC centres, 375 were returned complete, giving an overall response rate of 72%. Table 8.1 details the response rate by centre.

Table 8.1: Questionnaire distribution and response rates

Name of Centre	Size	Number of recruited staff members per centre	Number of respondents' per centre	Percent response rate per centre
PHC centre A	Medium	125	95	76%
PHC centre B	Large	171	120	70%
PHC centre C	Large	224	160	71%
Total	3	520	375	72%

Response rates were the highest among nurses: 84% in PHC centre A, 97% in the PHC centre B and 83% in the PHC centre C. Physicians were the second highest, with response rates of 95%, 68%, and 71% in PHC centres A, B, and C respectively. Response rates within the pharmacists ranged from 56% to 80% and among the technicians: 62% to 73%.

Administrators' response rates were from 52% to 70%. Dentists had the lowest response rates: 29% to 40%.

8.3.2. Demographics

Univariate analysis was conducted to describe the demographic characteristics of the respondents. As observed in Table 8.2, most respondents were female (62.1%), between 30 and 45 years of age (53.9%), and had been working at their centres for less than or equal to 5 years (48.3%). Of all the respondents, 37.4% were nurses, 21.2% were physicians and 13.7% were technicians. As expected, given there were two large PHCCs involved, the majority (74.9%) of the respondents were from the large-sized PHCCs.

Table 8.2: Demographics

	N	%
Gender		
Male	139	37.9
Female	228	62.1
Age (Years)		
< 30	83	23.1
30 – 45	194	53.9
46 – 55	60	16.7
> 55	23	6.4
Experience (Years)		
≤ 5	173	48.3
6 – 10	126	35.2
11 – 15	39	10.9
16 – 20	7	2.0
>20	13	3.6
Professional group		
Director of the centre	3	0.8
Nurse	139	37.4
Physician	79	21.2
Pharmacist	30	8.1
Social Worker	0	0.0
Unit assistant/Clerk/Secretary	26	7.0
Technician (e.g. EKG, Lab, Radiology)	51	13.7
Administration/Management	36	9.7
Dentist	8	2.1
PHC size		
Medium	94	25.1
Large	281	74.9

The characteristics and demographics of the respondents were then compared across the PHC centres (Table 8.3).

Although females were the majority in all 3 centres, they were less of a majority in the PHC centre C (57%) (Chi-squared=6.728; P-value= 0.035). PHC centre A had significantly younger (Chi-squared=21.0769; P-value= 0.002) and less experienced (Chi-squared=33.0088; P-value<0.001) respondents compared to PHC centres B and C. In PHC centre A, 90% of the

respondents were aged 45 and below, and 67.4% of them had less than or equal to 5 years of experience. Distribution of the professions also varied significantly among the PHCCs (Chi-squared=33.0088; P-value<0.001). Almost half of the respondents were nurses (48.3%) in the PHC centre B compared to 27.7% in the PHCC A and 34.8% in PHCC C (Chi-squared=53.4055; P-value<0.001). Physicians were relatively higher in numbers within the respondents in the PHC centre C (26.0%) than PHC centres A (20.2%) and B (15.8%). There were no respondents in PHC centre A who were managers/administrators and no dentists in PHC centre C.

Table 8.3: Distribution of respondents among the PHC centres

	PHC centre A	PHC centre B	PHC centre C	Pearson chi2 (P-value)
	N (%)	N (%)	N (%)	
Gender				
Male	24 (26.7)	47 (39.5)	68 (43.0)	
Female	66 (73.3)	72 (60.5)	90 (57.0)	
Total	90 (100)	119 (100)	158 (100)	6.728 (0.035)
Age (Years)				
< 30	27 (29.7)	16 (13.6)	40 (26.5)	
30 – 45	54 (59.3)	72 (61)	68 (45.0)	
46 – 55	9 (9.9)	19 (16.1)	32 (21.2)	
> 55	1 (1.1)	11 (9.3)	11 (7.3)	
Total	91 (100)	118 (100)	151 (100)	21.0769 (0.002)
Experience (Years)				
≤ 5	60 (67.4)	40 (35.4)	73 (46.8)	
6 – 10	34 (27)	41 (36.3)	61 (39.1)	
11 – 15	2 (2.3)	22 (19.5)	15 (9.6)	
16 – 20	0 (0)	5 (4.4)	2 (1.3)	
>20	3 (3.4)	5 (4.4)	5 (3.2)	
Total	89 (100)	113 (100)	156 (100)	33.0088 (<0.0001)
Professional group				
Director of the centre	1 (1.06)	1 (0.8)	1 (0.6)	
Nurse	26 (27.7)	58 (48.3)	55 (34.8)	
Physician	19 (20.2)	19 (15.8)	41 (26.0)	
Pharmacist	12 (12.8)	5 (4.2)	13 (8.2)	
Unit assistant/Clerk/Secretary	16 (17.0)	3 (2.5)	7 (4.4)	
Technician	16 (17.0)	13 (10.9)	22 (13.9)	
Administration/Management	0 (0)	17 (14.2)	19 (12.0)	
Dentist	4 (4.3)	4 (3.3)	0 (0)	
Total	94 (100)	120 (100)	158 (100)	53.4055 (<0.0001)

8.3.3. Respondents views as gathered by the accreditation questionnaire

Descriptive summaries and univariate analyses were done for all the 9 scales of the survey. For each item of the scales, numbers and percentages are reported in the tables below whereas the univariate summaries of the descriptive results are found in Appendix G.

i. Management and Leadership

There was a high level of agreement for many of the items in the Management and Leadership scale, indicating that the management of accreditation was well received by the respondents. More than 90% of respondents agreed that environment for quality improvement was maintained and that the leadership was the primary driving force behind quality improvement efforts. There was also a high level of agreement (over 80% of respondents), that senior executives demonstrated the ability to manage change, participated in activities to improve quality and were the driving force behind quality improvement in the primary care centres. However, slightly fewer respondents (less than 80%) agreed that the senior executives had put forward a “clear vision” for QI or had allocated adequate resources to the task (Table 8.4).

Table 8.4: Management and Leadership scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Management and Leadership						
1. The senior executives provide highly visible leadership in maintaining an environment that supports quality improvement.	4 (1.07%)	7 (1.87%)	23 (6.13%)	246 (65.6%)	95 (25.33%)	0(0%)
2. The top management is a primary driving force behind quality improvement efforts.	5 (1.33%)	22 (5.87%)	35 (9.33%)	206 (54.93%)	96 (25.6%)	11 (2.93%)
3. The senior executives allocate available resources (e.g. finances, people, time, equipment) to improving quality.	4 (1.07%)	37 (9.87%)	29 (7.73%)	214 (57.07%)	74 (19.73%)	17 (4.53%)
4. The senior executives consistently participate in activities to improve the quality of care and services.	2 (0.53%)	6 (1.6%)	32 (8.53%)	244 (65.07%)	79 (21.07%)	12 (3.20%)
5. The senior executives have articulated a clear vision for improving the quality of care and services.	2 (0.53%)	13 (3.47%)	54 (14.40%)	215 (57.33%)	69 (18.40%)	22 (5.87%)
6. The senior executives have demonstrated an ability to manage the changes (e.g. organizational, technological) needed to improve the quality of care and services.	2 (0.53%)	16 (4.27%)	32 (8.53%)	227 (60.53%)	89 (23.73%)	9 (2.40%)
7. The senior executives started to act on suggestions to improve the quality of care and services.	1 (0.27%)	23 (6.13%)	37 (9.87%)	232 (61.87%)	72 (19.20%)	10 (2.67%)
8. Based on the accreditation results, senior executives have a thorough understanding of how to improve the quality of care and services.	0 (0%)	7 (1.87%)	39 (10.4%)	211 (56.27%)	101 (26.93%)	17 (4.53%)
9. The senior executives generate confidence that efforts to improve quality will succeed.	0 (%)	0 (%)	47 (12.53%)	184 (49.07%)	110 (29.33%)	34 (9.07%)

ii. Strategic Quality Planning

Respondents were again in high agreement with most of the items in this scale. For example, about 81% of the respondents indicated that they were involved in developing plans for improving quality; while 79% agreed that staff members played a key role in setting priorities for quality improvement and three-quarters agreed that that patients' expectations about quality played a key role in setting priorities for quality. However, 12% felt that that staff members were not given adequate time to plan for and test quality improvements and 10% felt middle managers did not have key role in setting priorities for quality improvement (Table 8.5). Finally less than 70% of respondents felt that the quality improvement goals were known in their unit or department.

Table 8.5: Strategic Quality Planning scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Strategic Quality Planning						
1. Staff members are given adequate time to plan for and test quality improvements.	4 (1.07%)	41 (10.93%)	48 (12.8%)	224 (59.73%)	51 (13.6%)	7 (1.87%)
2. Each department and work group within this center maintains specific goals to improve quality.	2 (0.53%)	14 (3.73%)	60 (16%)	208 (55.47%)	84 (22.4%)	6 (1.6%)
3. The center's quality improvement goals are known throughout your unit.	0 (0%)	24 (6.4%)	80 (21.33%)	174 (46.4%)	86 (22.93%)	11 (2.93%)
4. Staff members are involved in developing plans for improving quality.	3 (0.8%)	23 (6.13%)	23 (6.13%)	215 (57.33%)	90 (24%)	21 (5.6%)
5. Middle managers (e.g. Nurse Heads, Director of Nursing, Clinical specialists) play a key role in setting priorities for quality improvement.	4 (1.07%)	34 (9.07%)	51 (13.6%)	184 (49.07%)	80 (21.33%)	22 (5.87%)
6. Patients' expectations about quality play a key role in setting priorities for quality improvement.	1 (0.27%)	25 (6.67%)	45 (12%)	232 (61.87%)	49 (13.07%)	23 (6.13%)
7. Staff members play a key role in setting priorities for quality improvement through representation in the center's organizational chart.	1 (0.27%)	17 (4.53%)	46 (12.27%)	221 (58.93%)	76 (20.27%)	14 (3.73%)

iii. Human Resources Utilisation

The majority of respondents agreed that staff members were given the education and training needed to improve skills and performance and to support quality improvement (Table 8.6).

However, fewer agreed that inter-departmental co-operation was supported or that there was a system to allow staff to make suggestions about quality improvement. Finally only 6 in 10 felt that staff effort was recognised and rewarded.

Table 8.6: Human Resource Utilisation scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Human Resources Utilization						
1. Staff members are given education and training in how to identify and act on quality improvement opportunities based on recommendations from accreditation surveys.	4 (1.07%)	23 (6.13%)	40 (10.67%)	212 (56.53%)	93 (24.8%)	3 (0.8%)
2. Staff members are given continuous education and training in methods that support quality improvement.	1 (0.27%)	22 (5.87%)	40 (10.67%)	209 (55.73%)	99 (26.4%)	4 (1.07%)
3. Staff members are given the needed education and training (through education programs) to improve job skills and performance.	2 (0.53%)	16 (4.27%)	36 (9.6%)	199 (53.07%)	114 (30.4%)	8 (2.13%)
4. Staff members are rewarded and recognized (e.g. financially and/or otherwise) for improving quality.	31 (8.27%)	60 (16%)	49 (13.07%)	148 (39.47%)	80 (21.33%)	7 (1.87%)
5. Inter-departmental cooperation to improve the quality of services is supported and encouraged.	9 (2.4%)	33 (8.8%)	52 (13.87%)	200 (53.33%)	71 (18.93%)	10 (2.67%)
6. The center has an effective system for staff members to make suggestions to management on how to improve quality.	10 (2.67%)	34 (9.07%)	59 (15.73%)	184 (49.07%)	71 (18.93%)	17 (4.53%)

iv. Quality Management

Most respondents agreed that their primary care centre had effective policies, encouraged staff to keep records of quality problems and viewed quality assurance as a continuous process (Table 8.7). However, fewer agreed that the services provided were tested for quality before implementation.

Table 8.7: Quality Management scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Quality Management						
1. The center regularly checks equipment and supplies to make sure they meet quality requirements.	14 (3.73%)	22 (5.87%)	29 (7.73%)	240 (64%)	67 (17.87%)	3 (0.8%)
2. The center has effective policies to support improving the quality of care and services	9 (2.4%)	14 (3.73%)	45 (12%)	205 (54.67%)	85 (22.67%)	17 (4.53%)
3. The center tries to design quality into new services as they are being developed.	3 (0.8%)	15 (4%)	41 (10.93%)	235 (62.67%)	65 (17.33%)	16 (4.27%)
4. The services that the center provides are thoroughly tested for quality before they are implemented.	3 (0.8%)	24 (6.4%)	57 (15.2%)	202 (53.87%)	67 (17.87%)	21 (5.6%)
5. The center views quality assurance as a continuing search for ways to improve.	3 (0.8%)	13 (3.47%)	48 (12.8%)	224 (59.73%)	77 (20.53%)	10 (2.67%)
6. The center encourages staff members to keep records of quality problems through documentation.	10 (2.67%)	16 (4.27%)	29 (7.73%)	228 (60.8%)	80 (21.33%)	12 (3.2%)

v. Quality Results

There was little variation in the percentage of respondents agreeing to questions relating to quality improvement in the centres. Between 70 to 77% of respondents agreed that their centre had shown steady improvements in the quality of services delivered to patients, in support services and in administrative services (Table 8.8). Overall, 77% of respondents agreed that their centre had maintained high quality health services (Table 8.9).

Table 8.8: Quality Results scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Quality Results						
1. Over the past year, the center has shown steady, measurable improvements in the quality of customer satisfaction.	2 (0.53%)	12 (3.2%)	47 (12.53%)	212 (56.53%)	73 (19.47%)	29 (7.73%)
2. Over the past year, the center has shown steady, measurable improvements in the quality of services provided by the administration (e.g. finance, human resources).	0 (0%)	11 (2.93%)	62 (16.53%)	216 (57.6%)	50 (13.33%)	36 (9.6%)
3. Over the past year, the center has shown steady, measurable improvements in the quality of care provided to patients (e.g. medical, surgical, obstetric, paediatric patients).	0 (0%)	11 (2.93%)	48 (12.8%)	199 (53.07%)	71 (18.93%)	46 (12.27%)
4. Over the past year, the center has shown steady, measurable improvements in the quality of services provided by clinical support departments (e.g. laboratory, pharmacy, radiology).	0 (0%)	8 (2.13%)	48 (12.8%)	199 (53.07%)	80 (21.33%)	40 (10.67%)
5. Over the past year, the center has maintained a high quality health services despite financial constraints.	0 (0%)	10 (2.67%)	47 (12.53%)	209 (55.73%)	80 (21.33%)	0 (0%)

vi. Patient Satisfaction

More than 80% of respondents stated that their centres performed a good job in assessing current patient needs and expectations and resolving their complaints. Moreover, almost 87% stated that these complaints were studied in order to learn lessons and prevent such problems from recurring. About three-quarters also agreed that their centre did a good job of assessing future patient needs and expectations and communicated this to staff (Table 8.9).

Table 8.9: Patient Satisfaction scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Customer (Patient) Satisfaction						
1. The center does a good job of assessing current patient needs and expectations.	2 (0.53%)	10 (2.67%)	36 (9.6%)	208 (55.47%)	99 (26.4%)	20 (5.33%)
2. The center does a good job of assessing future patient needs and expectations.	1 (0.27%)	7 (1.87%)	46 (12.27%)	203 (54.13%)	87 (23.2%)	31 (8.27%)
3. Staff members promptly resolve patient complaints.	2 (0.53%)	4 (1.07%)	34 (9.07%)	221 (58.93%)	99 (26.40%)	15 (4%)
4. Patients' complaints are studied to identify patterns and learn from them to prevent the same problems from recurring.	7 (1.87%)	5 (1.33%)	25 (6.67%)	226 (60.27%)	99 (26.4%)	13 (3.47%)
5. The center uses data from patients to improve services.	3 (0.8%)	10 (2.67%)	51 (13.61%)	183 (48.8%)	105 (28%)	23 (6.13%)
6. Data on patient satisfaction are widely communicated to staff members.	6 (1.60%)	13 (3.47%)	46 (12.27%)	192 (51.2%)	93 (24.8%)	25 (6.67%)
7. The center uses data on patient expectations and/or satisfaction when designing new services.	2 (0.53%)	20 (5.33%)	58 (15.47%)	175 (46.67%)	84 (22.4%)	36 (9.6%)

vii. Accreditation Impact

In the Accreditation Impact scale, most either strongly agreed or agreed that accreditation had had a good impact on the centres (Table 8.10). In particular, almost 90% felt that accreditation was a valuable tool to support the implementation of change and made the centres more responsive to change. Most also felt that accreditation supported the development of shared values amongst staff, encouraged team work and collaboration and improved patient care. The responses to this scale indicated that staff in the centres felt able to participate in the implementation of changes associated with the accreditation programme and make the centres more able to respond to the needs of their populations.

Table 8.10: Accreditation Impact scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Accreditation Impact						
1. During the preparation for the last survey, important changes were implemented at the center.	1 (0.27%)	18 (4.8%)	30 (8%)	227 (60.53%)	61 (16.27%)	38 (10.13%)
2. You participated in the implementation of these changes.	9 (2.4%)	25 (6.67%)	35 (9.33%)	234 (62.4%)	59 (15.73%)	13 (3.47%)
3. You learned of the recommendations made to your center since the last survey (if it's the case).	2 (0.53%)	22 (5.87%)	45 (12%)	214 (57.07%)	57 (15.2%)	35 (9.33%)
4. These recommendations were an opportunity to implement important changes at the center.	1 (0.27%)	12 (3.2%)	44 (11.73%)	224 (59.73%)	71 (18.93%)	23 (6.13%)
5. You participated in the changes that resulted from accreditation recommendations.	3 (0.81%)	17 (4.57%)	45 (12.1%)	221 (59.41%)	66 (17.74%)	20 (5.38%)
6. Accreditation enables the improvement of patient care.	4 (1.07%)	3 (0.8%)	28 (7.47%)	220 (58.67%)	102 (27.2%)	18 (4.8%)
7. Accreditation enables the motivation of staff and encourages team work and collaboration	9 (2.4%)	9 (2.4%)	39 (10.4%)	218 (58.13%)	91 (24.27%)	9 (2.4%)
8. Accreditation enables the development of values shared by all professionals at the center.	9 (2.4%)	10 (2.67%)	21 (5.6%)	245 (65.33%)	79 (21.07%)	11 (2.93%)
9. Accreditation enables the center to better use its internal resources (e.g. finances, people, time, equipment).	3 (0.8%)	15 (4%)	49 (13.07%)	197 (52.53%)	72 (19.2%)	39 (10.4%)
10. Accreditation enables the center to better respond to the populations needs.	2 (0.53%)	9 (2.4%)	37 (9.87%)	219 (58.4%)	85 (22.67%)	23 (6.13%)
11. Accreditation enables the center to better respond to its partners (e.g. other centers, diverse hospitals, private clinics, etc.)	3 (0.8%)	4 (1.07%)	40 (10.67%)	225 (60%)	69 (18.4%)	34 (9.07%)
12. Accreditation contributes to the development of collaboration with partners in the health care system.	0 (0%)	4 (1.07%)	29 (7.73%)	239 (63.73%)	71 (18.93%)	32 (8.53%)
13. Accreditation is a valuable tool for the center to implement changes.	1 (0.27%)	3 (0.8%)	20 (5.33%)	253 (67.47%)	80 (21.33%)	18 (4.8%)
14. The center's participation in accreditation enables it to be more responsive when changes are to be implemented.	1 (0.27%)	2 (0.53%)	24 (6.40%)	254 (67.73%)	73 (19.47%)	21 (5.60%)

viii. Staff Involvement

In general, most respondents agreed or strongly agreed that they had been well supported, both individually and as part of a team, during the accreditation process (Table 8.11). In particular, over 80% felt that participating in the accreditation process had contributed to their personal, professional and career development. However, 12.5% reported that they had not received sufficient training and support to allow them to meet their accreditation responsibilities. At an organisational level, accreditation was viewed by the majority as improving multidisciplinary working in the centres, and improving the standard of care both within

departments and across the centre. Overall over 80% of respondents agreed that accreditation is a worthwhile process.

Table 8.11: Staff Involvement in the Accreditation Process scale results of the survey

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Don't know
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Staff Involvement in the Accreditation Process						
1. I received sufficient training and support in order to fulfill my accreditation responsibilities.	11 (2.93%)	36 (9.6%)	37 (9.87%)	235 (62.67%)	41 (10.93%)	15 (4%)
2. There was sufficient leadership for the accreditation process.	3 (0.8%)	27 (7.2%)	54 (14.4%)	228 (60.8%)	47 (12.53%)	14 (3.73%)
3. The overall accreditation process was well managed.	3 (0.8%)	10 (2.67%)	66 (17.6%)	226 (60.27%)	47 (12.53%)	21 (5.6%)
4. Our team worked well together.	1 (0.27%)	11 (2.93%)	46 (12.27%)	229 (61.07%)	70 (18.67%)	16 (4.27%)
5. Everyone was encouraged to participate in the accreditation process.	1 (0.27%)	10 (2.67%)	38 (10.13%)	232 (61.87%)	63 (16.80%)	31 (8.27%)
6. Everyone had the opportunity to voice their opinions.	7 (1.87%)	25 (6.67%)	47 (12.53%)	206 (54.93%)	64 (17.07%)	26 (6.93%)
7. I felt part of an accreditation team.	2 (0.53%)	19 (5.07%)	59 (15.73%)	217 (57.87%)	51 (13.60%)	26 (6.93%)
8. Staff members took the agreed deadlines seriously.	1 (0.27%)	20 (5.33%)	45 (12%)	206 (54.93%)	73 (19.47%)	30 (8%)
9. I was fully committed to accreditation at all stages of the process.	0 (0%)	26 (6.93%)	45 (12%)	221 (58.93%)	61 (16.27%)	22 (5.87%)
10. Accreditation enhanced my relationships with my immediate work colleagues.	1 (0.27%)	16 (4.27%)	49 (13.07%)	200 (53.33%)	84 (22.4%)	25 (6.67%)
11. My work colleagues assisted and supported me in completing my accreditation tasks.	1 (0.27%)	20 (5.33%)	60 (16%)	190 (50.67%)	86 (22.93%)	18 (4.8%)
12. My line manager assisted and supported me in completing my accreditation tasks.	1 (0.27%)	12 (3.2%)	62 (16.53%)	192 (51.2%)	92 (24.53%)	16 (4.27%)
13. I got recognition from my work colleagues for my contribution to the accreditation process.	2 (0.53%)	15 (4.01%)	59 (15.78%)	203 (54.28%)	78 (20.86%)	17 (4.55%)
14. I got recognition from my line manager for my contribution to the accreditation process.	2 (0.53%)	16 (4.27%)	55 (14.67%)	208 (55.47%)	72 (19.2%)	22 (5.87%)
15. Involvement in the accreditation process has allowed me to reflect on my work practices.	3 (0.8%)	7 (1.87%)	60 (16%)	221 (58.93%)	68 (18.13%)	16 (4.27%)
16. Involvement in the accreditation process contributed to my personal development.	5 (1.33%)	5 (1.33%)	45 (12%)	230 (61.33%)	74 (19.73%)	16 (4.27%)
17. Involvement in the accreditation process contributed to my professional development.	1 (0.27%)	8 (2.13%)	38 (10.13%)	236 (62.93%)	86 (22.93%)	6 (1.6%)
18. Involvement in the accreditation process will contribute to my career advancement.	2 (0.53%)	4 (1.07%)	50 (13.33%)	232 (61.87%)	72 (19.2%)	15 (4%)
19. Accreditation has improved the level of multidisciplinary working in the center.	2 (0.54%)	6 (1.61%)	38 (10.22%)	222 (59.68%)	80 (21.51%)	24 (6.45%)
20. Accreditation has improved the standard and delivery of healthcare within my immediate work environment.	1 (0.27%)	6 (1.60%)	39 (10.4%)	239 (63.73%)	74 (19.73%)	16 (4.27%)
21. Accreditation has improved the standard and delivery of healthcare within the center.	1 (0.27%)	5 (1.33%)	34 (9.07%)	238 (63.47%)	72 (19.20%)	25 (6.67%)
22. Accreditation is a worthwhile process.	2 (0.53%)	7 (1.87%)	34 (9.07%)	202 (53.87%)	111 (29.6%)	19 (5.07%)

ix. Awareness of the Accreditation Process

While more than 80% of respondents stated that they were aware of the accreditation process and most also agreed that they were familiar with its aims and objectives, less than 60% felt that patients were aware the accreditation process had taken place and only 66% indicated that other healthcare organisations in the region were aware that the centres were participating in the accreditation process (Table 8.12).

Table 8.12: Awareness of the Accreditation Process

Awareness of the Accreditation Process						
1. Staff members in the center are aware that the accreditation process is taking place.	4 (1.07%)	5 (1.33%)	22 (5.87%)	243 (64.8%)	72 (19.2%)	29 (7.73%)
2. Staff members in the center are aware of the aims and objectives of the accreditation process.	4 (1.07%)	6 (1.6%)	44 (11.73%)	233 (62.13%)	61 (16.27%)	27 (7.2%)
3. Staff members in the center believe that accreditation is a worthwhile process.	4 (1.07%)	4 (1.07%)	51 (13.6%)	211 (56.27%)	80 (21.33%)	25 (6.67%)
4. Patients are aware that the accreditation process is underway.	6 (1.6%)	15 (4%)	83 (22.1%)	157 (41.87%)	62 (16.53%)	52 (13.87%)
5. Other associated healthcare organizations in the region are aware that the accreditation process in the center is underway.	6 (1.6%)	7 (1.87%)	60 (16%)	165 (44%)	83 (22.1%)	54 (14.4%)

8.3.4. Mean scores and Cronbach's alpha for each scale and summary of findings

Scores were created by summation of the items within each of the scales and dividing the sum by the number of items with non-missing values as previously reported by El-Jardali et al., 2008. This produced a score between 1 and 5 for each scale with higher scores indicating higher agreement. The mean scores computed for scales and subscales (Appendix G) were all high. Customer Satisfaction had the highest mean score (4.05), followed by Management and Leadership (4.04), Accreditation Impact and Quality Results (both having a mean score of 3.99), Accreditation Awareness (3.97), Staff Involvement (3.95), Quality Management (3.93), Strategic Quality Planning (3.91) and finally Human Resource Utilisation (3.86) (Table 8.13). Cronbach's alpha was used to measure the internal consistency and reliability of the scales; how closely related a set of items are as a group. All values were above 0.80 thus indicating good internal consistency and reliability (Table 8.13).

Table 8.13: Descriptive statistics and Cronbach's alpha

Scale	Items	Cronbach's alpha	n	Mean	Standard Deviation	Minimum	Maximum	25th percentile	Median	75th percentile
Management and leadership	9	0.881	375	4.04	0.53	1.38	5.00	3.78	4.00	4.38
Strategic quality planning	7	0.835	373	3.91	0.57	2.00	5.00	3.57	4.00	4.29
Human resource utilization	6	0.844	374	3.86	0.7	1.17	5.00	3.60	4.00	4.40
Quality management	6	0.859	373	3.93	0.63	1.00	5.00	3.67	4.00	4.33
Quality results	5	0.854	362	4.00	0.55	2.00	5.00	3.75	4.00	4.40
Patient Satisfaction	7	0.881	369	4.05	0.59	1.60	5.00	3.71	4.00	4.43
Accreditation										
Accreditation impact	14	0.901	371	3.99	0.52	1.36	4.86	3.79	4.00	4.31
Staff involvement	22	0.953	371	3.95	0.54	1.63	5.00	3.75	4.00	4.32
Accreditation awareness	5	0.891	363	3.97	0.62	1.00	5.00	3.75	4.00	4.25

In order to analyse the findings according to the demographics, the means of the scores created above for each scale were compared between the different categories of the demographic variables using the Kruskal-Wallis test. This was used instead of ANOVA because the distributions of the scores in all the 9 scales were found to be non-parametric. The demographic variables considered were gender, age, years of experience, professional group and PHC size.

In summary, for gender, the Kruskal-Wallis tests showed that difference in the mean scores between males and females was significant only in the Human Resource Utilisation, Customer Satisfaction and Accreditation Impact scales, with males having higher mean scores than females.

For age, there were significant differences in the scores for Management and Leadership, Human Resource Utilisation, Quality Management, Quality Results, Customer Satisfaction, Accreditation Impact, Staff Involvement and Accreditation Awareness. Respondents who were above 55 years of age had higher means in these scales compared to younger respondents.

Regarding experience, Kruskal-Wallis tests showed that results scores were significantly different between the different categories of experience in Human Resource Utilisation, and Customer Satisfaction scales, where means were highest among respondents with 16 or more years of experience.

For professional group and PHC size, tests showed that scores in all the scales were significantly different between the positions of the respondents (managers/administrators having highest mean scores compared to the others) and the size of the PHC centres (large PHC centres having highest mean scores)(Table 8.14).

Table 8.14: Summary of Significant and non-significant associations of demographic variables, professional group and PHC size with each scale

Scale	Gender	Age	Years of experience	Professional group	PHC size
Management & Leadership	NS	S	NS	S	S
Strategic Quality Planning	NS	NS	NS	S	S
Human Resources Utilisation	S	S	S	S	S
Quality Management	NS	S	NS	S	S
Quality Results	NS	S	NS	S	S
Patient Satisfaction	S	S	S	S	S
Accreditation Implementation	S	S	NS	S	S
Staff Involvement	NS	S	NS	S	S
Awareness of Accreditation Process	NS	S	NS	S	S

These results are presented in more detail for each scale in the following section.

8.3.5. Analysis of mean scores by demographics, professional group and PHC centre for each scale.

i. Management and Leadership

There was a significant difference in the mean scores for the Management and Leadership scale by age (Chi-squared=8.15, P-value= 0.043), professional group (Chi-squared= 72.45. P-value <0.001) and PHC size (Chi-squared=21.57, P-value <0.001) variables (Table 8.15).

Those who had higher mean scores were aged above 55 (Mean=4.25), who worked as administrators/managers (Mean=4.5) or who were in a large sized PHC centre (Mean=4.1) (Table 8.15).

Table 8.15: Management and Leadership scores in relation to demographics, professional group and centre size

	n	Mean	Kruskal Wallis chi-squared	P- Value
Gender				
Male	139	4.08	2.92	0.0875
Female	228	4.00		
Age				
< 30	83	4.01	8.149	0.043
30 – 45	194	4.00		
46 – 55	60	4.09		
> 55	23	4.25		
Experience (Years)				
≤ 5	173	4.03		

6 – 10	126	4.02		
11 – 15	39	4.03		
16 – 20	7	4.26		
>20	13	3.97	2.368	0.6683
Professional group				
Director of the centre	3	4.44		
Nurse	139	4.04		
Physician	79	3.98		
Pharmacist	30	4.04		
Unit assistant/Clerk/Secretary	26	4.24		
Administration/Management	36	4.5		
Technician (e.g. EKG, Lab, Radiology)	51	3.66		
Dentist	8	3.73	72.45	0.0001
PHC size				
Medium	94	3.85		
Large	281	4.10	21.571	0.0001

ii. Strategic Quality Planning

A significant difference in mean scores was found for professional group (Chi-squared=84.99, P-value< 0.001) and PHC size (Chi-squared= 12.02. P-value <0.001). Higher mean scores were recorded for those classified as administrator/manager (Mean=4.5) and for large sized PHC centres (Mean=3.97) (Table 8.16).

Table 8.16: Strategic Quality planning scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P- Value
Gender				
Male	137	3.91		
Female	228	3.90	0.376	0.5397
Age				
< 30	83	3.86		
30 – 45	193	3.85		
46 – 55	59	4.06		
> 55	23	4.01	6.995	0.0721
Experience (Years)				
≤ 5	172	3.90		
6 – 10	126	3.87		
11 – 15	38	3.85		
16 – 20	7	4.27		
>20	13	3.90	4.835	0.3046
Professional group				

Director of the centre	3	3.86		
Nurse	139	4.04		
Physician	79	3.71		
Pharmacist	30	3.79		
Unit assistant/Clerk/Secretary	26	4.23		
Administration/Management	36	4.45		
Technician (e.g. EKG, Lab, Radiology)	51	3.56		
Dentist	7	3.48	84.992	0.0001
PHC size				
Medium	94	3.7		
Large	279	3.97	12.02	0.0005

iii. Human Resources Utilisation

The mean scores of the Human Resource Utilisation scales were significantly different by gender (chi-squared=5.958, P-value< 0.0144), age (Chi-squared=18.909, P-value<0.0003), years of experience (Chi-squared= 9.888, P-value: 0.0424) professional group (Chi-squared=93.23, P-value< 0.001) and PHC size (Chi-squared= 15.3. P-value <0.001). Higher mean scores were associated with being male (mean 3.94), aged over 55 (4.29) and with 16-20 years of experience (Mean= 4.55). In addition those working as administrator/managers (Mean=4.4) and in the large sized PHC centre (Mean=3.96) obtained higher means (Table 8.17).

Table 8.17: Human Resource Utilisation scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	138	3.94		
Female	228	3.80	5.985	0.0144
Age				
< 30	83	3.71		
30 – 45	193	3.8		
46 – 55	60	4.08		
> 55	23	4.29	18.909	0.0003
Experience (Years)				
≤ 5	172	3.81		
6 – 10	126	3.84		
11 – 15	39	3.92		

16 – 20	7	4.55		
>20	13	3.85	9.888	0.0424
Professional group				
Director of the centre	3	4.38		
Nurse	139	4.01		
Physician	79	3.62		
Pharmacist	30	3.88		
Unit assistant/Clerk/Secretary	26	4.21		
Administration/Management	36	4.44		
Technician (e.g. EKG, Lab, Radiology)	51	3.32		
Dentist	7	2.69	93.234	0.0001
PHC size				
Medium	94	3.57		
Large	280	3.96	15.3	0.0001

iv. Quality Management

For the demographics, the difference between the mean scores of Quality Management scales were significant in age (Chi-squared=11.77, P-value<0.01), professional group (Chi-squared=102.36, P-value <0.001) and PHC size (Chi-squared=12.7, P-value <0.01) variables. Those who had higher significant mean scores were the ones aged above 55 (Mean=4.2), worked as administrators/managers (Mean=4.5) and in a large sized PHC centre (Mean=4) (Table 8.18).

Table 8.18: Quality Management scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P- Value
Gender				
Male	137	3.93		
Female	228	3.89	1.012	0.3144
Age				
< 30	83	3.76		
30 – 45	192	3.90		
46 – 55	60	4.10		
> 55	23	4.20	11.777	0.0082
Experience (Years)				
≤ 5	172	3.87		
6 – 10	126	3.99		
11 – 15	39	3.91		

16 – 20	7	4.43		
>20	17	4.04	8.667	0.07
Professional group				
Director of the centre	3	3.89		
Nurse	138	4.07		
Physician	79	3.79		
Pharmacist	30	3.80		
Unit assistant/Clerk/Secretary	26	4.31		
Administration/Management	36	4.48		
Technician (e.g. EKG, Lab, Radiology)	51	3.36		
Dentist	7	2.98	102.36	0.0001
PHC size				
Medium	93	3.70		
Large	280	4.00	12.701	0.004

v. Quality Results.

Regarding the findings in relation to the demographics, the difference between the mean scores of Quality Results scales were significant in age (Chi-squared=14.1, P-value<0.01), professional group (Chi-squared= 50.47, P-value <0.001) and PHC size (Chi-squared=23.85, P-value <0.01) variables. Those who had higher significant mean scores were the ones aged above 55 (Mean=4.3), worked as administrators/managers (Mean=4.5) and in a large sized PHC centre (Mean=4.1) (Table 8.19).

Table 8.19: Quality Results scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	134	4.05		
Female	220	3.96	1.953	0.1623
Age				
< 30	80	4.04		
30 – 45	187	3.91		
46 – 55	58	4.07		
> 55	22	4.28	14.105	0.0028
Experience (Years)				
≤ 5	164	3.95		

6 – 10	122	4.01		
11 – 15	39	4.02		
16 – 20	7	4.54		
>20	13	3.97	8.568	0.0729
Professional group				
Director of the centre	3	4.13		
Nurse	138	3.98		
Physician	70	3.81		
Pharmacist	28	4.07		
Unit assistant/Clerk/Secretary	26	4.15		
Administration/Management	36	4.49		
Technician (e.g. EKG, Lab, Radiology)	51	3.83		
Dentist	7	3.57	50.469	0.0001
PHC size				
Medium	91	3.74		
Large	271	4.08	23.85	0.0001

vi. Patient Satisfaction

The differences between the mean scores of Customer Satisfaction scales were significant in all the demographic variables: gender (Chi-squared=5.6, P-value<0.05), age (Chi-squared=9.98, P-value <0.05), experience (Chi-squared = 9.84, P-value<0.05), professional group (Chi-squared= 84.32, P-value <0.001) and PHC size (Chi-squared=22.5, P-value <0.001). Those who had higher significant mean scores were males (Mean=4.1), aged above 55 (Mean=4.4), had 16-20 years of experience (Mean=4.6), worked as administrators/managers (Mean=4.6) and in a large sized PHC centre (Mean=4.1) (Table 8.20).

Table 8.20: Customer Satisfaction scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	136	4.13		
Female	225	4.00	5.628	0.0177
Age				
< 30	83	3.94		
30 – 45	191	4.03		
46 – 55	58	4.15		

> 55	22	4.36	9.981	0.0187
Experience (Years)				
≤ 5	171	3.99		
6 – 10	125	4.05		
11 – 15	36	4.17		
16 – 20	7	4.61		
>20	13	4.06	9.841	0.0432
Professional group				
Director of the centre	1	4.17		
Nurse	138	4.15		
Physician	78	3.86		
Pharmacist	28	4.07		
Unit assistant/Clerk/Secretary	24	4.26		
Administration/Management	36	4.62		
Technician (e.g. EKG, Lab, Radiology)	51	3.67		
Dentist	7	3.07	84.32	0.0001
PHC size				
Medium	93	3.77		
Large	276	4.14	22.507	0.0001

vii. Accreditation Impact

The difference between the mean scores of Accreditation Impact scales were significant for gender (Chi-squared=5.55, P-value<0.05), age (Chi-squared=14.4, P-value<0.01), professional group (Chi-squared= 109.3. P-value <0.001) and PHC size (Chi-squared=3.99, P-value <0.05) variables. Those who had higher significant mean scores were males (Mean=4.1), and again aged above 55 (Mean=4.3), worked as administrators/managers (Mean=4.5) and in a large sized PHC centre (Mean=4) (Table 8.21).

Table 8.21: Accreditation Impact scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	135	4.08		
Female	228	3.94	5.548	0.0185
Age				
< 30	82	3.84		

30 – 45	191	3.98		
46 – 55	60	4.14		
> 55	23	4.34	14.436	0.0024
Experience (Years)				
≤ 5	172	3.97		
6 – 10	123	4.01		
11 – 15	39	3.99		
16 – 20	7	4.39		
>20	13	3.95	6.08	0.1933
Professional group				
Director of the centre	3	4.33		
Nurse	139	4.03		
Physician	76	3.91		
Pharmacist	30	3.99		
Unit assistant/Clerk/Secretary	26	4.3		
Administration/Management	36	4.46		
Technician (e.g. EKG, Lab, Radiology)	51	3.57		
Dentist	7	3.39	109.335	0.0001
PHC size				
Medium	94	3.86		
Large	277	4.04	3.995	0.0456

viii. Staff Involvement

Variations in mean scores for Staff Involvement were significant for age (Chi-squared=17.88, P-value<0.001), professional group (Chi-squared= 72.32. P-value <0.001) and PHC size (Chi-squared=21.14, P-value <0.001) variables. Those who had higher significant mean scores were aged above 55 (Mean=4.2), worked as administrators/managers (Mean=4.4) and in a large sized PHC centre (Mean=4) (Table 8.22).

Table 8.22: Staff Involvement scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	135	3.98		
Female	228	3.92	2.437	0.1185
Age				

< 30	82	3.83		
30 – 45	191	3.92		
46 – 55	60	4.11		
> 55	23	4.24	17.879	0.0005
Experience (Years)				
≤ 5	172	3.93		
6 – 10	123	3.93		
11 – 15	39	4.07		
16 – 20	7	4.33		
>20	13	3.93	7.515	0.111
Professional group				
Director of the centre	3	4.33		
Nurse	139	3.98		
Physician	76	3.69		
Pharmacist	30	4.10		
Unit assistant/Clerk/Secretary	26	4.27		
Administration/Management	36	4.39		
Technician (e.g. EKG, Lab, Radiology)	51	3.71		
Dentist	7	3.54	72.319	0.0001
PHC size				
Medium	94	3.71		
Large	277	4.03	21.138	0.0001

ix. Awareness of the accreditation Process

The difference between the mean scores were significant for age (Chi-squared=12.5, P-value<0.05), professional group (Chi-squared= 91.6. P-value <0.001) and PHC size (Chi-squared=8.2, P-value <0.01) variables. Those who had higher significant mean scores were aged above 55 (Mean=4.3), worked as administrators/managers (Mean=4.3) or as Unit assistants/Clerks/Secretaries (Mean=4.3) and in a large sized PHC centre (Mean=4) (Table 8.23).

Table 8.23: Awareness of the Accreditation Process scores in relation to demographics

	n	Mean	Kruskal Wallis chi-squared	P-Value
Gender				
Male	130	4.00	0.761	0.3829
Female	225	3.94		
Age				
< 30	81	3.96	12.529	0.0138
30 – 45	185	3.90		
46 – 55	60	4.09		
> 55	22	4.28		
Experience (Years)				
≤ 5	168	3.97	7.515	0.111
6 – 10	121	3.95		
11 – 15	37	3.89		
16 – 20	7	4.69		
>20	13	3.91		
Professional group				
Director of the centre	3	3.33	91.623	0.0001
Nurse	139	4.07		
Physician	76	3.55		
Pharmacist	30	4.11		
Unit assistant/Clerk/Secretary	24	4.34		
Administration/Management	36	4.34		
Technician (e.g. EKG, Lab, Radiology)	51	3.76		
Dentist	7	4.04		
PHC size				
Medium	93	3.76	8.202	0.0042
Large	270	4.04		

Correlation between Quality Results (dependent variable) and Other Scales

A correlation analysis was performed to assess the strength of the relationship between the Quality Results and the perception of the respondents regarding Management and Leadership, Strategic Quality Planning, Quality Management, Human Resource Utilisation, Customer Satisfaction, and Accreditation including Accreditation Impact, Staff involvement, and

Accreditation Awareness (Table 8.24). Analysis was conducted using mean scores for each scale; higher scores indicated higher levels of agreement within the scale.

Table 8.24: Correlation between Quality Results and the other scales

	Quality Results	
	Correlation Coefficient	P-Value
Management and leadership	0.5130	< <i>0.001</i> *
Strategic quality planning	0.5730	< <i>0.001</i> *
Quality management	0.5959	< <i>0.001</i> *
Human resource utilisation	0.5997	< <i>0.001</i> *
Customer satisfaction	0.6675	< <i>0.001</i> *
Accreditation		
Accreditation impact	0.5353	< <i>0.001</i> *
Staff involvement	0.5184	< <i>0.001</i> *
Accreditation awareness	0.3280	< <i>0.001</i> *

***Bold and italic formatting indicates significant P-values.**

As shown in Table 8.24, the results showed a significant positive correlation between Quality Results and all the other scales although, for accreditation awareness, the correlation coefficient was lower.

8.3.6. Relationship between Quality Results (as dependent variable) and independent variables

Linear regression models were used to further examine the findings in the above correlation analyses and determine if the perceptions of the respondents regarding the other 8 scales were individually explanatory or linearly associated with the Quality Results. The independent variables included in these models were the scores for the scales produced above measuring Management and Leadership, Strategic Quality Planning, Quality Management, Human Resource Utilisation, Customer Satisfaction, and Accreditation including Accreditation Impact, Staff involvement, and Accreditation Awareness. The dependant variable was the score of the Quality Results scale (Table 8.25).

Table 8.25: Linear regression results between the independent variables and Quality Results

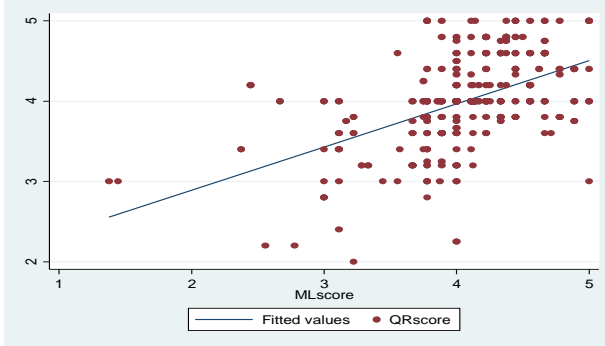
	Beta* (Std. error)	P-value
Management and leadership	0.538 (0.047)	< <i>0.001</i> *
Strategic quality planning	0.545 (0.041)	< <i>0.001</i> *
Quality management	0.528 (0.038)	< <i>0.001</i> *
Human resource utilisation	0.487 (0.034)	< <i>0.001</i> *
Customer satisfaction	0.633 (0.038)	< <i>0.001</i> *
Accreditation		
Accreditation impact	0.578 (0.048)	< <i>0.001</i> *
Staff involvement	0.533 (0.047)	< <i>0.001</i> *
Accreditation awareness	0.286 (0.044)	< <i>0.001</i> *

***Bold and italic formatting indicates significant P-values.**

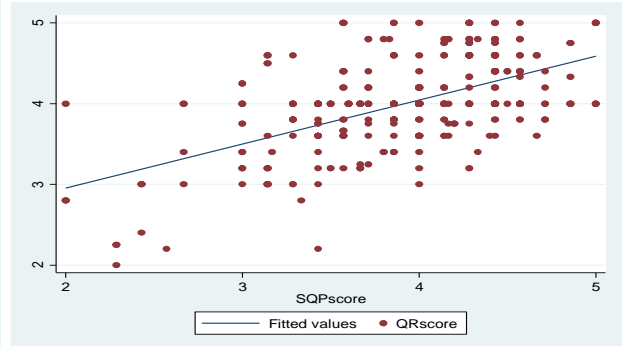
In the linear regression analyses, Quality Results were significantly and positively associated with all the independent variables (Table 8.25). The score on the Quality Results (QR score) increased by 0.538 (p-value < 0.001) for every unit increase in the score on Management and Leadership (ML score), controlling for all other variables. Similarly, the Quality Results score increased by 0.545 (p-value < 0.001) for every unit increase in the score on Strategic Quality Planning (SQP score). Increases of a similar margin were observed across the other scales (Table 8.25 and Graphs 1-8).

Figure 8.1: Graphs Scatter plot

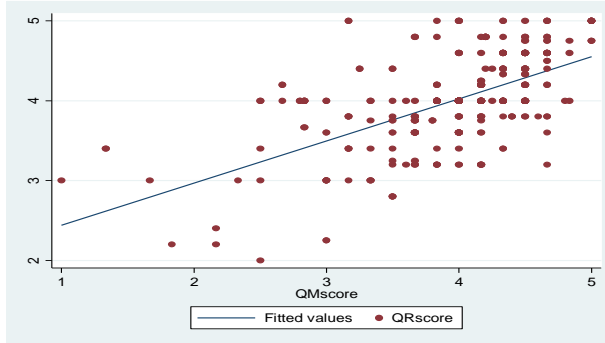
Graph 1- Scatterplot of QR score and MLscore



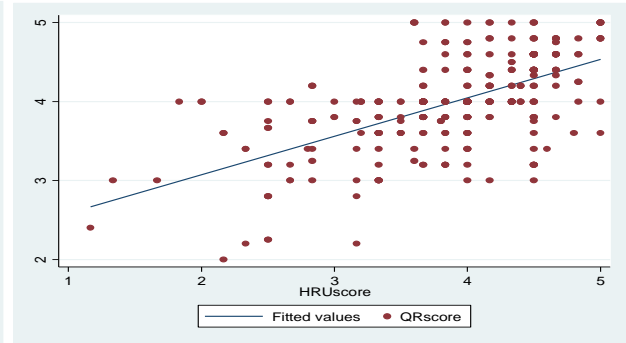
Graph 2- Scatterplot of QR score and SQPscore



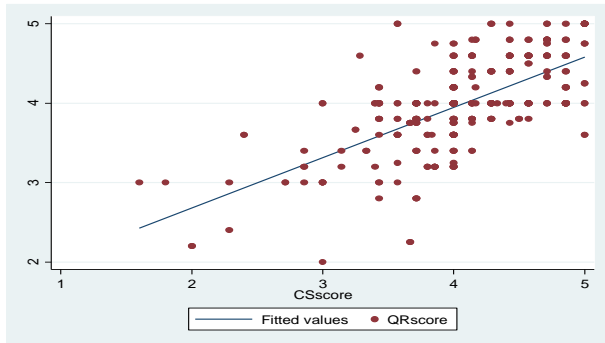
Graph 3- Scatterplot of QR score and QMscore



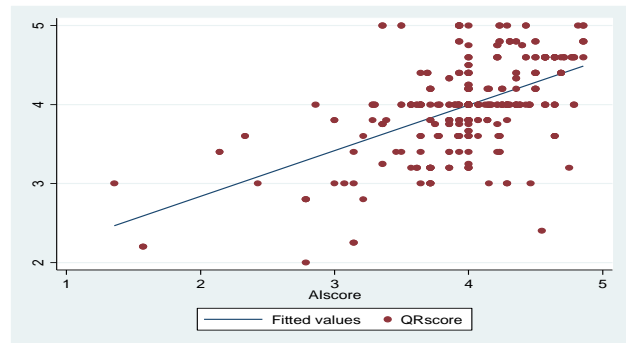
Graph 4- Scatterplot of QR score and HRU score



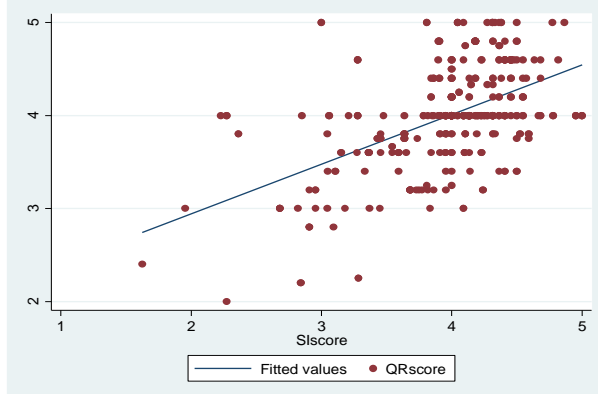
Graph 5- Scatterplot of QR score and CSscore



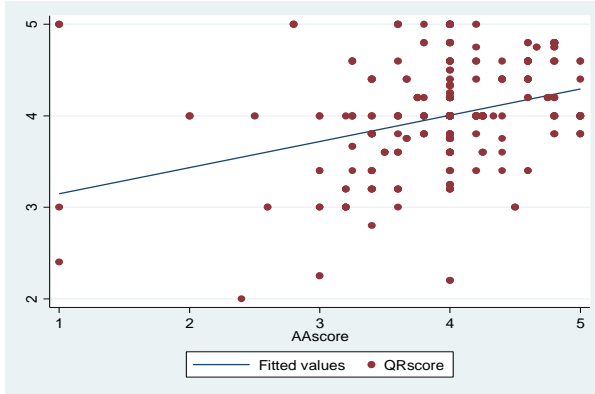
Graph 6- Scatterplot of QR score and AIscore



Graph 7- Scatterplot of QR score and SIscore



Graph 8- Scatterplot of QR score and AAscore



In order to control for any confounding/effect modification and further analyse the effects of these independent variables on Quality Results, a multivariate regression model was run between the dependant variable and independent variables listed above, together with the demographic variables, professional group and PHC size. Thus, the model was controlled for age, gender, experience; professional group and PHC size (Table 8.26).

Table 8.26: Multivariate Linear regression results

	Beta* (Std. error)	P-value
Management and leadership	0.015 (0.056)	0.785
Strategic quality planning	0.133 (0.053)	<i>0.014**</i>
Quality management	0.130 (0.057)	<i>0.024**</i>
Human resource utilisation	0.140 (0.049)	<i>0.005**</i>
Patient satisfaction	0.308 (0.058)	<i><0.001**</i>
Accreditation		
Accreditation impact	0.089 (0.061)	0.146
Staff involvement	-0.048 (0.065)	0.463
Accreditation awareness	0.019 (0.042)	0.659

*The model was controlled for age, gender, and experience at the centre, professional group and PHC size.

**Bold and italic formatting indicates significant P-values.

This model covered 55.7% (adjusted R-squared = 0.5574) of the Quality Results variability. Results of the multivariate linear regression model indicated that the predictors of better Quality Results scores were: Strategic Quality Planning, Quality Management, Human Resource Utilisation and Customer Satisfaction. Holding all the other variables fixed, the score on the Quality Results increased by 0.133 (p-value = 0.014) for every unit increase in the

score on Strategic Quality Planning. There was a mean increase of 0.130 (p-value = 0.024) in Quality Results was for every unit increase in Quality Management. Holding all the other variables fixed, Quality Results also increased by 0.140 (p-value = 0.005) and 0.308 (p-value < 0.001) for every unit increase in the scores of Human Resource Utilisation and Customer Satisfaction, respectively (Table 8.26).

8.4. Discussion

This study aimed to examine the changes brought due to the initiation of the ACI programme in three early adopting centres as perceived by the healthcare professionals. The results showed that accreditation was viewed as positively impacting on several areas of quality and performance. Moreover, several aspects of accreditation had a positive association with quality results. This included scales associated with increasing participation and associated with leadership.

There was, however, an overall skewed response towards positive responses across all the scales, with all the mean scores computed for the scales showing high levels of agreement among the participants. This reflected a positive attitude and perceptions from the healthcare professionals towards accreditation. These results suggested that the areas of highest improvement in accredited centres as perceived by healthcare professionals fall under management and leadership, patient satisfaction, and quality results which all obtained mean scores equal to or greater than 4 (agree). It is, however, important to note that with data of this kind, that although a score of 4.04 is higher than 3.86, both depict an overall level of agreement and it is difficult to determine if one is significantly 'better' than the other. This same tool was used by El Jardali et al., 2014, who recorded a mean score range between 4.02 and 4.28 for the research on primary healthcare accreditation and a range between 3.50 and 4.26 for hospital accreditation (El Jardali et al., 2008). Thus, they observed the same positive effect. This would suggest that either accreditation does have a positive impact, or that the individuals completing the questionnaire err on the side of positivity in their responses.

Healthcare professionals perceived accreditation to have a positive impact on management and leadership in the centres. In theory solid leadership and support from the management constitute a corner stone for implementing successful accreditation and improving quality of services in PHCCs (El Jardali et al., 2014). A significant p-value in correlating the

professionals' view on leadership and commitment with quality scores via linear regression confirmed findings reported by previous studies (El Jardali et al., 2008 and Woodcock et al., 2010). This study showed that professionals perceived management and leadership to be a predictor strongly associated with successful accreditation. In fact, Shortell, 1992 argued that the involvement of executive directors could create and sustain quality values that were part of the organization's management system. From an NPT perspective, it could be argued that this is evidence of cognitive participation, namely that there is strong and visible participation from the leadership of the centres.

When considering patient satisfaction, the positive results here differed from those of Sack et al., 2011 and Al Ghareeb, 2015, who found that that successful accreditation was not associated with better quality, as revealed by the view of the patients and professionals respectively. Other studies have shown that accredited centres reported an increased rate of customer satisfaction and higher number of patients visiting them (El Jardali et al., 2014). In this study, I found that more than 80% of the professionals agreed that patient satisfaction data are communicated to staff members and used to improve the service.

The overall mean score of 4.00 recorded for quality of care also indicated a fairly high level of agreement among professionals on quality improvement among accredited centres. Thus, professionals perceived accreditation to have an influence on the improvement of quality practices in their healthcare centre. These findings are not unique, with similar findings reported in the literature about the positive impact of accreditation on quality improvement (Alkhenizan and Shaw, 2011; Beaumont, 2002; Lantaigne, 2009; Pomey, 2003; Salmon et al., 2003; and Snyder and Anderson, 2005).

The results also found high levels of agreement as to the impact of accreditation on staff awareness and involvement in the process. Research suggests that staff involvement is a key determinant for perceiving the benefits of accreditation. One study has reported that staff who were not involved in the accreditation process could not perceive its benefits on their healthcare centre (Paccioni et al., 2008). One of the highest rates of disagreement observed in my work was in relation to the statement where participants were asked if they received sufficient training for fulfilling their accreditation responsibilities. Staff involvement and training was highlighted to be essential for overcoming resistance when implementing new initiatives in healthcare organizations (Seren and Baykal, 2007). Again, considering these findings from an NPT perspective, staff involvement is a key feature of the construct of

cognitive participation and is also necessary to ensure that staff are involved in the process of accreditation (under the construct of collective action or operational work). When staff are driven by enthusiastic leaders who take their opinion and involve them in decisions relating to their work and environment, the improvement is more likely to be successful.

One of the scales with the lowest mean scores was human resource utilization (3.86), which may indicate an area that needs more attention in future accreditation programmes.

Results of the multivariate linear regression model indicated that the predictors of better quality results scores were: strategic quality planning; quality management; human resource utilisation; and patient satisfaction. Interestingly, with the exception of the patient satisfaction scale, the variables that recorded the lowest mean scores were those significantly associated with quality results when controlling for age, gender, experience, professional group and PHC size. For example, while quality management, strategic planning and human resource utilization recorded the lowest mean scores, they showed to be significantly correlated with quality results in the multivariate regression analysis model.

8.4.1. Questionnaire distribution and response rates

The survey had an overall response rate of 72%. Response rates were the highest among nurses and physicians respectively. However the response rates within the pharmacists, technicians and administrators ranged from 52% to 80%. Dentists had the lowest response rates (below 50%). These findings are consistent with the study conducted by El Jardali et al., 2013 using the same questionnaire. The latter reported an overall response rate of 76%, with the highest response rates among physicians and nurses. Similarly, a study conducted in 2008 by the same researcher assessing the impact of hospital accreditation on quality of care from the perception of Lebanese nurses using a cross sectional survey reported a 76% response rate. A similar study assessing the impact of accreditation in Qatar using electronic surveys sent by email received a response rate of 58% (Ghareeb, 2015). Several studies on response rates suggested that surveys distributed by post or telephone received a higher response rate than that of emails or fax (Grava, Gubins and Scott, 2008; VanGeest et al., 2007). Various factors contributed to the resulting response rate. One factor could be the letter generated by the MOH which was attached to the consent form and informed the participants that the researcher is a Ministry employee pursuing a PhD degree. Another factor leading to this high response rate may be that the primary researcher held the position of the facilitator at the MOH and played a pivotal role during the pilot testing surveys conducted by the accreditation body. I had

previously visited the centres with accompanying ACI mentors as a coordinator representing the MOH therefore was well known to many of the employees. A third dimension which enhanced the participation in this survey was the on-going relationships I had with the heads of PHCCs. All these factors in addition to perseverance and constant follow up led to this high response rate in the questionnaire.

8.4.2. Demographics

While similar studies reported having a majority of female participants whose age ranged predominantly between 30 and 45, the years of experience and the distribution of the professions may have an influence on the findings. The distribution of professions varied significantly among the PHCCs however throughout the study the majority were nurses, followed by physicians. There were no respondents in PHC centre A who were managers/administrators and no dentists in the PHC centre C. These factors may have affected the results and the relative scores given by the professionals especially that some studies reported significant differences in the view of accreditation among professionals particularly nurses versus physicians whereby nurses are showed to be more in favour of accreditation than physicians (Alkhenizan et al., 2012). Testing the significance of mean scores in relation to demographics showed that there was a significant difference in mean scores among males and females in the patient satisfaction and accreditation impact scales only.

In addition, age was significantly correlated with all the scales except for strategic quality planning and human resource utilization. This may be because older respondents have seen great improvements in healthcare over time than younger respondents. Older respondents will also have more healthcare experience. Finally it is important to note that the mean scores for all the scales reported varied in a similar way by professional groups and the PHC size. In line with other research, larger healthcare centres reported higher mean scores for all scales.

Previous research showed that larger organizations are more likely to benefit from accreditation because of their hierarchy and bureaucracy which can better accommodate the organization and facilitation required (Montagu et al., 2003; Shortell et al., 1995) however, such efforts are often challenging. In smaller organization, the culture is usually more homogeneous and they are often burdened by the cost of compliance.

8.5. Limitations of the study

Although it is essential to have a continual assessment at the PHCCs that integrate the culture of accreditation in its system in order to sustain the improvement; yet process of evaluating improvement is often challenging and its associated research does not come without challenges. Below I list the main challenges and limitations encountered during this study.

- This research was done in an environment that is not familiar to research questionnaires since Health Care Accreditation is a new trend in Kuwait and not everyone is acquainted to the type of research that can be done in this area particularly. This presented an obstacle for me. For instance, many respondents asked for extra time to answer the questions, others were suspicious and preferred not to participate, and for many, the English language was a barrier.
- The centres were geographically dispersed which required more time to finish the surveying as I could not do them all at the same time.
- Because of the high turnover rate in departments not everyone was exposed to the accreditation programme which made it difficult to know who was present during the accreditation in 2012.
- In the Arab culture, it is part of the tradition to offer help and cooperate with guests which might have put the participants in a situation where they felt obliged to answer although it was voluntary. They stated it clearly during the distribution of the questionnaires and in the attached consent form.
- Coding the questionnaire – but not linking that code to an individual - was good practice for the sake of confidentiality, however it added to the workload as non-responders could not be targeted or identified.
- The study was limited to three centres only– all of which were middle or large PHCCs. Smaller centres are often more burdened with the cost of compliance and introducing change, thus some data would have been missed to that end.
- It is important to note that with data of this kind, though 4.04 is higher than 3.86, both depict an overall level of agreement and it is difficult to determine if one is significantly ‘better’ than the other.

8.6. Summary

This chapter presented the quantitative part of this thesis; the findings obtained from the surveys that were carried out in accredited PHCCs covering three health regions in Kuwait were discussed. In general, results showed that the PHC professionals demonstrated a positive attitude towards accreditation. The mean scores for each scale ranged between 3.85 and 4.05 with the highest being leadership and management scale and the least being human resource utilization score. When associated with quality results through linear regression, all the scales showed a positive correlation indicating that the chosen scales covered all the important elements of a successful foundation of an accreditation programme. An important finding as well was that all the scales were found to have significant difference with professional group and PHC size, whereby larger PHC size obtained higher mean scores and depending on the scale, different professional groups recorded higher mean scores.

In order to obtain a deeper knowledge of the ethos and understanding behind these findings, qualitative interviews were conducted with key players in the accreditation process. These findings are reported in chapter 9.

CHAPTER 9: Exploring stakeholders' views of accreditation: A qualitative study

9.1. Introduction

There are few studies that explore the perception of stakeholders concerning the impact of accreditation process in the PHC sector. Chapter 6 identified 5 international studies that were either entirely, or in part, qualitative. Findings suggested that the process of accreditation was more likely to be successful when it was well received by healthcare professionals and aligned with other regulatory systems (Hinchliff et al., 2013). Similar results were reported by Macfarlane et al, although concerns included the workload for assessors and the long-term sustainability of the programme (Macfarlane et al, 2004), while others reported that practices were concerned about accreditation leading to a 'tick-box' mentality (Campbell et al., 2010). However, there have been and no such studies conducted in Kuwait. Thus this chapter elaborates on the third phase of this PhD study, the conduct of qualitative semi-structured interviews with key stakeholders in Kuwaiti primary care. This study aimed to compare and contrast key stakeholders' attitudes, beliefs, and perceptions about the accreditation programme between those who were early adopters and those who were late adopters. This chapter presents the research design, methodology including the selection of respondents, the topic guide used for the interview, data collection, the process of the interviews and time line as well as the analysis of the interviews. In addition, the discussion of the results in comparison with the current literature will be incorporated. Since this is a novel study for Kuwait and the region, limitations and challenges arose and will be discussed at the end.

9.2. Interviews

Understanding the complexity of health care systems requires a range of methodologies (Barriball and While, 1994; Brookes, 2007; Hogston, 1995; McDowell and MacLean, 1998). Interviews are recognised as a good way of identifying and exploring stakeholders' perceptions and attitudes towards the accreditation process, as well as to understand the impact of accreditation, its benefits and challenges as faced in PHC in Kuwait. An interview can be defined as *"a face to face verbal communication between the researcher and the subject, during which information is provided to the researcher"* (Burns and Grove, 1993). The literature has identified three types of interviews: structured; semi-structured; and unstructured (Fox 2006; Ritchie and Lewis 2003). Structured interviews emphasize having the same

questions presented to each interviewee in exactly the same order. This kind of interview guarantees a confident comparison between sample subgroups and different research periods but can afford fewer opportunities for respondents to share what is important to them. In unstructured interviews the interviewer passes the control of the interview to the interviewee whose responses usually alter the flow of questions. In an unstructured interview the questions content and pattern are adapted to follow the respondent's understanding and beliefs (Bowling, 2002). In semi-structured interviews the interviewer usually prepares a framework of topics and questions to explore however its flexibility allows the introduction of new questions in reaction to the interviewee's responses (Grbich, 1999). Although a semi structured interview has a set of concepts that it aims to explore, the interviewer can move freely from one topic area to another and allow the respondent's cues to help determine the flow of the interview. For the purpose of this research, semi-structured interviews were preferred for three reasons. First, interviewees were coming from different back grounds such as physicians, surveyors, and directors with different professions, roles, education, and experiences. Second, this technique was appropriate for investigating the views, perceptions, and opinions of physicians, surveyors and directors working for the MOH concerning a new and sensitive topic such as the impact of accreditation on professional's attitudes, employee's satisfaction, and challenges faced throughout the process of accreditation and the role of MOH. Finally, by using this technique the researcher was able to probe to obtain further details and explanation from respondents in a way that could not be done using a more structured method. This helps the respondent recall information related to memory, and it also allows the interviewer to identify concepts mentioned by the respondent and obtain further clarification (Barriball and While, 1994). Semi-structured interviews also build interactive opportunities between the interviewer and the subject, consequently encouraging the respondents to express their thoughts freely (Strauss and Corbin, 1998).

9.3. Research Design

This study consisted of face-to-face semi-structured interviews with stakeholders including directors and facilitators from the MOH, the directors of primary care centres, and the coordinators from the MOH trained on the accreditation process and directly exposed to the programme. The interviews addressed the stakeholders' overall opinion about the accreditation process, challenges faced, areas of improvements and the overall impact on delivering health services. These data were collected through interviews and analysed using

thematic analysis; further analysis used Normalization Process Theory to better understand the implementation of accreditation. This final stage, and the integration of the interview data with the other studies, will be reported in Chapter 10.

9.4. Methodology

9.4.1. Setting of the study

As outlined in Chapter 7, the qualitative study was conducted in multiple sites as the stakeholders held different positions in different health care organizations within the MOH and beyond. The first group of stakeholders were located in the Quality and Accreditation directorate of the MOH. The second stakeholder group were those working in the early adopter PHCCs called PHC centre A, B, C. As described in Chapter 7, these centres were located in 3 different health regions 1, 2, and 3. The third group of stakeholders were the late adopter PHCCs coded as Ai, Bi, Ci and also distributed among the aforementioned health regions. The fourth group of stakeholders were the surveyors, who were located across the six different PHCCs where the surveyors were working. All of these sites belong to the MOH in Kuwait; the levels that the stakeholders worked in are shown in Figure 7.1. Those interviewed came from different backgrounds and had different levels of exposure to the accreditation process.

9.4.2. Choosing respondents and selection criteria

The overall aim was to compare the views and opinions of key stakeholders' in the Ministry, as well as Heads of PHCCs in both early adopting (PHCC A, PHCC B, and PHCC C) and late adopting (PHC Ai, PHC Bi, and PHC Ci) centres and surveyors. In order to select key stakeholders from these different groups, and to meet the aim of this study, a purposive sampling technique was used. This was to make sure subjects were selected from different organisations and reflecting the different groups of interest (Brink and Wood, 1998; Parahoo, 1997). Bowling defines purposive sampling as *“a deliberate non-random method of sampling, which aims to sample a group of people, or settings, with particular characteristics”* (Bowling, 2002).

A range of stakeholders were first identified in the Ministry of Health and in the selected PHCCs – these were:

- Assistant Undersecretary for Quality and Planning – MOH (1)
- Director of Accreditation and Quality Directorate – MOH (1)
- Head of Accreditation Department – MOH (1)
- Coordinators of the Accreditation programme – MOH (4)
- Local accreditation surveyors – MOH (6)
- Head of primary healthcare centres (early adopters) (3)
- Head of primary healthcare centres (late adopters) (3)

With the exception of the surveyors, each post was held by a single person, so there was no need to consider sampling. However, for the surveyors, there was a pool of 40 who were trained by the accreditation agency, the ACI. Here, six MOH accreditation surveyors were randomly selected from the wider pool by myself.

9.4.3. Development of the interview schedule

An interview schedule was developed based on findings from the systematic review reported in Chapter 6, discussion with the supervisory team and personal knowledge of issues that had arisen during the accreditation process. Qualitative work conducted by El Jardali into the implementation of accreditation in the Lebanon was also a source of interview topics (El Jardali et al., 2014).

The final interview schedule consisted of 13 questions aiming to examine the perspective of respondents about the contribution of the accreditation process to the improvement of quality of care at the PHCCs, the sustainability of changes brought about by accreditation, the influence of accreditation on employee and patient satisfaction, and barriers and facilitators to accreditation. The questions are outlined in Box 9.1.

Box 9.1. Interview schedule questions.

1. What does accreditation mean to you?
2. What is your role in the accreditation process?
3. Is this process newly introduced for you or you have been through before?
4. How did you engage your staff into the process? Was it easy or not to engage the staff?
5. What are the resources or funding did higher authority provide to facilitate the process of accreditation and its implementation?
6. Based on your experience, how has the accreditation process contributed to the improvement of the quality of care delivered by this centre?
7. In your opinion, how sustainable are the changes brought about by accreditation?
8. May you share your views on how accreditation has affected your satisfaction as an employee?
9. To what extent do you think the accreditation process has affected patient satisfaction in this centre?
10. List the top three barrier/challenges that you have faced throughout the accreditation process
11. What are, in your opinion, some strategies to better implement accreditation in the future?
12. From your perspective, what are the benefits of accreditation process on PHC?
13. Do you think accreditation on (PHC) system could leads to a more efficient health

Each of the main questions listed above had prompts to allow myself, as the interviewer, to adapt the schedule as required, to meet the direction of each interview, and to further probe and develop the answers given by interviewees (full version is contained in Appendix I).

Description of the interviews' sections:

Interviews typically started with a brief description of the study then moved to the schedule (Appendix H), which included 13 questions. The order of the interview schedule was as follows:

Demographic data and current position

This was an introductory section that first investigated demographic data about the interviewees such as their current position, the site of the interviewee occupation, and the participation code. Second, it contained a welcoming statement and obtained permission to start the interview.

Question One: Meaning of accreditation

This question explored the general understanding of the interviewee towards accreditation as a concept and how accreditation was perceived from the interviewee's point of view.

This allowed the interviewee to express her/his perception about accreditation and give a holistic picture about the main drivers of change that accreditation might bring to the primary health care sector.

Question Two: Participant's role

The aim of this question was to explore the participant's main role during the accreditation process and to which extent they were interested while participating in the programme. I also attempted to obtain further details about the characteristics of the interviewee's job and all the related responsibilities and how it contributed to the implementation of accreditation and to find out whether the candidate's role was interrelated to standards, patients, or staff.

Question Three: Previous exposure

It aimed to identify the previous experience of the interviewee with accreditation.

Additionally, I explored the different accreditation exposure to identify the level of the interviewee's involvement and how their years of experience might have affected their perception of accreditation.

Question Four: Staff engagement

This section focused on the different methods that the interviewee used during the accreditation process and the role they played to enhance staff engagement. I sought to discover the level of difficulty that one might face during the implementation, and the challenges and obstacles that interfered with staff engagement. All the discussion under this section was around the hurdles exclusively related to staff and how that impeded their involvement which is considered as one of the barriers of the implementation.

Question Five: Resources and funding

In this section I intended to find out what were the main resources and funding provided by the higher authorities in order to facilitate the application of the accreditation programme and how the participant used the available resources. This section also sought to identify facilitators of the programme such as the plans and funding schemes that have been provided by the MOH in Kuwait, as well as training and other resources.

Question Six: Quality improvement in PHC

In this section the interviewees were asked their opinion on the changes brought by accreditation in terms of the quality of services provided and whether they noticed any

improvement in the quality of care delivered in the PHCCs. In addition, they were asked about the potential improvement and accreditation impact at different levels: personal level, system or structure, and patients. Interviewees were also asked their opinion of sustainability of the programme and issues that it might depend on such as follow up from MOH, Accreditation Canada, patient satisfaction results as well as Staff satisfaction results.

Question Seven: Healthcare professional's satisfaction

It focused on how participants perceived the impact of accreditation on their own satisfaction as a health care professional. And whether accreditation enhanced communication between staff and the management.

Question Eight: Aspects affected by accreditation

This section was about how participants perceived the effect of accreditation on different aspects of work, including documentation, communication and relationship with other colleagues, and division of workload.

Question Nine: Patient satisfaction

This question explored the interviewee's insight with regards to the relation between accreditation and different aspects of patients' satisfaction such as relationship between patients and the medical team, patient trust in the centre, and satisfaction of patients with the setting, and quality of services. Furthermore, it encompassed how the subject perceived the degree of patient satisfaction in their setting, if applicable.

Question Ten: Barriers vs. facilitators

This identified the interviewee's top three barriers that he/she have faced throughout the process. The second part of this section was to assess the participants' point of view in relation to some approaches to overcome these challenges.

Question Eleven: Potential strategies

Here, I explored the views of the participants about the role of policy makers, role of practical training sessions and continuing education, the importance of follow-up meetings and communication and collaboration with the MOH, the accreditation team, and among PHC centres, as well as the importance of financial support from Ministry of Health and international agencies. This allowed the interviewee to express her/his perception of the main strategies that drive the changes in the PHCCs.

Question Twelve: Accreditation benefits

This question entailed general discussion about the benefits of accreditation and the rewards that the organization might get if it was exposed to accreditation.

Question Thirteen: Accreditation impact on health system

It entailed a discussion around how accreditation might affect the PHC system effectively from the participant's point of view. Was it by increasing quality, decreasing costs or increasing efficiency on the long run, or by providing quality primary healthcare and decreasing secondary healthcare admissions and complications, participants expressed their view on all these impacts.

9.4.4. Ethical approval

As mentioned earlier in chapter 8. Ethical approval to conduct this study was sought and obtained from the relevant committees at both the academic and governmental levels. These were the College of MVLS Ethics Committee at the University of Glasgow and the Medical Research Ethics Committee at the Kuwait Institute for Medical Specialization (KIMS) of the Ministry of Health.

Signed and approved informed consent from the participants was received electronically by email in addition to oral informed consent, Also PIS contains in depth discussion about the research project and its methodology was sent via email.

Confidentiality of respondents and their respective health care department were maintained by using codes instead of actual names. Participants were told that all the recorded interviews were to be kept securely in the audio tape and the researcher lap top which can be accessed by the researcher only as it is locked by password, also the transcribed interviews will be available only to the researcher and the primary supervisor throughout the whole period of the research project. Finally, it was also mentioned to them that the information gained through this study, will not, in any way, be used against any party involved in this study, rather it will only be used to develop a better understanding of accreditation and their perception towards accreditation implementation within the primary healthcare sector in Kuwait.

9.4.5. Pilot interview

Prior to commencing the interviews, a pilot interview was carried out with a health care professional who is working as a physician in a private health care institution. This interview was digitally recorded and lasted for 40 minutes. On completion, the interview was reviewed carefully in order to assess the efficiency of the interview schedule particularly in terms of the flow of questions and the time taken to work through them. In addition, this pilot allowed me

to review my interview skills and the suitability of the audio tape recorder and its quality the recording.

The pilot interview was very useful for the researcher, whose first language is not English and has limited interviewing experience. Discussion with both the interviewee and with PhD supervisors after the interview showed that there were no major problems. Some minor changes were made to certain terminologies such as question number 4: which was about the techniques used by the participants to enhance the employees' participation within the process. This question was found to be too vague and unclear thus we agreed to change the question into how did you engage your staff into the process? This was easier and better comprehended by the interviewee. Moreover, I received informative feedback with regards to my communication skills. This feedback was taken into consideration in the real interviews. Data from this pilot interview was not included in the actual analysis of the qualitative study, as the respondent did not fulfil the selection criteria.

9.4.6. Data collection

After obtaining the necessary ethical approvals, data collection commenced. Participants received an invitation via e-mail asking them to participate in the study. In this, participants were informed of the purpose of the study and were sent the consent form and the Participant Information Sheet (PIS). The email also clearly mentioned that their participation was completely voluntary. Those willing to be interviewed sent back a signed consent form which indicated that the respondent was willing to participate and gave an opportunity for the researcher to arrange an appointment for the interview.

In order to proceed with the interviews in a timely manner and allow the participants enough time to fit the research interview into their schedule, potential participants were contacted at least two weeks before the interview took place. At this point a convenient time and place was agreed upon. All the interviews were carried out according to these arrangements without any difficulty and no complaints were received (Legard et al., 2003).

As previously outlined, interviewees consisted of those working in the Ministry, the Heads of PHCCs and accreditation surveyors. Recognising that those in the Ministry and Heads of centres were more senior personnel – and had limited time to devote to being interviewed – I began by interviewing the facilitators from the Q&A Directorate. Starting with this group also allowed me to gain experience and confidence in the first few interviews, before moving on to interview those in higher positions of authority.

Interviews with stakeholders working on the same site were carried out on different days in order not to disturb the site schedule and create burden on the work place. All interviews took place between October, 2015 and June 2016 based on availability of respondents. All the interviews were conducted at the interviewees' sites in a suitable and quiet environment. Most interviews lasted between 30 to 55 minutes. Before the interview commenced, participants were given another chance to read the Participant Information Sheet, and clarify any issue they might have. The interviewee and I then signed a consent form giving permission of the interview to be recorded and covering future use of the transcripts. All interviews were then digitally recorded.

During the course of the interview, the broad topics of interest were introduced by the questions outlined in (Box 9.1). Interviewees were then encouraged to develop their answers through the use of prompts (Appendix I). Sometimes this was nothing more than nodding, or a simple interjection such as, "Uh-huh." "Yes." "How interesting." Others were specific questions such as: "How?" "Why?" and "And then...?" Finally, others were directly related to the question asked, directly asking them to expand on issues raised, such as staff resistance, policies and procedures, manpower and turnover.

9.4.7. Transcribing and checking of transcripts

Interviews were transcribed by a professional transcribing agency to save the researcher's time and effort. However, the last two interviews were transcribed by myself because they were carried out later and to give mean insight into the process of transcription.

Immediately after the transcripts were returned, I checked them by listening to the interview's audiotape and looking to the transcripts to make sure they are accurate and complete. Missing parts, for example due to the tape being inaudible, were reviewed and completed by hand, as far as possible. Once this was completed, the process of analysis began.

9.5. Data analysis

9.5.1. Approach to data analysis

The initial analysis, reported in this chapter, was a thematic analysis using the Framework Approach. Thematic analysis is considered as one of the most familiar types of analysis in qualitative study. It highlights, pinpointing, examining, and recording patterns (or "themes")

within data. To facilitate this approach, the Framework Approach was used (Ritchie and Spencer, 2002).

As this research study used a thematic analysis approach, it is important to define what such an analysis entails, how it was applicable to this particular research study, and what it has contributed towards the success of this study.

Although the nature and reliability of such an approach has been widely debated, it is nonetheless a rigorous form of qualitative research aimed at investigating and recording patterns within collected data from the research itself, which are then examined to help conclude certain interpretations pertaining to the research question. It is regarded as an appropriate method for understanding issues in their wider context, as well as finding solutions to 'real world' problems. (Guest, Macqueen, and Namey, 2012). Since it focuses on examining themes within data, it requires organization and a rich raw data collection to be able to determine both implicit and explicit ideas within the data. So as a pre-requisite to such analysis, the researcher must know the data well and have read it several times to ensure proper understanding and correct coding of information.

It usually starts with identifying themes which are generated from the interviews. The researcher may identify certain patterns or trends when analysing the data which may be worth documenting as potential interest (Braun and Clarke, 2006). The process entails several steps, beginning with data collection, which can be from several sources. Then data coding, whereby the researcher will modify the analysis as reflected by the data as ideas emerge. Then code validation to ensure there is no bias or misinterpretation, and finally theme identification, whereby patterns emerge from the coded data.

A major advantage of thematic analysis in this study is to help make sense of large amounts of related material. It is also flexible as it is not a theoretically driven process, therefore it allows analysis to incorporate the use of a theoretical framework if preferred by the researcher. This allows codes to be generated deductively from theory or from literature review, with data analysis done based on a predetermined framework, but also allows the identification of codes which emerge from the data during coding. In terms of applicability, this mode of research allowed for prior questions of interest to be integrated into the interviews. Such questions were generated from the systematic review as well as my personal experience with accreditation. Developing this analysis was informed by the Framework Approach as it is most commonly used for the thematic analysis of semi-structured interview transcripts (Pope & Mays, 2009). This method contributed greatly to the success of the study due to its ability to systematically

organize random qualitative data and categorizing it to be able to compare across and within 'cases', which in this study, refers to the different interviewees across different multidisciplinary organizations within the health sector (Gale et al., 2013).

It holds several advantages over other modes of research, specifically in the field of social research when it was first developed by Jane Ritchie and Liz Spencer in the 1980's (Ritchie and Spencer, 2002), and used successively in the field of health research. The distinctiveness of this mode of research is mainly in its matrix method, which helps categorize the data into 'cases' and 'codes' which in turn helps summarize and compress the data to analyse it. This provides ease of comparison of data across cases. It also offers easy retrieval of original text and documents when needed, and this transparency and accessibility is important for readers to be able to formulate judgements (Gale et al., 2013).

As with any research method, it has limitations. For example, it cannot accommodate highly heterogeneous data, as data must cover similar topics to be able to categorize it (Gale et al., 2013). As this research study covered related topics, driven by the use of the semi-structured interview schedule, such limitations were not a hindrance. It has also been linked to a deductive approach to qualitative analysis according to some literature reviews, although that doesn't mean that this is how it is exclusively used (Pope, Ziebland & Mays, 2000). In this study, it was coupled with an inductive approach to the thematic analysis.

It was deemed appropriate in this study as the framework method is better adapted when there is a limited time frame and specific research questions (Srivastava and Thomson, 2009).

Coding using the Framework approach is dynamic and open to amendment throughout the analytical process, which offers great flexibility for the researcher (Srivastava and Thomson, 2009). Moreover, it permits analysis within the same theme and among themes which enables comparisons between, and associations within, different themes to be made.

Framework Analysis encompasses five key stages (Lacey and Luff 2001;Ritchie and Spencer, 2002;Ritchie et al., 2003):

1. Familiarization of the data;
2. Identifying a thematic framework;
3. Indexing;
4. Charting;
5. Mapping and interpretation.

9.5.2. Conduct of the analysis

Throughout the interviews I kept notes, writing down remarks, thoughts and observations about each interview and adding these to the audio tape recordings to act as reminders about each interview. Informed by the Framework Approach, analysis developed in an iterative fashion.

First, there was a familiarization phase which involved reading and rereading the initial transcripts to identify broad categories and codes within those interviews. This step focused on the first five interviews. Guided by the questions in the interview guide, notes were made in the margins of the interviews highlighting chunks of text which could have a descriptive 'label' or 'code' attached to it e.g. job description; 'personal definition of accreditation'. This process fitted Bowling's description of data coding as '*relating sections of the data to the categories which the researcher has either previously developed or is developing on an ongoing basis as the data are being collected*' (Bowling, 2002). Initially, this process was carried out independently by myself and my primary supervisor; once we had each read and coded two of these interviews we discussed our developing coding. Then the next three interviews were independently coded and again discussed.

Second, a thematic framework was developed by grouping codes together into themes. For example, codes relating to an individual's understanding of accreditation were grouped together under the broad theme of 'Accreditation Meaning'. Again, this was first carried out independently by myself and the primary supervisor and then discussed to reach agreement and to ensure reliability and avoid any inconsistency. The full thematic coding framework is shown below (Table 9.1).

Table 9.1: Thematic Coding Framework

Themes and related subthemes	Comments
1. Accreditation meaning	- To cover personal understanding and definitions of accreditation; Also development of understanding across teams
- Accreditation definition	- Personal understanding of accreditation
- Quality and safety	- Discuss quality and safety, explicitly.
- Shared understanding of accreditation	- Transfer the concept and raise awareness about accreditation with teams or departments, or between practitioners and

	patients
- Standards	
- Quality improvement	- Discussion about accreditation as quality improvement tool
2. Engagement process	- personal role in accreditation and personal engagement; Getting others involved and what is needed to sustain that involvement
- Personal role in accreditation	
- Developing understanding	- Developing understanding of the staff – involvement. - Overlap with work involved and with training.
- Involving others	- Getting others involved in accreditation process – such as staff, or MOH
- Involving patients	- Explicit mention of involving patients
- Pride in involvement	- This might overlap with leadership
3. Work involved in accreditation/staff or others involvement	
- Communication	- Discussion of communicating across team, with MOH etc.
- Training	- Training implies for interested parties who are developing and delivering it - overlaps with engagement and involvement
- Creating documentation	- Creating policies, procedures, job descriptions for staff etc.
- Meetings	- Within teams, across departments, with MOH, Accreditation Canada. - Might overlaps with teamwork.
- Teamwork	- Across teams and departments.
- Previous experience	- Both as an individual, and as an organisation

- Engagement process	
- Challenges to engagement	
4. Facilitators for implementation	
- Resources	- Including reallocation of manpower
- Central support	
- Financial support	
5. Impact of accreditation process	
A. <u>Structural impact/impact on the system</u>	
- Impact on quality	- Perceptions of stakeholders in quality improvement
- Impact on staff	
- Teamwork	
- Organization of work	
- Work environment	- Changes that need to be made to infrastructure as a result of standards or recommendations in the assessment reports
- External support	- Support from higher authorities such as MOH, Accreditation Canada, NGOs, Cooperative society etc
- judging Impact	
- Relationships with patients	
5. Impact of Accreditation process	
B. <u>Personal impact</u>	
- Personal impact	
- Personal development	
- Personal goals	
- Documentation	- Accreditation assist health care professionals to develop policies and procedures OR highlighted their lack of existence

- Relationships with others	- Within teams and centres and also external
C. <u>Impact of Accreditation on patients</u>	
- Patients experience	- Patient's views, satisfaction and experience of care
- Patient safety	- Explicit mention of impact on patient safety
- Relationship with patients	
6. Sustainability	
- External resources	- Any external parties help in the sustainability of the programme such as MOH, Accreditation Canada, key personnel to retain sustainability... etc
- Funding	
- Monitoring	- Use of data to monitor sustainability
- Views of sustainability	
7. Challenges to implementation	
- Staff resistance	
- Manpower shortages & turnover	
- Policies and procedures	- Lack of these at the beginning
- Future resources	- HR and financial resources
- Leadership issues	- Difficulties in managing teams and centres - Lack of central leadership from MOH
- Training	
- Workload	
- Applicability of standards to the context	
8. Future development	
- Leadership	
- Training	
- Continued monitoring and support	

- Communication	- Across teams, centres and with MOH
- Data	- Explicit mention of using data in future developments of accreditation
- Resources	
- Strategic planning	
- Staff engagement	
9. Wider benefits to primary care	
- Quality and safety	- Where safety explicitly mentioned alongside quality
- Efficiency	
- Quality improvement	- More general discussion of quality improvement including staff satisfaction
- Policies and procedures	
- Strategic development of primary care	

Following agreement on the thematic coding framework, the third stage was the indexing phase, when the thematic framework was applied to all the interviews transcripts and pieces of data were identified which corresponded to the different codes. Throughout this process, however, I was attentive to the possibility of new codes and themes emerging from the data, especially as different groups of interviewees were interviewed later in this study.

The fourth entailed charting the data and extracting relevant codes and pieces of text from each transcript into charts according to broad themes and categories. Data extracts were grouped according to broad categories and sub-categories. In these charts, each row corresponded to an interviewee, thus facilitating easy comparison across individual participants and by broad group of interviewee. These charts were developed manually by myself, using Word tables, while my supervisor coded and charted using NVIVO software. The use of thematic coding allowed the identification and extraction of chunks of interview text according to codes and allowed the data to be analysed by respondent and, later, compared across respondents. This process was discussed and refined with my primary supervisor, who then reviewed all of the charts with me. An example of a thematic chart is shown in (Appendix J)

The final stage was mapping and interpretation; data were searched for patterns, associations, and explanations, for example, by comparing the responses of participants with particular categories, and analysing the different responses as per respondent professional group. This process was developed by writing up each thematic coding sheet in turn, reviewing quotes, comparing across respondents and interpreting findings in discussion with my primary supervisor.

9.5.3. Mapping of themes and sub-theme to NPT

The results obtained from this part of the research were mapped into the four constructs of the NPT and analysed in comparison to the findings from the other two parts of the research e.g.: the literature review and the quantitative survey. This exercise helped understanding the overarching concepts and implications behind each finding and its theme thereof.

9.5.4. Data presentation

The results section presents the findings of the interviews with the key stakeholders. Data are presented by theme, in a narrative approach that focuses on the story that the respondents gave, drawing on verbatim quotes to illustrate the points made. with emphases on the actual transcripts. Illustrative quotes give a short description of the position of the respondent to aid interpretation of the point being made.

9.6. Results

9.6.1. Demographics of the respondents

Eighteen interviews were conducted in total. There were three groups in interviewees: those based in the Ministry of Health (MOH) Quality and Accreditation Directorate; Heads of early and late adopting Primary Health Care Centres (PHCCs); and accreditation surveyors (Table 9.2). Only two of the interviewed were males working as facilitators in the Quality and Accreditation Directorate; all the other interviewees were females and were working in different positions. Of all those approached for interview, only one – based at the Ministry of Health – declined to be interviewed due to lack of time and other commitments he had.

Table 9.2: Interviews schedule

Site	Site's Code	Interviewee's Code
Quality and accreditation Directorate	A	A1
Quality and accreditation Directorate	A	A2
Quality and accreditation Directorate	A	A3
Quality and accreditation Directorate	A	A4
Quality and accreditation Directorate	A	A5
Quality and accreditation Directorate	A	A6
Early adopter (PHC centre B)	B	B1
Early adopter (PHC centre A)	B	B2
Early adopter (PHC centre C)	B	B3
Late adopter (PHC Ci for family medicine)	C	C3
Late adopter (PHC centre Ai)	C	C2
Late adopter (PHC centre Bi)	C	C1
MOH (PHC)	D	D1
MOH (PHC)	D	D2
MOH (PHC)	D	D3
MOH (PHC)	D	D4
MOH (PHC)	D	D5
MOH (primary health care unit in health region 1)	D	D6

As mentioned previously I interviewed the elite stakeholders from different levels, only once the interviews with one level group was completed moved to the next group. The first group was the accreditation facilitators at the Q&A Directorate. Their main role was to raise awareness about accreditation and prepare the centres for the survey as well as representing

the MOH during the survey. Since they were directly involved in the programme from the start, they were able to provide in depth opinion with regards to all the aspects of accreditation implementation. The second and third groups were the heads of early and late adopters who were family physicians who had managerial positions allowing them to play a major role in their centres in terms of leading their centres throughout the accreditation journey. They led the self-assessment teams and ensured that all standards and criteria were understandable by the staff within the departments. Also they relayed any enquiries from their staff to the MOH. The fourth group were surveyors who held different positions and careers within the PHC – for example, pharmacists, family physicians, and nurses. Their role was to maintain, organized credential files and assist with inspections. They were the one responsible for the final decision on recommendation for accreditation and provided consistency during the survey phase. The last group to be interviewed was the executive managers including the head of the accreditation department and the director of the Q&A directorate. The latter oversaw the coordination of the programme implementation and administration of all aspects of an ongoing process including planning, organizing, staffing, leading, and controlling the programme activities. She represented the direct link with the higher committee of accreditation and with the deputy assistant of the quality and planning. Also she was the coordinator of the higher committee of accreditation. The head of the Accreditation department role was mainly supervising the accreditation facilitators and delegating the tasks for them. She was the link between the director of Q&A directorate and the facilitators.

In this way, all the levels of management within the PHC system involved in the accreditation were represented with at least one interviewee.

Analysis of the 18 interviews identified 9 broad themes (Table 9.1), which will be presented in the following sections.

9.6.2. Accreditation meaning

Participants were asked about their personal understanding and definitions of accreditation and where they saw it fitting in terms of quality improvement. This highlighted several areas, now discussed in turn.

i. Personal definitions of accreditation

All had some personal definition of accreditation, but the terms used to define accreditation varied. Some referred to as a tool and others as a process. Expressions used to describe accreditation included: ‘*a measurement tool*’ (for example participant A2), “*a tool for standardization*”(participant D5), “*a continuous process of revision, inspection and checking*” (participant A6), and ‘*a process which enables review, validation and evaluation of the system*’(participants B2, C2). While not all respondents were able to elicit a clear description of accreditation, all were broadly positive towards it.

As might be expected respondents from the Quality and Accreditation Directorate were able to elaborate on accreditation as a concept better than the respondents who represented the MOH surveyors and the PHC centres, both the early and later adopters. Thus the responses of the coordinators and facilitators from the Quality and Accreditation Directorate were more elaborate and meticulous than those given by heads of the primary care centres.

For example respondent A4 who is an accreditation coordinator/facilitator in the Q&A directorate believed that

“Accreditation is everything. It is a process of review that health care organizations participate in to demonstrate the ability to meet predetermined criteria and standards. To provide best services With accreditation we are following a standardized policies and procedures and by following these policies and procedures all of the care services is standardised, so when you go to X Clinic you will find services and procedures very similar to Y clinic. So yes I believe so”. (A4)

Respondent B3 from an early adopting primary care centre suggested that “*accreditation is a top permit of the quality given from the services and health centres*” (B3), but was unable to develop his/her thinking of what accreditation meant. Given that B3 was head of a PHCC, this might be considered a limitation.

Respondent D3- a surveyor from the MOH- claimed that

“Accreditation was a new concept to me and to the system. I found it very helpful and fruitful and very important to be considered. It is not only on our medical services, it’s everywhere in life. Accreditation – economic, accreditation in politics maybe, accreditation in so many aspects of life so yes it’s very important.”(D3).

There was a clear difference in view, depending on the role that respondents viewed accreditation from, in particular if they were actively involved in accreditation activities or managing them from top of the pyramid. Some of them such as B1 (head of an early adopting centre PHCC) and A6 (MOH facilitator) defined accreditation based on the activities they were involved in while others, such as C3 (head of a late adopting PHCC), defined accreditation as more conceptually.

“As you know the accreditation process is relying on the process of surveys so it is a continuous process. From now and then there would be continuous assessment for the performance of the hospitals and PHCC. There's a group of professional surveyors who are doing this. So all scores are valid and reliable. So by doing this continuous evaluation you can compare the results and you can check the trend of performance every cycle. Accordingly you can do your corrective measures.” (A6)

“Accreditation meant that I would be going in an evaluation process and I have to do my best at this process, accreditation means to me that all parts of the clinics will be inspected, will be checked and everything should be the right way. I have to do everything the right way.” (B1)

“Accreditation is a process of validation in which institutions are evaluated.” (C3)

Although both C3 and B1 are heads of PHC centres, B1 demonstrated a much in depth understanding of the accreditation process where he/she elaborated on the activities involved in the process such as inspection. In contrast, C3 the head of a late adopter centre had a much narrower view by defining accreditation as simply a process of validation and evaluation. This might suggest that some were much more engaged and involved in the process than others. There were very positive attitudes towards the idea of accreditation, across the respondent groups, both in terms of organizations and for individuals. For example, C1 head of a late adopter, and D2 a surveyor at MOH stated:

“Accreditation is doing the things right in the right way, in the right time, in the right place. So accreditation means doing the right things in the right way at the right time.”(C1)

“It changed my whole perception. It changed the way I interact with people. It changed the way I manage things. I mean, my whole perception was different.”(D2)

ii. ***Quality and safety***

Some respondents discussed accreditation and the quality and safety agenda, seeing the two as linked. Among those were facilitators in the Q&A Directorate, early adopting PHC centres and surveyors from the MOH. However, none of the respondents representing the late adopters made this connection. Three respondents emphasized accreditation being a tool for quality improvement, two reflected on its impact on quality and safety, and one respondent saw it as an effective tool for enhancing safety. *“A tool improving the quality of work in my centre. It was a big job that we had done at that time and it meant a lot for us and my team in the clinic.”* (B1) - Head of a specialized health care centre (early adopter).

“If the national programme aims to improve a certain area on patient safety or in the communication between staff, accreditation can be the good choice for this. It's a tool for changing and system improvement in all aspects such as patient safety, quality of health care services” (A1- The director of Q&A Directorate)

While the respondents in the Q&A directorate viewed accreditation as a safety tool or as a process to enhance safety, other respondents saw it as a tool used to measure the quality of services, with a view to improving the services.

“It's the measurement tool for quality and safety, so it's a tool to initiate the culture of safety and quality” (A3).

“To measure the quality of services” (B2 - head of early adopter centre)

Although all surveyors played a similar role in the accreditation process, their responses also varied with regards to quality and safety. For example while D4 viewed accreditation as a quality improvement tool and indicator to evaluate individual progress:

“It means quality. It gives me an indicator of where I am and where should I reach”. (D4)

D5 viewed accreditation as a tool to decrease risk and prevent unnecessary errors in the practice thus optimising the system. The same respondent was the only one who mentioned accreditation as a safety tool for both employees and patients.

"Effective tool to have an effective system and minimise the risk of having improper processes and safety....it surely will enhance the safety of staff and patients". (D5).

iii. Standards

Participants were asked if they thought accreditation could lead to standardisation in the delivery of primary health care; only nine respondents explicitly mentioned standards as being a core concept in the accreditation process. They described standards as being a reference to predetermined, evidence based best practices and criteria, established by international, professional review boards to which their centres were being compared. They also agreed that Kuwait PHC centres would need time to achieve fulfilment in this direction. In addition, a few respondents highlighted the importance of standards in improving the PHC services.

"Before the accreditation standards were introduced to us, we were living in a chaos...every health centre was having its own standards, its own laws, its own way of managing patients but with the accreditation and when we were introduced to the standards everything was different." (D2 - Surveyor)

None of the coordinators/facilitators from the Q&A directorate discussed the importance of standards and their role within the process except the director (A1) who stated that standards are *"Used to assess the organization improvement against certain standards. This in turn will enhance the organization reputation "*. The heads of the late adopting centres also viewed standards as an instrument that enabled them to compare themselves against international criteria to attain international recognition.

"To compare the work to a standard where things have been done in the right way and trying to have this based on international criteria and evidence based, I compare myself to international organization and try to achieve the same level".

However, the heads of early adopters appeared to have a more developed view of the usefulness of accreditation as a tool used to apply standards and indicators.

"It is a good tool to apply the standards". (B2)- Head of early adopter.

"It is a tool to apply all the standards and indicators that should be done". (B3- Head of early adopter).

iv *Quality Improvement*

The majority of the respondents spoke about accreditation in relation to quality improvement (16 out of 18). With the exception of one respondent who was still sceptical about its impact, all the other interviewees demonstrated a positive attitude towards accreditation stating that it was a tool for quality improvement for PHC in Kuwait. A3 who is Accreditation coordinator/facilitator at the Quality and accreditation Directorate said:

"Well, at this time we cannot say so [accreditation might be used to improve the patient or the staff satisfaction], but maybe in the future it will raise the satisfaction rate of the patient because till now we don't have the objective instrument to measure the patient satisfaction in relation to accreditation and its implementation . We don't have such instrument that measure the satisfaction rate for the accreditation programme" (A3).

All the other respondents stated that it was definitely a tool for enhancing patient and employee satisfaction. This view is exemplified in the following quotation from a respondent who is a surveyor in the MOH

"You can see it with the patient satisfaction surveys. You can see it when we approach the patient they are happier than before. They are getting their investigations on time. Doctors are more satisfied. There are certain rules helped both patients and staff. So yes I think it's improving highly." (D2 - Surveyor).

Other interviewees believed that accreditation is a system improvement tool, and a valuable quality improvement tool as compared to the previous initiatives that were used by the Ministry as improvement plans. This reflected a favourable attitude towards accreditation, with a belief that it was more able to promote quality improvement than other past initiatives.

Another quote which reflected a positive attitude towards accreditation was by a surveyor D6 who claimed:

“I think it’s the only way for improvement here in reality in Kuwait. It’s a valuable tool to improve the quality of the health care system. It’s like a guidance, like a leader. In all aspects.” (D6)

One respondent stressed that accreditation could minimise problems and eliminate errors, especially human errors, since it decreased subjectivity and introduced systematic procedures into day to day tasks. It is important to note that the heads of Q&A directorate and the surveyors from the MOH were able to elaborate more on this sub-theme than others, in particular be reflecting on how accreditation improved quality as mentioned earlier in this paragraph. Other interviewees were straight to the point and chose brief descriptions such as accreditation as being:

“a guidance, like a leader, in all aspects” (D6).

9.6.3. Engaging in accreditation

As discussed previously, employee engagement is one of the main pillars for the success of an accreditation program. Thus, it was essential to ask the interviewees about their engagement in the accreditation process and understand the tasks they were involved in. The discussion revolved around their personal role in the processes in addition to their view on getting other employees and patients involved. This led to the identification of five sub-themes, which will be discussed in turn.

i. Personal role in accreditation

All of the respondents spoke about their personal contribution towards the accreditation exercise in the primary health care centres in Kuwait. The involvement of the interviewees differed depending on their position and place of work. Those who worked at the Ministry of Health encompassed two distinct groups: heads of departments and accreditation coordinators/facilitators. In general the heads of department's roles were strategic and revolved around the management of the program, overseeing its implementation, delegating tasks, and setting the long term vision for quality improvement. Facilitators from the Ministry of Health had a more ‘hands-on’ role in the programme. Their roles included following up the implementation of accreditation program, supervising and coordinating the surveying process,

and developing policies to administer the accreditation process. In fact, only one coordinator at the Ministry spoke about having a strategic role, mentioning the importance of developing policies and decisions to this end.

“Developing policies for the programme...Drafting policies to run a sustainable accreditation programme including a policy on surveyor selection criteria and surveyor training, educational curriculum for them....My role is to regulate the National Accreditation Programme including Primary Care.”(A5).

The analysis also identified a difference between the heads of early adopter centres compared to the heads of the late adopter centres. When talking about their role, the heads of the early adopting PHC centres expressed the view that they were leading and supervising the accreditation process. Their roles included leading the self-assessment teams, inspecting the clinics, and leading other departments. The Heads of the late adopting centres tended to describe their role in terms of the tasks they had to do, delegating jobs and ensuring accreditation criteria were met. However, the most emergent phrase in the interviews with the heads of the PHC centres was leadership, which reflected their important role as a link between the MOH and the medical and administrative staff.

B3 is the head of an early adopting centre, who described his role as

“I am the co-ordinator of the quality and safety in the clinic and I was the head of leadership team in the clinic and also I was the co-ordinator of all the other assessment team and this was also my other responsibility according to my job description as the head of the clinic/PHC centre.”(B3).

On the other hand C1, the head of a late adopting centre, described his role as

“I am the leader in this centre, and I run the leadership committee and the aim of the leadership is to organise, distribute, delegate, observe, and follow up, checking the income, check the process, check the outcome and try to improve the professionalism and improve the communication skills, improve the attitudes, make sure the ethics has been covered in this place.”(C1).

As might be expected, the people who demonstrated the most hands on experience and field work were the trained local surveyors. Their answers were the most elaborate and they described a wide variety of tasks. These included: acting as safety officer, conducting and

reporting on survey visits; collaborating with Accreditation Canada; searching for evidence of compliance with developing standards; observing the consultation process between the doctor and the patients; listening to the patients' feedback; and helping the PHC centres assess their status towards compliance with Accreditation Canada standards.

This was summed up well by surveyor D3:

“In the accreditation process I have a chance to be trained to become a surveyor so I had a couple of times to visit certain centres to do a survey visit. As a surveyor we got trained, we had like different workshops and courses done in collaboration with the quality and accreditation department in the Ministry of Health in Kuwait and with collaboration with the accreditation Canada in which we received a certificate of completion of this workshop. We investigate, we ask, we search for evidence, we search for documents, we check meeting minute records, we check signs, we have the opportunity to sit in a clinic and to observe a whole consultation between a doctor and a patient, we had a chance to hear patient feedback asking them some questions about the services we are giving.”(D3)

ii. Developing understanding

Twelve out of eighteen interviewees discussed their role in supporting an understanding of the accreditation process and, therefore, promoting engagement. Again, the hierarchy of positions was evident in the answers of the interviewees. In particular, the roles and responsibilities were often task-driven, rather than focused on bringing people 'on-board' with the concept of accreditation. Those who were Heads of Ministry departments placed priority on training the self-assessment teams and developing guidelines to explain the standards, criteria and process of accreditation. The facilitators and coordinators, who worked for the Heads of Departments at the Ministry, were the people who conducted those trainings and prepared the guidelines. For example, *“Preparing a guidance booklet for the centres to explain and interpret unclear criteria and give them an insight about its implementation”* (A3). Their role was particularly important at the launching of the accreditation programme awareness.

The heads of the PHC centres, as the leaders for the self-assessment teams within each centre, focussed on disseminating the information they obtained from the facilitators/ coordinators at the MOH during the training and orientation sessions to their staff at the centre. The heads of

the centres made sure that the medical and administrative staff understood what the accreditation was and the steps involved in the process.

“in the beginning we faced a difficulty that they comply but later on when everything was settled and we introduced for them the meaning of the quality and the meaning of accreditation, with the help of different lectures and different courses, they became more interested in this issue. I did a lot of lectures for myself and for my team about the leadership and also I did a lot of lectures and courses for the staff: like safety issues and quality issues and also I make an interview for each member in the clinic to introduce the accreditation program and to explain for them what is the meaning of accreditation itself ”(B3, Head of an early adopter PHC).

C3 claimed that he *“received lectures and training by ministry from Accreditation Canada to become a surveyor which allows me to give the training on accreditation standards and doing local surveys. Ensuring that staff comply with accreditation standards”* (C3, Head of a late adopter PHC).

The surveyors' role mainly revolved around aiding the teams at the PHC centres during the implementation of the accreditation where they delivered training and orientation sessions and offered help for clarifying standards.

“To help all other team members to understand the standards and the criteria they need to work with, answer their questions, give some points, small educational sessions for those who don't understand what to do or how to start. We give guidance to other teams to sit with them, explain things, and give them short briefs for what's been going on.”(D3- Surveyor)

iii. Involving others

Given this focus on tasks and activities, only some of the interviewees discussed their role in relation to involving others. Involving others was the main role of the team leaders. They distributed the tasks and acted as a link between all the involved groups. The role of the Ministry staff (heads and coordinators) was to initiate and lead the process; other tasks involved coordinating with Accreditation Canada.

This was well explained by A5, talking about his role as a facilitator *“Preparing all the pilot centres for the survey through face to face meetings, lectures, site visits , emails as well as*

creating study groups. To transfer the questions of the surveyor of ACI to the staff. I'm the link for both sides.” (A5)

Acting as the leaders of the self -assessment teams in the PHCCs, the heads of the early and late adopters had to conduct regular meetings with their staff in order to assign and delegate tasks and lead the local implementation process. No difference was noted between the tasks performed by the late adopters and early adopters to that end.

C2, the Head of a late adopter PHCC, mentioned that

“I used a schedule to facilitate the meetings with the self-assessment teams and to develop and implement communication plan between the staff self-assessment teams and other stakeholders. Also, to identify tasks and assignments for the staff, to undertake standards review, and I worked as a facilitator to collect the self-assessment questionnaires, also to collect applicable documents for the local surveys...”(C2).

The surveyor’s main role was to make sure that teams understood what they had to do and that the criteria were being met. D5 a surveyor said *“We work here on training, on safety solutions, risk management system, incident reporting, and also, we have like, tools to monitor the progress, to provide them with documents, with check-lists, and also to give them the opportunity to ask questions and respond to them correctly” (D5).*

Although much of the discussion suggested that engaging others was very much task-driven, some respondents talked quite explicitly about their pride in being involved in the accreditation process. This expression of pride was not associated with any one professional group or setting, but seemed quite individualistic. For example, the head of a late adopter centre explained in detail one of the successful tasks his centre conducted and how good it felt to achieve it *“So there were six and then we applied them in our clinic and it succeeded it gave a fantastic results. So the quality department they said can we start preparing you for the accreditation. So the quality and accreditation programme started from the capital area”.* (C1).

iv. Involving patients

Analysis identified a clear gap in transferring the knowledge about accreditation to patients. Only two out of the eighteen interviewees mentioned involving patients. The first interviewee C3 was the head of a late adopter who stated that they made sure that patients were satisfied

with the changes brought about by the accreditation, although they did not elaborate on this. Surveyor D5 also touched on patient safety by highlighting their role in ensuring that patient safety standards were met. However, none of the respondents reflected any role whereby they worked on involving patients in the accreditation process or making them aware of it. To conclude, employee engagement differed among the respondent groups, depending on their position and role, some provided the strategic and leadership roles, while others provided the support and operational roles.

9.6.4. Work involved in delivering accreditation

Having considered how people engaged with their staff to convince them of the worth of accreditation, this section considers the activities they undertook during that process of engagement. Respondents spoke about methods of communication used across teams, and with the MOH. In addition they discussed the training implications for those developing and delivering the accreditation procedure. They highlighted how the process required creating policies, procedures, and job descriptions for staff and the tasks required to ensure coordination between teams, across departments, with MOH, and Accreditation Canada.

i. Communication

Eight out of eighteen participants highlighted the importance of the accreditation process in enhancing communication among employees and across different institutions. Two respondents, one working as a facilitator at the MOH and another as the head of an early adopter highlighted the importance of social media as an informal communication route, in addition to the regular meetings being held.

“The formal methods like doing meetings, writing minutes, these things are done but also we are using current technologies like the mailing, social media, What's App groups, so we are using many methods to communicate with each other. Some of them are formal, some are not formal.”(A6- facilitator from Q&A directorate).

“We communicate through the meeting and sometimes through the circular as well. Also we introduced new technology for the purpose of communication which is what's App. Each assessment team got what's App group to inform each other about the meetings, about what we need from them. It was easier to

communicate like this especially in a setting or a centre like my centre, it's keep all staff up to date about what we have done in each department and the work we plan to do as assessment teams"(B2- Head of early adopter centre).

Participants at all levels expressed their views on the importance of communication in enhancing teamwork. Poor communication was recognised as a barrier to the implementation of accreditation, especially when there was no system or single platform which all participants could communicate through.

"We did face a problem in communication with different staff because the centre is big, so many centres, they have so many departments and some departments are not under the lead of the head of the centre" (D1- surveyor).

ii. Training and documentation

Only six out of the eighteen participants discussed training, although they represented all three levels of interviewees. For these participants, training was one of the main activities carried out in the accreditation process, and was viewed as an initial step that helped introduce those involved.

"We try to do our best to initiate our internal programme to train the trainers, to train the coordinators and the self-assessment team leaders that's why they were able to train their staff in the centres."(A3- facilitator from Q&A Directorate).

"So regular meetings, training, motivation, all helped."(B1-Head of early adopter centre).

"I tried to assign staff accreditation persons to involve them in accreditation training and phases." (C3- Head of late adopter centre).

A3, an accreditation coordinator/ facilitator, viewed training activities as an initial step for the accreditation process where coordinators and self-assessment teams had to be trained. However, the heads of the early and late adopters spoke about training from an engagement perspective, seeing it as a means to motivate and engage the employees.

As mentioned earlier in chapter 7, one of the fundamental steps of accreditation is creating policies and procedures, job descriptions, and systems for documenting the meeting of standards and criteria. Only one of the participants explicitly talked about taking on this task.

“I worked as a facilitator to collect the self-assessment questionnaires, also to collect applicable documents for the local surveys.”(C2)

However, none of the other participants elaborated on the type of activities carried out to develop or gather the necessary documentation needed for attaining the accreditation.

iii. Teamwork

Nine respondents discussed teamwork, generally in relation to communication and engagement. In fact the respondents spoke about teamwork when they were asked how they enhanced their employees' engagement in the accreditation process. The most important work achieved through teamwork was the completion of tasks performed by the self-assessment teams. Professionals from all the departments formed these teams, including physicians, nurses, clerks, and technicians. All three heads of early adopters highlighted the role of leadership in teamwork.

As B1 stated *“I had good people, I have led them to be responsible for the self-assessment team. I should select the best people to lead these teams and I succeed in that so it was much easier maybe than other clinics.”*

A lack of teamwork was seen to create a major barrier for the progress of the work.

“In the beginning I faced a barrier and I felt that older employees don't want to apply this new method or new concept in our clinic but later on when they shared, when they took the courses and when they know more about quality and safety, they appreciate and they become more engaged with the teamwork” (B3- Head of early adopter centre).

iv. Meetings

Overlapping with communication and teamwork, a key approach to formal communication and co-ordination was through meetings. Twelve out of the eighteen interviewees spoke about meetings as part of the activities carried out during accreditation: two approaches emerged. One group of participants spoke about the meetings as a means to distribute tasks and follow up on the duties undertaken by every team member. Participants who spoke from this

perspective were A3, B2, and D3. Both A3 and D3 are MOH employees, one is an accreditation facilitator and the other is a surveyor, while B2 is the head of an early adopter centre.

“We have weekly meetings. We sit together and we discuss each and every one. We are talking about who is responsible to do each task, so the rest of the group will know what is going on and what is there and through these meetings we discuss what should be done and who is going to do it and there is a board where everyone will see each task and who is responsible and the due date of it. So they will check by themselves whether they reach the required goals within the assigned time. Okay, this is for the staff in the department.”(A3).

Another group of participants spoke about the meetings as a means to help their teams understand accreditation better and orient them about it. Those participants were B3, C1, C2, C3, and D6. It is interesting to see that all the Heads of the late adopter centres had the same view on meetings, using them as a means to explain to their teams about the accreditation process rather than distribute the tasks – this may have been because they were still at an early stages of accreditation, so still had to get staff to ‘buy-into’ the idea of accreditation.

“I make a meeting for each member in the clinic to introduce and explain some of the quality concepts as well as the safety and accreditation”. (B3)

v. Previous experience in accreditation

Sixteen respondents spoke about their previous experience with accreditation. All those who worked at the directorate of Q&A (A1, A2, A3, A4, A5, A6 respectively), in addition to two heads of late adopter centres (C1, C2) had been exposed to this concept before. A2 who is the head of accreditation department recalled the measures that they had taken to pass the pre-qualification for the PHC accreditation.

“We have been exposed since a long time. Before the accreditation period we had what we call a period application, where we use what is called the essential requirements for accreditation”(A2).

C1 and C2 reported that their knowledge of accreditation came from their personal professional development through attending external trainings or conferences.

“So, with the help of external conferences and being part of the practice management programme which focuses on the audit and evaluation I've been exposed to the accreditation program long time ago.” (C1).

The remaining respondents who are all the Heads of early adopter centres and almost all surveyors (B1, B2, B3, D2, D3, D4, D5, and D6) claimed that this programme was their first exposure to the accreditation programme.

“In the past we hear about it and we hear that this HCO has earned their accreditation or they have reached this stage or whatever, but we didn't know before that.”(D4)

“It was new for us, the accreditation process per se, but for quality I have been in the quality process and training for several years before. So, this concept was not new to us but the process per say was new for us.”(B1)

vi. Engagement process

All the participants spoke about the engagement process in accreditation, discussing the means they used in order to facilitate staff engagement. It is important to note that there was almost complete agreement that the most effective way to engage employees was to explain to them the importance of accreditation and the benefits of its outcome.

“To convince anybody about something, [you] needs to show them the outcome, if the outcome will be for safety, for quality, for improvement so they will be convinced. Thus the first thing, convincing about the idea by showing them the outcome” (C1).

This view was also articulated by others, both across organisations and professional groups.

“When I sit with them and explain to them the idea and what's the benefit we will get out of that, they like the idea, they want to work.”(B2- Head of an early adopter).

“We have to calm them down. We have to explain to them that we are not investigators. The Accreditation Programme is not a punishment tool; it is a tool to learn from experience. We showed them that we are coming to help them to achieve their goals and we explain the benefits of the Accreditation Programme for both patient and the staff.”(D5- MOH surveyor).

The final quotation from D5, a surveyor at the MOH, underscored the potential misconceptions of employees towards accreditation. Addressing these misconceptions was a particular task for the surveyors, who explained the importance of employees viewing accreditation as an improvement tool rather than punishment or testing tool.

“We select them and we sit with them, we give them a good orientation about the whole process and how important it is, and what we expect from them, and what is their role, and the volume of support that is expected from them in influencing the decision making, in supporting the staff to be involved, encouraging them”(D6)

Thus, as shown by these quotes, communication, proper understanding, and building credibility were key in allowing the employees to actively engage in the accreditation process rather than having a top down approach and ordered to participate by the management.

Several other means of engagement were also listed by the respondents, including: emails, open door policy, courses and workshops, surveys of staff, contests for employee of the month and gift ceremonies for the hardest working employee in accreditation. All of these were considered as incentives to promote engagement.

9.6.5. Facilitators for implementation

During the interviews subjects were asked to discuss their views about the factors which facilitated the implementation of the accreditation programme. Three sub-themes emerged under this title where the interviewees referred to resources, central support and financial support.

i. Resources

Fifteen out of the eighteen interviewees discussed facilitators for implementation under this theme. The main resources mentioned by the respondents were: information books, guidelines, and documents detailing the standards and protocols. Training was also mentioned, although they didn't elaborate on the type or source of the training. There was no difference in the responses between the heads of PHCCs, be they early or late adopters, they all generally reflected a neutral stance. This was not seen across all of the professional groups however. One facilitator/coordinator at the Q&A directorate and two surveyors had a more negative

view of the resources provided. A6 who is a facilitator/coordinator at the Q&A directorate reported that *“They are suffering from the poor resources which are going to help in managing the data. So I think all the healthcare organisations here in Kuwait are in need for an electronic system which facilitate the data management. And as you know, without data management there is no way that we can improve the quality of services.”*(A6). This interviewee viewed IT as a key resource.

Another respondent who is an accreditation surveyor claimed that *“The problem it has been mainly personal, there is no funding at all, it all has to be personal effort to provide the brochures, the printing materials, the books, everything, depending on the people to do it, not systemised and not standardised.”*(D1).

ii. Central Support

Thirteen out of the eighteen respondents discussed the role of the central support in facilitating the implementation of the accreditation program. No evident agreement could be concluded from the answers of the respondents. While those working at the Q&A directorate reflected the need for additional support from the higher authorities [MOH], the heads of PHCCs reflected a very positive and satisfactory attitude towards the support they received from the Q&A Directorate. Thus, the Centre Heads generally felt they were receiving all the support they needed in terms of knowledge, information and facilitating paper work and permissions. As highlighted by one of the heads of an early adopting PHCC B2:

“Support from the head of the primary health care unit for [B] region by writing them letters. For example, For the security purpose one of the standards was for the safety of patients, safety of the employee, We send a letter for the PHC unit in our region who provide us with the approval to apply a camera which monitor the security issue at that stage....For anything related to what we need, we have to write it in a letter to our Higher Authority.”(B2).

However, as previously described, support from the Q&A Directorate to the implementing PHCCs was mainly in the resources mentioned earlier (guidelines, books, brochures, and expertise).

One interviewee also mentioned the potential for support from the external agency, ACI:

“Well in general support for the programme is not strong. But there is support...One area where there is support is the contract, the agreement with ACI,

which lays out their commitments to deliver many deliverables such developing a software system, to develop the standards, to maintain and modify them annually”(A5).

iii Financial Support

The most extensively discussed subtheme among the respondents was the issue of financial support. While all recognised that adequate financial support could be a key facilitator, all agreed that - aside from the contract agreement with ACI which included the workshops, trainings, and learning material for the standards - no one received any financial support. Indeed, financial support was such a barrier, that it will be discussed in Section 9.6.6 on challenges to accreditation.

9.6.6. Challenges to implementation

Interviewees identified a number of challenges including staff resistance, man power shortages, policies and procedures, and resources.

i. Staff resistance

Staff resistance was discussed by the Heads of the PHCCs and, in particular, by the surveyors. Different factors were suggested as contributing to this resistance. Communication, and motivation and accreditation as a ‘new’ concept were factors:

‘In the beginning when the concept was totally new for the leader, to engage them and motivate them and make them believe in the process and the importance of it was quite challenging, I found resistance from them.’(D4)

Some suggested that older staff members were more resistant to change. Others, however, thought there was no difference between the older and younger staff, and some suggested that younger staff were more challenging to engage with. Reasons included lack of motivation, fear of new change, and unwillingness to learn new system.

“Actually we face many challenges when we go to Centres as surveyors. Like staff resistance. Because they have workload and they don’t have time to work extra. Unfortunately it is from the younger generation because they are maybe

lazy; they don't want anything as extra work without any rewards. Rewards are a very important issue for them.”(D6-MOH surveyor).

“I think the resistance was more from the older generation such as 40 to 50 year old. They were just not willing to change what they are used to, plus they took at it as extra work to be done, like for example I’m treating these people why should I keep documents electronically or by paper, if I do it in one I don’t want to waste my time in doing it in two so the older generation.”(D1- MOH surveyor).

A number of respondents blamed the fact that the concept of accreditation was ‘new’ and this led to staff resistance. This was described by the head of a PHCC:

“Because it is new and they don’t know the result. They don’t want to bother, they want to do their job and they want to go home, they don’t want to be introduced to a new idea about the standard, about the quality and how to measure it. It was an extra work for them.”(B2-Head of early adopter centre).

However, for one surveyor, the PHCC heads had an important role in overcoming this resistance:

“I noticed that when the leader is not interested, the whole team will not be interested, we went to one centre that the leader either didn’t get the idea of accreditation or the leader was not really involved. It was clear that there was a list given to the staff to do the work. Basically if the leader was not engaged, the whole team was not engaged” (D4)

ii. Staff shortages and turnover

Staff shortages and turnover was a particular challenge to implementation, with 10 respondents raising this.

Most of the personnel at the Accreditation and Quality Directorate believed that there was a shortage in coordinators and surveyors.

‘So many of the surveyors lose interest and choose not to participate in any upcoming surveying or workshops due to lack of consistent incentives’. (A1-Head of the Q&A Directorate)

Shortage of staff and rapid turnover meant that PHCCs and surveyors constantly had to train and retrain staff.

“That time, it was stable but now maybe I am facing this problem because now I am having a turnover I have to reorganise my teams again and we have to solve this. Now we are in the process of retraining them again.”(B1-Head of early adopter centre).

“We faced shortage at a certain time and the problem was the turnover. We had so many changes in the staff throughout the last three years that turnover wise was a big problem with us because we had to retrain them from the scratch.”(D1-MOH surveyor)

This put pressure on healthcare providers and in turn was suggested to compromise quality of care, as mentioned by C3 – a late adopter: *‘I had a staff shortage which in turn leads to heavy work load.’*

Early and late adopter PHCC heads, held similar views in terms of high staff turnover being a major barrier: *"The turnover and shifting between the staff, we trained some of the staff who worked in the self-assessment teams and after a while, after they took their training they shift from one clinic to other clinic or from one area to another area"* (B3- Head of early adopting centre).

"We have high turnover, they have other jobs to do. It's not the shortage it is the turnover. We teach some of the staff in the self-assessment team, and then they go to another clinic or get promoted". (C2- late adopting centre).

The above comments suggest that staff retention is relatively low in PHCC in Kuwait and it could be due to heavy workloads associated with staff shortage, or staff promotions as suggested by (C1) late adopter *"Most of the turnover here is for promotion. So usually they are promoted and they go to another PHC centre."*

iii. Policies and standards

A lack of policies and procedures was also seen as a barrier to implementation by a number of interviewees. However, it is important to note that the respondents did not differentiate

between internal policies and procedure and those that were produced by the MOH in the form of regulation. The respondents often used the term policies and procedures for both. This raises questions as to how successfully such a program will be implemented if such core fundamentals are not available.

There was a sense of cynicism in the response of the early adopter PHCC head B2, who commented *'If the higher authority knows what is accreditation, they would help us by setting rules, regulations'*. Another early adopter B3 argued that there were no set policies and procedures, except for a few in the infection control department.

Late adopters C1 and C2, also felt there was a weak process for developing policies and procedures, but suggested there had been some improvement with the accreditation program, quoting respectively *"Since we applied the quality and accreditation programmes a lot of things have been discovered and they have put a plan for it" 'we didn't used to have any policy and procedures for the work but after adopting accreditation or during the accreditation implementation we get some.'*

One particular issue was the applicability of the ACI standards to primary care in Kuwait, with different views depending on the interviewee group. The majority of the PHC centres' heads said that the standards have been modified to suit the Kuwaiti context. However, surveyors believed they needed further modifications in coordination with Accreditation Canada International.

"Already they have been modified, Accreditation Canada has already modified some standards to suit Kuwait, for that reason there is no problem." (C1- Head of late adopter centre)

"I think the standards need more modification to suit the setting of Kuwait and; it should be modified to suit the primary care standards, without different language and terminology. So it needs more modification" (D6- Surveyor)

The head of the Q&A Directorate also highlighted an important hurdle faced by surveyors when dealing with the standards:

"One important challenge is the interpretation of standards by our surveyors is inconsistent. So two surveyors, each in a different team, each surveying a different healthcare organisation would both read the same passage of standard and each would understand it in a different way and would then grade the organisation in a

different way. Some would give not applicable while others would give zero or four.”(A1- Q&A Directorate).

iv. Leadership issues/Bureaucracy

A lack of support and proper leadership from the higher authorities was perceived to be a barrier by a majority of those interviewed. Interestingly enough even the highest rank of respondents, the Head of the Q&A Directorate, complained about the lack of leadership: *“Top of the list [of challenges to implementation] is the leadership commitment”* (A1- Q&A Directorate).

The issue of leadership commitment and involvement was recurrent among the interviewees who work at the MOH. The lack of independence of the Q&A Directorate and its dependence on the decisions of the Ministry was highlighted by several respondents:

“One important challenge is that we are a department at the Ministry of Health, we're not independent, and we are not perceived as independent. What we're actually doing is an internal review. We are doing it at a level beyond the healthcare organisation but still within the Ministry of Health. So we're not a so-called at arms' length organisation, we're a department within the broader Ministry of Health. We are reviewing our units internally, because we're one of the MOH units” (A5- Q&A Directorate)

The lack of leadership was also highlighted by the surveyors who worked for the MOH; however they viewed this from another perspective. As D6 mentioned, strong support and leadership from the MOH would have fostered the communication among all the departments at the ministry including the accreditation and the safety departments.

“The third challenge is the lack of coordination between the departments or the units inside the quality and accreditation directorate. They have safety units, they have accreditation unit. We cannot feel any kind of coordination between them, they are fragmented, why does the accreditation unit work without the support of safety and quality, they are experts in safety, they have to give the good information to self-assessment teams in the centre.”(D6- Surveyor)

The early adopters also complained about the lack of support from the higher authorities and also a bureaucratic system which delayed urgent matters. The views did not differ between

early and late adopters however it is important to note that the heads of PHC centres focused more on the bureaucracy of the system than on leadership.

“But the higher authority should be aware of this, because we need their support, even emotional support, not only financial. If I need anything to provide for my centre I have to write formal letter which might delay the process” (B2- Head of early adopter centre)

“This is really time and effort consuming [bureaucratic system]. It takes a long time and different minds and opinions and you need to convince others, that time spent for following paper and convincing higher authority I can use it to do something better for my centre.”(C1- Head of late adopter centre).

v. Resources and workload

At different stages of the interviews the issue of financial resources was brought up, particularly by the heads of PHCCs who claimed that any change or improvement identified during the process of accreditation would require extra budget. This appeared to be an issue whether they were head of an early or late adopting centre:

“Number three; we didn’t have any financial support, which will help a lot to implement some of the standards such as changing the building infrastructure.”(B3- Head of early adopter centre).

“Not at all [we did not receive any financial support], we lack budget to fix the infrastructure such as the building. For example one of the criteria was about the slippery ground. We have very smooth floors. I asked the MOH to change it [the floor], they refused...”

Interviewer: Did you raise the problem of the funding to higher authority in the Ministry of Health...

Respondent: Yes I did, yet nothing happened. No action. [Laughing...]” (C3).

Those working at the Q&A Directorate also expressed concerns about the lack of resources to support the accreditation process. This included funding for the PHCCs themselves and funding for the surveyors to properly support their work in the centres.

“For both of them [manpower and resources] there is no support whether it is funding or its financial support. Both of them are weak ...Hopefully in the future the decision makers have a better understanding of the importance of accreditation and the importance of having some financial support or funding support for the primary care centres, in order to have better support with human resources, supporting them with resources, support them with the incentives to push the programme forward... yes [there is lack of funding], well in general Without the contract I'd say we'd be in a much worse case. Support is very fragmented and unreliable.”(A3- facilitator, Q&A Directorate).

“So many of the surveyors lose interest and choose not to participate in any upcoming surveying or workshops due to lack of consistent incentives. There are no consistent incentives for the surveyors. So one year they'd be given X amount of money and next year nothing” (A1).

The surveyors had slightly different concerns regarding financial support where they believed that the training and workshops were given only once and over a short period. There was no continuity in the support received from Accreditation Canada and the surveyors received no financial credit for their effort. As highlighted by D2 *“All these lectures and training were given for the surveyors but for the staff of the health centres and the members of self-assessment teams it wasn't as much. Even like the training courses, or the programmes, or the material itself, even so. And if we are talking financially, for the surveyors we didn't receive any kind of payment and also for the health centres to engage in the process of accreditation they didn't receive any finance.”(D2).*

Workload was also an issue, with the accreditation process adding work load, especially with regards to documentation. As B1 and B2 the heads of early adopter PHCCs said *“because it was other than their [the staff's] usual work, we don't have somebody special for accreditation to work on, so I have to get them from their usual daily work and to work on implementing the accreditation standards as well. So there was a little bit of overwork for them, but we managed to do that. If you just organise yourself, you can do it.”(B1)*
“It was an extra work for them [staff]”. (B2)

This view was echoed by others, including the heads of late adopter centres: *“They [staff] don't have enough time”. (C2)* and *“Staff shortage leads to heavy work load”. (C3)*

9.6.7. Impact of accreditation process

The impact of the accreditation process was discussed at three levels. The first was the impact on the organization and delivery of care, the second was its personal impact on the healthcare professionals involved and the third was the impact on patients' satisfaction with the services provided from the perspective of the health care professionals.

i. Impact on organization and delivery of care

All 18 respondents were positive that participating in the accreditation program had improved quality of care in the PHCCs. However, much of this was anecdotal with less real evidence to support the claims they were making.

Respondents felt that there was more standardisation across services since accreditation and this contributed to improving patient safety and patient satisfaction as A3 stated:

"It might affect the performance of the primary healthcare positively by standardising the services provided. Patients will be satisfied because services were standardised, approved and no variation between A, B and C healthcare providers. I think this is the most important achievement for the accreditation in relation to primary healthcare".

While some respondents spoke about having data, such as patient satisfaction surveys, to back this up, at least one respondent suggested that the evidence for this view was mainly anecdotal.

"Although we don't have numbers, we don't have surveys, but even the people who are coming to us, the self-assessment teams, they are telling us that they are appreciating what they have been taught or learnt or experienced through these standards and the program and putting in mind that we ask the other departments to step in for safety and quality and this has helped a lot"(A2- Q&A Directorate).

Accreditation was also credited with raising healthcare professionals' awareness of the importance of standards, policies and procedure, and introducing them to tools for quality improvement. For example,

"[Accreditation helped in] building a local culture within the healthcare teams, within the healthcare providers, the front line employees. Now they are more aware

about quality and patient's safety which is reflecting positively in the system.”(A5-Q&A Directorate).

Partnership and teamwork was an important part of this, as highlighted here:

“when you have a team you will definitely feel a better work, you will have a better work environment, you will be relaxed, and you will feel supportive, so all of this will reflect on the quality of care.”(D4)

Most of those interviewed, regardless of level, commented on the way that undertaking the accreditation process had supported the development of teamwork within the centres and their departments, as stated by B2 *“in the self-assessment team we try to get one employee from each department to work together...and they all work together.”* Some respondents also commented that the accreditation process had given them the opportunity to share ideas and make decisions as a team. The head of one PHCC commented that *“we have involved our staff in a lot of decisions”* (B1), hoping this would encourage independence and confidence in the long-run in decision making and recommending improvements. Late adopter (C1) suggested there had been a 10% increase in employee satisfaction rate according to a job satisfaction survey (although no data were provided to support this view). Respondent B2 also stated that accreditation *“improves the relationship between the employees together and improves their way of communication”*, which could play an important role in the overall employee satisfaction rate. Respondents were quite optimistic about this and talked about good relationships between staff due to the accreditation program, which helped bring interdisciplinary people together to share ideas.

“You can see it through their sitting together and discussing things and you can hear them telling that.” (A2)

“The importance of meetings and groups study in order to discuss the multi discipline criteria which encourage pooling of different specialities under one umbrella” (A4).

However, a surveyor from the MOH, D4, did comment on seeing some resistance within staff working in administration, commenting on gaps between different staff groups. *“Definitely 100% the team work has improved, without a doubt. But there is resistance in the admin (the non-technical team). There is a big gap between the technicians, those with technical*

background and those with only admin background". This suggests that there was still work to do to ensure that all parts of the organisation were 'buying into' the process of accreditation. Accreditation was also credited with improving work practices within the PHCCs, both by centre heads and others.

"The presence of appointment system, this reflects back by reducing the number of patients, resulting in more organised work inside each department and each clinic".

(B3- Head of early adopter)

The head of a late adopting centre (C3) said, *"Incident reports decreased, complaints no more, waiting time decreased, mistakes less, referral to secondary[care] decreased by 7% than a year ago."*

Several respondents mentioned the implementation of a triage system as one of the accreditation criteria requirements, and how it had benefitted the centres. A MOH official said *"huge improvement especially when I visited one of the piloted centres and I found triage system to filter the patient and manage the cases."* (A4). This improved administrative issues according to (D3), who said: *"It improves the work condition in so many ways such as documenting all the meeting minutes, filling the patient records in a comprehensive way"* (D3-Surveyor).

While views on the organisation of work were similar, there was some variation in how to judge the impact of accreditation on PHC services. Some said it was too soon to judge, as per surveyor (D4) and early adopter (B2), while others suggested there was improvement, but lacked the data needed to prove this due to a lack of studies undertaken to compare the centres before and after implementation.

"There is a difference between their [Accreditation Canada] system and ours. I think there's improvement in our services yet due to the shortage of the pilot I can't judge, it was very early for me to judge the quality of care. But definitely if you apply accreditation standards in the right way after a while you will get a result". (B2)

"Difficult to judge [if accreditation process improved the quality of care delivered to PHC], we cannot say there are lots of things that have changed positively. For example in the health centre where they are working for patient identification has improved positively. I mean it's quite a new concept so you cannot see results right now, it's not easy to say that."(D4)

However, with the programme of accreditation was still in its early stages, it was recognised that there was still much to do. For example,

“To some degree yes. As a primary step yes, some centres increased their effort and things are starting to show. For a programme that's been there for only three years I think it's understandable and reasonable.” (D3- surveyor).

ii. Personal impact

The impacts of accreditation, and the related issue of development and training, were inter-linked for respondents. Most saw an improvement on a personal level as a result of being involved in the accreditation program, with many stating that they found themselves more organised, more knowledgeable about quality standards and accreditation, and better able to manage their time and tasks. Several respondents showed pride in themselves and their achievements and felt they conducted their tasks more professionally as a result of following international standards.

Surveyors D1 and D2 stated respectively *“knowing what should be done, knowing things that should be organised in a certain way, the whole order itself is helping, sticking to guidelines, updating yourself knowledge wise, keeping things updated, working in an ethical manner.”* And *“I know that I'm doing this based on international standard and if I apply it properly I have a good quality and if I have a good quality then I will be providing best practice”*. On a more personal level, D2 also stated *“I was nice with patients before but maybe I'm nicer now!”*

Ministry officials also talked about their personal development, for example A1 said:

“(It) enhanced my reputation among all other managers that I run such a huge program like accreditation” (A1).

In terms of enhanced knowledge, early adopter (B2) stated:

“Yes of course, so many like standards, Qmentum, accreditation itself, and also how we read the standards, how we understand the standards, the criteria, when we read the criteria and we know what we want from the criteria”

This view was reinforced by B3, who said: *“I learned a lot from the pilot study that was done after one year of applying the quality and accreditation process in my clinic”*. As early

adopters, these respondents were fortunate to go through the pilot study and gain insight from the early use of the supporting documentation and tools.

However, the heads of the late adopting PHCCs were also positive, mentioning teamwork for decision making which made everyone feel involved, as well as better organizing tasks and learning new concepts. This was both within the centres, but also with the Ministry.

“Accreditation strengthens the relationship with the Ministry of Health” (C3)

There were, however, some downsides particularly with regards to the amount of additional work and effort needed to be able to apply standards on top of daily job duties. Surveyor D1 stated bluntly: *“But on the other hand there was extra load and time and stress, this was the negative part of it”*. This view also came from Ministry officials:

“But with the presence of the Accreditation Programme, I think this Programme takes a lot of my time to coach and train so I have to be more specific with my time”.

(A6- MOH Facilitator)

Personal development was linked to personal impact through trainings and workshops – a point acknowledged by several interviewees. Learning from accreditation transferred into the day job, as described by (B2),

“I transfer this knowledge to my clinic here. It was a benefit for me to attend like these sessions, and it’s also enhanced my work as a head of the clinic”.

For one surveyor (D6) getting involved in accreditation led to a whole career shift due to a training course he attended by Accreditation Canada, from working as a pharmacist switching to *“a quality coordinator in the pharmacy department, an accreditation surveyor and a safety officer”*. He also stated *“the amount of training that I had received, just because being part of this accreditation program. The training satisfies me a lot. It gives me the opportunity to learn new skills, new experiences.”*

iii. Impact on patients

There was broad agreement that there had been an improvement in perceived patient satisfaction as a result of the accreditation program taking place. Some judged this based on patient satisfaction surveys carried out within the PHCC, while others judged it through word of mouth or just through instinct. A2, a head of accreditation department at Q&A directorate stated *‘We hear from here and there that... they [patients] found differences there [at the*

PHCC]’, while B2 stated *‘I can’t judge in facts but I feel it’*. Both early and late adopter PHCCs had generally positive views on the matter, basing their opinions on feedback received from patients and their own efforts to improve services. B3 claimed

‘they [patients] were trying to engage themselves within the activities which takes place... so I think after the pilot survey there was good consequences on both the patients and the employees...Also it improved the environment of the patient’.

Several respondents discussed survey results undertaken within the PHCC themselves, which indicated an increase in the percentage of patients reporting satisfaction. A4 declared:

‘Before we start the accreditation it [patient satisfaction] was really bad before the pilot survey and after the pilot improved’.

B1 also agreed *‘it was almost 85% (patient satisfaction in 2011)...for the 2014 it was much, much higher we nearly reached 100% satisfaction’*. C1 concurred too *‘Patient satisfaction surveys showed an increase by 10% post accreditation implementation.’* However, these results were not made available to this study.

A small number of respondents, mainly PHCC heads and surveyors, discussed patient safety. Early Adopter B1 discussed the safety team they had set up in each clinic to handle patient safety matters, mandated by the accreditation program.

‘Before we didn’t put our patients’ safety as a priority in all clinics. Now the first thing we are thinking about is patient safety’.

This view was also expressed by B2, who said *‘We have now a project called safety of patients, if we apply it and we train for it we will cover maybe three-quarters of accreditation standards’*. When asked whether accreditation improved employee awareness and involvement of patient safety, he saw it as everyone’s responsibility with a need to instil this mindset in all those working in the PHCCS.

9.6.8. Sustainability and future development

Interviewees were asked about the sustainability of the programme. This referred to both the sustainability of any improvements as a result of going through the accreditation process, and also the long-term sustainability of accreditation in Kuwaiti primary care. Interviewees spoke about several different aspects which they felt contributed to the continuation of the

programme, including support from external sources, funding, and monitoring. Of particular importance were the roles that the MOH and ACI play in the overall sustainability of the programme.

Unsurprisingly, funding was seen as crucial to sustainability at least for the 8 respondents who discussed this in detail. This included the need for financial support to support on-going education, both to update their own personal knowledge of accreditation and quality improvement but also to provide training programs, workshops, lectures for staff. One surveyor commented:

‘Continuous training is very important on different levels, at the level of the survey themselves and in conducting the survey visits and to the employee of the clinic that has been piloted or surveyed.’ (D3)

For some respondents, the use of data to monitor sustainability was also important. However there were different ideas on which data to use. For example for one surveyor, data had to come from both staff and patients: *‘Measuring the outcome on both the consumer and the employee and see the positive outcome resulting from this process’ (D3).*

However, for the Head of a PHCC, the patient view was the important issue *‘Patient satisfaction results to monitor the sustainability’.*

Less than half of those interviewed raised the issue of using local data to monitor the sustainability of the accreditation programme. As an early adopter, (B3) emphasized the importance of analysing statistics and indicators to help monitor sustainability, rather than solely rely on observed outcomes. One explanation for the lack of discussion on data use might come from an accreditation coordinator from the MOH, who said

"[there seems to be] poor data management and it's difficult in accessing the data system" (A6). This respondent went on to say that there was no data system in Kuwait and no one to conduct such needed studies. This would make the monitoring process difficult considering monitoring is based on data collection and analysis.

Respondents' reflected on what roles external resources and organisations could play in the sustainability of the programme. All of the interviewed individuals agreed that continuous support from the MOH would contribute to the success and sustainability of the accreditation program. As one of the respondents (B2), the head of an early adopter centre, said: *‘we need the support because as I told you [ensuring sustainability in my centre] is not my job as a head*

of PHC centre, it is the job of the Ministry of Health. ' The importance of the role of the MOH in providing local support was re-iterated by the head of late adopter centre (C1), when he said: *"MOH play a major role by providing manpower, well organized system and the evaluation which will guide the improvement"*. This support may be in development as, according to a surveyor at the MOH,

"Recently they [MOH] have allocated some kind of doctor to be like the link between the Ministry and the health centres and this person is doing some kind of visits to PHC centres to deliver their concerns to the MOH."(D2)

The other important organisation was ACI, with mostly positive attitudes towards their involvement, for example:

"We benefit a lot from the experience of the others, for instance, part of the accreditation contract with Accreditation Canada is the exposure of surveyors to an actual survey in Canada and all who went there they came back with a very positive response." (A2- Q&A Directorate).

The involvement of this external body with international standards was regarded as giving weight to the implementation of accreditation, forcing those involved to take things seriously. The involvement of ACI was seen to increase staff confidence and trust in the accreditation programme as one surveyor at MOH put it,

"Especially for the first five years for people to take it [Accreditation] seriously and for us as surveyors to be taught better and to be given more confidence in doing the surveys and more training." (D2- Surveyor)

As well as providing 'weight' to the process, ACI also provided practical support especially for the surveyors, some of whom spoke of a lack of experience and knowledge, but also of a willingness to learn and to become independent for future accreditation needs:

"for us as surveyors to be taught better and to be given more confidence in doing the surveys and more training....and if local surveyors gained more power and experience then no need [for supervision from ACI]". (D5)

However, sustainability also required that the role of front-line staff for their efforts in their daily routine jobs as well as the additional work which was required for the accreditation program as A2 stated:

'To sustain the improvement there should be a lot of things to be done..... you [Head of the centre] have to recognise and appreciate the work they are doing..... Adding to their usual routine work, seeing patients, treating patients, dispensing medications etc., the work for accreditation needs more time and more effort. They are doing it out of their own goodwill. They should be appreciated for that'.

Though, it was clear that there was also a need for the Ministry to address wider system-level issues as well:

'In order to achieve the basic level of improvement the whole structure needs to be changed. Here you will be faced big problems, big obstacles. It means that this place is not structured, it will never be accredited with this way of building, the building itself, the structure itself. For example, no matter how they work among the team, how about the bigger aspect, it cannot be sustainable and they will be demotivated and frustrated because nothing will be moving'. (D3- Surveyor).

Mechanisms to address this were not clear; conversely, some did suggest that one way forward will be to de-centralize the management and budgetary control for accreditation. In addition, accreditation in Kuwait should be under the control of an independent organization.

'The accreditation department should go out from the Ministry of Health and should not be only a decentralized and independent. But also should be an organisation by itself.' (A5)

Almost all the respondents agreed that the future development of accreditation needed training to enhance staff knowledge on the process and to support employee motivation, morale, and development. *'Strengthening the training [is needed] ... we need expert trainer, the amount of knowledge that I gained [from experts] was different, and the way they respond to our questions was different.'* (D6- Surveyor).

Accreditation coordinators and PHCC Heads suggested that the future development of the programme had to include on-going monitoring and support. For example, B3 said *'we need a follow up meetings at least every three months for each clinic that they have applied for the accreditation.'* The Heads of a late adopting centre said:

‘We still need the Accreditation Canada International Agency as a supervision body. I mean they prematurely abort this and I think they shouldn't, it's a new thing here in Kuwait still not very well understood.’(C1- Head of late adopter centre)

C2: ‘You need to keep in contact with the international programmes to update yourself all the time. For instance, the way of measuring the performance in hospitals is still use the old methodology (compared to the methodology) used by Accreditation Canada and the Joint Commission, where they would visit and sit with the assessment teams...we have to keep on exposure to what others are doing.’

This was supported by surveyors. Surveyor D1 suggested ‘*A monthly visit to the centres, checking the surrounding, see how the process is done, see what the difficulties in answering the self-assessment questions*’ are.

Incentives for surveyors were also suggested by one of those interviewed: ‘*The surveyor should receive some incentives to feel they are rewarded and appreciated.*

Developing the infrastructure of the healthcare system was also suggested by several respondents. A3 said ‘*To develop the infrastructure...providing central policies and procedures for the clinical, and non-clinical departments*’, as did D4 ‘*providing the fundamental requirements in the structures of the building*’. As well as this, ensuring standardisation of the policies and procedures required for accreditation was also viewed as important.

There was a clear view that developing local expertise, through local surveyors and other local experts, was important. As accreditation coordinator (A6) put it ‘*The Directorate people considered as a local experts, for sure we are very important and we are important for the sustainability of the programme, otherwise who will provide the coaching, the training, the guidance for the process here in Kuwait*’. Surveyor (D1) said:

‘In my opinion the local teams are more knowledgeable about the situation here in Kuwait. Rather than the international teams who don't have a clear idea about the real situation here in Kuwait and how things are done.’

9.6.9. Wider benefits of accreditation in PHC

Participants were asked what they thought the wider benefits of accreditation were to the primary care system in Kuwait. Participants discussed quality improvement and safety, health

system efficiency, cost effectiveness, strategic development of the sector, policies and procedure, in addition to its impact of secondary and tertiary treatment.

The importance of standardization as a tool for improvement within the PHC system was raised again— something that was part of the accreditation programme.

“...provides the quality in a systemic way for all the departments, for all the health centres who participate within the pilot.”(B2)

“It shows commitment to quality and patient safety, it increases capacity for managing the quality improvement and standardises all the services.”(D6).

No difference could be noted between the responses of early adopters and late adopters, or between those who were employees at the directorate of Q&A or led PHCCs.

Many participants also spoke about the increase of efficiency in the PHC services as a result of accreditation; however, their understanding of how this was achieved was not great. For example, while a facilitator at the MOH stated that better working hours reduced doctor burn out and thus decreased patient complaints, another believed that efficiency resulted from the competitive atmosphere created among PHCCs. Others suggested that continuous evaluation led to better efficiency, and that staff training and education was a key player in perceived efficiency increase.

“Evaluating everything, even small things such as patient files, the process of patient journey in the clinic, so definitely it is improving the system to be more efficient because all of this were evaluated.” (B1)

“Improving communication, collaboration within the organisation, increase credibility and demonstrate accountability and all directed towards efficient services. It has a great role in reducing the costs, the waste, effort, and time”
(D6)

Twelve out of the eighteen participants spoke about the cost effectiveness of the accreditation program. With the exception of two, all the respondents perceived accreditation to be a successful investment, where perceived improvements in the quality of services compensated for the cost of implementing the programme. However, it is important to note that none of the respondents were able to provide evidence or practical examples of the cost effectiveness of the programme.

“To fund such a huge programme it is very costly and needs a good budget but maybe after 10 years once all things work properly and things settle down it will become money saver.” (A4)

“It has a great role in reducing the costs in the long run. The only alternative for implementing accreditation is dealing with a crisis, we don’t want to manage a crisis which is costly, we need to be pro-active and that is what accreditation gives us.” (D6)

Two interviewees did express concern and uncertainty about the accreditation program. The first was the head of an early adopter centre, B1 who stated that *“Regarding the cost, I am not sure if it will reduce”* and the other is D1, a surveyor for the Ministry who said *“It is very costly and we have no funding, so mostly this is one of the major factors about resistance. But might reduce the cost in the future”*

A few suggested that improvement of services in PHC could decrease demand on the secondary and tertiary care.

“Less referral will be going. Doctors in the secondary hospitals will not be overwhelmed. Instead of pooling patient in the secondary for un necessary issues, giving them the proper service at the primary and let them feel happy.”(A4)

“Once the preventive part is being worked up on more effort the secondary will receive less patients load.” (D1)

9.7. Discussion

This was a qualitative study with a sample of health care professionals working in different positions and sites in primary care in Kuwait. While it could be argued that the findings are not generalizable to other settings in different health regions, I believe the converse to be true since the participants came from several backgrounds with a wide range of different managerial positions and were truly engaged in the accreditation process.

The aim of the study was to complement the quantitative study by providing a more detailed understanding of the impact of the accreditation and the changes brought in PHCCs in Kuwait after the introduction of the national accreditation programme in June 2012. Individual interviews would add depth to the research given the individual experience of the professionals as directly affected by the recent developments resulting from the implementation of the programme.

Accreditation Meaning

Respondents from the Q&A directorate were better able to define accreditation compared to surveyors and heads of PHCCs suggesting that stakeholders with a strategic role had more knowledge on the subject of accreditation compared to surveyors and staff at the PHCCs. This coincides with Manzo et al., 2012, who found that healthcare professionals did not have a consistent view of the accreditation process, and emphasized the importance of ensuring that all stakeholders are well informed of the process to reduce any opposition or resistance. Such findings also support Hinchcliffe et al., 2013, who found that stakeholder views on accreditation varied, and suggested that the implementation of accreditation may be more effective when programme aims, requirements and benefits are conceptually unified and then communicated appropriately to different health professional groups. Study of hospital accreditation programmes also found that exposure to the accreditation programme helped individuals understand and relate to it (Yan, 2016).

There was also a more positive attitude towards accreditation from heads of early adopter centres, which suggests a sense of optimism due to familiarity and involvement with the programme, compared to late adopters who have yet to complete the process. These findings complement the results of the study undertaken by Brasure et al., 2000, who found that most of hospital administrators of non-accredited hospitals did not think that the perceived benefits of accreditation were worth its cost or demands on staff time.

Engagement Process

Results suggested that the more employees were engaged in the accreditation work, the more confident they were about the positive impact that accreditation plays on quality improvement and the role they have to play in the process. The importance of such involvement was shown by Greenfield & Braithwaite, 2009; Ghareeb, 2016; El Jardaliet al., 2014 & Manzo et al., 2012, who found a strong link between effectiveness of accreditation and involvement and commitment from staff. It was observed that the employees' feeling of pride in their role in the accreditation process was strongly linked to the perceived benefits of the programme. This was reported by others who identified links between pride and satisfaction due to the feeling of responsibility for gaining the title and for the reputation of the hospital (Manzo et al., 2012; Nadia et al., 2016).

There was, however, little evidence of engagement or impact on patients. Patient awareness is an important element in the success of the programme, as emphasized by ACI in their 'Patients as Partners' philosophy which was implemented in 2012, advocating the importance of patient feedback based on their experiences and promoting the need for a culture change to allow patients to be partners in their care management (ACI, 2012). This, therefore, is an area that requires future work and development.

It was shown that heads of early adopter PHCCs expressed a more leadership-oriented role in the accreditation programme compared to late adopter centres. Strong leadership and so-called 'change champions' are critical characteristics which essentially guide organizational development and change.

Such findings support prior studies which emphasize the importance of such organizational features on the successful implementation of quality interventions (Greenfield, 2007; Hinchcliffe et al., 2013; El Jardali et al., 2014; Mosadeghrad, 2014).

Work involved in accreditation

Results presented here further support the available literature which shows the important role that effective communication plays in the implementation of an accreditation programme. Gloria et al., 2013, identified that lack of communication between departments is a detrimental factor to quality improvement activities, while Krit, 2006, found that healthcare professionals identified lack of communication between departments as a major problem for hospital's QI plans. Accreditation has been found to encourage a pathway to boost communication within organizations, resulting in more sharing of knowledge and information between employees (ACI, 2009). While the work here identified formal meetings as a key approach to formal communication, social media was also identified as an important informal mode of communication route. While the spontaneity and the opportunistic characteristics of such informal communication are helpful, it raises questions as to its suitability with older members of the workforce who may be more resistant to change (El Jardali et al., 2014).

Also, as the care of the patients is a multi-faceted one, the issue of confidentiality comes into play, whereby information might be shared in a way that breaks PHCC rules and guidance. This may be an area that requires development and guidance in the future.

Training was a main pillar upon which the success of accreditation depends, especially in terms of knowledge transfer and employee development. This role of training is supported by

others, with much of the available literature supporting the notion of continuous training affecting quality of healthcare services (El Jardali et al., 2014; Mosadeghrad, 2014).

Facilitators and barriers for implementation

Sustainability of accreditation is largely dependent on sufficient financing for initial development, ongoing operations, surveyor training and management, and needed improvements (Kedar et al., 2014).

Financial support was a major barrier which has affected several different aspects of the accreditation programme, including staffing issues, information dissemination, and training. El Jardali et al., 2014, also identified impediments in recruiting staff and equipment due to lack of financial resources, which is transferable to this study, such as staff shortages and a lack of an electronic system to systemize and standardize policies and procedures.

With regards to the role that the central support plays in facilitating the implementation of the accreditation programme, our study revealed conflicting results regarding the level of support provided by the higher authorities. Such centralization is debated in the available literature, with Mosadeghrad, 2014, stating that dependency on government is a major barrier to effective quality management, whereas Braithewaite et al., 2012, identified that low and middle income countries were very dependent on their governments due to resource limitations.

Staff resistance was also identified as a barrier, as identified by El Jardali et al., 2014. Staff shortage and high turnover rates were also found to be major challenges faced by the PHCCs in my study. While staff shortages overload existing staff duties which may hinder their ability to offer their full potential and in turn affect healthcare quality, high turnover rates may cause workflow inefficiencies and delay the delivery of care. There is also a constant need to re-engage with new employees, adding costs to the organization and adaptation time for old and new staff. These findings supported by (Manzo et al., 2012; Elkins, 2010; El Jardali et al., 2014), who found that such challenges accompanied healthcare accreditation programmes.

Impact of Accreditation Process

Findings presented here found that interviewees perceived improvements in the quality of services provided at the PHCCs, as well as enhanced teamwork and partnership between staff, which indirectly impacted on the quality of services. However, the lack of a data collection system made it difficult to monitor the extent of improvement. Previous research on the

impact of accreditation also showed inconsistent results and difficulties in demonstrating improvement (Braithewaite et al., 2012; El Jardali et al., 2014; Devkaran & O'Farrell, 2015). Results showed a perceived personal improvement for staff themselves, making them more organized, more knowledgeable, and improving their personal skills. It was seen that accreditation played a role in raising healthcare professionals' awareness of the importance of standards, policies and procedures. This is important, as the quality of healthcare service mainly depends on practitioners' knowledge and technical skills (Mosadeghrad, 2014). There was a noted improvement in documentation, which helped lay the ground for the development of basic policies and procedures. This also supports findings disclosed by El Jardali et al., 2014, who found that the progress in documentation led to better completion of medical records as well as documenting rules and regulations. Data monitoring was perceived as being weak, with a lack of data collection system in place to allow for proper monitoring. Proper monitoring is needed to guide organizations about whether they are achieving their goals or not.

Sustainability

In terms of sustainability, respondents showed a great dependency on the presence of the MOH and ACI for support to sustain the programme, with the MOH being the bigger influencer. There was concern that the MOH was not providing the expected support, especially financial, which had negative impacts on the sustainability of the programme. Such findings complement other study findings, mainly El Jardali et al., 2014, about the impediments resulting from lack of financial support to recruit needed staff and develop essential infrastructure.

It was also noted that when the programme initially started, there was more financial support from governing bodies compared to the current situation. Such cuts in funding may hinder the sustainability of the programme, as supported by Kedar et al., 2014, who argue that this should be an ongoing issue for governance and operations, trainings, and to make needed improvements.

The results also suggest the importance of an international accreditation body to oversee the implementation of the process for its future sustainability, as international standards are taken more seriously than local ones.

It was also seen that continuous education was a major factor contributing to the implementation and sustainability of the programme. Several studies support this notion

including ongoing training for assessors (Buetow, 2003 and El Jardali et al., 2014), stating educating and training of staff is critical for implementation of accreditation.

Results show that there are limitations in the system when it comes to monitoring in terms of data collection. Monitoring is needed to ensure the PHCCs is heading in the right direction and helping employees measure and compare their own performance against standards which will lead to improvement behaviour.

9.8. Strengths and Limitations

9.8.1. Strengths of the study

Diverse health care professionals from different sites were interviewed, allowing us to compare the views of health care professions who were working under similar conditions and shared similar positions. Moreover, the time of the interviews between 2015 and 2016 was just before the end of the contract agreement with ACI. This allowed them to express their opinion freely without any external influences. In addition these interviews happened towards almost completing the national accreditation programme which gave the interviewee a good exposure to the programme in order to give a holistic picture of the accreditation journey.

9.8.2. Limitations of the study

- i. The sample size of 18 interviews and the fact that all interviewed heads of health care centres were recruited from medium and large centres this may have reduced the generalizability of the results.
- ii. The research was carried out in the early stages of a transition process after the implementation of the pilot stage and after surveying the first group of PHC centres, many of centres are still waiting in the queue, so the results still need to be regarded as preliminary, and further empirical research is needed to confirm the actual and longer term impact of accreditation from key stakeholders point of view.
- iii. A number of the interviews, particularly with those in higher positions, were very short and there was less opportunity to probe for in-depth responses. Low flexibility and time granted from the interviewees with high positions.
- iv. The role and position of the researcher in MOH might have influenced the respondents' views although they were contented to provide a critical view.

- v. Since this is a newly introduced programme and the professional staff was directly involved with the implementation process, preference was given to study the impact of accreditation on professionals' perception rather than that of patients. This resulted in silencing the voice of patients and their opinion about accreditation. However, this may be an opportunity for the development of a future study.

9.9. Summary

It was clear that some issues were discussed at various points of the interviews. This included engagement with staff, the importance of understanding the process of accreditation, the importance of resources including financial resources and manpower. However, in order to fully understand this, the results of this study and the previous work were brought together using the theoretical framework of NPT. This is now presented in Chapter 10.

CHAPTER 10: Final synthesis, discussion and recommendations for future policy and research

10.1. Introduction

This chapter has three aims. First, it brings together the key findings from the three research studies that make up this PhD and integrates them using the theoretical framework selected for this work, Normalisation Process Theory. Next, it discusses the implications of this approach and findings, in particular developing our understanding of the implementation of accreditation in Kuwaiti primary care and considers the strengths and weaknesses of the work. Finally, this chapter presents recommendations for future policy and research and ends with my own reflections on the process of conducting this work.

10.2. Synthesis of key findings and mapping to NPT

As an initial step, I and my primary supervisor independently summarised the key findings from each study. These summaries were then compared to assess the level of agreement across the results. Finding that the two sets of summaries were broadly similar, the key findings were combined into one document (see Appendix K).

From that, the key findings were then mapped to NPT in a series of tables (Table 10.1 to 10.4). Using these, each finding was mapped to the appropriate construct or, in some cases, mapped to several constructs. This mapping to more than one construct was important, as it began to highlight the way in which the constructs interact in a fluid and dynamic way as suggested by May et al (May et al., 2009; May and Finch, 2009). This process was checked and discussed with my primary supervisor. Following this, relationships within and between constructs were described and mapped. These findings are now presented and discussed in turn.

Table 10.1: Mapping the key findings of the three studies into NPT construct 1: Understanding and sense-making work (Coherence):

Systematic Review	Survey (Quantitative)	Interviews (Qualitative)
<ul style="list-style-type: none"> - Individuals seemed to understand accreditation as a concept, but did not have a clear idea of its aims and objectives. -There were different definitions of accreditation. - Accreditation often a new concept in primary care – confused with certification and inspection. - Identified papers focused on organisational understanding, but not the individuals within the organisations. - Individuals unclear as to their own roles and responsibilities. - Those directly involved in the process of accreditation often had a better understanding of the aims and objectives of accreditation, but did not always pass this knowledge on to staff. <i>(This cross-maps to participation and willingness to drive forward implementation through knowledge sharing (Cognitive Participation)).</i> 	<ul style="list-style-type: none"> - Respondents were generally positive about the impact of accreditation on the areas tested in the questionnaire. - Accreditation was viewed as a valuable tool to support the implementation of change and made the centres more responsive to change. Most also felt that accreditation supported the development of shared values amongst staff, encouraged team work and collaboration and improved patient care. - 28% felt that patients were not aware of the accreditation process underway in their centre. <p><i>These relate to understanding of accreditation, but also map to an individual’s assessment of the benefits of going through the accreditation process (Reflexive Monitoring).</i></p>	<ul style="list-style-type: none"> - There were a variety of views in relation to what accreditation meant – this was partly due to the location in which a stakeholder worked. - Those with a strategic overview (e.g. at MOH) were better able to articulate the aims and objectives of accreditation in Kuwaiti primary care than those working in the PHCCs or the surveyors. - Heads of the early adopting PHCCs had a clearer understanding of what accreditation was about than those in the late adopting PHCCs. <p><i>(This cross-maps to participation in accreditation (Cognitive Participation) and also to actually ‘doing’ accreditation (Collective Action)).</i></p> <ul style="list-style-type: none"> - Most saw accreditation as an important part of quality improvement. However, some described it as a tool for quality improvement; others saw it as an on-going process. - Some viewed accreditation as

<p>While the aims of accreditation might be encompassed within the organization's visions and policy, employees not informed of this.</p> <p>- Little data on what individuals or organisations thought were the benefits of accreditation; can be seen as 'box ticking'.</p> <p>- Taking part in accreditation can increase understanding of what it is about. <i>(This cross-maps to participation and engagement (Cognitive Participation) and the work of accreditation (Collective Action)).</i></p>		<p>certification or inspection; others viewed is as a punitive measure rather than as quality improvement process.</p> <p>- Accreditation was seen as an important part of quality and safety, although again some viewed accreditation as a safety tool, or a safety process.</p> <p>- For many, accreditation had an important role to play in standardising the delivery of primary care across PHCCs in Kuwait.<i>(This cross-maps to monitoring and appraisal (Reflexive Monitoring) – need to have the data to know if services are becoming standardised)</i></p> <p>- Overall, there was a clear sense of individuals' having their own working definition of accreditation, but there was less evidence of a coherent organisational view, particularly in the PHCCs.</p>
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Table 10.2: Mapping the key findings of the three studies into NPT construct 2: Engagement and participation (Cognitive Participation):

Systematic Review	Survey (Quantitative)	Interviews (Qualitative)
<ul style="list-style-type: none"> - Accreditation needs to involve all stakeholder groups, including different professional groups and assessors, for it to be seen as credible and to become part of routine practice, involving all relevant parties was a major challenge for accreditation. - A key facilitator was the presence of a champion or key figure to co-ordinate and drives the process. - Collaboration broke down organisational barriers and promoted teamwork. - Credible leaders took time to explain the ethos of accreditation (<i>thereby increasing Coherence</i>), created a sense of ownership, and distributed responsibilities across staff (<i>thereby facilitating Collective Action</i>). - Ensuring staff and leaders ‘bought into’ accreditation was important. - Less consideration of the activities needed to sustain the implementation of 	<ul style="list-style-type: none"> - Managers were viewed as being visible, but about one-fifth of respondents felt managers didn’t allocate enough resources (in terms of finances, people, time or equipment) and didn’t articulate a clear vision for improving quality of care and services. <p><i>This cross-map to resources (Collective Action) and to Coherence.</i></p> <ul style="list-style-type: none"> - 24% felt that inter-departmental co-operation to improve service quality was not supported or encouraged. - Accreditation was viewed as a valuable tool to support the implementation of change and made the centres more responsive to change. Most also felt that accreditation supported the development of shared values amongst staff, encouraged team work and collaboration and improved patient care. - One-fifth did not agree that line manager or work colleagues had supported them in completing accreditation tasks or that work colleagues recognised their 	<ul style="list-style-type: none"> - Heads of the PHCCs were key in engaging centre staff to participate in the implementation of accreditation. - A perceived lack of engagement by the Centre Head made it harder to engage and motivate other staff. - Ensuring that staff understood the aims and objectives of the accreditation process helped to ensure their engagement with it. <i>Achieving this also increases understanding (Coherence).</i> - The more staff engaged in the work of accreditation, the more confident they became about the aim and objectives of the accreditation process. - The heads of early adopter PHCCs expressed a more leadership-oriented role in the accreditation programme compared to those in the late adopting centres; they described their role as ‘leading and organising’. - Heads of the late adopting PHCCs spent

<p>accreditation (activation).</p> <ul style="list-style-type: none"> - Surveyors/assessors were recognised as a key group, but there was little research on their activities in accreditation process. - Many papers focused on getting the ‘right’ professionals involved. 	<p>contribution to accreditation.</p> <p><i>While this relates to an individual’s willingness to participate, cross-maps to the actual workload (Collective Action).</i></p> <ul style="list-style-type: none"> - 28% felt that patients were not aware of the accreditation process underway in their centre. - Almost one-fifth (19%) felt that other health care organisations in the region were unaware that an accreditation process was underway in the centre. 	<p>more time engaging the ‘hearts and minds’ of their staff, whereas those in early adopting centres had now moved on to task-oriented activities, delegating tasks and supervising teams.</p> <p><i>Suggesting that once participation and ‘buy-in’ is established, the focus can shift to the work of ‘doing’ accreditation (Collective Action).</i></p> <ul style="list-style-type: none"> - Good communication and regular meetings facilitated the development of teamwork. <p><i>The cross-maps to the work of accreditation (Collective Action).</i></p> <ul style="list-style-type: none"> - Teamwork had to involve all staff groups, including clinical and non clinical staff. - MOH surveyors were the closest to the on-the-ground assessment teams in the PHCCs, training, supporting staff, writing standards and policies, and generally were the key link between the centres and the Ministry staff. <p><i>Surveyors key facilitators but also carry out a lot of the work (Collective Action).</i></p> <ul style="list-style-type: none"> - Little evidence of patient involvement in
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		<p>the implementation of accreditation.</p> <ul style="list-style-type: none"> - Central support, from the Ministry and in particular the Quality and Accreditation Directorate, was also an important facilitator. <p><i>This cross-map to the availability of resources (Collective Action).</i></p> <ul style="list-style-type: none"> - Staff resistance was considered a particular challenge especially among older staff who were resistant to change, exacerbated by an unwillingness to learn new tasks and resistance to using IT. For others, it was younger staff and a perception that they would only work for incentives. - A lack of leadership and direction was an issue for stakeholders at all levels. Each level of staff suggested that the process would be enhanced by clearer support and leadership from higher up the hierarchy (e.g. surveyors about PHCC Heads and the MOH); PHCC Heads about the MOH; MOH about higher levels of government.
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Table 10.3: Mapping the key findings of the three studies into NPT construct 3: Work involved in implementing accreditation (Collective Action)

Systematic Review	Survey (Quantitative)	Interviews (Qualitative)
<ul style="list-style-type: none"> - Key activities in accreditation included choosing facilitators, distributing tasks amongst staff, assigning credible leaders that champion continuous quality improvement, and explaining the ethos behind the accreditation process. <p><i>These overlap with enrolment (Cognitive Participation) and with increasing understanding (Coherence).</i></p> <ul style="list-style-type: none"> - Accreditation activities had to fit with current activities and not get in the way of doing the ‘day job’, for example by making it harder. - Accreditation mustn’t decrease GPs’ sense of control and autonomy. - Accreditation shouldn’t shift the focus from clinical care to wider issues of quality and safety. - Those being assessed must also have confidence and trust in the assessors. - Goals of accreditation must align with national and organisational goals and 	<ul style="list-style-type: none"> - The area of highest agreement in the accredited centres, as perceived by the healthcare professionals, was in the Management and Leadership scale. Management support and leadership were seen as key drivers for successful accreditation. <p><i>This cross-map to participation and willingness to lead accreditation (Cognitive Participation).</i></p> <ul style="list-style-type: none"> - Around one-fifth felt that groups and departments did not maintain specific goals to improve quality and those middle managers didn’t have a key role in setting priorities for QI. - Most agreed that staff members were given the education and training needed to improve skills and performance and to support quality improvement. - Over one-third of respondents felt that staff members were not rewarded and recognised (financially or otherwise) for improving quality. 	<ul style="list-style-type: none"> - Communication across staff in the PHCCs was key – this involved formal methods such as meetings, but also relied on informal methods, using social media platforms such as What's App. - Regular meetings helped to facilitate the development of a team ethos. - Training was another vital activity, acknowledged by MOH facilitators and PHCC heads. - The development of documents, policies and standards was also an important area of activity for each centre. - Good teamwork was essential for the implementation of accreditation, and had to involve all staff groups. - Resources, in particular good documentation, and training were considered important facilitators. - Financial resources were widely regarded as crucial.

<p>policies and there must be sufficient resources, in terms of training, staff and finance.</p> <p>- The literature suggested mixed views on whether professionals ‘trusted’ the accreditation process or not.</p>	<p>- One-fifth did not agree that line manager or work colleagues had supported them in completing accreditation tasks or that work colleagues recognised their contribution to accreditation.</p> <p><i>This cross-maps buy-in and recognition (Cognitive Participation) – the work being done has to be recognised by others.</i></p>	<p>- Heavy workload for staff was another area that was recognised as a challenge.</p> <p>- Accreditation activities were, for many staff, an ‘add-on’ activity, conducted on top of their routine job.</p> <p>- Some saw a lack of policies and procedures – both at a national and local level – as a barrier.</p> <p>- Shortages of staff and staff turnover were another key challenges. In particular, there was view that staff were trained, and then moved on.</p> <p>- This constant turnover meant that new staff constantly had to be trained to take on accreditation activities.</p> <p>- A lack of resources – both financial and in terms of personnel – was a recurrent issue.</p> <p>- Financial support was a major barrier, affecting different aspects of the accreditation programme, including staffing issues, information dissemination, and training.</p>
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Table 10.4: Mapping the key findings of the three studies into NPT construct 4: Monitoring and appraisal of accreditation (Reflexive monitoring):

Systematic Review	Survey (Quantitative)	Interviews (Qualitative)
<ul style="list-style-type: none"> - Participants must be able to see the impact of accreditation – this means ensuring that there are data on process indicators, but also outcomes. - Outcome data is collected less often. - Those taking part also need to receive feedback on their progress. - Informal monitoring, such as how practitioners feel about the process is also important. - To date there is little or no data collected on the impact on patients. - Accreditation is essentially about CQI, and so modifications need to be enacted on. However, lack of data made it difficult for individuals and organisations to judge the impact of accreditation. - Participants need to be able to evaluate the impact and benefits of accreditation and to adapt systems in response to that data. 	<ul style="list-style-type: none"> - Respondents were generally positive about the impact of accreditation on the areas tested in the questionnaire. - While most respondents indicated that they were involved in developing plans for improving quality, 25% of respondents felt staff were not given enough time to plan for and test quality improvements. - Over 25% felt that the centre’s quality improvement goals were not known in their unit. <p><i>Cross-maps to understanding (Coherence) – if QI goals not known, how can you make sense of them?</i></p> <ul style="list-style-type: none"> - Over one-third of respondents felt that staff members were not rewarded and recognised (financially or otherwise) for improving quality. - One-quarter felt there was not an effective system in the centre for staff to make suggestions to management about how to improve quality. 	<ul style="list-style-type: none"> - Financial support was seen as essential to ensure sustainability of the accreditation programme. - Sustainability of accreditation, in terms of dealing with recommendations from the pilot phase, also required financial support from the Ministry e.g. to meet requirements to improve buildings, infrastructure and increase manpower. - On-going training programmes and support were also felt to be important. <p><i>These three points cross-map to resources and policies (Contextual Integration sub-construct of Collective Action).</i></p> <ul style="list-style-type: none"> - Some stakeholders raised the need for good quality data to monitor impact and sustainability, including better data collection and IT systems. - The MOH and, to a lesser extent, ACI were seen to have an important role to play in on-going support and sustainability. Yet, a number of respondents felt that the MOH had to

	<ul style="list-style-type: none"> - Respondents agreed that their centre had shown steady improvements in the quality of services delivered to patients, in support services and in administrative services. - 22% did not feel that the services provided by the centres were thoroughly tested for quality before they were implemented. - Respondents felt their centres used data to assess current patient needs and expectations, used data from complaints to learn lessons and prevent such problems from recurring. - Most (over 80%) agreed that accreditation had a good impact on their PHCC. - The majority felt that they had participated in the implementation of change. - At an organisational level, accreditation was viewed by the majority as improving multidisciplinary working in the centres, and improving the standard of care both within departments and across the centre. 	<p>take ownership of the programme for itself and decrease its reliance on ACI.</p> <p><i>Cross-maps to Cognitive Participation and who should be driving the accreditation programme.</i></p> <ul style="list-style-type: none"> - Patient involvement and better monitoring of the impact on patients was also suggested. - Accreditation was seen to improve the quality of services delivered, in particular through standardising delivery of services, improving the local healthcare culture and improving teamwork and collaboration across the PHCCs. - Working practices improved, in particular through improvements in the delivery of care such as better appointment systems, better systems of referral and the implementation of triage systems. - There was anecdotal evidence that patient satisfaction had increased, although no centres provided data to support this (although some had conducted patient satisfaction surveys). - Staff satisfaction was also thought to
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	<ul style="list-style-type: none"> - The results showed that accreditation incurred positive impacts on several areas of quality and performance. - The areas of highest improvement in accredited centres as perceived by healthcare professionals fall under management and leadership, patient satisfaction, and quality results. 	<p>have improved.</p> <ul style="list-style-type: none"> - There was a clear impact on many of the stakeholders in terms of personal development; this included through training and personal pride in being involved in such a programme.
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10.3. Understanding the accreditation process: Synthesis of findings

As described in chapter 5, one of the main strengths of a mixed method approach is that it allows the examination of a process or system from multiple perspectives. The systematic review helped in identifying the most commonly researched impacts of accreditation, its facilitators and barriers to its implementation. The survey sought the views of staff involved in the process, providing valuable data on what people thought, but not why or how. This perspective came from the qualitative interviews, albeit with key stakeholders rather than from the staff. Using NPT to organise the data by NPT construct facilitated a comparison of findings across these research methods, as well as identifying the interactions between the NPT constructs.

Understanding and sense-making work (Coherence)

Many of the issues identified in the systematic review were mirrored in the data collected during the interview phase of the study (Table 10.1). While policies and those involved in the strategic planning of accreditation may have a clear idea of what accreditation was trying to achieve, this was not always clear to those on the ground. As a result, accreditation could be viewed a punitive tool, rather than as an approach to quality improvement, with some understanding accreditation in terms of ‘box-ticking’. In the UK, the negative connotations and workload associated with box-ticking in the Quality and Outcomes Framework (QOF) of the GMS contract has led to a steady disillusionment of the value and worth of the QOF (Gillam, 2010; Grant et al., 2015).

What was apparent was that becoming involved in the accreditation process and doing the work required by accreditation then enabled individuals to develop a clearer view, and understanding of what accreditation was about. This was apparent at all levels, for example Heads of PHCCs that had already been through the pilot stage had moved beyond telling their staff what accreditation was about and were now letting their staff get on with the work of accreditation. Taking part also helped individuals see the value and benefits of being an accredited organisation.

Others have also found that a lack of understanding can lead to negative views. Waldorff and colleagues, in a study conducted among Danish general practitioners, demonstrated negative attitudes towards a mandatory accreditation programme (Waldorff et al., 2016). However, a study conducted in Netherlands concluded that an accreditation programme had positive

effects on team climate and commitment to quality of care in the practice team; however patient care was not directly influenced by the accreditation programme.

Participation in accreditation (Cognitive participation)

Employee engagement and participation in the accreditation programme helped break down professional barriers, created a sense of teamwork, and increased confidence in the process and what accreditation was aiming to achieve. The systematic review identified several strategies that promoted staff engagement in the accreditation process, including selecting key facilitators or ‘champions’, assigning credible leaders that champion continuous quality improvement, and explaining the ethos behind the accreditation process. This latter activity again linking into the need to increase staff understanding of the aims of accreditation. These findings were also identified in the interviews, with credible leaders engaging staff in the process early on and MOH surveyors having a key role to play as the bridge between the Ministry and the Heads of the PHCCs and the staff. The key role of surveyors in the accreditation process has, until very recently, been overlooked (Greenfield, Pawsey & Braithwaite, 2010; Hinchcliff, Greenfield & Braithwaite, 2014). The staff survey also identified that, while the majority were satisfied with the role of managers in the process, about one-fifth felt that managers were not visible and they were not supported. This suggests that there is still work to be done with staff in terms of engagement and support. Effective communication is thus a key activity when developing the accreditation process. Recent work is now recognising that quality improvement interventions are social processes, with interactions between people, organisational structures and processes (Marshall et al., 2017) and so communication and good explanations of what the aims of such interventions are clearly crucial. The application of NPT made clear that this entails ‘doing’ or enactment work – namely that communication and building teamwork requires time and energy and is a task-driven activity.

The qualitative interviews suggested that staff awareness and involvement had increased, and that this may have empowered employees within the workplace and allowing them to voice their opinions more freely. It was also noted that there was a sense of partnership and teamwork which became more evident during the accreditation process, again suggesting that a key focus during the implementation should be on staff motivation.

Work involved in implementing accreditation (Collective Action).

Most of the evidence gathered, across the three studies, related to the work of actually carrying out accreditation activities and tasks. Importantly, in NPT terms, this construct is also the one which focuses on the role and availability of resources (both financial and personal) and training.

The data across the three studies suggest that the more staff participated in the tasks associated with accreditation work, the more confident they tend to be about the positive impact that accreditation plays on quality improvement and the role they have to play in the process. However, this can entail a significant workload for staff, which must be recognised – this recognition may be financial (e.g. incentives) or could be about line managers recognising and acknowledging the work that people are undertaking. Indeed, personal pride appeared to be a strong motivating factor (Galletta, Portoghese, & Battistelli, 2011; Leonard & Masatu, 2010). Financial support for accreditation came up in all three studies, but particularly in the review and the interviews. Indeed, most of the articles identified in the review discussed the importance of financial resources as a barrier for implementing accreditation. Staff shortages and turnover were another issue. The accreditation process requires sustainability and experience, thus turnover and staff shortage represent major barriers to successful implementation. As a knock-on effect, constant staff turnover led to decreases in both understanding (coherence) and participation (cognitive participation) as new staff had to be brought into ‘up to speed’ with the aims and tasks of accreditation (Richman et al., 2008; Ongori, 2007).

Sustainability of accreditation is largely dependent on sufficient financing for initial development, ongoing operations, surveyor training and management, and improvements suggested as a result of monitoring (Kedar et al., 2014). Financial support was a major barrier which has affected several different aspects of the accreditation programme, including staffing issues, information dissemination, and training (El Jardali et al., 2014). He showed impediments in recruiting staff and equipment due to lack of financial resources. Another area that was highlighted in the interviews, but given less attention elsewhere, was the need for good information and data collection systems in order to routinely collect usable data into the impact of accreditation. This would support the process of monitoring and appraisal of the impact of accreditation (fitting with the construct of reflexive monitoring).

An important facilitator during the accreditation process was the provision of training and documentation, including guidelines and clear standards. The systematic review revealed that a significantly greater proportion of accredited healthcare centres reported having training in several health topics (Braun et al., 2008). Staff involvement and training was highlighted to be essential for overcoming resistance when implementing new initiatives in healthcare organizations (Seren and Baykal, 2007). There was also clear evidence that taking part in accreditation boosted individual's personal sense of involvement and increased their skills levels. However, this might not be the full answer, as Nouwens reported that receiving a certificate for completing an accreditation programme seemed to have little added value to participants (Nouwens et al., 2014).

Monitoring and appraisal of accreditation (Reflexive monitoring)

One of the key strength of this research was filling in the gap that was identified by the literature review. The initial review showed a lack of literature falling under reflexive monitoring in order to evaluate the impact of accreditation. The survey and interviews were designed in such a way to determine the professionals' perception of the impact of accreditation on PHC. While every accreditation process requires the feedback from the participants, the systematic review revealed that there is little information available about the effectiveness of the process itself especially with regards to patient outcomes (Hinchliff et al., 2012).

Accreditation was seen to improve the quality of services delivered, in particular through standardising delivery of services, improving the local healthcare culture and improving teamwork and collaboration across the PHCCs. Both the quantitative and qualitative survey agreed that professionals' had a positive attitude towards accreditation. In spite of this agreement, the qualitative survey results showed that when looking at the perceived advantages of accreditation, it is evident that the participants could not identify tangible benefits to the programme. Their responses reflected a rather general view of its benefits. While participants agreed that accreditation contributed to the improvement of quality and safety, the mechanism of this improvement was still unclear to most. The two areas often highlighted were the generally favourable atmosphere towards continuous improvement that accreditation plants within the system, and a reduction in complaints and incidents. There was, however, a lot of variation in the views of participants. Such responses were regardless of the position of the respondent or his/her work since no difference was noted between the early or

late adopters. A lack of monitoring data might be part of the issue, as this meant that the reported views were not supported by evidence based research or monitoring plans that could determine and quantify the exact benefits to accreditation when it comes to quality. A study by Nouwens et al., in 2014, concluded that while participating practices in the study reported that they had achieved their chosen goals for accreditation improvement projects, the primary outcomes did not actually improve. Another study which compared the quality of chronic disease management pre- and post-accreditation concluded that while improvements were found, these could not be attributed to the accreditation programme (Klomberg et al., 2014). These results came in spite of the high expectations of the effects of accreditation among participants and stakeholders.

An important feature revealed by the quantitative survey was that patient satisfaction also recorded one of the highest means scores in this study indicating that professionals in accredited PHC perceived that accreditation made their patients more satisfied with their service. Moreover, in the qualitative interviews there was broad agreement that there had been an improvement in perceived patient satisfaction as a result of the accreditation programme taking place. However, evidence to support these views was scarce. Some had judged this based on patient satisfaction surveys carried out within the PHCCs, while others judged it through word of mouth or just through instinct which confirmed the findings in the systematic review.

10.4. Summary of the synthesis of findings of accreditation using NPT

This synthesis has highlighted the complex and inter-related nature of the work that is required to implement the complex system change that is accreditation. In the process, those taking part must be engaged, must understand what the aims are, must be willing to participate, must have the time and resources to carry out the tasks required and must be able to see the impact of their work. This entails a complex interaction between people, organisational structures and processes and must be adequately resourced – in terms of finances, people and infrastructure (Kaplan et al., 2010; Kringos et al., 2015; Marshall et al., 2017).

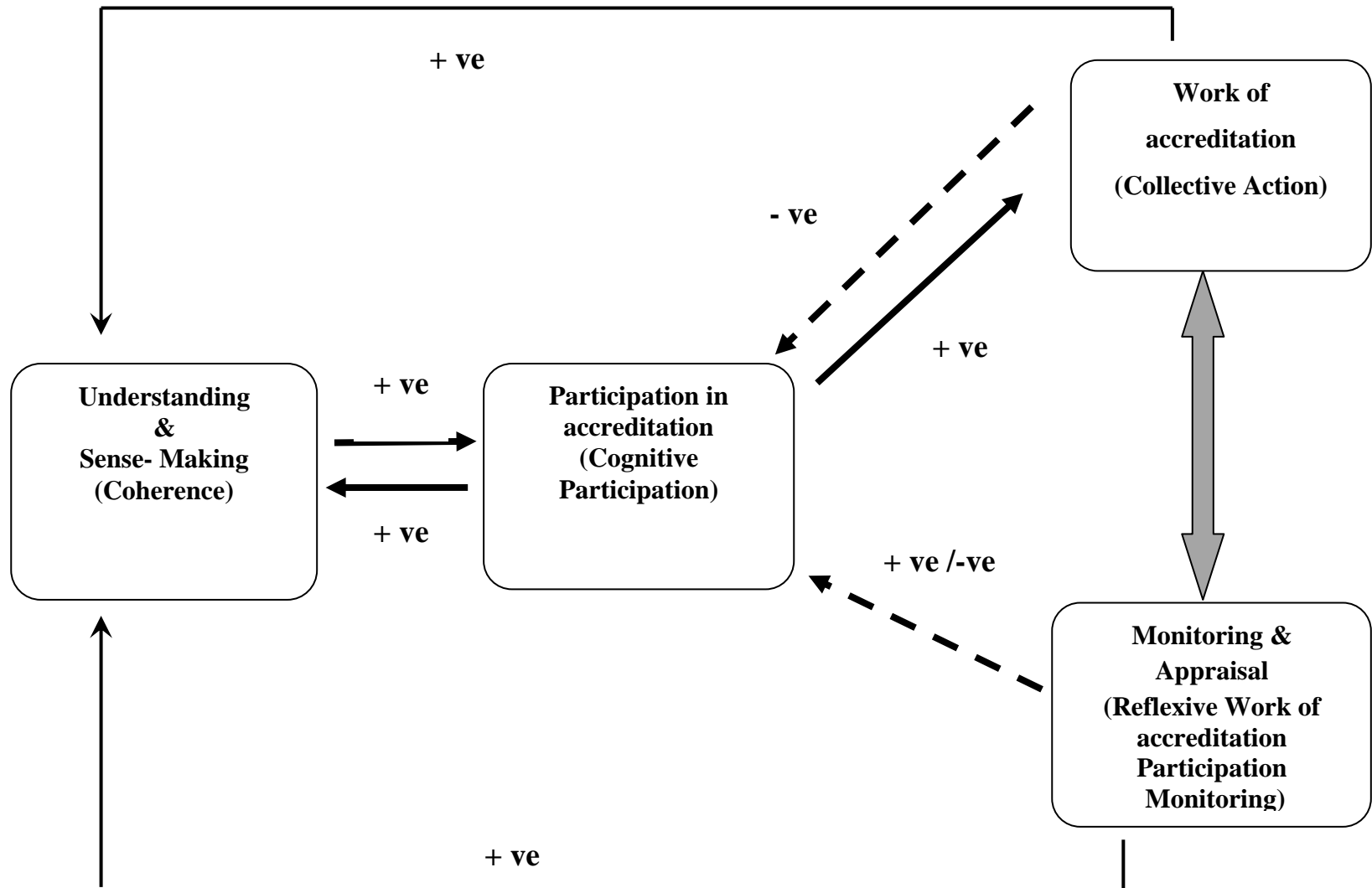
Those in charge of implementing accreditation, or other complex system changes, need to understand this and allow sufficient time for this to occur. As a starting point, the model illustrated in Figure 10.1 offers an idea of how the constructs of NPT might interplay to help facilitate this process.

This model might allow us to identify whether or not we can use NPT to predict outcomes e.g. it could be used to predict whether the centre would be more or less likely to get accreditation status successfully depending on the stages of the intervention.

As the figure depicts, the base on which all the positive inter-relations are built is having a solid understanding of the accreditation process including its aims and benefits. Participation, both by individuals and by their encouraging others to get involved, consequently projects a positive correlation with collective action and work involved in accreditation. However, if the work involved is too great or cannot be fitted in alongside the routine 'day job', the work involved in accreditation has an inverse relation to cognitive participation. As the workload increases, employees are less motivated to participate particularly with the lack of incentives. If employees are able to integrate the work involved in accreditation into their routine work or tasks, their understanding of accreditation increases forming a positive relationship between collective action and coherence.

Finally, depending on the results of evaluating the impacts of accreditation, reflexive monitoring can either encourage cognitive participation, or hinder it. If professionals are able to perceive the benefits of such a programme they might be more likely to participate and engage in it. Alternatively, failure to see any advantages to the programme will result in their discouragement from participation. Nevertheless, reflexive monitoring opens the door for a better understanding of accreditation regardless if its impacts are positive or unchanging. The development of a quantitative measures of implementation readiness based on NPT, the NoMAD tool (Finch et al., 2015) and the plan to further roll out accreditation across other PHCCs in Kuwait, may now offer the opportunity to test and develop this model.

Figure 10.1: Illustrates how the constructs of NPT may interplay to help facilitate the process of accreditation implementation.



+ ve means increasing
- ve means decreasing

10.5. Strengths and limitations

This is the first study of its kind to have been conducted in primary care in Kuwait. Although some of the limitations discussed below did constrain what was possible, this study has been able to combine data from staff and from key stakeholders with a rigorous systematic review. This mixed methods approach thus provided rich data from several perspectives. The review, quantitative and qualitative methods complemented each other and gave in-depth information about PHC professionals' perspectives and their roles within the programme. This mixed approach reduced the potential for professional bias, and allowed for methodological triangulation (Thurmond, 2001; Hammersley, 2008; Tobin & Begley, 2004). The combination of front line staff, surveyors and elite stakeholders working at the MOH in Kuwait working in different positions from lower to higher positions also increased the generalizability of the study. Moreover, the opportunity to interview heads of the centres and surveying health personnel within the same PHCC gave a unique perspective to the research, providing an opportunity to explore the views of both professional groups.

A further strength of the survey was the inclusion of all departments within the 3 PHCCs who had participated in the pilot phase of accreditation. This included clinical and non-clinical employees, which minimised bias by not leaving out any particular group. The response rate of 72% was respectable and similar to that achieved other recent studies, e.g. the El-Jardali study of nurses in the Lebanon achieved a 76% response rate (El Jardali et al., 2014). This may have reflected the desire of healthcare professionals in MOH in Kuwait to express their views and use the opportunity to make their voices heard by policy makers, especially after the changes brought by the accreditation programme. However, it is also important to acknowledge that almost 30% of staff did not choose to participate and it is unclear if this was a particular group or scattered throughout the population.

The survey was carried out at an important time, during the second cycle of the accreditation programme, thus allowing professionals to reflect on their first experience of taking part in the accreditation programme which was supervised by local surveyors and managed locally. This could have encouraged healthcare professionals to participate in the study whether by completing the questionnaire or taking part in the interviews.

Limitations included the limiting of the sample first to only three health regions; the selection of urban health regions means that it is unclear how generalizable the findings are to the more rural health regions of Kuwait. An additional limitation was the need to limit the number of

PHCCs selected to participate in the survey and the interviews. As a result, only medium and large sized PHCCs were included. Again, the exclusion of small PHCCs means that the findings cannot be generalised to all of primary care in Kuwait.

The decision to include semi-structured interviews as a method of data collection with key stakeholders proved to be challenging. Many of the respondents, particularly in higher ranking positions, had very little time to offer when I went to interview them. This meant that the opportunity to dig ‘under the surface’ of their responses was often difficult. Nevertheless, the interviews have provided useful and authoritative data from people unused to being interviewed for research purposes.

The MOH in Kuwait kept the feedback report confidential with regards the piloted centres (early adopters) as well as the other report about late adopters. Thus I was unable to access data on the accreditation surveys and results or to corroborate process or outcome data with the perceptions of interviewees. The lack of data on system or patient outcome hampered my ability to assess the primary care system in the way described in chapter 3 by Starfield or by Kringos (Kringos et al., 2010; Starfield, Shi & Macinko, 2005). However, what did become apparent is that the data generated fits well with the WHO Framework for Health Systems (WHO, 2007), which describes a health system in terms of ‘building blocks’, including leadership, financing, health workforce, information and research, and service delivery. This suggests a way of defining the Kuwaiti primary care system until such times as there is more robust data on outcomes.

Finally, although all staff completed the survey, there was no opportunity to interview hands-on staff about their experiences of accreditation, nor any time to carry out work with patients. My own position as an accreditation coordinator working in the Ministry of Health Quality and Accreditation Directorate (funded by the MOH in Kuwait to carry out this PhD), and a doctor, was both a strength and a limitation. On the one hand, my known position in the area may have facilitated entry to both the PHCCs and to the elite stakeholders. On the other hand, my position may have intimidated some people in terms of concerns about anonymity or how the data generated would be used. While I tried to reassure people of my independence in this study, that may still have been an issue for some potential participants.

10.6. Researcher's reflection

I am an accreditation coordinator, working in the MOH Quality and Accreditation Directorate and they funded this PhD. In addition, I am a physician researcher and female. All of these matter when conducting research in a setting such as Kuwait. Being both a physician, employee in the health care sector administration, and an academic researcher gave me a unique position in viewing the topic from different angles and this makes this research unique. Solo travel for research is rarely cast in this light of self-discovery. In particular, the position of a woman researcher conducting fieldwork can be precarious especially in a setting such as Kuwait. However, it also offers a unique experience and opportunity for independence. As a researcher I have learned to appreciate the peaceful, yet exhilarating moments when my mind engages with an author's thoughts on a page. As Toni Morrison says in *The Dancing Mind*, "[reading is] to experience one's own mind dancing with another's." In my early days as a PhD student, I wanted to know the "true" meaning of a work or what the author intended, however, I have now realized this would remove from the literature its noteworthy complexities. Individual interpretations bring about varied insights to a work and it points out messages the author may not have realized s/he included in the piece.

I have always been a thinker, but throughout my coursework, I have greatly sharpened my critical analysis skills. Instead of focusing on proposed meanings or biographical background, I have learned to continuously ask "why" on many different levels. I challenge myself to dig into a text as deeply as possible and unpack every detail to develop a satisfying close read. Also, by reading multiple articles for the same topic I have learned to identify different perspectives and make connections that weave texts together; this helped me develop a deeper understanding of my topic of interest.

Writing had always been one of my strengths, but it was challenging to take the step which is writing a PhD thesis. This has greatly opened my mind. My thoughts are have become more complex because I have learned how to sustain a logical argument in an organized manner. My writing has also become increasingly more concise. Another improvement was developing a systematic review of literature which was quite challenging as it was a new research design for me. However this has significantly widened the scope of my research.

Furthermore, collecting data in Kuwait, a country that is not used to this type of research was both challenging and interesting. I had the perseverance to insist on personally distributing all the questionnaires and to encourage healthcare personnel to participate. Given that the holy month of Ramadan happened during the survey I remember fasting for more than 16 hours,

while also going outdoors to meet with staff in a temperature rising above 50 C. This was one of the most challenging parts and I insisted on doing it by myself and I've learned a lot from this. First, nothing is impossible and if you have the will and proper planning. Secondly, I realized that I am born to make a difference in the life of others and to leave my fingerprint thus I embarked in this journey. The PhD provided me with the required experience to examine and develop my practice through research and engagement with relevant theoretical perspectives and professional academic literature. It provided me with the opportunity to develop my capacity for critical thinking achieved through the use of reflection and the integration of academic and professional knowledge. Also it enhanced my personal development planning which is explicitly encouraged as a part of higher education, including at doctoral level.

What I learned during this experience is how many times young researchers have felt let down by their institutions during their fieldwork, made avoidable mistakes, and generally been ill-prepared for the fieldwork experience. Although I was lucky enough to have a supportive background both personally and through my supervisors, I still found the experience challenging. For those with less than supportive situations, the combination of factors can be extremely limiting. Fieldwork is really tiring. You spend a lot of time distributing questionnaires, conducting meetings to explain the research and encourage people to participate, waiting on replies to phone calls and emails, and conducting interviews, but its worth at the end.

10.7. Recommendations for policy and research

This research was able to identify gaps in our knowledge about the implementation of accreditation and areas that could be improved to reach maximum benefits from this national programme.

A key recommendation for the MOH is the need to develop robust systems of data collection and monitoring. Monitoring is needed to ensure the PHCCs are achieving the standards and helping employees measure and compare their own performance against standards which will lead to improvement behaviour.

In order to address the issues of staff shortage and high turnover, the responsible authority is strongly advised to consider a system of incentives for employees to encourage them to stay and contribute to future rounds of accreditation, thus ensuring continuity of knowledge, skills

and expertise. There also needs to be better allocation of human and financial resources to support the tasks required.

Organising in-house trainings using local expertise can be beneficial to enhance the understanding of accreditation among the employees. This says a lot about wanting self-development and is a stepping stone to achieving such progress. However it is important before arranging a training course for staff, to understand what is required to ensure that the resources invested in are targeted at areas where training and development is needed and a positive return on the investment is guaranteed.

There needs to be support for clinics going through the accreditation phase, and people involved should feel supported. Another message taken from this research is that involving the right people in the programme is very beneficial, if not to get valuable advice, then at least to raise awareness of the programme to different sectors of the community.

Although the MOH has set a long term plan and target for the nationwide accreditation programme, there is a need to remove current barriers and develop strategic plans to identify priorities going forward. There is also need for a strategy for communication between lower and higher levels of management. Although it may not be the job of the surveyor to comment positively or negatively about the performance of staff, but to collect needed data relevant to the accreditation programme. Such boundaries must be established before and clear job descriptions outlined so that staff will know where they stand and to what they hold accountability.

An important note for consideration could be giving an independent status for the Q&A Directorate. This will offer more freedom in decision making and resource allocation for the management, and this sense of individual accountability and responsibility may help achieve better results.

In terms of resources several areas need strengthening: the shift to an electronic, web-based system; strengthening of the vital statistics system, especially in relation to reporting deaths; and improving the reporting of morbidity data.

10.8. Recommendation for future research

In the systematic review identified a gap in the literature in relation to the economic outcome of accreditation. Elnour et al., 2014, concluded from their research on impact of accreditation on patient safety in general practice that tangible evidence of patient safety activities is needed as indicators to determine the effectiveness of the accreditation programme. This remains the

case, with the relationship between accreditation and patient safety an area that requires further research.

Evaluating such quality improvement programmes is indeed a difficult task; however it is far from being impossible (Overtveit & Gustafson, 2003). While this study contributed to the knowledge of how professionals perceive the real outcomes of accreditation there was no opportunity to assess patient views. Patient views of accreditation remains an under researched area and, again, a programme of research would be beneficial to the long-term implementation of accreditation programmes.

The model of NPT interactions suggested in this chapter is entirely new and, as such, requires testing. In particular, it could be tested to assess if it is valid and predictive of PHCCs that might, or might not, be successfully accredited.

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APPENDICES

Appendix A. Countries contained in the WHO Income Groups and the Eastern Mediterranean Region (WHO, 2015 p.6788)

WHO Income Groups.	
High	Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Bahrain, Barbados, Belgium, Brunei Darussalam, Canada, Chile, Croatia, Cyprus, Czech Republic, Denmark, Equatorial Guinea, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Kuwait , Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Oman, Poland, Portugal, Qatar, Republic of Korea, Russian Federation, Saint Kitts and Nevis, San Marino, Saudi Arabia, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States of America, Uruguay.
Upper middle	Albania, Algeria, Angola, Argentina, Azerbaijan, Belarus, Belize, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria, China, Colombia, Cook Islands, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, Fiji, Gabon, Grenada, Hungary, Iran, Iraq, Jamaica, Jordan, Kazakhstan, Lebanon, Libya, Malaysia, Maldives, Marshall Islands, Mauritius, Mexico, Montenegro, Namibia, Nauru, Niue, Palau, Panama, Peru, Romania, Saint Lucia, Saint Vincent and the Grenadines, Serbia, Seychelles, South Africa, Suriname, Thailand, The former Yugoslav Republic of Macedonia, Tonga, Tunisia, Turkey, Turkmenistan, Tuvalu, Venezuela.
Lower middle	Armenia, Bhutan, Bolivia, Cabo Verde, Cameroon, Congo, Cote d'Ivoire, Djibouti, Egypt, El Salvador, Georgia, Ghana, Guatemala, Guyana, Honduras, India, Indonesia, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Mauritania, Micronesia, Mongolia, Morocco, Nicaragua,

	Nigeria, Pakistan, Papua New Guinea, Paraguay, Philippines, Republic of Moldova, Samoa, Sao Tome and Principe, Senegal, Solomon Islands, South Sudan, Sri Lanka, Sudan, Swaziland, Syrian Arab Republic, Timor-Leste, Ukraine, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia.
Low	Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic People's Republic of Korea, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Myanmar, Nepal, Niger, Rwanda, Sierra Leone, Somalia, Tajikistan, Togo, Uganda, United Republic of Tanzania, Zimbabwe.
Eastern Mediterranean Region	Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait , Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen.

Appendix B: The results of the search strategy in Science direct and Scopus respectively

[All Sources(- All Sciences -)]		
<input type="checkbox"/>	(((pub-date > 2002 and accredit* or audit*) OR (pub-date > 2012 and "authoriz*" or "certif*")) AND ((pub-date > 2012 and Primary Health Care) OR (health primary care OR comprehensive care OR general practice OR family medicine))) AND (pub-date > 2012 and "total quality management" or "quality improvement" or "quality assurance" or "quality awards") AND LIMIT-TO(contenttype, "1,2","Journal") AND LIMIT-TO(topics, "quality improvement,health care,primary care,patient safety,patient,public health,nhs") [All Sources(- All Sciences -)]	128 articles  Edit  Delete
<input type="checkbox"/>	accredit* in primary health care [All Sources(- All Sciences -)]	6 articles  Edit  Delete
<input type="checkbox"/>	pub-date > 2003 and accreditation AND primary health care AND LIMIT-TO(topics, "health care,patient safety,public health,quality improvement,cardio vascular") [All Sources(Medicine and Dentistry)]	415 articles  Edit  Delete
<input type="checkbox"/>	(primary health care) or (primary health care services) [All Sources(- All Sciences -)]	484,145 articles  Edit  Delete
<input type="checkbox"/>	(pub-date > 2002 and Joint Commission on Accreditation of Healthcare Organizations or Accreditation*) AND ((primary health care) or (primary health care services)) AND LIMIT-TO(topics, "health care,patient safety,patient,joint commission,quality improvement,medication error,medi care,critical care,cme activity,medical error,performance measure") [All Sources(- All Sciences -)]	366 articles  Edit  Delete

Search for articles from our full-text collection using this search form. Click the **Help** button for step-by-step instructions on conducting a search using this form. Consult the Search Tips for information about the use of connectors, wildcards, and other search options which can improve the precision of your search.

TO(SUBJAREA, "Undefined"))

- 7 ☐ ((joint commission on accreditation of healthcare organizations OR accreditation) AND (primary health care OR primary health care services)) AND (LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003) OR LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003)) AND (LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003)) AND (LIMIT-TO(DOCTYPE, "ar")) AND (LIMIT-TO(LANGUAGE, "English")) AND (LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003)) AND (LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003)) AND (LIMIT-TO(DOCTYPE, "ar")) AND (LIMIT-TO(LANGUAGE, "English")) AND (LIMIT-TO(PUBYEAR, 2013) OR LIMIT-TO(PUBYEAR, 2012) OR LIMIT-TO(PUBYEAR, 2011) OR LIMIT-TO(PUBYEAR, 2010) OR LIMIT-TO(PUBYEAR, 2009) OR LIMIT-TO(PUBYEAR, 2008) OR LIMIT-TO(PUBYEAR, 2007) OR LIMIT-TO(PUBYEAR, 2006) OR LIMIT-TO(PUBYEAR, 2005) OR LIMIT-TO(PUBYEAR, 2004) OR LIMIT-TO(PUBYEAR, 2003)) AND (LIMIT-TO(LANGUAGE, "English")) AND (LIMIT-TO(DOCTYPE, "ar")) AND (LIMIT-TO(LANGUAGE, "English")) OR LIMIT-TO(LANGUAGE, "English"))

17 Feb 2014

345 Scopus

- All results
- New results

 Edit |  Set alert |  Set feed

Appendix C: Prospero registration sheet

PROSPERO International prospective register of systematic reviews

Identification of the barriers and facilitators to accreditation in primary health care centres: a theoretically-informed systematic review

Limya Al Aradi, Catherine O'Donnell, Graham Watt, Azari Al Halil

Citation

Limya Al Aradi, Catherine O'Donnell, Graham Watt, Azari Al Halil. Identification of the barriers and facilitators to accreditation in primary health care centers: a theoretically-informed systematic review. PROSPERO 2015:CRD42015014398 Available from http://www.crd.york.ac.uk/PROSPERO_REBRANDING/display_record.asp?ID=CRD42015014398

Review question(s)

To assess the impact of accreditation in primary health care centres on the quality of health care services particularly as perceived by professionals
To identify the barriers and facilitators of implementation in primary health care centres
To map these barriers and facilitators to the theoretical framework of Normalisation Process Theory

Searches

Searches were conducted in 5 electronic bibliographic databases: Scopus, MEDLINE, EMBASE, Cochrane Library, and Science Direct. The time frame of the searches was from 2003 onwards, to reflect the increasing focus on accreditation schemes from that period onwards. Searches were restricted to English language, partly because this is a PhD study with limited funding but also previous systematic reviews in this area have indicated that most of the published literature is from the US, Canada, Australia and Europe.

After scoping the most useful search terms, main key words included in the current research methodology were

"accreditation". and terms related to "Joint Commission on Accreditation of Healthcare Organizations", as previously cited by Greenfield and Braithwaite in 2008 in their systematic review on health sector accreditation. Both terms were used as keywords and as MESH terms.

These were joined with the search terms "health care quality/ or health care policy/ or health care planning/ or patient satisfaction/ or organization and management/ or primary health care/ or primary health care services/ or health care delivery/".

Types of study to be included

There will be no restriction on study design. Included: Systematic reviews; randomised controlled trials; other controlled interventions; service evaluations; case-control studies; case studies; questionnaire surveys; routine data analysis, qualitative research designs; mixed methods. Excluded: Editorials; opinion pieces.

Condition or domain being studied

This systematic review is focussed on the impacts of accreditation schemes on primary health care.

Participants/ population

The setting of the study is primary health care, including general/family practices and primary health care centres. The focus is on the impact of accreditation on professionals, so all professional groups working in such settings will be included; where appropriate, patient views will also be included. Papers discussing accreditation of hospital settings rather than primary health care will be excluded. Other exclusion terms will be papers about: the accreditation of health care professionals such as mid-wives and dental students and the accreditation of medical education programs which revolves around accreditation in an academic sector and not the medical sector.

Intervention(s), exposure(s)

This research will include papers that discuss the implementation of accreditation processes and the various accreditation systems. Articles on accreditation and patient satisfaction, accreditation and safety, accreditation and patient experience, will be included. The implementation of performance measures related to accreditation, and their impact on professionals and on patient care, will also be reviewed.

As described above (Participants/population), papers discussing accreditation of hospital settings rather than primary health care will be excluded. Other exclusion terms will be papers about: the accreditation of health care professionals such as mid-wives and dental students and the accreditation of medical education programs which revolves around accreditation in an academic sector and not the medical sector.

Comparator(s)/ control

Where available, papers which compare accredited and non-accredited primary health centres/practices will be included.

Context

All primary care settings, in high, middle and low income countries will be included. Studies set in the hospital sector will be excluded.

Outcome(s)

Primary outcomes

Barriers and facilitators to implementation.
Professional views.
Impact on professionals and on patient care.

Secondary outcomes

Advantages, and limitations and challenges of the implementation of accreditation in primary health care

Data extraction, (selection and coding)

Following searching, title and/or abstracts will be retrieved and uploaded into the bibliographic data management software DistillerSR. Titles and abstracts will be screened independently by two reviewers (LA-A and COD) to

identify studies that potentially meet the inclusion criteria. Discrepancies and disagreements will be reviewed and resolved by the two reviewers; if agreement cannot be reached, the third reviewer (GW) will be consulted.

Following this, full papers will be obtained and reviewed; any further papers not meeting the inclusion criteria will be excluded at this point. The final batch of papers will be reviewed and data extracted on citation; location of work; setting; professionals involved; duration of study; study design and data collection method(s); aims; key findings; and limitations.

The quality of each included study will be assessed using CASP-based checklists. Two reviewers will review each paper independently; discrepancies will be resolved through discussion, or by the third reviewer (if required).

Risk of bias (quality) assessment

Quality assessment will be carried out using CASP checklists. The quality questions will vary according to the study design being assessed. For example:

Systematic reviews will focus on the clarity of the search strategy; clear statement of inclusion and exclusion criteria; assessment of bias; description of data extraction; duplicate review; clarity of presentation of results.

RCTs will focus on: randomisation description; blinding; objective assessment of outcomes.

Qualitative research will focus on: clear statement of aims; appropriateness of methodology; recruitment strategy; description of data collection; description of analysis.

Other quantitative designs will focus on: identification of cases; representativeness of target population; response rate; clear reporting of respondents; clear description of analysis.

In each case studies will be scored against each criterion as follows: 2 = Good; 1 = Fair; 0 = Poor; to give a global score of Good quality; Fair quality; Poor quality.

No study will be excluded at this point on the basis of quality, but an assessment of study quality will be useful in order to inform our interpretation of the quality of the evidence used in the synthesis.

Strategy for data synthesis

Full text papers will be imported into NVIVO v10 for qualitative coding. A theoretically informed coding framework will be used to guide analysis. The theoretical framework to be used is Normalisation Process Theory (NPT: May et al Implementation Science 2009; 4: 29).

NPT will thus be applied to each of the papers in turn, with textual data within each paper coded to NPT. Following this, codes will be extracted across papers in order to compare and contrast the barriers and facilitators identified in relation to the implementation of accreditation in primary care.

Analysis of subgroups or subsets

NPT

Dissemination plans

Conference papers; journal articles; chapter in PhD thesis.

Contact details for further information

Dr Limya Al Aradi

drlamia@windowslive.com

Organisational affiliation of the review

University of Glasgow

<http://www.gla.ac.uk/>

Details of any existing review of the same topic by the same authors

none

Anticipated or actual start date

01 September 2014

Anticipated completion date

01 September 2015

Funding sources/sponsors

Kuwait Ministry of Health

Conflicts of interest

None known

Language

English

Country

Scotland

Subject index terms status

Subject indexing assigned by CRD

Subject index terms

Accreditation; Humans; Primary Health Care

Stage of review

Ongoing

Date of registration in PROSPERO

16 February 2015

Date of publication of this revision

19 February 2015

DOI

10.15124/CRD42015014398

Stage of review at time of this submission

Preliminary searches

Piloting of the study selection process

Formal screening of search results against eligibility criteria

Started

yes

yes

Yes

Completed

Yes

Yes

yes

287

Appendix D: Data extraction form

Data Extraction Form

Reference ID: _____

Authors: 1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Title: _____

Source: _____

Year: _____ Volume: _____ Issue: _____ Page _____ – _____
duration of the study:

Number of participants: _____

participants characteristics (age/sex): _____

Study Design: _____

Study location (city; country; setting): _____

Healthcare professional involved in the study:

- ☐ Nurses
- ☐ pharmacist
- ☐ physicians
- ☐ general practitioner
- ☐ healthcare managers

Aims of the study: _____

Summary of the main findings:

Citation: _____

Limitations : _____

Outcomes: _____

Appendix E: Checklist to assess the quality of included papers

The systematic review scoring sheet

Criteria	Yes	Can't tell	No
1. Were the inclusion and exclusion criteria clearly stated and reasonable? Score:			
2. Were all information sources and date last searched clearly described? Score:			
3. Was the full electronic search strategy presented for at least one database? (Score: If full search given = 2; List of key words and MESH terms = 1; short list of key word = 0.) Score:			
4. Was the process for selecting studies clearly stated? Score:			
5. Was there any measure to reduce selection bias? Score:			
6. Was the method of data extraction from reports well described? Score:			
7. Was the assessment of risk of bias of individual studies clearly stated and acceptable? Score:			

8. Were the results clearly presented?			
Score:			
Quality Score: /9			

Qualitative Research scoring sheet

Criteria	Yes	Can't tell	No
Was there a clear statement of the aims of the research? Score:			
Is a qualitative methodology appropriate? Score:			
Was the research design appropriate to address the aims of the research? Score:			
Was the recruitment strategy appropriate to the aims of the research? Score:			
Was the data collected in a way that addressed the research issue? Score:			
Have ethical issues been taken into consideration? Score:			
Was the data analysis sufficiently rigorous? Score:			
Is there a clear statement of findings? Score:			
Quality Score:			

Score scale: 2 Good, 1 fair, 0 poor

Descriptive studies scoring sheet

Criteria	Yes	Can't tell	No	N/A
Randomizes controlled trials				
Cohort				

Case-control				
Cross-sectional				
Survey				
Descriptive analysis				
Interrupted time series				
Other, specify				
Was the study described as randomized?				
If YES, was the method of randomization described? Score:				
Was the research question clearly stated? Score:				
Was the source of cases identified? Score:				
Are the individuals selected likely to be representative of the target population? Score:				
What percentage of selected individuals agreed to participate? Score:	100-80%	60-79%	<60%	
Were the numbers of individuals at each stage of study clearly reported and explained? Score:				
Was the duration of study clearly stated? Score:				
Was there any pilot phase, and changes made were clearly explained? Score:				
Were there any efforts to address potential sources of bias? Score:				
Was the analysis method described clearly? Score:				
Quality Score:				

PHC CentreCode:
 Questionnaire Serial:

A. QUALITY OF CARE

In this section, you will evaluate your center's involvement in the improvement of customers' quality of care. Read the following sentences and circle the appropriate answer (1= strongly disagree, 5= strongly agree). When you answer these questions you must think of your center at the present time and not how it was or how it will be.

Management and Leadership (<i>circle the appropriate number</i>)						
	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. The senior executives provide highly visible leadership in maintaining an environment that supports quality improvement.	1	2	3	4	5	9
2. The <i>top management</i> is a primary driving force behind quality improvement efforts.	1	2	3	4	5	9
3. The senior executives allocate available resources (e.g., finances, people, time, and equipment) to improving quality.	1	2	3	4	5	9
4. The senior executives consistently participate in activities to improve the quality of care and services.	1	2	3	4	5	9
5. The senior executives have articulated a clear vision for improving the quality of care and services.	1	2	3	4	5	9
6. The senior executives have demonstrated an ability to manage the changes (e.g., organizational, technological) needed to improve the quality of care and services.	1	2	3	4	5	9
7. The senior executives started to act on suggestions to improve the quality of care and services.	1	2	3	4	5	9
8. Based on the accreditation results, senior executives have a thorough understanding of how to improve the quality of care and services.	1	2	3	4	5	9
9. The senior executives generate confidence that efforts to improve quality will succeed.	1	2	3	4	5	9

Strategic Quality Planning						
	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
10. Staff members are given adequate time to plan for and test quality improvements.	1	2	3	4	5	9
11. Each department and work group within this center maintains specific goals to improve quality.	1	2	3	4	5	9
12. The center's quality improvement goals are known throughout your unit.	1	2	3	4	5	9
13. Staff members are involved in developing plans for improving quality.	1	2	3	4	5	9
14. Middle managers (e.g., Nurse Heads, Director of Nursing or Clinical specialist) play a key role in setting priorities for quality improvement.	1	2	3	4	5	9
15. Patients' expectations about quality play a key role in setting priorities for quality improvement.	1	2	3	4	5	9
16. Staff members play a key role in setting priorities for quality improvement through representation in the center's organizational chart	1	2	3	4	5	9

Human Resources Utilization						
	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
17. Staff members are given education and training in how to identify and act on quality improvement opportunities based on recommendations from accreditation surveys.	1	2	3	4	5	9
18. Staff members are given continuous education and training in methods that support quality improvement.	1	2	3	4	5	9
19. Staff members are given the needed education and training (through education programs) to improve job skills and performance.	1	2	3	4	5	9
20. Staff members are rewarded and recognized (e.g., financially and/or otherwise) for improving quality.	1	2	3	4	5	9
21. Inter-departmental cooperation to improve the quality of services is supported and encouraged.	1	2	3	4	5	9
22. The center has an effective system for staff members to make suggestions to management on how to improve quality.	1	2	3	4	5	9

Quality Management						
	Strongly disagree	disagree	Neither disagree nor agree	agree	Strongly agree	Don't know
23. The center regularly checks equipment and supplies to make sure they meet quality requirements.	1	2	3	4	5	9
24. The center has effective policies to support improving the quality of care and services (example: Five Rights Principle in Drug Administration).	1	2	3	4	5	9
25. The center tries to design quality into new services as they are being developed.	1	2	3	4	5	9
26. The services that the center provides are thoroughly tested for quality before they are implemented.	1	2	3	4	5	9
27. The center views quality assurance as a continuing search for ways to improve.	1	2	3	4	5	9
28. The center encourages staff members to keep records of quality problems through documentation.	1	2	3	4	5	9

Quality Results						
	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
29. Over the past year, the center has shown steady, measurable improvements in the quality of customer satisfaction.	1	2	3	4	5	9
30. Over the past year, the center has shown steady, measurable improvements in the quality of services provided by the administration (finance, human resources, etc.).	1	2	3	4	5	9
31. Over the past year, the center has shown steady, measurable improvements in the quality of care provided to patients (e.g. medical, surgical, obstetric and paediatric patients).	1	2	3	4	5	9
32. Over the past year, the center has shown steady, measurable improvements in the quality of services provided by clinical support departments such as laboratory, pharmacy, and radiology.	1	2	3	4	5	9
33. Over the past year, the center has maintained a high quality health services despite financial constraints.	1	2	3	4	5	9

Customer (Patient) Satisfaction						
	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
34. The center does a good job of assessing current patient needs and expectations.	1	2	3	4	5	9
35. The center does a good job of assessing future patient needs and expectations.	1	2	3	4	5	9
36. Staff members promptly resolve patient complaints.	1	2	3	4	5	9
37. Patients' complaints are studied to identify patterns and learn from them to prevent the same problems from recurring.	1	2	3	4	5	9
38. The center uses data from patients to improve services.	1	2	3	4	5	9
39. Data on patient satisfaction are widely communicated to staff members.	1	2	3	4	5	9
40. The center uses data on patient expectations and/or satisfaction when designing new services.	1	2	3	4	5	9

B. ACCREDITATION IMPACT

The goal of this section is to examine the impact of the accreditation in terms of bringing quality improvement practices to your center. For each of the following sentences, please circle the appropriate number.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. During the preparation for the last survey, important changes were implemented at the center.	1	2	3	4	5	9
2. You participated in the implementation of these changes.	1	2	3	4	5	9
3. You learned of the recommendations made to your center since the last survey (if it's the case).	1	2	3	4	5	9
4. These recommendations were an opportunity to implement important changes at the center.	1	2	3	4	5	9
5. You participated in the changes that resulted from accreditation recommendations.	1	2	3	4	5	9
6. Accreditation enables the improvement of patient care.	1	2	3	4	5	9
7. Accreditation enables the motivation of staff and encourages team work and collaboration	1	2	3	4	5	9
8. Accreditation enables the development of values shared by all professionals at the center.	1	2	3	4	5	9
9. Accreditation enables the center to better use its internal resources (e.g., finances, people, time, and equipment).	1	2	3	4	5	9
10. Accreditation enables the center to better respond to the populations needs.	1	2	3	4	5	9
11. Accreditation enables the center to better respond to its partners (other centers, diverse hospitals, private clinics, etc.)	1	2	3	4	5	9
12. Accreditation contributes to the development of collaboration with partners in the health care system.	1	2	3	4	5	9
13. Accreditation is a valuable tool for the center to implement changes.	1	2	3	4	5	9
14. The center's participation in accreditation enables it to be more responsive when changes are to be implemented.	1	2	3	4	5	9

C. LOOKING BACK AT THE ACCREDITATION PROCESS*

The following series of statements relate to your views about the accreditation process.
For each of the following sentences, please circle the appropriate number.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. I received sufficient training and support in order to fulfill my accreditation responsibilities.	1	2	3	4	5	9
2. There was sufficient leadership for the accreditation process.	1	2	3	4	5	9
3. The overall accreditation process was well managed.	1	2	3	4	5	9
4. Our team worked well together.	1	2	3	4	5	9
5. Everyone was encouraged to participate in the accreditation process.	1	2	3	4	5	9
6. Everyone had the opportunity to voice their opinions.	1	2	3	4	5	9
7. I felt part of an accreditation team.	1	2	3	4	5	9
8. Staff members took the agreed deadlines seriously.	1	2	3	4	5	9
9. I was fully committed to accreditation at all stages of the process.	1	2	3	4	5	9
10. Accreditation enhanced my relationships with my immediate work colleagues.	1	2	3	4	5	9
11. My work colleagues assisted and supported me in completing my accreditation tasks.	1	2	3	4	5	9
12. My line manager assisted and supported me in completing my accreditation tasks.	1	2	3	4	5	9
13. I got recognition from my work colleagues for my contribution to the accreditation process.	1	2	3	4	5	9
14. I got recognition from my line manager for my contribution to the accreditation process.	1	2	3	4	5	9
15. Involvement in the accreditation process has allowed me to reflect on my work practices.	1	2	3	4	5	9
16. Involvement in the accreditation process contributed to my personal development.	1	2	3	4	5	9
17. Involvement in the accreditation process contributed to my professional development.	1	2	3	4	5	9
18. Involvement in the accreditation process will contribute to my career advancement.	1	2	3	4	5	9

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
19. Accreditation has improved the level of multidisciplinary working in the center.	1	2	3	4	5	9
20. Accreditation has improved the standard and delivery of healthcare within my immediate <u>work environment</u> .	1	2	3	4	5	9
21. Accreditation has improved the standard and delivery of healthcare <u>within the center</u> .	1	2	3	4	5	9
22. Accreditation is a worthwhile process.	1	2	3	4	5	9
* Adapted from Milner et al. (2007)						

D. AWARENESS OF THE ACCREDITATION PROCESS*

The following series of statements relate to your views about the general level of awareness and commitment to the accreditation process. For each of the following sentences, please circle the appropriate number.

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. Staff members in the center are aware that the accreditation process is taking place.	1	2	3	4	5	9
2. Staff members in the center are aware of the aims and objectives of the accreditation process.	1	2	3	4	5	9
3. Staff members in the center believe that accreditation is a worthwhile process.	1	2	3	4	5	9
4. Patients are aware that the accreditation process is underway.	1	2	3	4	5	9
5. Other associated healthcare organizations in the region are aware that the accreditation process in the center is underway.	1	2	3	4	5	9
* Adapted from Milner et al. (2007)						

E. INFORMATION ABOUT YOURSELF

1. Gender

☐ Female

☐ Male

2. Age

☐ Below 30 years

☐ Between 30 and 45 years

☐ Between 46 and 55 years

☐ Over 55 years

3. How long have you worked for or been associated with this center?

/_____/ years /_____/ months

4. Is the center:

☐ For profit?

☐ Not for profit?

5. What is your work role (occupational category) at the center?

- a. Director of the center
- b. Nurse
- c. Physician
- d. Pharmacist
- e. Social Worker
- f. Unit assistant/Clerk/Secretary
- g. Technician (e.g. EKG, Lab, Radiology)
- h. Administration/Management
- i. Other, Please specify:_____

Please comment generally or specifically on the accreditation process, highlighting any activities that you feel are working particularly well and/or any changes that you would like to see made.

Thank you for your collaboration

Appendix G: Univariate Summary Statistics of the survey items

Scale	n	Mean	Standard Deviation	----- Minimum	----- 0.25	Quantiles Median	----- 0.75	----- Maximum
Management and Leadership								
1. The senior executives provide highly visible leadership in maintaining an environment that supports quality improvement.	375	4.12	0.69	1	4	4	5	5
2. The top management is a primary driving force behind quality improvement efforts.	364	4.01	0.85	1	4	4	5	5
3. The senior executives allocate available resources (e.g. finances, people, time, equipment) to improving quality.	358	3.89	0.89	1	4	4	4	5
4. The senior executives consistently participate in activities to improve the quality of care and services.	363	4.08	0.65	1	4	4	4	5
5. The senior executives have articulated a clear vision for improving the quality of care and services.	353	3.95	0.74	1	4	4	4	5
6. The senior executives have demonstrated an ability to manage the changes (e.g. organizational, technological) needed to improve the quality of care and services.	366	4.05	0.74	1	4	4	4	5
7. The senior executives started to act on suggestions to improve the quality of care and services.	365	3.96	0.76	1	4	4	4	5

8. Based on the accreditation results, senior executives have a thorough understanding of how to improve the quality of care and services.	358	4.13	0.67	2	4	4	5	5
9. The senior executives generate confidence that efforts to improve quality will succeed.	341	4.18	0.65	3	4	4	5	5
Strategic Quality Planning								
1. Staff members are given adequate time to plan for and test quality improvements.	368	3.75	0.87	1	3	4	4	5
2. Each department and work group within this center maintains specific goals to improve quality.	368	3.97	0.77	1	4	4	4	5
3. The centre's quality improvement goals are known throughout your unit.	364	3.88	0.84	2	3	4	4	5
4. Staff members are involved in developing plans for improving quality.	354	4.03	0.81	1	4	4	5	5
5. Middle managers (e.g. Nurse Heads, Director of Nursing, Clinical specialists) play a key role in setting priorities for quality improvement.	353	3.86	0.92	1	3	4	4	5
6. Patients' expectations about quality play a key role in setting priorities for quality improvement.	352	3.86	0.75	1	4	4	4	5
7. Staff members play a key role in setting priorities for quality improvement through representation in the	361	3.98	0.74	1	4	4	4	5

centre's organizational chart.

Quality Management

1. The centre regularly checks equipment and supplies to make sure they meet quality requirements.	372	3.87	0.9	1	4	4	4	5
2. The centre has effective policies to support improving the quality of care and services	358	3.96	0.86	1	4	4	4	5
3. The centre tries to design quality into new services as they are being developed.	359	3.96	0.73	1	4	4	4	5
4. The services that the centre provides are thoroughly tested for quality before they are implemented.	353	3.87	0.83	1	4	4	4	5
5. The centre views quality assurance as a continuing search for ways to improve.	365	3.98	0.75	1	4	4	4	5
6. The centre encourages staff members to keep records of quality problems through documentation.	363	3.97	0.85	1	4	4	4	5

Human Resources

Utilization

1. Staff members are given education and training in how to identify and act on quality improvement opportunities based on recommendations from accreditation surveys.	372	3.99	0.84	1	4	4	4.5	5
2. Staff members are given continuous education	371	4.03	0.8	1	4	4	5	5

and training in methods that support quality improvement.								
3. Staff members are given the needed education and training (through education programs) to improve job skills and performance.	367	4.11	0.79	1	4	4	5	5
4. Staff members are rewarded and recognized (e.g. financially and/or otherwise) for improving quality.	368	3.51	1.23	1	3	4	4	5
5. Inter-departmental cooperation to improve the quality of services is supported and encouraged.	365	3.8	0.94	1	3	4	4	5
6. The centre has an effective system for staff members to make suggestions to management on how to improve quality.	358	3.76	0.97	1	3	4	4	5
Quality Results								
1. Over the past year, the centre has shown steady, measurable improvements in the quality of customer satisfaction.	346	3.99	0.73	1	4	4	4	5
2. Over the past year, the centre has shown steady, measurable improvements in the quality of services provided by the administration (e.g. finance, human resources.	339	3.9	0.67	2	4	4	4	5
3. Over the past year, the centre has shown steady, measurable improvements in the quality of care provided to patients (e.g. medical,	329	4	0.7	2	4	4	4	5

surgical, obstetric, paediatric patients).

4. Over the past year, the centre has shown steady, measurable improvements in the quality of services provided by clinical support departments (e.g. laboratory, pharmacy, radiology).

335	4.05	0.69	2	4	4	4	5
-----	------	------	---	---	---	---	---

5. Over the past year, the centre has maintained a high quality health services despite financial constraints.

346	4.04	0.69	2	4	4	4	5
-----	------	------	---	---	---	---	---

Customer (Patient)

Satisfaction

1. The centre does a good job of assessing current patient needs and expectations.

355	4.1	0.73	1	4	4	5	5
-----	-----	------	---	---	---	---	---

2. The centre does a good job of assessing future patient needs and expectations.

344	4.07	0.7	1	4	4	5	5
-----	------	-----	---	---	---	---	---

3. Staff members promptly resolve patient complaints.

360	4.14	0.67	1	4	4	5	5
-----	------	------	---	---	---	---	---

4. Patients' complaints are studied to identify patterns and learn from them to prevent the same problems from recurring.

362	4.12	0.75	1	4	4	5	5
-----	------	------	---	---	---	---	---

5. The centre uses data from patients to improve services.

352	4.07	0.79	1	4	4	5	5
-----	------	------	---	---	---	---	---

6. Data on patient satisfaction are widely communicated to staff members.

350	4.01	0.84	1	4	4	5	5
-----	------	------	---	---	---	---	---

7. The centre uses data on patient expectations and/or satisfaction when designing new services.	339	3.94	0.84	1	4	4	4	5
Accreditation Impact								
1. During the preparation for the last survey, important changes were implemented at the centre.	337	3.98	0.72	1	4	4	4	5
2. You participated in the implementation of these changes.	362	3.85	0.86	1	4	4	4	5
3. You learned of the recommendations made to your centre since the last survey (if it's the case).	340	3.89	0.78	1	4	4	4	5
4. These recommendations were an opportunity to implement important changes at the centre.	352	4	0.7	1	4	4	4	5
5. You participated in the changes that resulted from accreditation recommendations.	352	3.94	0.76	1	4	4	4	5
6. Accreditation enables the improvement of patient care.	357	4.16	0.69	1	4	4	5	5
7. Accreditation enables the motivation of staff and encourages team work and collaboration	366	4.02	0.82	1	4	4	4	5
8. Accreditation enables the development of values shared by all professionals at the centre.	364	4.03	0.78	1	4	4	4	5
9. Accreditation enables the centre to better use its internal resources (e.g. finances, people, time, equipment).	336	3.95	0.79	1	4	4	4	5

10. Accreditation enables the centre to better respond to the populations needs.	352	4.07	0.7	1	4	4	4	5
11. Accreditation enables the centre to better respond to its partners (e.g. other centres, diverse hospitals, private clinics, etc.)	341	4.04	0.67	1	4	4	4	5
12. Accreditation contributes to the development of collaboration with partners in the health care system.	343	4.1	0.57	2	4	4	4	5
13. Accreditation is a valuable tool for the centre to implement changes.	357	4.14	0.57	1	4	4	4	5
14. The centre's participation in accreditation enables it to be more responsive when changes are to be implemented.	354	4.12	0.56	1	4	4	4	5
Staff Involvement in the Accreditation Process								
1. I received sufficient training and support in order to fulfil my accreditation responsibilities.	360	3.72	0.9	1	4	4	4	5
2. There was sufficient leadership for the accreditation process.	359	3.81	0.79	1	4	4	4	5
3. The overall accreditation process was well managed.	352	3.86	0.7	1	4	4	4	5
4. Our team worked well together.	357	4	0.69	1	4	4	4	5
5. Everyone was encouraged to participate in the accreditation process.	344	4.01	0.66	1	4	4	4	5
6. Everyone had the opportunity to voice their	349	3.85	0.87	1	4	4	4	5

opinions.

7. I felt part of an accreditation team.	348	3.85	0.75	1	4	4	4	5
8. Staff members took the agreed deadlines seriously.	345	3.96	0.77	1	4	4	4	5
9. I was fully committed to accreditation at all stages of the process.	353	3.9	0.77	2	4	4	4	5
10. Accreditation enhanced my relationships with my immediate work colleagues.	350	4	0.77	1	4	4	4	5
11. My work colleagues assisted and supported me in completing my accreditation tasks.	357	3.95	0.81	1	4	4	4	5
12. My line manager assisted and supported me in completing my accreditation tasks.	359	4.01	0.77	1	4	4	5	5
13. I got recognition from my work colleagues for my contribution to the accreditation process.	357	3.95	0.78	1	4	4	4	5
14. I got recognition from my line manager for my contribution to the accreditation process.	353	3.94	0.77	1	4	4	4	5
15. Involvement in the accreditation process has allowed me to reflect on my work practices.	359	3.96	0.71	1	4	4	4	5
16. Involvement in the accreditation process contributed to my personal development.	359	4.01	0.72	1	4	4	4	5
17. Involvement in the accreditation process contributed to my professional development.	369	4.08	0.66	1	4	4	4	5

18. Involvement in the accreditation process will contribute to my career advancement.	360	4.02	0.66	1	4	4	4	5
19. Accreditation has improved the level of multidisciplinary working in the centre.	348	4.07	0.68	1	4	4	4	5
20. Accreditation has improved the standard and delivery of healthcare within my immediate work environment.	359	4.06	0.64	1	4	4	4	5
21. Accreditation has improved the standard and delivery of healthcare within the centre.	350	4.07	0.62	1	4	4	4	5
22. Accreditation is a worthwhile process.	356	4.16	0.72	1	4	4	5	5
Awareness of the Accreditation Process								
1. Staff members in the centre are aware that the accreditation process is taking place.	346	4.08	0.65	1	4	4	4	5
2. Staff members in the centre are aware of the aims and objectives of the accreditation process.	348	3.98	0.69	1	4	4	4	5
3. Staff members in the centre believe that accreditation is a worthwhile process.	350	4.03	0.72	1	4	4	4	5
4. Patients are aware that the accreditation process is underway.	323	3.79	0.87	1	3	4	4	5
5. Other associated healthcare organizations in the region are aware that the	321	3.97	0.84	1	4	4	5	5

Appendix H : Interview's Schedule prompt

[Shake hands]My name is Limya Al Aradi. Currently, I'm a PhD candidate at Glasgow University. I'm very glad to make this interview with you , your participation will be confidential and codedI would like to ask you some questions about your personal opinion, your perception, some experiences you have had, and some of challenges you faced throughout the accreditation process. In order to learn more about health care professional attitudes and perception towards accreditation. Your participation is highly appreciated and I hope this interview will going smoothly. You have the right to stop me at any time and asking me any question come into your mind and you have the right to withdraw from the study at any time during the interview. The interview consists of 13 questions and might take about 30 - 40 minutes. Are you ready to start the interview right now?

1. What does accreditation mean to you?

- It means to:
 - Assess quality
 - Improve quality
 - Standardize primary health care
 - Improve patient/staff satisfaction
- It means to help centres meet international criteria of primary healthcare

2. What is your role in the accreditation process?

- Ensuring that the quality aspect of the accreditation is implemented and highlighted
- Ensuring that all accreditation criteria are met
- Training on accreditation standards and doing local surveys
- Ensuring that staff comply with accreditation standards
- Ensuring that patients are satisfied with changes brought about by accreditation

3. Is this process newly introduced to you or you have been exposed to it before?

- Yes, it is new
- No, it isn't new, I have been exposed to it previously, through:
 - Higher education studies
 - Working abroad
 - Studying abroad
 - Working within different accreditation mechanisms at hospital level
 - Previous readings (research, online articles, news...)

4. How did you engage your staff into the process?

- Engaging staff through:
 - Meetings, briefing sessions, town meetings, staff meetings, weekly accreditation briefs, assigning staff accreditation focal persons, involving staff in accreditation training and surveys, explaining the benefits of accreditation
- B- Was it easy or not to engage the staff? Challenges faced staff:
 - Staff resistance
 - Accreditation was a new and vague concept
 - Difficulty in communicating the importance of accreditation
 - Resistance more prevalent among older employees
 - Staff shortages
 - Heavy workload
 - Not able to ensure enough physicians and specialists
 - High turnover rate of staff
 - Physicians have limited time to assess medical history and complete medical record

5. What are the resources or funding did the higher authority provide to facilitate the process of accreditation and its implementation?

- Resources
 - Information, guidebooks, training, guidance, support, books, websites, brochures...
- Funding for:

Training, accreditation process, costs to recruit additional accreditation personnel, costs of necessary infrastructural work (redesigning the centre to meet criteria), accreditation costs...

6. In your opinion, did the accreditation process improve the quality of care delivered by PHC centres? If Yes..... (How)??

- Documentation
 - Recording minutes of meetings
 - Thoroughly completing medical records
 - Documenting rules and regulations
- Translation of theories of quality into actions
- Introduction and reinforcement of quality standards
 - Infection control
 - Occupational safety
 - Waste management
 - Fire management
 - Incident and accident reporting
- Enhanced employee awareness and involvement
 - Giving guidance to employees
 - Empowering employees and engaging them in decision making
 - Developing a job description for employees and clarifying their tasks
 - Better evaluation of employees
- Better relationship between the centres and the communities they serve
 - Role of social workers
 - Health awareness lectures and campaigns
 - Community needs assessment
 - Home visits
- Improved work conditions
 - Work flow became more organized and systematic
- Enhanced role of management and leadership
 - Forming interdisciplinary quality team
 - Strategic plans

Action plans

- Better relationship between the centres and patients

Follow-up on patients

Taking client suggestions, complaints and compliments into consideration

Enhanced patient confidentiality

- Better relationship between the centres and local authorities

Strengthened relationship with the Ministry of Health

Strengthened relationship with municipalities/ governorates/ other local authorities?

- To what extent do you think this improvement is sustainable?

- Very sustainable

- Somehow sustainable

- Not sustainable

- Sustainable depending on:

MOH strategic decision

Availability of funding

Sufficient/necessary provision of training

Staff compliance (nurses, doctors, allied health practitioners...)

Follow up from MOH

Follow up from accreditation Canada

Patient satisfaction results

Staff satisfaction results

7. Did the accreditation enhance your satisfaction as a health care professional? If Yes.....
(How) accreditation has affected your satisfaction?

- Staff training, education and development

Staff perceived accreditation as an opportunity to develop themselves

Staff perceived accreditation as an opportunity to help the society

Accreditation made staff more aware about their rights

- Enhanced communication between staff and the management

Engaging staff from the beginning of the process

Allowing staff to voice their opinions and concerns regarding accreditation

➤ Enhanced communication among staff

The importance of teamwork was emphasized

8. What aspects of your work have been affected by accreditation?

➤ Documentation

Recording minutes of meetings

Thoroughly completing medical records

Documenting rules and regulations

➤ communication and relationship with other colleagues

➤ learning new concepts

➤ better organize your tasks

➤ time management

➤ affect your way treating your patients which in turn positively affect patient satisfaction

9. Did accreditation enhance patient satisfaction? If yes

a) what aspects of patient satisfaction?

➤ Increased patient satisfaction

- Increased satisfaction with the setting/ sanitation/ quality of services
- Increased patient trust in the centre
- Enhanced relationship between patients and the medical team
Physicians' compliance to appointments.

b) To what extent do you think the accreditation process has affected patient satisfaction in the PHC?

➤ Highly affected patient satisfaction

➤ moderately

➤ mildly

10. List the top three barriers/challenges that you have faced throughout the accreditation process and mention some of the approaches to overcome those challenges

- Financial barriers
- Staff resistance
 - Accreditation was a new and vague concept
 - Difficulty in communicating the importance of accreditation
 - Resistance more prevalent among older employees
- Staff shortages
 - Heavy workload
 - Not able to ensure enough physicians and specialists
 - High turnover rate of staff
 - Physicians have limited time to assess medical history and complete medical record
- Not all the standards are applicable to the context of all PHC centres in Kuwait
- Referral system among centres and to hospitals is lacking

11. What are, in your opinion, some strategies to better implement accreditation in the future?

- Financial support
 - From Ministry of Health and international agencies
- Follow-up meetings and communication and collaboration with the MOH, the accreditation team, and among PHC centres, and hospitals
- Local experts are recommended to perform assessment
- Practical training sessions and continuing education
- Engaging municipalities or local authorities to gain their support

12. From your perspective, what are the benefits of accreditation process on PHC?
(prompts may be same as that of question #6)

13. Do you think accreditation on primary healthcare (PHC) system could lead to a more efficient health system? If yes how?

- By increasing quality.
- By decreasing costs and increasing efficiency on the long run

Appendix I: Prompt Technique

The technique used by the researcher was prompting. Prompting poses many advantages during the interview process. They are as important as the questions themselves in semi-structured interviews. Prompts do two things: they keep people talking and they rescue interviewer when responses are slippery. Probably the most instinctive type of prompt is an informal prompt. This is an unscripted prompt that may be nothing more than nodding, reassuring noises and interjections that people make during any conversation to show that they are listening and interested: "Uh-huh." "Yes." "How interesting." Floating prompts, for example, are used to clarify. These may be nothing more than raising an eyebrow and cocking one's head, or they may be specific questions: "How?" "Why?" and "And then...?" One way to ask for clarification and at the same time build rapport is to repeat the key term of the respondent's last remark as a question.

As a qualitative researcher conducting interviews, should both trust the instincts and be ready for surprises. Creating probes or prompts for each question helps keep the researcher on track. Prompts also help to remind the researcher of the questions while at the same time allowing for unexpected data to emerge. To use prompts effectively, the researcher must first design a broad question that might take an interviewee in several different directions. Directly under this question, the researcher should design bullet points that remind him/her of areas that have emerged from the literature which might enrich the data. In essence, the researcher asked the general question, let the interviewee talk in any direction, and then used prompts to get at pre-planned specifics they did not mention. The researcher used prompting and probing at many points during the interview process. For example when asking subjects about the challenges faced during the accreditation process, the researcher was able to identify broad themes: such as staff resistance, policies and procedures, manpower and turnover. Pinpointing those themes and having them repeated guided the coding process.

Another helpful tool used in the interviews was the audiotape to record the interview. Audio tapes are widely used in interviews for the many advantages

Appendix J: Interviews coding sheet (Theme 1)

Code	Theme 1 : Accreditation Meaning			
	Accreditation definition	Quality and safety	Standards	Quality Improvement
A1	<ul style="list-style-type: none"> Accreditation is a set of standards. Accreditation would push behaviours, influence the behaviours of healthcare workers and staff. It is a subjective tool rather than objective 	<ul style="list-style-type: none"> So if the national programme aims to improve a certain area on patient safety or in the communication between staff, accreditation can be the good choice for this. R: Yes definitely it's a tool for changing and system improvement in all aspects such as patient safety, quality of health care services 	<ul style="list-style-type: none"> Used to assess the organization improvement against certain standards. This in turn will enhance the organization reputation. 	<ul style="list-style-type: none"> it is a tool for managing and influencing change among healthcare workers. I: Do you think accreditation is a tool of improvement or not ? R: Yes definitely it's a tool for changing and system improvement in all aspects such as patient safety, quality of health care services, patient satisfaction, employees satisfaction and personal satisfaction
A2	<ul style="list-style-type: none"> It means a tool for measurement, as simple as that. 		<ul style="list-style-type: none"> I: Do you think that accreditation might help the centres to meet the international criteria or to reach the international level of quality services? R: By time yes, it needs time to reach to the international level 	<ul style="list-style-type: none"> I: Do you think that accreditation might improve the primary health care sector or the health care in general or not? R: Yes, yes it will. I am a believer.
A3	<ul style="list-style-type: none"> Actually, it was started in primary care in 2012, so it is a recent programme initiated in primary health care. 	<ul style="list-style-type: none"> It's the measurement tool for quality and safety, so it's a tool to initiate the culture of safety and quality 		<ul style="list-style-type: none"> I: Do you think accreditation might be used to prove the patient or the staff satisfaction or not? R: Well, at this time we cannot say so, but maybe in the future it will raise the satisfaction rate of the patient because till now we don't have the objective instrument to measure the patient satisfaction in relation to accreditation and its implementation . We don't have such instrument that measure the satisfaction rate for the accreditation programme
A4	<ul style="list-style-type: none"> I believe accreditation is everything. It is a process of review that health care 			<ul style="list-style-type: none"> I: Do you think that accreditation might be used to improve patient and staff satisfaction or you don't think so?

	<p>organizations participate in to demonstrate the ability to meet predetermined criteria and standards. To provide best services.</p> <ul style="list-style-type: none"> • I: Do you think accreditation might be used as a tool to standardise the primary health care or you don't think so? • R: Yes Of course. With accreditation we are following a standardized policies and procedures and by following these policies and procedures all of the care services is standardised, so when you go to X Clinic you will find services and procedures very similar to Y clinic. So yes I believe so. 			R:I totally believe in this, yes.
A5	<ul style="list-style-type: none"> • A tool to ensure a consistent level of healthcare and health service quality across all services provided under the programme, in the nation and in the territory under which the accreditation programme works. 			<ul style="list-style-type: none"> • Accreditation is one of the tool to improve quality
A6	<ul style="list-style-type: none"> • As you know the accreditation process is relying on the process of surveys so it is a continuous process. From now and then there would be continuous assessment for the performance of the hospitals and PHCC . There's a group of 			<ul style="list-style-type: none"> • Accreditation is the most well defined tool to improvement to use ever in the Ministry of Health. So I think it's going to be the most effective quality improvement tool than the formal tools that was used by the Ministry before like the other quality programmes and improvement plans. And so, it is predicted to be the most effective and efficient quality improvement tool.

	<p>professional surveyors who are doing this. So all scores are valid and reliable. So by doing this continuous evaluation you can compare the results and you can check the trend of performance every cycle. Accordingly you can do your corrective measures.</p>			
B1	<ul style="list-style-type: none"> • Accreditation meant that I would be going in an evaluation process and I have to do my best at this process, accreditation means to me that all parts of the clinics will be inspected, will be checked and everything should be the right way. I have to do everything the right way. 	<ul style="list-style-type: none"> • A tool improving the quality of work in my centre. It was a big job that we had done at that time and it meant a lot for us and my team in the clinic. 		<ul style="list-style-type: none"> • I: So do you mean that accreditation is a tool for improvement? • R: Certainly, for me it was a tool for improving, a tool also for training my staff, improving their work,
B2	<ul style="list-style-type: none"> • Accreditation, it's the process of review of the health care organisation. 	<ul style="list-style-type: none"> • To measure the quality of services 	<ul style="list-style-type: none"> • It is a tool to apply the standards. • I: does accreditation help the centres to meet the international criteria? • R: Not all of the standards, some of the standards, yes, but the others it wasn't applicable at the time to my centre. 	
B3	<ul style="list-style-type: none"> • accreditation is a top permit of the quality given from the services and health centres. 		<ul style="list-style-type: none"> • it is a tool to apply all the standards and indicators that should be done . 	<ul style="list-style-type: none"> • A tool to improve the requirements of the primary health centres. • I: do you think that accreditation might improve the patient and staff satisfaction? • Yes of course
C1	<ul style="list-style-type: none"> • Accreditation is doing the 		<ul style="list-style-type: none"> • To compare the work to a 	<ul style="list-style-type: none"> • I: So do you think accreditation can be used as

	things right in the right way, in the right time, in the right place. So accreditation means doing the right things in the right way at the right time .		standard where things have been done in the right way and trying to have this based on international criteria and evidence based, I compare myself to international organization and try to achieve the same level.	improving tool for the quality of services or not? • R: Definitely, definitely this is to improve the quality of the service.
C2	<ul style="list-style-type: none"> Accreditation is a process of review that health care organisations they participate in. 		<ul style="list-style-type: none"> Demonstrate HCO ability to meet the international criteria and part of it a pre-determined criteria and standards that is usually established by a professional accreditation agency. 	<ul style="list-style-type: none"> Do you think accreditation can be or can't be used as an improvement tool? Yes of course I: And do you think it can/can't improve the quality of services? R: Yes, for sure, it improves the services.
C3	<ul style="list-style-type: none"> Accreditation is a process of validation in which institutions are evaluated. 		<ul style="list-style-type: none"> The standards for accreditation are set by a peer review board. and a tool to normalise the Primary Health Care services. R: It means to help centres meet international criteria of Primary Health Care. 	<ul style="list-style-type: none"> It is a tool to improve the quality.
D1	<ul style="list-style-type: none"> Accreditation means a good system for organising things and making it more standardised between different clinics in the same place, also it's a way to make sure things are done properly and in order. It's a method for making sure that everything goes as smooth 			<ul style="list-style-type: none"> R: Once you have things in order, as an example as guidelines or policies or ways to do things in step so everybody would know how to react in each different situation and make sure that all the people would do it the same way, this would help minimise the problems, eliminate errors, especially human errors, things are done subjectively by people, these should all be eliminated if it's done systematically.

	as possible to minimise the problems that people would acquire either as an employee or as a patient or a visitor.			
D2	<ul style="list-style-type: none"> • Accreditation sets out a very lovely concept. I wish it could be more relatable. I wish it could be more effective but I think we are on the process of going there. • I believe accreditation is everything. It changed my whole perception. It changed the way I interact with people. It changed the way I manage things. I mean, my whole perception was different. Now even like when I go out to another hospital or to another place where there is like a service is provided I always looks with the eyes of the surveyor, is there a fire plan? Is there an exit? Is the exit very obvious? is there a map all over it? • I: Do you think that accreditation might be used as a tool to standardise the primary health care or you don't think so? • R: Of course and we've seen it. • Now we know that we have to follow policies and procedures and by following them all the care services will be standardised 		<ul style="list-style-type: none"> • So the perception of accreditation and the standards and all of these things is very important and I think it means everything actually • Before the accreditation standards were introduced to us, we were living in a chaos. • every health centre was having its own standards, its own laws, its own way of managing patients but with the accreditation and when we were introduced to the standards everything was different. . 	<ul style="list-style-type: none"> • I: Do you think accreditation might be used to improve patient and staff satisfaction or you don't think so? • R: I totally believe in this, yes, and again I've seen it. you can see it with the patient satisfaction surveys. You can see it when we approach the patient they are happier than before . They are getting their investigations on time. Doctors are more satisfied. There are certain rules helped both patients and staff. so yes I think it's improving highly.

D3	<ul style="list-style-type: none"> accreditation was a new concept to me and to the system. I found it very helpful and fruitful and very important to be considered. It is not only on our medical services, it's everywhere in life. <p>Accreditation – economic, accreditation in politics maybe, accreditation in so many aspects of life so yes it's very important.</p>			
D4	<ul style="list-style-type: none"> Accreditation, it's quite a complex term, okay for me as a surveyor and for me as a health care provider. 	<ul style="list-style-type: none"> It also means team work because without team work nothing can be achieved. It also means quality. It gives me an indicator of where I am and where should I reach. 		<ul style="list-style-type: none"> It could mean that there is a process of change from stage to stage that is of course a positive change or improvement.
D5	<ul style="list-style-type: none"> I: Do you think accreditation might be used as a tool to standardise the Primary Healthcare? R: Yes by using policy and procedure we can standardise all our procedures that happen in Primary Healthcare Centres. 	<ul style="list-style-type: none"> Effective tool to have an effective system and minimise the risk of having improper processes and safety. I: Do you think accreditation might enhance the safety? R: Yes, it surely will enhance the safety of staff and patients. 		<ul style="list-style-type: none"> I think accreditation is an effective tool to improve quality of the services in Primary Healthcare Centres
D6	<ul style="list-style-type: none"> It's a valuable tool to improve the quality of the health care system. it's like a guidance, like a leader. in all aspects 		<ul style="list-style-type: none"> It has very clear standards which help to decrease the gap between reality and what international standards require. 	<ul style="list-style-type: none"> I think it's the only way for improvement here in reality in Kuwait. it's not only a good tool, it's a valuable and a very important tool, since, accreditation, guides us, step by step, So, it's really a valuable tool, a valuable guiding tool for us.

Systematic Review (Chapter 6)

Data extraction and analysis of papers identified in the systematic review used NPT. This provided a more nuanced understanding of the impact, facilitators and barriers to the implementation of accreditation. Most of the attention of the international literature was on the work required to implement accreditation and monitor its impact, using either formally collected data or informal, reflective methods. However, much of this focused on process indicators, not outcomes. There was, however, less consideration of the issues of understanding and sense-making or of engaging people in the process of accreditation.

Models of care varied from small general practices in the UK to large PCOs, for example in Australia. However, despite this heterogeneity in the model of primary care, there were common lessons.

Understanding and sense-making work (Coherence):

- While the healthcare professionals understood accreditation is as a concept, they did not have a clear understanding about its aims or impacts. This led to different definitions and approaches.
- Those directly involved in the process of accreditation often had a better understanding of the aims and objectives of accreditation, but did not always distribute this knowledge to all the employees. While the aims of accreditation might be encompassed within the organizations' visions and policy, employees were not properly informed of this.
- There was confusion and a lack of understanding amongst individuals about their roles and responsibilities, leading to multiple views of what accreditation was. Accreditation could be confused with certification and with inspection.
- Taking part in accreditation did increase one's understanding of what it was – both collectively as an organisation and at the individual level. This is important as, to date, there was little in the literature to help us understand what individuals know and think about accreditation.

- There was little in the literature on what individuals or organisations thought were the benefits of accreditation. This meant participants might see accreditation as merely ‘box-ticking’ or a similar process to certification or inspection.

Engagement and participation (Cognitive Participation):

- Employee engagement and participation in the implementation of accreditation helped break down professional barriers, created a sense of teamwork across groups and organizations, and increased awareness of quality issues such as patient safety.
- While employee engagement fostered the implementation of the accreditation process, sustaining accreditation activities helped maintain such relationships within the organisational culture.
- A key facilitator was the presence of a champion or a key figure who would coordinate the process and drive it forward, be it a manager or a healthcare professional.
- Credible leaders took time to explain the ethos of accreditation, created a sense of ownership, and distributed responsibilities across.
- Ensuring staff and leaders ‘bought into’ accreditation was important.
- Accreditation needed to involve all stakeholder groups in order for it to be seen as credible and to become part of routine practice. This meant involving clinical, technical/laboratory and administrative staff.
- Employee participation and engagement created a sense of ownership towards the process.
- Many papers focused on getting the ‘right’ professionals involved, both at individual and group level. It was important to involve all key professional groups including GPs/family doctors. Involving all relevant practitioners was a major challenge for accreditation.

- **Work involved in implementing accreditation (Collective Action):**

- Key activities in accreditation included choosing facilitators, distributing tasks amongst staff, assigning credible leaders that champion continuous quality improvement, and explaining the ethos behind the accreditation process.
- Accreditation activities had to fit with current activities and not get in the way of doing the ‘day job’, for example incorporating the standards into routine work should not make that work harder.

- Accreditation processes mustn't decrease GPs sense of control and autonomy. It was important that accreditation shouldn't shift the focus from clinical care to wider issues of quality and safety.
- Those being assessed must also have confidence and trust in the assessors. The literature suggested mixed views on whether professionals 'trusted' the accreditation process or not.
- A key issue is that the goals of accreditation must align with national and organisational goals and policies and there must be sufficient resources, in terms of training, staff and finance.
- A key facilitator was the presence of legal requirements or policies that supported accreditation.

Monitoring and appraisal of accreditation (Reflexive monitoring):

- Changes identified as a result of accreditation, for example implementation of standards and criteria, need to be acted upon. Several papers focused on the use of external audits and assessors as tool for revisiting standards and monitoring the impact of changes to systems.
- Participants must be able to see the impact of accreditation – this means ensuring that there are data on not only process, but outcomes. However, to date, outcome data is collected less often.
- Those taking part also need to receive feedback on their progress. Informal monitoring, such as how practitioners feel about the process is also important. However, to date there is little or no data collected on the impact on patients.
- Lack of data made it difficult for individuals and organisations to judge the impact of accreditation. This was particularly true in relation to cost effectiveness of accreditation and impact on patient satisfaction.

Quantitative survey of healthcare professionals (Chapter 8)

- Overall, respondents were generally positive about the impact of accreditation on the areas tested in the questionnaire.

- The area of highest agreement in the accredited centres, as perceived by the healthcare professionals, were in the Management and Leadership scale. This was a predictor strongly associated with successful accreditation. The environment for quality improvement and leadership were seen as key drivers for accreditation.
- Managers were viewed as being visible, but about one-fifth of respondents felt managers didn't allocate enough resources (in terms of finances, people, time or equipment) and didn't articulate a clear vision for improving quality of care and services.
- While most respondents indicated that they were involved in developing plans for improving quality, 25% of respondents felt staff were not given enough time to plan for and test quality improvements.
- Over 25% felt that the centre's quality improvement goals were not known in their unit.
- Around one-fifth felt that groups and departments didn't maintain specific goals to improve quality and that middle managers didn't have a key role in setting priorities for QI.
- The majority of respondents agreed that staff members were given the education and training needed to improve skills and performance and to support quality improvement.
- Over one-third of respondents felt that staff members were not rewarded and recognised (financially or otherwise) for improving quality.
- One-quarter felt there was not an effective system in the centre for staff to make suggestions to management about how to improve quality.
- 24% felt that inter-departmental co-operation to improve service quality was not supported or encouraged.
- Respondents agreed that their centre had shown steady improvements in the quality of services delivered to patients, in support services and in administrative services.
- However, 22% did not feel that the services provided by the centres were thoroughly tested for quality before they were implemented.
- Respondents felt their centres used data to assess current patient needs and expectations, used data from complaints to learn lessons and prevent such problems from recurring.
- Most (over 80%) agreed that accreditation had had a good impact on their PHCC.
- The majority felt that they had participated in the implementation of change.
- Accreditation was viewed as a valuable tool to support the implementation of change and made the centres more responsive to change. Most also felt that accreditation

supported the development of shared values amongst staff, encouraged team work and collaboration and improved patient care.

- Just over 20% did not agree that they received sufficient training and support to fulfil their accreditation responsibilities; that there was sufficient leadership; or they felt part of an accreditation team.
- One-fifth did not agree that line manager or work colleagues had supported them in completing accreditation tasks or that work colleagues recognised their contribution to accreditation.
- 28% felt that patients were not aware of the accreditation process underway in their centre.
- Almost one-fifth (19%) felt that other health care organisations in the region were unaware that an accreditation process was underway in the centre.
- At an organisational level, accreditation was viewed by the majority as improving multidisciplinary working in the centres, and improving the standard of care both within departments and across the centre.
- The results showed that accreditation incurred positive impacts on several areas of quality and performance
- The areas of highest improvement in accredited centres as perceived by healthcare professionals fall under management and leadership, patient satisfaction, and quality results.
- Patient satisfaction also recorded one of the highest means scores in this study indicating that professionals in accredited PHC perceive their centres to make their patients more satisfied with their service.

Qualitative interviews with stakeholders (Chapter 9)

Accreditation meaning.

- There were a variety of views in relation to what accreditation meant – this was partly due to the location in which a stakeholder worked.

- Those with a strategic overview (e.g. at MOH) were better able to articulate the aims and objectives of accreditation in Kuwaiti primary care than those working in the PHCCs or the surveyors.
- Heads of the early adopting PHCCs (who had completed the pilot phase) had a clearer understanding of what accreditation was about than those in the late adopting PHCCs.
- Most saw accreditation as an important part of quality improvement. However, while some described it as a tool for quality improvement, others saw it as an on-going process.
- Some viewed accreditation as certification or inspection; others viewed it as a punitive measure rather than as a quality improvement process.
- Accreditation was seen as an important part of quality and safety, although again some viewed accreditation as a safety tool, while others considered it a safety process.
- For many, accreditation had an important role to play in standardising the delivery of primary care across PHCCs in Kuwait.
- Overall, there was a clear sense of individuals' having their own working definition of accreditation, but there was less evidence of a coherent organisational view, particularly in the PHCCs.

Engaging in the implementation of accreditation

- There were a number of roles identified, depending on the stakeholder interviewed.
 - Strategic roles, overseeing the process of accreditation, were a feature of MOH Heads of Directorates.
 - Operational roles, focused on managing the process, supervising and co-ordinating fell to MOH facilitators and, in particular, to the Heads of the PHCCs.
 - Heads of the PHCCs were key in engaging centre staff to participate in the implementation of accreditation. A perceived lack of engagement by the Centre Head made it harder to engage and motivate other staff.
-
- Ensuring that staff understood the aims and objectives of the accreditation process helped to ensure their engagement with it.
 - The more staff engaged in the work of accreditation, the more confident they became about the aim and objectives of the accreditation process.

- The heads of early adopter PHCCs expressed a more leadership-oriented role in the accreditation programme compared to those in the late adopting centres; they described their role as ‘leading and organising’.
- Heads of the late adopting PHCCs spent more time engaging the ‘hearts and minds’ of their staff, whereas those in early adopting centres had now moved on to task-oriented activities, delegating tasks and supervising teams.
- Good communication and regular meetings facilitated the development of teamwork,
- Teamwork had to involve all staff groups, including clinical, technical/laboratory and administrative.
- MOH surveyors were the closest to the on-the-ground assessment teams in the PHCCs, training and supporting staff.
- Surveyors had a very ‘hands-on’ role with the staff in PHCCs, offering training, writing standards and policies, and generally being the main point of contact.
- Surveyors were often the key link between the centres and the Ministry staff.
- There was little evidence of patient involvement in the implementation of accreditation.

Work involved in delivering accreditation.

- Communication across staff in the PHCCs was key – this involved formal methods such as meetings, but also relied on informal methods, using social media platforms such as WhatsApp.
- Training was another vital activity, acknowledged by MOH facilitators and PHCC Heads.
- The development of documents, policies and standards was also an important area of activity for each centre.
- Good teamwork was essential for the implementation of accreditation, and had to involve all staff groups including clinical, technical and administrative staff. Regular meetings helped to facilitate the development of a team ethos.

Facilitators for implementation

- Resources, in particular good documentation, and training were considered important facilitators.
- Financial resources were widely regarded as crucial.
- Central support, from the Ministry and in particular the Quality and Accreditation Directorate, was also an important facilitator.

Challenges to implementation

- Staff resistance was considered a particular challenge, although stakeholders discussed this in different ways. For some it was older staff who were resistant to change, exacerbated by an unwillingness to learn new tasks and resistance to using IT. For others, it was younger staff and a perception that they would only work for incentives.
- Shortages of staff and staff turnover was another key challenge. In particular, there was view that staff were trained, then moved on.
- This constant turnover meant that new staff were constantly having to be trained to take on accreditation activities.
- Heavy workloads for staff was another area that was recognised as a challenge.
- Accreditation activities were, for many staff, an ‘add-on’ activity, conducted on top of their routine job.
- Some saw a lack of policies and procedures – both at a national and local level – as a barrier.
- A lack of leadership and direction was an issues for stakeholders at all levels. Each level of staff suggested that the process would be enhanced by clearer support and leadership from higher up the hierarchy (e.g. surveyors about PHCC Heads and the MOH); PHCC Heads about the MOH; MOH about higher levels of government.
- A lack of resources – both financial and in terms of personnel – was a recurrent issue.
- Financial support was a major barrier, affecting different aspects of the accreditation programme, including staffing issues, information dissemination, and training.

Impact of accreditation

- Accreditation was seen to improve the quality of services delivered, in particular through standardising delivery of services, improving the local healthcare culture and improving teamwork and collaboration across the PHCCs.

- Working practices improved, in particular through improvements in the delivery of care such as better appointment systems, better systems of referral and the implementation of triage systems.
- There was anecdotal evidence that patient satisfaction had increased, although no centres provided data to support this (although some had conducted patient satisfaction surveys).
- Staff satisfaction was also thought to have improved.
- There was a clear impact on many of the stakeholders in terms of personal development; this included through training and personal pride in being involved in such a programme.

Sustainability

- Financial support was seen as essential to ensure sustainability of the accreditation programme.
- Sustainability of accreditation, in terms of dealing with recommendations from the pilot phase, also required financial support from the Ministry e.g. to meet requirements to improve buildings and infrastructure.
- On-going training programmes were also felt to be important.
- Some stakeholders raised the need for good quality data to monitor impact and sustainability, including better data collection and IT systems.
- The MOH and, to a lesser extent, ACI were seen to have an important role to play in on-going support and sustainability. However, a number of respondents felt that the MOH had to take ownership of the programme for itself and decrease its reliance on ACI.

Future developments

- Additional support from the MOH and from Government was suggested by a number of respondents; this support included increased financial support and manpower.
- On-going training and support was also suggested.
- Data gathering, including to assess the cost-effectiveness of accreditation, was considered necessary for the future development of accreditation; this also required improved IT systems to gather data.



University of Glasgow | College of Medical,
Veterinary & Life Sciences

23 March 2015

Professor Kate O'Donnell

General Practice & Primary Care

College of Medical, Veterinary & Life Sciences University of Glasgow

1 Horselethill Road

Glasgow G12 9LX

Dear Professor O'Donnell

MVLS College Ethics Committee

Project Title: An Assessment of the Impact of Accreditation from the Perception of Professionals' in Primary Healthcare Centres: A Case Study from Kuwait

Thank you for submitting to the MVLS College Ethics Committee a copy of the ethics approval letter issued by the Kuwaiti Ministry of Health, for the above project.

We will retain a copy of this letter in our files, together with the full set of application documents you supplied relating to the project. The MVLS Ethics Committee is satisfied that these documents are in order and comply fully with the ethical procedures of the University of Glasgow. Accordingly, you and your co-applicants at the University of Glasgow require no further ethical clearance to proceed. This permission is subject to the conditions detailed below:

- Project end date: 31 December 2016.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research:
(http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.

Yours sincerely

Professor William Martin

College Ethics Officer

Professor William Martin

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**Ministry of Health
The Standing Committee for
Coordination of Health and Medical Research**

البيانات الرئيسية لمشروع بحث للعرض على اللجنة

تاريخ تقديم الطلب: 27/ 01/ 2015

لسنة: 2015

رقم البحث:

باحثون مشاركون:	Name of the researcher idarA IA aimal :Dr. فاكس: +96597754001 هاتف نقال: Telephone
مدة مشروع البحث duration of the research: 2013-2016	Location of the research : القسم / الإدارة / المستشفى / المنطقة <u>The Capital Health Region:</u> Al Saqer specialized health care centre and Al Yarmouk health care centre <u>The Hawally Health Region:</u> Al Salam health care centre and Al Shuhada health care centre <u>Al Ahmadi Health Region:</u> Al Qurain specialized health care centre and Al Qurain health care centre for Family Medicine

Research Title: عنوان البحث المقترح/ An Assessment of the Impact of Accreditation from the Perception of Professionals' in Primary Healthcare Centres: A Case Study from Kuwait

Objectives: أهداف البحث This study aims at assessing the perception of the staff of the primary health care centres concerning the accreditation results and the accreditation process by: 1- Evaluating the centre's involvement in the improvement of customer's quality of care 2- Examining the impact of accreditation at the level of implementation of the improvement practices in the centre 3- Studying the views of the staff about the accreditation process 4- Assessing the views of the staff concerning the general level of awareness and commitment to the accreditation process
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Research plan/protocol:(1) ملخص خطوات البحث This study is a cross-sectional study, which uses a multi-site study design with embedded case studies and mixed methods approach to data collection for the purpose of fully exploring and understanding the impact of PHC accreditation on professionals' attitude. The study therefore will involve the use of three different approaches, which are; systematic review of the literature, quantitative assessment, and qualitative comparative assessment
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Expected Outcome النتائج المتوقعة It is expected that the results of this study will show that accreditation does have a positive impact on all the scales used, namely: Management and Leadership, Human Resource Utilization, Strategic Quality Planning, Quality Management, Quality Results, and Customer Satisfaction. This positive impact may vary from one primary healthcare centre to another, and may be revealed at different rates from one quality indicator to another. Furthermore, in analyzing data comparing the qualitative views of early adopters versus late adopters, it may be evident that early adopters, or those who have been involved in the accreditation process for a longer period of time than their late adopter counterparts, may have a more elaborate perspective on the impacts of accreditation on the quality of care provided by their centres. Finally, it is expected that the qualitative semi-structured interviews result in a list of accreditation benefits, as well as challenges that may be used to address accreditation issues at later stages.

Informed Consent : (2) إقرار الموافقة على المشاركة بالبحث (يرجى إرفاق نسخة من الإقرار باللغة العربية والإنجليزية)
Kindly, find the informed consents for both the interviews (qualitative) and the questionnaires (quantitative) attached to this document.

ethical considerations : إجراءات حقوق المرضى لضمان سرية المعلومات والخصوصية

Following the basic ethical principles, as per the Belmont Report (1979), the researcher will ensure respect for persons by giving them the **freedom to participate** in the study or decline to do so, by administering an **informed consent** that clearly states the purpose of the study and the right for an individual to decide whether or not he or she would want to take a part in it. The respondents' confidentiality will also be carefully maintained, by using **serial number instead of respondent names**. Similarly, the confidentiality of the primary healthcare centres will be kept by using **codes for each primary healthcare centre, in lieu of using their actual names**.

Confidentiality will be further enhanced by **keeping all relevant research material (interview recordings, filled questionnaires...) under lock** and available only to the research team members, throughout the process of data analysis. Finally, it is essential to mention that **the information gained through this study, will not, in any way, be used against any party involved in this study**, rather it will only be used to develop a better understanding of accreditation and its impacts at primary healthcare level.

Main funder : جهة التمويل الخارجية Kuwaiti Ministry of Health		The cost of the research : الميزانية التقديرية	
assigned personnel for approval الموافقة على تقديم البحث			
director of the directorate : مدير المستشفى/ الادارة Dr. Buthaina Al Modaf	head of the department : رئيس القسم Dr. Ghofran Okasha		main researcher : الباحث الرئيسي Dr. Limya Alaradi

ملاحظات

يتم استلام هذا النموذج من قسم البحوث بإدارة التخطيط والمتابعة، ويقوم الباحث المتقدم بعد استيفاء البيانات بالنموذج وإرفاق الوثائق المذكورة أعلاه بأرقام (1)، (2) بتسليمهم للسيدة / رئيس قسم البحوث بإدارة التخطيط والمتابعة حيث سيرسل للجنة الدائمة والتي بواسطتها سيبلغ المتقدم برأى اللجنة لاحقاً.

يكتب على الفاكس عبارة 24863680 فاكس : 2362/2848 داخلي 24878168/2487422 بدالة: 24863829 هواتف قسم البحوث: مباشر ((للعناية السيدة/ رئيس قسم البحوث خاص بالبحث رقم))



السيد د. هادي منقح حوكي لصحة
اعتم

التاريخ: ٢٠١٥/١١/٢٠

الرقم: ٢٠٦٠٤

المحترم

سطة حوكي الصحية
المرشد الوارد
٢٠١٥/١١/٢٠

السيد الفاضل / د. وكيل الوزارة

تحية طيبة وبعد،،،،

الموضوع / تسهيل مهمة الدكتور / لمياء العرادي
رقم البحث (٢٠١٥ / ٢٠٧) لإجراء بحث تحت عنوان :

**"An Assessment of the Impact of Accreditation from the
Perception of professionals in Primary Healthcare Centres : A
Case Study from Kuwait "**

يرجى التفضل بالإحاطة بأن اللجنة الدائمة لتنسيق البحوث الطبية والصحية
المشكلة بموجب القرار الوزاري رقم ٢٠٧ لسنة ٢٠١٢ قد أوصت باجتماعها السادس
عشر (٢٠١٥/٢) المنعقد يوم الثلاثاء بتاريخ ٢٠١٥/٣/٣ بالموافقة على إجراء البحث
رقم (٢٠١٥/٢٠٧) المقدم من الدكتورة / لمياء العرادي بتاريخ ٢٠١٥/٢/٢٢
تحت عنوان :

**"An Assessment of the Impact of Accreditation from the
Perception of professionals in Primary Healthcare Centres : A
Case Study from Kuwait "**

وذلك بعد أن قامت اللجنة إستناداً للقرار الوزاري رقم ٢٠٧ لسنة ٢٠١٢ والتعميم
الصادر من السيد / وكيل الوزارة برقم ١٥٦ لسنة ٢٠١٢ باستطلاع آراء الجهات ذات
العلاقة بموضوع البحث حيث وافق السيد / الوكيل المساعد للشؤون القانونية بالكتاب
الوارد رقم ٢٦٨٢٩ بتاريخ ٢٠١٥/٢/٢٣ ووافقت السيدة د. مدير الإدارة المركزية
للرعاية الصحية الأولية بالكتاب رقم ٢٦٨٠٦ بتاريخ ٢٠١٥/٢/١٩ .

٢٠١٥/١١/٢٠
Hassan