The Quality Management of Service Committee (QMSC) and the Professional Standards Directorate spent almost two years developing a scheme which has attracted strong support from many high level stakeholders. During that two year period, a number of anaesthesia departments in the NHS were kind enough to give their time and effort to the ACCSA pilot. Those departments provided a rich resource of learning about the process. In addition, from looking at the small sample of hospitals that took part, themes began to emerge which revealed much about the problems that are common in anaesthesia today.

Here, we will describe the findings of the ACCSA pilot project; what we learnt about accreditation and how we plan to use that knowledge, and also the themes that the specialty may wish to consider as a starting point for making positive changes.

Summary of Pilot Project

Between October 2011 and June 2013, a total of 25 hospital trusts and health boards were involved in the ACCSA pilot project. Of those 25, nine took part in an on-site ACCSA review at their department. Data was collected in two phases. A total of 20 departments submitted information during the first phase using a simple form. The form included numerical fields (for example the number of beds, the number of consultants), but the main focus of the scrutiny was the information provided as free text in response to open questions. This was not only labour intensive but impersonal. The amount and quality of information that could be gleaned from reading a form varied greatly.

Following the first phase pilot project, the QMSC set about writing the ACCSA standards, a set of objective benchmarks developed from the publication ‘Guidelines for the provision of anaesthetic services’, each of which could be assessed only as ‘met’ or ‘unmet’. After the standards had been written, in October 2012, some of the original pilot sites and some new ones were engaged and agreed to submit a second return. The second-stage return was a self-assessment against the ACCSA standards. Data was submitted using Excel spread sheets. The main purpose of the submission was not to benchmark departments at this stage, but to test the data gathering and submission process. The data submission served as the basis for a pilot on-site review of compliance with standards in nine departments. Reviewers were drawn from members of the Quality Management of Service Committee, Patient Liaison Group and ACCSA administration team. Initially, a team of three spent one day on site but during the four months of the on-site reviews, this evolved to be four reviewers and at least one and a half days on-site. Each review began with a general verbal presentation about the department, then a close look at the unmet standards. This formed the basis of a constructive conversation about how they might be met in the future.

The reviews finished each time with a discussion about how the ACCSA process could be refined and what the ACCSA team could do for departments to ensure that it was a beneficial process.
What was learnt about accreditation?

The process of capturing information from departments was a rich learning curve, allowing consideration about how information can best be submitted, and the kind of information that is available in departments, and a surprising amount about what was not! It also informed a discussion about how to measure what is good and what is bad. At the beginning of the data collection from pilot sites over two years ago there was an expectation that the return of simple form from a department might be enough to gauge whether or not they could be given some kind of quality mark by the College. The standards by which departments are measured have become much more sophisticated, as has the format for collection, and now requires the online tool Adobe© FormsCentral, which allows fast access to references.

The approach to conducting an on-site review, the criteria for reviewers and required training, how to prepare and what exactly what to look for, are now established. However, working with departments also demonstrated that accreditation presents an enormous opportunity for initiating change. Undergoing such scrutiny should really act as the start point and not the end point, if the process is going to offer any benefit. In his talk at the ACSA launch, Professor Sir Bruce Keogh said ‘Accreditation is not just about looking at minimum levels, it’s about driving improvement’. That is a lesson we learnt gradually, by taking data that the pilot sites worked hard to provide, looking at it and realising that actually the process would be pointless if it did not mark the beginning of a phase of improvement.

What were the areas of strength?

It was reassuring to learn from the data collection that most of the pilot sites were largely compliant with most of the standards. The ACSA process includes a period of detailed self-assessment and then an on-site review during which just a sample of the standards are tested by the ACSA review team. The question has been raised about whether sampling the standards, rather than scrutinising every standard, is rigorous. One of the significant learning points to be taken from the ACSA pilot project was the honesty of departments in assessing themselves. The pilot sites used the self-scrutiny to take stock, to really consider how good they actually are and to look for ways in which they might become better.

Openness is an integral element in getting the most out of the process, and without it the benefits of the scheme are greatly reduced. All reviewers relayed how impressive was the level of engagement of the pilot sites, who used the project as an opportunity to improve and dedicate time to self-reflection. To quote feedback from two clinical directors following ACSA pilot on-site review:

‘The ACSA process allowed us to reflect not only on where we could make improvements but also the wealth of resource already available within the department. Life moves so quickly that it was good to stop and reflect.’

‘The process of preparing for and undergoing external scrutiny was a very effective way of focusing on critical aspects of our department’s structure and working practices, and helped shine a light into some areas where it was not previously apparent that improvement was required. Overall a very useful process.’

Areas of national difficulty

Some standards were more often unmet than others. The ten most commonly unmet standards at the departments that we sampled are included below*. The best way to tackle non-compliance with each standard will vary from department to department, and one of the benefits of ACSA is a tailored approach for each organisation. Below are some

| 1.1.1.4 | There is a policy for the provision of sedation |
| 1.1.1.9 | There is a policy for the management of morbidly obese patients as appropriate in all areas |
| 1.1.1.10 | There is a policy for the post-procedural review of all patients |
| 1.1.1.17 | There is a policy to address death in the operating theatre |
| 1.1.1.18 | There is a policy to address the airway management of patients in the emergency department |
| 1.2.3.1 | A process is in place to ensure that abnormal results of investigations are flagged to the relevant person in a timely manner |
| 1.5.0.6 | Patients have a formal risk assessment performed which informs the process of consent |
| 2.2.4.1 | Drugs intended for regional anaesthesia are stored separately from those intended for intravenous use |
| 2.4.1.2 | Appropriate office space is provided for all aspects of the anaesthesia service |
| 2.5.1.1 | There are sufficient administrative staff to support all aspects of the anaesthesia service |
examples of the guidance offered to pilot sites for the ten most often unmet standards.

Some other common guidance given to the pilot sites was that the involvement of more members of the department in completing the self-assessment increases the awareness of policies and guidance documents that are already in place or in stages of development. A number of departments were advised to review standards against all of their organisations policies, rather than just those originating in the anaesthesia department.

*Not all departments that were involved in the pilot were non-compliant with the ten most unmet standards. The standards that were met or unmet were different for each department and information about specific standards is confidential between the RCoA and the organisation.

**There is a policy for the provision of sedation (1.1.1.4)**

The results of the pilot study suggest that hospital-wide policies for administration of sedation are absent or inconsistent. There is often no lead clinician, and responsibility for sedation lies with individual clinicians, especially for endoscopy. Training is poor. Work from the Academy of Medical Royal Colleges is awaited and will help to encourage formulation of policy.

**There is a policy for the management of morbidly obese patients as appropriate in all areas (1.1.1.9)**

Whilst equipment is often available for morbidly obese patients, for example, operating tables, individual policies and guidelines, standards and processes need to be co-ordinated into formalised guidelines following the pathway of the patient from the point of preoperative assessment to surgery, and post-operative care. A lead anaesthetist should be appointed to co-ordinate policy. Morbidly obese patients having anaesthesia delivered by trainees should have a robust risk

assessment, the responsible consultant should be made aware if there is perceived risk, and that consultant’s name should be documented.

**There is a policy for the post-procedural review of all patients (1.1.1.10)**

Whilst emphasis is often placed upon preoperative assessment, it is far less common to find patients routinely visited after discharge from the recovery room. The role of the anaesthetist as a peri-operative physician needs to be developed and time allocated for this activity.

**There is a policy to address death in the operating theatre (1.1.1.17)**

A policy that addresses all the issues, including dealing with relatives, should be developed in consultation with other members of the theatre team. The policy should encompass all aspects of care of the deceased patient, including the dignity and preparation required to meet coroners’ needs, staff and family support, debriefing of staff and appropriate cover. This is a very rare event, and information should be at hand to help cover lists, debrief staff and provide pastoral care. An anaesthetist should write a policy in conjunction with a senior member of the theatre nursing staff. This may be a project suitable for a senior trainee to engage with and to help draft.

**There is a policy to address the airway management of patients in the emergency department (1.1.1.18)**

Trainee anaesthetists are often left with intubated patients and no assistance in the emergency department. In order to demonstrate compliance with this standard a more formal ratification of current processes and access to support and leadership are required. The roles and responsibilities of anaesthetists, emergency physicians and intensivists often need to be clarified. Discharges from ICU need to be audited with a reduction in bed blocking affecting pathways further back, where patients need admission to ICU. Funding is often insufficient to release an ODP/anaesthetic nurse from theatre to assist and should be built into business plans.

**A process is in place to ensure that abnormal results of investigations are flagged to the relevant person in a timely manner (1.2.3.1)**

Last-minute cancellations for medical reasons are unacceptable when previous results have not been acted upon. Often person to person communication systems are the only ones in place but better IT helps. Funding and job planning should allow consultant input into preoperative assessment, and consultant input should take place well in advance of the day of elective surgery.

**Patients have a formal risk assessment performed which informs the process of consent (1.5.0.6)**

It is recommended that all patients should undergo POSSUM scoring which should then be documented and communicated to patients as part of the consent procedure. Patients and relatives should be helped to understand the risks and benefits that inform the consent process. It may require investment in making appropriate space available. Developing a same day admission unit enables the anaesthetist to conduct pre-assessment more easily with improved theatre efficiency.

**Drugs intended for regional anaesthesia are stored separately from those intended for intravenous use (2.2.4.1)**

This simple policy is frequently not
adhered to despite recommendations, but is easy to address.

**Appropriate office space is provided for all aspects of the anaesthesia service (2.4.1.2)**

Anaesthetic departments are often the largest in the hospital, but office space remains a perennial problem. An area for administration, teaching and personal interaction somewhere close to the main work area of the members of the department is essential.

**There are sufficient administrative staff to support all aspects of the anaesthesia service (2.5.1.1)**

Anaesthetists often have to undertake their own administrative work due to lack of secretarial support. This is wasteful of consultant time and resource. The provision of administrative staff should match the provision in the AAGBI guideline.

**Conclusion**

ACSA is already producing information from the analysis of the pilot study, and much information will be gleaned as the project develops further. The future is exciting, and not only will a good practice library will be developed to share best practice nationally, but trends of concern founded upon a strong evidence base will also be identifiable, providing the opportunity to focus energy on matters that will improve anaesthetic care for all of our patients. As Sir Bruce Keogh said, ‘with this project, accreditation has come of age.’

For more information please contact ACSA@rcoa.ac.uk.

(L-R): Professor Terence Stephenson, Chairman of the Academy of Medical Royal Colleges; Professor Sir Bruce Keogh, Medical Director of NHS England, and Dr J-P van Besouw, President of the Royal College of Anaesthetists, at the launch event of ACSA on 15 June 2013