planning will increase. At the heart of providing the care that people want when they die is in understanding the individual values, beliefs and concerns for each person. The nature of critical illness may prevent direct and effective discussions with individual patients. To ensure people receive the care they deserve and the outcome they desire, we are going to have to begin that conversation early, when capacity is intact. With an increasing number of people passing through preoperative assessment clinics each year, whom appear to be open to discussing end of life care, there is an opportunity to engage in a constructive dialogue which seeks to empower patients, reduce harm and suffering and support family members.

Declaration of interest
Professor Mythen is a BJA Editorial Board member. No other interests have been declared.

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Quality care in anaesthesia: roles of regulation and accreditation
P. J. Venn1,* and M. Nevin2
1 The Queen Victoria Hospital NHS Foundation Trust, East Grinstead, West Sussex RH19 3DZ, UK, and 2 University Hospitals Bristol NHS Foundation Trust, Upper Maudlin Street, Bristol BS2 8HW, UK
*Corresponding author: E-mail: pvenn@rcoa.ac.uk

Delivering best patient outcomes and satisfaction within a culture of optimal safety is the ultimate goal of everyone who commits their working life to the UK National Health Service (NHS). Nevertheless, history tells us that, despite these laudable intentions, ‘quality care’ has not always been delivered to patients by the NHS. The ‘Bristol heart scandal’ shocked the world. The
of patient care is also the goal, then practising front-line clinicians must contribute to the setting and implementation of professional standards.

In anaesthesia, the definition of quality service provision has been laid down by the Royal College of Anaesthetists (RCoA) in Guidelines for the Provision of Anaesthetic Services (GPAS). Peer-reviewed benchmarking of clinical departments against such guidelines is a natural forerunner to the development of accreditation of services, providing a robust and consistent approach to quality improvement from the ‘bottom up’. When used in conjunction with the ‘top-down’ approach, accreditation is working hand in hand with regulation.

Consequently, the Royal Colleges of Physicians, Psychiatrists, Radiologists, and Surgeons have all been developing peer-reviewed programmes of accreditation and, although at differing stages of development and implementation, offer a clear guide to the likely road ahead. At the same time, the Academy of Medical Royal Colleges has joined some of these initiatives together in a multidisciplinary approach to patient care. Returning clinicians to the driving seat of patient care is now high on the quality agenda and, although a long time coming, is widely welcomed by outside stakeholders.

What is Anaesthesia Clinical Services Accreditation?

Anaesthesia Clinical Services Accreditation (ACSA) is a set of standards developed from GPAS, which is a multi-author document. GPAS is based upon national guidance and recommendations from a range of stakeholders, including Royal Colleges, specialist societies, the Department of Health, NHS England, National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), the National Health Service Litigation Authority (NHSLA) and the defence organizations. GPAS is only available on-line, enabling it to be updated yearly, and new ACSA standards are developed from the update as required.

Anaesthesia Clinical Services Accreditation is organized into five domains, each with subdomains and areas containing the individual standards. Four of the domains apply to general hospital anaesthetic services, while the fifth applies to subspecialist areas and is being developed by the specialist anaesthetic societies. This ensures that the process enables peer review in the true sense. Recently, the standards have been mapped to the KLoEs used by the CQC in its new model for acute hospital inspection.

The accreditation process is voluntary and represents the initiation of a long-term partnership between the Royal College of Anaesthetists and respective departments of anaesthesia. As departments sign up, the College hopes that a domino effect will occur and that, in the future, accreditation will become the norm. Sir Mike Richards, Government Chief Inspector of Hospitals, has stated publicly that the CQC will regard accredited departments as being of high quality. This will clearly be of interest to chief executives and trust boards when the CQC is planning a visit to their hospital. Furthermore, representatives from education and training boards have stated that they would prefer to send trainees to accredited departments; good departments train well.

At the time of writing, ACSA has generated a great deal of interest among clinical directors and those involved in the running of departments, with more than 50 hospitals at different stages of engagement. For the first time within UK anaesthesia, hospital chief executive officers, medical directors, and clinical
directors can benchmark their anaesthetic service against defined quality standards. The ACSA process is one that should involve every member of the anaesthetic department, with discussion and debate resulting in a joint commitment to the process. Once agreed, the department can self-assess its compliance against the standards to identify areas of non-compliance, and work with the ACSA team from the RCoA through an on-site review to achieve accreditation.

**Why become accredited?**

Accreditation lasts for 4 years from the date of engagement, after which it must be renewed. This should provide an impetus to maintain quality care. Like revalidation with the GMC, however, it is designed to be a continuous process, and not a 4th year process. After accreditation is awarded, the partnership between the RCoA and department continues with frequent contact and central support from the RCoA. Local practice should adapt to ensure compliance with new standards in order to maintain accreditation status. It is anticipated that such a regular, ongoing and continuous appraisal of standard compliance (together with the incorporation of best practice adopted from other accredited departments) will lead to widespread and continuous improvements in patient outcome measures. The NCEPOD estimates that it takes up to 10 years for national recommendations to become embedded into normal health-care practice (Ian Martin - Clinical Co-ordinator NCEPOD personal communication). The RCoA estimates that this will be shortened to <2 years in accredited departments.

**The future**

The ACSA process will also provide in-depth, locally agreed, and up-to-date information on the provision of anaesthesia across the UK, identifying areas of best practice and common areas in need of improvement. Information from the ACSA pilot on-site reviews conducted in 2012 identified unmet standards common to a number of hospitals. The ability for ACSA to provide real-time, cross-departmental networking at a clinical director and department manager level will be an invaluable tool in ensuring the efficient and effective delivery of anaesthetic services. ACSA is helping the College to build a best practice library, accessible to participating departments to share examples of best practice, efficiency savings, and innovative service problem solutions.

The RCoA hopes to develop links with the independent sector, and BMI and Nuffield and Spire Hospitals have expressed an interest in accrediting anaesthesia within their groups. With the new status of Any Qualified Provider (AQP) and the prospect of increasing numbers of NHS patients being treated in independent hospitals, it makes sense for ACSA to develop the same quality standards for anaesthesia in independent hospitals as within the NHS.

Although these are still early days, the project is already beginning to pull departments together in a way that has not been possible previously. To quote Sir Bruce Keogh at the launch of ACSA on June 18, 2013, ’With this project, peer-reviewed accreditation appears to have come of age’.

**Declaration of interest**

P.J.V. and M.N. are both members of the RCoA ACSA Team.

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