CSAA
Clinical Service Accreditation Alliance

Clinical Service Accreditation Alliance: Work stream 3

A map of clinical services for accreditation schemes

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Version 1

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Background: About the Clinical Service Accreditation Alliance and about this guidance

About the Clinical Service Accreditation Alliance

This guidance is one of six resources created by the Clinical Service Accreditation Alliance (CSAA). The CSAA is a collection of professional bodies, which came together in 2013 with the aim of standardising and improving the quality of healthcare service accreditation, ensuring patient focus, improvements in standards of care and minimal administrative burden on the healthcare system.

The Alliance's work culminated in November 2016 with the first publication of the guidances and this work is now housed with the Healthcare Quality Improvement Partnership (HQIP) with oversight from the CSAA Sponsor Group, whose members are drawn from the Royal College of Nursing, Royal College of Physicians, Royal College of Surgeons, Royal Pharmaceutical Society, Allied Health Care Professionals and the Academy for Healthcare Science. More information can be found here: *www.hqip.org.uk/national-programmes/accreditation-of-clinical-services/*

CSAA outputs: Tools, guidance and resources

As part of its two-year collaboration, the Alliance has developed a suite of resources to support professional bodies who wish to develop professionally-led and patient-centred clinical accreditation schemes. These will publish in late November 2016 and comprise:

- Work stream 1: Requirements and guidance for accreditation of Certification Bodies (in conjunction with UKAS)
- Work stream 2: Sharing and improving accreditation methodologies
- Work stream 3: A map of clinical services for clinical services accreditation schemes (this document)
- Work stream 4: A generic framework of standards for accrediting clinical services ('Healthcare – Provision of clinical services – Specification' or PAS1616 – produced by BSI)
- Work stream 5: Requirements for clinical services accreditation IT systems
- Work stream 6: Developing accreditation schemes for clinical services

About this guidance

Work stream 3 was the first work stream of the CSAA to begin and hosted its first workshop in April 2014. The aims and objectives of this work stream are summarised below:

Aim:

Deliver a map of clinical services for the purposes of accreditation schemes

Objectives:

- Consider how to incorporate primary, secondary and community care services into the mapping exercise
- Consider whether it would be possible to accredit services from a patient pathway perspective and not just a traditional clinical team perspective
- Develop and test criteria for determining the scope of accreditation schemes
- Develop and test criteria to prioritise the establishment of new accreditation schemes

Working group

To bring together the expertise required to meet the aim and objectives, we convened a working group, comprising the following members (roles accurate for the membership period):

- Professor Mike Horrocks (Chair) (council Lead for service accreditation, Royal College of Surgeons)
- Ruth Bridgeman (national programme director, National Peer Review Programme)
- Sue Browning (deputy chief executive, Chartered Society of Physiotherapy and allied health professional representative on the CSAA Project Board)
- Dr Taj Hassan (vice president, Royal College of Emergency Medicine)
- Ms Sue Hill (deputy council Lead for service accreditation, Royal College of Surgeons)
- Professor Peter Kay (Royal College of Surgeons council member and national clinical director for musculoskeletal services)
- Dr David Paynton (national clinical Lead, Royal College of General Practitioners Centre for Commissioning)
- Stan Silverman (deputy medical director, Trust Development Agency)
- Dr Roland Valori (clinical director for accreditation, Royal College of Physicians)
- Dr Peter Venn (Chair, Professional Standards Committee, Royal College of Anaesthetists)
- David Whitney (lay member, Royal College of Surgeons Board)
- Graham Mockler (Secretariat) (policy and implementation manager, Royal College of Surgeons)

The working group first met in May 2014, and had seven further meetings; the final of these in October 2015. We continued to meet for an extended period due to the complex and detailed nature of the discussions involved.

Review of outputs, aims and objectives

The main output produced to meet the aim of this work stream is the map of clinical services for accreditation (Appendix 1). This map was created following extensive discussion, which reviewed numerous options and created several iterations of the map. This map will aid discussions and help to direct the creation of accreditation schemes in a manner that is sustainable and does not put an excessive administrative burden on the healthcare system. While it is not mandated, the map will help to show how accreditation can cover healthcare in a minimal number of schemes, and discourage the creation of small schemes that do not fit with the Alliance's vision.

The working group agreed the map once the inclusion of primary, secondary and community care services in accreditation schemes had been reviewed. The possibility of accrediting services from the patient pathway perspective was also reviewed. These factors were included in the creation of the map. The map is largely disease-based and does not differentiate between the settings in which the different aspects of care for each disease process occur. Network accreditation was also considered, and this is not excluded by the map.

The scope of schemes is implicitly included within the map. This is an area significant time was spent debating, to determine the feasibility of accrediting across the patient pathway. The group determined that ambitions should be set high and reduced when necessary, rather than the other way round. There is the possibility for schemes starting small and testing aspects of the patient pathway, and building up to testing the full patient pathway once ready.

The prioritisation of new schemes has been based on a number of factors:

- The existence of current quality improvement initiatives in that area of healthcare (the existence of these reduces the urgency of developing accreditation)
- The difficulty in configuring a scheme in that area (while we should not be put off by developing accreditation schemes in areas whose configuration makes this difficult, testing pathway accreditation will be challenging enough without added complications)
- The drive from an area of healthcare to develop accreditation (accreditation works best when driven by the profession. Buy in from all relevant stakeholders helps to push accreditation and builds momentum for its development and adoption)
- The need for quality improvement in that area of healthcare

The four factors above will contribute to the order in which new schemes are developed. These factors are subject to change frequently – prioritisation included in the map will change as these do. Further to creating the map as the main output, guidance to support discussions that emerging schemes have with their stakeholders have been drawn up and has been fed into work stream 6 (Developing accreditation schemes for clinical services).

Benefits

It is envisaged the outputs of this mapping work stream will convey the following benefits:

- Provide direction for the development of accreditation schemes to minimise the administrative burden on the system
- Help to drive the development of accreditation in line with the vision of the CSAA, including ensuring accreditation schemes are patient focused and not limited by organisational boundaries
- Provide prioritisation for the development of accreditation schemes in areas that most need and most want this

The benefits of this work stream will be realised over time and longer-term evaluation of these benefits will naturally be required.

Challenges

While the map is deliberately designed to be straightforward and simple to understand, the discussions that led to this point were not. This was a complex task, and in hindsight the group felt it may have underestimated this complexity, and the difficulty stakeholders may have in viewing accreditation from the patient pathway perspective. The opinion that accrediting across organisational boundaries to match the patient pathway is not feasible and too difficult, are well known and these concerns have not been ignored in this project. Due to these concerns, these ideas have been tested with some areas of healthcare identified within the map, including learning disability, musculoskeletal services and heart disease. The working group was encouraged by the positive responses from stakeholders in these areas to the challenges we presented to them in terms of accrediting from the patient perspective.

A further challenge for the future of this work will be to influence stakeholders to ensure accreditation schemes are developed in line with CSAA's vision and aims. The map is not mandated and as such adherence to it will largely depend on whether organisations developing schemes are engaged and bought into the aims of the Alliance. Communications work will be required to disseminate the work of the Alliance and influence organisations developing schemes.

Conclusion

There is confidence the map produced appropriately sets out how accreditation can cover all of healthcare through a reasonable number of accreditation schemes. This confidence has been gained through discussing the map with a wide variety of stakeholders, who responded positively.

It is recognised the map does not show current accreditation schemes, of which there are many. For healthcare to be covered by the schemes shown in this map, some rationalisation of current schemes will be required. This is not something that the Alliance is pushing, but something that is worth considering for the accreditation landscape in the future.

Appendix 1: Clinical service mapping

This work has used NHS England's National Clinical Director (NCD) areas (2015) as a starting point for mapping clinical services across healthcare for accreditation purposes. When this map was developed, there were 23 NCD areas, which cover a large proportion, but not all, of healthcare. Areas not covered by NCDs have been added to provide a comprehensive covering of healthcare clinical services. These additional areas have been drawn from the original list of healthcare services developed by the working group.

The areas in the table do not delineate between primary, secondary, tertiary and community care. Schemes created around the NCD and other areas should be able to incorporate all aspects of care that affect the patient pathway.

The table shows a number of aspects that will affect the priority it is believed should be placed on implementing an accreditation scheme. These include whether there is a current scheme and/or current quality improvement mechanisms in place; how desirable a scheme would be based on concerns regarding quality and whether quality monitoring is in place; and how difficult it would be to configure a scheme in that area.

Key

Priority levels:

1. High – accreditation scheme highly desirable: little quality improvement work to date and/or major concerns about quality
2. Medium – accreditation scheme desirable: little or some quality improvement work to date and/or some concerns about quality
3. Low – quality improvement processes in place, no major concerns about quality

n/a – areas with n/a stated are those with accreditation schemes currently in place

Configuration:

- **a.** Configuration clear cut, boundary of scheme obvious
- **a.** Configuration less clear cut
- **a.** Configuration not clear cut, will need further clarification

Cross cutting: Within the cross cutting services, there are two types identified:

- Those that provide a service that other services access, for example diagnostics
- Those that impact on other services in a major way, for example end of life care and learning disability services

Common acronyms:

NCA: national clinical audit
CORP: clinical outcome review programme

Area	Priority (1-3)	Configuration (a, b, c)	National audit or other service improvement	Cross cutting?	Comments
Emergency preparedness	2	C			Overlap with: emergency surgery; trauma; emergency medicine
Acute medicine	2	B/C		Y	
Emergency general surgery	3	B/C	RCS developing EGS QI work currently		
Trauma	2	A/B	• Emergency laparotomy NCA • Major trauma NCA • Falls and fragility fractures NCA (includes the hip fracture database)		
Urgent care	2	B		Y	
Neurology services					
Adult neurological conditions	1	C			
Spinal disorders	2	A			Too specific?
Metabolic medicine and cardiovascular services					
Heart disease	1	A	• Acute coronary syndrome or Acute MI national clinical audit (NCA) • Cardiac arrhythmia NCA • Congenital heart disease NCA • Coronary angioplasty NCA • Heart failure NCA • Myocardial ischaemia national audit project		
Cardiothoracic	1	A	• RCS IRM proactive reviews • Adult cardiac surgery NCA		
Obesity and diabetes (metabolic disease)	1	B	• Adult diabetes NCA • Paediatric diabetes NCA		

Stroke	3	A	• Sentinel stroke NCA		
Pathology services					
Pathology	n/a	A		Y	
Haematology	2	B	• Blood transfusion programme comparative audit	Y	
Clinical genetics	2	A		Y	
Immunology/allergy	n/a	B	• Rheumatoid and early inflammatory arthritis NCA		
Anaesthetics and critical care					
Anaesthetics	n/a	A	• Procedural sedation in adults	Y	
Critical care	2	C	• Medical and Surgical Clinical Outcome Review Programme (sepsis/ICU)		Overlap with: emergency surgery; trauma emergency medicine
Renal and urology					
Renal disease	2	A	• Chronic kidney disease in primary care NCA • Renal replacement therapy NCA		
Urology	2	A	• GIRFT • Prostate cancer NCA		
Dementia and elderly care					
Dementia	1	A	• National dementia NCA	Y	
Integration and frail and elderly care	1	C	• Falls and fragility fractures NCA (includes the hip fracture database) • Parkinson's audit	Y	
Diagnostics and imaging					
Imaging	n/a	n/a		Y	
Physiological services	n/a	n/a		Y	
GI and liver disease					
Liver	n/a	A			

GI	1	B	• Bowel cancer NCA • IBD NCA • Oesophago-gastric cancer NCA		
Endoscopy	n/a	A		Y	
Cancer	n/a	n/a	• Head and neck cancer NCA • Bowel cancer NCA • Lung cancer NCA • Oesophago-gastric cancer NCA • Prostate cancer NCA	Y	Should be included in specialty based schemes?
Children, young people and the transition to adulthood	2	C	• Clinical outcomes review programme (CORP) x2 (Child Health Clinical Outcome Review Programme and Child Death Review Database Development Project) • Paediatric intensive care NCA • Vital signs in children NCA • Diabetes transition		
End of Life Care	2	C	• Care in last days of life in acute hospitals audit • National care of the dying audit of hospitals	Y	
Learning Disability	1	B	• Learning disability mortality CORP • Self-assessment framework	Y	
Maternity and women's health	1	A	• CORP (Maternal, Newborn and Infant) • Neonatal intensive and special care NCA		Should these be separate?
Mental health	n/a	n/a	• Mental health CORP • Prescribing observatory for mental health		

Musculoskeletal services	1	A	• GIRFT • National Joint Registry		
Rehabilitation and recovering in the Community	1	C	• Specialist Rehab for Patients with Complex Needs NCA	Y	
Respiratory services	2	A	• Lung cancer NCA • Emergency oxygen NCA • Paediatric asthma NCA • Cystic fibrosis registry		
Pulmonary rehabilitation	1	A	• COPD NCA • Scheme being developed by RCP		
Breast	1	A	• Breast cancer national audit in development		
Day surgery	1	A			
Dermatology	1	A			
ENT	2	A	• GIRFT		
Ophthalmology	1	A	• Ophthalmology NCA		
Oral and maxillofacial surgery	2	A	• GIRFT		
Pain management	1	A		Y	
Plastic surgery	2	A	• GIRFT		
Sexual health	1	A	• HIV/STD NCA		
Vascular surgery	2	A	• GIRFT • National vascular registry		

This guidance is produced on behalf of the Clinical Service Accreditation Alliance

Further information is available at:
www.hqip.org.uk/national-programmes/accreditation-of-clinical-services/

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