Royal College of Physicians

Pulmonary Rehabilitation Services Accreditation Scheme

Pulmonary rehabilitation services accreditation scheme

Accreditation standards and evidence requirements

Published September 2020

Contents

Introduction

This document has been designed to assist pulmonary rehabilitation (PR) services in all sectors to prepare for their Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) assessment. It defines the standards and evidence required to achieve PRSAS accreditation.

The standards have been established with the PR community and are based on the **British Thoracic Society's (BTS) quality standards** and the **British Standard Institute's (BSI)** specification for accreditation of clinical services, and take into account the **NHS England and Improvement PR Service Guidance**.

You can find a number of helpful templates and guidance documents in the resources library on the accreditation website at **www.prsas.org/resourcelibrary**

This is an interactive document.
When you see this symbol next to the text, it means further information is available in a short explanatory video.

Press this symbol whenever you need a bit more information:

- on why a particular domain is important for your service
- about how to meet a particular standard
- on what kind of documents can be used as evidence.

Getting started checklist

1. Log into the website and set up logins for all relevant staff (max 10 people) ☐
2. Locate the resource library on the website at **www.prsas.org/resourcelibrary**. The resource library contains template documents that can be adapted and used to help meet PRSAS standards ☐
3. Book onto a PRSAS accreditation training session **www.prsas.org/events** ☐
4. Set up an accreditation programme working group or add as an item on the team meeting agenda ☐
5. Share out tasks with the team ☐
6. Involve patients in your accreditation journey ☐
7. Watch video guide for uploading evidence at **www.prsas.org/video-guides** ☐
8. Ensure documents are all less than 12 months old where necessary ☐
9. Start uploading evidence onto the website ☐
10. Review and meet eligibility criteria to request an assessment ☐

Eligibility criteria for assessment

To request an assessment all criteria in the accreditation standards must be fully evidenced.

Assessment eligibility	
All evidence uploaded against the accreditation standards is correct, up to date and relevant	☐
Your service has at least 12 months' of funding for continued service	☐
Your service is participating in the national pulmonary rehabilitation (PR) audit that is part of the National Asthma and COPD Audit Programme (services in England and Wales only)	☐
Your service's annual subscription is up to date and there are no outstanding invoices	☐
A representative of your service has attended a PRSAS accreditation training session	☐
Patient Identifiable Data (PID) I confirm that I have not uploaded any Patient Identifiable Information or data in the assessment evidence	☐
Clinical effectiveness	
If using the 6-minute walking test as an outcome measure, the course is 30 metres in length	☐
All patients complete a practice walk test a maximum of 4 weeks before completing a walk test during the initial assessment	☐
Service profile	
All contact details for staff at your service have been verified as correct (Assessment dashboard → Service user accounts)	☐
All registration details are correct and up to date, including your service name, your organisation and details of your organisation leads (Assessment dashboard → Service information)	☐
Assessment requirements	
Your service will have a PR class running on the day of the site assessment	☐
Your service lead, a clinical director or equivalent, and patients will be available and present on the day of the site assessment to talk to the assessment team	☐
Services that run PR classes on multiple sites	
All site details are correct on the website (Assessment dashboard → Service information) A site is a location where PR classes take place	☐
All policies are shared across all sites within your service	☐
All audits are conducted and presented as a service	☐
All accreditation standards are met at all sites within your service	☐

Leadership, strategy and management

Standard 1.1: The ethos, culture and team approach of the service is defined and published.

Evidence requirement

- Documentation outlining the ethos, culture and team approach in the service (in the operational plan for the service and displayed on the organisation's website).

Guidance

- This might be in a mission, vision and values statement that links to the organisation's values and objectives.
- Ethos: This might describe what the team is committed to and the principles they apply. Components that make up this ethos include patient-centredness, commitment to quality and outcomes, culture, safety, safeguarding and working in partnership with patients.
- Culture: This might describe the commitment of the leadership team to promote a sense of belonging and ownership to every member of staff through expectations and excellence in service delivery. It should be supported by a commitment to a programme of continuous professional development and support.
- Team approach (professional): The team approach for a service should be established on core values that underpin every aspect of its work: being person-focused, professional, open, caring and respectful.

Standard 1.2: The service has a leadership team that is visible, approachable and communicates regularly with staff members.

Evidence requirement

- A document outlining the names of leadership and staff team, including a summary of key clinical and managerial roles and responsibilities.
- Evidence of relevant qualifications/training certificates of leadership team.
- Organogram of team structure with clear lines of responsibility/accountability/ line management.
- Evidence of feedback process for leaders, including feedback data and action plans with timelines.
- Annual feedback in various forms from referrers of the service with accompanying evidence of discussion of feedback and planned actions to continue to improve.
- Examples of notices/bulletins or other such communications to staff and stakeholders to share updates and highlight changes to service delivery.

Guidance

- The roles and responsibilities of individuals in the leadership team should be clearly defined. The service should be delivered by experienced and specialist healthcare professionals – it is expected that the service will have physiotherapist and/or nursing input in collaboration with a broader multidisciplinary team.
- The named lead clinician should be a registered healthcare professional with appropriate specialist competencies in this role and should undertake regular clinical work within the service. The lead clinician should have overall responsibility and accountability for the service.
- Leads for the service should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services.

Standard 1.3: The service has a leadership team that is responsible for operational planning and service development.

Evidence requirement

- Operational plan.
- Evidence of annual review of operational plan (in team meeting minutes and in operational plan).

Guidance

- The operational planning/service development process must consider:
  - the needs of the local population, including geographical and clinical profiling
  - disease burden
  - national and local requirements
  - value for money
  - promotion of the service
  - review of demand and capacity of the service.
- The operational plan should include as a minimum:
  - accessibility (including reasonable adjustments for those with specific needs and signage for service), clinical space, facilities and equipment, what is available at the different sites and how appropriateness and suitability of the site was determined
  - safety/adverse event monitoring and reporting in the service
  - measurable objectives, key performance indicators (KPI), service evaluation and metrics for the service, including patient-reported experience and outcome measures (PREMS and PROMS)
  - roles and responsibilities for the staff members involved in the service
  - staff induction and training, mandatory and specialist training requirements and competency sign off process
  - how staff debriefing/handover occurs, including at times of annual leave
  - key relationships with organisations involved in the service
  - organisational chart/organogram for the service
  - statement on improvement, innovation and transformation
  - plans for development, including strategies for the development of the service to meet the needs of the local population across the clinical pathway
  - training and workforce development plan which includes succession planning to meet the needs of the service
  - procedures for collecting, monitoring, reviewing and analysing quantitative and qualitative data and feedback.
- The operational plan should be developed with multidisciplinary input.

Standard 1.4: There are escalation procedures for staff members.

Evidence requirement

- Service standard operating procedure (SOP) that includes a section on raising concerns.
- Whistleblowing policy and/or harassment and bullying policy (can be organisation's policy).
- Evidence of disseminating policy/ies and principles of escalation to staff team.

Guidance

- This must include:
  - the sharing of information and raising general concerns
  - challenging questionable and/or poor clinical practice
  - breaches of code of conduct and accountability; raising concerns of an ethical nature
  - disrespectful, discriminatory, abusive behaviour or harassment
  - provision of information and support for staff members raising concerns to clarify that there is no blame for adverse consequences
  - staff awareness of service/organisational policy on 'bullying and harassment'.

Standard 1.5: The service promotes the health and wellbeing of staff members.

Evidence requirement

- Examples of how wellbeing is promoted.
- Process in place for debriefing after a 'critical incident/event' within the service.

Standard 1.6: The service leadership team carry out a PR staff survey and provide opportunities for informal feedback.

Evidence requirement

- Staff survey template, data, and action plan outlining areas to improve and ways to continue to do well (where feedback is positive), including timescales and named leads.
- Team meeting minutes within the past year that demonstrate clear staff involvement in the service.
- Examples of informal ad hoc feedback, where appropriate.

Guidance

- There are systems in place to ensure that staff are able to feedback in confidence.
- The staff survey should include:
  - if staff feel wellbeing is supported
  - support from leadership
  - experience of implementing improvements in the service
  - experience of IT systems to support clinical work
  - working environment and safety
  - service delivery and staffing levels.

Standard 1.7: There is promotion of the service to referrers and potential patients.

Evidence requirement

- Examples of relevant literature/online material and how this is shared with patients/carers/referrers.
- Evidence of review of referral forms with relevant stakeholders (at relevant intervals, as determined by service need).
- Evidence that PR is available for people with Chronic Obstructive Pulmonary Disease (COPD) with an Medical Research Council (MRC) breathlessness score of 2, as well as those with other respiratory diseases as defined by the **BTS quality standards for PR.**

Guidance

- The service promotion must describe:
  - the scope of the service provided (including who the service aims to provide treatment/care to and whether research or training is undertaken)
  - the range of services offered and expected clinical outcomes
  - service organisation including the team members involved in delivering the service, frequency of clinics and opening times, their location(s), including satellite services, how to contact the service for help and advice, including out of hours
  - facilities available, including access for users with specific needs
  - expected timescales for the patient pathway, including initial assessment, start of PR, length of programme and discharge assessment
  - information regarding volunteers participating in the PR programme, if applicable to service
  - any links with other services/stakeholders, including how referral pathways are managed, eg information about other services in patient pack or referral agreements/pathway documents.

Systems to support service delivery

Standard 2.1: The service has defined roles and responsibilities for facilities, equipment and IT management, in accordance with the operational plan.

Evidence requirement

- Written summary of managerial and administrative support for the service and IT support, including audit (in operational plan).

Standard 2.2: The service carries out an assessment of the clinical space, facilities and equipment required to deliver the service.

Evidence requirement

- Reporting procedures for damaged equipment and repair.
- Evidence of well-maintained and adequate space for the number of patients and types of activity being performed (to be reviewed by assessment team at site assessment).
- A risk assessment of clinical space, facilities and equipment.
- Evidence of:
  - filled out equipment and facilities checklists completed prior to the commencement of PR classes
  - planned replacement/maintenance contracts of existing facilities and equipment
  - planned purchase of facilities and equipment
  - adequacy of clinical space.
- Photographic evidence of all clinical areas within the service (photographs of all sites, covering all areas used by staff and patients). If patients are in the photos, please ensure consent is gained.

Guidance

- There are systems in place to ensure that access to particular areas is restricted where appropriate.
- As a minimum, the equipment available onsite must include:
  - aerobic equipment
  - weights and resistance equipment
  - oximeters, BP monitor, weight scales, height chart
  - stopwatches (for assessments and exercise sessions, one for each patient)
  - music player, two bright cones, tape measure (10 metre for incremental shuttle walk test (**ISWT**) or 30 metre for 6-minute walking test (**6MWT**))
  - chairs
  - telephone access
  - emergency equipment
  - laptop/projector/flipcharts/white boards and supplementary written material for educational sessions.

Standard 2.3: The service uses IT systems which are designed to facilitate the collection, management and monitoring of data to support service delivery.

Evidence requirement

- Evidence of review of IT system needs (in team meeting minutes/operational plan).

Guidance

- The service must identify information standards and IT systems relevant to the specific needs of the service.
- If purchasing or implementing new IT systems; how they relate, communicate and interact with other IT systems within the service shall be assessed.

Standard 2.4: The service has a procedure for the storage of data, which includes the requirements for back-up, retention, archiving and any encryption.

Evidence requirement

- Section in SOP relating to storage of data.
- Staff training and/or education regarding data storage and information governance.

Guidance

- It is expected that the policy should include the transportation of data off site.

Standard 2.5: The service has a process for document management and control.

Evidence requirement

- Process of document management and control in the service.
- Evidence that documents, including SOP, follow document control process and are reviewed at appropriate timescales.

Guidance

- The process for the control of documents requires that:
  - documents are kept up to date, secure and, where necessary, confidential
  - information that is obsolete is removed from use and archived.

Person-centred treatment and/or care

Standard 3.1: Patients and carers are involved in the development of the service.

Evidence requirement

- Evidence of patient/carer involvement in the running and development of the service (for example minutes of focus groups or meetings).

Guidance

- Information about how a shared common purpose is established with patient/carer groups.

Standard 3.2: There are procedures to respect and protect patients/carers and their belongings.

Evidence requirement

- Evidence of all staff attending dignity and respect training.
- A SOP for the service, including information on:
  - service approach to privacy, dignity and respect
  - patient security
  - managing belongings.

Guidance

- The procedures should be developed to safeguard the rights, privacy, dignity, confidentiality and security of patients/carers at all times, especially during subjective parts of initial and discharge assessment.

Standard 3.3: The service communicates to the patient their responsibilities.

Evidence requirement

- Section in SOP describing patient responsibilities.
- Anonymised patient letter examples.

Guidance

- This must include:
  - keeping appointments
  - notifying the service of appointment changes or cancellations
  - discussing with the service desired changes or decisions to terminate treatment and/or care
  - discussing with the service where expectations of treatment and/or care are not being met
  - abiding by any codes of conduct (eg zero tolerance for aggressive behaviour) or patient charters.

Standard 3.4: The service reviews and acts on did not attend (DNA) rates.

Evidence requirement

- DNA management procedure for the service (in SOP).
- Evidence that DNA rates are reviewed and actions to improve performance are discussed at meetings regularly.

Standard 3.5: The service monitors waiting times and completion rates and keeps patients informed if journey times are expected to exceed locally set targets.

Evidence requirement

All nations

- Waiting times and completion data for all patients.
- Evidence that waiting time and completion data for all patients are regularly scrutinised and effective action plans are in place to improve performance against local and national targets (where these exist).

England and Wales only

- Evidence of meeting national median for:
  - % of patients with stable COPD enrolled within 90 days of referral
  - % of patients referred following hospitalisation for acute exacerbation of COPD (AECOPD) and enrolled within 30 days of referral
  - % of COPD patient completion rates as evidenced by patients attending a discharge assessment and receiving a written discharge exercise plan, or
  - evidence that waiting time and completion data are regularly scrutinised, and action plans are in place to improve performance against national targets.

Standard 3.6: The service monitors and reviews inappropriate referrals.

Evidence requirement

- Procedure to review and communicate inappropriate referrals to the referrer.
- Evidence of implementing methods to reduce inappropriate referrals.

Standard 3.7: The service has a procedure for managing patient transitions within the service, out of the service, to self-management or to other services.

Evidence requirement

- A SOP for the service, including a section on transition care.
- Evidence that all individuals completing PR are provided with an individualised written plan for ongoing exercise, (discharge exercise plan) after leaving the programme.
- Evidence of discharge exercise plans being co-produced with patients/carers.
- Evidence of the promotion of self-management.

Guidance

- Evidence of links and referral pathways to community-based opportunities.
- The service identifies, makes patients aware of and encourage access to, local and national patient support groups and provides access to information to support patients manage their condition.

Standard 3.8: The service documents person-centred treatment/care plans, based on the needs of the individual.

Evidence requirement

- A SOP on care plans and promoting joint decision making (evidencing care/treatment plans are co-produced with patients/carers), and references to other care policies and protocols.
- Evidence that the service supports families and carers when they are involved in patient care.
- Evidence that all patients undertaking PR receive an aerobic exercise programme, which is individually prescribed and progressive.
- Evidence that all patients undertaking PR receive a resistance training exercise programme, which is individually prescribed and progressive.
- Evidence that patient knowledge/learning needs assessment has been undertaken.

Guidance

- These are fundamental aspects of care for any patient, including:
  - relationships with key staff
  - communication
  - ensuring comfort, alleviating pain
  - promoting independence.

Standard 3.9: The service enables patients and carers to feed back on their experience of the service confidentially.

Evidence requirement

- Patient/carer survey template covering:
  - space/facilities/equipment during both assessments and PR classes
  - privacy, dignity and respect
  - involvement of the service user in their treatment/care
  - quality and clarity of information provided.
- Patient/carer survey data/completed surveys (anonymised).
- Actions plans (minutes of meetings showing evidence of patient/carer feedback discussions with agreed actions taken).
- Details of changes made in response to patient/carer feedback (eg you said, we did).
- Evidence of how the service gives feedback to patients/carers who have shared their views.

Guidance

- These procedures should include at a minimum feedback on:
  - quality and safety of treatment and/or care provided
  - involvement of patients in their treatment/care
  - quality and clarity of information provided
  - dignity, respect and compassion
  - all aspects of the patient pathway including referral and assessment.
- Staff members should explain these feedback procedures to patient/carers.
- Staff members should be notified of positive feedback from patients/carers.
- Actions taken and improvements made by the service in response to patient/carer views should be offered to patients/carers who have provided feedback.

Standard 3.10: The service records and investigates concerns, complaints and feedback.

Evidence requirement

- A SOP and policy on managing complaints.
- Examples of concerns/complaints (eg anonymised complaints log), actions taken, dissemination methods and learning from feedback/concerns/complaints.

Guidance

- The service has processes in place to ensure complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon.

Domain 4

Risk and safety

Standard 4.1: The service has risk management procedures.

Evidence requirement

- Risk management policy outlining responsibilities of individuals and reporting process.
- Training for staff awareness.
- Evidence of communication to staff about findings from risk management activities, including risk mitigation plans, risk reduction activities and the results of risk assessments and associated metrics (team meeting minutes/staff bulletins).

Standard 4.2: The service records risks in a risk register.

Evidence requirement

- A risk register to include named risk owners, risk mitigation, timescales for implementing changes and evidence of escalation, where appropriate.

Guidance

- The risk register will cover as a minimum:
  - infection control
  - medicine management
  - oxygen management
  - adequacy of clinical space
  - workforce planning
  - slips, trips and falls.

Standard 4.3: The service has a procedure for how incidents, adverse events and near misses are reported, investigated and used to inform changes to service delivery.

Evidence requirement

- Examples of communication to staff to encourage reporting.
- Meeting agendas and minutes demonstrating discussions of incidents and outcomes.
- Examples of how learning is communicated to all staff.

Standard 4.4: The service undertakes and records a clinical risk assessment of individual patients.

Evidence requirement

- Standard operating procedure for completing clinical risk assessments with individual patients.
- Evidence of individual risk assessments where clinical risk has been identified.
- Evidence of staff training/competence in clinical risk assessment.

Guidance

- The clinical risk assessment must include:
  - the risk of harm to the servicer user and others
  - the patient's changing risks
  - deteriorating health and wellbeing
  - challenging behaviour
  - medical emergencies
  - medication management.
- The results of the risk assessment must be recorded in the patient record.

Clinical effectiveness

Standard 5.1: The service measures and manages clinical outcomes.

Evidence requirement

- Evidence of validated measurement of exercise capacity, breathlessness and health status at the start and end of a PR programme.
- Evidence of recommended validated walking tests used at the start and end of a PR programme (**6MWT/ISWT/ESWT**).
- Evidence of walking test SOP, including evidence that walking tests are conducted to national and international technical standards.
- Evidence of validated measurement of strength used at the start and end of a PR programme.
- Evidence of use of disease-specific quality of life questionnaires.

All nations

- Outcome data for all patients
- Evidence that outcome data for all patients are regularly scrutinised and effective action plans are in place to improve performance against local and national targets (where these exist).

England and Wales only

- Evidence of meeting national median for:
  - % of COPD patients achieving satisfactory outcomes for exercise performance
  - % of COPD patients achieving satisfactory clinical outcomes for health status, or
  - evidence that outcome data are regularly scrutinised, and action plans are in place to improve performance against national targets.

(Data to be measured against accepted minimal clinically important differences (MCID) and/ or national audit figures (services in England and Wales only)).

Standard 5.2: The service provides a comprehensive programme of education.

Evidence requirement

- Evidence of a comprehensive programme of education and learning in line with content set out in the **BTS PR quality standards** (topics to be covered are identified in the BTS EBG (Appendix H).
- Evidence that the learning/education programme has been developed by a multidisciplinary team.
- The learning material offered equates to at least 6 hours of learning.
- Evidence that the learning/education programme has been adapted for those with specific needs.
- Evidence that the learning material is available for participants to learn independently (written information/ videos/website).

Standard 5.3: The service participates in local and national audit/assessment programmes.

Evidence requirement

- Evidence of an annual audit of individual outcomes for each PR programme.
- Evidence of an annual audit of rates of commencement, adherence and completion.
- A documented annual audit plan for the service, including those of patient experience (patient survey) and staff satisfaction (staff survey), with clear timescales for audit completion and named leads.
- Contribution to the national PR audit programme (services in England and Wales only).
- A documented process for gaining consent and documenting dissent for the national audit (services in England and Wales only).
- Process document which describes how the service validates audit data and ensures there is correct and complete data entry.

Standard 5.4:The service reviews all relevant guidelines, quality standards and benchmarking data.

Evidence requirement

- Evidence of annual review of national guidance (team meeting minutes).
- Benchmarking of audit data to national thresholds (services in England and Wales only).

Standard 5.5: The service keeps a register of all research undertaken in the clinical service, including ethics approval, where relevant.

Evidence requirement

- List of research activities, published articles, conference presentations or policies where relevant.

Guidance

- The service should review participation rates in research projects where relevant.

Staffing a clinical service

Standard 6.1: The service undertakes a review of the workforce.

Evidence requirement

- Evidence of administrative and clinical workforce review annually, or earlier if there is a significant change in the service.
- Summary of workforce and skillmix needs for the service (should include any planned appointments to support new work).
- Evidence to show that the minimum staffing levels recommended in the **national PR service guidance** are adhered to:
  - a ratio of 1:8 for exercise sessions
  - a ratio of 1:16 for education sessions
  - a minimum of two staff members in attendance, one of whom must be a qualified respiratory specialist healthcare professional to supervise the exercise component (NB: greater staff:patient ratio is required if oxygen users/complex patients are in attendance).
- Meeting minutes or action plans that show how deficits in service provision will be addressed, where applicable.

Guidance

- The review should include any planned appointments to support new work and skillmix of the team.

Standard 6.2: There is a service-specific induction programme, which new staff members and those with a change in role are required to complete.

Evidence requirement

- An induction pack based on competencies and adapted to staff groups if required.
- Completed competency assessments for different grades of staff.
- Feedback from staff regarding the induction process and how this has been used to enhance future inductions.
- Relevant staff members to attend the **BTS Fundamentals in PR and Advanced practitioner** courses.
- Evidence of staff attending postgraduate training programmes relevant to PR.
- A competencies framework for completion of exercise and strength testing.

Standard 6.3: The service has an appraisal process for staff members.

Evidence requirement

- A policy that describes appraisals and staff development processes and managing and supporting performance.
- Log of appraisal dates for the team.

Standard 6.4: The service has training plans in place for staff members.

Evidence requirement

- Training needs analysis for substantive staff, including how training will be resourced.
- Examples of training discussions in appraisal paperwork (anonymised).
- Mandatory training schedule and compliance.
- Log of training records of all educational and professional development activities for staff members.
- A safeguarding policy and evidence of its implementation.
- A health and safety policy and evidence of its implementation.

Guidance

- Team members should receive mandatory training procedures to safeguard patients and to protect the health and safety of patients and staff members.

Standard 6.5: The service implements a process to assess staff members as competent before using techniques and specialist equipment.

Evidence requirement

- A template of competency framework used and completed examples (anonymised).
- A description of how the service uses temporary staff and their competency checks.

Standard 6.6: The service has documented procedures in place for staff members who have responsibility for students, trainees and observers.

Evidence requirement

- Documented training of key staff for student placements.
- Documentation from the end of the student/trainee placement interview.
- Evidence of student/trainee feedback data and evidence of review of data and actions to continually improve.

Improvement, innovation and transformation

Standard 7.1: The service develops a quality improvement (QI) plan based on clinical quality metrics and patient/carer feedback.

Evidence requirement

- Completed QI plans and timelines.
- Named lead(s) for QI.
- Examples of evidence-based QI methodology being used.
- Evidence of engaging staff and patients/carers in developing the QI plan.
- Evidence of dissemination of key areas of the QI plan to staff members, patients/carers and stakeholders as appropriate.

Guidance

- The QI plan should include:
  - all potential areas for improvement based on staff feedback, patient/carer feedback, stakeholder feedback and organisational needs
  - measurable objectives and timescales for improvement initiatives
  - metrics for clinical effectiveness
  - information on how the QI plan is reviewed, monitored, reported and evaluated
  - allocation of time, resources and staff members training to achieve the above.
- Where clinical metrics and/or patient/carer data demonstrates positive results, the QI plan should focus on ways to maintain the results and continue to improve.

Standard 7.2: The service provides staff members with the support, training and protected time to undertake improvement initiatives.

Evidence requirement

- Study leave policy (can be trust/organisational policy).
- Clinical supervision policy (can be trust/organisational policy).
- Evidence of staff training in QI.
- Evidence of dedicated time allocated to staff to conduct appropriate QI work.
- Staff feedback about their experience in implementing improvements.
- Examples of QI projects by the team.

Standard 7.3: The service develops an innovation programme.

Evidence requirement

- Evidence of adoption of innovation (service innovations or ways of working) to improve the service.

Guidance

- Innovation could include:
  - research to develop new ways of working
  - recommendations by national or regional bodies
  - the adoption of technology, facilities and equipment to improve quality/value.

Version history:

V1	July 2018	
V2	July 2019	Editorial changes to wording and change of numbering. Some standards condensed owing to repetition.
V3	March 2020	Update to some evidence requirements and streamlining of standards.
V4	September 2020	Editorial changed to wording of some standards.

Further information

For further information on PRSAS visit
www.prsas.org

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If you have any queries about the work of the PRSAS, please email us at
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Services Accreditation Scheme