Accreditation of acute in-patient mental health services

The difficulties confronting acute psychiatric wards have been extensively reported over the past 15 years. Recent surveys and reviews undertaken by national bodies suggest that 7 years after the publication of the mental health national service framework in England (Department of Health, 1999) these problems persist (Marshall et al, 2004; Healthcare Commission, 2005; Mental Health Act Commission, 2005; Sainsbury Centre for Mental Health, 2005). Table 1 is a summary of the issues raised by these reports and by other commentators.

### Table 1. Summary of problems facing acute psychiatric wards

| Problem                                                                 | Solution                                                                 |
|----------------------------------------------------------------------|--------------------------------------------------------------------------|
| The focus has been on community developments                        | Jobs in community teams more glamorous and better paid                   |
| Wards seen as recruiting grounds for the community                   | Managers’ attention on developing community services                     |
| Under-investment in the physical environment of wards                | Under-investment in the physical environment of wards                   |
| The role of the acute ward is ill defined                            | Dumping ground for people whose community care has broken down           |
| Very diverse casemix                                                 | Function is an ad hoc mix of care, containment and accommodation          |
| The environment is not therapeutic                                   | Staff with no time to deliver talking therapies                           |
| Emphasis on pharmacotherapy                                          | Little input from therapists                                              |
| Limited access to day hospitals and no structured day                | Limited access to day hospitals and no structured day                    |
| Poor physical health care                                            | Poor physical health care                                                |
| Wards are dangerous and chaotic                                      | Violence and absconding everyday occurrences                             |
| Staff always ‘fire-fighting’                                         | Staff always ‘fire-fighting’                                             |
| Zero tolerance cannot be enforced                                    | Substance misuse causes major problems                                   |
| There is a lack of leadership                                        | The ward manager with little authority                                   |
| Multiple consultants admitting to one ward – none taking a lead     | The ward manager with little authority                                   |
| Trust management is obsessed with bureaucracy                       | Multiple consultants admitting to one ward – none taking a lead          |
| Paperwork taking staff away from patients                            | Paperwork taking staff away from patients                                 |
| Risk management is filling in questionnaires                         | Risk management is filling in questionnaires                              |
| There is a staffing crisis                                           | Risk management is filling in questionnaires                              |
| Problems with recruitment and retention; over-reliance on agency and bank | Problems with recruitment and retention; over-reliance on agency and bank |
| Difficulties in releasing staff for training                         | Difficulties in releasing staff for training                              |
| Low morale/high sickness rates                                       | Low morale/high sickness rates                                            |
| Bed management systems cause a problem                               | Ward staff with little control over admission decisions                  |
| Preoccupation with finance (preventing out of area placements) rather than quality | Preoccupation with finance (preventing out of area placements) rather than quality |

The problem for the National Health Service (NHS) is not a lack of policy and guidance but the absence of effective mechanisms for bringing about meaningful service improvement. It has been argued that the sheer volume of guidance, and the accompanying micro-management from the centre through top-down performance management, are themselves barriers to change. This is compounded by the Government’s repeated reconfiguration of services, and other NHS and local authority structures (Smith et al, 2001). Long-term planning and sustained investment are difficult; the task for provider services has become to hit this year’s target or meet this

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**This is the first of a series of papers on acute in-patient services.**
Although in-patient care cannot be considered in isolation from other elements of acute psychiatric care, or from the interfaces with community services that affect admission and discharge, the focus of any quality improvement work has to be the ward itself. Attempts to improve quality have to work within the complex ‘black box’ that is acute in-patient psychiatry and have to look outwards from that perspective at the essential interfaces with other service elements.

There has been movement in this direction. Some wards in some regions have participated in acute care collaboratives. These follow an approach applied in the north of England, which was itself modelled on methods of quality improvement developed by the US Institute of Health Improvement (Griffiths, 2002). This approach uses a framework of measurable standards, and works through learning networks, to support front-line staff making incremental improvements in the quality of service. The same principles are applied in the National Audit of Violence which enables staff, service users and visitors to review a ward with the help of a template of standards, to share their findings and to create and implement an action plan for improvement. The last round of the audit included 120 acute psychiatric wards (Healthcare Commission, 2005). The Sainsbury Centre for Mental Health (2006) has also been piloting a practical approach to engage staff, patients and carers in making incremental improvements to acute psychiatric wards.

Why do we need an accreditation system?

An accreditation system is several steps beyond the acute care collaboratives, and formalises the approach to improving wards piloted by the National Audit of Violence and the Sainsbury Centre. The staff in wards that participate adopt a common set of national standards, work to demonstrate adherence to these and have the driver of passing accreditation to catalyse or lever change in the direction of improvement. Such a system could become a permanent feature of the landscape, unlike most national initiatives driven by the Department of Health and regulators, which are time limited. It could create an incentive for provider organisations to undertake a sustained programme of improvements to their wards, and enables sharing of good ideas between staff in different parts of the country. Furthermore, there is the potential to drive ongoing quality improvement by increasing the standards year on year, so raising the bar.

This approach has been successfully applied to clinics that administer electroconvulsive therapy (ECT); within 2 years, about 40% of all ECT clinics in England, Wales, Ireland and Northern Ireland have voluntarily enrolled with the ECT Accreditation Service (ECTAS), and many have reported improvements as a result (Caird et al, 2004; Cresswell et al, 2006).

How does the accreditation service work?

Accreditation of acute in-patient mental health services (AIMS) is modelled on ECTAS. The system is standards based. Standards are graded into those that are essential if accreditation is to be achieved and those that, if met, are indicators of excellence. A period of self-review is followed by a peer-review visit by staff from other participating wards. Service users are involved, both as sources of information about the quality of the ward and as reviewers. Data collection is aided by carefully designed audit tools. The results are compiled into a report for the ward concerned that recommends actions where necessary. This report is the basis of the decision about accreditation status. As is the case with ECTAS, the accreditation decision for some wards is deferred, to give staff an opportunity to take corrective action to meet essential standards. Accreditation is for a set period of 3 years, but is subject to regular self-review and affirmation that the standards have been maintained. It is also expected that wards that are accredited demonstrate engagement in an ongoing process of improvement, working on areas that were highlighted during the review.

A set of principles underpin AIMS and differentiate it from centrally imposed inspection systems.

- Local ownership. Wards only participate if front-line staff and local service users agree. The local review process must be owned by front-line staff and must incorporate true peer review.
Engagement. The system engages all relevant groups, including all staff that work on the ward, senior service managers and service users.

Credibility. The accreditation process is transparent and the standards that underpin it are explicit. The steering group for AIMS includes service users, carers and representatives from the professional bodies whose members are most involved in in-patient care (British Psychological Society, College of Occupational Therapists, Royal College of Nursing and Royal College of Psychiatrists). In England, AIMS has working links with, but is independent of, the Healthcare Commission, the National Institute for Mental Health in England and the National Patient Safety Agency. In this way, it is anticipated that participation in AIMS will provide evidence of adherence to the requirements of national regulators. The AIMS standards are also informing national developments in Wales and Scotland.

Responsiveness. Feedback to participating wards is prompt and includes advice and support about how to meet standards. Networking is encouraged through newsletters and an email discussion group.

A focus on development. Although accreditation is only awarded to wards that demonstrate that they meet minimum standards, the purpose of the process is to support and help wards to achieve this.

The accreditation standards cover: physical environment and ward facilities; staffing (including leadership and training); care processes; factors relating to patient and staff safety; ‘the patient day’ and access to therapies; admission and discharge procedures; links with community services; and patient rights and safeguards, including the use of mental health legislation. The standards were developed through a structured process which started with a review of all documents containing recommendations that might be translated into standards (national reports, policy documents and guidance). The results were refined through an iterative process of consultation that involved all groups with a legitimate interest in acute in-patient services. Standards will be revised annually.

Update
To date, 21 wards have volunteered for the development phase. The first edition of the standards has been developed (http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/aims.aspx), and fieldwork to test the systems of data collection, through both self-review and peer review, was completed in June 2006, when recruitment of the first wave of wards into the accreditation process also started.

Conclusions
Since the quality of healthcare is determined by clinical staff interacting with patients, the healthcare provider organisation should do everything in its power to support and enable these staff to work as well as possible. This is sometimes lost when the agenda is set centrally and then handed down. AIMS is an attempt by the professions, working in partnership with service users, to reassert a leadership role in improving the quality of service. The mechanism by which it does this is to engage directly with the front-line staff responsible for delivering care.

Declaration of interest
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