editorial

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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

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
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
Poor physical health care
Wards are dangerous and chaotic
Violence and absconding everyday occurrences
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
Trust management is obsessed with bureaucracy
Paperwork taking staff away from patients
Risk management is filling in questionnaires
There is a staffing crisis
Problems with recruitment and retention; over-reliance on agency and bank
Difficulties in releasing staff for training
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

Acute in-patient psychiatry as a national priority

There is now a consensus among the agencies responsible for setting standards, overseeing patient safety and regulating healthcare in the UK that something must be done to raise the quality of acute psychiatric wards and to improve their safety – the two issues are strongly associated. The Department of Health has issued policy guidance (Department of Health, 2002*a*); the National Institute for Health and Clinical Excellence (NICE) has published clinical guidelines on the management of disturbed behaviour in in-patient mental health settings (NICE, 2005); the National Patient Safety Agency has chosen safer wards for acute psychiatry as its first priority in mental health (Marshall *et al*, 2004) and the Healthcare Commission funds the national audit of violence in in-patient settings (Healthcare Commission, 2005) and is starting a national thematic review of the quality of psychiatric in-patient care in 2006. In Scotland, the Mental Health Director has asked the Scottish Division of the Royal College of Psychiatrists to convene a group to make recommendations about the way forward for acute in-patient services. In 2003, the All Wales Senior Nurse group presented its concerns about psychiatric wards to the Welsh assembly, via the Chief Nursing Officer.

Challenge of improving ward 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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year's indicator, rather than address local, long-term priorities for service improvement. Inevitably national targets or indicators are often poor proxies for local service quality.

This performance management at a distance is somewhat removed from the principles espoused by the Department of Health for securing service improvement. These emphasise the importance of 'putting patients and staff absolutely at the heart of the NHS . . . by giving greater authority and decision making power to patients and frontline staff' with a Department of Health that 'adopts a less hands-on approach with clear priorities, fewer targets and less guidance and instruction from the centre' (Department of Health, 2002*b*). These principles apply as much to mental health services as to other sectors of healthcare (Kennedy & Griffiths, 2003).

Those who attempt to improve acute psychiatric in-patient services tend to seek the solution to the problem by looking elsewhere. There seems to be a prevailing view that if community care is working well and, in particular, if crisis resolution and home treatment teams are in place, the pressure on acute wards will be relieved and the problems will take care of themselves. This has not been the case historically (Fitzpatrick *et al*, 2003) and is unlikely to be in the future. There is little empirical evidence that the reduction in bed usage reported by studies of intensive community care transfers to the real world. What has happened is that reduction in bed numbers, made by optimistic planners in parallel with or ahead of the introduction of 'alternatives to admission', has increased pressure on in-patient services. It has also led to the in-patient case mix becoming increasingly concentrated towards the more severe and is perhaps an example of when taking a systems-based approach to a problem has not worked.

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.

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- 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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