Standard Development and Accreditation Process for Inpatient Rehabilitation Units

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This booklet describes *Accreditation for Inpatient Mental Health Services – Rehabilitation Units* (AIMS-Rehab), and provides information about the accreditation process and the accreditation ratings awarded.

A separate document is available for the versions of AIMS for general working-age adult wards (AIMS-WA), assessment/triage wards (AIMS-AT), wards for older people (AIMS-OP), learning disability inpatient units (AIMS-LD), and psychiatric intensive care units (AIMS-PICU).

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Introduction

Accreditation for Inpatient Mental Health Services – Rehabilitation Units (AIMS-Rehab) is a collaboration between the Royal College of Psychiatrists’ Centre for Quality Improvement (CCQI) and the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists.

AIMS-Rehab seeks to meet the need for an accreditation process able to address the unique features of inpatient rehabilitation units. Rehabilitation services work to much longer timescales than acute assessment and treatment wards. They focus on addressing disability secondary to psychiatric disorder and on personal recovery and social integration. Rehabilitation units come in many shapes and sizes. They may be very small units in an adapted house in the community or a secure ward on a large hospital site. They should, however, have much in common, in terms of the difficulties they seek to address, the use of a recovery model, encouraging an atmosphere of hope and optimism, using the full range of biopsychosocial treatments – including medication, psychological therapies and developing occupational and functional skills – and working in close collaboration with patients and carers. In an increasingly competitive and financially constrained environment, and with a lack of clear national guidance, there is a need to be able to demonstrate the quality of rehabilitation services to commissioners, clinicians, service users and carers.

AIMS-Rehab has developed from the earlier versions of AIMS for working-age adults (AIMS-WA), assessment/triage wards (AIMS-AT), wards for older people (AIMS-OP), learning disability inpatient units (AIMS-LD), and psychiatric intensive care units (AIMS-PICU). AIMS-Rehab has been developed and revised with a focus on rehabilitation and, in addition to the AIMS-Rehab standards and data collection tools, utilises the Quality Indicator for Rehabilitative Care (QuIRC) – a web-based toolkit which rates units against norms for all English NHS rehabilitation units (giving immediate early feedback) – and a patient-rated Good Milieu Index (a measure of the unit’s therapeutic environment).

AIMS-Rehab:

- sets standards for the organisation and delivery of inpatient rehabilitation services;
- engages with front-line staff and supports them to measure their own service against these standards;
- recognises local achievement, including offering accreditation, and identifies areas for improvement;
- works with local teams to develop and implement plans for service improvement;
• works actively with other professional bodies, so that staff of all disciplines are engaged in the process;

• works in partnership with service users and carers, and encourages local mental health services to do the same;

• works with both NHS and independent sector services in the UK;

• encourages staff from different services to support each other and share good ideas through the peer-review process.
Background

The work of the CCQI has created a new and enhanced role for clinicians and their professional bodies in raising standards. Its national initiatives engage directly with clinicians, managers, service users and carers, and supports them to take responsibility for improving local mental health services. More than 90% of mental health Trusts in the UK participate in the work of the CCQI.

The Faculty of Rehabilitation and Social Psychiatry has worked for many years to improve the provision and standards of rehabilitation services in the UK and the Republic of Ireland. Lack of UK government policy for mental health rehabilitation services in recent years has led to patchy investment in these services nationally, and an expansion of “out of area treatments” (OATs) in inpatient, nursing and residential care settings in the independent sector for service users with higher levels of needs who cannot be discharged home from hospital. Whilst a minority of these placements provide very specialist services that cannot be provided locally, and many provide good quality care, there are significant concerns about the lack of rehabilitation focus in some, poor links with local care managers and the social dislocation that being placed many miles from home represents.

Data from Freedom of Information requests carried out by the Royal College of Psychiatrists’ Policy Unit show that OATs cost considerably more than local placements, even taking into account the small number of very specialist placements required for people with very particular needs. This inefficient outflow of resource from the local mental health economy has been addressed in some areas (e.g. Berkshire, Bromley, Hackney, Islington and Wigan) by careful review and repatriation of service users placed out of area into more appropriate local services and supported accommodation, often developed through reinvestment of the very significant associated financial flows, in partnership with third sector organisations (Killaspy and Meier, 2010).

The Rehabilitation and Social Faculty of the Royal College of Psychiatrists has published a service template to guide commissioners and service providers in the UK in the kinds of rehabilitation services they need to provide locally. A copy of this document – “Enabling recovery for people with complex mental health needs: A template for rehabilitation services”, edited by Paul Wolfson, Frank Holloway and Helen Killaspy – can be downloaded at: www.rcpsych.ac.uk/pdf/fr_rs_1_forwebsite.pdf.

The development of AIMS-Rehab therefore comes at a time when there is a renewed focus on inpatient rehabilitation services in terms of providing efficient and local services to those who can be cared for in their local communities and on ensuring the quality of more specialist services that, of necessity, need to be provided to larger populations. AIMS-Rehab is an accreditation service for inpatient rehabilitation services, defined as hospital beds able to care for detained patients.
The Rehabilitation Service Template

The rehabilitation service template advises that a range of inpatient services should be provided across the dimensions that are described below. Inevitably, not all dimensions will be provided by local NHS services; units provide services over a range of dimensions, and independent providers and regional/national services will provide part of the functional network.

- **Length of admission**: from shorter-term assessment and treatment of 6–12 months, through more prolonged rehabilitation of 1–2 years, to longer-term care over many years.
- **Functional ability of residents**: from domestic environments concentrating on acquiring and utilising, on a daily basis, Activities of Daily Living skills for community living, through to high-dependency settings with domestic services provided by the unit rather than its residents.
- **Risk management**, including risks to self, others, health and vulnerability: from open, low-staffed community units, through local higher-staffed (often locked/lockable) units able to manage behavioural disturbance, to secure rehabilitation.
- **Degree of specialisation**: from local generic rehabilitation units predominantly for patients with treatment-resistant psychosis available in all Trusts serving a population of around 300,000, through to highly specialist facilities for people with specific conditions and complex co-morbidities, requiring specialist treatment programmes for populations of several million.

Five different types of inpatient rehabilitation units are described in the rehabilitation service template:

**Community rehabilitation unit**

- **Client group and focus**: many people, although not needing an acute admission ward or intensively staffed services, need time to recover from a psychotic episode, to optimise medication and reduce side-effects to a minimum. There is a focus on engagement with services, psychological interventions and activities of daily living skills.
- **Recovery goal**: to develop skills and support packages that include families and carers, for a successful return to community living with variable degrees of support.
- **Site**: ideally, this is community-based, with a focus on developing practical activities of daily living skills in a domestic environment close to a person’s home community.
- **Length of admission**: usually up to one year.
- **Functional ability**: domestic environments concentrating on acquiring and utilising on a daily basis activities of daily living skills for community living.
- **Risk management**: generally low-staffed open units which may have some specialist risk assessment skills.
- **Degree of specialisation**: local generic rehabilitation units predominantly for patients with treatment-resistant psychosis should be available in all Trusts.
serving a population of around 300,000.

High-dependency rehabilitation

- Client group and focus: people who need this kind of facility will be highly symptomatic, have several or severe co-morbid conditions, significant risk histories, and a high proportion will be detained and have ‘challenging behaviours’. Often they will have had forensic admissions or spent periods of time in psychiatric intensive care units. The focus is on thorough ongoing assessment, medication, engagement, supporting clients in managing their behaviour and re-engaging with families and communities.
- Recovery goal: usually involves a move on to other facilities in the rehabilitation service before community living or residential care.
- Site: usually hospital-based to benefit from support from other units and out-of-hours cover.
- Length of admission: one to three years.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher-staffed (often locked/lockable) units able to manage behavioural disturbance.
- Degree of specialisation: should be available in all Trusts serving a population of around 600,000 to one million; has a major role in repatriating patients from secure services and out-of-area placements.

Longer-term complex care

- Client group and focus: patients will usually have high levels of disability from complex comorbid conditions, with limited potential for future change and associated with significant risk to their own health and safety or to others. In addition to mental health problems, co-morbidity with serious physical health problems will be common and will require ongoing monitoring and treatment.
- Recovery goal: other rehabilitation options will usually have been explored; disability and risk issues remain but a more domestic setting that offers a high level of support is practical. The emphasis is on promoting personal recovery and improving social and interpersonal functioning.
- Site: usually community-based, sometimes on a hospital campus.
- Length of admission: several years.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher staffed units but with emphasis on unqualified support staff; risk management based on relational skills and environmental management, for example low expressed emotion.
- Degree of specialisation: should be available in all Trusts serving a population of around 600,000 to one million.
Secure rehabilitation

- Client group and focus: this group has diverse needs but have all have been involved in offending behaviour. They will all be detained under the relevant Mental Health Act and the majority under Forensic Sections of the Act. Levels of security will be determined by Ministry of Justice requirements and a key task will be the accurate assessment and management of risk. Residents will have varying levels of functional skills and are likely to require therapeutic programmes tailored to their offending behaviour in addition to their mental disorders.
- Recovery goal: to leave hospital with the probability of close supervision by a local community forensic team or assertive outreach team.
- Site: usually a hospital campus.
- Length of admission: two years-plus; variable, depending on the nature of the offending behaviour and psychopathology.
- Functional ability: domestic services provided by the unit rather than its residents, although participation in domestic activities with support encouraged as part of therapeutic programme.
- Risk management: higher-staffed units able to manage behavioural disturbance with full range of physical, procedural and relational security and specialist risk assessment and management skills.
- Degree of specialisation: low secure for populations of one million-plus to high secure for populations of around 15 million.

Highly specialist services

- Client group and focus: these units cater for people with very particular needs, for example acquired brain damage, severe personality disorder, co-morbid autism-spectrum disorder. Psychological approaches to treatment and management predominate. Often, nearby step-down units will be required that allow people to move on but maintain contact with the specialist expertise they require. Very active liaison with referrers is an essential aspect of the working of these services.
- Recovery goal: for patients to move on to more independent settings often with complex care packages developed with the advice of the specialist service.
- Site: within hospital complexes or in stand-alone units.
- Length of admission: one to three years, but highly variable depending on the nature of the conditions and specialist treatment programmes.
- Functional ability: variable, but hopefully covering a range from full domestic services to high levels of patient participation in activities of daily living.
- Risk management: varies with risk profile and treatment needs.
- Degree of specialisation: highly specialist facilities for people with specific conditions and complex co-morbidities, requiring specialist treatment programmes for populations of several million.

A recent survey of Rehabilitation and Social Psychiatry Faculty executive members and regional representatives received returns from services covering
a total population of 7.5 million in the UK and the Republic of Ireland (6 million from England). Levels of rehabilitation inpatient services were highly variable, but universally felt to be inadequate. Many units were trying to span a variety of functions described above, limiting their effectiveness for certain groups. Major service gaps were in high-dependency and low secure rehabilitation and supported accommodation for patients to move on to.

It is therefore in this context that AIMS-Rehab was developed, with the intention of providing a standards-based accreditation service designed to improve the quality of care in rehabilitation units. Standards are drawn from authoritative sources and cover all aspects of the inpatient journey. Compliance is measured by self- and peer-review, and accreditation is valid for up to three years, subject to an interim self-review.
Standards Development Process

The standards development process involves a review of currently available standards, regulatory guidance and relevant literature led by the staff at the CCQI. This was translated into relevant clinical standards by a multi-professional Standards Development Group, which involved clinicians from rehabilitation services. Developing the accreditation process involved recruiting a number of units for a pilot phase. Clinical staff (representing a variety of disciplines), service users and carers were recruited via the pilot units to form a Standards Development Group. This group worked with the staff of the CCQI to develop standards and an accreditation process that is relevant and acceptable to the units that AIMS-Rehab is intended to serve. In this way standards are hopefully seen as relevant and shared rather than externally imposed. The CCQI have been supported in this task by Dr Helen Killaspy (Chair) and Dr Steffan Davies (Financial Officer) of the Faculty of Rehabilitation and Social Psychiatry of the Royal College of Psychiatrists.

The Quality Indicator for Rehabilitative Care (QuIRC)

The QuIRC is a web-based toolkit (available at www.quirc.eu) which assesses the living conditions, treatment, care and human rights of people with longer term mental health problems in psychiatric and social care units. It was developed through a collaborative study in ten European countries funded by the European Commission. Its content was derived from three sources: a review of the published evidence on the most effective aspects of care in rehabilitation units (Taylor et al., 2009); a review of national care standards for these services; and a consensus exercise that collated the views of experts in rehabilitative mental health care: service users, clinicians, carers and advocates (Turton et al., 2010).

The QuIRC forms part of the AIMS-Rehab accreditation process and will be used to support and inform accreditation decisions alongside the battery of other self-review tools (see self-review section of this document). The QuIRC has been developed for completion by the Unit Manager. The reliability of the QuIRC has been tested and found to be very good (Killaspy et al., 2011) and good correlation has been found between service users’ experience of their care and the QuIRC results (Killaspy et al., 2012).

The Unit Manager will be able to have immediate access to a report produced following completion of the QuIRC. This report presents the performance of their unit on seven domains of quality (Living Environment; Therapeutic Environment; Treatments and Interventions; Self-management and Autonomy; Human Rights; Social Interface; Recovery-Based Practice) derived from the answers to the QuIRC questions. The average performance in these domains for similar units in the country are also shown, along with details of the aspects of care that may be below average and require improvement.

The patient questionnaire has also been adapted to include the Good Milieu Index, a five-item validated measure of the unit’s therapeutic environment.
Diagram Showing Review Cycle
(for example purposes only, assuming a January start)

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Objectives

The purpose of AIMS is to improve the care provided by inpatient mental health services in the United Kingdom and Ireland.

It will achieve this by:

- Accrediting inpatient mental health services.
- Creating a national network to support staff through:
  - a database of standards for inpatient care;
  - the AIMS peer-review process;
  - an online discussion forum.
- Maintaining a database of standards for inpatient care.

The ‘Mission Statement’ and Standards

The ‘mission statement’ for AIMS is:

| Inpatient mental health services offer a timely and purposeful admission in a safe and therapeutic environment. |

The standards are drawn from a range of authoritative sources (details can be downloaded from our website, www.rcpsych.ac.uk/AIMS) and also incorporate feedback from Service User and Carer representatives, pilot studies and experts from a range of relevant professions.

The set of standards is comprehensive and some standards are aspirational; it is unlikely that any unit could meet all of them. To support their use in the accreditation process, each standard has been categorised as follows:

- Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
- Type 2: standards that an accredited unit would be expected to meet;
- Type 3: standards that an excellent unit should meet or standards that are not the direct responsibility of the unit.

Note: In the event that AIMS finds evidence that the Trust’s (or other organisation’s) inpatient mental health service threatens the safety, rights or dignity of patients, the Trust (or other organisation) will be informed, in writing, and is expected to take appropriate action. If the Royal College of Psychiatrists is not satisfied that appropriate action has been taken, it reserves the right to inform those with responsibility for the management of the service and/or the relevant regulatory body.
The standards have been used to generate a series of data collection tools for use in the self- and peer-review processes. Some standards may not be included in the tools because they cannot be measured objectively and reliably.

There are several data collection tools because it is important that each standard is evaluated using the most appropriate method(s) and source(s) of information. The methods are described more fully in the sections below that describe the self-review and peer-review phases of the accreditation process.

**The College Website**

Units which are members of AIMS-Rehab will be listed on the Royal College of Psychiatrists’ website. Once a final accreditation rating has been awarded, this will be posted on the website next to the unit’s name.

**The Accreditation Process**

The time from registration as a member of AIMS-Rehab to a unit’s accreditation status being decided will be between six and nine months (assuming that self-review data is collected and returned and the peer-review visit takes place within the timeframes set out in the diagram on page 9). There are three main phases: self-review, a peer-review visit, and a decision about accreditation status.

**Phase 1: Self-Review**

This is an opportunity for the local multi-disciplinary team to review its local procedures and practices against the AIMS standards and, if necessary, to make the changes required to achieve accreditation.

Before commencing the self-review data collection period, the local AIMS-Rehab lead will be sent the current edition of Standards for Rehabilitation Units and a link to the Quality Indicator for Rehabilitative Care (QuIRC), which provides details of how to register and access this online tool.

The report generated by the QuIRC will be available to the unit and give them an indication of how they compare with other rehabilitation services in England. The report will also be emailed to the AIMS-Rehab Project Team and form their initial baseline data. The QuIRC must be completed within one week, after which the unit will be sent the remaining data collection tools – at this point the unit’s three-month data collection period commences.

The self-review has a number of components and must be completed and returned within three months. Unless otherwise stated, the tools are completed using direct web-based entry:
Carer Questionnaire. Carers will return these themselves, directly to the AIMS-Rehab Project Team, using the ‘Postage Paid’ envelopes provided.

Patient Questionnaire. Patients will return these themselves, directly to the AIMS-Rehab Project Team, using the ‘Postage Paid’ envelopes provided.

Unit Manager Questionnaire

Staff Questionnaire

An audit of Health Records

A checklist of policies, procedures and protocols

An audit of the environment and facilities

A summary of the results from the self-review will inform discussions at the visit by the peer-review team.

Phase 2: Peer-Review Visit by an External Team

The purpose of the one-day visit by a peer-review team is to validate the self-review findings and to provide a valuable opportunity for discussion, and for the review team members to share ideas, make suggestions, offer advice and give support.

The peer-review visit will be scheduled for four to eight weeks after the self-review data have been returned. Staff from other units participating in AIMS-Rehab will be invited to act as members of peer-review teams, and the team will typically consist of four members (three professionals and one Service User and/or Carer). The team will have undergone specific training at the Royal College of Psychiatrists’ Centre for Quality Improvement.

Only one peer-review visit will normally be made to the unit during the three-year cycle. If a further visit is required because it is identified that the unit poses a threat to patient/staff safety, the re-visit will be charged at the rate of £800 +VAT per day. Review visits which are cancelled by the unit will also incur a charge of £800 +VAT per day. Review visits which are cancelled by the AIMS-Rehab Project Team, or for reasons beyond the control of the unit, will not incur a charge.

Two further data collection tools are used at peer-review visits:

- Peer-Review Carer Questionnaire
- Peer-Review Patient Questionnaire
**Phase 3: Accreditation Decision**

Data from the self- and peer-review will be compiled by the AIMS-Rehab Project Team into a summary report of the unit’s strengths and areas for improvement. Once this has been verified by the lead reviewer who visited the unit, the AIMS Accreditation Committee (AC) will consider the data and recommend an accreditation status for the unit. This will then be passed to the Royal College of Psychiatrists’ Special Committee on Professional Practice and Ethics (SCPPE) for ratification. Accreditation is not confirmed until the SCPPE ratifies the recommendation of the AC, and the unit will not be notified of their accreditation status until after the SCPPE has met.

There are four categories of accreditation status:

- **Category 1: “accredited as excellent”**.  
  The unit would at the point of peer-review:
  - meet all Type 1 standards;
  - meet at least 95% of Type 2 standards
  - meet all or the majority of Type 3 standards, with a clear plan for how to achieve the others.

  Accreditation at Category 1 is valid for up to three years, subject to satisfactory completion of interim self-review.

- **Category 2: “accredited”**.  
  The unit would at the point of peer-review:
  - meet all Type 1 standards;
  - meet at least 80% of Type 2 standards;
  - meet many Type 3 standards.

  Accreditation at Category 2 is valid for up to three years, subject to satisfactory completion of interim self-review.

- **Category 3: “accreditation deferred”**.  
  The unit would at the point of peer-review:
  - fail to meet one or more Type 1 standards but demonstrate the capacity to meet these within a short time;
  - fail to meet a substantial number of Type 2 standards but demonstrate the capacity to meet the majority within a short time.

  The unit would receive a report detailing the strengths and weaknesses that had been identified, with an emphasis on those standards that need to be addressed for accreditation to be awarded. Data may be collected through a further self- and/or peer-review within a three/six-month period to confirm that the unit now meets the criteria for Category 2 approval.
• **Category 4: “not accredited”**.
  
  The unit would *at the point of peer-review*:

  - fail to meet one or more Type 1 standard and not demonstrate the capacity to meet these within a short time;
  - fail to meet a substantial number of Type 2 standards and not demonstrate the capacity to meet these within a short time.

  The unit would receive a report detailing the strengths and weaknesses that have been identified and a clear statement of which standards have to be met for the unit to be approved.

  Units which fail to submit adequate self-review data may also be considered for Category 4.

**The Final Report and Accreditation Certificate**

Once a unit has been accredited, a final bound report (including an action planning template) and an accreditation certificate will be sent to the unit, and their accreditation status will be listed on the Royal College of Psychiatrists’ website.

Accreditation certificates are issued for three years.

The unit will be recorded as accredited for up to three years from the date of the first available SCPPE meeting, and normally extends approximately six to nine months beyond the end of Cycle One membership. Cycles One and Two of the review process therefore overlap, in order to ensure continuous accreditation.

**The Appeals Process**

The grounds for an appeal against a decision about accreditation category are that:

- the decision has been made on the basis of a summary report that contains *factual inaccuracies* about the unit at the time of the review, and/or;
- the decision is not consistent with stated criteria that determine categories of accreditation.

An appeal must be lodged in writing to the AIMS Programme Manager within eight weeks of the accreditation decision having been communicated to the local AIMS lead. Appellants are asked to provide documentary evidence to support claims of factual inaccuracy and/or a clear statement of in what way(s) they consider the decision to be inconsistent with the stated criteria for the category of accreditation awarded. A detailed description of the stages of the appeals process is available on request.
Activities and Support During a Unit’s Accredited Period

In order to maintain their level of accreditation, a unit must continue to meet the standards met at peer-review, or show improvement. Units which fail to submit adequate interim self-review data may be considered for Category 4.

Interim Assessments

To ensure that accredited units are continuing to meet standards, they are required to undertake a brief self-review approximately eighteen months after their start date (the middle of year two), regardless of the date of accreditation.

Standards Revision

AIMS will undertake an annual revision and update of standards to take account of new developments. Once the updated standards have been published, all member units will be informed via the online discussion forum. Units are assessed against the set of standards that were in place when they commenced their self-review until the point of accreditation. Subsequent interim reviews are based on whichever set of standards is currently in place.

Online Discussion Forum

Throughout the period of accreditation, unit staff will have access to advice and support from the Royal College of Psychiatrists and their peers through our online discussion forum. Any member of staff from a member unit can join the group by emailing AIMS-Chat@cru.rcpsych.ac.uk with the word “join” in the subject line. Please contact the AIMS-Rehab Project Team for more information.

How Can You Become More Involved?

Join a Peer-Review Team

It is expected that staff from participating units and local service users and carers will visit other units as members of review teams. This will normally involve spending a day at a unit and possibly commenting on a draft of the unit’s report. Travel and – where necessary – accommodation expenses will be reimbursed in accordance with the policy of the Royal College of Psychiatrists.

In order to become a reviewer, staff, service users and carers must attend a reviewer training day. These take place at least twice a year, with dates advertised via the online discussion forum. Please contact the AIMS-Rehab Project Team for more information.
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