

THE HEALTHCARE COMMISSION-FUNDED NATIONAL AUDIT OF VIOLENCE

Report of work
April 2005 - March 2006

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SUMMARY

Between 2003 -2005, the Royal College of Psychiatrists' Research and Training Unit (CRTU) engaged 60 mental health care provider organisations and over 260 individual wards and units, in a national audit to improve the prevention and management of violence. The end of data collection coincided with a time of unprecedented national interest in the subject. The audit team, based at the CRTU, requested further funding to support a series of discrete activities that would raise awareness of the findings and promote implementation of the report's recommendations. The purpose of this work was to:

1. Develop ways of supporting local services to implement findings from the audit.
2. Complete the audit cycle by measuring the impact of this action in the wards and units that participated in the 2003-5 phase.
3. Disseminate the audit findings locally and nationally.
4. Recruit to a new cycle that would engage all English and Welsh mental health services in the audit.

1. Supported implementation

The project team consulted widely with its network members to determine the most appropriate ways of supporting them to take forward service improvements identified through the audit. Two approaches were chosen.

1.1 Topic-based workshops

A series of one-day workshops was delivered. Local project leads were consulted about both the content of, and the speakers for, these events. At the request of the participating trusts (and in order to support their wish to attend), the letters of invitation and associated fliers were copied to CEOs.

These events were widely publicised and well attended. The programmes were designed to encourage delegates to explore new ideas and to action plan. Speakers were selected who could bring local or national expertise relating to the subject area being covered, ie.

- **Local 'good practice'**: on the basis of presentations delivered at the earlier regional feedback events, local teams were invited to present their audit findings and to showcase aspects of excellence in their service delivery.
- **National initiatives**: these speakers were selected either because of their links into relevant policy initiatives, or because of the relevance of their own work.

The venues for workshops alternated between London (felt to be acceptably accessible to most), and the north of England. The topics covered, and the venues, were as follows (for details, see Appendix 1).

1. Supporting Services to Implement Zero Tolerance to Violence (London)
2. How Can Your Organisation Help to Prevent Violence? (York)
3. Empowering the Ward Manager (London)
4. How to Get the Most out of Service User Involvement (Manchester)
5. The Management of Violent Incidents (London)

Attendance at the events varied but was generally high.

Workshop	Number of trusts	Number of bookings
1.	15	66
2.	15	92
3.	17	76
4.	12	38
5.	23	75

Some feedback from the workshops

"I feel this workshop has been invaluable, I am looking forward to hear more about these much needed initiatives."

"(I) will take a lot away, ready to start changing things. Feel empowered!"

"Really good day, really motivational speakers."

"Very informative and inspiring. Helps to put everything into perspective i.e. knowing that problems for inpatient wards are common to wards/staff nationally."

"Maybe because some of the speakers were not veterans of the lecture circuit it felt more real - less ivory tower - more we work in difficult circumstances how can we make it better with limited resources."

"Thank you for the opportunity - an excellent day. I have taken some new ideas, good information to take back to the ward team. Well done all."

"I felt that a service user's view was excellent in the admission to an inpatient service and gave me far more insight into the feelings."

1.2 Development of accreditation service for acute psychiatric wards

The audit findings highlighted serious problems in many service areas, particularly in many of the 120 acute psychiatric wards that had taken part. In response, in December 2004, the CRTU hosted a meeting of key professionals from acute wards to discuss ways forward, in particular, whether the formation of an 'association' for acute wards would be of help (see Appendix 2 - minutes of meeting).

Whilst the group were in general agreement that an association would be of some benefit, there was consensus that the development of a system for accrediting acute psychiatric wards would have more impact. A larger follow-up meeting was held in April 2005 (see Appendix 3 - programme) and from this meeting, it was agreed that the CRTU would lead the work to establish 'Accreditation for Acute Inpatient Mental Health Services' (AIMS).

1.2.1 Recruitment of members

An invitation, to join the development phase of the accreditation system, was sent to all trusts that had participated in the National Audit. 21 acute psychiatric wards managed by 10 trusts opted to join.

Name of trust	Number of participating wards
Cardiff and Vale NHS Trust	2
Cornwall Partnership NHS Trust	1
North East Lincolnshire Primary Care Trust	2
Dudley, Beacon & Castle PCT	4
East Sussex County Healthcare NHS Trust	3
Manchester Mental Health & Social Care NHS Trust	1
Newcastle, North Tyneside & Northumberland Mental Health NHS Trust	3
Nottinghamshire Healthcare NHS Trust	1
Surrey & Borders Partnership NHS Trust	3
West Kent NHS & Social Care Trust	1
Total	21

As part of the registration process, trusts were sent an outline description of what would be involved (see Appendix 4), and were asked to sign a 'Memorandum of Understanding'¹ that detailed the expectations that the Central Project Team and their Local Project Team would have of each other.

1.2.2 Governance arrangements

A Steering Group was established to lead the new programme of work.

During the early 'developmental' stages, membership of the Steering Group was intentionally kept small to allow the group to work together to set up the infrastructure for the service: all key professional groups were represented (British Psychological Society, College of Occupational Therapists, Royal College of Nursing and Royal College of Psychiatrists); service user and carer representatives were recruited; participating trusts were asked to nominate member representatives and four nominees were elected.

Once the infrastructure for AIMS was established, membership was reviewed and extended to include a broader representation of countries and groups.

1.2.3 Development of manual standards

The standards were drawn from authoritative sources to ensure that wards would be evaluated against accepted best practice. These include: the Department of Health's policy implementation guides (2002 & 2004); the findings of the Confidential Inquiry into Suicide and Homicide (2002); recommendations by NHS Estates' (1996) and the Royal College of Psychiatrists (1998) about ward design; NICE guidance (eg. NICE, 2005); the National Patient Safety Agency's Safer Wards for Acute Psychiatry initiative; the

¹ Experience of running quality improvement programmes has shown that many local teams are hampered by a lack of support from their senior managers and trust board (or equivalent). The requirement to sign a 'Memorandum of Understanding' was intended to anchor the trust's commitment to their team's active participation in the programme of work.

Healthcare Commission-Funded National Audit of Violence, and; the National Institute for Mental Health (England) acute ward collaboratives.

The process for developing the manual of standards was iterative, highly transparent, and had significant input from the Steering Group and member trusts. The stages can be detailed as follows:

1. Compilation of core reference list (see Appendix 5) and extraction of relevant statements e.g. recommendations, standards, practice guidance.
2. Rating of statements by Steering Group members.
3. First consultation workshop with Steering Group and member wards (to agree principles for AIMS, and contribute to on-going development of the structure and content of the manual of standards).
4. First reduction by Project Team of statements (based on relevance, duplication, etc).
5. Review of revised list of statements by Steering Group members.
6. Second consultation workshop with Steering Group and member wards (to comment in detail on the emergent sections of statements).
7. Second reduction by Project Team of statement, based on feedback from second workshop.
8. Final edit by Project Team and Steering Group members.

1.2.4 Development of audit tools

At an early stage in the process, the Steering Group was encouraged to begin to think about how AIMS would measure compliance with standards. Some key considerations:

- **Reliability and Validity:** many different methods can be used to ‘measure’ compliance e.g. staff questionnaires, an audit of aspects of the environment, an audit of case records, however, not every measure will be accepted as ‘reliable’.
- **Capacity:** for local teams going through the accreditation process, the methods need to be ‘do-able’ (as well as meaningful).

1.2.5 The accreditation process

The time from registration as a member of AIMS to a decision being made about a ward’s accreditation category will be between six and nine months.

There are three main phases: self-review; a peer-review visit, and; the decision about accreditation category and feedback.

Phase 1: Self-review

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

At the beginning of the self-review period, the local AIMS lead will be sent a copy of the AIMS ‘Standards for Acute Inpatient Mental Health Services’ and the self-review data

collection tools. The latter should be completed and returned within three months. The self-review has a number of components. Unless otherwise stated, the tools are completed using direct web-based entry:

- **Ward Manager Questionnaire**
- **Staff Questionnaire** of which a minimum of 20 should be completed Accreditation for Acute Inpatient Mental Health Services (AIMS)
- **Patient Questionnaire** of which a minimum of 20 should be completed. Patients will return these themselves using the Freepost envelopes provided, to ensure anonymity.
- **Carer Questionnaire** of which a minimum of 20 should be completed. Carers will return these themselves using the Freepost envelopes provided, to ensure anonymity.
- **A review of a minimum of 20 Health Records**
- **A review of other key documents** including policies, procedures and protocols.
- **A review of the environment** by the multi-disciplinary team. 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 4-8 weeks after the self-review data has been returned. Staff from wards participating in AIMS will be invited to act as members of peer-review teams, and the team will typically consist of 3 or 4 members. The team will be led by a lead reviewer who will have undergone specific training at the Royal College of Psychiatrists.

Phase 3: Accreditation Decision

Data from the self- and peer-review will be compiled by the AIMS team into a summary report of the ward's strengths and areas for improvement. Once this has been verified by the lead reviewer who visited the ward, the AIMS 'Accreditation Advisory Committee' will consider the data and their recommendation about the accreditation status of the ward will be passed to the 'Royal College of Psychiatrists' Court of Electors' for ratification. There are four categories of accreditation status:

- **Category 1: "approved with excellence"**
- **Category 2: "approved"**
- **Category 3: "approval deferred"**
- **Category 4: "not approved"**

1.2.6 Recruitment of future members

A mailing will be sent out late spring 2006 and a cohort of wards will begin the accreditation cycle in October 2006.

2. Collation of action plans

Prior to the beginning of the programme of work, the CRTU stipulated that it would not directly share local reports with the Healthcare Commission. For this reason, the Healthcare Commission was better-placed to request local teams to provide copies of their local action plans arising from the audit.

Between September and December 2005, action plans and progress reports were called for from all the trusts that took part in the audit. A sample of trusts were then visited or spoken to about the improvements that they had been able to bring about following on from the audit and its findings. The study indicated that the audit was perceived to be a success by staff working on the participating wards, in clinical leadership roles, and in clinical governance departments. For some, their successes were relatively simple - for example, moving public 'phones to more private areas, the introduction of routine incident de-briefing, and increasing service user involvement in ward decision-making. Others had engaged in complex, time-consuming and sometimes costly ventures - for example, relocating smoking facilities, installing electronically-controlled blinds to assist temperature control, working with local police to minimise substance misuse, or purchasing new alarm systems. The follow-up survey concluded that many trusts had used the findings from the audit to drive improvements.

"In all situations where the therapeutic environment was improved, levels of aggression were diminished. Staff reported that they felt greater job satisfaction and retention of staff was easier. Junior staff particularly felt that senior management and the boards were willing to listen and had not necessarily experienced this previously. They put this down to the fact that the audit was very 'hands on' for ward staff and, in this, they were the 'experts' Patients felt that their opinions counted especially when their views were used in planning activities and in debriefing sessions. Some felt that staff dealt with issues in a more caring, confident and containing manner."

(Healthcare Commission, 2006).

CASE STUDY 1

Provided by Liz Fair, Clinical Effectiveness Manager, Sussex Partnership NHS Trust, on behalf of Rose Ward

Action point 1: through the audit of the environment, it was agreed that the ward was overcrowded, that there was insufficient space to see patients individually, and that action should be taken to reduce overcrowding and provide more therapeutic space that emphasised engagement, observation and recreation. A new unit is scheduled to be built and to be ready in 2008 but it was agreed that action was needed in the meantime.

A refurbishment programme was started in mid-October 2005 and is now complete: there are now extra interview rooms available, and extra seating (via the reassignment of an old dining room into a lounge/dining room).

Action point 2: the audit highlighted concerns around the lack of meaningful activity. A basic grade OT has since been reappointed and continued attempts are being made to engage the nursing team. As of March 2006, all people being newly admitted are being assessed within 72 hours and given a full activity programme.

CASE STUDY 2

Provided by Lou Bean, Clinical Audit Manager Mental Health, East Kent NHS and Social Care Partnership Trust, on behalf of Edgehill Ward.

Edgehill Ward is a 19-bedded mixed sex acute admission ward, built in approximately 1993 with long narrow corridors, poor observation lines, limited natural daylight and ventilation. Around the same time as the ward was taking part in the audit programme, Edgehill Ward was also selected by the trust to take part in a project run by the Kings Fund - 'Enhancing the Healing Environment'. Findings from the audit were fed into plans for a series of environmental improvements.

The biggest impact was expected to result from changing the use of space by the patients within the ward: the existing dining was not being used outside of mealtimes and service users were instead congregating in a windowless small lounge; a link was made between the resultant overcrowding and the occurrence of violent incidents - especially during summer months when temperatures rose due to the lack of ventilation. Improvements included:

- the use of calming colour schemes;
- better access to hot and cold drinks for service users;
- improved observation and greater feel of safety;
- the creation of new sitting areas;
- the introduction of artwork in communal areas.

CASE STUDY 3

Provided by Helen Bennett and Andy Morgan, Cardiff and Vale NHS Trust

Cardiff and Vale were able to produce longitudinal data over the period of the audit, relating both to the frequency and the management of challenging behaviour on three of their wards, and to corresponding staff sickness levels. The results were encouraging.

		June 04/May 05	June 05/May 06
Ward A	Number of incidents of challenging behaviour	86	41
	Number of incidents requiring use of restraint	8	11
	Staff sickness	4.5%	3%

Ward B	Number of incidents of challenging behaviour	117	91
	Number of incidents requiring use of restraint	47	62
	Staff sickness	6.2%	5.8%
Ward C	Number of incidents of challenging behaviour	61	40
	Number of incidents requiring use of restraint	21	19
	Staff sickness	7.5%	9.2%

3. Dissemination of audit findings

3.1 Local and national reports

Copies of reports were sent to all participating teams.

3.2 Press Launch

A press launch was held on 18 May 2005; attended by the CEO of the Healthcare Commission and representatives from the CRTU audit team. The report generated considerable interest and was picked up by local and national radio, television, the popular press, and several professional journals.

3.3 Presentations

The findings from the audit have been presented at a number of national and international conferences.

- NIMHE Conference, Preston, 2005
- 4th International Conference on the Care and Treatment of Offenders with a Learning Disability, Preston 2005
- Clinical Audit 2005, London
- NPSA Conference, London 2005
- National Control and Restraint General Association 10th Annual Conference, Newcastle 2005
- 4th European Congress on Violence in Clinical Psychiatry, Vienna 2005

3.4 Contribution to the development of policy and guidance

3.4.1 National Patient Safety Agency (NPSA): the topic of ‘violence’ was chosen as its first programme of work in mental health. The National Audit findings was one factor that influenced the decision by the NPSA to set up the “Safer Wards for Acute Psychiatry” (SWAP) initiative. Staff at the CRTU worked to ensure that the two programmes dove-tailed. This included the CRTU audit team being asked to develop a local audit tool that will be one of the main products of the SWAP initiative.

3.4.2 Counter Fraud and Security Management Services (CFSMS): the audit team has contributed to work that the CFSMS is taking forward to support staff to prevent and manage violence in the workplace.

3.4.3 Cross-Government Group ‘Management of Violence’ Group. This was set up to pull together national policy initiatives relating to the prevention and management of violence across and between public sector services. Findings from the audit have been brought to the attention of this group and, in turn, the audit team has been enabled to keep participating trusts abreast of national policy and practice changes.

3.4.4 Cross-Government Group ‘Management of Violence’ Sub-Group: The Accreditation and Regulation of Physical Intervention Trainers and Programmes of Education and Training: the work of this sub-group has been directly informed by some of the audit findings.

3.4.5 NIMHE’s London Development Centre’s ‘Acute Care Collaborative’ programme: as members of the Steering Group, the audit team was able to contribute both to the development of the standards and the methods for this work.

3.4.6 NICE Guideline: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments:

- Reference to audit tools (Appendix D):
<http://www.nice.org.uk/pdf/cg025niceguideline.pdf>
- NICE ‘Cost impact report: <http://www.nice.org.uk/page.aspx?o=257224>

3.4.7 Mental Health Act Commission’s Eleventh Biennial Report: the report frequently cites findings from the audit programme.

<http://www.mhac.org.uk/Pages/documents/publications/MHAC%2011%20TEXT%20FA.pdf>.

3.4.8 NIMHE/HC handbook of standards: NIMHE had been asked by the Healthcare Commission to develop a handbook of standards to support the latter’s 2007 improvement reviews in acute psychiatric wards. Initially, the AIMS Project Team was invited to join the sub-group leading the NIMHE work. However, it became clear that there could be a potential risk of confusion in trusts between the CRTU scheme, and NIMHE regarding the production of respective manuals/handbook. It was therefore agreed that it would be better to develop a joint expanded handbook publication between the Royal College of Psychiatrists’ AIMS Team and NIMHE later in the year which will fit the improvement review timescales.

4. Recruitment to the next wave

An invitation was extended to every NHS and independent sector provider of mental health services in England and Wales (n=101) to take part in a programme of work that will begin in May 2006. Trusts/organisations have been asked to put forward three wards for inclusion, in accordance with the following criteria:

- one acute ward
- one older people's ward
- one other mental health ward

At time of writing, 40 organisations have registered the following wards onto the programme.

Ward type	Number
Acute psychiatric ward	46
Older people with mental health problems	42
Forensic mental health	10
Psychiatric intensive care	15
Rehabilitation	3

REFERENCES

Palmer, C. (1996) Clinical practice guidelines: the priorities. *Psychiatric Bulletin*, 20, 40-43.

Wing, J.K., Marriott, S., Palmer, C. and Thomas, V. (1998) *The Management of Imminent Violence: Clinical Practice Guidelines to Support Mental Health Services*. Occasional Paper OP41. London: Royal College of Psychiatrists.

Healthcare Commission (2006) *National Audit of Violence Action Plan Follow-up*. London: Healthcare Commission.

APPENDIX 1



The Healthcare Commission National Audit of Violence

Supporting Services to Implement Zero Tolerance to Violence

Overview

Findings from the audit indicate that while there are some services that have effectively implemented a 'zero tolerance' approach to managing violence, they are by far in the minority. The impact of routine violence of service users cannot be overstated. This workshop will support trusts to develop strategies for dealing with this complex subject. Topics covered will include:

- The role of the CFSMS
- Joint policy development with local police
- Joint training with local police
- Incident reporting systems and use of information

Who should attend?

- Anyone who wants to develop their understanding about ways of making services safer place to live, work and spend time.

The speakers will include:

- **Maria Nyberg-Coles** - Counter-Fraud and Security Management Service
- **Kathryn Hil** - National Patient Safety Agency
- **Colin Dale** - NIMHE/NPSA Joint Project Manager
- **Catherine Courtney** - Devon Partnership NHS Trust
- **Andy Smith** - Camden PCT
- **Janey Antoniou** - Service User Consultant
- **Joe Joyce** - South Essex Partnership Trust

The format for the day will allow participants to hear about all of the pieces of work in the morning, and to explore them in more detail through afternoon workshops.



The Healthcare Commission National Audit of Violence

Implementation Workshop No. 2

Friday 9th September - York

How Can Your Organisation Help to Prevent Violence?

Overview

The minimisation of risk, and the promotion of effective ways of managing violence, are high-level governance issues. This workshop is highly participative and will encourage participants to share good practice, explore innovative ideas, and develop new ways in which to improve their services. Topics covered will include:

- Supporting staff who work in services where violence occurs
- The impact of the physical environment on people's behaviour
- Developing a 'safer services strategy'
- What we know about designing safe wards/units.

Who should attend?

- Staff and service users who are currently involved in designing new facilities
- Ward managers and ward staff
- Estates and facilities personnel
- Commissioners

The speakers will include:

- **Mr Peter McBride** - Director, Carecall
- **Dr Michael Phiri** - Senior Research Fellow, School of Architecture, University of Sheffield
- **Mr Jim Halliwell** - Project Manager, Construction, NHS Estates
- **Gail Miller** - NHS Security Management Services
- Mersey Care NHS Trust
- South Essex Partnership Trust

The format for the day will allow participants to hear about all of the pieces of work in the morning, and to explore them in more detail through afternoon workshops.



The Healthcare Commission National Audit of Violence

Implementation Workshop No. 3

Tuesday 25th October - London

Empowering the Ward Manager

Overview

The audit findings revealed that many ward staff feel disempowered to effect improvements within the services they provide. This workshop will fundamentally challenge this belief and allow participants to explore practical and dynamic ways of working.

- Hear about the 'Refocusing' approach to service development, including examples and case studies of where changes have been successfully achieved and sustained (*see overleaf for more details*)
- Find out more about domestic violence and its impact on the ward
- Explore ideas about re-engineering services through the work of the NPSA's 'Safer Wards' Project
- Learn about what has been achieved through the London Development Centre's 'Acute Care Collaborative' Project

Who should attend?

- Senior managers who are ready to support ward-level improvements
- Ward managers and ward staff who are keen to make dynamic changes
- Commissioners who are willing to support long-term service improvement

The speakers will include:

- **Nick Bowles** - University Of Bradford
- **Christine Mann** - National Domestic Violence Co-ordinator, Department of Health
- **Sue Brace** - Project Manager, NPSA
- **Sylvia Barry** - Project Manager, London Development Centre
- **Darren Bickerstaffe** - Doncaster and South Humber Healthcare NHS Trust

The format for the day will allow participants to hear about all of the pieces of work in the morning, and to explore them in more detail through afternoon workshops.



The Healthcare Commission National Audit of Violence

Implementation Workshop No. 4

Tuesday 15th November - Manchester

How to Get the Most out of Service User Involvement

Overview

Involving service users at all levels of decision-making is both challenging and complex. The workshop will take a very practical focus and will provide you with information and ideas from experts in their subjects.

- Find out more about the different ways of involving service users
- Listen to service users' experiences of being involved in service monitoring and planning
- Learn about the 'dos' and 'don'ts' of working with service users
- Explore the strengths and weaknesses of using advance directives
- Find out more about advocacy and what it can do for your service

Who should attend?

- Senior managers who want to learn more about good practice in service user involvement
- Ward teams who want to expand their thinking about dynamic ways of engaging with service users

The speakers will include:

- **Sarah King** - Service User Consultant, Impact Research
- **Janey Antoniou** - Service User Consultant
- **Helen Blackwell** - Service User Consultant
- **Jon Hyslop** - Director, Oxfordshire Mental Health Matters

The format for the day will allow participants to hear about all of the pieces of work in the morning, and to explore them in more detail through afternoon workshops.



The Healthcare Commission National Audit of Violence

Implementation Workshop No. 5

Tuesday 13th December - London

The Management of Violent Incidents

Overview

The audit revealed considerable national variation in relation to the ways that services are able to respond to actual incidents of violence. This workshop will bring together local and national expertise in the area.

- Find out more about the ways that the Security Management Service is working to tackle violence against staff
- Learn about the Security management Services new 'Promoting Safer and Therapeutic Services' training from one of the course developers
- Hear about the latest work that NIMHE/NPSA is doing to support staff in tackling violence
- Learn about exciting and innovative practices from two local centres of excellence, in Cardiff and Hampshire

Who should attend?

- Anyone who wants to learn more about good practice in relation to the management of violence

The speakers will include:

- **Brodie Patterson** - University of Stirling
- **Rick Tucker** - Counter-Fraud and Security Management Services
- **Colin Dale** - NIMHE/NPSA Joint Project Manager
- **Helen Bennett** - Cardiff and Vale NHS Trust
- **Jackie Hollingsworth** - Hampshire Partnerships Trust

The format for the day will allow participants to hear about all of the pieces of work in the morning, and to explore them in more detail through afternoon workshops.

APPENDIX 2

CONCLUSIONS OF A FIRST MEETING TO DISCUSS WHETHER WE NEED A UK ASSOCIATION FOR THOSE WORKING ON ACUTE PSYCHIATRIC WARDS HELD ON 2nd DECEMBER 2004

Present

Henry Andrews (henry.andrews@beh.mht.nhs.uk; 020 8379 4142)
Francis Adzinku (francis.adzinku@oxleas.nhs.uk; 07989111284)
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Apologies

Rachel Christian-Edwards (rachelce@btconnect.com)
Maureen McGeorge (mmcgeorge@msn.com)

Problems for acute psychiatric wards

The tabled list were agreed as being a reasonable reflection of the challenges facing acute psychiatric wards. Several other issues were raised. Attachment 1 is an updated summary that includes these.

Is there a need for an association?

After a lengthy discussion it was agreed that the idea warranted further exploration. The main points raised were:

1. Although acute psychiatric wards have been a neglected component of mental health services over the past two decades, in the past two or three years there have been a number of national and regional initiatives that have focused attention on them. It is important that any association complements these. In particular, it would have to define how it relates to the acute care forums and the NIMHE collaboratives.
2. An association would have to define its remit clearly.
3. It must be seen to be independent (i.e. owned and led by its members), truly inter-professional (nursing, psychiatry, OT, social work, psychology, therapies, pharmacy) and authoritative.
4. Before its establishment, it would have to decide how it would engage with service users (at all levels).

5. One benefit of an association might be its longevity; compared with time-limited initiatives (e.g. the collaboratives and, presumably, acute care forums).
6. The problems for acute wards are well recognised. Any association must be seen to be a body that attempts to do something about these; ie. it must be action-oriented.
7. An association should be “standards-based”; that is, its members should sign-up to a core set of standards that they aspire to attain (these standards should be wide-reaching and might include those relating to: the ward environment (architecture and ambience); staffing (skills mix, competencies, training, leadership, admin support etc); the “patient day”; access to therapies; key policies and procedures; links to other components of service).
8. It would not be helpful for an association to advocate a single model of acute in-patient care. It must accept that there is more than one way of achieving the same end.
9. Its initial focus would be on acute psychiatric wards. However, it is recognised that, increasingly, acute wards work more closely with crisis resolution and home treatment services. An association should remain receptive to widening its remit to include such integrated services as and when they become more common.
10. It was thought that, in general, membership would be “institutional”; ie. a ward or unit would join (but would have named lead individuals). However, the option should be left open for there to be individual membership; perhaps of staff working in services that are not ready for institutional membership.
11. An association should be UK-wide (and consider including services from Ireland if there is interest).
12. It is unlikely that central funding could be found to pump-prime an association. The only realistic source of income (in the short to medium term) would be “subscriptions” by members.

Possible functions for an association for acute psychiatric wards

Attachment 2 provides a list of possible functions that were discussed:

There was strong support for an association to develop a system for accrediting acute psychiatric wards as one of its early tasks. It was agreed that this would be a unique and valuable contribution, and would thus define the association, and was likely to be of interest to services. The first step in establishing an accreditation system would be to develop a set of standards. These would draw on existing guidance from a number of authoritative sources and would require the gaining of consensus from those working on acute wards. The latter would establish local ownership for the standards and engage members in the early work of the association.

The other functions would follow as the association finds its feet.

Next steps

It will be a challenge to establish an association with no pump-priming funding. The following steps were agreed:

1. Each person who attended the meeting will spread word of this proposal to colleagues who might be interested; including those in neighbouring areas to

their trust. PL will produce a simple one-page summary to facilitate this. That aim is to identify at least two people (most likely a nurse manager/nurse consultant/modern matron and a consultant psychiatrist) from each interested service. Names and full contact details should be passed to PL.

2. If there is sufficient interest in exploring the proposal in a larger forum, a meeting will be organised for next year to present and discuss it. This might or might not be linked with a regional collaborative group and might or might not have more than just the proposal on the agenda. Delegates and/or their service might have to meet the costs of room hire/refreshments. The day will:
 - present the proposal, including draft terms of reference
 - receive feedback and suggestions
 - seek expressions of interest from participants
3. If the proposal receives backing, there will be a recruitment drive. In the absence of central funding, the association could only be established if sufficient services were willing to subscribe.

Tasks

- Draft terms of reference and options for structure and governance (PL)
- Scope accreditation process (PL)
- Identify delegates for forum to explore the idea (all)
- Organise forum (CRU)

Attachment 1: PROBLEMS FOR ACUTE PSYCHIATRIC WARDS

The focus has been on community developments:

- jobs on ACTs, HTTs and CMHTs are “more glamorous”
- pay and conditions are better in community-based jobs
- wards are seen as recruiting grounds for the community
- managers’ attention is on developing new community services
- there has been 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 case mix (young/old; detained/informal; substance misuse/not substance misuse; violent/vulnerable; mentally ill/personality disorder)
- function is an ad hoc mix of care, containment and accommodation

The environment is therapeutic

- staff have no time to deliver talking therapies
- emphasis on pharmacotherapy
- little input from outside therapists (OT, psychology, substance misuse workers etc)
- limited access to day hospitals
- no structured day
- inability to manage physical ill health adequately

Wards are dangerous and chaotic

- violence and absconding are everyday occurrences
- staff are always “fire-fighting”
- “zero tolerance” cannot be enforced
- Substance misuse cause major problems

There is a lack of leadership

- the ward manager has no authority
- multiple consultants admit to one ward - none takes a lead
- relationship between nurses and consultants sometimes poor
- ward staff have no control over admissions and limited control over discharge

Trust management is obsessed with bureaucracy

- every new problem calls for a new form
- risk management is about filling in questionnaires
- ward staff spend more time with the paperwork than with patients

There is a staffing crisis

- over-reliance on agency and bank
- problems with recruitment and retention
- difficulties in releasing staff for training
- low morale/high sickness

Bed management systems cause a problem

- ward staff have little control over admission decisions
- problems with “bed blocking”
- preoccupation with finance (ie. preventing out of area placements)

Attachment 2: POSSIBLE FUNCTIONS FOR AN ASSOCIATION

To advocate for acute in-patient services

- to work nationally to keep acute in-patient care in the public and policy eye after attention shifts elsewhere
- to advise trusts that wish to develop or improve their in-patient service
- forge links with professional bodies

To define acute in-patient care as a specialism

To define and promote the concept of career progression within acute in-patient services (for all disciplines)

To promote better training and education for in-patient staff

- establish training requirements
- “accredit” practice standards
-

To support quality improvement activity in acute in-patient services

- set standards for in-patient services (e.g. staffing, procedures, patient day, admission/discharge practice, links with other elements, skills mix etc)
- develop local and national audit tools
- support self- and peer-review against the standards
- enable networking and sharing of good practice (e.g. through a regular “Bulletin”; via e-mail discussion group; annual meeting etc.)
- manage a process of accreditation
- provide advice to service planners and some form of management consultancy

To support and promote research

Improve the image of acute in-patient services

- work with service users
- promote good practice
- to create and promote a “vision” of the future of in-patient care

APPENDIX 3



PROPOSAL TO ESTABLISH AN ACCREDITATION SYSTEM AND ASSOCIATION FOR ACUTE PSYCHIATRIC IN-PATIENT CARE

One-day Workshop, Thursday 7 April

Royal College of Psychiatrists' Research Unit (CRU)
4th Floor, Standon House, London E1 (see map, attached)

Programme for the day

9.30	Coffee and registration	
10.00	Welcome, introductions and aims of the day	Paul Lelliott, CRU
10.15	The national context: brief presentations from 4 major pieces of work in acute psychiatric services	
	<ul style="list-style-type: none"> The NIMHE/Sainsbury Centre Benchmarking Exercise 	Ines Garcia and Mansur Qureshi, Sainsbury Centre
	<ul style="list-style-type: none"> The Mind Watch Campaign 	Moira Fraser, Mind
	<ul style="list-style-type: none"> The Healthcare Commission National Audit of Violence 	Maureen McGeorge, CRU
	<ul style="list-style-type: none"> The NPSA Safer Wards for Acute Psychiatry Initiative 	Sue Brace, NPSA
11.00	Panel session: questions and discussion	ALL
11.30	Presentation: what might accreditation look like?	Paul Lelliott/Adrian Worrall, CRU
11.50	Plenary: questions and discussion	
12.00	Small group exercise: what are the <u>opportunities</u> and <u>threats</u> of accreditation for acute psychiatric in-patient services?	
12.45	Plenary feedback	
1.00	LUNCH	
1.45	Plenary: issues arising from the morning and outline of the afternoon	
2.00	Presentation: what other functions might an Acute In-patient Care Association support?	Paul Lelliott
2.20	Group work: other functions of an Association <ul style="list-style-type: none"> At the individual practitioner level At the wards/unit level At the broader, national level 	
3.00	Plenary feedback and discussion	
3.30	Closing session: what happens next?	
4.00	Close	

APPENDIX 4

ACCREDITATION SYSTEM AND ASSOCIATION FOR ACUTE PSYCHIATRIC WARDS

1. Background and rationale for setting up the programme

Many service users find admission to be the most unsatisfactory aspect of their mental health care. The acute psychiatric ward is also a challenging environment for staff; with problems of recruitment, retention and sickness. These issues are compounded by uncertainty about the precise role of inpatient care in today's mental health services and its relationship to other forms of acute care. Despite these difficulties, senior management attention can focus on community developments, at the expense of work to improve conditions on the wards.

About 60 senior nurses, consultant psychiatrists, and OTs attended two meetings to discuss a proposal to establish an independent accreditation system and an association for acute psychiatric wards. The aims will be to:

- drive quality improvement through a process that engages front-line staff;
- better define the role and purpose of the acute psychiatric ward;
- promote inpatient psychiatry as a career for all disciplines;
- create a voice to speak on behalf of staff who work on acute psychiatric wards.

2. What will the programme involve?

2.1 The Accreditation Programme

2.1.1 The model

The model for this is the ECT Accreditation Service (ECTAS) managed by the Royal College of Psychiatrists' Research Unit (Caird et al, 2004). The acute psychiatric ward accreditation system will be standards-based, will include both self-review and peer-review, and will be developmental, in that it will be applied in a way that supports ongoing service improvement.

The key principles underpinning the accreditation system will be:

- **Local ownership and trust**: the process will be owned by front-line staff and will incorporate true peer-review.
- **Engagement**: the system will engage all relevant groups, including all staff who work on the ward, senior service managers, and local service users.
- **Credibility**: the accreditation standards will be explicit and the accreditation process transparent. We will seek recognition and engagement from the professional bodies of those working in mental health care, national organisations representing the service user perspective, the Healthcare Commission, NIMHE, NICE and the National Patient Safety Agency.
- **Responsiveness**: feedback to participating wards will be prompt and will include advice and support about how to meet standards. Networking will be encouraged through newsletters and an e-mail discussion group.

- ***A focus on development***: although accreditation will only be awarded to wards that demonstrate that they meet minimum standards, the purpose of the process will be to support and help wards to achieve this.

The standards

The accreditation standards will cover:

- the physical environment and ward facilities;
- staffing (including leadership and training);
- care processes;
- factors that relate to patient and staff safety;
- “the patient day” and access to therapies;
- admission and discharge procedures and links with community services;
- patient rights and safeguards, including the use of the Mental Health Act.

Standards will be drawn from authoritative sources to ensure that wards are evaluated against accepted best practice. These will include: the Department of Health’s policy implementation guides (2002 & 2004); the findings of the Confidential Inquiry into Suicide and Homicide (2002); recommendations by NHS Estates’ (1996) and the Royal College of Psychiatrists (1998) about ward design; NICE guidance (eg. NICE, 2005); the National Patient Safety Agency’s Safer Wards for Acute Psychiatry initiative; the Healthcare Commission-funded National Audit of Violence, and; the National Institute for Mental Health (England) acute ward collaboratives.

The complete set of standards will be aspirational and no ward could meet every one. Standards will be categorised into two types:

1. those that are essential to safety and patient dignity, and so must be met if accreditation is to be awarded, and;
2. those that are indicators that a ward is of excellent quality.

The process of selecting and categorising standards will recognise that acute wards are diverse and that the provision of high quality care does not necessarily require a new purpose-built ward.

The set of standards will be developed through a process of consultation that takes full account of the views of front-line staff and service users, and will be subject to annual review.

2.1.3 The process

- Stage 1:*** Simple audit tools will be developed and tested to support evaluation against the standards.
- Stage 2:*** After an induction event, wards will undertake self-review using a range of methods.
- Stage 3:*** The ward will host a peer-review visit by a multi-professional team that includes service users (team leaders will be provided with training).
- Stage 4:*** Feedback will give a provisional decision about accreditation status, highlight issues that need attention, and include advice and comments from the review team.
- Stage 5:*** Action planning and implementation of findings. This will be supported centrally and through the encouragement of networking between participating wards.

Accreditation will be for a set period of time (probably three years) but will be subject to regular (probably annual) self-review and affirmation that the standards necessary for accreditation have been maintained. It would be expected that wards that are

accredited would demonstrate engagement in an ongoing process of improvement, working on areas that had been highlighted during by the review.

2.2 The Acute Psychiatric Ward Association

The potential functions of an acute ward association will include:

- advocating for acute inpatient services;
- keeping acute inpatient care in the public and policy eye;
- advising about the development and improvement of inpatient services and forging links with professional and other national bodies;
- defining acute inpatient care as a specialism;.
- promoting career progression in inpatient settings (for all disciplines) eg. defining and promoting training requirements; brokering the provision of training;
- supporting quality improvement: setting standards for inpatient services, supporting the process of self- and peer-review against the standards, enabling networking and sharing of good practice and benchmarking.

3. Healthcare Commission Standards

A table outlining the Core and Developmental HCC standards that membership of ASAAPW will most directly help your Trust to achieve - whilst also contributing to many others - is included at **Annex 1**.

4. Memorandum of understanding

The following represents the expectations that the Central Project Team and your Local Project Team will have of each other.

The ASAAPW Central Project Team will ensure that it offers an efficient and effective service by:

- developing a manual of standards in consultation with participating organisations;
- facilitating an induction event prior to data collection;
- developing a series of audits with associated data collection instruments, guidance, data analysis, and reporting that will support evaluation against the standards;
- providing relevant summaries of the audit findings for your locality, and supporting you to compare your findings with other teams in your region and nationally;
- supporting a peer review visit by a multi-professional team;
- providing feedback about accreditation status;
- encouraging action planning and implementation of improvements.

Your Chief Executive will support participation by:

- offering high-level, visible support to the project eg. attendance at the induction workshop;
- supporting a senior individual to work as project lead for your team;
- ensuring that your team members are allocated time to devote to the project activities;
- ensuring that team members are allocated resources to carry out project activities eg. personnel, meeting rooms, access to hard/software;
- identifying a conduit between the project team and appropriate local committees (such as the Trust Board, Clinical Governance Committees, Practice Improvement Groups, etc);

- monitoring performance measures of improvement in your organisations and documenting the outcomes;
- paying for accommodation and travel costs for staff to attend workshops, learning sets, training sessions etc.

ANNEX

Healthcare Commission Standards

Domain	Domain outcome	Core and Developmental Standards
Safety	Patient safety enhanced by use of health care processes, working practices and systematic activities that prevent or reduce risk of harm to patients	<p><i>Core Standard C1</i> Improvements in practice are made as a result of local and national incidents.</p>
Clinical and Cost Effectiveness	Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.	<p><i>Core Standard C5</i> There are mechanisms in place to ensure that all staff involved in delivering clinical care and treatment receive appropriate supervision.</p> <p>Clinical leadership is supported and developed across all disciplines.</p> <p>Clinical professionals from all disciplines have access to and participate in activities to update the skills and techniques relevant to their clinical work.</p> <p>Clinical professionals participate in reviewing the effectiveness of clinical services.</p>
Governance	Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.	<p><i>Core Standard C8</i> The healthcare organization has processes in place to support staff to raise concerns over any aspect of service delivery, treatment or management.</p> <p>The healthcare organization ensures that staff from minority groups have access to organisational and personal development programmes to help address under representation in different parts of the workforce.</p> <p><i>Core Standard C11</i> The healthcare organization identifies the training required to enable its staff to provide all aspects of its service.</p> <p>The healthcare organization provides appropriate staff induction.</p>

Patient Focus	Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.	<p>Core Standard C13 The healthcare organisation has taken steps to ensure patients, carers and relatives are treated with dignity and respect.</p> <p>The healthcare organization monitors its performance with regard to treating patients and carers with dignity and respect.</p> <p>Core Standard C14 The healthcare organization ensures that patients, relatives and carers have access to a formal complaints system.</p> <p>The healthcare organisation provides information to ensure that patients, relatives and carers understand how to make a formal complaint.</p> <p>The healthcare organisation provides opportunities for patients, relatives and carers to give feedback on the quality of services they receive.</p> <p>The healthcare organisation uses feedback from patients, relatives and carers to improve service delivery.</p>
Accessible and Responsive Care	Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.	<p>Core Standard C17 The healthcare organisation seeks the views of patients, carers and the local community (<i>not local community</i>).</p> <p>The views of patients, carers and the local community are taken into account in designing, planning, delivering and improving health and healthcare services.</p>
Care environment and amenities	Care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.	<p>Core Standard C20 The healthcare organisation minimises the environmental risks to patients, staff and visitors.</p> <p>The healthcare organisation protects patients, staff and visitors by providing a</p>

		<p>secure environment.</p> <p>The healthcare organisation protects its physical assets and those of patients, staff and visitors (<i>not staff and visitors</i>).</p> <p>The healthcare organisation has taken steps to provide services in environments that are supportive of patients privacy and confidentiality.</p> <p>Core Standard C21</p> <p>The healthcare organisation provides care in well designed and well maintained environments.</p> <p>The healthcare organisation provides care in an environment that meets the national standard for cleanliness.</p>
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APPENDIX 5

Sources for AIMS Standards

Abolition of the Supervision Register Criteria for a Robust CPA. CPAA (2003).

Acute Care 2004. A National Survey of Adult Psychiatric Wards in England. Sainsbury Centre for Mental Health (2005).

Acute Care Collaborative standards. London Development Centre for Mental Health, the King's Fund and London's Mental Health Provider Trusts (2004).

Acute In-patient Mental Health Care: Education, training and continuing professional development for all. National Institute for Mental Health in England (2004).

Acute In-patient Psychiatric Care for Young People With Severe Mental Illness. Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists. Royal College of Psychiatrists (2002).

Acute Problems. A survey of the quality of care in acute psychiatric wards. Sainsbury Centre for Mental Health (1998).

Alcohol Harm Reduction Strategy for England. Cabinet Office (2004).

Assessment for Improvement: Understanding the standards. Healthcare Commission (2004).

Audit Pack for Monitoring the Care Programme Approach, An. Department of Health (2001).

Breaking the Circles of Fear: A review of the relationship between mental health services and African and Caribbean communities. Sainsbury Centre for Mental Health (2002).

Capable Practitioner, The. Sainsbury Centre for Mental Health (2001).

Clinical Governance Standards for Mental Health and Learning Disability Services. Department of Health.

Code of Practice, Mental Health Act 1983. Pursuant to Section 118 of the Act (1999).

CPA Care Planning for Service Users who are Repeatedly Detained Under the Mental Health Act. Sainsbury Centre for Mental Health (2005).

Delivering Race Equality in Mental Health Care. Department of Health (2005).

Depression. NICE Clinical Guideline (2004).

Designed for Life: Creating world-class health and social care for Wales in the 21st century. Welsh Assembly Government (2005).

Developing Services for Carers and Families of People With Mental Illness. Department of Health (2002).

Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. NHSE and SSI (1999).

Engaging and Changing: Developing effective policy for the care and treatment of black and minority ethnic detained patients. National Institute for Mental Health in England (2003).

Equity, Empowerment, Effectiveness and Efficiency. National Assembly for Wales (2001).

Essence of Care: Patient-focused benchmarks for clinical governance. Department of Health (2003).

Green Light for Mental Health. Department of Health (2004).

HBN35P1A: Accommodation for people with mental illness. NHS Estates Schedules of Accommodation v1.0, April 2003.

Health and Safety at Work Act, 1974.

Healthy Body Healthy Mind. SHIFT and National Institute for Mental Health in England (2004).

Independent Specialist Advocacy in England and Wales: Recommendations for good practice. Department of Health (2002).

Inside Outside: Improving mental health services for black and minority ethnic communities in England. National Institute for Mental Health in England (2003).

Interfaces Project Report. National Institute for Mental Health in England (2003)

London's State of Mind. The King's Fund (2003)

Mainstreaming Gender and Women's Mental Health. Department of Health (2002).

Management of Health and Safety at Work Regulations, 1999.

Mental Health National Service Framework (and the NHS Plan): Workforce planning, education and training underpinning programme. Department of Health (2001).

Mental Health Nursing: Addressing acute concerns. NMC (1999).

Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision. Department of Health (2002).

Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings. National Institute for Mental Health in England (2004).

Mental Health Policy Implementation Guide: Dual Diagnosis. Department of Health (2002).

Mental Health Policy Implementation Guide: National minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments. Department of Health. (2002).

Mental Health Workforce for the Future, A: A planner's guide. Sainsbury Centre for Mental Health (2003).

Moving On: Key learning from Rowan Ward. CSIP (2005).

National Service Framework for Mental Health, The. Department of Health (1999).

National Suicide Prevention Strategy for England. Department of Health (2002).

National Visit, The: A one-day visit to 309 acute psychiatric wards by the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health. Sainsbury Centre for Mental Health (1997).

New Roles for Psychiatrists. Department of Health (2004).

NHS Plan, The - Better hospital food. Department of Health (2000).

Not Just Bricks and Mortar: Report of the working group on the size, staffing, structure, sitting and security of new acute adult psychiatric in-patient units. Royal College of Psychiatrists (1998).

Organising and Delivering Psychological Therapies. Department of Health (2004).

Patient Environment Action Teams. NHS Estates (2005).

Patient's Charter, The: Privacy and dignity and the provision of single sex accommodation. Department of Health (1998).

Perinatal Maternal Mental Health Services: Recommendations for provision of services for childbearing women. Royal College of Psychiatrists (2001).

Placed Amongst Strangers. Mental Health Act Commission, Tenth Biennial Report (2004).

Protecting NHS Trust Staff from Violence and Aggression. Wales Audit Office (2005).

Realising the Potential: A strategic framework for nursing, midwifery and health visiting in Wales into the 21st century. National Assembly for Wales (2001).

Reconsidering the Patient's Journey Through Acute Care: Some suggestions for standards setting. Draft report.

Safer Wards for Acute Psychiatry: a review of the available evidence. National Patient Safety Agency (2004).

Safety First: Five-year report of the National Confidential Inquiry into suicide and homicide by people with mental illness. Department of Health (2001).

Safety, Privacy and Dignity in Mental Health Units: Guidance on mixed sex accommodation for mental health services. NHS Executive (1999).

Schizophrenia. NICE Clinical Guideline (2002).

Service Standards for Therapeutic Communities. Royal College of Psychiatrists (2005).

Spoonful of Sugar, A: Medicines management in NHS Hospitals. Audit Commission.

Under Pressure: Report of the risk and quality review of NHS mental health patients. Wales Collaboration for Mental Health (2005).

Violence: The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. NICE Clinical Guideline (2005).

Ward Watch: Mind's campaign to improve hospital conditions for mental health patients. Mind.

Wish You Were Here? Ethical considerations in the admission of patients to substandard psychiatric units. Royal College of Psychiatrists (1996).

Working Together - Learning Together: A framework for lifelong learning for the NHS. Department of Health (2001).