



Third National Report for Working-Age Adult Acute Wards

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Foreword

It is a pleasure to write the foreword for this, the Third National Report for Working-Age Adult Acute Wards. AIMS commenced work with a pilot project of 16 wards in 2006 and, therefore, this year celebrates its 10th anniversary, an achievement which will be marked with a “celebratory” Annual Forum on 14 December 2016.

The unique and fundamental strength of the AIMS project is the central role played by patients and their carers. In our busy world we regularly hear of targets being set which often seem to signify little and may be ignored or failed, before being shelved and forgotten. It is, therefore, really refreshing for the AIMS project to be based around standards that really matter to the people who use the services and the people who care for them.

It is my experience both as a reviewer and as chair of the Working Age Adult Advisory Group that this central role is neither a “box-ticking exercise” nor a sinecure. This project has at its heart the unwavering intention to improve services in ways that are meaningful to patients and their families. AIMS remains focused on this goal by not just involving patients and carers, but by placing them at the centre of its activities. It is often to the patients and carers that we turn at times of uncertainty or when faced with a dilemma. Their comments are usually the most pertinent and incisive that we hear at the Advisory Group meetings and during reviews. This central role for patients and carers ensures that the work of the AIMS group and the standards set for wards to achieve are ones that make a genuine difference to people using the service. In my experience, this places patients and carers in a unique position within the world of service delivery and quality improvement.

AIMS could not function without the dedication and diligence of the staff at the College Centre for Quality Improvement (CCQI) and their tireless endeavours. They face onerous – perhaps often tedious – tasks, awkward reviewers, deflated and despondent services and ongoing pressure to advance the project with professionalism, and a calm and cheerful demeanour. Their work should not be underestimated.

Despite the undoubted achievements of the last 10 years, work remains to be done. Those services involved with AIMS are undoubtedly changing for the better, but we reach, perhaps, half of all adult inpatient services in the country. Recruiting those not yet acquainted with the process, in my opinion, is the primary challenge facing AIMS in the coming years. The development of Associate Membership status is likely to provide a helpful stepping stone en route to full membership.

All involved in mental health services should salute the anniversary and achievements of this project in its first ten years, offer our support in whatever ways we can and join AIMS in looking forward to the next ten years of relentless improvement in the experience of our patients and their carers.

Dr Ty Glover

Consultant Psychiatrist and Chair of AIMS-WA/AIMS-AT Advisory Group

Introduction

Accreditation for Inpatient Mental Health Services (AIMS) was established in 2006 to promote better standards of care within mental health inpatient wards. AIMS is run by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) and works with service users, carers and clinicians from multi-disciplinary backgrounds working in inpatient services.

The AIMS project was created as a result of the findings of the National Audit of Violence 2003-2005 which highlighted key areas of concerns, in particular the high prevalence of violence on acute wards, but also concluded that the examples of good practice were going unrecognised. An accreditation network for inpatient wards would help by setting national standards and rewarding wards which achieve high standards. The pilot of the AIMS project was conducted in 2006 with 16 wards, and seven of these wards have subsequently gone through three cycles of the AIMS self-and peer-review process. The project has rapidly expanded over the last 10 years and had 145 members as of July 2016.

Services are reviewed against a set of standards specific to working-age adult wards (WA). The AIMS-WA standards¹ are based on best available evidence and national guidance. They are reviewed by a multi-professional group, service users and carers on a regular basis and member wards are expected to update their practice in line with the revised standards.

Alongside the AIMS-WA project, there is also a small branch of AIMS for Assessment and Triage Services, known as AIMS-AT, launched in 2008. A specific set of standards was created for wards that follow this model, with most standards in common with the AIMS-WA standards, but with additional standards focusing on issues related to short-stay admissions, transfer and discharge. The accreditation process is the same as AIMS-WA. There are five members of AIMS-AT as of July 2016. For the purposes of this report we will look at the data from the AIMS-WA wards as it would be difficult to draw conclusions about AT wards based on only five.

Objectives

The aim of the project is to accredit inpatient services which offer a timely and purposeful admission in a safe and therapeutic environment. In addition to this it aims to create a national network to engage and support staff through:

- a database of standards for inpatient care;
- the AIMS peer-review process – both by the peer-review received by a member service and by participating in other members' peer-reviews;
- an email discussion group;
- events run by the Project Team.

¹ Cresswell, J., Beavon, M. and Robinson, H. (2014) Standards for Acute Inpatient Services for Working-Age Adults, Fifth Edition (www.rcpsych.ac.uk/AIMS-WA).

The Accreditation Process

Accreditation involves assessing wards against a set of standards through the process of self-review and peer-review.

The standards are graded into three types:

Type 1 Standards are essential to safety, rights, dignity and the law.

Type 2 Standards are those an accredited ward would be expected to meet.

Type 3 Standards are those that an excellent service would be expected to meet or standards that are not the direct responsibility of the service.

There are three phases of the AIMS accreditation process:

Self-Review

Wards undergo a self-review period of three months, which requires the service to gather data using a range of audit tools: patient questionnaires, carer questionnaires, an environment and facilities audit, a ward protocol checklist, ward manager questionnaire, staff questionnaires and health record audits.

Peer-Review

Following the self-review period, a one-day peer-review visit is arranged that will include staff from other services participating in AIMS. The teams will usually consist of five reviewers; three professionals (at least one of whom is a nurse), a service user and a carer representative. The role of the peer-review team is to validate the self-review data as well as identifying areas of achievement and areas for improvement.

Accreditation Decision

The Accreditation Committee (AC) is made up of individuals who are representative of the multi-disciplinary nature of member services, as well as service user and carer representatives. The role of the AC is to review the self-review data and peer-review comments and reach an accreditation decision for the ward. A ward's accreditation may be deferred for up to a year whilst improvements are made to address any unmet Type 1 Standards highlighted by the self-/peer-review.

The AIMS model is more than a one-off inspection to assess the current standards being met. Its purpose is to encourage wards to improve continuously and to achieve excellence.

As of January 2015 each AIMS cycle takes three years. After a full self- and peer-review, a decision is made about accreditation status. After 18 months, there is an interim self-review to ensure the ward is maintaining standards. Once a ward has completed the full three-year cycle, the process begins again and the ward moves to the next cycle.

Further information on the AIMS-WA standards and process can be found at www.rcpsych.ac.uk/AIMS-WA.

Figure 1 shows the complete AIMS-WA Accreditation Cycle.

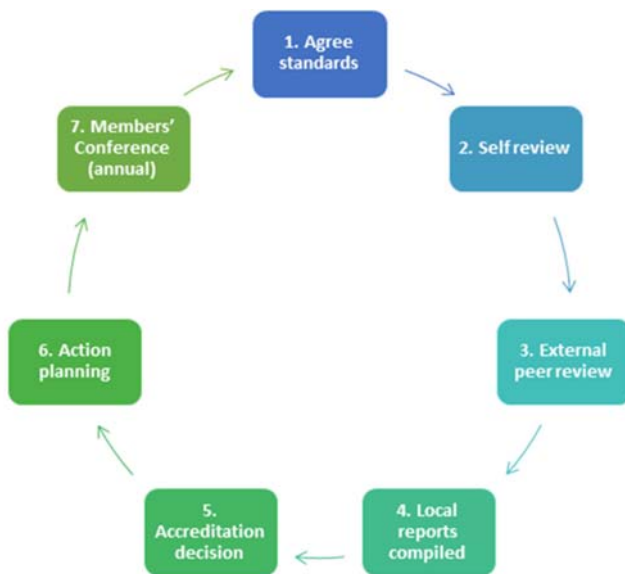


Figure 1. The AIMS-WA Accreditation Cycle

There are four categories of accreditation status:

“Accredited as excellent” (discontinued December 2014)

The ward/unit would at the point of peer-review:

- meet all Type 1 standards;
- meet at least 95% of Type 2 Standards;
- meet the majority of Type 3 Standards.

“Accredited”

The ward/unit would at the point of peer-review:

- meet all Type 1 Standards;
- meet at least 80% of Type 2 Standards, with no significant gaps in any particular section of the standards;
- meet many Type 3 Standards.

“Accreditation Deferred”

The ward/unit would at the point of peer-review:

- fail to meet one or more Type 1 Standard 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.

“Not Accredited”

The ward/unit would at the point of peer-review:

- fail to meet one or more Type 1 Standards and not demonstrate the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 Standards, or a cluster of Type 2 Standards, and not demonstrate the capacity to meet these within a short time;
- fail to have submitted adequate self-review data.

This Report

This Third Edition of the AIMS-WA National Report explores how well 145 wards enrolled with the project are undertaking actions which lead towards quality improvement in their services.

The report begins with an overview of the overall performance of 145 member wards, including their performance in the review cycles. It also analyses contextual data gathered from 104 wards which have started the self-review stage of the process during 2015-16. This data includes number of beds, bed occupancy rates, average stay and staffing levels. Key themes, which have emerged from the data collected from 92 wards, are explored, including organisational themes, as well as themes which have emerged from analysing patient and carer responses.

The report then goes on to a brief discussion around the data gathered from 49 wards which have completed both the self-review and peer-review stages. It particularly focuses on Type 1 Standards that were most commonly marked as 'Not Met' during both stages.

This report also compares the themes which emerged from data collected for the last two National Reports, 2007-2009 and 2010-2011 respectively, and summarised it in the section headed 'Update on the data from the 2nd National Report'.

As the main aim of the AIMS-WA project is to support member wards to continuously improve the quality of care that they provide, standards are reviewed and updated regularly. During the last 10 years AIMS-WA has published six editions of standards (including the pilot edition). In this National Report we were able to compare how well the wards scored when undergoing the review cycles under several editions of the standards.

Finally, this report concludes with a recommendations section which encompasses the emerging themes and the frequently-unmet Type 1 Standards. Six recommendations are made which include an emphasis on patient and carer involvement; staffing levels and staff wellbeing; planned evening and weekend activities for patients; medication competency assessments; and the ward environment and facilities.

Note on the Data Within This Report

The data used within this report has been gathered from different sources. The number of wards included in the data reported differs, depending on where in the process each ward has reached. The contextual data was taken from the 'starter form' that all wards complete at the start of each self-review period, and 104 wards had completed this form. Of these 104 wards, 92 wards had completed or were undertaking their self-review: the key themes were drawn from data across these 92 wards. Forty-nine wards have completed self-review and received a peer-review visit since January 2015 and the frequency of Not Met Type 1 Standards was gathered from these 49 wards.

Overall Performance of Member Wards

By July 2016, 145 working-age wards had enrolled in AIMS. Of these, 134 were located in England, four in Wales, three in Northern Ireland, three in Scotland, and one in Jersey. Of these, seven wards are suspended and six wards are Not Accredited and are not participating in the AIMS process.

The table below shows all the active AIMS-WA/AT member wards:

Accreditation Status	Numbers of WA Wards (AT wards)
Accredited as Excellent*	43 (2)
Accredited	49 (2)
Accreditation Deferred	22
Not Accredited	6
In Self-/Peer-Review Stage	14
Membership Suspended	6 (1)
Total	140 (5)

Table 1. Status of member wards as of July 2016

* From 1 January 2016, the accreditation status of 'Accredited as Excellent' is no longer being offered to member services. Wards Accredited as Excellent before January 2016 will retain their status until their next full review, subject to satisfactory interim review.

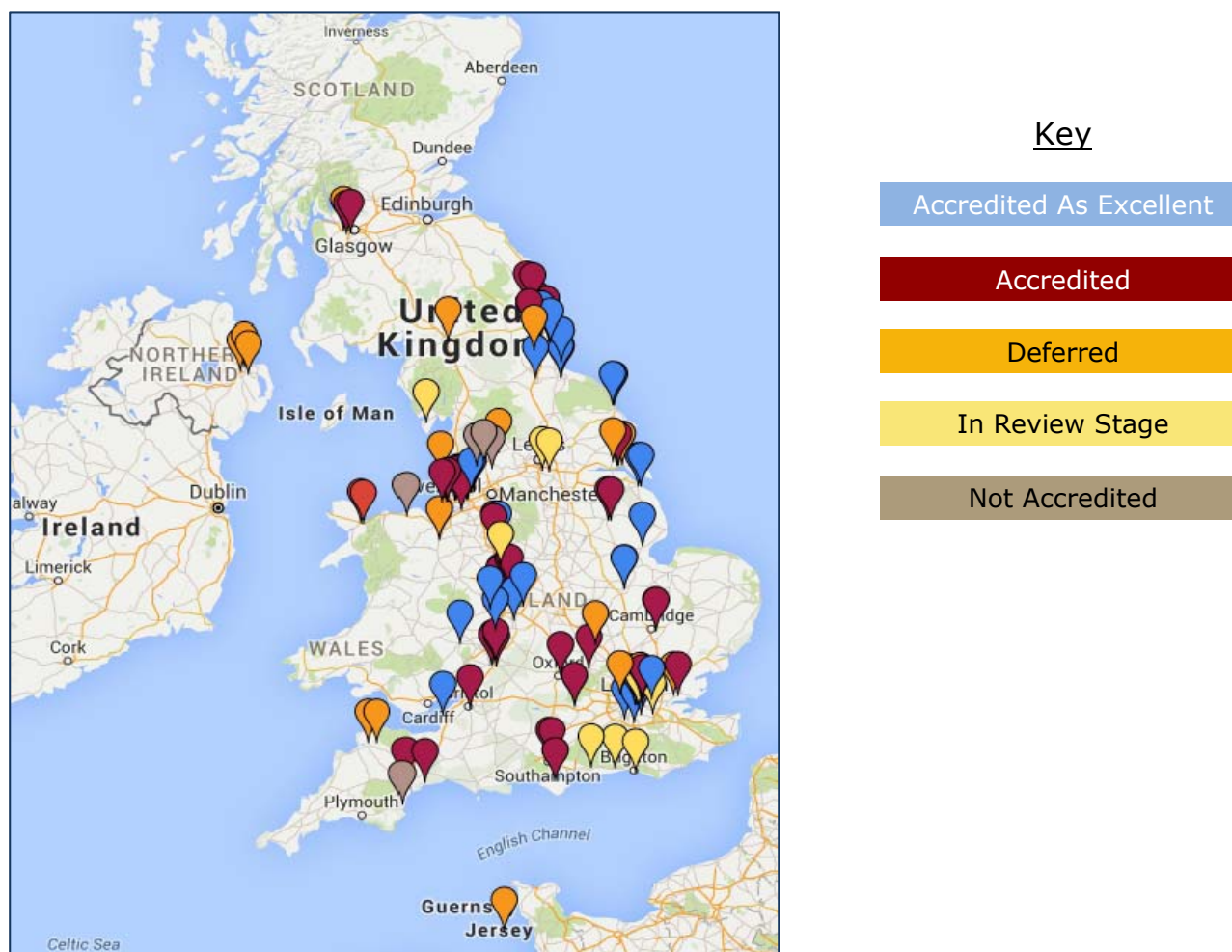


Figure 2. Map showing location and accreditation status of AIMS-WA members as of July 2016

Subsequent Cycles of Review

Sixty wards have completed their second full review in 2012-2016. Six wards are still undergoing their second cycle review. A comparison of their accreditation status between first and second cycles is displayed in Table 2. This is a snapshot of the wards' accreditation statuses as of July 2016. Wards which are accredited may have previously been deferred, and wards currently deferred will in most cases subsequently be re-accredited after their period of deferral.

Accreditation Status	Number of wards	Percentage of wards
Remained 'Accredited as Excellent'	14	21%
Moved from 'Accredited' to 'Excellent'	18	27%
Remained 'Accredited'	10	15%
Moved from 'Excellent' to 'Accredited'	5	8%
Moved from 'Accredited' to 'Not Accredited'	1	2%
Deferred in second cycle	12	18%
Still under review in second cycle	6	9%

Table 2. Change in accreditation status from first to second cycle of AIMS

Seventeen wards have completed their third full review in 2012-2016 and 12 wards are undergoing their third cycle review. A comparison of their accreditation status between second and third cycles is displayed in Table 3.

Accreditation Status	Number of wards	Percentage of wards
Remained 'Accredited as Excellent'	2	7%
Moved from 'Accredited' to 'Excellent'	1	3%
Remained 'Accredited'	4	14%
Moved from 'Excellent' to 'Accredited'	4	14%
Moved from 'Accredited' to 'Not Accredited'	0	0%
Deferred in third cycle	6	21%
Still under review in second cycle	12	41%

Table 3. Change in accreditation Status from second to third cycle of AIMS

As mentioned above, the option of 'Accredited as Excellent' was no longer available to wards undergoing their second or third cycle after January 2016. This is likely to have had a negative effect on the numbers remaining as 'Accredited as Excellent' or moving to 'Excellent' and will have likely increased the number of wards moving from 'Excellent' to 'Accredited'. This makes it difficult to conclude how many wards have maintained the threshold for 'Excellent' but it does help to show that only one previously- accredited ward was now Not Accredited, and illustrates that 71% of wards at cycle 2 have been

re-accredited. It also shows that 18% and 21% of wards are currently deferred in second and third cycle respectively.

Contextual Data

All wards starting a self-review period are asked to provide up-to-date contextual data, including number of beds, bed occupancy, and average stay. The following figures are based on data gathered from 104 wards that have started their self-review over the last year. This excludes data from four Assessment and Triage wards. It can be seen in figure 5 that the average length of stay is quite varied, ranging from five days to a maximum of 76 days. However, more than half of the wards had an average length of stay of 30 days or under (n=54, 53%). Only four wards had an average length of stay longer than 60 days.

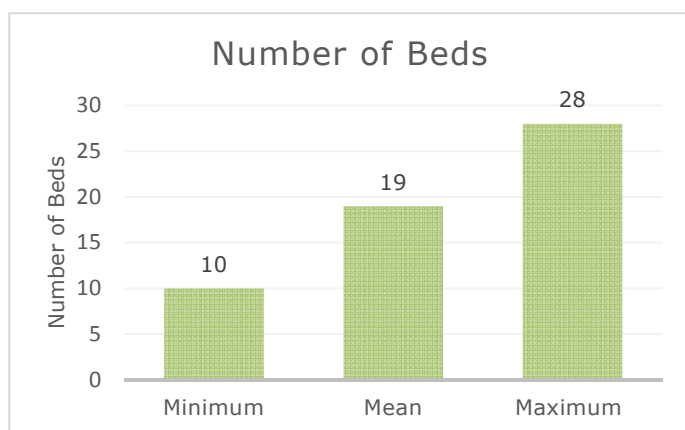


Figure 3.

Figures 3, 4 and 5 show the mean, minimum and maximum figures for the number of beds, percentage occupancy and average length of stay.

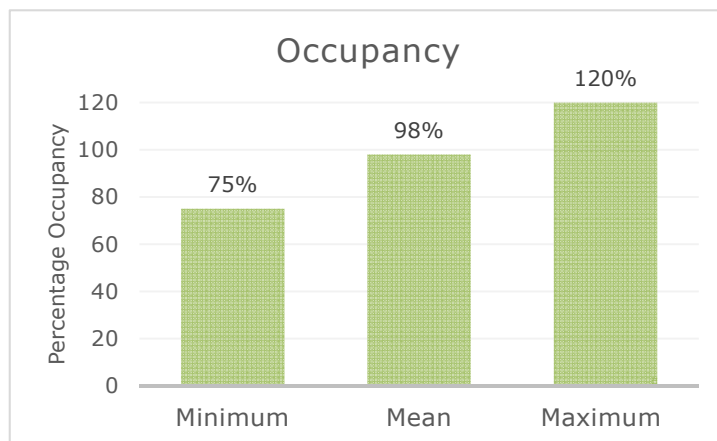


Figure 4.

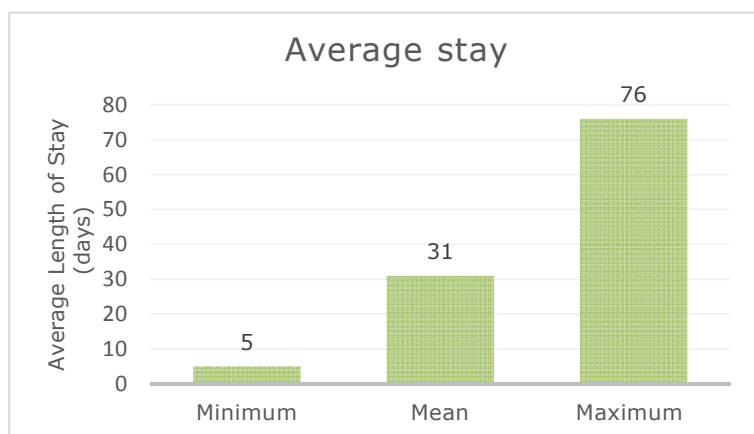


Figure 5.

Table 4 demonstrates that more than a quarter of AIMS-WA wards have admitted a young person to the ward in the last year. Our questionnaire does not currently ascertain how often in the last year wards have admitted a young person so we are unable to report the frequency this occurs. The frequency that a young person is admitted to working-age services suggests the importance for AIMS-WA to include standards around young person admissions on adult wards.

Admission of under-18s	Number of wards	Percentage of wards
Admitted under-18s	29	28%
Not admitted under-18s	65	62%
Not answered	11	10%

Table 4. The number and the percentage of wards admitting a young person (under 18 years) in the last year

Figure 6 shows the mean number of staff across the professions working on the member services. Only 14 wards out of 104 reported having no psychologist working on the ward. Three wards out of 104 had no occupational therapist.

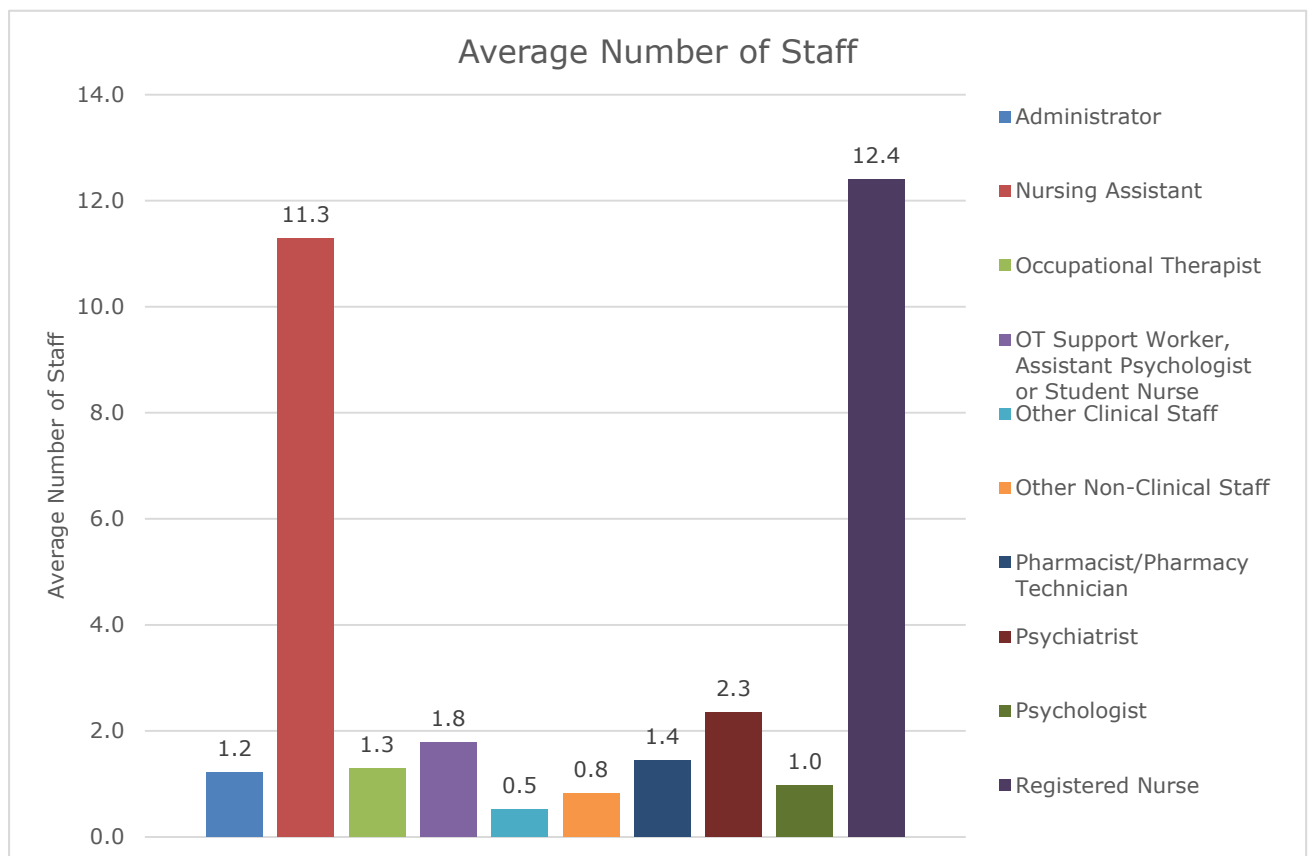


Figure 6. Mean number of staff on AIMS-WA wards

Staffing Levels

On all 104 wards, the minimum number of qualified nurses on early shifts was two. However, a minimum of one qualified nurse on late shifts was stated by two wards, and 39 had a minimum of one qualified nurse on night shifts (37%). This is significant as it is often cited as a reason that nursing staff are unable to take a break on the ward as there is no other qualified nurse to cover for them.

Figure 7 shows there is some variation for agreed minimum staffing levels across the three shifts for both qualified and unqualified nurses.

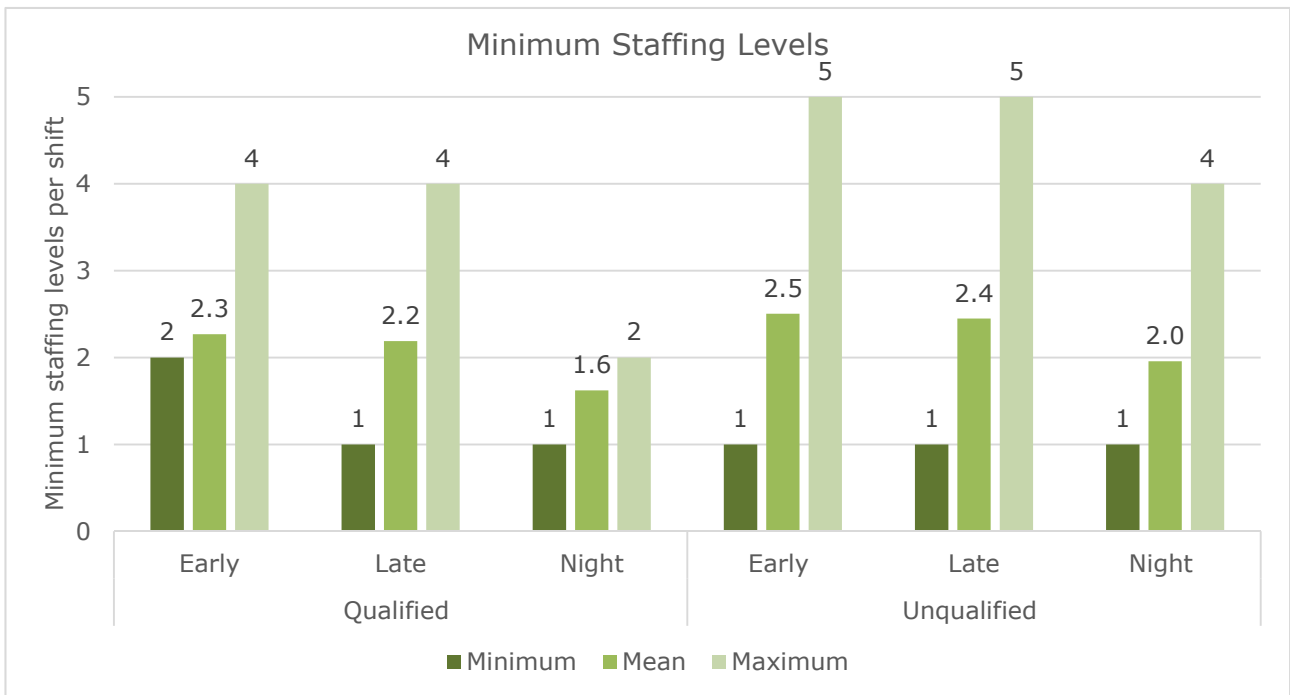


Figure 7. Minimum staffing levels per shift for both qualified and unqualified nursing staff

Key Themes from 2015-16 Data

In 2015-2016, 92 member wards completed a self-review period on the same set of standards (*Standards for Acute Inpatient Services for Working-Age Adults – 5th Edition*). Of these 92 wards, 56 were wards completing a full review and were scheduled to have a peer-review to validate the data (49 of which had taken place by July 2016), the other 36 were at the interim stage and only completed the self-review.

As AIMS-WA runs on a rolling cycle, with wards starting self-review at any point during the year, the cut-off point for data for this report was done by date (January 2015 to July 2016). Not all wards included in this report had submitted all their data. As a result, some questionnaires have all 92 wards' data but others have fewer than this.

The self-review data has been collated for these 92 wards and we have been able to highlight the main themes emerging from the data. The organisational themes identified include staff training, access to psychological interventions, activities, breaks, supervision and appraisals, and seclusion. The themes from patient and carer responses include information and communication, food, respect and dignity, and carer involvement.

Organisational Themes

Staff Training

The questions on training are asked in the Staff Questionnaire and are routed to only ask certain staff members the questions where the training is required for their role. These reflect the varying response rates for questions, ranging from 2462 (all staff) to 976 (registered nurses only). Staff questionnaires have been completed by a variety of professions: administrators (n=117), nursing assistants (n=785), occupational therapists (n=96), OT support workers/assistant psychologists/student nurses (n=107), other clinical staff (n=71), other non-clinical staff (n=54), pharmacists/pharmacy technicians (n=56), psychiatrists (n=152), psychologists (n=48) and registered nurses (n=976).

- *Areas of Achievement*

Nearly all staff (96%) had completed a course covering safeguarding children and vulnerable adults. Of staff who undertake assessment and care planning, 87% have received training in care planning including CPA and discharge planning, 87% have received training in how to assess capacity and the Mental Capacity Act and 95% had completed training on risk management and risk assessment.

Impressively, 88% of staff have received training and support to provide basic psychological and psychosocial interventions. This shows a vast majority of staff working on acute wards have a working knowledge of basic psychological interventions. It also suggests an improvement from data gathered from the previous National Report which showed that 58% of staff had completed a course covering basic CBT and 62% of staff had received training on other basic psychological interventions.

- *Areas for Improvement*

Of the staff who administer medication, 23% had not completed a medication competency assessment in the previous 12 months (U8.4 [1]). This was the third most frequent standard wards were not meeting after peer-review, with 25 out of 49 wards not meeting this standard. There appears to be differences across the various Trusts/organisations nationally over how frequently nurses are assessed on this. Many Trusts/organisations seem to require this to be completed three-yearly while some Trusts/organisations did not have a formal requirement to review this unless a medication error occurs. As this is an important area and it is vital wards are proactive in maintaining staff competency to administer medication, member wards are required to assess this yearly regardless of their local requirements.

Overall, 31% of staff said training had been cancelled in the last 12 months due to a lack of staff cover. At peer-reviews staff provided other reasons for staff training being cancelled, including courses being cancelled by the organisers or training being overbooked, which were reasons that would be outside the ward's control. Seven wards were marked as not meeting this standard at peer-review.

Access to Psychological Interventions

- *Areas of Achievement*

We have already established that a greater percentage of staff are being trained to deliver basic psychological interventions than seen in the previous National Report. Encouragingly the self-review data shows there has also been an increase in access to specialist practitioners of psychological interventions (51.2 [1]). In the 2012 National Report, 72% of 25 wards reported they had access to specialist practitioners of psychological interventions for one half-day per week per ward. Current data shows 91% of 92 wards have access to the same. In 2012, 48% of wards had access for more than one day per week per ward compared to 77% of wards now.

This improvement can also be seen at the point of peer-review. In this report's data only 12% of wards were not meeting this standard at peer-review compared with 35% of wards in the 2012 report.

Additionally the percentage of wards where at least one staff member linked to the ward is delivering one basic, low intensity psychological intervention is now 96% of wards.

- *Areas for Improvement*

When asked about whether patients are invited to attend therapeutic group contact for at least one half-hour per day (Monday-Friday), staff scored themselves higher compared with the responses from patients (staff: 88%; patients: 66%). Moreover, 85% of staff and 63% of patients said patients are able to access regular group meetings with a psychoeducational focus.

Patient Comments:

"Level of therapy is very poor and should be increased, improved..."

"Some therapy is somewhat ad hoc. Not really enough."

"Some extra group work facilitated by staff maybe beneficial in relation to psycho-education."

Activities

- *Areas of achievement*

All but one Ward Manager stated that activities were provided on a timetabled basis Monday to Friday, and 88% of patients agreed there was a timetable of activities Monday to Friday.

Patient Comments:

"There are plenty of activities available if you choose to attend."

"Always offered to join in on games or activities and reassured it is okay to say no."

"I like the activities there are lots to choose from."

"The activities team are always getting patients and staff involved in all sorts of different activities which is excellent!"

- *Areas for improvement*

Although activities are generally provided during Monday-Friday, 9-5, outside of these times there is still a need for more scheduled activities. Eighty-six Ward Managers stated activities are provided at weekends (53.11 [1]) and 82 stated that activities are provided during the evenings (53.12 [1]). However, 68% of patients said activities are provided during the weekend and 62% of patients said activities are provided during the evenings.

After discussion with patients on the peer-review days, these two standards were the most common Type 1 Standards to be marked as Not Met. These standards were designated as Not Met for 26 out of 49 wards (weekends) and 25 out of 49 wards (evenings).

Patient Comments:

"More activities should be provided to reduce boredom, likewise therapy."

"There needs to be more structured activities, as well as activities that patients can be involved in during the weekends."

"Range of activities not adequate to keep patients positively occupied. If you do not like gym or art nothing else much to do."

Staff Access to Breaks, Supervision and Appraisals

▪ *Areas of achievement*

The percentage of staff who have received an appraisal in the past year is high. Ninety-nine percent of Ward Managers have had an annual appraisal and 90% of staff reported receiving an appraisal in the previous year.

We asked staff who responded 'no' to this question to provide a reason why not. Of the 237 staff, 34% of staff members said that at the point they completed a questionnaire they had not yet worked on the ward for a whole year, and 17% of staff members said they were temporary members of staff. Given these explanations, more than half of the 'no' responses could be classed as 'not applicable', which would increase the percentage of staff receiving an appraisal.

There were quite varied reasons given for not having had an appraisal, including maternity leave, sick leave and management changes.

▪ *Areas for improvement*

Although the percentages of staff saying they receive clinical supervision every eight weeks, and regular management supervision, is high (81% and 86% respectively), at peer-review 12 out of 49 wards were not meeting the clinical supervision standard and six wards were not meeting the management supervision standard. This suggests that this is an area to continue to work on within acute inpatient settings, to ensure that supervision is routinely completed.

Eighty-two percent of staff reported that they could take allocated breaks away from patients during each shift. Of the 447 staff who said 'no' to this question, 82% of staff said this was due to a shortage of staff on the ward or too much work or clinical acuity. Twenty-three staff members mentioned they are usually unable to take a break because they are the only qualified member of staff on shift. Sixteen members of staff said they are not entitled to a break, with some staff indicating that breaks are not allocated for 7.5 hour shifts.

It is also interesting to note that when looking at how staff responded taking into account their professions, registered nurses most frequently were unable to take a break away from patients each shift (25%) followed by nursing assistants (20%). The other professions showed percentages that were all 10% or lower.

This data suggests that there is still more that could be done to ensure that staff are able to take a break away from patients each shift and there is perhaps still a cultural shift within nursing that is needed to prevent staff staying on the ward because of the amount of work to be done, or because of clinical acuity.

Seclusion

The standards around seclusion were amended for the 5th Edition of standards. The seclusion room standard was promoted to a Type 1 Standard and as a result wards have to meet all parts of the standard for the standard to be marked as Met. The standard specifies that there is a designated room fit for purpose, that this room allows for clear observation, is well insulated and ventilated, has access to toilet/washing facilities, is able to withstand attack or damage, has a two-way communication system and has a clock that patients can see.

Of 92 wards, 41 have a seclusion room or the use of one within their unit. Only one ward said the room was not fit for purpose. Table 5 shows the responses to the specific questions about the seclusion room.

Standard	Response	Percentage
The seclusion room: allows clear observation;	40 yes 1 no	98%
is well insulated and ventilated;	40 yes 1 no	98%
has access to toilet/washing facilities;	41 yes	100%
is able to withstand attack/damage;	40 yes 1 no	98%
has a two-way communication system;	37 yes 4 no	90%
has a clock that patients can see.	41 yes 1 no	98%

Table 5. The responses to the specific questions about the seclusion room

Of the 49 wards that went on to have a peer-review visit, 22 wards had a seclusion room or access to one. After seeing the seclusion rooms on peer-review visits, seven out of the 22 wards were found not to be meeting aspects of this standard. The most common reason was not having a two-way communication system but access to toilet facilities was also raised as an issue, and one ward did not have a clock displayed.

Themes from Patient Responses

The self-review data from the patient questionnaires has provided insight into the patient experience on acute inpatient wards. The patient questionnaire was completed by 1777 patients. As patients are able to skip questions the number of responses to each question does differ, ranging from 1519 to 1704.

Information and Communication

- *Areas of achievement*

On admission, 84% of patients were welcomed by a member of staff and offered refreshments, staff were asked whether this was offered to each patient and only six staff said 'no'. The majority of patients said they were introduced to a member staff who would be their point of contact for the first few hours of admission (89%), and 99% of staff reported that this happens. Eighty-seven percent of patients reported that they were shown around the ward as soon as possible after admission, and only eight staff said this does not happen.

Given the nature of admission and that patients often report how confusing and stressful the first few days of admission are, these percentages and patient comments (some examples below) show that in general the welcome to the ward is a positive one.

Patient Comments:

"Felt comfortable as soon as I arrived. Friendly staff came across very approachable."

"A named nurse told me how to meet them. Nice nurse [name] sat with me and told me stuff."

"I arrived early hours of the morning and the night staff who were on duty were really lovely."

"Came in during the night so was shown around the next day."

All 89 wards said they provided both informal and detained patients with information on their rights and 69% of patients said they received information on their rights. This represented an improvement from 2012 where 60% of patients said they were given information on their rights. Wards have been working creatively to ensure this information is actively communicated, and not just included in the welcome pack or handed in leaflet form. This included repeating rights information regularly, not just on admission, explaining rights at community meetings, prompts on admission checklists for staff and regularly auditing whether this information was communicated to both detained and informal patients.

- *Areas for improvement*

The percentages of ward responses indicate that information is provided to patients on how to provide feedback to the service (100%) and provide information on advocacy (100%). However, patient responses do not indicate that they have all been provided with this information: 70% of patients said they were told how to make a complaint and 67% of patients were given information on advocacy. Although this would seem to suggest that more needs to be done to ensure patients are familiar with this information, qualitative feedback suggested that patients were happy to approach staff when needed.

Patient Comments (Complaints):

[Are you told how to make a complaint if you want to?] "No, though if I felt the need to make a complaint I would speak to the nurse in charge or the senior charge nurse."

"I don't have to complain at the moment but am sure, if I need to, I can ask the staff they are friendly."

Patient Comments (Advocacy):

"I wasn't aware of advocacy, how to access local organisations, but know how to approach nursing team if need any help to find answers/support."

"I wasn't told what advocacy was at all."

[Were you given information on what advocacy is, and how to access it?] – "I believe so."

All wards said they explain to patients the level of observation they are under but 71% of patients responded that this had been explained. Improvements are needed to ensure patients are involved in the discussion of observation.

Patient Comment:

"It would be helpful if it could be explained about the observations."

Only 67% of patients had been offered a copy of their care plan. Qualitative feedback suggests that patients did not feel involved in creating their care plan.

Patient Comments:

"I asked for a care plan 4 days in a row and then gave up I became exhausted constantly being on my feet trying to get someone to spare a minute or so."

"I was given a care plan and it was not discussed and handed to me."

"Never had my medication or care plan discussed!"

"I was told by another patient how to access my care plan."

Sixty-four percent of patients had been told they could speak to a pharmacist or pharmacy technician to discuss their medication.

Quality, Well-Prepared Food Catering for Individual Needs

The question of food quality is a subjective one but in general patients appear satisfied with the quality of the food, with 82% of patients saying the food is of good quality. Three wards said the food provided is not of good quality. As a result of patient feedback on the peer-review day, six wards (out of 49) were found not to be meeting the standard on quality of food.

Patient Comments:

[Food quality] "Room for improvement."

"The food has got better i.e. more choice. There is more fruit available."

"Food okay."

"The food is of excellent standards."

"Food is lovely."

"I'm a picky eater, the food is good quality but suitable options are not always available."

"The food is not great and seems to be getting worse."

"Not enough food at meal times for me."

Eighty-one percent of patients said the food is well-prepared and meets their individual needs. One ward said there is not a choice of well-prepared food that meets individual needs.

Respect, Dignity and Confidentiality

A large majority of patients (93%) said that staff treat them with respect. Ninety-two percent of patients reported that staff respect their personal space and 91% of patients felt their privacy, dignity and confidentiality was ensured when receiving medication.

A new question was created for this edition of standards that asked staff about mutual respect, and 90% of staff responded that staff and patients treat one another with mutual respect.

Staff Comments:

"I enjoy the mutual respect and interaction between staff members and patients."

"I think we have good MDT working and have a mutual respect for each other's work."

Staff comments suggest that some negative responses to this question were due to staff not feeling that patients respect staff on the ward.

Staff Comments:

"Staff respect patients but the same cannot be said for the patients respecting staff, the staff on the ward put up with unacceptable behaviour from patients every day."

"Staff treat patients with respect and dignity at all times whereas some patients treat staff with contempt, often verbally abusive and derogatory and occasionally physically abusive."

"Patients and staff generally treat each other with mutual respect however; some patients have been verbally hostile and assaultive towards staff."

Themes from Carer Responses

The carer questionnaire was completed by 461 carers. Some questions were routed so that carers were only asked the question if they responded yes to a previous question. Also, as with the patient questionnaire, carers were able to skip questions, so the response numbers for each question varies from 313 to 453.

Carer Involvement and Communication

- *Areas of achievement*

Ninety-two percent of carers responded that they had been given contact details for the ward and 90% of carers had received information about ward procedures.

Eighty-eight percent of carers said staff had discussed the reasons for the patient's admission to the ward.

Carer Comments:

"We are extremely happy with the help/advice we have received whilst [Name] has been having treatment."

"I have been well supported by staff off the ward. I'm reassured on a daily basis by [Name] who makes my [relative] being in hospital an easier experience."

"I felt empowered during my [relative's] stay."

"I have had professional treatment from start to finish."

"We have been more than happy with the help and support."

"This ward, when I was a carer, rang to enquire of my [relative's] presentation, was very open in discussing his wellbeing which was positive."

Fifty-four percent of carers had been able to access regular group meetings that focus on understanding mental health problems and its treatment, either on or

off the ward. This is a Type 3 Standard currently, and is therefore more aspirational, but it is encouraging that more than half the carers reported this was available.

On examining the carer comments it appears that this percentage would be higher if the data takes into account carers who have declined to attend or have not been able to access regular group meetings due to work or other commitments. This suggests that the wording of the standard could be improved and might be influencing the response, with "able to access" implying more than whether group meetings are available either on or off the ward/unit.

Carer Comments:

"Was offered about carers Group Meetings, but did not want to take part. I do not feel comfortable with it, prefer one to one with professional."

"...but this is because of my personal circumstances I have repeatedly been made aware of the group meetings which are available to me and have been offered support."

"Time is a constraint as I work full-time."

- *Areas for improvement*

Sixty percent of carers had not received a copy of the patient's care plan and 52% of carers had not been told they could speak to a pharmacist or pharmacy technician.

When analysing the carer comments in the questionnaire there were many on the theme of lack of information and communication. Below are some examples:

Carer Comments:

"Little/no information offered to next of kin. Obtaining information on patient's wellbeing/treatments is difficult as will not give updates on the telephone and they are invariably busy when attempting to speak in person on the ward. Akin to wading through treacle...."

"There seems to be a major problem with communication (or should I say lack of it) between hospital staff and my family, we have to constantly ask different staff if we want information regarding our [relative's] care, in our opinion this is wrong, staff should be keeping us informed every step of the way. However, this has not been the case, improvements with communication need to be made."

"My [relative] was on the ward some weeks before I was given any information about having a carer's assessment. I felt quite isolated getting information. The staff are so busy in the office it is awkward to disturb them. However I have been supported by some staff members really well."

Carer Comments continued:

"I have found communication lacking. Initially I had no clue about expectations etc. as above and I have learnt more by feel than explaining. When stressed and terrified, better communication would go a long way to help cope with the situation."

"We have been told absolutely nothing from ward staff. They don't approach or speak to you even at visiting. The only time we have been told about advocacy or anything else was at the meeting that was arranged on (date) from the staff."

"Have not been informed of any of the above. As a caring family it would have been useful to have known this information earlier. Thank you for sending this questionnaire as we now know what to ask for."

Peer-review reports showed that information is often displayed on notice boards or included in welcome packs, however it is possible the information is not clear or displayed in suitable places on the ward. Wards could create carer information booklets that include information on how to get in contact with the ward.

It is also clear from peer-review reports that the issue of consent to share information is often given as a reason that carers are not able to be informed about the patient's treatment. However, wards can still provide generic information and signpost to services for carer support.

Friends and Family Test

A recent addition to the self-review tools with the latest revision of the standards was the Friends and Family Test, a tool that is used within all NHS services around the country. We are able to look at the data across member services and provide a national picture.

Patients were asked in the patient questionnaire "how likely are you to recommend the ward/unit to friends and family if they need similar care or treatment?" Figure 8 shows a visual representation of the patient responses to this question.

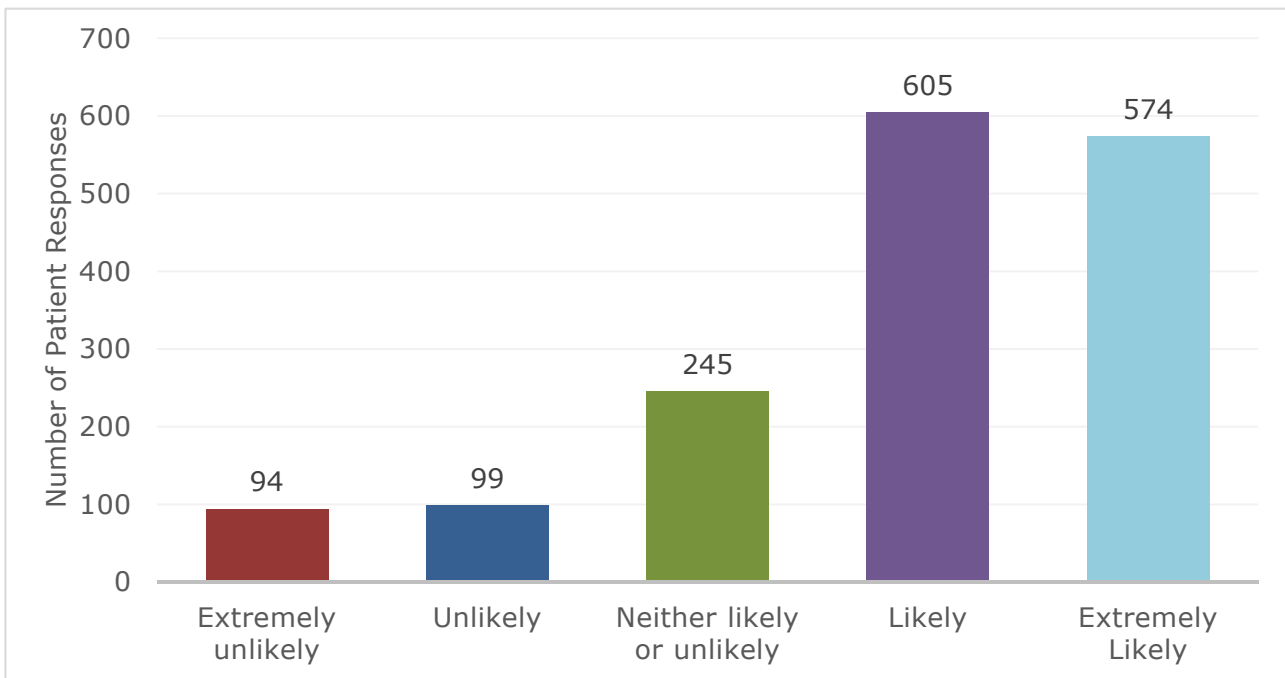


Figure 8. A visual representation of the patient responses to this question

The graph above demonstrates that 73% of patients responded positively (either likely or extremely likely to recommend).

Patient Comments:

"There are much worse managed wards. That's why I would recommend this one."

"I would most definitely recommend to other people found to be in my position."

"I would like to see a lot more promotion of activities, counselling and less abruptness from staff before recommending this ward."

"I recommend all patients to [ward name] as they look after you one to one any time of the day. All nursing staff are excellent."

"Would recommend [other site] rather than [this site]."

We also asked staff in the staff questionnaire whether they agree with the statements “I would be happy for a family member or close friend to be treated on this ward” and “I would encourage a family member or close friend to apply for a job on this ward.” Figure 9 shows the responses to the statement “I would be happy for a family member or close friend to be treated on this ward”.

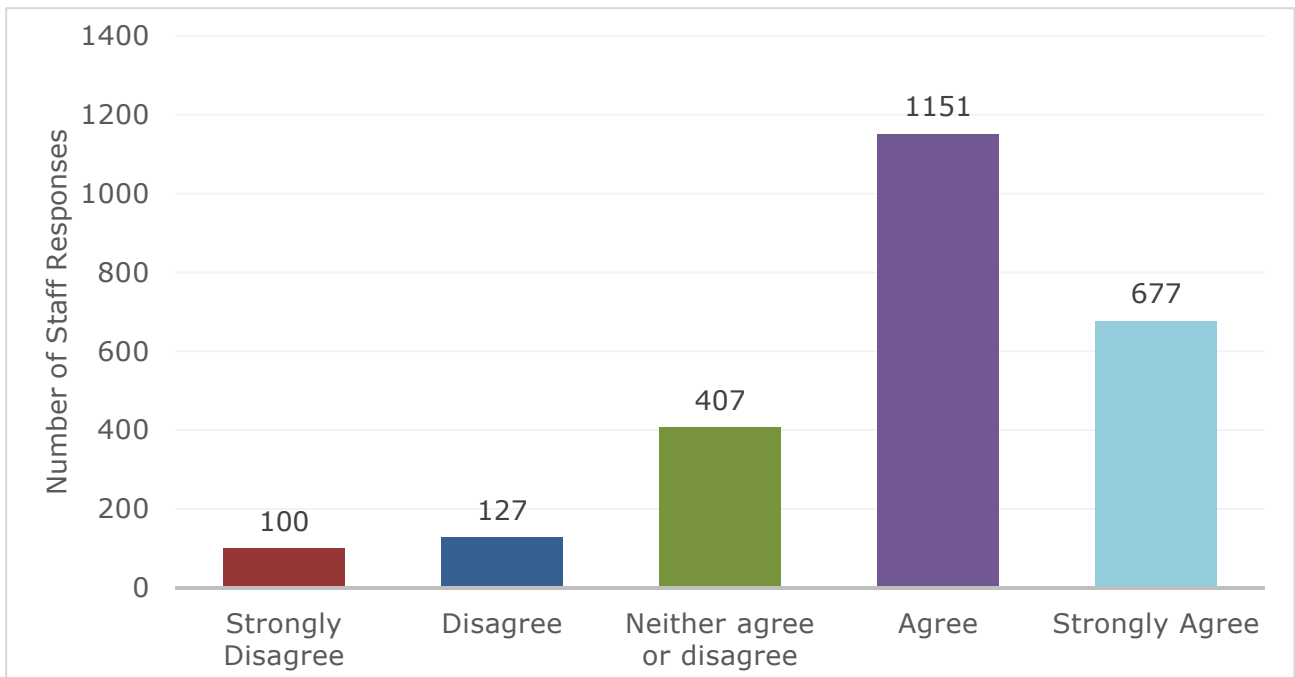


Figure 9. A visual representation of the staff responses to this statement

Figure 9 shows that 74% of staff responded positively that they would recommend their ward to family or a friend who needed mental health care.

Figure 10 shows the responses to the statement “I would encourage a family member or close friend to apply for a job on this ward”.

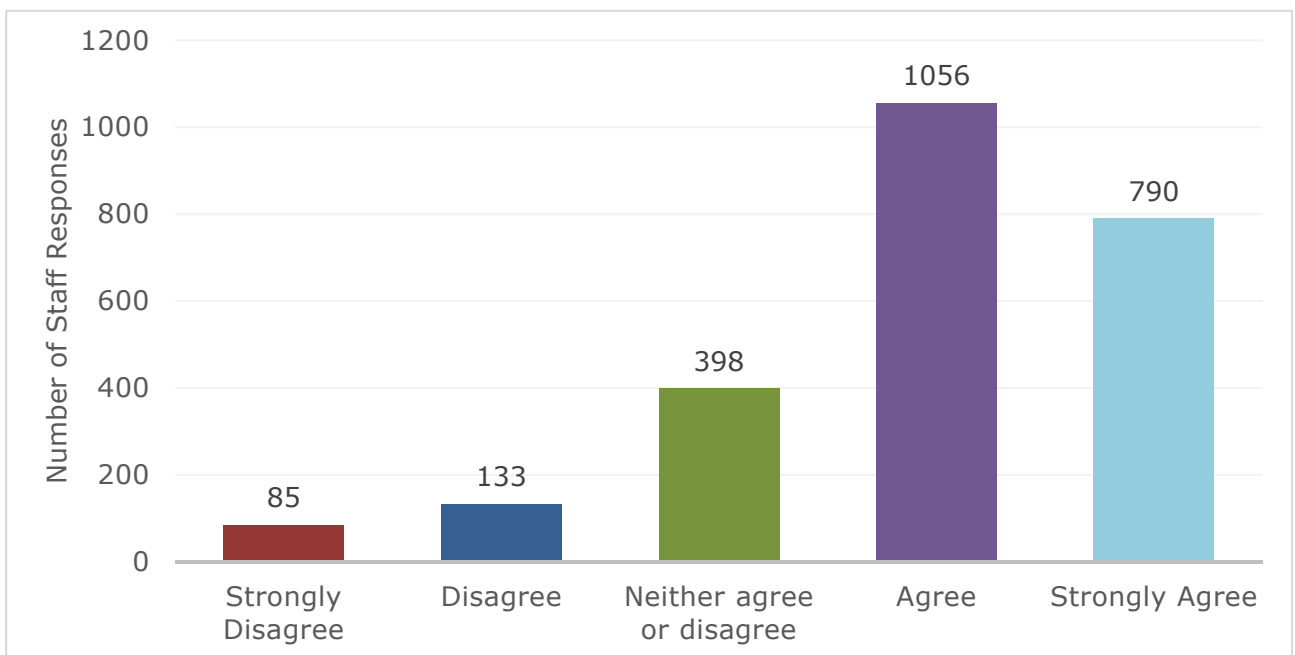


Figure 10. A visual representation of the staff responses to this statement

The graph above shows that 75% of staff responded positively to the statement that they would recommend a family member or friend applies for a job on their ward.

Staff provided comments along with their responses:

Staff who selected Strongly Agree:

"I am relatively new on the ward but [Ward] is one of the most well run wards I have worked on. The team are exceptionally caring, professional and really have compassion for the patients that we care for. I love working on this ward and am very lucky to be part of such an exceptional team."

"[Name] ward is a great place to work. All staff are really good at their jobs, and genuinely care for our patients. I would definitely recommend the ward to friends and family."

"This is a really good team to work for and we are very committed and hard working."

"I believe the Team on [Name] ward work well together, putting aside personal differences and all pulling in the same direction, to achieve a relaxed therapeutic environment where individuals can recover and receive the best possible care for them."

"This is a lovely ward to work on, staff are great and good at their job."

"I have worked on [Name] Ward for less than five months and it has been a very positive experience. At times there have been very ill patients on the ward but this is never used as an excuse to lower the very good standards of care or compromise on standards."

"I am really proud to work on this ward: the staff, managers and patients all work together to make a good atmosphere and effective therapeutic space."

Staff who selected Strongly Disagree:

"On the whole the wards are understaffed on a regular basis, with an ever increasing workload. I have worked here for over nine years and have never been as badly managed as I am now. It is chaotic and disorganised on the ward. There isn't a lot of structure. As a result of this the morale amongst the staff is very low."

"I would not have any concerns with the ward team caring for a family member or close friend however due to staff shortages I would not be happy with them being nursed within the ward environment."

"Staff morale is at an all-time low, ward staff are burnt out and sickness levels are high. There seems to be no team work and no vision as a team, every shift feels like we are firefighting for 12 hours just to get through the day. Staff nurses hardly take breaks."

"At times I would not feel that a family member of mine, or friend would be safe on the ward, or that it would help them with their illness."

Good Milieu Index

The Good Milieu Index is part of the Quality Indicator for Rehabilitative Care (QuIRC²). This tool was created for rehabilitation services to assess the therapeutic environment and consists of five questions that have been validated as a measure of a ward’s therapeutic milieu. It was also added to the most recent version of the AIMS-WA patient questionnaire to determine the therapeutic atmosphere of general adult wards and to provide some context for the visiting review team. The table below shows patient responses to each of the questions in the Good Milieu Index.

Questions from the Good Milieu Index	Not at all	Little	Somewhat	Quite a lot	Very much
Q1: In general, how satisfied are you with this unit?	5%	5%	20%	36%	34%
Q2: In general, how much do you like the staff on this unit?	1%	3%	14%	33%	49%
Q3: In general, how much do you like the other patients/residents on this unit?	3%	9%	34%	32%	22%
Q4: Does what you do on the unit help you to have more confidence in yourself?	10%	13%	27%	27%	23%
Q5: Does what you do on the unit give you a chance to see how good your abilities really are?	12%	12%	28%	26%	22%

Table 6. Percentages of responses to each question in the Good Milieu Index

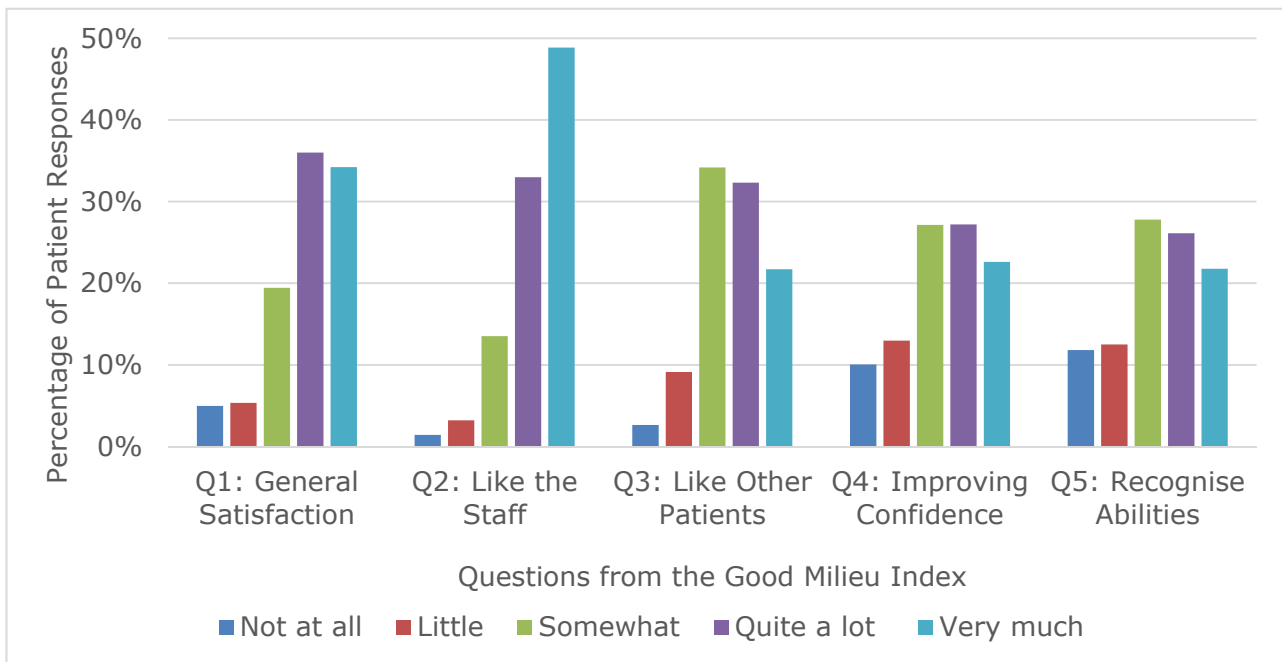


Figure 11. A visual representation of the responses to the questions in the Good Milieu Index

² More information on the QuIRC is available at www.quirc.eu

For the question on how satisfied the patient was with the unit, just over 70% of patients gave a positive response (“quite a lot” or “very much”). When asked how much they like the staff, 82% of patients gave a positive response. It is encouraging to see that a large majority of patients are happy with their ward and like the staff involved in their care.

There was a more even spread for the questions related to whether what the patient does on the unit helps them to have more confidence in themselves and to see how good their abilities are. This could be due to acute wards’ focus being on the stabilising of acute illness and managing medication, and less on rehabilitation and therapeutic activities.

The comment below came from a staff member from an AIMS-WA ward and highlights this emphasis on medication.

Staff Comment:

“In terms of patient care I was also shocked to learn that pretty much all we are doing is eliminating patients' symptoms by feeding them with meds until they are better; then we send them off and one month later they seem to be returning to the ward with the same problem. Why is there not more psychology on the ward? Why are there no therapeutic groups? Clearly this is not the way forward - there is a massive flaw somewhere in the chain of care!”

Frequently Unmet Type 1 Standards

As 49 wards have now completed the self-review and peer-review stages we are able to evaluate which Type 1 Standards are most frequently marked as Not Met at peer-review. The 20 most common Not Met Type 1 Standards have been recorded in Table 7 below but the full table can also be found in Appendix 2.

It is important to note that unmet Type 1 Standards are identified at the point of peer-review, and all wards have the opportunity to provide evidence to demonstrate compliance with these standards after the peer-review visit and during any period of deferral.

The most frequent standards designated as Not Met are the two activity standards which have recently been promoted to Type 1 Standards. It is interesting to note that more than half of the wards (26 out of 49) were found not to be providing regular weekend activities (53.11 [1]), and 25 wards were not providing regular evening activities (53.12 [1]). This is a common theme on inpatient wards, where staffing issues and the acuity of the ward can prevent consistent activities from being provided. It is an area for improvement on working-age wards, as patients reported in both questionnaires and on peer-review visits that boredom is common and television can be the only option for evening entertainment.

Over half of wards (25 out of 49 wards) were not meeting the standard requiring all staff who administer medication to have completed an assessment demonstrating they are competent to do so (U8.4 [1]). This standard is most often marked as Not Met because the standard requires this to be assessed yearly and some Trusts only assess this every three years. To meet this standard, wards would have to demonstrate they are assessing this yearly and all relevant staff have completed this. Wards involved in AIMS-WA have had to establish this as an annual competency regardless of their Trust protocol. This could explain the high percentage of wards not meeting this requirement at peer-review.

Twenty wards were not meeting the standard on supervisors having completed appropriate training (U6.6 [1]) which is another standard that was a Type 2 Standard in the previous edition but is a Type 1 Standard in the current edition. Wards would need to demonstrate that all staff who supervise others are trained to do so.

The standard on managing blind spots on the ward (34.2 [1]) was not being met by 37% of the wards. The standard requires the ward to demonstrate they are managing blind spots rather than eradicating them as this would be impossible for any ward not in a purpose built building. Wards subsequently would have to demonstrate measures taken to address this whether this is with the addition of mirrors or staff engagement and observation.

Over a quarter of wards were marked as Not Met for the standard requiring that all staff are able to take allocated breaks away from patients (U6.12 [1]). As discussed earlier on in this report, staff breaks, especially for nursing staff, are not always prioritised if the staff perceive the ward as especially busy or of high acuity. It is important for staff well-being and patient safety that staff take a break away from patients each shift.

The most frequent Type 1 Standards designated as Not Met after peer-review have been included in the table below along with how many wards and the percentage of the wards that were not meeting these standards.

Standard number	Standard	Occurrence	Percentage
53.11	Social and recreational activities are provided at weekends.	26	53%
53.12	Social and recreational activities are provided during the evenings.	25	51%
U8.4	All staff who administer medication have been assessed as competent to do so. This is repeated annually using a competency-based tool.	25	51%
U6.6	Supervisors receive appropriate training as agreed in local policy, taking into consideration profession-specific guidelines.	20	41%
34.2	Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by the use of mirrors.	18	37%
U6.12	All staff are able to take regular allocated breaks away from patients during their shift.	13	27%

8.14	All staff have received diversity awareness training.	13	27%
U6.4	Clinical supervision occurs at least every eight weeks, or more frequently as per professional body guidance.	12	24%
U8.24	Staff who undertake assessment and care planning have received training in how to assess capacity, and the Mental Capacity Act (England and Wales).	12	24%
U19.2	During intimate or physical examinations a chaperone is always considered, depending on the risks and needs of the patient or staff, and the ward/unit has a protocol relating to this.	12	24%
U34.6	An assessment of the necessity of any fitting that could be a potential ligature point is undertaken. Where this is unavoidable, fixings are not able to bear a load larger than 20 kilos.	11	22%
U18.5	On the day of admission or as soon as they are well enough, the patient is given a 'welcome pack' that contains: <ul style="list-style-type: none"> • a clear description of the aims of the ward/unit; • the programme and modes of treatment; • a clear description of what is expected and rights and responsibilities; • a simple description of the ward/unit's philosophy, principles and their rationale; • the ward/unit team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse; • visiting arrangements; • personal safety on the ward/unit; • facilities and the layout of the ward/unit; • programme of activities; • what practical items patients need in hospital and what should be brought in; • resources to meet ethnicity and gender needs. 	11	22%
U8.23	Staff who undertake assessment and care planning have received training in care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.	10	20%
U48.1	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.	9	18%
U37.2	The crash bag is maintained and checked weekly and after use.	8	16%
U8.25	Staff who undertake assessment and care planning have received training in risk assessment and management.	8	16%
U8.6	Staff are trained in safeguarding children and vulnerable adults.	8	16%
U20.9	The patient is offered a copy of their care plan and the opportunity to sign it, and/or is able to access their care plan when requested.	7	14%
U38.1	All patient information is kept in locked cabinets or offices or is securely password-protected on IT systems.	7	14%

U39.2	<p>In services where seclusion is practiced, there is a designated room fit for the purpose. The seclusion room:</p> <ul style="list-style-type: none"> • allows clear observation; • is well insulated and ventilated; • has access to toilet/washing facilities; • is able to withstand attack/damage; • has a two-way communication system; • has a clock that patients can see. 	7	14%
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Table 7. Frequency of the top 20 Not Met Type 1 Standards and the percentage of wards not meeting each standard

Update on the Data from the 2nd National Report

A number of key themes were identified out of the previous National Report containing data from 2010-2011. These data were compared with the data collected in 2015-2016. Improvements in positive responses are shown highlighted in yellow, a reduction in positive responses have been highlighted in red and where there is no change they remain without a highlight. In some instances the wording of the questions differs slightly between the two versions of audit tools; in those cases the wording has been taken from the latest edition. Where there is no comparison standard this has been indicated with a hyphen.

Key: WMQ – Ward Manager Questionnaire; SQ – Staff Questionnaire; TG - Training Grid; PQ – Patient Questionnaire; CQ – Carer Questionnaire

Staff Perspective

Appraisal and Supervision

Table 8 shows an improvement in staff reporting they receive clinical supervision every eight weeks or more frequently in 2015-16, with more than a 10% increase in positive staff responses. The data from 2015-16 also show a greater percentage of staff receiving an annual appraisal. For the first time in 2015-16 data, staff were asked to provide a reason for not having had an appraisal. From this, it was apparent that some 'no' responses could be categorised as 'not applicable' as staff had not been on the ward a year by that point or they were temporary staff.

Question	2010-2011 data	2015-2016 data
WMQ: Do you receive an annual appraisal including personal development planning or equivalent?	100%; 25/25	99%; 87/88
SQ: Do you receive an annual appraisal including personal development planning or equivalent?	88%; 567/644	90%; 2225/2462

WMQ: Clinical supervision occurs at a minimum of every eight weeks, or more frequently, as per professional body guidance.	100%; 25/25	-
SQ: Do you receive clinical supervision at least every eight weeks, or more frequently as per your professional body guidance?	69%; 415/518	81%; 1860/2291

Table 8. Comparison of appraisal and supervision data from 2010-2011 with data from 2015-2016

Training

The method used to gather data on staff training has changed since the National Report completed in 2012. Previously the questions were in a 'training grid' that was completed by the Ward Manager; now the questions are asked of each staff member as part of the staff questionnaire. The staff questionnaire is routed so that only the professions expected to complete a training course would be asked the question.

The table below shows that in three areas the percentages have increased with a marked improvement for staff trained on how to involve patients and carers.

Question	2010-2011 data	2015-2016 data
Have you been trained in the following:		
TG/SQ: How to assess capacity, and the Mental Capacity Act?	93%; 452/486	87%; 1066/1128
TG/SQ: Self-harm and suicide awareness and prevention techniques?	87%; 471/539	83%; 938/1128
TG/SQ: Procedures for assessing carers' needs, including ensuring a carer's assessment has been completed?	69%; 286/415	72%; 817/1128
TG/SQ: Risk management and risk assessment?	94%; 508/542	95%; 1066/1128
TG/SQ: How to involve patients and carers in all aspects of care?	63%; 380/599	88%; 991/1128

Table 9. Comparison of training data from 2010-2011 with data from 2015-2016

However, there are three areas where the percentage of staff trained has decreased. The difficulty found when reviewing training is that Trusts often have different names for training courses around the UK, or training courses might include a particular topic but the title of the course is not the same as the name used in the standard. This has an effect on the staff responses to the question. On peer-review visits when further discussion can be had, it often became apparent that a particular topic was part of a course that staff have completed.

Patient Perspective

In 2015-16 data there was an additional option within the patient questionnaire with 'can't remember' to avoid respondents selecting 'no' when they really wished to answer 'can't remember'. As a result the 'can't remember' responses have been deducted from the total responses.

Communication

Question	2010-2011 data	2015-2016 data
PQ: When you arrived on the ward, did a member of staff welcome you and offer you refreshments?	94%; 402/427	84%; 1278/1513
PQ: As soon as possible after you arrived, were you shown around the ward/unit, including where the toilets were?	82%; 344/419	87%; 1367/1580
PQ: Were you given a "welcome pack" or introductory booklet when you arrived?	57%; 240/419	64%; 948/1491

Table 10. Comparison of communication data from 2010-2011 with data from 2015-2016

Table 10 shows the data on the theme of communication with patients from 2010-11 and the comparison with the 2015-16 data. In two out of three cases the 2015-16 data shows an improvement with a greater percentage of patients reporting they had been shown around the ward and had received a welcome pack. Fewer patients responded 'yes' to the question on being welcomed on arrival in the 2015-16 data. The lower percentage might be as a result of the change in wording of the question. In the 2010-11 the question was "When you arrived on the ward were you greeted by a member of staff?" and in 2015-16 the question was "When you arrived on the ward, did a member of staff welcome you and offer you refreshments?"

Medication

Question	2010-2011 data	2015-2016 data
PQ: Pre-2015: Have staff explained any limitations of the medication?	64%; 260/407	-
PQ: Pre-2015: Have staff explained any side effects of the medication?	67%; 280/419	-
PQ: Post-2015: Do staff help you to understand the functions, limitations and side effects of your medication and to manage it yourself as far as possible?	-	81%; 1336/1647
PQ: Have you been told that you could speak to a pharmacist or pharmacy technician to discuss medications?	58%; 237/409	64%; 1063/1655
PQ: When you are receiving medication, were your privacy, dignity and confidentiality ensured?	85%; 357/418	91%; 1508/1666

Table 11. Comparison of medication data from 2010-2011 with data from 2015-2016

Table 11 shows the questions looked at under the theme of medication from 2010-11 and the comparison with the 2015-16 data. In each case the percentage of patients responding positively has increased. This is particularly the case with staff providing patients with information on their medication.

Ward Activities

The questions from 2010-11 on ward activities were asked in the Ward Manager questionnaire only but from 2015 the questions were asked additionally in the Patient questionnaire. As a result we can only compare the data from the Ward Manager questionnaire.

Question	2010-2011 data	2015-2016 data
WMQ: Are activities provided on a timetabled basis, Monday to Friday?	100%; 25/25	99%; 87/88
PQ: Is there a timetable of activities, Monday to Friday?	-	88%; 1445/1640

WMQ: Are social and recreational activities provided during the evenings?	92%; 23/25	90%; 79/88
PQ: Are there social and recreational activities during the evenings?	-	62%; 987/1603
WMQ: Are social and recreational activities provided at weekends?	96%; 24/25	93%; 82/88
PQ: Are social and recreational activities provided at weekends?	-	68%; 1080/1593
PQ: Are you able to access regular group meetings that focus on understanding mental illness and its treatment, either on or off the ward/unit?	77%; 314/410	63%; 988/1572

Table 12. Comparison of ward activity data from 2010-2011 with data from 2015-2016

Table 12 shows the data on the theme of ward activities with patients from 2010-11 and the comparison with the 2015-16 data. Fewer Ward Managers reported that activities are provided during the evenings and weekends in 2015-16 than in 2011-12. This could be a result of financial limitations placed on the ward and greater staff shortages making it harder for staff to provide activities on a regular basis.

Although we do not have data from the patients' perspective about activities in 2010-11, we can see from 2015-16 that patient responses are lower than the Ward Managers with 68% of patients saying that activities are provided at weekends and only 61% of patients saying that activities are provided during the evenings. It is clear from these responses that this is still an area that working-age wards could improve upon.

Carer Perspective

Assessment of Needs

Question	2010-2011 data	2015-2016 data
CQ: Have you been advised how to obtain an assessment of your own needs as a carer?	56%; 68/122	61%; 271/447

SQ: Is the patient's principal carer advised how to obtain an assessment of their own needs?	87%; 218/251	91%; 885/976
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Table 13. Comparison of assessment of needs data from 2010-2011 with data from 2015-2016

Table 13 shows that across both staff and carer perspectives the percentages have increased for carer access to assessments of their needs. Ninety-one percent of staff responded saying they advise carers of how to obtain an assessment of their needs and 61% carers agreed they had been advised about a carers' assessment. The second National Report concluded that although the percentages had increased in 2010-11 there was still a possibility for improvement. It is encouraging to see that year-on-year this is improving.

Involvement in Care and Collaboration with Practitioners

Question	2010-2011 data	2015-2016 data
CQ: Were you contacted within 72 hours of the patient's admission and offered a meeting with a named professional?	61%; 78/127	72%; 326/454
CQ: Are reviews facilitated to allow you to contribute and express your views?	88%; 110/125	82%; 362/444

Table 14. Comparison of involvement in care and collaboration with practitioners from 2010-2011 with data from 2015-2016

Table 14 shows an improvement in responses from carers about being contacted within 72 hours of admission but the percentage has dropped in response to the question about reviews being facilitated to allow carers to contribute and express their views. This correlates with the qualitative feedback from carers from the 2015-16 questionnaires that illustrate that carer involvement and communication require improvement on acute wards.

Wards That Have Completed Three Cycles³

The first five wards completed the third cycle of AIMS on the 4th edition of the AIMS-WA standards as this occurred prior to the publication of the 5th edition of the AIMS-WA standards. The remaining eleven wards completed the third cycle review on the 5th edition of AIMS-WA standards. As the standards in these two editions are very different they have been presented here separately.

This graph below (figure 12) illustrates an improvement in standards met across all three types of standard across the cycles. This demonstrates a steady improvement for these five wards including any raising of standards since these wards started their first cycle in 2006.

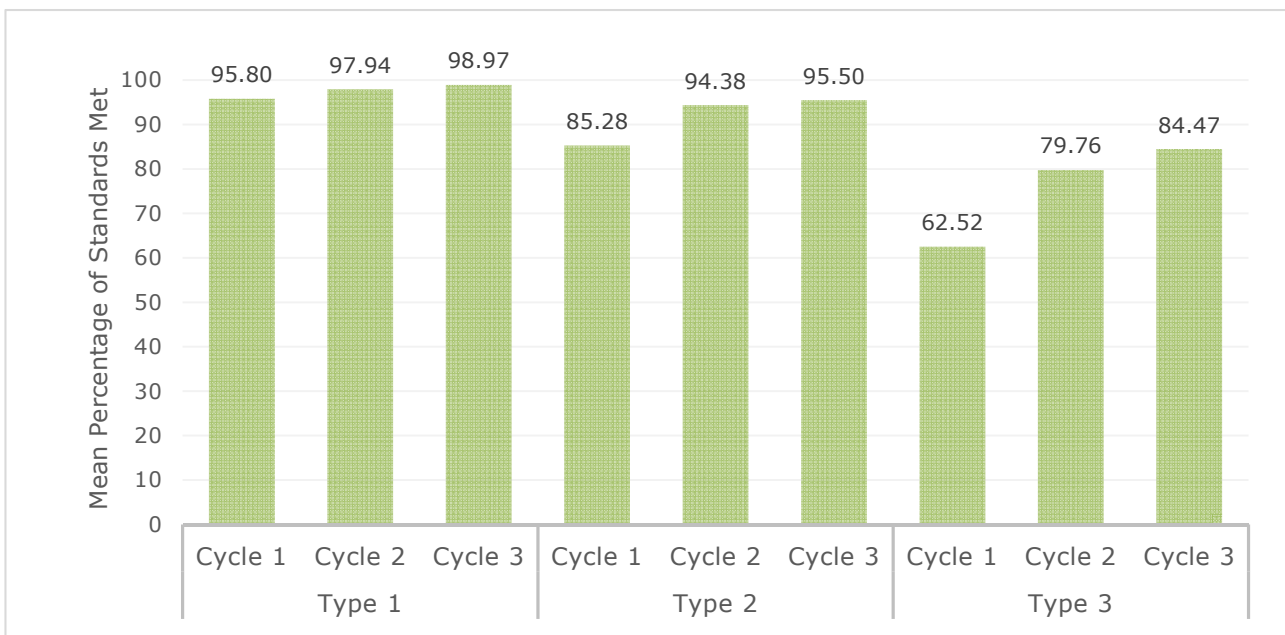


Figure 12. The mean percentage of standards met for the five wards that have completed their peer-review of their third cycle of AIMS on the 4th edition of AIMS-WA standards

Figure 13 (below) illustrates that there has been an improvement made in the percentage of Type 1 Standards met between Cycle 1 and 2 but the percentage decreases between Cycle 2 and 3. The Type 2 Standards show a large increase between Cycle 1 and 2 and a marginal increase between Cycle 2 and 3. The mean percentage of Type 3 Standards met increased between Cycle 1 and 2 but then decreased between Cycle 2 and 3.

³ The percentages of standards Met are taken after peer-review at each cycle. Wards would have demonstrated they were meeting all Type 1 Standards by the time they were awarded accreditation.

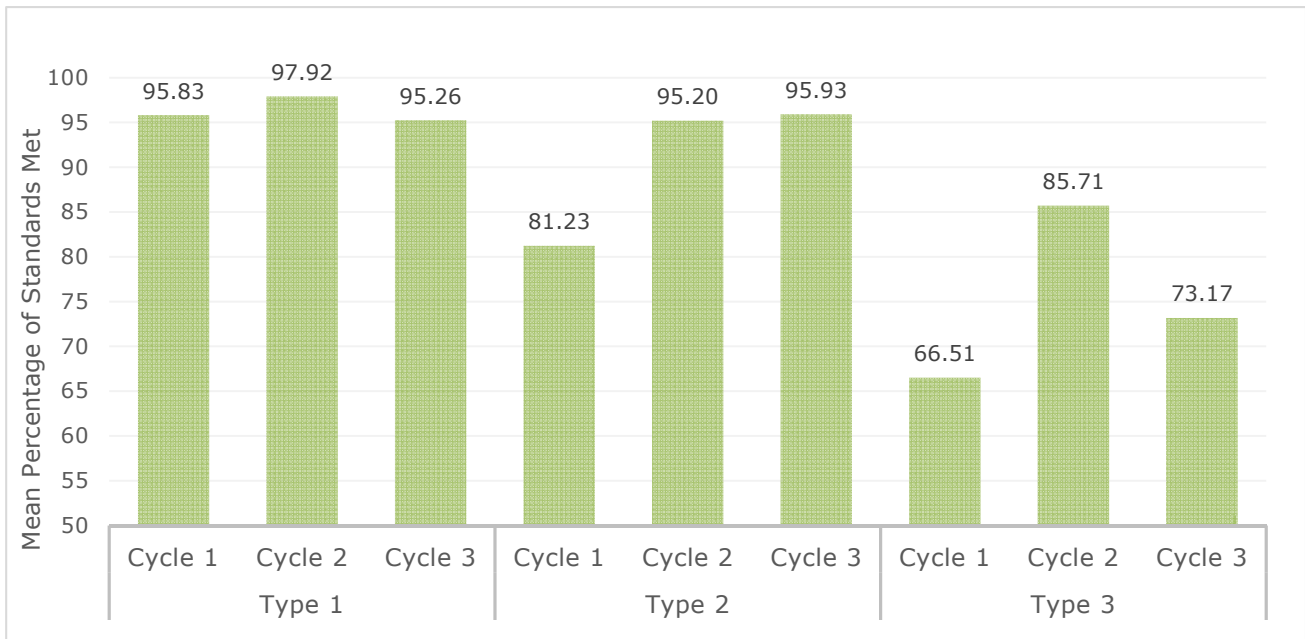


Figure 13. The mean percentage of standards Met at Cycle 1, 2 and 3 for the 11 wards that have completed their third cycle of AIMS on the 5th edition of AIMS-WA standards

In 2014 the 5th edition of standards were published and the latest edition has considerably more Type 1 Standards which wards are being assessed against. The 4th edition had 80 Type 1 Standards; in contrast the 5th edition now has 114 Type 1 Standards. Some of these standards were Type 2 Standards previously but have been promoted to Type 1 Standards. Wards going through the second and third cycles of AIMS-WA would have to demonstrate they are meeting these standards even though they were first accredited on earlier versions of AIMS-WA standards.

Furthermore, some of the revised Type 1 Standards now have additional criteria to the question, for example, the standard relating to the welcome pack requires the welcome pack to include a list of items. In the previous edition of the standards, wards had to demonstrate that the patient is given a welcome pack or introductory booklet but the peer-review reports did not assess in detail the contents of the pack. For a ward to meet this standard now the ward’s welcome pack has to include all the items listed. This could contribute to the increasing difficulty in meeting Type 1 Standards.

These explanations could contribute to the improvement between the earlier two cycles but the drop between cycles 2 and 3.

Wards That Have Completed Two Cycles

In addition to the 16 wards that completed three cycles there are 20 wards that have completed two cycles of review on the current edition of standards.

Figure 14 illustrates a similar pattern to the wards that were assessed on the current edition of standards for their third cycle. In this case all types of standards did decrease at Cycle 2 with a greater difference in Type 1 Standards across the two cycles than the other two types of standards. The reasons discussed above could be applied to these wards too as the 5th edition of standards have 'raised the bar' in terms of what we expect wards to meet.

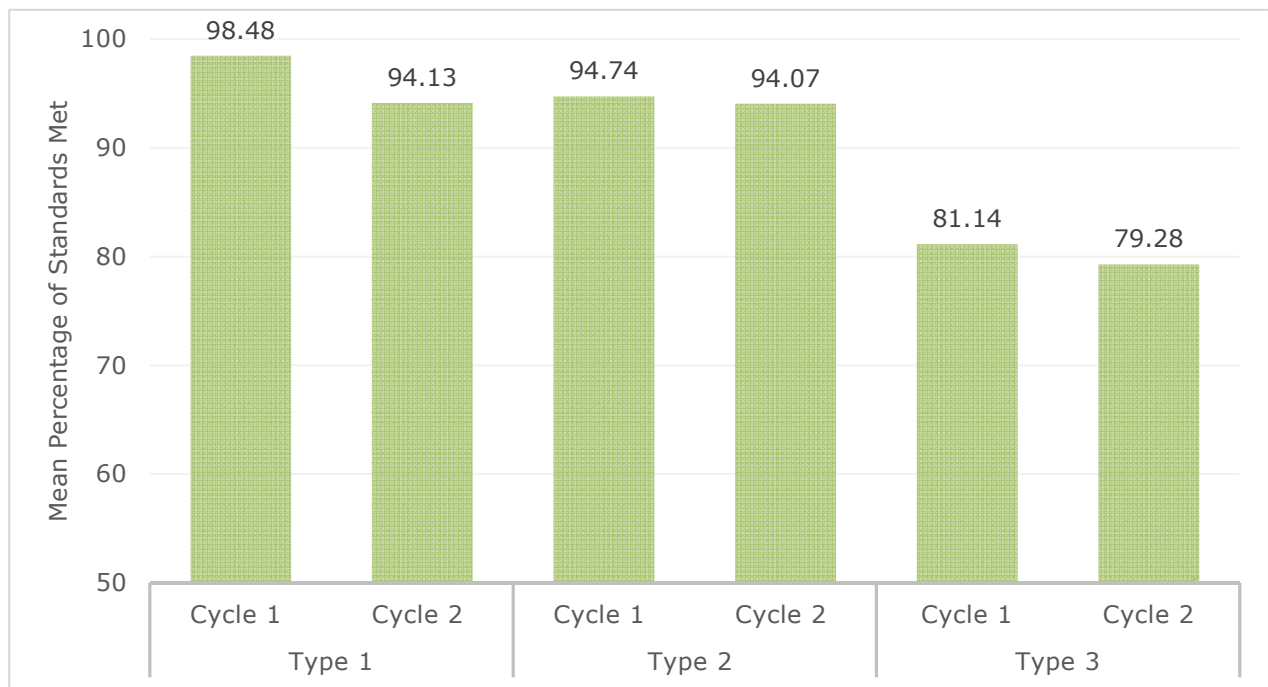


Figure 14. The mean percentage of standards met at Cycle 1 and Cycle 2 for the 20 wards that completed their second cycle on the 5th edition of AIMS-WA standards

Recommendations

Using the themes from the 2015-16 data and the frequently unmet Type 1 Standards, certain recommendations have been made by AIMS-WA for working-age inpatient services.

1) Sight Lines and Ligature Points

Two standards which frequently come up on the peer-review day as areas for improvement are managing blind spots and assessing potential ligature points. There is a need for continued investment in ward environments, changing fixtures and fittings to anti-ligature wherever possible and installing mirrors to improve sightlines. It is also important to note that where wards use staff monitoring alone to address blind spots and ligatures, it can be a problem when staffing levels are reduced.

2) Yearly Medication Competency Assessments

The standard on an annual medication competency assessment has been within the AIMS-WA standards since 2010 and there are still wards within the membership that complete these at different intervals. It is suggested that medication competency assessments are completed as part of annual appraisals, therefore ensuring that medication competency assessments are completed every year, as per the standard.

3) Patient Involvement in Care Plans

An area for improvement identified from patient responses was that patients did not always feel involved in their care plan, given the opportunity to discuss its contents or offered a copy of their care plan. Some patients reported that they found out about their care plan from other patients rather than through a clinician. It is important that patients are actively involved in creating their care plan. There are resources available that encourage patients to document their thoughts on their current situation and to plan goals for their admission. An example of this is the Wellness Recovery Action Plan (WRAP) or the Mental Health Recovery Star. Some wards have created a 'this is me' care plan or 'my care plan' document which can be completed individually by the patient or with staff support.

4) Scheduling Evening and Weekend Activities

Activities at evenings and weekends are often ad hoc and whether they go ahead or not is largely dependent on staffing levels. Patients report boredom on the ward out of hours and staff comments have highlighted the difficulties of providing escorts or running activities at evenings and weekends. There is a need for wards to schedule activities during the evenings and weekends so that patients are aware in advance of planned activities and for wards to ensure these scheduled activities go ahead. Wards have found it useful to recruit peer support workers or volunteers to run recreational activities on the ward at evenings or

weekends, when staffing levels are lower. Additionally, there are online resources available such as Wardipedia (www.wardipedia.org) that could be utilised for ideas for recreational activities.

5) Involvement and Communication with Carers

This report has shown that in certain areas wards have continued to improve their communication with carers: more carers were aware of carers' assessments than in the previous national report, and the vast majority of carers had received information about ward procedures and reasons for admission. However, fewer than half of carers had received a copy of the patient's care plan and reviews were not always facilitated to allow carers to express their views. It is important that services continue to work on their involvement of carers during the patient's admission. Qualitative feedback also showed that carers still feel information is lacking and they had to seek out the information they needed. Resources are available for wards on improving communication and involvement of carers: an example of this is the Triangle of Care project (www.carers.org/triangle-care).

6) Staffing Levels

Low staffing levels have a huge impact on the care staff are able to provide and on staff well-being and morale. There are areas for improvements highlighted within this report that could be addressed with more staff available on the ward. The themes of these data demonstrated that a high proportion of staff who were unable to take a break said this was due to a shortage of staff on the ward, too much work or clinical acuity. It was also illustrated that having minimum staffing levels of one qualified nurse on night shifts makes it difficult for staff to take a break during the shift. If wards have only one registered nurse on a shift it is essential that there is a system in place to relieve that staff member so that they can take their break. It would, however, be preferable to have a minimum of two registered nurses on the ward at all times, to facilitate breaks.

In addition to breaks there are other areas which suffer when there is low staffing. Supervision is one area of good practice that can be omitted when pressure on the ward is high, training can be postponed due to lack of staff cover and fewer activities are provided when there are staffing issues (more details on this point below).

Qualitative feedback from staff suggests that staff shortages on the ward have an impact on how safe staff feel on the ward, how stressful they find the job, how much time is available for therapeutic activities and one-to-one time with patients, and ultimately how likely they are to recommend the ward for a family member or friend to be treated on their ward or apply for a job on the ward.

In summary, although this report has shown that in certain areas wards have continued to improve their communication with carers (e.g. more carers were aware of carers' assessments than in the previous national report), a majority of carers had not received a copy of the patient's care plan and fewer carers felt reviews were facilitated so that they could contribute than in the previous national report. There is, therefore, a definite need for the wards to improve their strategies to increase carer involvement.

Taken together, these findings suggest that staffing levels play a crucial role in the way wards organise and deliver quality services. Staff morale and well-being directly impacts on quality of care and the experience of patients and carers, during a significant period of their lives.

It is vital that project members continue to work collaboratively with AIMS-WA and AIMS-AT towards assuring and improving the quality of care in inpatient services for working-age adults, improving the standards, and further strengthening patient and carer involvement.

What's Next for AIMS-WA/AIMS-AT?

AIMS-WA Annual Forum

The AIMS-WA/AIMS-AT annual forum will be held on 14 December 2016. This year is AIMS-WA's 10th anniversary and the event will mark 10 years of working together to improve care on inpatient working age wards. It is an event for staff working within working age inpatient services as well as patient and carer representatives who have worked with us on accreditation committees, advisory groups, peer-reviews, and so on. Presentations and workshops will focus on examples of good practice and areas of quality improvement relevant to working age wards.

Standards Revision

The AIMS-WA and AT standards are being revised incorporating the College Centre for Quality Improvement's core standards. A stakeholder event occurred in October 2016 with representatives from across our members from both WA and AT wards. Following this event, the first draft of the standards has been sent out to all members for consultation.

Developmental Membership

AIMS-WA is planning to offer a developmental membership option for wards that would like to be part of the network and would like to complete the self- and peer-review process but are not yet ready for the full accreditation process. Wards would be able to send staff on peer-reviewer training and subsequently to peer-reviews at other member wards as well as being part of the AIMS-WA/AIMS-AT discussion group connecting wards across the United Kingdom.

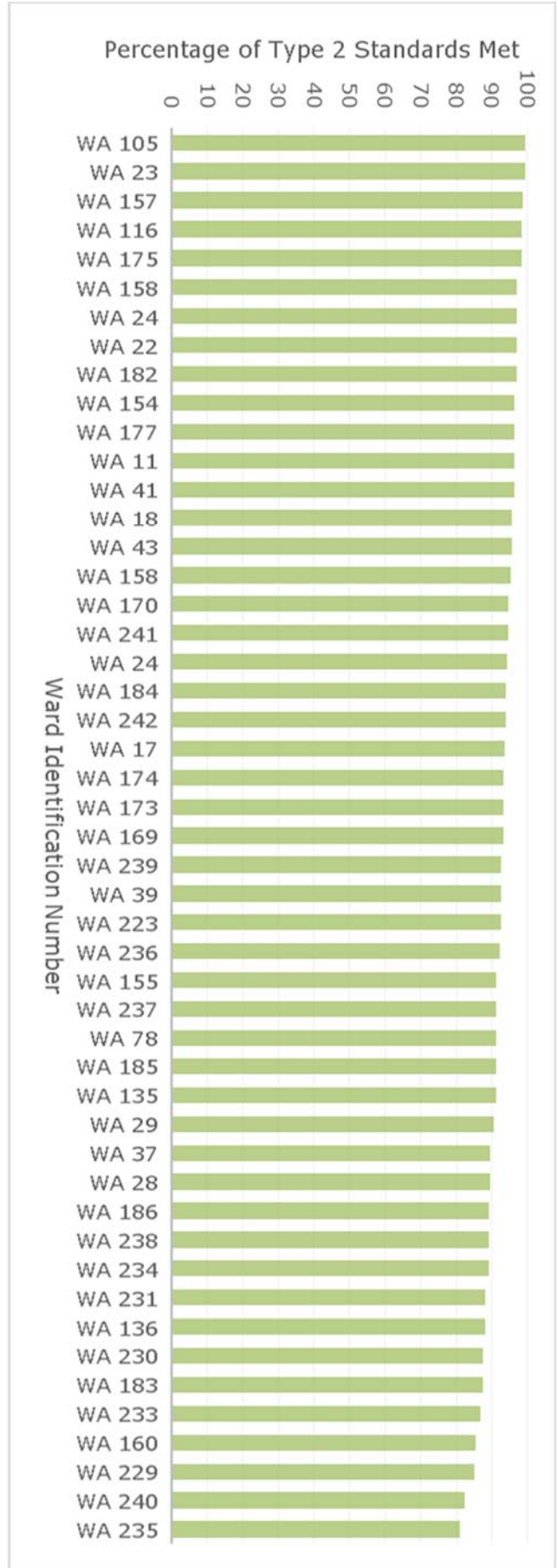
Appendix 1: Benchmarking – wards have been listed in order of percentage of Type 1 Standards met and Type 2 Standards met.

NB: The tables below include all wards that have completed a self-review and peer-review since the last revision of the AIMS-WA standards in January 2015.

Rank	Ward ID no.	% Type 1 Standards met
1	WA 41	100.00
1	WA 174	100.00
2	WA 23	99.12
2	WA 24	99.12
2	WA 170	99.12
3	WA 105	99.11
3	WA 239	99.11
4	WA 160	99.09
5	WA 11	98.23
5	WA 78	98.23
6	WA 157	98.20
7	WA 22	97.35
8	WA 154	96.49
9	WA 158	96.46
10	WA 43	95.54
10	WA 116	95.54
11	WA 18	94.64
12	WA 158	94.59
12	WA 236	94.59
12	WA 237	94.59
13	WA 155	93.86
14	WA 223	93.81
15	WA 173	93.75
16	WA 185	92.86
16	WA 234	92.86
16	WA 184	92.79
16	WA 169	92.79
17	WA 175	91.15
18	WA 17	91.07
19	WA 242	90.38
20	WA 240	90.18
21	WA 30	90.09
21	WA 182	90.09
21	WA 241	90.09
22	WA 231	89.19
23	WA 230	89.09
24	WA 177	88.60
25	WA 224	88.50
26	WA 183	88.18
27	WA 135	87.61
28	WA 235	87.39
29	WA 186	87.16
30	WA 21	86.73
31	WA 39	86.49
32	WA 136	85.84
33	WA 229	84.82
34	WA 233	81.82
35	WA 232	77.27

Rank	Ward ID No.	% Type 2 Standards Met
1	WA 105	99.26
2	WA 23	99.24
3	WA 157	98.70
4	WA 116	98.55
5	WA 175	98.53
6	WA 158	97.10
7	WA 24	97.06
7	WA 22	97.06
8	WA 182	96.99
9	WA 154	96.38
10	WA 177	96.35
11	WA 11	96.32
11	WA 41	96.32
12	WA 18	95.65
13	WA 43	95.62
14	WA 158	95.45
15	WA 170	94.78
16	WA 241	94.74
17	WA 24	94.20
18	WA 184	94.07
19	WA 242	94.03
20	WA 17	93.48
21	WA 174	93.39
22	WA 173	93.33
23	WA 169	93.28
24	WA 239	92.70
25	WA 39	92.65
26	WA 223	92.54
27	WA 236	92.24
28	WA 155	91.30
29	WA 237	91.24
30	WA 78	91.18
30	WA 185	91.18
31	WA 135	91.11
32	WA 29	90.44
33	WA 37	89.63
34	WA 28	89.55
35	WA 186	89.05
35	WA 238	89.05
35	WA 234	89.05
36	WA 231	88.24
37	WA 136	88.06
38	WA 230	87.41
39	WA 183	87.38
40	WA 233	86.76
41	WA 160	85.52
42	WA 229	85.19
43	WA 240	82.48

Benchmarking – graphs showing the percentages of Type 1 and Type 2 Standards met for each ward



Appendix 2: Frequency of Type 1 Standards Not Met in 2016 data.

Standard number	Standard	Frequency
53.11	Social and recreational activities are provided at weekends.	26
53.12	Social and recreational activities are provided during the evenings.	25
U8.4	All staff who administer medication have been assessed as competent to do so. This is repeated annually using a competency-based tool.	25
U6.6	Supervisors receive appropriate training as agreed in local policy, taking into consideration profession-specific guidelines.	20
34.2	Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by the use of mirrors.	18
U6.12	All staff are able to take regular allocated breaks away from patients during their shift.	13
8.14	All staff have received diversity awareness training.	13
U6.4	Clinical supervision occurs at least every eight weeks, or more frequently as per professional body guidance.	12
U8.24	Staff who undertake assessment and care planning have received training in how to assess capacity, and the Mental Capacity Act (England and Wales).	12
U19.2	During intimate or physical examinations a chaperone is always considered, depending on the risks and needs of the patient or staff, and the ward/unit has a protocol relating to this.	12
U34.6	An assessment of the necessity of any fitting that could be a potential ligature point is undertaken. Where this is unavoidable, fixings are not able to bear a load larger than 20 kilos.	11
U18.5	On the day of admission or as soon as they are well enough, the patient is given a 'welcome pack' that contains: <ul style="list-style-type: none"> • a clear description of the aims of the ward/unit; • the programme and modes of treatment; • a clear description of what is expected and rights and responsibilities; • a simple description of the ward/unit's philosophy, principles and their rationale; • the ward/unit team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse; • visiting arrangements; • personal safety on the ward/unit; • facilities and the layout of the ward/unit; • programme of activities; • what practical items patients need in hospital and what should be brought in; • resources to meet ethnicity and gender needs. 	11
U8.23	Staff who undertake assessment and care planning have received training in care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.	10
U48.1	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.	9
U37.2	The crash bag is maintained and checked weekly and after use.	8
U8.25	Staff who undertake assessment and care planning have received training in risk assessment and management.	8
U8.6	Staff are trained in safeguarding children and vulnerable adults.	8
U20.9	The patient is offered a copy of their care plan and the opportunity to sign it, and/or is able to access their care plan when requested.	8
U38.1	All patient information is kept in locked cabinets or offices or is securely password-protected on IT systems.	7

U39.2	In services where seclusion is practiced, there is a designated room fit for the purpose. The seclusion room: <ul style="list-style-type: none"> • allows clear observation; • is well insulated and ventilated; • has access to toilet/washing facilities; • is able to withstand attack/damage; • has a two-way communication system; • has a clock that patients can see. 	7
U8.2	Access to training is facilitated, including arrangements for staff cover to allow staff to attend training.	7
U3.1	The ward/unit has its own dedicated lead consultant clinician who will provide expert input into key matters of service delivery, staff support and supervision, and overall service co-ordination. Specific sessions are set aside in the consultant's job plan to ensure sufficient time is available for their consistent and regular input to the team and related forums.	6
U6.7	Staff who receive regular management supervision do so from a person with appropriate experience and qualifications.	6
25.5	The patient is given a copy of a written aftercare plan, agreed on discharge, when they leave the ward/unit, which sets out: <ul style="list-style-type: none"> • the care and rehabilitation to be provided; • the name of their Care Co-ordinator (if they require further care); • the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment; • specific action to take in the first week. 	6
41.25	The food provided to patients is of good quality.	6
51.2	Patients have access to staff trained and supervised to deliver psychological interventions for at least one half-day (four hours) per week per ward/unit.	6
U20.11	All assessments are documented, signed or validated (if using electronic records) and dated by the assessing practitioner.	5
U27.2	There is a management plan to address any shortfalls in the safety of the clinical environment.	5
18.6	If the patient is admitted informally, on the day of their admission or as soon as they are well enough they are given accessible written information on their rights, rights to advocacy and second opinion, right of access to interpreting services, professional roles and responsibilities and the complaints procedure.	5
U42.8	There is a policy on the use of devices with the capacity to communicate and/or record (including mobile phones), which is communicated to staff, patients and visitors, e.g. by means of a poster or leaflet.	5
U10.5	There is evidence of audit, action and feedback from complaints, suggestions and compliments.	4
U27.1	There is an annual and comprehensive general risk assessment to ensure the safety of the clinical environment.	4
U29.1	At all times, a doctor is available to quickly attend an alert by staff members when interventions for the management of disturbed/violent behaviour are required, in accordance with NICE CG25.	4
U29.3	There is a written mutual code of conduct or similar for ward/unit behaviour of which patients are advised, and adherence to this is monitored.	4
U6.1	All staff have an annual appraisal including personal development planning or equivalent.	4
18.10	If a patient is being admitted directly from the community, the	4

	admitting nurse checks that the referring agency gives clear information about the security of the patient's home, whereabouts of children/animals etc.	
U40.2	Bathrooms are in a good state of repair and are clean.	4
U28.1	There is a policy on patient safety and observation during the use of therapeutic interventions that includes: <ul style="list-style-type: none"> • how activities, therapies and staff skill mix are used specifically to improve patient safety; • how patients are informed about maintaining their personal safety including the use of alarms; • who can instigate observation above the general level and who can change the level of observation; • who should review the level of observation and when reviews should take place (at least every shift); • how the patient's perspective will be taken into account; • the process for review by a full clinical team if observation above the general level continues for more than one week. 	3
U33.2	There are clear and comprehensive policies and procedures regarding positive risk-taking and illicit drug use within the ward/unit.	3
19.8	The patient meets with their Primary or Allocated Nurse to complete the initial assessment and initiate their care plan within the first 72 hours following admission. This includes: <ul style="list-style-type: none"> • ethnicity; • employment status; • gender needs; • spiritual needs; • cultural needs; • social needs; • physical needs; • assessment of mental capacity (if required); • continuing consent or refusal of consent to treatment. 	3
24.1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.	3
41.4	Hot drinks are available to patients 24 hours a day upon request. Any restrictions are individually care planned and not implemented as a blanket rule.	3
u13.1	Patients and their carers are informed verbally and in writing of their right to confidentiality and its limitations.	3
U9.1	The ward/unit has a working relationship with a range of advocacy services including the IMCA service.	3
U19.4	If the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint this is: <ul style="list-style-type: none"> • clearly documented in their records; • regularly reviewed; • communicated to all MDT members; • evaluated with them and, where appropriate, their carer/advocate. 	2
U2.1	The ward/unit has an agreed minimum staffing level across all shifts which is met.	2
U2.11	There is capacity to increase nursing levels according to clinical need.	2
U23.3	There is a standardised process for assessing mental capacity, using a formal document or assessment tool.	2
U29.6	The use of rapid tranquillisation, physical intervention or seclusion, and any adverse outcomes, are recorded contemporaneously, using a local template.	2
U53.7	At least one staff member based on the ward/unit is trained and supervised to deliver one basic, low intensity evidence-based psychological intervention.	2

2.8	The nominated person in charge of the shift is the point of contact for consultation, negotiation, and decision-making for all ward/unit operational matters.	2
2.9	An experienced member of staff is assigned to maintain general observation in patient areas, monitor patient interaction, observe for risk behaviour and provide first point of contact to deal with patient needs when the Primary or Allocated Nurse is absent or unavailable.	2
20.1	Care plans are negotiated with the patient as far as possible, and are based on a comprehensive physical, psychological, social, cultural and spiritual assessment. They include a comprehensive risk and strengths assessment, taking into account the patient's preferences and goals.	2
41.24	There is a choice of well prepared food that meets individual needs. Guidance: This includes cultural, nutritional and clinical needs	2
U40.1	All fixtures, fittings and equipment are in a good state of repair.	2
U10.2	Written information is offered to patients and carers about how to give feedback to the service, including compliments, comments, concerns and complaints.	1
U11.4	Staff receive up-to-date training and development appropriate to their role to recognise the signs or symptoms associated with: <ul style="list-style-type: none"> • physical abuse; • sexual abuse; • emotional abuse; • financial abuse; • institutional abuse; • self-neglect; • neglect by others. 	1
U14.2	There are systems in place to raise concerns about inpatient mix, and the Ward/Unit Manager's views are considered by the senior team.	1
U21.1	If a detained patient is identified as having a risk of absconding, a crisis plan is completed, which includes instructions for alerting carers and any other person who may be at risk.	1
U22.1	The patient's main carers are identified and contact details are recorded.	1
U23.8	Patients have a comprehensive, ongoing assessment of risk to self and others with full involvement of the patient and their carer (with the patient's agreement) and have corresponding care plans.	1
U29.18	A collective response to alarm calls is agreed before incidents occur and consistently rehearsed and applied.	1
U29.2	There is an operational policy on searching, based on legal advice, which complies with NICE guidance and the Human Rights Act.	1
u42.10	Patients have access to items associated with specific cultural, religious or spiritual practices, e.g. covered copies of faith books.	1
U42.3	Patients can access resources that enable them to meet their individual self-care needs, including ethnic- and gender-specific requirements.	1
U43.6	The design of windows considers safety and patient comfort and is consistent with Health Building Notes.	1
U6.2	The ward/unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee to cover: <ul style="list-style-type: none"> • learning/training objectives; • resolution of conflict (arbitrator identified); • roles and responsibilities; • practicalities, e.g. location; • boundaries, e.g. time and agreed agenda; • documentation to be used; • confidentiality (adherence to professional code of conduct and Trust/organisation policy); 	1

	<ul style="list-style-type: none"> • actions in event of non-attendance or cancellation; • frequency and duration. 	
U8.3	<p>All staff have received awareness training in how to communicate effectively, including:</p> <ul style="list-style-type: none"> • understanding the person's preferred means of communicating; • the use of different communication methods and visual aids; • the importance of tone of voice; • non-verbal communication; • the use of appropriate language; • active listening techniques; • recognising when people might be suggestible or acquiescing; • recognising when people are communicating distress, and responding to it; • the link between communication and challenging behaviour; • the appropriate use of interpreters. 	1
U8.36	Clinical staff receive training and supervision from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions (including, but not limited to, conflict resolution and de-escalation, engagement activity scheduling, group facilitation).	1
16.4	The aims of admission are agreed among the referring team, the ward/unit team and the patient and carers.	1
24.7	Full MDT clinical review meetings occur at least once a week.	1
25.12	The ward/unit has a referral process for outpatient psychology, CMHT-based or otherwise.	1

Appendix 3: AIMS-WA Accredited Wards

Wards accredited as of July 2016, listed in alphabetical order by Trust/Organisation name.

Trust Name	Ward Name	Hospital/Unit Name
2gether NHS Foundation Trust	Abbey	Wotton Lawn Hospital
	Dean	Wotton Lawn Hospital
	Kingsholm	Wotton Lawn Hospital
	Priory	Wotton Lawn Hospital
5 Boroughs Partnership NHS Trust	Coniston	Whiston Hospital
	Grasmere	Whiston Hospital
	Lakeside	Leigh Infirmary
	Taylor	St. Helens Hope and Recovery Centre
Avon and Wiltshire Partnership NHS Trust	Silver Birch	Callington Road Hospital
Belfast Health and Social Care Trust	Ward J	Mater Hospital
Berkshire Healthcare NHS Foundation Trust	Bluebell	Prospect Park Hospital
	Daisy	Prospect Park Hospital
	Rose	Prospect Park Hospital
	Snowdrop	Prospect Park Hospital
Betsi Cadwaladr University Health Board	Aneurin	Ysbyty Gwynedd
	Cynan	Ysbyty Gwynedd
Birmingham and Solihull Mental Health NHS Foundation Trust	Bruce Burns Unit	Solihull Hospital
Cambridgeshire and Peterborough NHS Foundation Trust	Acute Assessment Unit (AT)	Cavell Centre
	Mulberry 1 (AT)	Fulbourn Hospital
	Mulberry 2	Fulbourn Hospital
	Oak 1	Cavell Centre
	Oak 2	Cavell Centre
Cygnnet Healthcare	Sandford	Cygnnet Hospital Kewstoke
Devon Partnership NHS Trust	Coombehaven	The Cedars
Dudley and Walsall Mental Health Partnership NHS Trust	Ambleside	Dorothy Pattison Hospital
	Clent	Bushey Fields Hospital
	Kinver	Bushey Fields Hospital
	Langdale	Dorothy Pattison Hospital
	Wrekin	Bushey Fields Hospital
East London NHS Foundation Trust	Brett	City and Hackney Centre for Mental Health
	Brick Lane	Tower Hamlets Centre for Mental Health
	Emerald	Newham Centre for Mental Health
	Globe	Tower Hamlets Centre for Mental Health
	Opal	Newham Centre for Mental Health
	Roman	Tower Hamlets Centre for Mental Health
	Ruby Triage (AT)	Newham Centre for Mental Health
	Sapphire	Newham Centre for Mental Health
Topaz	Newham Centre for Mental Health	

Humber Mental Health NHS Teaching Trust	Avondale (AT)	Miranda House
Lincolnshire Partnership NHS Trust	Charlesworth	Peter Hodgkinson Centre
	Conolly	Peter Hodgkinson Centre
	Ward 12	Pilgrim Hospital
Mersey Care NHS Trust	Albert	Broadgreen Hospital
	Brunswick	Broadgreen Hospital
	Harrington	Broadgreen Hospital
	Windsor	Liverpool
NAVIGO Health and Social Care CIC	Meridian Lodge	Harrison House
	Pelham Lodge	Harrison House
	Waveney	Hellesdon Hospital
NHS Greater Glasgow and Clyde	Ward 4a	Leverndale Hospital
	Ward 4b	Leverndale Hospital
North Staffordshire Combined Healthcare NHS Trust	Ward 1	Harplands Hospital
	Ward 2	Harplands Hospital
	Ward 3	Harplands Hospital
Northumberland, Tyne and Wear NHS Foundation Trust	Collingwood Court	St. Nicholas Hospital
	Embleton	St. George's Park
	Fellside	Tranwell Unit
	Lamesley	Queen Elizabeth Hospital
	Longview	Hopewood Park
	Lowry	St. Nicholas Hospital
	Shoredrift	Hopewood Park
	Springrise	Hopewood Park
	Warkworth	St. George's Park
Oxford Health NHS Foundation Trust	Allen	Warneford Hospital
	Phoenix	Littlemore Hospital
	Ruby	Whiteleaf Centre
	Sapphire	Whiteleaf Centre
	Vaughan Thomas	Warneford Hospital
	Wintle	Warneford Hospital
South London and Maudsley NHS Foundation Trust	Eileen Skellern 2	The Maudsley Hospital
	Jim Birley	The Maudsley Hospital
	LEO Unit	The Maudsley Hospital
	Luther King	Lambeth Hospital
	Ruskin	The Maudsley Hospital
	Wharton	University Hospital Lewisham
Southern Health NHS Foundation Trust	Saxon	Antelope House
	Trinity	Antelope House
Surrey and Borders Partnership NHS Trust	Delius	Epsom General Hospital
	Elgar	Epsom General Hospital
Tees, Esk and Wear Valleys NHS Foundation Trust	Bilsdale	Roseberry Park Hospital
	Bransdale	Roseberry Park Hospital
	Danby	Cross Lane Hospital
	Esk	Cross Lane Hospital
	Lincoln	Sandwell Park
	Maple	West Park Hospital
	Overdale	Roseberry Park Hospital
	Stockdale	Roseberry Park Hospital
Worcestershire Health and Care NHS Trust	Harvington	Kidderminster Hospital
	Hill Crest	Alexandra Hospital
	Holt	Newtown Hospital

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