ECTAS
ECT ACCREDITATION SERVICE
CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

ECTAS 6th National Report

October 2013 - October 2015

Publication date: April 2016
Publication no. CCQI228

Correspondence:
Nicky Buley
ECT Accreditation Service
Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London
E1 8BB

Tel: 020 3701 2653
Fax: 08436 593694

Email: ECTAS@rcpsych.ac.uk

Website: www.ectas.org.uk

Royal College of Psychiatrists' Centre for Quality Improvement, 21 Prescot Street, London E1 8BB www.rcpsych.ac.uk/CCQI

Introduction to ECTAS

The ECT Accreditation Service (ECTAS) was established in 2003 to promote better standards of practice in ECT services in England, Wales, Northern Ireland and the Republic of Ireland.

ECTAS is managed by the Royal College of Psychiatrists' Centre for Quality Improvement and works in partnership with the Royal College of Anaesthetists, the Royal College of Nursing and Service Users.

The ECTAS standards are based on current best available evidence. They are reviewed every eighteen months by a multi-disciplinary reference group. The new edition is published following this review.

The standards are graded into three types:

Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
Type 2: standards that an accredited clinic would be expected to meet;
Type 3: standards that an excellent clinic should meet.

In order to achieve accreditation a clinic must meet all Type 1, the majority of Type 2 and some Type 3 standards. If a clinic does not meet this level it will be deferred for a short period of time in order to make the necessary improvements.

The ECTAS model is about more than one-off inspection to assure that minimum standards are met. Its purpose is to encourage clinics to improve continuously.

Accreditation entails a rigorous process of self- and peer-review against the standards. This involves an audit of health records, policies and procedures, evaluation of the treatment environment and facilities and structured feedback from clinic staff, referring psychiatrists, patients and carers who have used the service.

Each ECTAS cycle takes three years. It begins with a full self- and peer-review, after which a full report is sent to the clinic. At 18 months, there is an interim self-review to ensure the clinic is maintaining standards. Once a clinic has completed the full three-year cycle, the process begins again and the clinic moves to cycle 2 and so on.

Further information on the ECTAS standards and process can be found at www.ectas.org.uk.

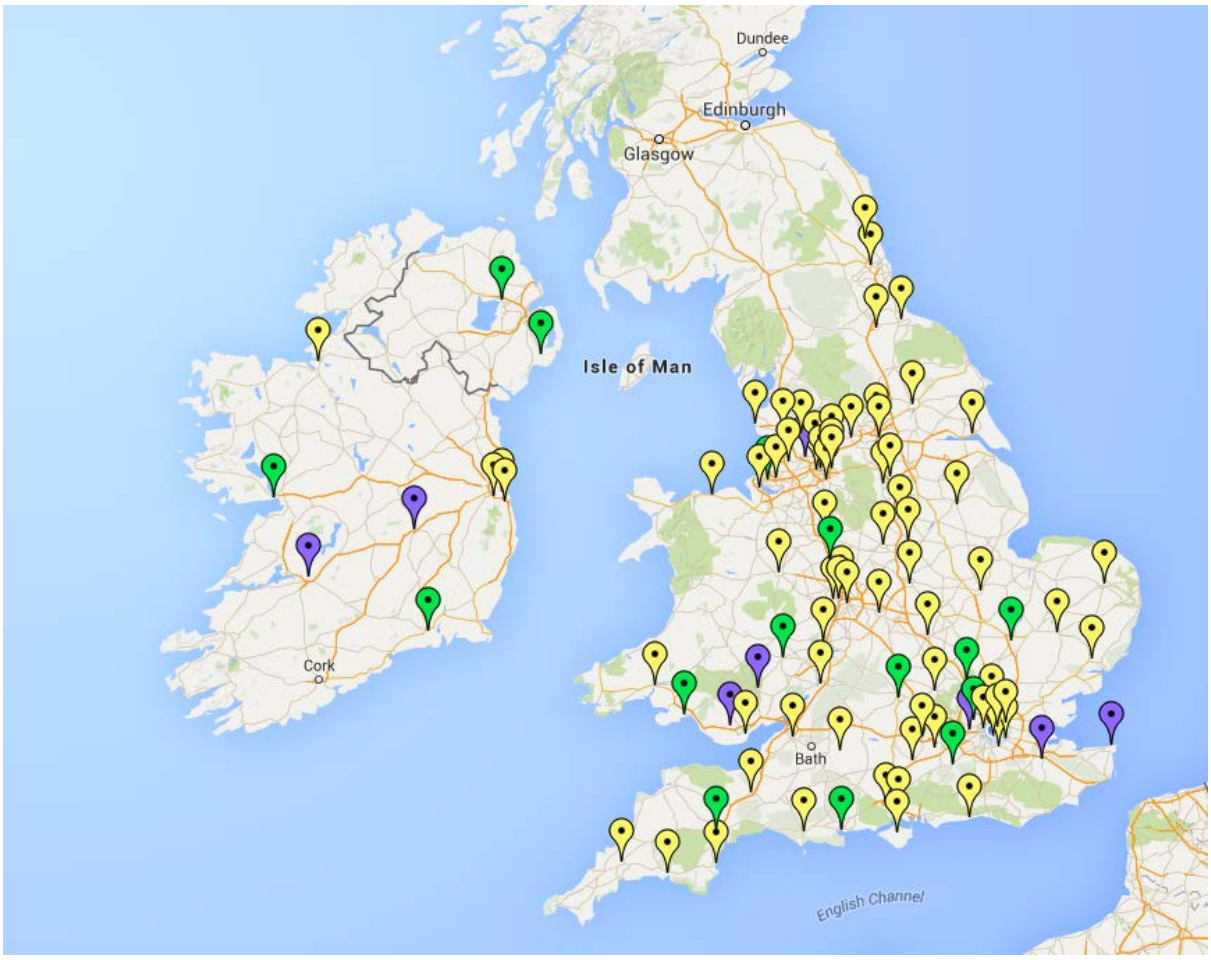
Overall performance of ECTAS member clinics

In October 2015, 96 clinics were members of ECTAS. Seventy nine of these were located in England, 6 in Wales, 9 in Ireland and 2 in Northern Ireland. Three ECTAS member clinics have closed since October 2013.

Ninety four clinics were active (in review or accredited) in October 2015 and two were dormant (i.e., they were ECTAS members but not currently reviewing).

ECTAS estimates that there are 86 ECT clinics in England, 7 in Wales, 20 in Ireland and 9 in Northern Ireland. This means that 78.7% of all eligible ECT clinics participate in ECTAS, and in England the figure is 91.9%. A full list of ECT clinics, together with their participation and accreditation status, can be found at www.ectas.org.uk.

Figure 1: Location of ECTAS Member Clinics (October 2015)



Accredited as excellent Accredited Currently in review/dormant

Table 1: Status of ECTAS member clinics (October 2015)

Accreditation status		Number of clinics	Percentage
Accredited as Excellent		32	33.3%
Accredited as Continuing Excellent		36	37.5%
Accredited	1st time	4	4.2%
	Following deferral	13	13.5%
Deferred		1	1.1%
In review		8	8.3%
Dormant		2	2.1%
TOTAL		**96**	**100%**

Table 2: Status of active ECTAS member clinics by cycle (October 2015)

Accreditation status		Cycle 1	Cycle 2	Cycle 3	Cycle 4
Accredited as Excellent		3	7	3	18
Accredited as Continuing Excellent		-	-	19	21
Accredited	1st time	1	2	0	1
	Following deferral	1	2	4	4
Deferred		0	0	0	1
In review		7	0	0	0
TOTAL		**12**	**11**	**26**	**45**

Accredited as Excellent

In October 2015, 31 ECTAS member clinics were accredited as excellent. This means that they met 100% of Type 1 standards, 95% of Type 2 standards and the majority of Type 3 standards at the point of peer review.

In 2015, a decision was made across all of the accreditation programmes run by the College Centre of Quality Improvement to no longer accredit teams as excellent. This change took effect as of January 2016. The main reason for this change is that patients, staff and the members of the public would expect that a team accredited by the Royal College of Psychiatrists is excellent. In addition, a general award of “excellent” is misleading if the team is not excellent in every area of the standards. Although ECT clinics can no longer be accredited as excellent, there are ongoing discussions regarding how very good practice can be recognised and rewarded through the accreditation process.

Accredited as Continuing Excellent

Forty clinics were accredited as continuing excellent in October 2015. The continuing excellent scheme is an option for clinics that have completed at least two cycles of accreditation, and have been accredited as excellent in their most recent cycle. The scheme involves clinics completing a questionnaire on an annual basis for the three year cycle, confirming that no major changes have taken place to their staffing, environment, documentation and service provision since their previous cycle. If changes have taken place in any of these domains, additional evidence is requested and reviewed by the Accreditation Committee.

Following a cycle on the continuing excellent scheme, clinics revert to the full cycle of self and peer review. As of October 2015, fourteen clinics had completed a full self and peer review following a cycle of continuing excellence. Thirteen of these clinics had been accredited as excellent, and one was accredited. In 11 of the clinics, the number of Type 2 and 3 standards they met had improved since their previous full review. Three clinics met slightly fewer standards, although 2 of these 3 retained their accredited as excellent status.

Clinics which were already on the continuing excellent scheme as of January 2016 will continue on this scheme until the end of their 3 years when they will complete a full cycle of self and peer-review. No further clinics will be able to move onto this scheme.

This change supports the partnership between ECTAS and the CQC. As outlined further on in this report, ECTAS is recognised as a source of information by the CQC. This has been identified by member clinics as a very important benefit of membership. One of the requirements set out by the CQC is that review visits must be recent, and this would not be the case for those clinics on the continuing excellent scheme. Ensuring that review visits do take place regularly is therefore an important component of ECTAS' work with the CQC.

Comparison of performance over four review cycles

The ECTAS review cycle is 3 years. All ECTAS member clinics complete a full self and peer review every 3 years in order to maintain their accreditation. ECTAS has now been running for 13 years, and 45 clinics have entered their fourth cycle. As of October 2015, 1 clinic had entered their fifth cycle, and several more will do so in early 2016.

Table 3 below shows the number of clinics who have taken part in 1, 2, 3 and 4 cycles of review.

Table 3: The number of clinics who have taken part in 1, 2, 3 and 4 cycles of review (current ECTAS members only)

Cycles	Number of clinics
1st cycle	97
1st & 2nd cycle	84
1st, 2nd & 3rd cycle	72
1st, 2nd, 3rd & 4th cycle	45

Figure 2: Accreditation status by ECTAS cycle

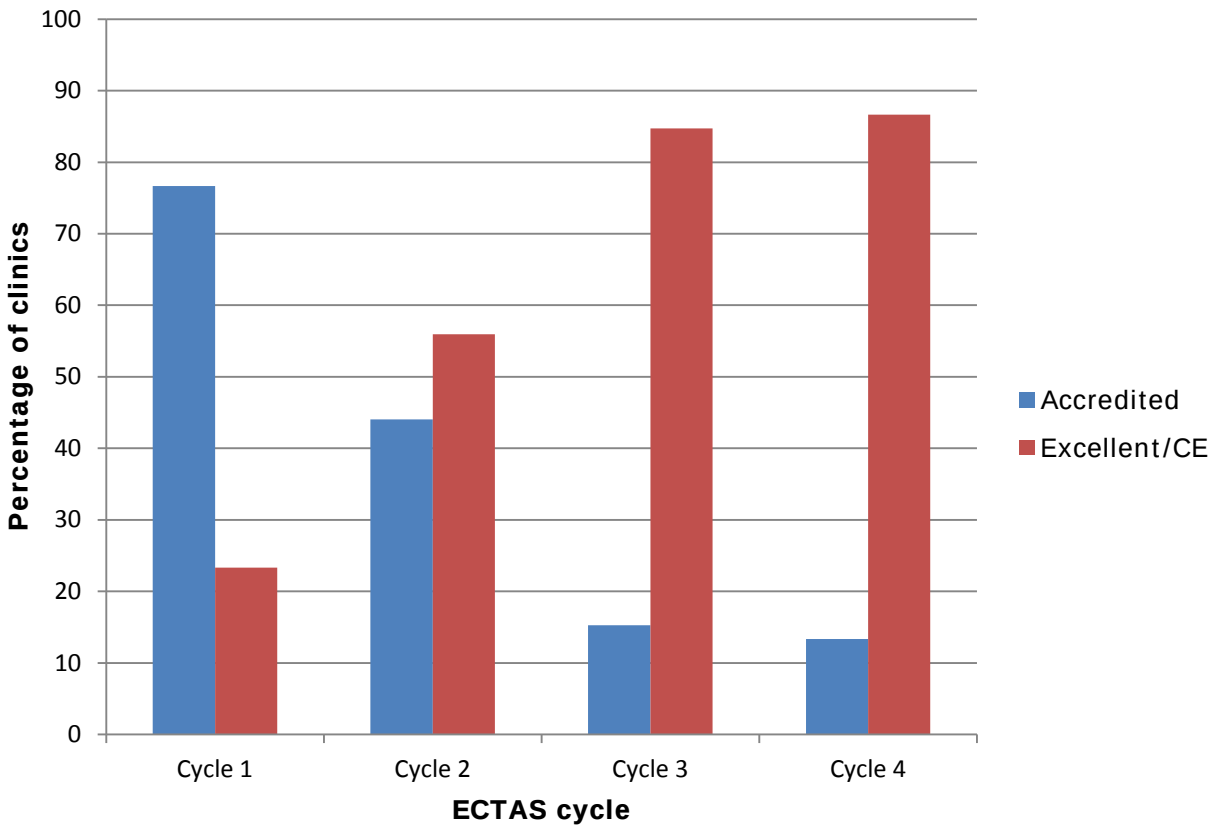


Figure two shows that as clinics move through the cycles, they are increasingly likely to be accredited as excellent/continuing excellent. There is a marked increase in the number of clinics accredited as excellent/continuing excellent in between cycle 1 and 2, and cycle 2 and 3. There is a much smaller increase between cycles 3 and 4. This is likely to be due to the fact that clinics tend to make big improvements in practice early on in their participation in ECTAS, and by the time they have reached cycle 4, they already meet a large number of the standards, and are therefore maintaining an already very high standard of practice.

Figure 3: Percentage of standards met by ECTAS cycle

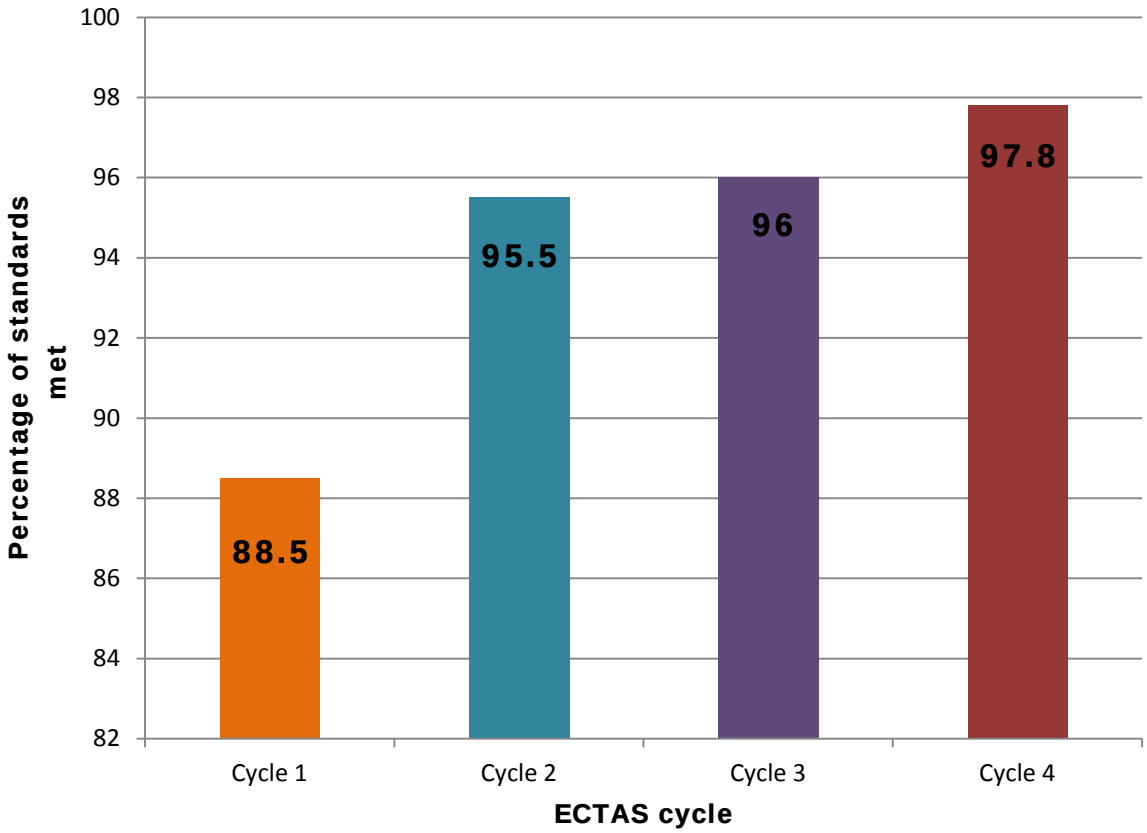


Figure 3 shows that the average percentage of standards met by clinics increases cycle on cycle. The most marked increase is between cycle 1 and cycle 2, and again, this is likely to be due to the fact that clinics make significant changes to their practice early on in the ECTAS process, and then work on maintaining these standards, and achieving the more aspirational standards, as they move through the cycles.

Figure 3: Percentage of each type of standard met by ECTAS cycle

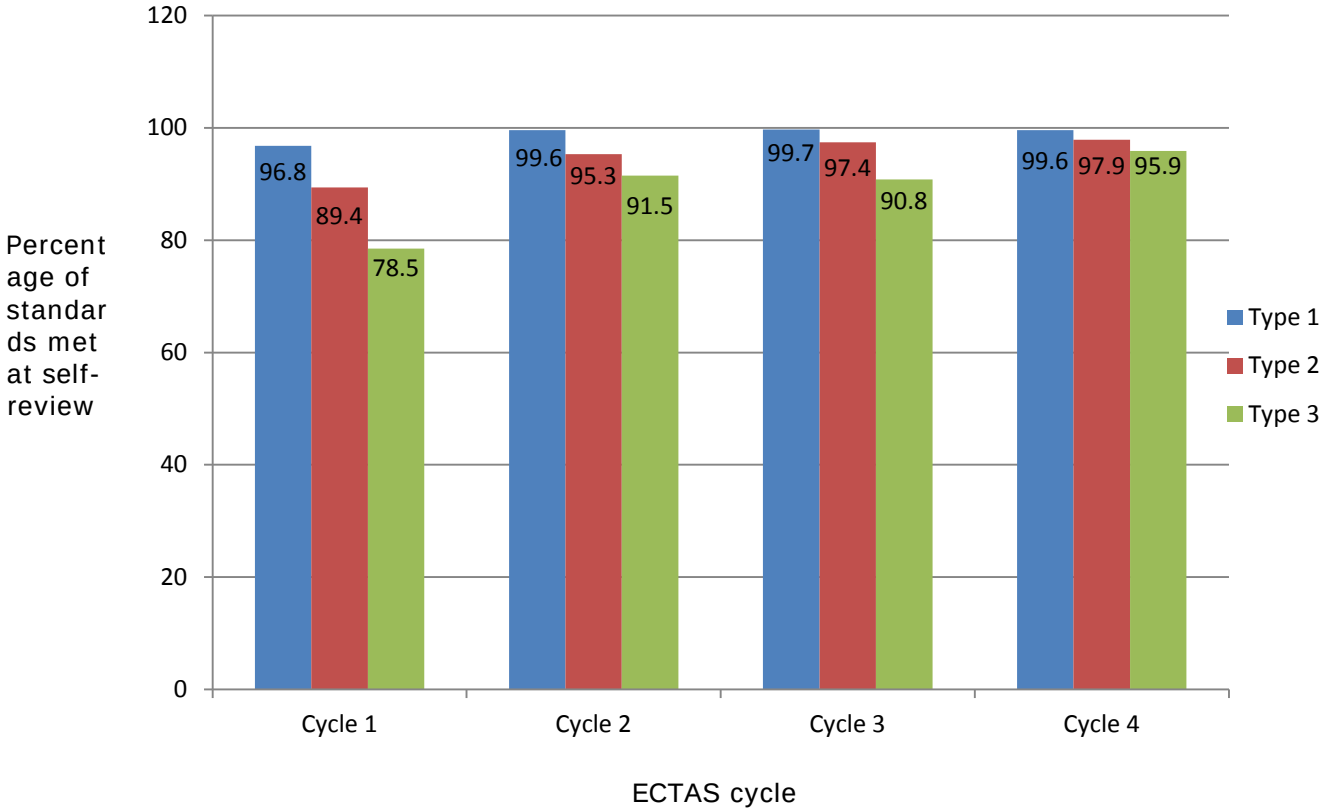
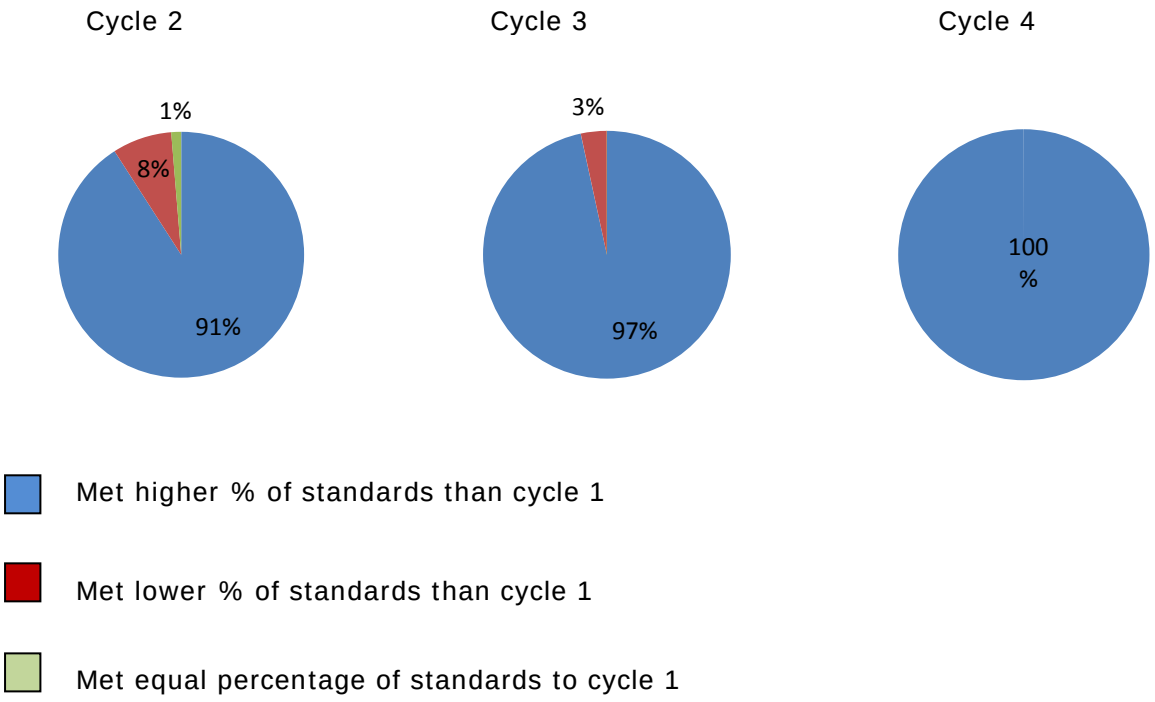


Figure 3 also demonstrates that the average percentage of standards that clinics meet rises most in between cycle 1 and cycle 2. The average number of type 1 standards met then stays very high, while the general pattern is that the percentage of type 2 and 3 standards increases, although we do see a slight drop in between cycle 2 and cycle 3. Figure 4 shows that the majority of clinics perform better as they move through the cycles.

It is important to remember that the ECTAS standards are regularly reviewed, with the aim of continuing to drive up quality. New standards are introduced, type 3s become type 2s, and type 2s become type 1s. This may account for the fact that clinics may occasionally perform slightly worse as they move on to their next cycle. Sometimes challenges faced by the clinics - such as changes in staffing, facilities or service provision – may result in fewer standards being met.

Figure 4: Comparison of clinics between cycle 1, and cycles 2, 3 and 4



All of the clinics who have taken part in their fourth cycle of review have performed better than in their first cycle. By the time clinics come to complete their fourth cycle, they will have been ECTAS members for nearly 10 years, and as such, have a very good knowledge of the standards and process and will be actively addressing any changes that need to be made before they come to be reviewed.

Table 4: The number of clinics to meet 100% of standards

Cycle	Number of clinics (% of clinics in the cycle)
1	2 (2.2%)
2	5 (5.8%)
3	5 (6.3%)
4	8 (15.4%)

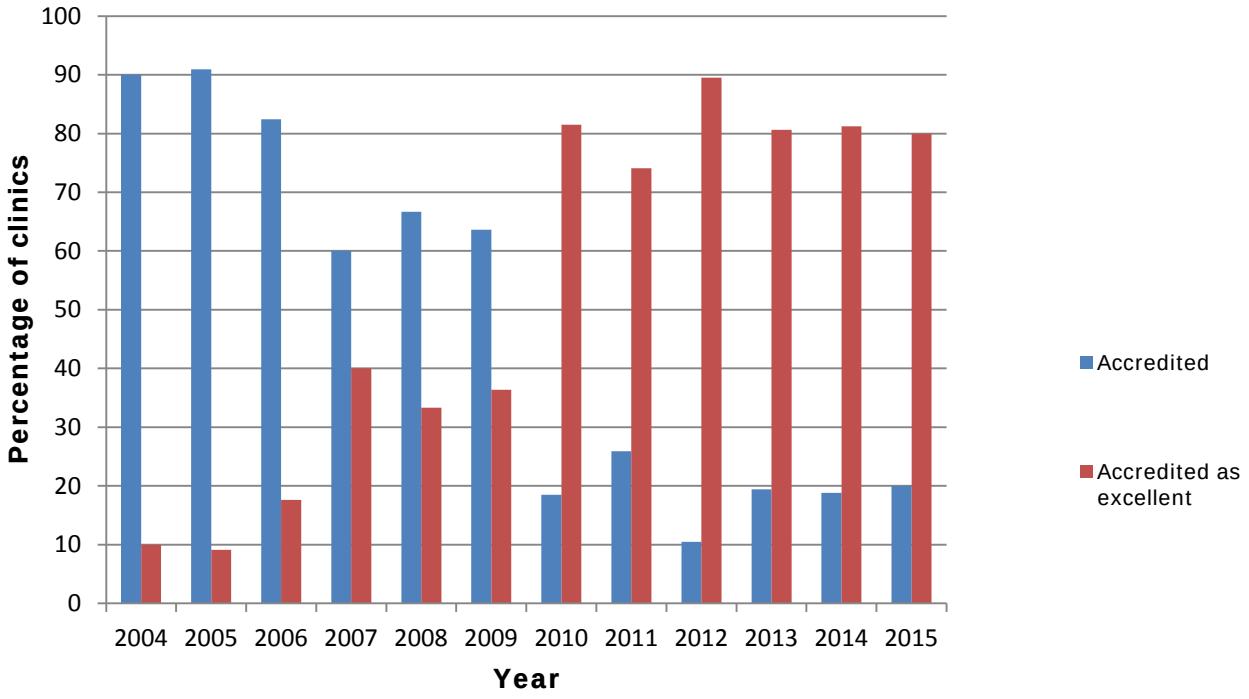
There are a small number of clinics who meet 100% of standards at the point of peer review. Table 4 shows that the number of clinics to achieve this increases between cycle 1 and 2, and between cycle 3 and 4, although as a proportion of clinics who have taken part in those cycles, it increases cycle on cycle.

Comparison of performance over 12 years of ECTAS

Figure 5 demonstrates that, over the past 12 years, the proportion of clinics accredited as excellent has increased. In 2004, just 10% of clinics were accredited as excellent, whereas in 2015, 80% of clinics had achieved this accreditation status. As was demonstrated in figure 2, as clinics move through the cycles, they are more likely to be accredited as excellent, as they make improvements cycle on cycle.

While there has been an overall increase in the proportion of clinics accredited as excellent, this has not been a smooth increase, and the proportion of clinics accredited as excellent has varied slightly year on year. There are a number of likely explanations for this. One is that the ECTAS standards are revised on a regular basis, and become tougher each time. This can result in clinics performing slightly worse in subsequent cycles. During 2012 and 2013, ECTAS saw a number of clinics close, with several trusts amalgamating clinics to reduce costs. Amalgamation, in the context of wider changes in the NHS such as the abolition of Primary Care Trusts, may have had an impact on the ability of clinics to meet ECTAS standards. This highlights the way in which wider organisational factors can have an impact on the outcome of the accreditation process.

Figure 5: Percentage of clinics accredited, and accredited as excellent, over 12 years of ECTAS



Standards commonly not met

Between October 2013 and October 2015, 32 clinics were considered by the ECTAS Accreditation Committee. There were certain standards which were commonly unmet by these clinics at the point of peer review, and as with previous years, these relate to two areas of practice; those requiring staff external to the clinic to complete assessments and paperwork in between treatments, and those relating to nurses having the opportunity to attend training and learning events. Table 5 shows the standards most commonly unmet between October 2013 and October 2015.

Table 5: Standards commonly unmet between October 2013 and October 2015

Standard	Number of clinics not meeting
7.12.1 [2] - The patient's cognitive side effects/memory are assessed using a standardised cognitive assessment tool and subjective questioning in a clinical interview at 1 or 2 months follow up	13
2.59 [3] - ECT nurses attend their regional ECT nurse special interest group	9
2.58 [3] - Other nurses within the clinic attend the Royal College of Psychiatrists' / NALNECT course for nurses in ECT	7
3.11 [2] - An assessment of memory is recorded using a standardised cognitive assessment tool and subjective questioning	7
7.12 [2] - The patient's orientation and memory is assessed before and after the first ECT, and re-assessed at intervals throughout the treatment course, using a standardised cognitive assessment tool	7

Table 6 shows that the clinics who were not meeting these standards were not necessarily those in their first or second ECTAS cycle; a number of clinics who had moved into their fourth cycles were also struggling with these standards. As several of these standards have also been highlighted in previous national reports as commonly unmet, it does appear that there are persistent problems with compliance.

Table 6: Standards commonly unmet by clinic cycle

Standard	Number of clinics not meeting – cycle 1	Number of clinics not meeting – cycle 2	Number of clinics not meeting – cycle 3	Number of clinics not meeting – cycle 4
7.12.1 [2] - The patient's cognitive side effects/memory are assessed using a standardised cognitive assessment tool and subjective questioning in a clinical interview at 1 or 2 months follow up	2	4	1	6
2.59 [3] - ECT nurses attend their regional ECT nurse special interest group	1	2	1	5
2.58 [3] - Other nurses within the clinic attend the Royal College of Psychiatrists' / NALNECT course for nurses in ECT	2	1	2	2
3.11 [2] - An assessment of memory is recorded using a standardised cognitive assessment tool and subjective questioning	1	3	1	2
7.12 [2] - The patient's orientation and memory is assessed before and after the first ECT, and re-assessed at intervals throughout the treatment course, using a standardised cognitive assessment tool	3	2	1	1

The assessments and paperwork required by standards 7.12.1, 7.12 and 3.11 are often the responsibility of the referring psychiatrist, and as such, fall outside the direct control of clinic staff. Many clinics have made efforts to raise awareness amongst referrers of the necessity of completing assessments, either through writing to them, discussion during meetings or teaching events. There are some clinics who have taken over responsibility for completing these assessments, creating a

'one stop shop' for patients. However, this is not an option for every clinic, as the resources may not be available to offer this kind of service.

ECTAS has seen improvements in some aspects of referring psychiatrists' practice – for example, the findings from the 1st ECTAS National Report found that over half of referring psychiatrists needed further training on ECT, and a regular training course was implemented as a result of this. Now, very few referring psychiatrists report needing additional training. It would seem that there is a need for a similar raising of awareness about the necessity of completing assessments and paperwork during and after the course.

ECT nurses attending their regional special interest group is a commonly unmet standard. Many ECT nurses only have limited dedicated time for ECT, and it can be difficult to be released from other duties in order to attend. Some nurses have also cited distance of travel as a barrier, or being unsure where their nearest group is. The National Association of Lead Nurses in ECT (NALNECT) have done a great deal of work in the past year to raise awareness of and encourage attendance at special interest groups. A new group has been established in London, where there was previously a gap. A list of special interest groups is available on the ECTAS website, and contact details can be obtained from ECTAS.

Another standard which is commonly unmet relates to nurses other than the lead nurse attending the RCPsych/NALNECT ECT nurse training course. In most clinics, the lead nurse will have attended this training course, but limited time to attend courses, as well as limited budgets, can have an impact on whether other staff are able to attend. There was previously a very high demand for training courses, which meant not all nurses were able to secure a place, and in order to address this, two courses are now run each year, rather than one. It is hoped that this will go some way towards addressing this.

Revision of the ECTAS audit tools

The ECTAS Standards are revised regularly in order to ensure they are up-to-date with current practice. The full of set of standards are designed to be aspirational and clinics are not expected to meet all of them; therefore year on year as clinics improve, the bar is raised to keep improving the quality of care delivered. This is done by upgrading the Type of current standards, and introducing new standards.

New standards introduced between 2013-2015 include the following:

N2.23.2 [3]
The lead nurse is trained in Immediate Life Support

N2.37.1 [2]
[Staff are trained in] The Mental Capacity Act

N4.17.3 [2]
Patients receiving maintenance ECT are advised not to drive for 24 hours following treatment, and receive individualised advice about driving whilst they are undergoing maintenance treatment

The ECTAS Standards have previously been revised on an annual basis. However, as the standards have now been in existence for over 10 years, major adjustments are not needed so often. It was decided in 2012 that the standards revision should take place less frequently. As such, the standards will now be revised every 18 months, with the next edition due for publication in April 2016.

The introduction of patient representatives

ECTAS has always had a strong emphasis on the ECT clinic and its processes, and it is clear that there have been significant improvements in practice since the inception of the scheme. With an increasing number of clinics now being accredited as excellent, and several clinics also meeting 100% of standards, there is a need to look at other ways of continuing to drive up quality. Within this context, there is the potential to focus more closely on the patient experience. To this end, ECTAS has introduced a number of initiatives which aim to make the patient experience more central to the accreditation process.

Self review feedback
Feedback collected during the self-review period from the patient questionnaire was previously included in the peer review booklet as contextual data. As of January 2015, standards have been 'triangulated' so that the results of the patient questionnaire directly inform whether the standard is met or not. This gives the patient feedback greater weight, as it can directly impact the decision to rate a standard as met or not met, and therefore has an influence on the outcome of accreditation.

Between October 2013 and October 2015, 202 patient questionnaires were returned to ECTAS. Feedback was generally extremely positive. For example;

- 85.5% of people answered 'yes' to the question 'did your doctor speak to you about ECT before you agreed to treatment?'. Only 3.5% said 'no', and the remainder responded, 'don't know/can't remember'.
- 88% of people agreed that clinic staff were friendly and reassuring.

Free text comments often praised the quality of care and the friendliness and caring attitude of staff. The following is illustrative:

"Received great care and attention both before and after ECT."

In addition, 77% of people responded 'yes' to the question 'did ECT help you?'. 12% of people said 'no' and the remainder responded 'don't know/can't remember'.

Peer reviewers
In 2014, ECTAS made the decision to introduce patient representatives as members of the peer review team. Patient representatives are now routinely invited to attend peer reviewer training. The first patients were trained in May 2015, and there are currently 5 trained patient reviewers, with 4 more due to attend training at the time of writing. Since May 2015, there has been a patient representative on 45% of all reviews that have taken place. As the number of patients who are trained increases, ECTAS aims to have patient representatives in attendance at 100% of reviews.

Patient representatives on committees
ECTAS has always had patient representatives sitting on the standards development group. However, there were no patients sitting on the Accreditation Committee. This position was advertised through member clinics, and applicants were interviewed in November 2014. Two people were recruited, and as of December 2015, there has been a patient representative in attendance at every meeting.

Carer questionnaire

In addition to making the patient voice more central to the ECTAS process, in 2015, ECTAS introduced a questionnaire to the self-review focusing on the experiences of relatives, friends and carers. Every clinic that has begun their self-review in 2015 has been asked to distribute copies of this questionnaire, and these are returned directly to ECTAS. As of October 2015, 36 carer questionnaires had been returned by 14 clinics. Early results suggest that carers are generally pleased with the care that their relative or friend has received at the clinic. The following is illustrative:

"I was very pleased with the standard of care given to my relative at the ECT clinic. They treated her with dignity and respect and were very kind to us both."

Minimum Data Set

Between April 2014 and March 2015, ECTAS repeated data collection for the minimum dataset, originally conducted in 2012/13. Key details on treatment were collected for every patient who had begun an acute course of ECT after 1st April 2014, and on patients who were receiving maintenance ECT in March 2015. The data was compared with that from 2012/13. Key findings included the following:

- 81 clinics took part in the data collection – one more than 2012/13.
- 2148 acute courses of ECT were given to 1969 people – representing an increase from the previous round of data collection.
- The majority of people to receive an acute course of ECT were female (65%), in their sixties or seventies and referred for depression (84.4%). These figures are very similar to the previous round of data collection.
- The majority of patients (51.4%) were informal and capacitous at the start of treatment.
- 91.5% of patients showed an improvement in their Clinical Global Impression score over the course of treatment, 6.8% made no change and 1.7% got worse. Again, these figures are similar to those collected in 2012/13.
- 155 people were receiving maintenance ECT in March 2015; 74% were female, the average age was 65 and 92.3% were referred for recurrent symptoms of depression. Most people (29.7%) received maintenance ECT monthly. These figures were very similar to those from March 2013.

In 2016, ECTAS plans to run the dataset on a rolling basis, collecting the data year on year. This will allow ECTAS to build a much clearer picture of the rates of use of ECT amongst its member clinics, and will allow the identification of trends over time.

The Care Quality Commission (CQC) and ECTAS

The CQC recognises the potential value of clinical service accreditation and peer-review schemes as information sources to support its inspections. Such schemes have the potential to provide useful intelligence and provide independent assurance that accredited services meet standards.

The Healthcare Quality Improvement Partnership (HQIP) has developed, in association with the cross-college clinical services accreditation stakeholder's advisory group, a set of criteria to help CQC determine

schemes that can provide robust and reliable information for consideration ahead of and during inspections.

ECTAS has applied and been approved as an official information source.

Any publically available information (for example accreditation status) will be taken into account in the CQC inspection methodology.

Recommendations & Goals for 2016/17

1. ECT clinics to strengthen their relationships with referring psychiatrists

A common theme to emerge in a number of ECTAS National Reports is that standards which require the referring psychiatrist to complete assessments and paperwork between treatments are commonly unmet. As this has been identified over a number of years now, ECTAS plans to identify clinics that have evidenced good practice in this area, with the aim of creating some case studies of good practice, and recommendations for improvement. These will then be shared with ECTAS members.

2. ECTAS to collect the dataset on a continuous basis

As of April 2016, ECTAS will begin to collect the ECT Minimum Data Set on a rolling basis. Clinics will be able to enter the data for acute and maintenance treatments each year. This should build up a much more comprehensive picture of rates of ECT use nationally, and will allow ECTAS to identify trends over time.

3. An advanced training course to be set up for nurses

Feedback from the ECT Nurses' two Day Training course has identified the need for an additional training day for Lead ECT Nurses. ECTAS will work in partnership with NALNECT to develop a more advanced course for lead nurses, and hopes to make this available to member clinics in 2017.

4. New information management system

Following the standards revision in April 2016, ECTAS will start using a new online information management system. Teams will be able to sign up to ECTAS online, monitor their self-review returns and access their reports directly through an online portal. This will provide members with quicker and easier access to their data.

Appendix 1 – ECTAS clinics which have completed at least 1 cycle

This table lists all the clinics which have undertaken at least one self-review and peer-review. Member services will be able to identify their own clinic from the clinic number in the first column. Clinics are listed in descending order of the overall percentage of standards met in the most recent cycle; that is, the best performing clinics come first. CE denotes the continuing excellence programme.

Rank	Clinic No.	Overall			
		% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 4
1	2	81.3	100	CE	100
2	10	90.7	99.7	CE	100
3	30	88.3	99.7	CE	100
4	36	99.3	97.3	CE	100
5	58	95.7	97.7	CE	100
6	46	84.0	95.7	97.1	100
7	14	88.0	97.0	CE	100
8	24	75.0	96.0	CE	100
9	107	91.0	98.8	100	
10	99	94.7	95.0	100	
11	7	86.3	95.0	100	CE
12	28	83.7	93.7	100	
13	66	84.7	92.3	100	CE
14	83	99.3	100	CE	
15	92	97.0	100	CE	
16	78	93.7	100	CE	
17	96	86.0	100	CE	
18	51	93.7	99.3	CE	99.7
19	21	79.7	99.3	CE	99.7
20	41	86.3	95.0	95.7	99.7
21	6	91.3	94.7	CE	99.7
22	27	80.0	94.7	CE	99.7
23	3	85.3	96.0	99.7	CE
24	118	100	99.7		
25	117	93.0	99.7		
26	65	84.0	99.7	CE	
27	104	99.3	99.6	CE	
28	35	91.0	96.0	99.6	CE
29	73	88.0	96.3	99.6	CE
30	115	95.0	99.6	CE	
31	29	79.0	94.3	99.3	CE
32	94	89.0	99.3	CE	
33	110	97.0	99.1		
34	95	99.0	99.0	CE	
34	82	99.0	99.0	CE	
36	59	90.7	95.0	98.9	CE
37	43	90.7	94.7	98.9	CE
38	62	91.7	85.7	98.8	CE
39	56	90.7	96.7	98.8	CE
40	81	85.3	98.7	CE	
41	55	85.0	97.7	98.5	
42	114	97.7	98.5	CE	
43	17	76.3	96.7	98.5	CE
44	76	88.7	98.0	CE	
45	11	79.3	91.3	94.3	97.9
46	31	82.0	95.3	CE	97.7
47	98	83.3	97.7	CE	
48	54	94.7	98.7	CE	97.3
49	91	92.0	97.3	CE	
50	125	97.2			
51	12	81.7	98.7	CE	97.0
52	22	85.7	95.7	97.0	CE
53	111	99.3	96.8	CE	
54	39	77.7	95.3	96.7	CE
55	119	93.7	96.7		
56	4	85.7	97.0	CE	96.5
57	18	66.7	91.0	92.7	96.4
58	84	92.7	96.3	CE	
59	116	92.3	96.3		
60	71	81.3	96.3	CE	
61	32	69.0	87.3	96.3	CE
62	63	93.0	96.0	CE	96.0
63	79	71.0	96.7	95.8	
64	122	100	95.7		
65	34	78.0	83.3	95.7	CE
66	52	93.7	98.7	CE	95.3
67	44	79.9	85.3	92.5	95.0
68	90	90.3	95.0	CE	
69	13	96.7	97.7	94.7	CE
70	126	94.7			
71	124	94.2			
72	123	94.1			
73	97	86.0	94.0	CE	
74	112	98.3	93.9		
75	75	94.7	93.0	93.7	
76	68	88.2	93.5		
77	45	93.4	93.4		
78	121	97.1	93.0		
79	101	98.0	92.8		
80	87	92.7	92.7		
81	53	77.3	91.3	93.0	
82	37	83.7	91.3	92.4	
83	38	84.0	89.0	92.0	CE
84	128	92.0			
85	20	87.0	87.3	89.0	91.3
86	33	72.3	87.0	90.3	CE
87	40	80.7	90.0	90.2	CE
88	109	98.7			
89	5	83.0	89.0	93.3	89.0
90	50	78.0	91.7	87.0	CE

Appendix 2 – ECTAS clinics which have completed 2 cycles

This table lists the clinics which have undertaken the self-review and peer-review on two occasions and compares their performance in cycle 1 with that in cycle 2.

Member services will be able to identify their own clinic from the clinic number in the first column. Clinics are listed in descending order of the overall percentage of standards met; that is, the best performing clinics come first.

Rank	Clinic No.	Type 1 Standards		Type 2 Standards		Type 3 Standards		Overall	
		% Met Cycle 1	% Met Cycle 2	% Met Cycle 1	% Met Cycle 2	% Met Cycle 1	% Met Cycle 2	% Met Cycle 1	% Met Cycle 2
1	**118**	100.0	99.1	100.0	100.0	100.0	100.0	100.0	99.7
2	**117**	100.0	100.0	87.0	99.1	92.0	100.0	93.0	99.7
3	**110**	100.0	100.0	98.0	97.3	93.0	100.0	97.0	99.1
4	**119**	100.0	100.0	92.0	97.0	89.0	93.0	93.7	96.7
5	**116**	97.0	100.0	87.0	97.3	93.0	91.7	92.3	96.3
6	**122**	100.0	100.0	100.0	99.0	100.0	88.0	100.0	95.7
7	**121**	100.0	100.0	97.7	97.0	93.5	82.0	97.1	93.0
8	**112**	100.0	100.0	99.0	100.0	96.0	81.8	98.3	93.9
9	**68**	98.5	96.7	80.7	91.5	85.4	92.3	88.2	93.5
10	**45**	89.0	100.0	79.0	90.0	59.0	90.3	93.4	93.4
11	**101**	100	93.9	94.0	91.3	100.0	93.3	98.0	92.8
12	**87**	97.0	100.0	94.0	85.0	87.0	93.0	92.7	92.7

Appendix 3 – ECTAS clinics which have completed 3 cycles

This table lists the clinics which have undertaken the self-review and peer-review on three occasions, and those which have undertaken them on two occasions as well as completing one cycle of the continuing excellent scheme, and compares their performance in cycle 1, 2 and 3.

Member services will be able to identify their own clinic from the clinic number in the first column. Clinics are listed in descending order of the overall percentage of standards met; that is, the best performing clinics come first (according to the data from their most recent full cycle). CE denotes the continuing excellent scheme.

Rank	Clinic No.	Type 1 Standards			Type 2 Standards			Type 3 Standards			Overall		
		% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3
1	**83**	100	100	CE	98.0	100	CE	100	100	CE	99.3	100	CE
2	**107**	99.0	100	100	90.0	100	100	84.0	96.4	100	91.0	98.8	100
3	**92**	100	100	CE	98.0	100	CE	93.0	100	CE	97.0	100	CE
4	**99**	100	100	100	95.0	95.0	100	89.0	90.0	100	94.7	95.0	100
5	**78**	100	100	CE	92.0	100	CE	89.0	100	CE	93.7	100	CE
6	**96**	97	100	CE	95	100	CE	66.0	100	CE	86.0	100	CE
7	**65**	100	100	CE	89.0	98.0	CE	63.0	100	CE	84.0	99.7	CE
8	**104**	100	100	CE	98.0	98.9	CE	100	100	CE	99.3	99.6	CE
9	**115**	100	100	CE	96.0	98.6	CE	89.0	100	CE	95.0	99.6	CE
10	**94**	88.0	100	CE	89.0	98.0	CE	90.0	100	CE	89.0	99.3	CE
11	**82**	100	100	CE	97.0	100	CE	100	97.0	CE	99.0	99.0	CE
11	**95**	100	100	CE	97.0	100	CE	100	97.0	CE	99.0	99.0	CE
13	**55**	91.0	100	100	84.0	96.0	95.5	80.0	97.0	100	85.0	97.7	98.5
14	**81**	92.0	100	CE	89.0	96.0	CE	75.0	100	CE	85.3	98.7	CE
15	**114**	100	100	CE	96.0	95.6	CE	97.0	100	CE	97.7	98.5	CE
16	**76**	95.0	100	CE	88.0	98.0	CE	83.0	96.0	CE	88.7	98.0	CE
17	**98**	97.0	100	CE	85.0	97.0	CE	68.0	96.0	CE	83.0	97.7	CE
18	**91**	99.0	100	CE	94.0	99.9	CE	83.0	93.0	CE	92.0	97.3	CE
19	**111**	100	100	CE	98.0	100	CE	100	90.3	CE	99.3	96.8	CE
20	**84**	97.0	99.0	CE	88.0	97.0	CE	93.0	93.0	CE	92.7	96.3	CE
21	**71**	84.0	100	CE	89.0	96.0	CE	71.0	93.0	CE	81.3	96.3	CE
22	**79**	88.0	100	99.3	79.0	93.4	100	46.0	96.6	88.2	71.0	96.7	95.8
23	**90**	97.0	100	CE	95.0	97.0	CE	79.0	88.0	CE	90.0	95.0	CE
24	**97**	99.0	100	CE	88.0	99.0	CE	71.0	83.0	CE	86.0	94.0	CE
25	**75**	100	100	100	98.0	93.0	88.0	86.0	86.0	93.0	94.7	93.0	93.7
26	**53**	93.0	95.0	98.4	80.0	89.0	99.3	59.0	90.0	81.3	77.3	91.3	93.0
27	**37**	90.0	100	93.9	83.0	93.0	93.6	78.0	81.0	89.6	83.7	91.3	92.4

Appendix 4 – ECTAS clinics which have completed 4 cycles

These tables list the clinics which have undertaken the self-review and peer-review on four occasions or on three occasions as and have completed one cycle of the continuing excellent scheme, and compare their performance in cycle 1, 2, 3 and 4. The first table shows performance in terms of the percentage of standards of each type that were met and the second table in terms of the four key sections of the ECTAS audit.

Member services will be able to identify their own clinic from the clinic number in the first column. Clinics are listed in descending order of the overall percentage of standards met; that is, the best performing clinics come first (according to the data from their most recent full cycle). CE denotes clinics on the continuing excellent scheme.

Rank	Clinic no.	Type 1 standards				Type 2 standards				Type 3 standards				Overall			
		% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 4	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 4	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 4	% Met Cycle 1	% Met Cycle 2	% Met Cycle 3	% Met Cycle 4
1	**2**	98.0	100	CE	100	82.0	100	CE	100	64.0	100	CE	100	81.3	100	CE	100
2	**10**	96.0	100	CE	100	94.0	99.0	CE	100	82.0	100	CE	100	90.7	99.7	CE	100
3	**30**	98.0	100	CE	100	91.0	99.0	CE	100	76.0	100	CE	100	88.3	99.7	CE	100
4	**58**	100	100	CE	100	97.0	96.0	CE	100	90.0	97.0	CE	100	95.7	97.7	CE	100
5	**36**	100	100	CE	100	98.0	98.0	CE	100	100	94.0	CE	100	99.3	97.3	CE	100
6	**46**	99.0	100	100	100	87.0	91.0	91.3	100	66.0	96.0	100	100	84.0	95.7	97.1	100
7	**14**	98.0	100	CE	100	92.0	98.0	CE	100	74.0	93.0	CE	100	88.0	97.0	CE	100
8	**24**	92.0	100	CE	100	83.0	95.0	CE	100	50.0	93.0	CE	100	75.0	96.0	CE	100
9	**7**	96.0	100	100	CE	89.0	92.0	100	CE	74.0	93.0	100	CE	86.3	95.0	100	CE
10	**28**	100	99.0	100	CE	81.0	89.0	100	CE	70.0	93.0	100	CE	83.7	93.7	100	CE
11	**66**	97.0	100	100	CE	89.0	93.0	100	CE	68.0	84.0	100	CE	84.7	92.3	100	CE
12	**51**	97.0	100	CE	100	96.0	98.0	CE	99.0	88.0	100	CE	100	93.7	99.3	CE	99.7
13	**21**	88.0	100	CE	100	78.0	98.0	CE	99.0	73.0	100	CE	100	79.7	99.3	CE	99.7
14	**41**	92.0	100	99.0	100	89.0	92.0	95.0	99.0	78.0	93.0	93.0	100	86.3	95.0	95.7	99.7
15	**6**	96.0	100	CE	100	99.0	98.0	CE	99.1	79.0	86.0	CE	100	91.3	94.7	CE	99.7
16	**27**	97.0	99.0	CE	100	85.0	95.0	CE	99.0	58.0	90.0	CE	100	80.0	94.7	CE	99.7
17	**3**	96.0	100	100	CE	86.0	92.0	99.0	CE	74.0	96.0	100	CE	85.3	96.0	99.7	CE
18	**73**	98.0	100	100	CE	87.0	97.0	98.9	CE	79.0	92.0	100	CE	88.0	96.3	99.6	CE
19	**35**	100	100	100	CE	90.0	92.0	98.9	CE	83.0	96.0	100	CE	91.0	96.0	99.6	CE
20	**29**	90.0	100	100	CE	84.0	93.0	97.8	CE	63.0	90.0	100	CE	79.0	94.3	99.3	CE
21	**59**	100	99.0	100	CE	96.0	95.0	100	CE	76.0	91.0	96.6	CE	90.7	95.0	98.9	CE
22	**43**	98.0	100	100	CE	96.0	98.0	100	CE	78.0	86.0	96.7	CE	90.7	94.7	98.9	CE
23	**56**	99.0	100	100	CE	95.0	93.0	100	CE	78.0	97.0	96.5	CE	90.7	96.7	98.8	CE
24	**62**	100	95.0	100	CE	97.0	92.0	100	CE	78.0	70.0	96.5	CE	91.7	85.7	98.8	CE
25	**11**	94.0	100	100	98.1	75.0	91.0	95.0	95.5	69.0	83.0	88.0	100	79.3	91.3	94.3	97.9
26	**31**	97.0	100	CE	100	86.0	96.0	CE	99.0	63.0	90.0	CE	94.0	82.0	95.3	CE	97.7
27	**54**	100	100	CE	100	96.0	96.0	CE	98.0	88.0	100	CE	94.0	94.7	98.7	CE	97.3
28	**12**	98.0	100	CE	100	85.0	100	CE	97.0	62.0	96.0	CE	94.0	81.7	98.7	CE	97.0
29	**22**	92.0	100	100	CE	85.0	94.0	99.0	CE	80.0	93.0	92.0	CE	85.7	95.7	97.0	CE

30	**39**	90.0	99.0	100	CE	82.0	97.0	100	CE	61.0	90.0	90.0	CE	77.7	95.3	96.7	CE
31	**4**	98.0	100	CE	100	82.0	95.0	CE	97.3	77.0	96.0	CE	92.3	85.7	97.0	CE	96.5
32	**18**	96.0	100	100	97.2	68.0	91.0	92.0	91.9	36.0	82.0	86.0	100	66.7	91.0	92.7	96.4
33	**32**	88.0	100	100	CE	73.0	87.0	100	CE	46.0	75.0	89.0	CE	69.0	87.3	96.3	CE
34	**63**	100	100	CE	100	91.0	97.0	CE	100	88.0	91.0	CE	100	93.0	96.0	CE	96.0
35	**34**	96.0	96.0	100	CE	79.0	85.0	100	CE	59.0	69.0	87.0	CE	78.0	83.3	95.7	CE
36	**52**	100	100	CE	100	96.0	96.0	CE	92.0	85.0	100	CE	94.0	93.7	98.7	CE	95.3
37	**44**	98.0	99.0	100	99.2	82.0	88.0	92.3	97.5	59.0	69.0	85.2	88.2	79.7	85.3	92.6	95.0
38	**13**	96.0	99.0	100	CE	97.0	94.0	98.0	CE	97.0	100	86.0	CE	96.7	97.7	94.7	CE
39	**38**	95.0	100	100	CE	91.0	88.0	97.0	CE	66.0	79.0	79.0	CE	84.0	89.0	92.0	CE
40	**20**	100	97.0	100	96.8	85.0	83.0	95.0	95.8	76.0	82.0	72.0	81.3	87.0	87.3	89.0	91.3
41	**33**	88.0	99.0	100	CE	71.0	93.0	96.0	CE	58.0	69.0	75.0	CE	72.3	87.0	90.3	CE
42	**40**	91.0	100	100	CE	79.0	98.0	97.7	CE	72.0	72.0	73.0	CE	80.7	90.0	90.2	CE
43	**5**	98.0	100	100	99.0	82.0	92.0	94.0	91.0	69.0	75.0	86.0	76.9	88.3	89.0	93.3	89.0
44	**50**	94.0	99.0	100	CE	86.0	93.0	97.8	CE	54.0	83.0	63.3	CE	78.0	91.7	87.0	CE

ECTAS

The Royal College of Psychiatrists

21 Prescot Street

London

E1 8BB