








QNWA Fourth National Report

Aggregated data from 2019 – 2022

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The artwork displayed on the front cover of this report was kindly provided by the patients at Bushey Fields Hospital, Black Country Healthcare NHS Foundation Trust.

FOREWORD

As the serving Chair of the Quality Network for Inpatient Working Age Mental Health Services (QNWA) Advisory Group, I am delighted to provide a foreword for the QNWA's fourth National Report, which provides aggregated data for the period 2019 to 2022.

As a Consultant in General Adult Psychiatry working in an inpatient setting in the North West of England, it has always been central to my clinical practice to aspire to ensure that safe and high-quality care is provided to each and every patient that is admitted to the ward I work on, and I hope that this can be replicated across each and every general adult inpatient ward in the UK. My desire to achieve this goal was what drove me to become actively involved in the work of the QNWA.

Whilst the process of securing accreditation with QNWA may require time and effort, the subsequent rewards are plentiful and sustainable. The process of accreditation is designed in such a way to support inpatient teams from the start of the process, with the offer of a developmental review being a helpful lead-in to then seeking review for accreditation.

In the current climate of Consultant Psychiatrist vacancies on general adult inpatient wards across the UK, shortage of nursing staff and reliance on bank staff, and lack of psychology and OT input on general adult inpatient wards, on the back of the COVID-19 pandemic leading to an explosion of individuals experiencing periods of mental ill-health, it has never been more important to re-focus on what should be the central goal of everyone who works in, or who utilises or is exposed to, a general adult inpatient setting - putting the care of the individual person at the heart of everything that we do.

Striving for accreditation with the QNWA represents an excellent opportunity to quality assure and to celebrate the care that your ward provides and facilitate achieving that sought after goal of the provision of safe and high-quality care to each and every patient. But more than that, accreditation also aims to facilitate preservation of the mental and physical wellbeing and level of competence of all staff members who work on the general adult inpatient ward so that they can feel positive, confident and well supported in their respective roles and in the care that they provide to patients.

Dr Declan Hyland

**Consultant in General Adult Psychiatry
Weaver Ward, Brooker Centre, Runcorn, Mersey
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I have been involved with the QNWA since the summer of 2020 as a patient representative and have valued the opportunities since joining the network to visit psychiatric wards as part of the network's peer-reviews, meeting patients, their carers and staff. During peer-review visits, I lead the patient interviews, finding out about their experiences on the wards, as well as contributing to the interviews and discussions with staff throughout the visit. It is a privilege to be involved in the QNWA, and I use my position to ensure that patients' perspectives are heard and reflected in the feedback and reports received by the wards after the peer-review days. It is always inspiring and encouraging to see the passion ward and QNWA staff have, and I have taken part in many interesting discussions about new initiatives for improving patient care throughout my time working at the Royal College of Psychiatrists.

It is important to present reports like this one, as it helps to identify areas of achievement and challenge faced by wards across the UK and places a spotlight on areas of focus for the future. Gathering and comparing data also supports the sharing of ideas and best practice; something that I have seen a lot in my time working with the QNWA.

The data in this report was gathered mostly during the pandemic and lockdowns. During this time, staff experienced unique challenges such as managing infection control and increased acuity, and our role in supporting them became even more vital. Despite the challenges, we saw staff continue to work hard for their patients and many achieved accreditation.

This report highlights several areas that wards are doing well, and also highlights common areas for unmet standards, suggesting ideas for local quality improvement initiatives that wards can realistically undertake. One positive note from the reports is that 100% of wards have used Quality Improvement projects, demonstrating dedication to amelioration. Another positive note of the report that stood out to me is that all wards invite community team representatives to ward rounds to contribute to care and discharge planning. This shows an awareness of the importance of multidisciplinary working and ensures that patients continue to receive care and support post-discharge, increasing their chances of success in the community.

Since the last report, carer engagement and support has declined, although the pandemic would have played a role in this. 89% of carers reported feeling involved in discussions in the previous report, but only 76% reported this in the current report. Fewer carers were also informed about carer's assessments: in the previous report, 84% of carers said they had, whereas in the new report only 39% of carers said they had (with 18% stating they were "not sure"). These findings highlight the need for dedicated carer's leads on wards; a role that I have seen have very positive impacts on the feedback given by carers during peer-reviews.

I hope this report is used to continue to improve the service provided to patients during their stay in psychiatric wards, as well as improve the working environment for staff on the wards. I look forward to working more on projects in the future with the QNWA.

Gila Ehrenstein

QNWA Patient Representative

INTRODUCTION

Introduction

Welcome to the **Fourth National Report of the Quality Network for Inpatient Working Age Mental Health Services (QNWA)**. This report aggregates data collected from 2019 to 2022 through peer-reviews of member wards. The data stems from wards seeking accreditation against the 7th Edition Standards for Acute Inpatient Services for Working Age Adults.

The core purpose of this report is to highlight areas of good practice in acute inpatient mental health wards across England and Scotland, while also providing quality improvement suggestions for areas identified as needing further development. With a focus on benchmarking performance, the report provides both quantitative data and qualitative examples of good practice, quality improvement initiatives, and practical advice for wards considering accreditation.

Throughout the review period, 37 wards participated in the accreditation process, engaging in a peer-review cycle that assessed their adherence to QNWA standards. To maintain confidentiality, the wards are represented by anonymised service codes. A complete list of participating member wards can be found in **Appendix 1**.

Aims of this report

This national report serves several key aims:

- **Explore Trends:** By presenting aggregated data, this report seeks to identify patterns across member wards, shedding light on compliance rates with QNWA standards, and highlighting both strengths and areas for improvement within the wards.
- **Encourage Continuous Improvement:** Through detailed analysis, the report aims to promote continuous quality improvement in acute inpatient mental health services by identifying good practices, providing feedback, and offering guidance to wards engaged in or considering the accreditation process.
- **Support Best Practices:** The report not only benchmarks performance but also offers practical recommendations and showcases quality initiatives to help wards on their journey towards providing higher standards of care.
- **Facilitate Peer Learning:** By sharing the experiences of accredited wards, the report aims to foster collaboration where member wards can learn from each other's successes and challenges.

Who should read this report?

This report is designed to be a comprehensive resource for a diverse range of stakeholders involved in the improvement of acute inpatient mental health services for working-age adults. Key audiences for this report include:

- **Service Providers and Clinical Teams:** Professionals working within acute inpatient mental health services who are directly involved in delivering care. This includes ward managers, nursing staff, psychiatrists, psychologists, occupational therapists, and other allied health professionals. The report offers valuable insights into service performance, quality benchmarks, and practical examples of good practice that can help shape service development.
- **Healthcare Leaders and Commissioners:** Decision-makers responsible for the strategic direction, funding, and oversight of mental health services. This report provides a high-level overview of trends and service performance that can inform resource allocation, policy development, and commissioning decisions.
- **Regulatory Bodies and Inspectors:** Organisations such as the Care Quality Commission (CQC) and other regulatory bodies may find this report useful for understanding the standards and performance metrics used by the Royal College of Psychiatrists' Centre for Quality Improvement to accredit wards.
- **Patients, Carers, and Advocacy Groups:** While primarily a resource for professionals, this report also has relevance for patients, their families, and advocacy organisations who are keen to understand the quality and safety of care being provided. It can offer reassurance of the continuous efforts being made to uphold and improve care standards within these wards.

WHO WE ARE AND WHAT WE DO

Who we are

The Network, originally established in 2006 under the name AIMS-WA (Accreditation for Working Age Inpatient Mental Health Services), underwent a transformation in 2020 to become the Quality Network for Inpatient Working Age Mental Health Services (QNWA), coinciding with the introduction of a new developmental option for members.

We are one of 29 quality networks, accreditation and audit projects organised by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI) working with mental health services to assess and improve the quality of care they provide.

The Network was created as a result of the findings of the National Audit of Violence (2003-2005) which highlighted the concerning high prevalence of violence on acute wards, but also concluded that examples of good practice were going unrecognised. Since the first set of standards were published in 2006, we have grown to include over 120 member wards/units. A full list of member wards is available to view on our [website](#).

What we do

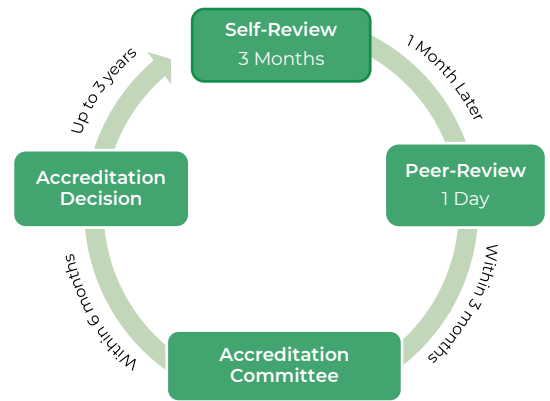
Our purpose is to facilitate and empower wards in a journey of continuous quality improvement. We achieve this by publishing [specialist standards](#) which wards can use as a framework for QI initiatives as well as be assessed against to achieve accreditation.

We provide a stepped pathway to accreditation beginning with the developmental process. This allows wards to familiarise themselves with the standards and review process. Through a developmental review, wards identify areas of strength and areas requiring improvement. This insight enables them to initiate quality improvement efforts before pursuing accreditation.

The accreditation process then provides recognition for wards who meet a set threshold of standards and who are deemed to be operating at a level that achieves accreditation.

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The accreditation pathway



The accreditation process is made up of four main stages:

1. Self Review Period (3 Months):

During this phase, the ward assesses its compliance with QNWA standards, self-scoring as "meeting" or "not meeting" each standard. Additionally, feedback from patients, carers and staff is collected via online questionnaires, and a health record audit is undertaken.

2. Peer Review Visit (1 Day):

Whereby a team of 4-5 peer-reviewers attend the ward to validate the self-review data and provide further insights.

3. Accreditation Report, Actioning Planning & Intervention Implementation:

Following the peer review visit, the ward receives a comprehensive report detailing the peer review team's assessment of its performance against QNWA standards. The report includes a summary of areas of achievement and areas for improvement. Clear recommendations are provided for any standards marked as "not met," outlining the evidence required for it to be upgraded to "met."

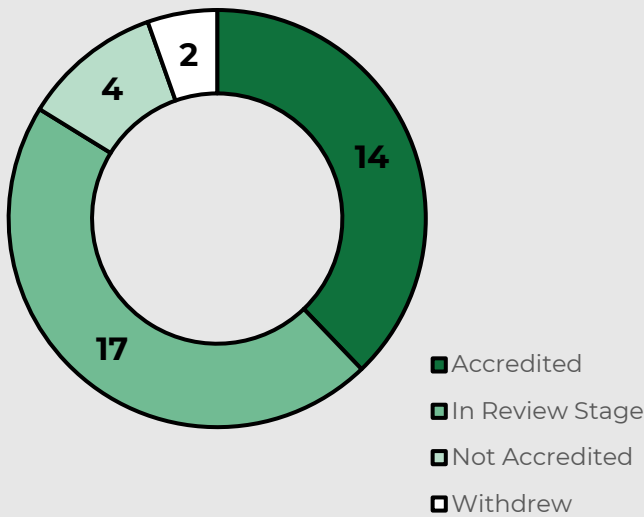
4. Accreditation Committee

Wards may be presented at up to three Accreditation Committees within a six-month period from the first presentation. If awarded accreditation, it lasts for up to three years, contingent upon a satisfactory interim review.

REPORT DATA

Overview of member wards

Of the **37** wards included in this report, **35** are based in England, and **2** in Scotland. As of **October 2022**, when the last peer-review took place against the 7th edition standards, **14** of these wards were 'Accredited'; **17** were 'In Review Stage', **4** wards were 'Not Accredited', and **2** wards withdrew from the accreditation process.



Jargon Buster

Accredited

Used to describe a ward which has undertaken the accreditation process and has demonstrated that they meet the requirements to be awarded accreditation.

In Review Stage

Used to describe a ward which has completed the self and peer review stages and is now working towards becoming accredited.

Not accredited

Used to describe a ward which has undertaken the accreditation process and has failed to demonstrate that they meet the requirements to be awarded accreditation.

Categorisation of Standards by Type

The complete set of standards aims for excellence, acknowledging that it's rare for any ward to meet them all. To assist in the accreditation process, the standards are categorised into three types as follows:

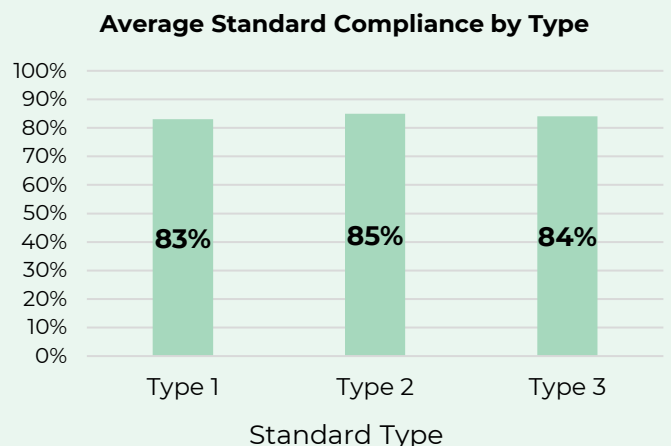
- **Type 1:** Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment.
- **Type 2:** Criteria that a ward would be expected to meet.
- **Type 3:** Criteria that are desirable for a ward to meet, or criteria that are not the direct responsibility of the ward.

To achieve accreditation, a ward must meet 100% of Type 1 standards, 80% of Type 2 standards, and 60% of Type 3 standards.

The data included in this report is from the 37 wards who undertook an accreditation peer-review against the 7th Edition QNWA standards.

At the point of peer-review, on average, member wards achieved full compliance with **86%** of QNWA standards.

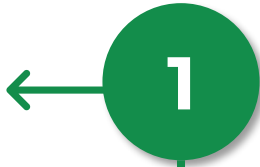
More specifically, the average compliance rates were **83%** for **Type 1** standards, **85%** for **Type 2** standards, and **84%** for **Type 3** standards, as depicted in this graph.



DATA COLLECTION



During the **3-month self-review period**, wards self-assess against QNWA standards, submit evidence, distribute staff, patient, and carer questionnaires, and conduct a health record audit.



Across 37 wards, **1848** staff questionnaires, **796** health record audits, **709** patient questionnaires, and **390** carer questionnaires were collected.



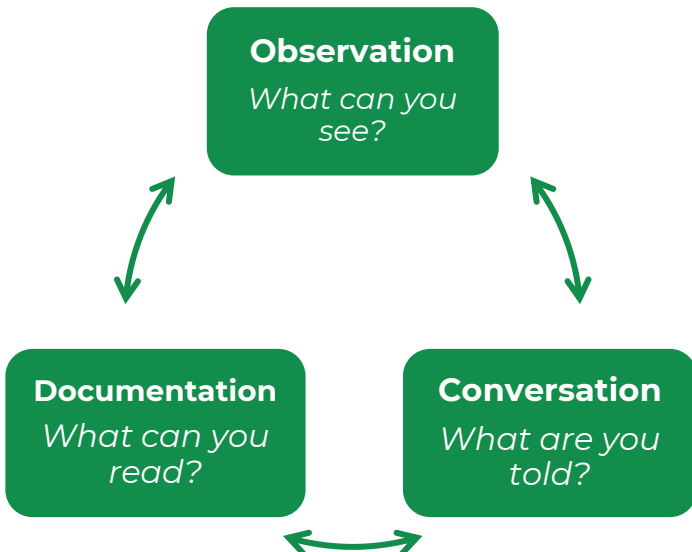
After the self-review, wards participate in a **1-day peer-review visit** to validate the data they collected during the self-review period. The ward is visited by a **peer-review team** consisting of inpatient mental health professionals, an expert by experience, and a QNWA representative.



The peer-review team **decides whether a standard is 'Met' or 'Not Met'** on the day of the peer-review, and this data has been analysed in the 'Key Findings' section of the report.



Triangulation



How is a standard scored 'Met'?

We base the decision to score a standard as 'met' on both the self-review findings and the evidence gathered during the peer-review day.

We collect evidence in three primary ways: through observation, conversation, and documentation review.

If most of this information shows that the ward is meeting the standard's requirements, we mark it as 'met'.

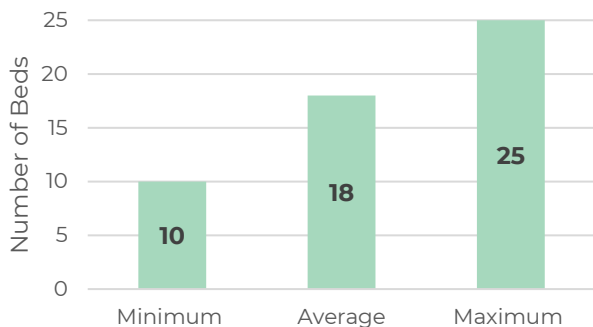
This approach, known as data triangulation, helps us balance any weaknesses in one set of data with the strengths of others, resulting in more dependable and credible results.

THIS REPORT

Contextual Data

As part of the self-review process, wards are requested to submit current contextual data, such as the number of beds, bed occupancy rate (%), and average length of stay. Additionally, wards are asked to report on the number of restraints, complaints, and serious incidents over the past 12 months. The figures presented below are derived from data collected from the 37 wards that participated in the accreditation review process against the 7th edition standards.

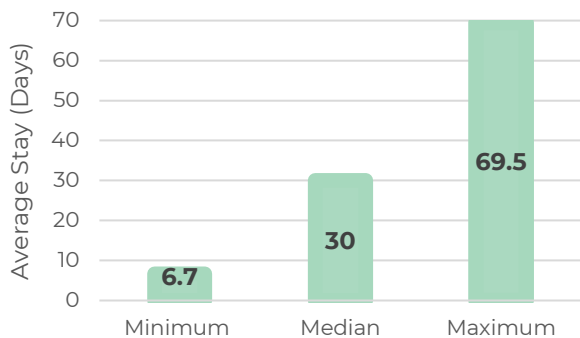
Number of beds



Across the 37 wards, there was a range in the number of beds on each ward. The smallest ward had 10 beds, while the largest had 25 beds. On average, each of these wards accommodated approximately 18 beds.

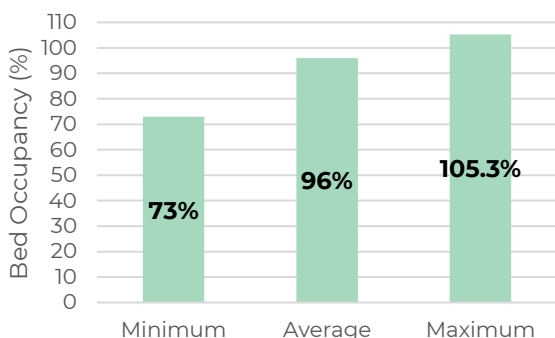
This diversity in bed numbers displays the varying sizes and capacities of wards undertaking the accreditation review process.

Average length of stay (days)



The average length of stay (in days) varied among the 37 wards. The shortest average stay was 6.7 days, while the longest was 69.5 days. The median length of stay, representing the midpoint, stood at 30 days.

Bed occupancy (%)



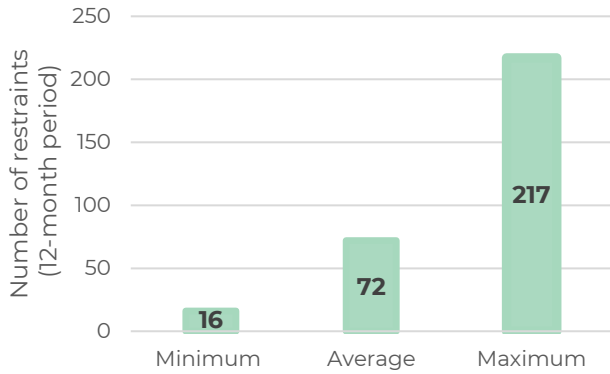
Bed occupancy* (%) ranged from 73% to 105.3% across the wards. The ward with the lowest bed occupancy was a 25-bedded ward, recording 73% occupancy. Conversely, the highest bed occupancy was observed in a 19-bedded ward, reaching 105.3%. On average, bed occupancy across all 37 wards stood at 96%.

It's worth noting that these figures were collected during the COVID-19 pandemic, where bed occupancy may have been adjusted for infection control purposes.

**Please note that the definition of bed occupancy varied among wards, potentially including or excluding leave. This should be considered when interpreting the data.*

Out of the 37 wards, data on restraints, complaints, or serious incidents was not provided by 5 wards. Therefore, the following data is derived from the remaining 32 wards that did:

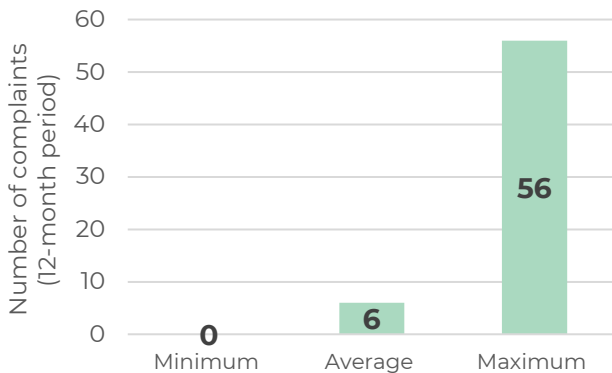
Number of restraints over a 12-month period



The lowest number of reported restraints* within a 12-month period was 16, while the highest was 217. On average, the number of reported restraints over this period across the wards was 72.

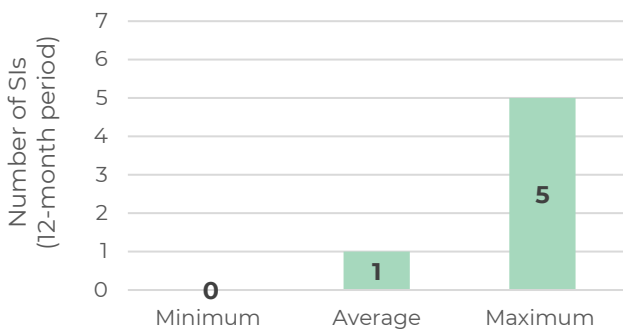
**It's important to note that the definition of restraint was not standardised among the wards, potentially leading to variation in reported data based on individual ward or Trust interpretations. This should be kept in mind when analysing the data.*

Number of complaints over a 12-month period



During a 12-month period, 3 wards reported no complaints, while 2 wards reported only 1 complaint each. The highest number of complaints reported within the same timeframe was 56. On average, the number of complaints reported across all wards over this period was 6.

Number of serious incidents over a 12-month period



During a 12-month period, 11 out of 32 wards reported no serious incidents*, while the highest number of serious incidents reported within the same timeframe was 5. On average, the number of serious incidents reported across all wards over this period was 1.

**It's important to note that the definition of serious incidents varied among wards, potentially leading to differences in reported data based on individual ward or Trust categorisations. This variability should be considered when interpreting the data.*

Recommendations

Standardisation of Definitions: Given the variability in definitions for restraints and serious incidents across wards, implementing standardised definitions and reporting criteria can ensure consistency in data collection and interpretation. This can facilitate more accurate comparisons and assessments of performance across wards, this is something the QNWA team are working towards for the next edition of standards.

Training and Education: Providing comprehensive training to staff on the appropriate use of restraints and the reporting of incidents can help mitigate unnecessary interventions and ensure incidents are documented accurately. Additionally, education on de-escalation techniques and alternative strategies to restraint can reduce the need for such interventions.

Incident Review Processes: Establishing robust incident review processes within each ward can enable thorough analysis of reported incidents, identifying root causes and implementing corrective actions to prevent future occurrences. Regular reviews can also facilitate continuous improvement in patient care practices.

Patient Feedback Mechanisms: Encouraging open communication channels for patients to report concerns and feedback can empower them to voice their experiences and contribute to quality improvement efforts. Implementing systems for capturing and addressing patient complaints in a timely manner can enhance patient satisfaction and safety.

STAFFING



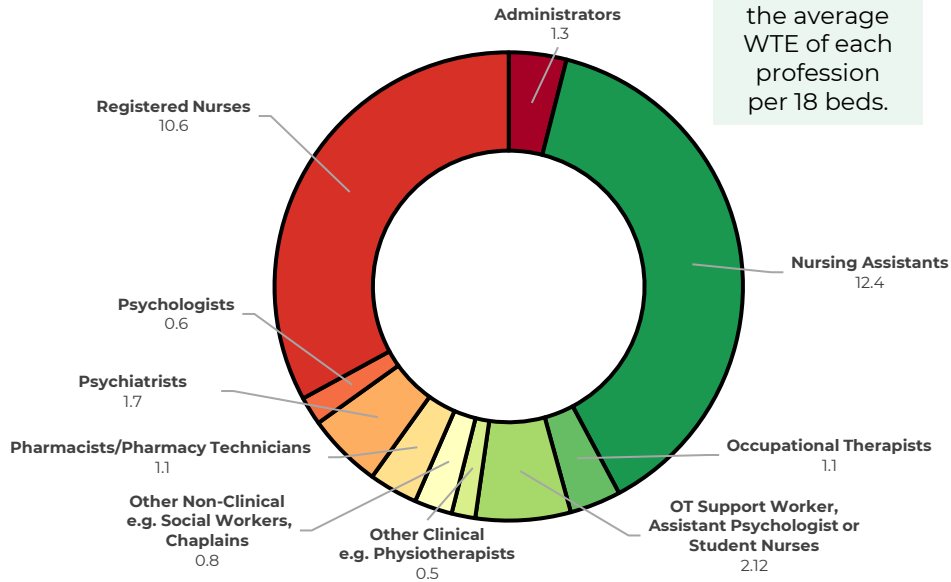
We gather data from each ward regarding the quantity and Whole Time Equivalent (WTE) of staff across various disciplines contributing to the ward. Our findings reveal significant variations in staffing levels between wards. However, a common sentiment among most wards is that they feel stretched and would welcome additional staff members.

What do acute working-age wards look like?

Our analysis indicates that wards are primarily staffed by registered nurses and nursing assistants.

Among various staffing categories, "other clinical" roles, such as physiotherapists and dieticians, have the lowest average Whole Time Equivalent (WTE) of 0.5 per 18 beds.

Following this are psychologists, averaging at 0.6 WTE per 18 beds, and "other non-clinical" roles, such as social workers and chaplains, with an average WTE of 0.8 per 18 beds.



This chart demonstrates the average WTE of each profession per 18 beds.

Jargon Buster

Whole Time Equivalent

A "Whole Time Equivalent" (WTE) is a measure used to standardise the number of hours worked by employees, contractors, or part-time workers into a single unit, typically based on full-time hours. For instance, if a full-time nurse typically works 37.5 hours a week, then a part-time nurse working 22.5 hours a week would be expressed as 0.6 WTE.

This measurement provides a clearer picture of the resources allocated to the ward. For instance, there would be more input from two psychiatrists working full-time compared to two psychiatrists working part-time.

What are staff telling us about staffing levels?

*"Staffing has a **huge impact** on the time we can offer patients."*

*"Short staffing can sometimes make it **difficult** or **unsafe** to do my job effectively."*

*"Staffing levels are an **ongoing concern**."*

*"Even with the right number of staff when the ward is busy and you have a lot escorted leave and other tasks to do, it still feels like **choosing between maintaining safety and fulfilling everything that needs to be done**. Sometimes it feels that **patient care is being compromised** by a lack of available staff."*

Ideas for local QI:

Review Staffing Ratios: Evaluate the current staffing ratios to ensure alignment with patient care needs and acuity levels. Consider adjusting staffing levels in accordance with patient demographics, complexity of cases, and specific care requirements to optimise resource utilisation and enhance quality of care.

Foster Multidisciplinary Collaboration: Promote interdisciplinary teamwork and collaboration among different staff categories to leverage diverse expertise and perspectives in patient care. Encourage regular communication, case discussions, and joint care planning to ensure comprehensive and coordinated care delivery that addresses the complex needs of patients.

KEY FINDINGS

This section offers a summary of the results gathered from the accreditation peer-review process conducted across 37 wards, assessing their adherence to the 7th Edition QNWA standards.

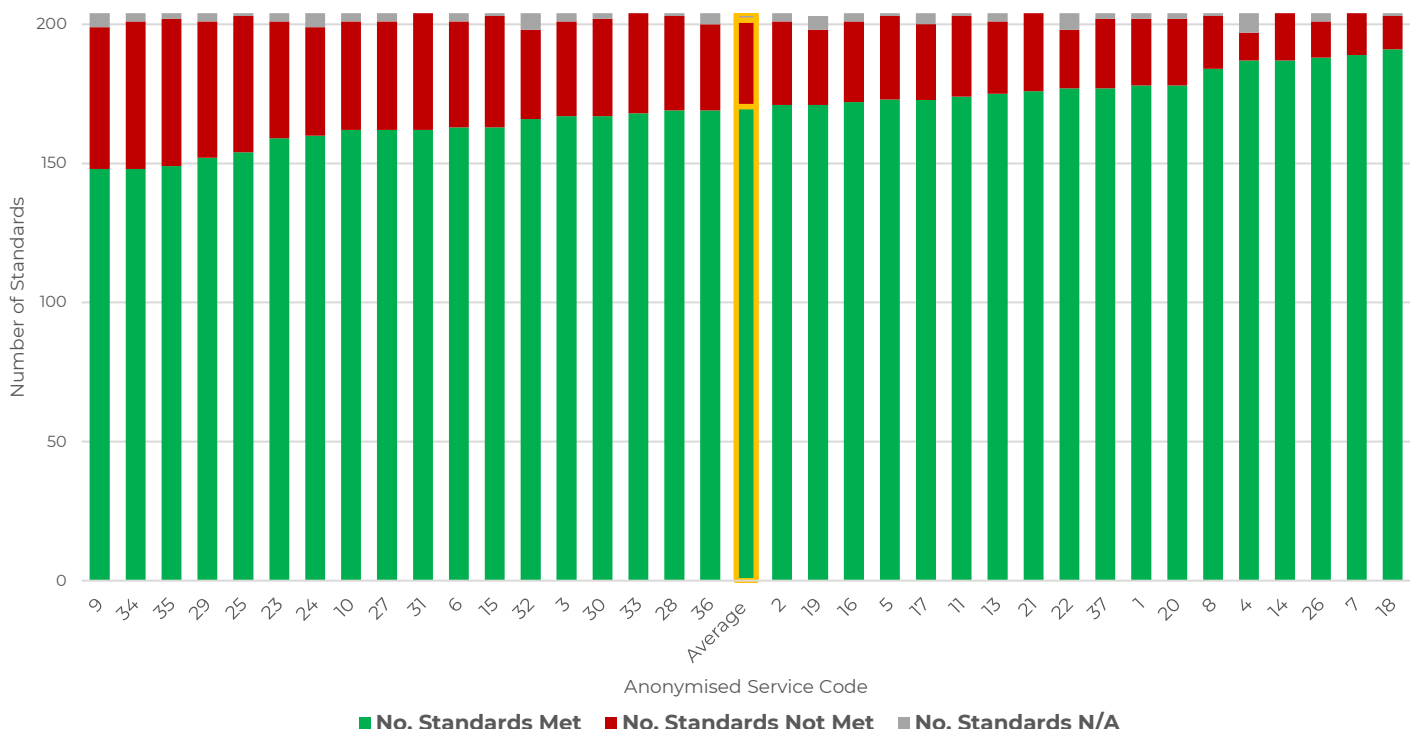
It delves into the main findings regarding the wards' performance across seven key areas: admission and assessment; care planning and treatment; referral, transfer, and discharge; patient and carer experience; staffing and training; environment and facilities; and governance.

Overview

On average, member wards who undertook an accreditation peer-review against the 7th Edition QNWA standards were found to be fully compliant with **86%** of QNWA standards for acute inpatient services for working age adults. The table below demonstrates the overall score for each ward according to their individual anonymised service code.

Service	1	2	3	4	5	6	7	8	9	10
Score	88%	85%	83%	95%	85%	81%	93%	91%	74%	81%
Service	11	12	13	14	15	16	17	18	19	20
Score	86%	97%	87%	92%	80%	86%	87%	94%	86%	88%
Service	21	22	23	24	25	26	27	28	29	30
Score	86%	89%	79%	80%	76%	94%	81%	83%	76%	83%
Service	31	32	33	34	35	36	37			
Score	79%	84%	82%	74%	74%	85%	88%			

The graph below illustrates the number of standards met or not met by each individual ward after their peer-review, categorised by their unique service code. It showcases the wards with the lowest to highest number of standards met, arranged in ascending order.



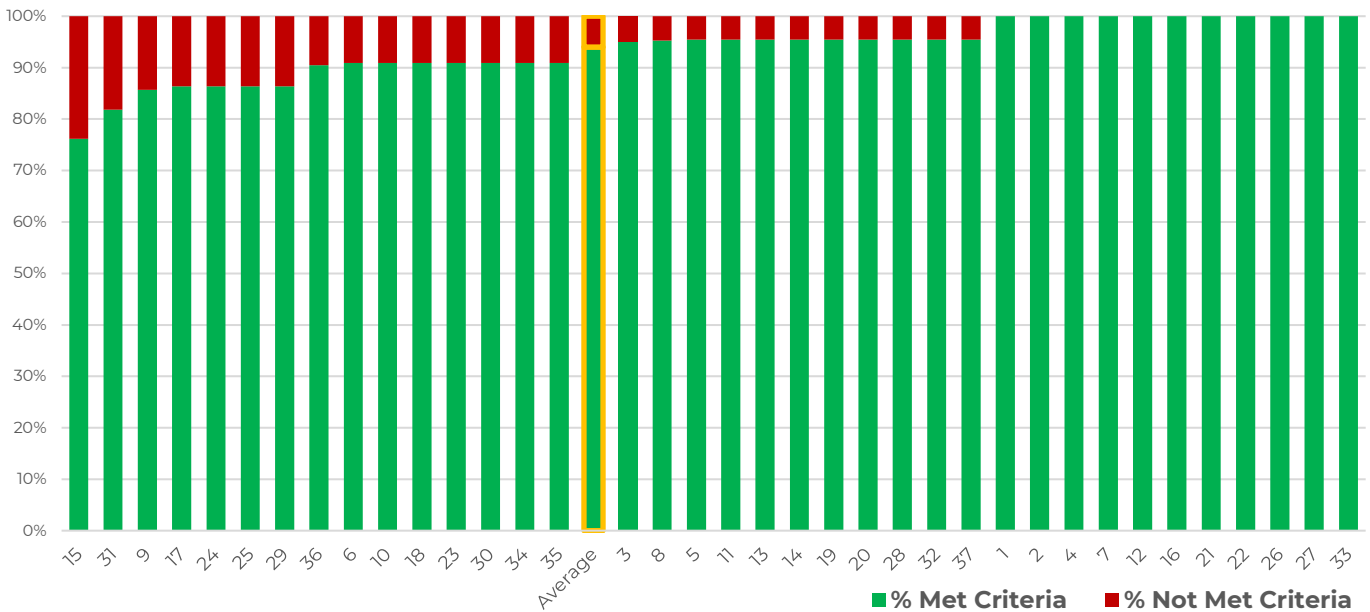
ADMISSION AND ASSESSMENT



On average, wards met **94%** of standards within this category.

In this category, **all wards** successfully met **9 out of the 22 standards**. Some notable examples include:

- Providing information on how to make a referral to the ward.
- Identifying and documenting a contact or link person for each agency involved with the patient.
- Identifying the patient's main carer and recording their contact details.



Commonly Unmet Standards

In this category, the most commonly unmet standards revolved around **patient information**:

- **41%** of wards failed to meet the standard of providing patients with an information pack upon admission which contained all of the relevant information outlined in the standard.
- Additionally, **46%** of wards did not meet the standard of providing accessible written information to patients, which staff members would then discuss with them as soon as possible.

"I didn't receive a welcome pack, there wasn't clarity or reassurance of what is happening to me..."

"No one has spoken to me about my illness or offered any written information about it"

Ideas for local QI:

1. Maintain Information Packs in Patient Bedrooms: Consider storing copies of the information pack in patients' bedrooms for easy access. Creating a designated folder or directory containing essential ward information can ensure patients have access to important resources from the outset of their admission. Staff should be trained to direct patients to this resource upon admission, promoting awareness and utilization.

2. Display Accessible Written Information on Noticeboards: Ensure that accessible written information, such as posters advertising Patient Advice and Liaison Services (PALS) or advocacy services, is prominently displayed on noticeboards throughout the ward. This can enhance visibility and awareness of support services among patients, facilitating access to essential resources and assistance. Regularly updating and maintaining these noticeboards can ensure that information remains current and accessible to all patients.

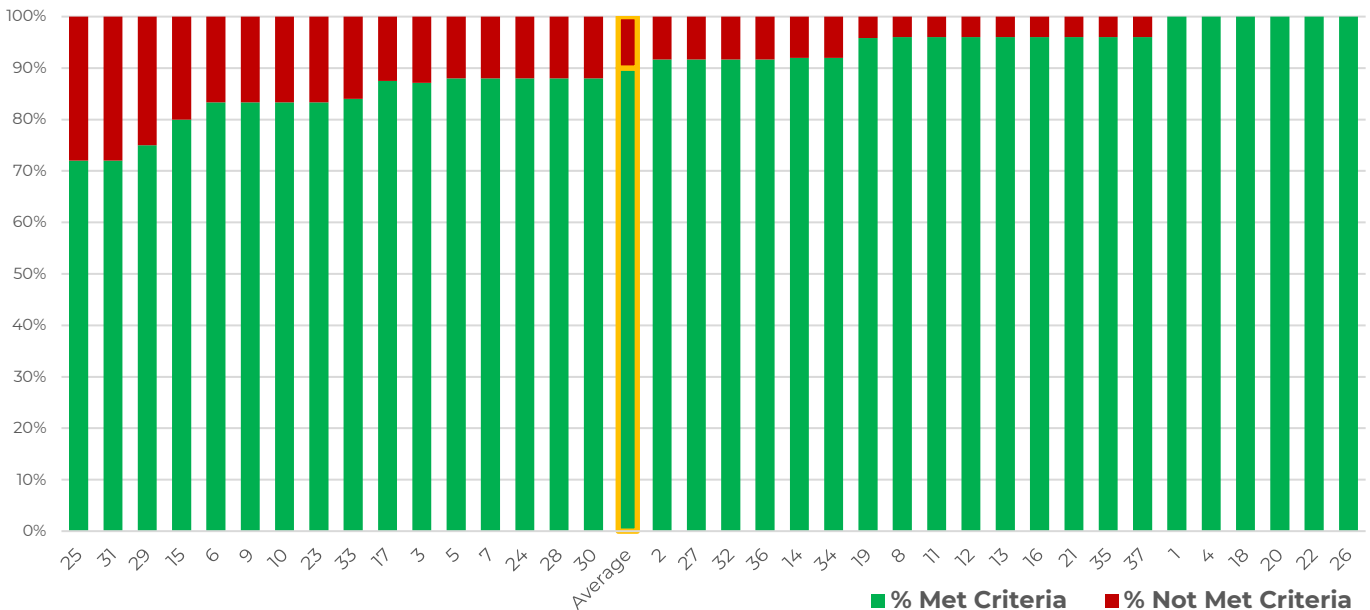
CARE PLANNING AND TREATMENT



On average, wards met **90%** of standards within this category.

In this category, **all wards** successfully met **7 out of the 25 standards**. Some notable examples include:

- The inpatient team following the Trust AWOL policy when patients are absent without leave.
- Knowing how to respond to carers when patient consent is not provided.
- Patients with substance misuse problems having access to specialist help.



Commonly unmet standards

In this category, the most commonly unmet standards related to **ward activity provision**.

54% of wards failed to meet the standard that every patient has a 7-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with.

“There aren’t many off-ward activities. There could be more activities and/or groups on weekends/evenings.”

“Patients don’t often get to vote on individual and group activities they would like to do”

“Use the outdoor space available to encourage patients to engage in physical activities...”

Ideas for local QI:

- 1. Prioritise patient-requested activities on the ward timetable:** to ensure that patients are provided with the opportunity to choose activities they would like to engage in. Staff should routinely ask patients what activities they would like to participate in to ensure activities are patient-centred, meaningful and flexible to the dynamic needs of patients. This could reduce boredom, frustration and could lead to reduced incidents on acute inpatient wards.
- 2. Wards could employ an activity worker/s** to run activities on weekends/evenings. Alternatively, nursing staff can be trained to deliver activities to ensure that activities are accessible and available to patients outside core working hours.

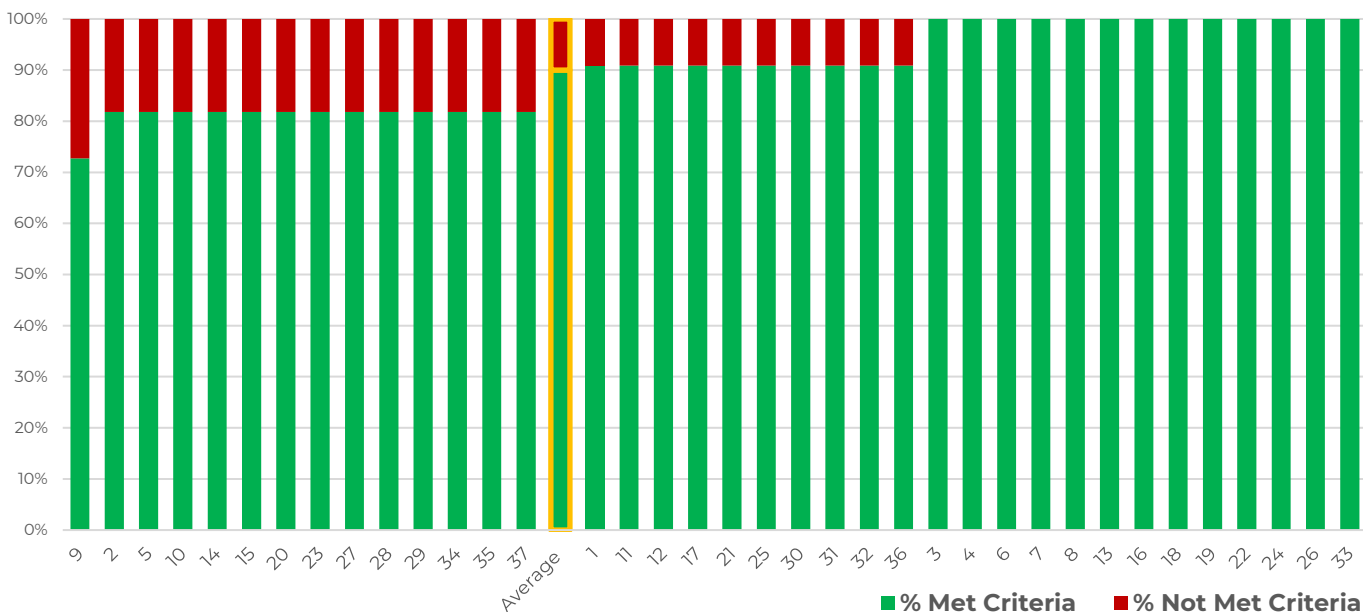
REFERRAL, TRANSFER AND DISCHARGE



On average, wards met **90%** of standards within this category.

In this category, **all wards** successfully met **7 out of the 11 standards**. Some notable examples include:

- The inpatient team inviting a community team representative to attend and contribute to ward rounds and discharge planning.
- A discharge summary is sent within a week to the patient's GP.



Commonly unmet standards

In this category, the most commonly unmet standards related to **joint working protocols**.

- **43%** of wards failed to meet the standard that there are joint working protocols/care pathways in place to support patients in accessing A&E, social services, local and specialist mental health services, primary health care teams, secondary physical healthcare and home treatment/crisis resolution teams.
- **51%** of wards failed to meet the standard that there are protocols for transfer or shared care between learning disability and generic mental health services.

“There are no opportunities to receive training in other specialist areas such as physical health, diabetes, dementia, learning disability, personality disorder”

Ideas for local QI:

1. **Ensure all staff receive mandatory training** on how to recognise and communicate with patients with cognitive impairment and learning disabilities, for example the [‘Oliver McGowan Mandatory E-learning Training on Learning Disability and Autism’](#) which is free and open to all NHS staff.
2. **Acute wards could work to improve collaboration between Learning disability (LD) services.** For example, wards could arrange for an LD service to attend their team away day to provide knowledge and awareness around implementing reasonable adjustments on the ward.
3. **All wards should have valid and in-date policy/protocol** that covers joint working principles.

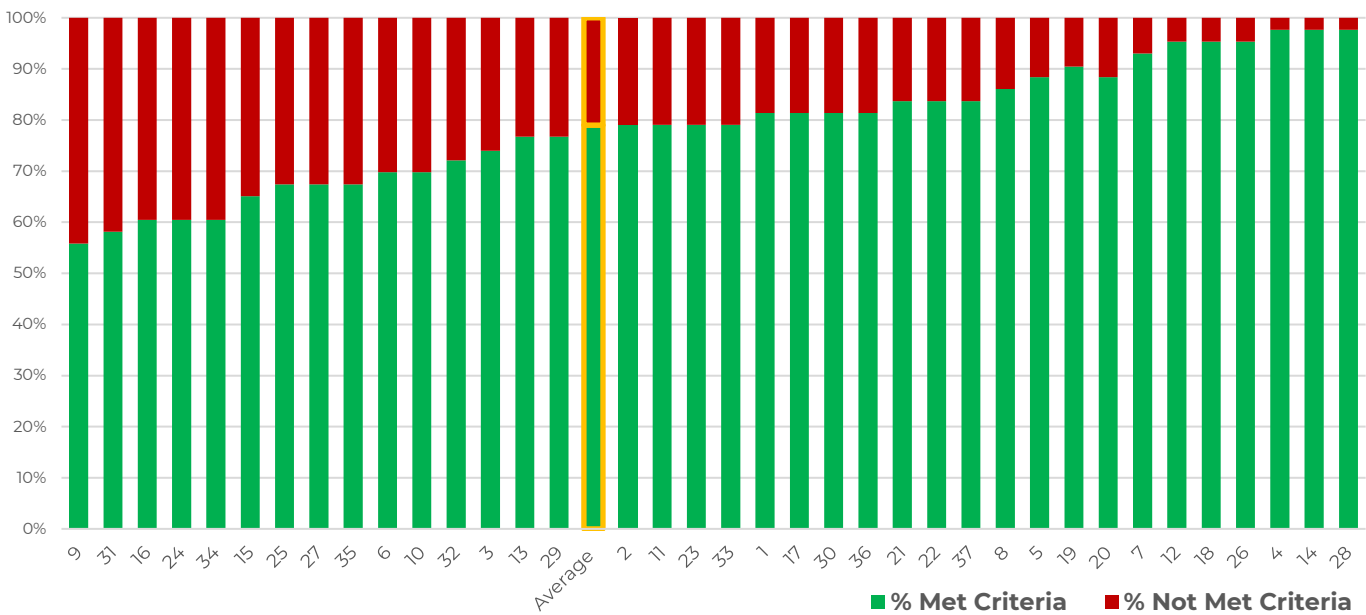
PATIENT AND CARER EXPERIENCE



On average, wards met **79%** of standards within this category.

In this category, **all wards** successfully met **9 out of the 43 standards**. Some notable examples include:

- Supporting patients in accessing support with finances, benefits, debt management, and housing.
- Providing patients access to resources that cater to their individual self-care needs, including ethnic- and gender-specific requirements.



Commonly Unmet Standards

The most frequently unmet standards in this category focused on supporting carers:

- **70%** of wards failed to meet the standard **of providing accessible carer's information**.
- **65%** of wards did not offer carers **individual time with staff within 48 hours** of the patient's admission to address concerns and needs.
- **62%** of wards did not support carers in accessing a **statutory carers' assessment** through the appropriate agency.

"I would like more basic information to be given if [my] family member isn't consenting for me to be involved in their care, this may help with me feeling worried"

"More regular contact maybe weekly with one appointed person to give carers a better understanding of their loved one's treatment / how they are doing. This could avoid carers having to call frequently and ensure that messages aren't confused..."

Ideas for local QI

1. Appoint a dedicated carers lead or champion within the ward staff to oversee communication and ensure that carer needs are effectively addressed and supported. Having a designated individual can enhance coordination and responsiveness to carer-related matters.

2. Implement a carer-specific admission checklist to ensure comprehensive support for carers. This checklist could outline specific actions for staff to undertake with the consent of the patient. These actions may include providing a welcome pack tailored to carer needs, offering individual sessions within 48 hours and facilitating access to statutory carers' assessments through appropriate agencies..

PATIENT FEEDBACK SPOTLIGHT



We analysed patient questionnaire data from **709** individuals who provided feedback during the self-review period.

Positive Feedback

90% of patients reported having the opportunity to engage in activities such as creative work, hobbies, and special interests. Furthermore, **81%** of patients reported that staff members knock and wait before entering their bedrooms, while **84%** indicated they can make and receive telephone calls in private.

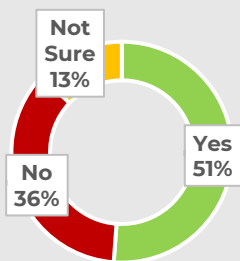
"The day and night staff were instrumental in helping me achieve positive mental health. There was always somebody I could talk to 24/7 and I felt they were genuinely concerned about my welfare."

"Timetable and time keeping of staff is excellent. I know what to expect at what time. I feel supported and safe. The staff are not too pushy; if I want to do something I feel supported but if I don't want to, I also feel supported."

"The staff are approachable and supportive. I feel comfortable to talk to staff, and they are good at encouraging me to use my healthy coping mechanisms."

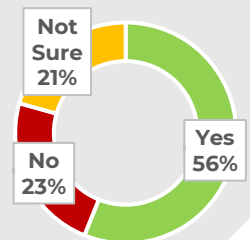
"The nurses are always alert and are ready to attend to your needs 24/7 no matter the reason. I feel safe on the ward and nurses give me hope that I will get better."

Areas for improvement



Nearly half of patients reported either that staff do not assist them in **preparing for ward rounds (36%)** or that they are unsure whether they receive support for this purpose **(13%)**.

Likewise, more than a third of patients either stated that they do not possess a **written care plan** reflecting their individual needs **(23%)** or expressed uncertainty about whether they have one **(21%)**.



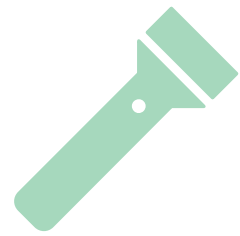
Ideas for local QI:

To support patients in preparing for ward rounds, introducing a [preparation sheet](#) can be beneficial. This sheet allows staff to gather feedback from patients regarding topics they wish to discuss and any questions they have.

[Care plans](#) should be person-centered, reflecting the individual needs of the patient. They should incorporate the patient's own language, avoiding jargon and abbreviations, and incorporate goals, aims, and outcomes identified by the patient.



CARER ENGAGEMENT SPOTLIGHT



We analysed carer questionnaire data from **388** individuals who provided feedback during the self-review period.

Positive Feedback

There was a significant amount of positive feedback from carers, with **93%** expressing feeling **treated with compassion, dignity, and respect** by staff members. Moreover, **84%** of carers reported **feeling supported** by staff, while **76%** stated they **feel involved in discussions** about the care and treatment of their loved ones.

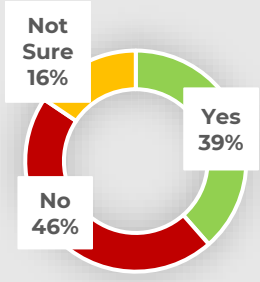
"This is a well-run ward with friendly and dedicated staff. Security is excellent and the ability to contact the ward at any time to check progress has been reassuring. Also, post-discharge care at home as been excellent."

"The staff are fantastic. Hugely helpful, supportive and friendly. All delivered with empathy. They are a credit to the NHS."

"Very attentive, professional mental health care. Staff had regular contact with us and gave us updates about the patient."

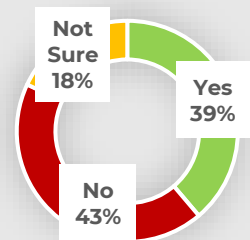
"When my loved one is there, I feel like he is in a safe place."

Areas for improvement



The findings revealed that a significant portion of carers (**62%**) either reported **not receiving a carers' pack (46%)** or were unsure whether they had received one (**16%**).

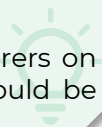
Moreover, more than half of carers (**61%**) either stated they had not been informed about **accessing a carers' assessment (43%)** or were unsure if they had been offered this guidance (**18%**).



Ideas for local QI:

Wards should ensure that they have a ward specific carer's pack that includes information on how to access a carer's assessment, local carer support groups/networks, etc.

It would be useful if the carer's lead takes a role in ensuring this is sent out to all carers on admission. If the carer cannot come onto the ward on admission, arrangements should be made to post or email the pack to them.



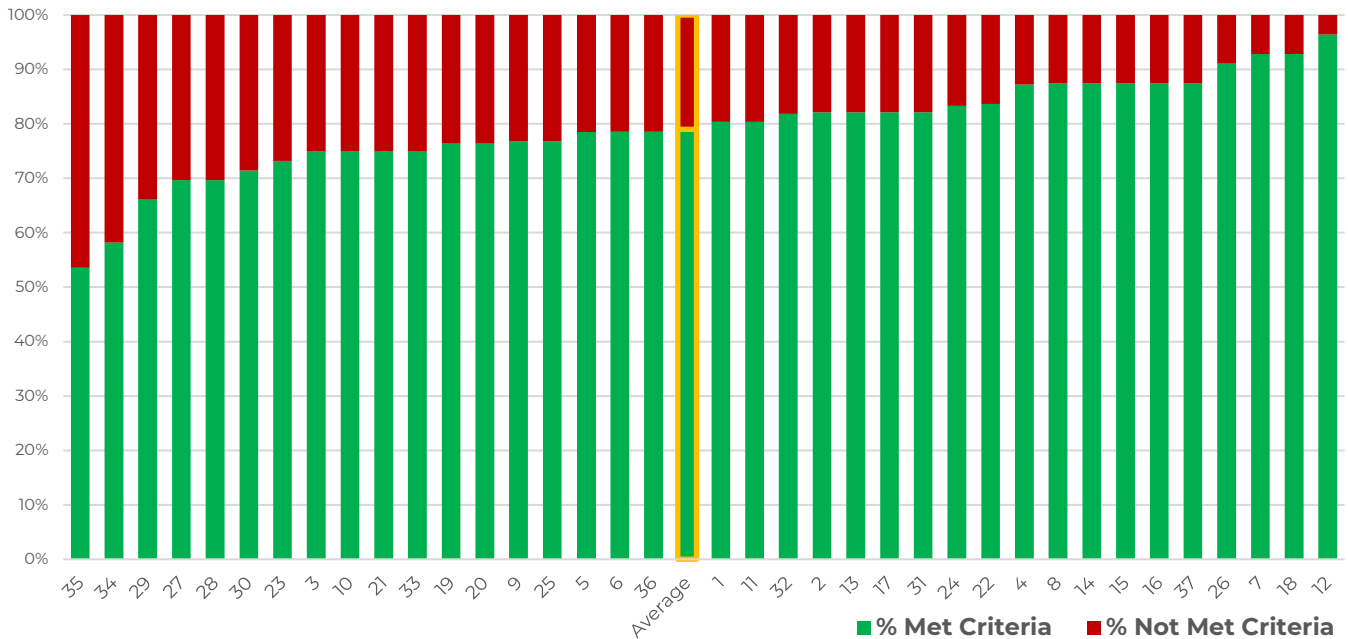
STAFFING AND TRAINING



On average, wards met **79%** of standards within this category.

In this category, **all wards** successfully met **5 out of the 56 standards**. Some notable examples include:

- Wards utilised Quality Improvement (QI) initiatives to enhance their ward.
- Additionally, staff conducted reviews of their team composition and skill mix at least annually.
- Moreover, staff were provided with lockers or secure areas to store their personal belongings.



Commonly Unmet Standards

The most frequently unmet standards in this category related to **training** and **supervision**.

- Only **30%** of wards were able to demonstrate at least 90% compliance for monthly clinical supervision for all clinical staff.
- Only **24%** of wards were able to demonstrate at least 90% compliance for risk assessment and risk management training.
- Only **19%** of wards were able to demonstrate at least 90% compliance for training around recognising and communicating with patients with cognitive impairment or learning disabilities.

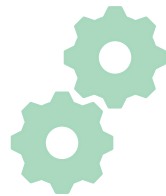
"I would feel more supported if I had access to all of the required training for my role within a month of starting."

"I would like to have protected time for supervision."

"Psychological intervention training such as CBT/DBT training on [the] ward would be helpful."

Ideas for local QI:

Implement a comprehensive training management system whereby wards maintain a documented training matrix accessible online for all staff. This matrix should delineate required training modules along with corresponding completion dates or scheduled training days. Additionally, consider utilising coding within the system to automate reminder emails for staff when training is nearing expiration or requires renewal. Specifically for clinical staff, ensure inclusion of monthly clinical supervision sessions, distinct from line management supervision, to foster professional development and support.

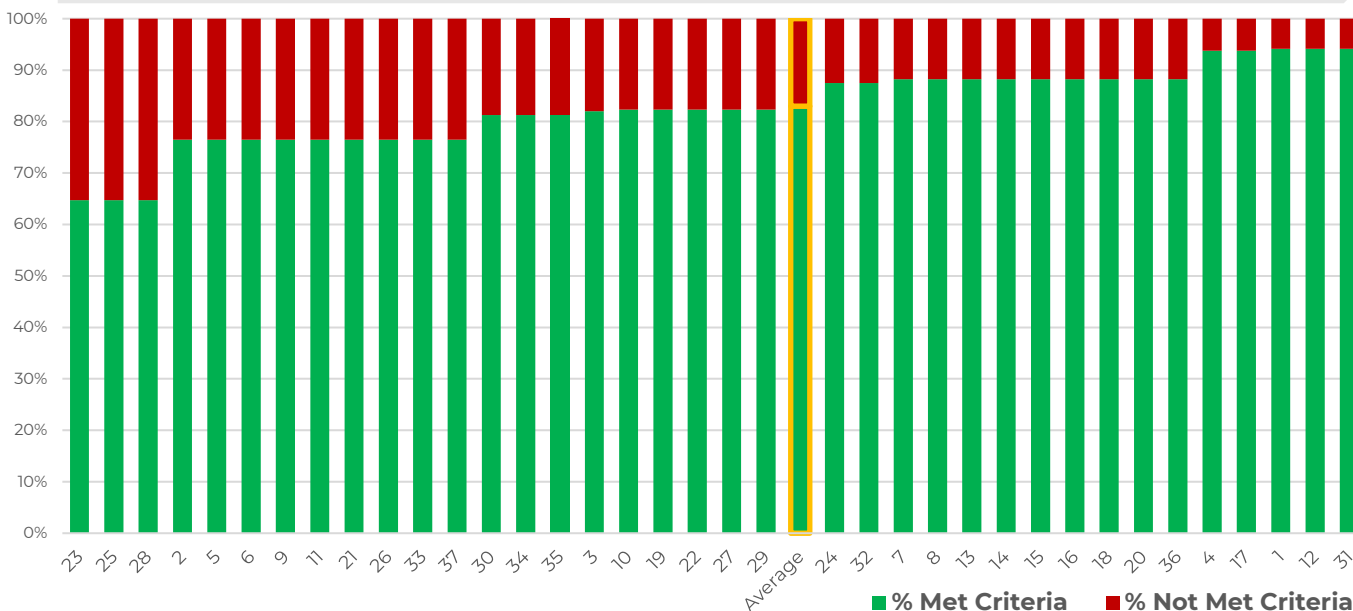


GOVERNANCE

On average, wards met **83%** of standards within this category.

In this category, **all wards** successfully met **9 out of the 17 standards**. Some notable examples include:

- Ward manager attends monthly business meetings.
- Lessons learned from untoward incidents are shared with the team and wider organisation.
- Mistakes in care are discussed with patients and their carers, in line with the Duty of Candour.



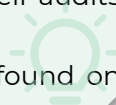
Commonly Unmet Standards

The most frequently unmet standards in this category related to **policies** and **audits**.

- Only **19%** of wards provided a sufficient audit on the use of [high-risk medication](#), as required at least annually and at a service level.
- Just **36%** of wards provided a valid comprehensive visiting policy in place, outlining procedures for specific groups like children or unwelcome visitors, such as those who might pose a threat to patients or staff.
- Only **53%** of wards provided an in-date clear written policy regarding the use of seclusion, compliant with the Mental Health Act and NICE NG10 guidelines.

Top Tips:

- When conducting your self-review, make sure to check the review date of the policies before submitting them. If they're out of date, try to provide evidence that they're currently being reviewed and updated. You could include an email from the relevant department or person confirming the policy is undergoing review and ratification.
- If any policies are in draft form, aim to have these finalised before the peer-review day.
- For lengthy documents like policies, it's helpful to highlight the most important information relevant to the standard or make a note of the page numbers where it can be found. This makes it easier for your review team to navigate and understand.
- During your self-review, schedule meetings with the relevant teams to discuss if their audits align with the standard's requirements.
- Guidance on what a 'best practice' high-risk medication audit looks like can be found on [page 26](#).



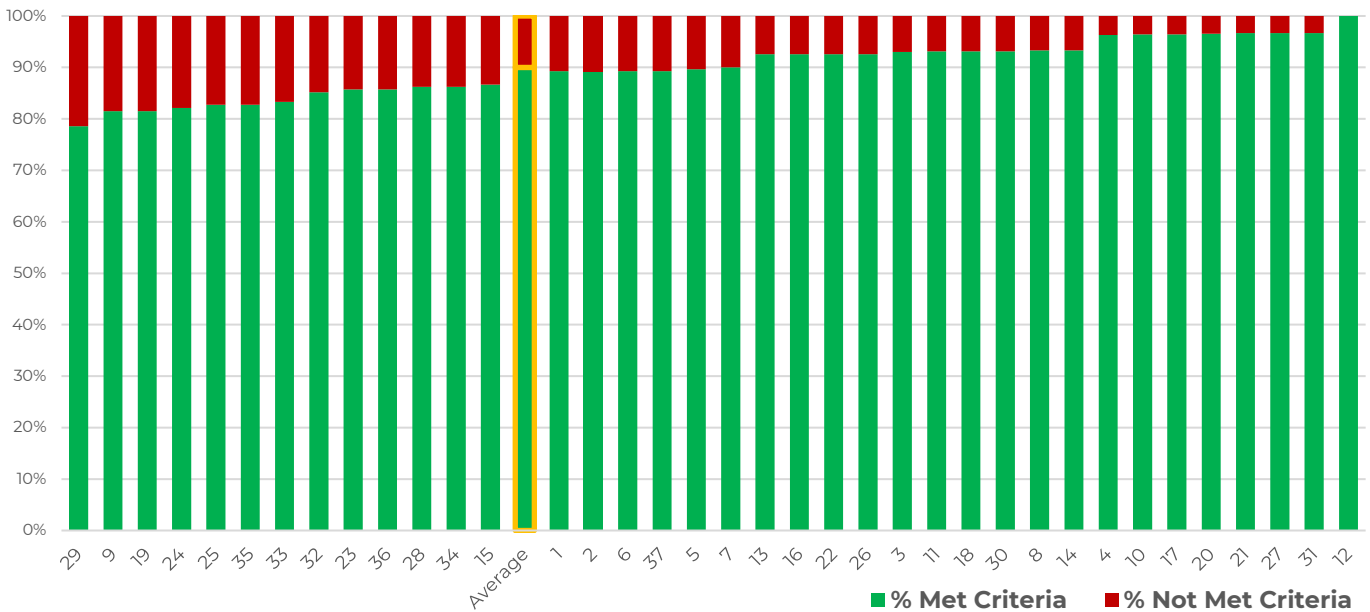
ENVIRONMENT AND FACILITIES



On average, wards met **90%** of standards within this category.

In this category, **all wards** successfully met **10 out of the 30 standards**. Some notable examples include:

- Ward/unit entrance and key clinical areas are clearly signposted.
- Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.
- Patients have access to the day room at night when they cannot sleep.



Commonly Unmet Standards

The most frequently unmet standards in this category related to **fire drills** and **audits**.

- Only **39%** of wards provided evidence of a sufficient audit of environmental risk that is conducted annually and includes a risk management strategy that is agreed and acted on.
- Only **58%** of wards could demonstrate that the agreed response to fire drills is rehearsed at least every six months.

Top Tips:

- Ensure that the fire drill procedure is practiced at least 6-monthly, not just the fire alarm testing. Include a copy of the latest fire drill report and confirm the date of the next planned fire drill. This could be documented through email correspondence from the fire officer stating when the next visit is scheduled.
- The environmental risk audit should assess all potential ligature points on the ward, assigning a color-coded risk rating (e.g., Red, Amber, Green) to each identified risk. A clear risk management plan should be developed for addressing each risk. It's important to conduct this audit annually and document the findings. Additionally, the audit should specify who is responsible for addressing identified risks and set clear deadlines for completing actions.

ACCREDITATION STORY: WARDS 2 & 3



From Challenge to Success: How Wards 2 & 3 Achieved Accreditation

This case study explores the journeys of Wards 2 & 3, NHS Forth Valley, Scotland who **initially faced numerous unmet standards** during their accreditation process but **ultimately achieved accreditation** through **dedication** and **engagement**.

Challenges Faced:

Following their virtual peer-review visits, there were a **significant number of unmet standards across various domains**, including care planning, staff training, patient safety, and governance.

Response and Engagement:

Rather than being disheartened by this, the ward team **embraced the feedback constructively**. They recognised the accreditation process as an opportunity for growth and improvement. The ward leadership **mobilised the staff to actively engage in addressing the identified areas for improvement**. Regular meetings were held to discuss strategies for improvement, and staff members were encouraged to contribute ideas and suggestions.

Action Plan Implementation:

The ward teams developed a **comprehensive action plan** to address the identified gaps and improve compliance with QNWA standards. This plan included **specific objectives, timelines, and responsible individuals for each action item**. Training sessions were organised to enhance staff skills and knowledge. The ward teams **recognised the importance of collaboration** and sought support from various stakeholders, including the QNWA project team.

Achieving Accreditation:

Through dedication, perseverance, and collective effort, the wards made **significant strides in improving their standards of care**. The wards commitment to quality and patient safety was evident as they successfully addressed the previously identified areas for improvement. Ultimately, the wards **achieved accreditation**, marking a significant milestone in their journeys towards excellence in mental healthcare provision.

Timeline



"I can't thank you enough for all your support throughout. It's been an amazing experience and it's lovely to see the day-to-day changes on our ward...Now that it's 'embedded' in our units, I think it'll be easier to continue QI development, having this background structure."

Dr Gary Cooney, Consultant Psychiatrist

Recognition in Parliament

The Scottish Parliament tabled the motion to congratulate Wards 2 and 3 at Forth Valley Royal Hospital for achieving accreditation from the Royal College of Psychiatrists and recognised their commitment to delivering high-quality care.

GOOD PRACTICE EXAMPLES

Below are some good practice examples submitted by QNWA member wards on peer-review days or at Accreditation Committees:

Patient Information Packs

At a minimum, your patient information pack should include:

- a description of the service;
- the therapeutic programme;
- information about the staff team;
- the unit code of conduct;
- key service policies (e.g. permitted items, smoking policy);
- resources to meet spiritual, cultural and gender needs.

What does best practice look like?

- packs that have been co-produced with patients
- packs that are accessible and easy to read

An example section on the ward's smoking policy:

Smoking

The law bans smoking in all enclosed public spaces; this includes hospital wards and grounds; therefore, you are not permitted to smoke on the ward. Please let staff know what your usual smoking habits are, they will make sure you are prescribed Nicotine Replacement Therapy (NRT) to help you manage your cravings. You may use e-cigarettes to help you; however, these must be disposable and not the rechargeable variety. If you are unsure or would like more information or support, please speak to a member of staff. We understand this may be very challenging. Once you are admitted, staff are trained to help you.

Care Plans

At a minimum, your care plans should be:

- person-centred, reflecting their individual needs;
- written in collaboration with patients and their carers (where consent is given);
- offered to patients in a format that is easy to read and understand;
- reflective of the individual's cultural and ethnic background as well as their gender, sexuality, race, economic disadvantage, age, religion/spirituality, and disability;
- updated at least weekly or more frequently if the plan changes.

What does best practice look like?

- using people's own words and phrases – avoiding jargon and abbreviations
- using goals, aims and outcomes identified by the patient

Examples of a way to write a personalised care plan

"I will attend emotional regulation groups to increase my understanding of emotions and how to change my unhelpful thoughts"

"My mum will support me with breathing exercises if I have a panic attack"

"Due to having a broken right arm and reduced eyesight I am not able to fully manage my personal care. I would like to be clean and dressed every day in an outfit I choose as this helps with my low mood"

Activity Timetable

At a minimum, your activity timetable should include:

- timetabled activities in the morning, afternoon and evening 7 days a week;
- psychological and occupational therapy (OT) led activities in addition to those led by nursing staff;
- sufficient activities taking place on the ward for patients who may not be granted leave to attend activities elsewhere.

What does best practice look like?

- activity timetables dictated by patients' interests and preferences

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Breakfast Club 9:30-10:30	Yoga 10:00-11:00	Healthy Living 9:30-10:30	Mindfulness 10:30-11:15	Relaxation 10:00-11:00	Breakfast Club 9:30-10:30	Mindfulness 10:30-11:15
Afternoon	Goal Setting 12:00-13:00 Gym 2:30-4:30	Cooking Group 12:00-1:00 Emotional Regulation 2:00 - 3:00	Benefits and Employment Advisor 12:00-2:00	Knitting 12:00-1:30 Community Meeting 2:00 - 2:30	Wellbeing Walk 12:00-12:45 Art Club 2:00-4:00	Make your own lunch 12:00-2:00 Wellbeing Walk 3:00-4:00	Baking 12:00-2:00
Evening	Quiz Night 6:30	Movie Night 6:30	Pamper Session 6:30	Music & Singing 6:30	Games Night 6:30	Smoothie Making 6:30	Movie Night 6:30

MDT Review/Ward Round Preparation

To enhance patient engagement and ensure their concerns are addressed during ward rounds or multidisciplinary team (MDT) reviews, a feedback mechanism should be implemented on the ward. This could take the form of a "preparation sheet" where patients can express their thoughts and preferences before the meeting.

Example questions for the preparation sheet may include inquiries about treatment preferences, concerns about side effects or symptoms, and suggestions for improving the care experience. Additionally, patients can use the sheet to highlight any specific topics they feel are important to address during the meeting.

MDT Preparation

1. Is there anything from the last week that you want to talk about in the MDT?
2. Are you having any side-effects from your medication?
3. Are there any changes you would like to make to your care plan, for example starting activities, getting help with a drug or alcohol problem, a review of your medication or meeting with a psychologist?

High Risk Medication Audit

At a minimum, your high risk medication audit should:

- be conducted with the involvement of the mental health pharmacist and should clearly indicate activity at service not just Trust level
- include the following groups of patients receiving; Clozapine Antipsychotics in excess of BNF limits [singly and in combination], Lithium, Benzodiazepines. *(The detailed monitoring requirements for each of these can be found in Trust protocols, relevant RCPsych guidance and NICE/SIGN)*
- demonstrate adherence to the monitoring protocols and actions to be taken in the event of deviation

Please note that this is **not** the same as an audit of 'controlled drugs'.

Below is an example of a results compliance table from a Lithium Baseline Audit

Target Compliance Rate = 100%

	Standard / Criteria	Compliance (%)
1.	Documented evidence should be available in the clinical records that the following tests or measures were carried out in the 2 months prior to starting lithium?	
a.	eGFR (Estimated Glomerular Filtration Rate)	100%
b.	U&Es (Urea and Electrolytes)	100%
c.	Calcium	100%
d.	FBC (Full Blood Count)	100%
e.	TFTs (Thyroid Function Tests)	100%
f.	Weight or BMI (Body Mass Index)	100%
g.	ECG (Electrocardiogram) - within 6 months	100%
2.	At the time that lithium was initiated there should be documented evidence that the patient was informed of the side effects of lithium?	25%
3.	At the time that lithium was initiated, there should be documented evidence that the patient was informed of the signs and symptoms of impending lithium toxicity?	0%
4.	At the time that lithium was initiated, there should be documented evidence that the patient was informed of the risk factors for lithium toxicity?	25%
5.	Patients should be provided with a copy of the NPSA lithium patient information pack	80%
6.	For women under 50 only At the time that lithium was initiated, is there documented evidence that the patient was informed of the potential effects on the foetus (teratogenicity) when lithium is taken during pregnancy?	100%
Overall (average taken of the 6 standards)		55%

APPENDIX 1: LIST OF MEMBERS

This list consists the 37 wards who participated in this report. The wards have been anonymised by an individual service code within this report. The list below is not representative of the order of service codes used throughout this report.

Ward Name	Trust/Organisation	Location
Shannon Ward	Barnet, Enfield and Haringey Mental Health NHS Trust	Middlesex
Snowdrop Ward	Berkshire Healthcare NHS Foundation Trust	Berkshire
Oak 1	Cambridge and Peterborough NHS Foundation Trust	Cambridgeshire
Eastlake Ward	Central and North West London NHS Foundation Trust	London
Ferneley Ward	Central and North West London NHS Foundation Trust	London
Thames Ward	Central and North West London NHS Foundation Trust	London
Frays Ward	Central and West London NHS Foundation Trust	Greater London
Beechwood Ward	Coventry and Warwickshire Partnership NHS Trust	West Midlands
Springrise Ward	Tand Wear NHS Foundation Trust	Tyne and Wear
Warkworth Ward	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Northumberland
Willow Ward	East London NHS Foundation Trust	Bedfordshire
Ash Ward	East London NHS Foundation Trust	Bedfordshire
Opal Ward	East London NHS Foundation Trust	Greater London
Gosfield Ward	Essex Partnership University NHS Foundation Trust	Essex
Ardleigh Ward	Essex Partnership University NHS Foundation Trust	Essex
Ward 12	Lincolnshire Partnership NHS Trust	Lincolnshire
Chebsey Ward	Midlands Partnership NHS Foundation Trust	Staffordshire
Milford House	Midlands Partnership NHS Foundation Trust	Staffordshire
Ward 2	NHS Forth Valley	Stirlingshire
Ward 3	NHS Forth Valley	Stirlingshire

APPENDIX 1: LIST OF MEMBERS CONT.

This list consists the 37 wards who participated in this report. The wards have been anonymised by an individual service code within this report. The list below is not representative of the order of service codes used throughout this report.

Ward Name	Trust/Organisation	Location
Monet Ward	North East London Foundation Trust	Greater London
Turner Ward	North East London Foundation Trust	Greater London
Picasso Ward	North East London Foundation Trust	Greater London
Ogura Ward	North East London Foundation Trust	Greater London
Kahlo Ward	North East London Foundation Trust	Greater London
Knight Ward	North East London Foundation Trust	Greater London
Cove Ward	Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire
Avocet Ward	Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire
Harbour Ward	Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire
Sandpiper Ward	Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire
Kingfisher Ward	Northamptonshire Healthcare NHS Foundation Trust	Northamptonshire
Rowan Ward	Nottinghamshire Healthcare NHS Foundation Trust	Nottinghamshire
Nottingham Priory	Priory Group	Nottinghamshire
St Andrews Ward	Somerset Partnership NHS Foundation Trust	Somerset
Kingsley Ward	Southern Health NHS Foundation Trust	Hampshire
Jade Ward	Sussex Partnership NHS Foundation Trust	West Sussex
Maple Ward	Tees, Esk and Wear Valleys NHS Foundation Trust	County Durham

QNWA

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