

Acute inpatient mental health service review 2006/2007

Final detailed scoring framework guidance

Detailed scoring framework guidance

Contents

1 Overview of the assessment framework scoring structure

2 Deriving the overall trust score from indicators, question and criteria scores

3 Scoring individual indicators

Appendix A Individual indicator constructions and scoring

Appendix B Key for policy documents

Acute inpatient mental health service review

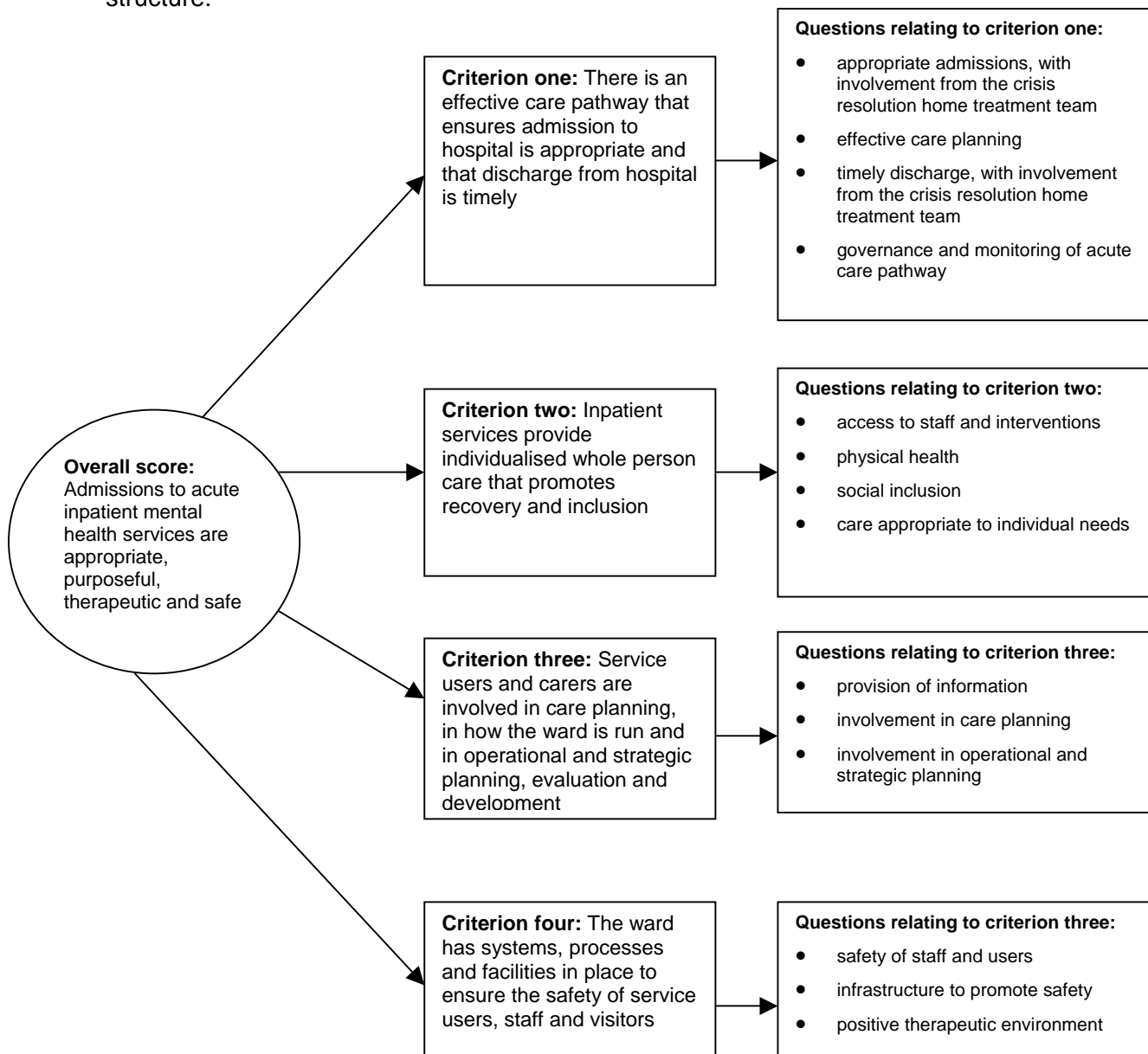
1 Overview of the assessment framework scoring structure

In your report you will receive scores at the following levels:

- overall organisation score
- criteria scores
- question scores
- indicator scores

The overall service review score is calculated from the criteria scores. Each criterion score is calculated from the question scores that link into that criterion. Each question score is calculated from the indicators that link into that question.

Hence, the scoring has a pyramid structure, which follows the assessment framework structure:



Further details of the final assessment framework and the scope of services covered may be found in the document 'final assessment framework' which can be downloaded from the Healthcare Commission website:

www.healthcarecommission.org.uk/acuteinpatientmentalhealthservicereview

Acute inpatient mental health service review

2 Deriving the overall trust score from data indicators, question and criteria scores

The overall trust, criteria and questions are scored on a 1-4 scale as follows:

- Level 1 (weak): performance that does not meet minimum requirements or the reasonable expectations of patients and the public.
- Level 2 (fair): performance that meets minimum requirements and the reasonable expectations of patients and the public.
- Level 3 (good): performance that goes beyond minimum requirements and the reasonable expectations of patients and the public.
- Level 4 (excellent): performance that goes well beyond minimum requirements and the reasonable expectations of patients and the public.

Aggregation of criterion scores to overall trust review score

The overall trust review score is calculated by adding the four criterion scores together and then assigning scores according to the thresholds shown in the table below:

Overall score	1	2	3	4
Sum of criterion scores	4-6	7-9	10-12	13-16

For example, Trust A's criterion scores were as follows:

Criterion 1 they scored a '2'
Criterion 2 they scored a '2'
Criterion 3 they scored a '4'
Criterion 4 they scored a '3'

Trust A's sum of criterion scores is $2 + 2 + 4 + 3 = 11$. This means that Trust A's overall review score is level '3' (Good).

Aggregation of question scores to criterion scores

Each criterion score is calculated by adding together the scores from the questions that feed into that criterion, then assigning a score using the thresholds shown in diagrams 1 and 2 (below). For example, Trust B scored the following for questions relating to Criterion 1:

Question 1.1 they scored a '2'
Question 1.2 they scored a '1'
Question 1.3 they scored a '2'
Question 1.4 they scored a '3'

Trust B's sum of question scores for Criterion 1 is $2 + 1 + 2 + 3 = 8$. This means that Trust B scores '2' (Fair) for Criterion 1. Please use diagrams 1 and 2 to check the thresholds for each criterion, as the thresholds differ depending on the number of questions that feed into the criteria.

Diagram 1: Aggregation process and thresholds for Criterion 1 and Criterion 2

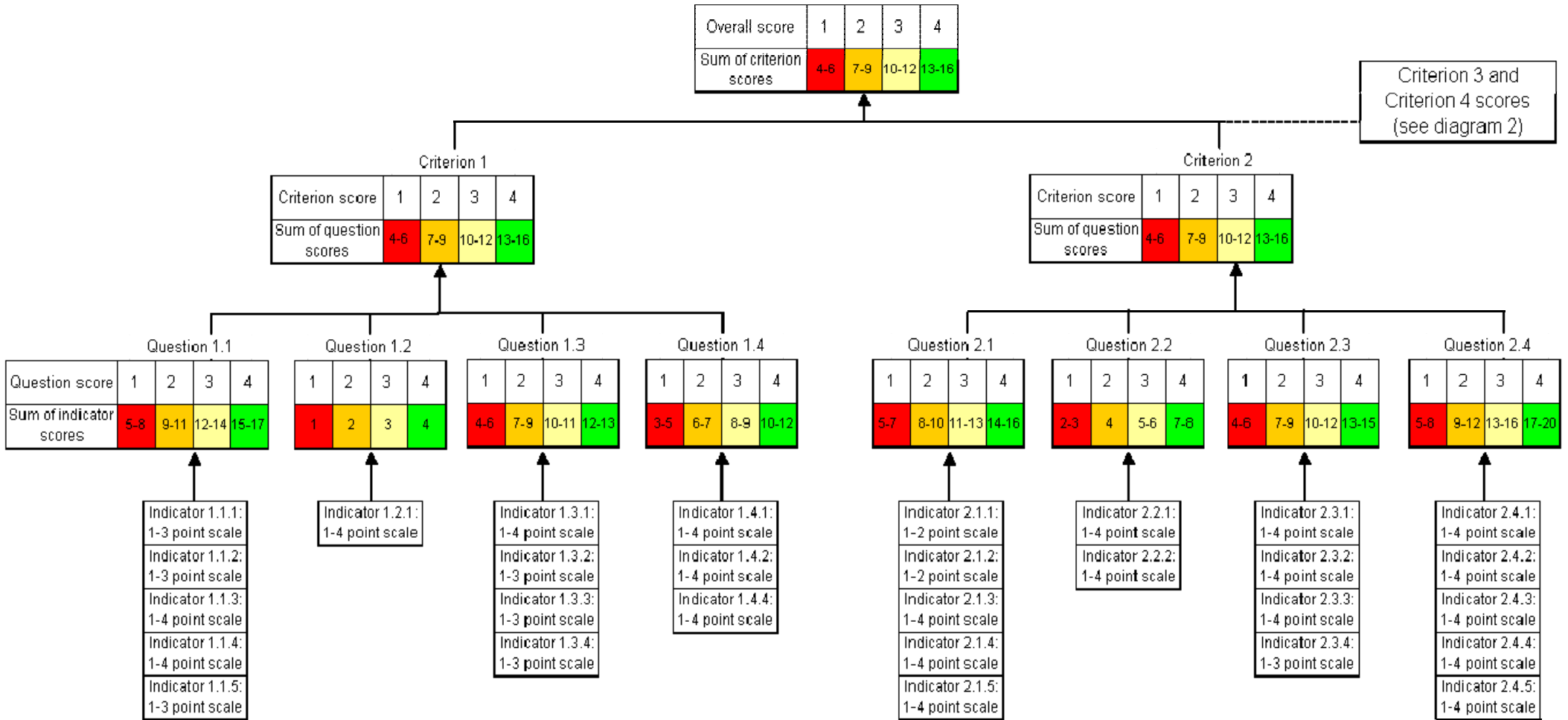
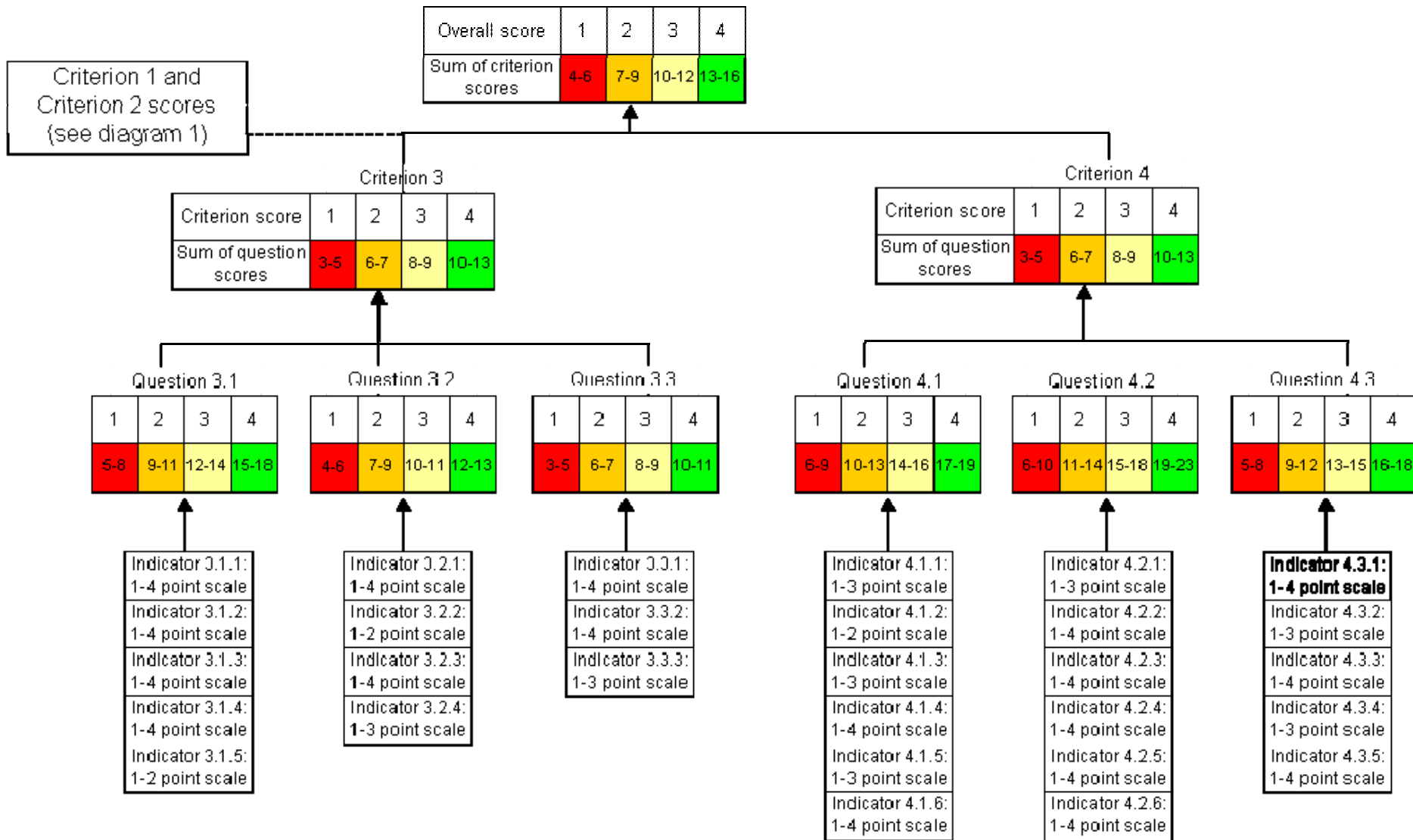


Diagram 2: Aggregation process and thresholds for Criterion 3 and Criterion 4



Aggregation of indicator scores to question level score

Each question score is calculated by adding together the indicator scores that feed in to that question, then assigning a score using the thresholds shown in diagrams 1 and 2.

For example, Trust C scores the following for indicators feeding into Question 1.1:

Indicator 1.1.1 they scored a '2'
Indicator 1.1.2 they scored a '2'
Indicator 1.1.3 they scored a '3'
Indicator 1.1.4 they scored a '4'
Indicator 1.1.5 they scored a '1'

Trust C's sum of indicator scores for Question 1.1 is $2 + 2 + 3 + 4 + 1 = 12$. This means that Trust C's score for Question 1.1 is '3' (Good).

All indicators within each question are equally weighted, with the exception of Indicator 3.2.1, within Question 3.2 on service user and carer involvement in care and treatment. This indicator has been given more weight to reflect the importance of service user involvement in care planning. **Trusts who score '1' for indicator 3.2.1 will automatically receive a score of '1' for question 3.2.**

For example, Trust C scores the following for indicators feeding into Question 3.2:

Indicator 3.2.1 they scored a '1'
Indicator 3.2.2 they scored a '2'
Indicator 3.2.3 they scored a '3'
Indicator 3.2.4 they scored a '3'

Trust C's sum of indicator scores for Question 3.2 would have been $1 + 2 + 3 + 3 = 9$. However, because Trust C scored '1' for Indicator 3.2.1 the trust's score for Question 3.2 is '1' (Weak).

The thresholds to achieve a question score are determined by the number of indicators within a question and whether each indicator is a 1-2 point scale, a 1-3 point scale, or a 1-4 point scale. This means the thresholds for each question are different. Please use diagrams 1 and 2 (above) to check the thresholds for each question.

Acute inpatient mental health service review

3 Scoring individual indicators

Indicator constructions

Appendix A sets out the construction, data source and scoring method for all indicators in the scored assessment framework.

Indicator scoring methods

The indicator level of the assessment framework employs two different types of measures – absolute and relative.

Absolute measures

Absolute measures may either measure the presence or absence of something (for example whether or not a service is provided) or assess performance against a fixed standard or threshold. All indicator thresholds for this review have been set based on national policy and guidelines, research and best practice, and in consultation with the expert reference group for the review.

Relative measures

Relative measures compare the organisation to the national average (mean) for the indicator, and assign scores based on whether the organisation performs significantly better or worse than the national average. To calculate the national average for some indicators in this review, we have used the 'unit mean'. The unit mean is the average of all of the trusts' proportions for a particular indicator.

For this review we have used two methods for calculating relative measures: Z scores and confidence intervals.

Z scores

Z scores are a way of standardising data so that it can be compared easily. To calculate Z scores, first you calculate the mean and the standard deviation for the data set, then for each observation the Z score is the number of standard deviations the observation is from the mean. Essentially, this provides a mathematical expression of how different the outcome on a specific measure for a given trust is from the average performance for all trusts. The precise formula for calculating Z scores varies depending on the type of data being analysed.

The scoring rules for most relative indicators analysed using Z scores have three levels as follows:

- Z score of less than -2 means the trust performed significantly below the national average
- Z score of -2 to +2 means the trust performance was not significantly different from the national average
- Z score of more than +2 means the trust performed significantly above the national average

Thresholds of +2 and –2 were chosen because they are consistent with 95% confidence levels, a commonly accepted standard for statistical significance.

There are two exceptions within the framework, which are Indicators 2.1.1 and 2.1.2. These indicators have been analysed using Z scores with two levels and are as follows:

- Z score of less than -2 means the trust values were significantly lower than the national average
- Z score of more than -2 means the trust values were not significantly lower than the national average

Confidence intervals

A confidence interval is an estimated range of values calculated from a given data set that has a specific likelihood of including a population parameter (e.g. the mean). For this review, we have used confidence intervals to score one indicator: Indicator 1.3.3 (Proportion of emergency readmissions between 0 and 29 days from 1 April 2006 to 31 December 2006). In this case, confidence intervals were used to assess whether each trust's actual performance was better, worse or not significantly different from the expected level of performance for that trust. Actual performance was divided by expected performance and a 95% confidence interval was constructed around the result. This 95% confidence interval was compared to 100, which would represent actual performance identical to expected performance, and assessed as follows:

- If the upper confidence limit is below 100, the trust's actual performance was significantly better than expected.
- If the confidence interval contains 100, the trust's actual performance was not significantly different from what was expected.
- If the lower confidence limit is above 100, the trust's actual performance was significantly worse than expected.

For this review we have used 95% confidence intervals, which means that there is a 95% likelihood that the value we are testing against falls within the estimated range, a commonly accepted standard for statistical significance.

Approach to missing and suppressed data

For a variety of reasons, data for some indicators are not available for all organisations. In some cases the organisation does not provide a specific service and the indicator is therefore not applicable to that organisation. In others the organisation has failed to return the data in time, either to us or to another national source. We use the following rules to deal with missing data:

Data not applicable

If an indicator is not applicable to the organisation, for example because it does not provide the service that is the focus of the measure, we give that organisation the most common score (modal value) for that indicator. This means that the indicator does not impact the organisation's final score compared to other organisations, and it is therefore not unfairly penalised.

Cases where we have used the data not applicable rule are indicated by the code 'NAP' in the Flag column.

Data not available

Data not available is used to describe the situation when, although the data indicator is applicable to the organisation, for reasons beyond that organisation's control we were not able to use the data in the calculation. In these cases we give that organisation the most common score (modal value) for that indicator.

Cases where we have used the data not available rule are indicated by the code 'NAV' in the Flag column.

Data not returned

Data not returned means that data was not provided, or was not provided in time to meet the deadline for required data collections, and we have been informed of no good reason why they were not. This applies regardless of whether this data has been collected as a statutory national data set or specifically for this review. Data not returned gives the organisation a score of '1' for the affected indicator.

This may also be applied where the data returned was invalid within the rules of the data collection.

Cases where we have used the data not returned rule are indicated by the code 'NR' in the Flag column.

Composite indicators

Some indicators in the review are based on more than one piece of information. In these cases we have formed a composite indicator by scoring each component separately according to the relevant scoring rule, then averaging the scores together. We then score the average using the following thresholds:

For three-level indicators:

Score of 1: Average score of 1 to 1.66

Score of 2: Average score of greater than 1.66 and less than or equal to 2.34

Score of 3: Average score of greater than 2.34 to 3

For four-level indicators:

Score of 1: Average score of 1 to 1.75

Score of 2: Average score of greater than 1.75 and less than or equal to 2.5

Score of 3: Average score of greater than 2.5 and less than or equal to 3.25

Score of 4: Average score of greater than 3.25 to 4

For example, Trust C scored '2' for part A and scored '3' for part B of a three-level composite indicator. Trust C's average score for the indicator is 2.5, which results in an indicator score of '3'.

Mapping performance from PCTs to mental health provider trusts

The unit of assessment for the service review is an NHS trust that provides acute inpatient mental health services. However, data for two indicators are only available at the primary care trust (PCT) level:

- Indicator 1.1.2 Part B: Commissioning of crisis resolution home treatment services
- Indicator 1.3.4: Care Programme Approach seven day follow up

The data for mental health provider trusts for these indicators were calculated by using a weighted average of PCT-level data based on the PCTs which commission mental health services from each mental health provider trust. The weighted averages were based on PCTs which commissioned at least 10% of mental health services from each mental health provider trust, which we identified from Hospital Episode Statistics (HES) discharge data for quarters three and four (2005/2006). We asked mental health provider trusts to check this list during registration and to advise us of any significant changes to their local commissioning arrangements. We have published the results of this exercise on the review webpage and have used the final version of the mapping of mental health provider trusts to commissioning PCTs to calculate the two indicators listed above.

Amendment to indicators

Following analysis, quality assurance and consideration of other factors, one indicator has been removed from the scoring model. This is Criterion 1, Question 4, Indicator 3: Proportion of trust board (or nominated sub-committee) meetings at which acute care services have been reviewed.

Due to problems with the quality of the data for one component, we have also only used three (rather than four) data items to score Indicator 4 in Criterion 1, question 4: Data quality on ethnic group and diagnosis (Hospital Episode Statistics, 2006/2007 (quarters 1 to 3) and Mental Health Minimum Data Set, 2006/07 (quarter 1)). This means that this indicator is only scored on the following components (as detailed in the final assessment framework):

- a) proportion of patient records with valid diagnosis codes recorded in Hospital Episode Statistics
- c) proportion of patient records with valid ethnicity codes recorded in Hospital Episode Statistics
- d) proportion of patient records with valid ethnicity codes recorded in Mental Health Minimum Data Set.

Appendix A

Individual indicator constructions and scoring

For each scored indicator, this appendix provides detailed information about

- the data source
- the time period to which the data relate
- the rationale for including the indicator in the assessment
- how the indicator is constructed (where relevant providing details of the numerator and denominator)
- the scoring rule.

Please note that indicator ID denotes the indicator's ID code. These relate to the structure of the assessment framework and the order of the indicators in the final assessment framework. This means, for example, that Indicator 1.3.2 is the second indicator in Question 3 of Criterion 1.

For each of the indicators based on the Healthcare Commission's bespoke data collection, we have indicated in the 'data source' section from which of the tools the data is drawn. In the construction section, we have indicated which questions have been used to derive the indicators. We have used the following prefixes to denote questions from the four bespoke data collection tools:

- 'T' refers to questions on the questionnaire for trust acute inpatient leads
- 'W' refers to questions on the questionnaire for ward managers
- 'SU' refers to questions on the questionnaire for service user groups
- 'Q' refers to questions on the audit of care records.

For example, in Indicator 4.1.3 (Average rate of service users absent without leave from 1 October 2006 to 31 March 2007), the numerator is the number of service users absent without leave (T9a). T9a is question nine, part a) of the questionnaire for trust acute inpatient leads. Copies of the bespoke data collection tools are available on the review webpage at:

www.healthcarecommission.org.uk/acuteinpatientmentalhealthservicereview

(tables begin on the next page)

Indicator 1.1.1

Indicator (long title)	Proportion of service users who have the number of someone from their local NHS mental health service that they can phone out of office hours
Indicator (short title)	Service users with an out of hours phone number
Data source	Healthcare Commission Survey of users of community mental health services
Time period	2007
Rationale	Service users should have 24 hours a day access to a phone number in a crisis if they need support (DH 2001d). There is evidence of considerable variability in the percentage of service users who can access crisis services out-of-hours (CSIP and DH 2006; HC 2007)
Construction and scoring	
Construction	Proportion
Numerator	Number of service users with out of hours access by telephone to their local NHS mental health service
Denominator	Total number of respondents
Scoring rule	1: Proportion of service users with out of hours access by telephone to their local NHS mental health service is significantly below the national average proportion (unit mean) 2: Proportion of service users with out of hours access by telephone to their local NHS mental health service is not significantly different from the national average proportion (unit mean) 3: Proportion of service users with out of hours access by telephone to their local NHS mental health service is significantly above the national average proportion (unit mean)

Indicator 1.1.2

Indicator (long title)	Availability and take up of alternatives to admission
Indicator (short title)	Availability and take up of alternatives to admission
Data source	Mental Health Strategies, Adult Mental Health Service Mapping and Healthcare Commission, Performance Ratings
Time period	2007
Rationale	<p>Patients should have access to treatment in the least restrictive environment consistent with the need to protect them and the public, which is as close to home as possible (Council of Europe 2004; DH 2001c; DH 1999a).</p> <p>There should be joint working and regular dialogue between acute inpatient services and community-based teams to ensure that inpatient admission is appropriate. The crisis resolution home treatment team should assess all potential admissions to acute inpatient care to determine whether an alternative to inpatient admission is appropriate, such as crisis or respite houses or acute focused day services (CSIP-NIMHE 2007; DH 2001d; DH 2002b).</p>
Construction and scoring	
Construction	<p>Combined indicator using:</p> <ul style="list-style-type: none"> a) Availability of crisis accommodation, respite care and day hospitals b) Commissioning of crisis resolution home treatment services <p>Component a) was scored on a points basis as follows: 1 = None or one of the following are available: crisis accommodation, respite care, day hospitals 2 = Two of the following are available: crisis accommodation, respite care, day hospitals 3 = Three of the following are available: crisis accommodation, respite care, day hospitals</p> <p>Component b) was scored follows: Healthcare Commission Performance Ratings 2007 scores for the commissioning of crisis resolution home treatment services are: 3 = achieved 2 = underachieved 0 = failed These were recoded to be consistent with review scoring, as follows: 3 = 3 (good) 2 = 2 (fair) 0 = 1 (poor)</p> <p>Commissioning information identified from HES discharge data for Quarters 3 and 4 2005/2006 and confirmed during registration was used to construct weighted average scores for each mental health provider. PCTs commissioning 10% or more of a mental health provider's services were included in the weighted average for that provider. Where recorded</p>

	<p>commissioning PCTs did not add up to 100% of services commissioned, the remaining proportion of the weighted average was calculated using the standard average score for the provider (ie the straight average of recorded commissioning PCTs' scores). Average scores were then adjusted back to a three point scale.</p> <p>Scores for the two components (a and b) were then averaged and adjusted back to a three-point scale.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Average score is less than or equal to 1.66</p> <p>2: Average score is greater than 1.66 and less than or equal to 2.34</p> <p>3: Average score is greater than 2.34</p>

Indicator 1.1.3

Indicator (long title)	Proportion of admissions to acute wards that were gate kept by the crisis resolution home treatment team during the six months from October 1st 2006 to March 31st 2007
Indicator (short title)	Crisis resolution home treatment team gatekeeping
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 1st 2006 to March 31st 2007
Rationale	The crisis resolution home treatment team should act as the gatekeeper to all people requiring access to inpatient mental health services or other emergency care. Gatekeeping is an essential component of the crisis resolution home treatment team (DH and CSIP 2006; DH 2001d).
Construction and scoring	
Construction	Proportion
Numerator	Number of admissions that were gate kept by a crisis resolution home treatment team (T1)
Denominator	Total number of admissions (T2)
Scoring rule	1: Less than or equal to 50% of admissions were gate kept by the CRHT 2: More than 50% and less than or equal to 70% of admissions were gate kept by the CRHT 3: More than 70% and less than or equal to 90% of admissions were gate kept by the CRHT 4: More than 90% of admissions were gate kept by the CRHT

Indicator 1.1.4

Indicator (long title)	Trust attainment for Information Governance Toolkit question: does the mental health trust ensure that accident and emergency records are contained within the main record for patients who are subsequently admitted and is there a system to ensure that the GP is sent a copy of the A&E record?
Indicator (short title)	Information from A&E shared with mental health provider trusts and primary care
Data source	NHS Connecting for Health Information Governance Toolkit
Time period	2006/2007
Rationale	<p>Information sharing arrangements and protocols should be in place between relevant agencies involved in the care planning and provision processes (DH 2006e). Protocols enable information to be shared confidently and effectively between staff in agencies providing services within agreed and appropriate parameters (DH 1999b).</p> <p>Primary care, in partnership with secondary mental health services, should maintain and receive regular reports from a shared information system on services users within the care programme approach. A copy of the service user's care plan should be sent to his/her GP (DH 1999b).</p>
Construction and scoring	
Construction	<p>Constructed based on IGT attainment levels for question 407, which are:</p> <ul style="list-style-type: none"> • Attainment level 0: A&E records are not routinely filed within the main health record for patients who are subsequently admitted and GPs are not routinely sent a copy of the A&E record • Attainment level 1: The trust has a documented process to ensure that a copy of the A&E record is filed routinely in the main health record when a patient is subsequently admitted. The trust has a documented tracking/tracing system in the A&E Department that enables the original record to be located if it is removed from the department for any reason. • Attainment level 2: The trust ensures that a copy of the A&E record is routinely filed in the main health record when a patient is subsequently admitted and that the GP is routinely sent a copy of the A&E record. There is a tracking/tracing system that enables the original record to be located if it is removed from the department for any reason. All relevant staff members are effectively informed of the processes and procedures. • Attainment level 3: The trust undertakes regular review of the processes and systems to ensure compliance so that a copy of the A&E records is always filed in the main health record when a patient is subsequently admitted; the GP is sent a copy of the A&E record and the tracking/tracing system is used appropriately. Action is taken if there is evidence of non-compliance with the processes or system. Process documentation is regularly reviewed and updated as necessary.

Numerator	N/A
Denominator	N/A
Scoring rule	1: IGT Attainment level 0 2: IGT Attainment level 1 3: IGT Attainment level 2 4: IGT Attainment level 3

Indicator 1.1.5

Indicator (long title)	Access to health based, dedicated Section 136 place of safety assessment facilities
Indicator (short title)	Access to a health-based dedicated Section 136 place of safety
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	2007
Rationale	A person thought to suffering from a mental disorder who is detained in a place of safety under section 136 of the Mental Health Act should preferably be detained within a hospital rather than a police station (DH and Welsh Office 1999). The capital allocation process recommends that each mental health trust should have access to at least one health-based place of safety/section 136 assessment facility. Each mental health trust should have robust arrangements in place for the assessment of people under section 136 of the Mental Health Act. This includes a local agreed policy between all stakeholders, such as A&E departments, ambulance service, social services, police, mental health services, GPs and forensic examiners (DH 2006a).
Construction and scoring	
Construction	Based on assessment of whether the trust has access to at least one health based, dedicated Section 136 place of safety assessment facility and whether the facility or facilities meet the criteria set out in 'capital allocation process: £130million for improvements in safety on adult inpatient mental health wards' (T13 and T13.1)
Numerator	N/A
Denominator	N/A
Scoring rule	1: Trust does not have access to any health based, dedicated Section 136 place of safety assessment facilities 2: Trust has access to at least one health based, dedicated Section 136 place of safety assessment facility, but not all of their facilities meet the criteria set out in the 'capital allocation process: £130 million for improvements in safety on adult inpatient mental health wards' 3: Trust has access to at least one health based, dedicated Section 136 place of safety assessment facility, and all of their facilities meet the criteria set out in 'capital allocation process: £130million for improvements in safety on adult inpatient mental health wards'

Indicator 1.2.1

Indicator (long title)	Proportion of care records for which a range of care planning tasks were completed
Indicator (short title)	Range of care planning tasks undertaken
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	<p>a) The reasons for admission should be clearly documented and an expected date of discharge should be set at admission. Addressing these issues should be proactively managed against the care plan (CSIP-NIMHE 2007).</p> <p>b) The first 72 hours are particularly important in an individual's admission. The initial care plan should be developed, and an assessment of risk should be carried out, within the first 72 hours of admission, with the involvement of the service user and carer. (DH 2002b, RCP 2006a).</p> <p>c) Under the common law, valid consent is required from all patients before medical treatment can be given, except where common law or statute provides authority to give treatment without consent. The Code of Practice for the Mental Health Act 1983 states that capacity to consent should be fully recorded in the patient's medical notes. Further, assessment of capacity should be undertaken whenever a specific treatment decision is proposed, as capacity can be variable over time (DH and Welsh Office 1999). Mental capacity to consent should be assessed for all service users in relation to the arrangements made for their care, and methods of treatment being considered, to ensure they are not provided with treatment against their will unless it is in their "best interests" (TSO 2005; DH and Welsh Office 1999).</p> <p>d) Planning for acute inpatient care should include continuity of contact with CPA care coordinators. Community services and resources should be engaged at the earliest stage after admission and there should be ongoing collaboration between inpatient and community services in assessment, delivery and discharge planning (DH 2002b).</p> <p>e) A CPA review by the multi-disciplinary team should take place within one week of admission (RCP 2006a).</p>
Construction and scoring	
Construction	<p>Constructed by assessment of whether the following care planning activities took place:</p> <p>a) The purpose for the admission and the outcomes to be achieved were recorded (Q1)</p> <p>b) An initial care plan was developed to cover the first 72 hours of admission (Q2)</p> <p>c) Mental capacity to consent was assessed within seven days of admission (Q3h)</p> <p>d) The community care coordinator provided input into the service user's care review meetings 'most of the time' or 'all of the time' (Q8)</p> <p>e) A multi-disciplinary team care review meeting was held within seven days of admission (Q9)</p> <p>An initial care plan was developed to cover the first 72 hours of admission</p>

	(Q2) and any three of the other care planning assessments must have been completed for the care record to count as a positive value in the numerator.
Numerator	Number of care records showing that an initial care plan was developed to cover the first 72 hours of admission and any three of the other care planning assessments took place
Denominator	Total number of care records audited (50)
Scoring rule	<p>1: Less than or equal to 50% of care records show that a range of care planning tasks were completed</p> <p>2: More than 50% and less than or equal to 70% of care records show that a range of care planning tasks were completed</p> <p>3: More than 70% and less than or equal to 90% of care records show that a range of care planning tasks were completed</p> <p>4: More than 90% of care records show that a range of care planning tasks were completed</p>

Indicator 1.3.1

Indicator (long title)	Proportion of discharges that occurred early with support from the crisis resolution home treatment team during the six months from October 1st 2006 to March 31st 2007
Indicator (short title)	Discharges facilitated early with crisis resolution home treatment team support
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 1st 2006 to March 31st 2007
Rationale	<p>Patients should be discharged as soon as they are no longer in need of inpatient care (Council of Europe 2004; DH 1994).</p> <p>Discharge planning should include crisis resolution home treatment teams to support leave and facilitate early discharge. This should only be where such an approach is appropriate, so that individuals are not prematurely discharged placing them at risk (DH 2002b).</p>
Construction and scoring	
Construction	Proportion
Numerator	Number of discharges that occurred early with support from the crisis resolution home treatment (CRHT) (T3)
Denominator	Total number of discharges (T4)
Scoring rule	<p>1: Less than or equal to 40% of discharges occurred early with support from the CRHT</p> <p>2: More than 40% and less than or equal to 55% of discharges occurred early with support from the CRHT</p> <p>3: More than 55% and less than or equal to 70% of discharges occurred early with support from the CRHT</p> <p>4: More than 70% of discharges occurred early with support from the CRHT</p>

Indicator 1.3.2

Indicator (long title)	Average rate of delayed discharges during the six months from January 1st to June 30th 2007
Indicator (short title)	Delayed discharges
Data source	Department of Health SITREPS
Time period	January 1st 2007 to June 30th 2007
Rationale	<p>Patients should be discharged as soon as they are no longer in need of inpatient care (Council of Europe 2004; DH 1994).</p> <p>A lack of clear protocols regarding admission and discharge criteria, and the role and purpose of acute inpatient care, are factors which contribute to delayed discharge (CSIP-NIMHE 2007).</p>
Construction and scoring	
Construction	<p>Z Score analysis (Proportion)</p> <p>Constructed by combined indicator using:</p> <ul style="list-style-type: none"> a) Number of days of delayed discharges caused by accommodation factors b) Number of days of delayed discharges caused by health and social care factors <p>Both components were adjusted by number of occupied mental health beds and scored on a relative basis as follows:</p> <ul style="list-style-type: none"> 1 = Number of days of delayed discharges was significantly higher than the national average proportion (unit mean) 2 = Number of days of delayed discharges was not significantly different from the national average proportion (unit mean) 3 = Number of days of delayed discharges was significantly lower than the national average proportion (unit mean) <p>Scores for the two components were then averaged and adjusted back to a three point scale.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Average score is less than or equal to 1.66</p> <p>2: Average score is greater than 1.66 and less than or equal to 2.34</p> <p>3: Average score is greater than 2.34</p>

Indicator 1.3.3

Indicator (long title)	Proportion of emergency readmissions between 0 and 29 days during the nine months from April 1st 2006 to December 31st 2006
Indicator (short title)	Readmission rates
Data source	Healthcare Commission Hospital Episode Statistics
Time period	April 1st 2006 to December 31st 2006
Rationale	There should be effective discharge/planning to enable transition from hospital to home support, in order to prevent re-occurrence of crisis and therefore re-admission (MHAC 2006; CSIP-NIMHE 2007; SCMH 2005a). Where appropriate, discharge planning should include crisis resolution home treatment teams to support leave and facilitate early discharge, so that individuals are not prematurely discharged placing them at risk (DH 2002b; SCMH 2006).
Construction and scoring	
Construction	Actual emergency readmissions were compared to expected emergency readmissions using 95% confidence intervals.
Numerator	N/A
Denominator	N/A
Scoring rule	1: Actual emergency readmissions between 0 and 29 days were significantly above expected 2: Actual emergency readmissions between 0 and 29 days were not significantly different from expected 3: Actual emergency readmissions between 0 and 29 days were significantly below expected

Indicator 1.3.4

Indicator (long title)	Care Programme Approach seven day follow up
Indicator (short title)	Care Programme Approach seven day follow up
Data source	Healthcare Commission Performance Ratings
Time period	2007
Rationale	All patients should have face-to-face or telephone contact with community services within seven days of discharge (Healthcare Commission 2007b; SCMH 2005b; Northern Development Centre 2000). There are clear policies on effective follow-up to inpatient general psychiatric care, after both planned and unplanned discharges. This includes taking into account the needs of patients who may need special consideration, for example because they are known to have a potential for dangerous or risk-taking behaviour (Health Advisory Service 2001; DH 1994).
Construction and scoring	
Construction	Healthcare Commission Performance Ratings 2007 scores are: 3 = achieved 2 = underachieved 0 = failed These were recoded to be consistent with review scoring, as follows: 3 = 3 (good) 2 = 2 (fair) 0 = 1 (weak) Commissioning information identified from HES discharge data for Quarters 3 and 4 2005/2006 and confirmed during registration was used to construct weighted average scores for each mental health provider. PCTs commissioning 10% or more of a mental health provider's services were included in the weighted average for that provider. Where recorded commissioning PCTs did not add up to 100% of services commissioned, the remaining proportion of the weighted average was calculated using the standard average score for the provider (ie the straight average of recorded commissioning PCTs' scores). Average scores were then adjusted back to a three point scale.
Numerator	N/A
Denominator	N/A
Scoring rule	1: Average score is less than or equal to 1.66 2: Average score is greater than 1.66 and less than or equal to 2.34 3: Average score is greater than 2.34

Indicator 1.4.1

Indicator (long title)	Acute care services and commissioning involvement in the acute care forum/fora
Indicator (short title)	Acute care services and commissioning involvement in the acute care forum/fora
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	2007
Rationale	The acute care forum should include the following membership: frontline ward staff, senior designated leads from each of the key professional groups, mental health commissioners, representatives of community acute care services, voluntary and advocacy groups, service users and carers (NIMHE 2004c).
Construction and scoring	
Construction	Constructed by attendance of front line ward staff, senior designated leads from each of the key professional groups, mental health commissioners, representatives of community acute care services at least half of all acute care forum/fora meetings held in the year (T17c, T17d, T17e and T17f).
Numerator	N/A
Denominator	N/A
Scoring rule	1: No groups or one group attended at least half of all acute care forum/fora meetings held in the year 2: Two groups attended at least half of all acute care forum/fora meetings held in the year 3: Three groups attended at least half of all acute care forum/fora meetings held in the year 4: Four groups attended at least half of all acute care forum/fora meetings held in the year

Indicator 1.4.2

Indicator (long title)	Review of acute care forum action plan by acute care forum/fora, trust board, local implementation team and clinical governance committee
Indicator (short title)	Review of acute care forum/fora action plan
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 1st 2006 to March 31st 2007
Rationale	There is an acute care forum (or equivalent), with links across the elements of the acute care system (to include intensive care) and with involvement of patients and carers to agree and regularly review the operation and co-ordination of the range of acute care services (DH 2002b; DH and Welsh Office 1999; DH 2004b) The capable acute care forum is configured to facilitate the meaningful involvement of all local acute inpatient and related provision and is clear about how it maintains effective dialogue with other parts of the mental health services and all key stakeholders (NIMHE 2004c; Munday M. and Kay, D. 2006)
Construction and scoring	
Construction	Constructed by assessment of the number of the following groups which have reviewed the acute care forum/fora action plan: <ul style="list-style-type: none"> • Acute care forum/fora • Trust board • Local implementation team • Clinical governance committee (T18, T18.1)
Numerator	N/A
Denominator	N/A
Scoring rule	1: Acute care forum action plan has not been reviewed by any groups or has been reviewed by one group only 2: Acute care forum action plan has been reviewed by two groups 3: Acute care forum action plan has been reviewed by three groups 4: Acute care forum action plan has been reviewed by four groups

Indicator 1.4.3

Indicator (long title)	Proportion of trust board (or nominated sub-committee) meetings at which acute care services have been reviewed
Indicator (short title)	Review of acute care service by trust board or nominated sub-committee

Please note: this indicator has been removed from the scored framework for the review.

Indicator 1.4.4

Indicator (long title)	Data quality on ethnic group and diagnosis (Hospital Episode Statistics, 2006/2007 (quarters 1 to 3) and Mental Health Minimum Data Set, 2006/2007 (quarter 1))
Indicator (short title)	Quality of coding in Hospital Episode Statistics and Mental Health Minimum Data Set
Data source	Healthcare Commission Hospital Episode Statistics Mental Health National Minimum Dataset
Time period	April 1st 2006 to December 2006 for HES April 1st 2006 to June 2006 for MHMDS
Rationale	All monitoring of acute service use should be undertaken by gender and ethnicity (DH 2002b). Information on quality of care and management should be available from operational IT systems (DH 2001b). All providers of specialist mental health services for adults and older adults are mandated to collect MHMDS data (http://www.ic.nhs.uk/datasets/datasets/mentalhealth). Mental health services should record service users' ethnicity, and other relevant data, such as religion and language, for planning care (DH 2005a).
Construction and scoring	
Construction	Constructed by combined indicator using: a) Proportion of patient records with valid diagnosis codes recorded in Hospital Episode Statistics c) Proportion of patient records with valid ethnicity codes recorded in Hospital Episode Statistics d) Proportion of patient records with valid ethnicity codes recorded in Mental Health Minimum Data Set Absolute thresholds for the validity of ethnicity and diagnosis coding: 1= Less than or equal to 80% of codes were valid 2= More than 80% but less than or equal to 90% of codes were valid 3= More than 90% of codes were valid Scores for each coding type were then averaged together and converted back to a three point scale to create the final score for the indicator.
Numerator	a) Number of patient records with valid diagnosis codes recorded in Hospital Episode Statistics c) Number of patient records with valid ethnicity codes recorded in Hospital Episode Statistics d) Number of patient records with valid ethnicity codes recorded in Mental Health Minimum Data Set
Denominator	a) Number of patient records with speciality 710 recorded in Hospital Episode Statistics c) Number of patient records with speciality 710 recorded in Hospital Episode Statistics d) Number of patient records in Mental Health Minimum Data Set

Scoring rule	<p>1: Average score is less than or equal to 1.66</p> <p>2: Average score is greater than 1.66 and less than or equal to 2.34</p> <p>3: Average score is greater than 2.34 to 3</p>
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Indicator 2.1.1

Indicator (long title)	Level of whole time equivalent workforce input to acute inpatient wards
Indicator (short title)	Level of workforce input to acute inpatient wards
Data source	Mental Health Strategies Adult Health Service Mapping
Time period	2007
Rationale	<p>There should be a sufficient number of nursing staff with the skills and competence in order to provide therapeutic care. (DH 2002b)</p> <p>Safety and quality are not simply related to the number of beds or staff on the ward. However, the staffing resource is probably the most important single determinant upon which to build a service that is therapeutic, safe and of high quality. A wide range of variables impact on the day-to-day running of acute wards, many of which are specific to the local situation and will be dynamic, thereby making it almost impossible to have a single method of determining the 'correct' staffing levels. However, benchmarking across services is a useful method of locating individual wards and trusts within their local systems (Ryan, T., Hills B. and Webb, L. 2004).</p> <p>The Acute Policy Implementation Guidance does not recommend the nursing establishment required for an inpatient ward, as this is influenced by a number of complex factors such as ward size, the configuration of local services, existing staff levels and local needs. It states that acute care fora and collaborative development networks should identify appropriate staffing establishment benchmarks (DH 2002b).</p>
Construction and scoring	
Construction	<p>Z Score analysis (Ratio)</p> <p>The whole time equivalent for all staff types (nursing staff, medical staff, allied health professionals and social care staff and ancillary and administrative staff) have been summed and adjusted by the number of beds. The results were then compared on a relative basis.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: The total whole time equivalent workforce input per bed is significantly lower than the national average proportion (unit mean)</p> <p>2: The total whole time equivalent workforce input per bed is not significantly lower than the national average proportion (unit mean)</p>

Indicator 2.1.2

Indicator (long title)	Level of whole time equivalent workforce input to psychiatric intensive care units
Indicator (short title)	Level of workforce input to psychiatric intensive care units
Data source	Mental Health Strategies Adult Health Service Mapping
Time period	2007
Rationale	<p>There should be a sufficient number of nursing staff with the skills and competence in order to provide therapeutic care. (DH 2002b)</p> <p>Safety and quality are not simply related to the number of beds or staff on the ward. However, the staffing resource is probably the most important single determinant upon which to build a service that is therapeutic, safe and of high quality. A wide range of variables impact on the day-to-day running of acute wards, many of which are specific to the local situation and will be dynamic, thereby making it almost impossible to have a single method of determining the 'correct' staffing levels. However, benchmarking across services is a useful method of locating individual wards and trusts within their local systems (Ryan et al. 2004).</p> <p>The Acute Policy Implementation Guidance does not recommend the nursing establishment required for an inpatient ward, as this is influenced by a number of complex factors such as ward size, the configuration of local services, existing staff levels and local needs. It states that acute care fora and collaborative development networks should identify appropriate staffing establishment benchmarks (DH 2002b).</p>
Construction and scoring	
Construction	<p>Z Score analysis (Ratio)</p> <p>The whole time equivalent for all staff types (nursing staff, medical staff, allied health professionals and social care staff and ancillary and administrative staff) have been summed and adjusted by the number of beds. The results were then compared on a relative basis.</p> <p>PLEASE NOTE: The 21 trusts that did not register a PICU are assigned the modal score for this indicator</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: The total whole time equivalent workforce input per bed is significantly lower than the national average proportion (unit mean)</p> <p>2: The total whole time equivalent workforce input per bed is not significantly lower than the national average proportion (unit mean)</p>

Indicator 2.1.3

Indicator (long title)	Proportion of service users who had regular one to one sessions with nursing staff in the first week of admission
Indicator (short title)	Regular one to one sessions with nursing staff
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	<p>There should be protected therapeutic engagement time between mental health nurses and service users (DH 2006c). Staff should be given planned and protected time to make sure activities and interventions are provided regularly and routinely (RCP 2006a). The frequency, regularity and diversity of activities should be monitored (SCMH 2005a).</p> <p>Service user feedback has indicated that more one-to-one contact with staff would make the biggest difference to their experience of acute inpatient mental health wards (Janner M. 2006). Research has indicated that the amount of meaningful time nurses spent with patients has been limited (Ryan et al. 2004).</p>
Construction and scoring	
Construction	Constructed by assessment of the number of days during the first seven days of admission that the service user had (or was offered but refused) at least one one-to-one session (15 minutes or longer) with a nurse. Regular is defined as at least four out of seven days.
Numerator	Number of care records with at least one one-to-one session with a nurse recorded on at least four out of seven days during the first seven days of admission (Q4)
Denominator	Total number of care records audited (50)
Scoring rule	<p>1: Less than or equal to 50% of service users had regular one to one sessions with nursing staff in the first week of admission</p> <p>2: More than 50% but less than or equal to 70% of service users had regular one to one sessions with nursing staff in the first week of admission</p> <p>3: More than 70% but less than or equal to 90% of service users had regular one to one sessions with nursing staff in the first week of admission</p> <p>4: More than 90% of service users had regular one to one sessions with nursing staff in the first week of admission</p>

Indicator 2.1.4

Indicator (long title)	Proportion of wards with a range of therapies available for service users
Indicator (short title)	Range of therapies provided for service users
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	2007
Rationale	All patients should have access to a broad range of appropriate psychological therapies and interventions, in line with current evidence (DH 2003c). All patients should be offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (for example, NICE guidance) (RCP 2006a). Inpatients should be offered a range of three or more psychological interventions in line with current evidence (RCP 2006a).
Construction and scoring	
Construction	Constructed by an assessment of the availability of the following therapies: a) talking therapies b) psychosocial family interventions c) occupational therapy d) art/music/drama therapy e) psychoeducation groups f) relapse prevention/self-management g) hearing voices groups h) concordance therapy Talking therapies and any other of the five types of therapy must be available for the ward to be counted in the numerator.
Numerator	Number of wards that provide talking therapies and any five of the other types of therapy (W6)
Denominator	Total number of wards
Scoring rule	1: Less than or equal to 40% of wards provide talking therapies and any other of the five types of therapy 2: More than 40% but less than or equal to 60% of wards provide talking therapies and any other of the five types of therapy 3: More than 60% but less than or equal to 80% of wards provide talking therapies and any other of the five types of therapy 4: More than 80% of wards provide talking therapies and any other of the five types of therapy

Indicator 2.1.5

Indicator (long title)	Proportion of wards providing clinical staff supervision and ward manager leadership development
Indicator (short title)	Clinical staff supervision and ward manager leadership development
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	April 1st 2006 to March 31st 2007 and 2007
Rationale	Ward staff should be appropriately clinically supervised (DH 2002b; DH 2006c; RCP 2003; RCP 2006a) There should be investment in the development of managerial and leadership competencies of ward managers and sister/charge nurses (DH 2002b; RCP 2006a).
Construction and scoring	
Construction	<p>Constructed by combined indicator using:</p> <p>a) Proportion of wards providing clinical supervision for all clinical ward-based staff (W7). Regular was defined as 'most of the time' or 'all of the time'. This component was scored as: 1 = Less than or equal to 50% of wards provide clinical supervision for all clinical ward-based staff 2 = More than 50% but less than or equal to 65% of wards provide clinical supervision for all clinical ward-based staff 3 = More than 65% but less than or equal to 80% of wards provide clinical supervision for all clinical ward-based staff 4 = More than 80% of wards provide clinical supervision for all clinical ward-based staff</p> <p>b) Proportion of ward managers for whom leadership training and development requirements have been assessed as part of their development review, and have received the training, learning and development that was identified in their plan (W15). This component was scored as: 1 = Less than or equal to 50% of ward managers have received the training, learning and development that was identified in their plan. 2 = More than 50% but less than or equal to 65% of ward managers have received the training, learning and development that was identified in their plan. 3 = More than 65% but less than or equal to 80% of ward managers have received the training, learning and development that was identified in their plan. 4 = More than 80% of ward managers have received the training, learning and development that was identified in their plan.</p> <p>The two components (a and b) were then averaged together and then adjusted back to a four point scale.</p>

Numerator	N/A
Denominator	N/A
Scoring rule	1: Average score is less than or equal to 1.75 2: Average score is greater than 1.75 and less than or equal to 2.5 3: Average score is greater than 2.5 and less than or equal to 3.25 4: Average score is greater than 3.25

Indicator 2.2.1

Indicator (long title)	Proportion of service users who have had physical health assessments and checks completed on admission
Indicator (short title)	Physical health checks on admission
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	<p>The standardised mortality ratios for people with severe ongoing mental illnesses is two and a half times greater than the national population average (Disability Rights Commission 'Equal Treatment'). People with conditions such as schizophrenia and bi-polar disorder are at increased risk of physical illnesses and conditions, such as heart disease, diabetes, obesity, respiratory conditions, and infections (DH 2004a; SHIFT/NIMHE 2004; DH 1999b). A high proportion of users of adult acute inpatient mental health services are heavy tobacco users (Kings Fund 2006). NICE depression and schizophrenia guidelines recommend that services undertake regular full assessments of service users' physical health (NICE 2004; NICE 2002).</p> <p>Trusts should identify the minimum standard for all in-patient services with regard to the physical assessment and examination of service users (NHSLA 2005). Patients should have their physical needs and condition fully assessed by a medical practitioner at a minimum frequency of once every six months for the first year and annually thereafter (NIMHE 2004c; SHIFT/NIMHE 2004).</p> <p>On the day of their admission or as soon as they are well enough, the patient should receive a basic structured standard medical assessment which matches the assessment undertaken in the Quality and Outcomes Framework in the General Medical Services contract (RCP 2006a).</p>
Construction and scoring	
Construction	<p>Constructed by assessment of the following physical health checks (Q6):</p> <ul style="list-style-type: none"> a) baseline physical examination b) baseline lifestyle assessment c) baseline haematological and biochemical screening d) baseline electrocardiogram e) history of past and current use of physical, psychotropic and non-prescribed medications <p>Baseline physical examination, baseline lifestyle assessment and baseline haematological and biochemical screening and any one of the other two physical health checks must have been completed on admission for the care record to be counted in the numerator.</p>
Numerator	Number of care records showing that a baseline physical examination, baseline lifestyle assessment and baseline haematological and biochemical screening, and any one of the other two physical health checks were completed on admission

Denominator	Total number of care records audited (50)
Scoring rule	<p>1: Less than or equal to 50% of service users had physical health assessments and checks completed on admission</p> <p>2: More than 50% but less than or equal to 70% of service users had physical health assessments and checks completed on admission</p> <p>3: More than 70% but less than or equal to 90% of service users had physical health assessments and checks completed on admission</p> <p>4: More than 90% of service users had physical health assessments and checks completed on admission</p>

Indicator 2.2.2

Indicator (long title)	Proportion of wards offering a range of health promotion activities to service users
Indicator (short title)	Health promotion activities
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	2007
Rationale	<p>All mental health providers should take steps to ensure that the physical health of people with serious mental illness is not overlooked and that provision is implemented and managed effectively. The nurse lead should support service users to access appropriate healthcare and health promotion services (DH 2004a; DH 2006c).</p> <p>a) diet/healthy eating The need for access to and regular input to the inpatient ward by physiotherapy and dietetics, and support for healthy eating, should be clearly defined, understood and deliverable (DH 2002b; Janner, M. 2006).</p> <p>b) physical activity/exercise It is recommended that a physiotherapist or sports trainer run group exercises and individual coaching and planning (Janner, M. 2006) and that patients have access to a gym (Janner, M. 2006; NIMHE 2004b; RCP 2006a).</p> <p>c) substance misuse including alcohol Mental health staff need to be competent in intervening in drug and alcohol use as an integral part of providing treatment and care. This might be by offering drug and alcohol treatment and prevention as a separate programme within mental health services, delivered by specialist staff (DH 2006b).</p> <p>d) smoking cessation There should be support for staff and patients to assist with the smoking policy, including:</p> <ul style="list-style-type: none"> • consideration of the use of NRT while on the hospital premises to help with withdrawal or as a coping strategy; • a comprehensive support programme, with information available about the support on offer; • strategies to make sure staff know and understand the Trust's policy, and monitor levels of comprehension (HDA 2004; HDA 2001; RCP 2006a). <p>Advice and encouragement for healthy eating and giving up smoking available on all wards (Janner, M. 2006).</p> <p>e) pregnancy/contraception/sexual health Inpatient units should provide access to appropriate advice and services to deal with contraception, pregnancy and sexual health (NPSA 2006).</p>

Construction and scoring	
Construction	<p>Constructed by assessment of the availability of the following health promotion activities on each ward:</p> <ul style="list-style-type: none"> a) diet and healthy eating b) physical activity and exercise c) substance misuse including alcohol d) smoking cessation e) pregnancy, contraception and sexual health <p>All five health promotion activities must be offered for the ward to be counted in the numerator</p>
Numerator	Number of wards offering all five health promotion activities (W8)
Denominator	Total number of wards
Scoring rule	<p>1: Less than or equal to 25% of wards offer all five health promotion activities</p> <p>2: More than 25% but less than or equal to 50% of wards offer all five health promotion activities</p> <p>3: More than 50% but less than or equal to 75% of wards offer all five health promotion activities</p> <p>4: More than 75% of wards offer all five health promotion activities</p>

Indicator 2.3.1

Indicator (long title)	Proportion of assessments that include assessment of employment/education status, accommodation status and needs, and caring responsibilities
Indicator (short title)	Employment/education status, housing status and needs and caring responsibilities included in assessments
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	Staff should identify if people are in employment or education at the time of admission, maintain contact with families, and help resolve any financial issues (Office of the Deputy Prime Minister 2004). Trusts should be sensitive to the impact of psychiatric hospital admission for the individual and their family and carers (DH 2002b). Staff should identify the service user's current housing status (DH 2002b; DH 1999b).
Construction and scoring	
Construction	Proportion
Numerator	Number of care records showing that assessments included employment/education status, accommodation status and needs, and caring responsibilities (Q3)
Denominator	Total number of care records audited (50)
Scoring rule	<p>1: Less than or equal to 50% of care records audited had all three assessments recorded</p> <p>2: More than 50% but less than or equal to 70% of care records audited had all three assessments recorded</p> <p>3: More than 70% but less than or equal to 90% of care records audited had all three assessments recorded</p> <p>4: More than 90% of care records audited had all three assessments recorded</p>

Indicator 2.3.2

Indicator (long title)	Proportion of wards with service user access to a phone line that can be used in private and a computer with internet access
Indicator (short title)	Service user access to phone line that can be used in private and computer with internet access
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	2007
Rationale	Arrangements need to be in place for ensuring privacy for service users to make phone calls (DH 2002b). Patients should have access to a telephone in private (RCP 2005; RCP 2006a). Wards should have internet-connected computers (Janner, M. 2006).
Construction and scoring	
Construction	Proportion
Numerator	Number of wards with service user access to a phone line that can be used in private and a computer with internet access (SU8a and SU8b)
Denominator	Total number of wards
Scoring rule	1: Less than or equal to 25% of wards provide service user access to a phone line that can be used in private and a computer with internet access 2: More than 25% but less than or equal to 50% of wards provide service user access to a phone line that can be used in private and a computer with internet access 3: More than 50% but less than or equal to 75% of wards provide service user access to a phone line that can be used in private and a computer with internet access 4: More than 75% of provide service user access to a phone line that can be used in private and a computer with internet access

Indicator 2.3.3

Indicator (long title)	Proportion of wards with input from employment support, education, housing, and finance/benefits advice
Indicator (short title)	Input to address social needs
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	2007
Rationale	<p>It is important that inpatient services maximise their connections to community services and supports and vice versa. The inpatient service can have a more positive impact if it develops partnerships and maintains liaison and communication arrangements with key agencies in the community: housing, benefits, employment, education and leisure (DH 2002b).</p> <p>More creative responses to service user needs for therapeutic, social and recreational activities during inpatient care need to be developed and need to be supported by inreach from multi-disciplinary teams and other community support services, including voluntary and non-statutory services (DH 2002b).</p>
Construction and scoring	
Construction	Proportion
Numerator	Number of wards providing employment support, education, housing, and finance/benefits advice services on the ward (W9)
Denominator	Total number of wards
Scoring rule	<p>1: Less than or equal to 25% of wards provide all four advice services on the ward</p> <p>2: More than 25% but less than or equal to 50% of wards provide all four advice services on the ward</p> <p>3: More than 50% but less than or equal to 75% of wards provide all four advice services on the ward</p> <p>4: More than 75% of provide all four advice services on the ward</p>

Indicator 2.3.4

Indicator (long title)	Service user links with the community and activities facilitated by external community organisations during the four weeks from July 2nd to July 29th 2007
Indicator (short title)	Facilitation of links with the community
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	July 2nd to July 29th 2007
Rationale	Ward arrangements should facilitate contact, input and joint work with the normal sources of mental health, social support and self esteem that service users access in the community, for example, family/carers, mental health and primary care support (DH 2002b).
Construction and scoring	
Construction	<p>Constructed by combined indicator using:</p> <p>a) Number of times service users are facilitated to leave the ward to participate in community activities per bed scored relatively compared to the national mean national average proportion (unit mean)? (W4): 1 = The number of times service users are facilitated to leave the ward to participate in community activities per bed is significantly below the national average proportion (unit mean) 2 = The number of times service users are facilitated to leave the ward to participate in community activities per bed is not significantly different from the national average proportion (unit mean) 3 = The number of times service users are facilitated to leave the ward to participate in community activities is significantly above the national average proportion (unit mean)</p> <p>b) Proportion of activity sessions facilitated by external community organisations (W5): 1= Less than or equal to 5% of sessions are facilitated by external community organisations 2= More than 5% but less than or equal to 15% of sessions are facilitated by external community organisations 3 = More than 15% of sessions are facilitated by external community organisations.</p> <p>The two components (a and b) were then averaged together and then adjusted back to a three point scale.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Average score is less than or equal to 1.66</p> <p>2: Average score is greater than 1.66 and less than or equal to 2.34</p> <p>3: Average score is greater than 2.34</p>

Indicator 2.4.1

Indicator (long title)	Proportion of wards with access to specialist support and advice for specific service user groups
Indicator (short title)	Specialist team support for specific service user groups
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	2007
Rationale	<p>Admission to an adult unit of people under the age of 18 should only happen if:</p> <ul style="list-style-type: none"> • the local authority is informed of the admission • the length of stay anticipated is less than three months • the MHAC is informed (if the patient is detained) • a single room is available • the patient is under constant observation for the duration of their stay • CRB checks have been completed • there is access to child and adolescent psychiatric consultation and advice throughout admission <p>(Wales Collaboration for Mental Health 2005; RCP 2006a)</p> <p>There should be named consultant psychiatrist leads from both mental health and learning disability services for each in-patient unit (DH 2004b).</p> <p>There should be access to specialist support for dual diagnosis (DH 2006b), people with personality disorders (DH 2003d; NIMHE 2003a;), older people's mental health services (DH and CSIP 2005), learning disabilities services (DH 2005b), child and adolescent mental health services (RCP 2002a), and perinatal care (NICE 2007).</p>
Construction and scoring	
Construction	<p>Constructed by assessment of access to specialist support from the following teams:</p> <ol style="list-style-type: none"> a) child and adolescent mental health services b) older adults services c) learning disabilities services d) dual diagnosis services e) perinatal services <p>All mixed gender and female-only wards must have access 'most of the time' or 'all of the time' to all five specialist support services to count in the numerator. All male only wards must have access 'most of the time' or 'all of the time' to four out of four specialist support services (excluding perinatal services which are not applicable) to count in the numerator.</p>
Numerator	Number of wards with access to all five types of specialist support (W10)
Denominator	Total number of wards

Scoring rule	<p>1: Less than or equal to 50% of wards provide access to specialist support</p> <p>2: More than 50% but less than or equal to 65% of wards provide access to specialist support</p> <p>3: More than 65% but less than or equal to 80% of wards provide access to specialist support</p> <p>4: More than 80% of wards provide access to specialist support</p>
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Indicator 2.4.2

Indicator (long title)	Proportion of all staff who report having received training in at least two types of diversity training
Indicator (short title)	Training on diversity
Data source	Healthcare Commission Staff Survey
Time period	2006
Rationale	<p>Trusts should enhance training for all staff in race equality issues (DH2005a). Training in gender awareness should be provided to staff in specialist mental health services (DH 2003c). Organisations should consider training needs for disability equality and allocate appropriate budgets for training, research and involvement (Disability Rights Commission).</p> <p>There should be procedures and policies in place on bullying, harassment, whistle blowing, tackling violence, racial and other forms of discrimination, and staff should be aware of these (DH 2001a). All service planners and providers should receive training in cultural sensitivity, e.g. in religious and linguistic needs, care and recovery planning, needs assessment and community engagement (DH2005a; NIMHE 2004a).</p>
Construction and scoring	
Construction	Constructed by assessment of a range of diversity training (equal opportunities, racial awareness, gender awareness, disability awareness, religious awareness). Staff need to report having received at least two types of diversity training to be included in the numerator.
Numerator	Number of staff who reported having received at least two types of diversity training
Denominator	Total number of respondents
Scoring rule	<p>1: Less than or equal to 50% of staff reported having received at least two types of diversity training</p> <p>2: More than 50% and less than or equal to 65% of staff reported having received at least two types of diversity training</p> <p>3: More than 65% and less than or equal to 80% of staff reported having received at least two types of diversity training</p> <p>4: More than 80% of staff reported having received at least two types of diversity training</p>

Indicator 2.4.3

Indicator (long title)	Patient Environment Action Team (PEAT) score for facilities for people with disabilities
Indicator (short title)	Patient Environment Action Team facilities for people with disabilities
Data source	National Patient Safety Agency Patient Environment Action Team
Time period	2007
Rationale	<p>The trust complies with PEAT standards in relation to facilities for people with disabilities. PEAT guidance states that:</p> <ul style="list-style-type: none"> • the hospital should, as far as is practicable, cater for the needs of disabled users • access should be provided to all areas for unaccompanied wheelchair users and other disabled patients and visitors. This may include the provision of automatic doors at main entrances, or staff available to help if necessary. • ramps or lowered curbs should be in place to facilitate easy movement around the grounds • where necessary, reception desks should have a lowered area accessible to those in wheelchairs • lifts should be easily accessible and placement of lift controls should take into account the needs of disabled users <p>(http://patientexperience.nhsestates.gov.uk/clean_hospitals/ch_content/home/background.asp)</p>
Construction and scoring	
Construction	<p>PEAT provided data at the site level, and scores were assigned for each site using PEAT scoring thresholds:</p> <p>1 = less than or equal to 50% 2 = more than 50% but less than or equal to 60% 3 = more than 60% but less than or equal to 75% 4 = more than 75% but less than or equal to 95% 5 = more than 95%</p> <p>These site scores were averaged to derive a trust level score, which was then adjusted back to a five point scale as follows:</p> <p>1 = average PEAT score less than or equal to 1.8 2 = average PEAT score greater than 1.8 but less than or equal to 2.7 3 = average PEAT score greater than 2.7 but less than or equal to 3.5 4 = average PEAT score greater than 3.5 but less than or equal to 4.3 5 = average PEAT score greater than 4.3</p> <p>Review scores were then assigned based on these trust level PEAT scores.</p>
Numerator	N/A
Denominator	N/A

Scoring rule	<p>1: Average adjusted PEAT score is 1 or 2</p> <p>2: Average adjusted PEAT score is 3</p> <p>3: Average adjusted PEAT score is 4</p> <p>4: Average adjusted PEAT score is 5</p>
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Indicator 2.4.4

Indicator (long title)	Assessment of, and access to staff support for, cultural and spiritual needs
Indicator (short title)	Assessment of, and access to staff support for, cultural and spiritual needs
Data source	Healthcare Commission bespoke data collection Care records audit Questionnaire for ward managers
Time period	December 1st 2006 to May 31st 2007 2007
Rationale	<p>Trusts should ensure that they overcome any barriers to communication that may exist, for example, through the provision of interpreters (including BSL and Makaton as well as other languages), translators or advocates (NIMHE 2004c; DH 2003b; NIMHE 2003b; DH 2002a; DH2005a)</p> <p>There is access to relevant faith-specific support preferably through someone with an understanding of mental health issues (DH 2002d). The importance and relevance of service user spirituality and religion in mental health care is being increasingly recognised, and there is a growing body of research on how a personal sense of meaning and identify can aid people's recovery. The Chief Nursing Officer's review of mental health nursing (DH 2006c) recommends that all mental health nurses recognise and respond to the spiritual and religious needs of service users. An assessment of the service user's spiritual needs should be part of the overall assessment of their immediate needs carried out upon admission (RCP 2006a). The Star Wards report (Janner, M. 2006) recommended that prayer, faith and cultural meetings (for example, black and ethnic minority, men-only and women-only groups) be supported, through a combination of: staff support; a hospital culture of religious diversity and absence of actual or perceived dominance of one faith; the provision of a quiet room that can be used by people of different faiths, and none, for prayer and contemplation.</p>
Construction and scoring	
Construction	<p>Combined indicator that contains the rule that if a trust scores a '1' on either part a or b then they score a '1' overall for this indicator:</p> <p>a) Proportion of assessments which include assessment of spiritual and cultural needs (Q3i and Q3j), scored as: 1 = Less than or equal to 25% of care records have assessment of spiritual needs and cultural needs recorded 2 = More than 25% but less than or equal to 50% of care records have assessment of spiritual needs and cultural needs recorded 3 = More than 50% but less than or equal to 75% of care records have assessment of spiritual needs and cultural needs recorded 4 = More than 75% of care records have assessment of spiritual needs and cultural needs recorded</p> <p>b) Proportion of wards which provide interpreters for care review meetings (W12a) AND for therapies 'most of the time' or 'all of the time' (W12c); AND which provide interpreters for activities (W12d) AND/OR pastoral and spiritual support 'most of the time' or 'all of the time' (W11), scored</p>

	<p>as:</p> <p>1 = Less than or equal to 25% of wards provide interpreters for care review meetings AND for therapies 'most of the time' or 'all of the time'; AND provide interpreters for activities AND/OR pastoral and spiritual support 'most of the time' or 'all of the time'</p> <p>2 = Greater than 25% but less than or equal to 50% of wards provide interpreters for care review meetings AND for therapies 'most of the time' or 'all of the time'; AND provide interpreters for activities AND/OR pastoral and spiritual support 'most of the time' or 'all of the time'</p> <p>3 = Greater than 50% but less than or equal to 75% of wards provide interpreters for care review meetings AND for therapies 'most of the time' or 'all of the time'; AND provide interpreters for activities AND/OR pastoral and spiritual support 'most of the time' or 'all of the time'</p> <p>4 = Greater than 75% of wards provide interpreters for care review meetings AND for therapies 'most of the time' or 'all of the time'; AND provide interpreters for activities AND/OR pastoral and spiritual support 'most of the time' or 'all of the time'</p> <p>Scores for the two components (a and b) were then averaged together and adjusted back to a four point scale.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Average score is less than or equal to 1.75 OR the trust scores '1' on part a or part b</p> <p>2: Average score is greater than 1.75 and less than or equal to 2.5.</p> <p>3: Average score is greater than 2.5 and less than or equal to 3.25.</p> <p>4: Average score is greater than 3.25</p>

Indicator 2.4.5

Indicator (long title)	Score for Patient Environment Action Team part eight: social spaces
Indicator (short title)	Score for Patient Environment Action Teams part eight: social spaces
Data source	National Patient Safety Agency Patient Environment Action Team
Time period	2007
Rationale	<p>Trusts should comply with PEAT standards in relation to social spaces for mental health. This covers the following elements:</p> <ul style="list-style-type: none"> • women only day area • family visiting areas • activity areas <p>(http://patientexperience.nhsestates.gov.uk/clean_hospitals/ch_content/home/background.asp)</p> <p>Provision including access to a private space and refreshments should be made to encourage and facilitate carer and family involvement and visiting (DH 2002b; RCP 2006a). Patients should have access to an activities room equipped with board games, stereo, art equipment etc (NIMHE 2004b; RCP 2006a). There should be women-only and men-only lounge areas (RCP 2006a).</p>
Construction and scoring	
Construction	Proportion
Numerator	Number of social spaces (women-only day areas, family visiting areas and activity areas) available within the trust
Denominator	Total possible social spaces within the trust (number of sites multiplied by three)
Scoring rule	<p>1: Trust provides less than or equal to 50% of possible social spaces</p> <p>2: Trust provides more than 50% and less than or equal to 65% of possible social spaces</p> <p>3: Trust provides more than 65% and less than or equal to 80% of possible social spaces</p> <p>4: Trust provides more than 80% of possible social spaces</p>

Indicator 3.1.1

Indicator (long title)	Proportion of wards which have a welcome pack or information guide for service users that contains a range of information that has been reviewed and updated where necessary within the last two years
Indicator (short title)	Availability of welcome pack or information guide for service users
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	April 1st 2005 to March 31st 2007
Rationale	<p>On the day of their admission or as soon as they are well enough, the patient should be given a welcome pack or introductory booklet that contains the following:</p> <ul style="list-style-type: none"> • a clear description of the aims of the acute ward • the current programme and modes of treatment • a clear description of what is expected and rights and responsibilities • a simple description of the ward's philosophy, principles and their rationale, and the ward team membership <p>(DH 2003a; RCP 2002b; RCP 2005; RCP 2006a; DH 2003b; SHIFT/NIMHE 2004; DH 2005a)</p> <p>There should be a mutual code of conduct for ward behaviour. Patients should be advised of its existence on admission, and adherence should be monitored (London Development Centre et al. 2006; DH 2002b). Hospital managers have a statutory duty to give information to detained patients, and to their nearest relative, unless the patient objects. On the day of their admission or as soon as is practicable after their admission, the patient should be given written information on their legal status and rights (in accordance with Section 132 of the MHA), rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures (RCP 2006a).</p>
Construction and scoring	
Construction	<p>Constructed by assessment of the availability of a welcome pack or information guide for service users that has been reviewed and updated where necessary within the last two years that contains:</p> <ol style="list-style-type: none"> a) the purpose of the ward (aims and philosophy) b) a description of what to expect from staff on the ward c) a description of what is expected of service users on the ward d) information on how and when service users are able to leave the ward e) treatments and therapies available on the ward f) health and safety procedures g) how to make a complaint h) how to report an incident i) rights under the Mental Health Act 1983 j) the current programme of activities k) practical information e.g. visiting hours, parking arrangements, items available for purchase on the ward l) directory of service user support services and organisations m) information about spiritual and cultural services, choices and support available on the ward

	The welcome pack on each ward needs to contain at least 11 out of 13 types of information listed to count in the numerator.
Numerator	Number of wards that have 11 out of the 13 types of information listed in their welcome pack or information guide for service users (SU2)
Denominator	Total number of wards
Scoring rule	<p>1: Less than or equal to 25% of wards have a welcome pack or information guide for service users that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>2: More than 25% and less than or equal to 50% of wards have a welcome pack or information guide for service users that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>3: More than 50% and less than or equal to 75% of wards have a welcome pack or information guide for service users that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>4: More than 75% of wards have a welcome pack or information guide for service users that contains a range of information that has been reviewed and updated where necessary within the last two years</p>

Indicator 3.1.2

Indicator (long title)	Proportion of wards which have a welcome pack or information guide for carers (including young carers) that contains a range of information that has been reviewed and updated where necessary within the last two years
Indicator (short title)	Availability of welcome pack or information guide for carers
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	April 1st 2005 to March 31st 2007
Rationale	Information for carers should be available on the ward and elsewhere in the hospital (e.g. the café) (DH 2002b; Janner, M. 2006). The principal carer should be offered an assessment of their own needs, their involvement, and their willingness and ability to collaborate with practitioners in order to provide care (DH 2003a; RCP 2006a).
Construction and scoring	
Construction	Constructed by assessment of the availability of a welcome pack or information guide for carers that has been reviewed and updated where necessary within the last two years that contains: a) the purpose of the ward (aims and philosophy) b) a description of what to expect from staff on the ward c) a description of what is expected of visitors to the ward d) right to carer assessment e) rights of nearest relative under the Mental Health Act 1983 f) ward contact details and visiting hours g) information about how to access carer support workers h) directory of carer support organisations, information sources and resources The welcome pack on each ward needs to contain at least 6 out of 8 types of information to count in the numerator.
Numerator	Number of wards that have 6 out of the 8 types of information listed in their welcome pack or information guide for carers (SU3)
Denominator	Total number of wards

Scoring rule	<p>1: Less than or equal to 25% of wards have a welcome pack or information guide for carers (including young carers) that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>2: More than 25% and less than or equal to 50% of wards have a welcome pack or information guide for carers (including young carers) that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>3: More than 50% and less than or equal to 75% of wards have a welcome pack or information guide for carers (including young carers) that contains a range of information that has been reviewed and updated where necessary within the last two years</p> <p>4: More than 75% of wards have a welcome pack or information guide for carers (including young carers) that contains a range of information that has been reviewed and updated where necessary within the last two years</p>
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Indicator 3.1.3

Indicator (long title)	Proportion of wards which have welcome packs or information guides for service users and carers available or accessible in a range of formats and languages
Indicator (short title)	Accessibility of welcome pack or information guide for service users and carers
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	April 1st 2005 to March 31st 2007
Rationale	Information needs to be provided in an appropriate and accessible format on privacy and confidentiality, accessing help, getting information, housekeeping and related ward arrangements (DH 2002b). Information should be provided in different formats, such as in different languages, or in ways to meet the needs of patients with sensory disabilities or learning disabilities (DH2005a; Munday, M. and Kay, D. 2006).
Construction and scoring	
Construction	Constructed by assessment of: a) the number of wards that have a welcome pack or information guide available for service users in languages other than English and braille or spoken formats and at least two other formats from a possible four: age-appropriate formats, simple language formats, large print and/or formats suitable for individual people with learning difficulties b) the number of wards that have a welcome pack or information guide available for carers in languages other than English and braille or spoken formats and at least two other formats from a possible four: age-appropriate formats, simple language formats, large print and/or formats suitable for individual people with learning difficulties The scores for the two components (a and b) were then averaged and adjusted back to a four point scale.
Numerator	Number of wards that have which have welcome packs or information guides for both service users and carers available in languages other than English, braille or spoken formats and in at least two of the other formats (SU4)
Denominator	Total number of wards
Scoring rule	1: Average score is between 1 to 1.75 2: Average score is between 1.76 to 2.5 3: Average score is between 2.6 to 3.25 4: Average score is between 3.26 to 4

Indicator 3.1.4

Indicator (long title)	Proportion of wards which have an up-to-date photo board of ward-based staff prominently displayed where it can be seen by service users and visitors
Indicator (short title)	Photo board of ward staff
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	2007
Rationale	Good practice aspects of reception and service orientation include a picture board of ward staff, prominently displayed (DH 2002b).
Construction and scoring	
Construction	Proportion
Numerator	Number of wards which have an up-to-date photo board of ward-based staff prominently displayed where it can be seen by service users and visitors (SU1)
Denominator	Total number of wards
Scoring rule	<p>1: Less than or equal to 25% of wards have an up-to-date photo board</p> <p>2: More than 25% and less than or equal to 50% of wards have an up-to-date photo board</p> <p>3: More than 50% and less than or equal to 75% of wards have an up-to-date photo board</p> <p>4: More than 75% of wards have an up-to-date photo board</p>

Indicator 3.1.5

Indicator (long title)	Proportion of care records for which it is recorded that service users rights under the Mental Health Act (1983) were explained
Indicator (short title)	Explanation of rights for detained patients
Data source	Mental Health Act Commission
Time period	June 1st 2005 to December 31st 2006
Rationale	Service users should have explained upon admission their rights under the Mental Health Act (DH and Welsh Office 1999).
Construction and scoring	
Construction	Proportion
Numerator	Number of service users detained under the Mental Health Act (1983) for whom it was recorded that their rights under the Act were explained to them
Denominator	Total number of service users detained under the Mental Health Act (1983)
Scoring rule	1: Less than 100% of service users detained under the Mental Health Act (1983) had their rights explained 2: 100% of service users detained under the Mental Health Act (1983) had their rights explained

Indicator 3.2.1

Indicator (long title)	Proportion of care records with service user views recorded on their most recent care plan
Indicator (short title)	Service users views recorded on most recent care plan
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	Service users should be given a copy of their care plan which they have signed, which records their consent to treatment and their views (DH 1999b; DH 2006e).
Construction and scoring	
Construction	Proportion PLEASE NOTE: If a trust scores a '1' on indicator 3.2.1 the question 3.2 overall scores a '1'
Numerator	Total number of care records with service users views recorded on their most recent care plan (Q7)
Denominator	Total number of care records audited (50)
Scoring rule	1: Less than or equal to 50% of care records have service user views recorded on their most recent care plan 2: More than 50% and less than or equal to 65% of care records have service user views recorded on their most recent care plan 3: More than 65% less than or equal to 80% of care records have service user views recorded on their most recent care plan 4: More than 80% of care records have service user views recorded on their most recent care plan

Indicator 3.2.2

Indicator (long title)	Proportion of care records on which service user consent to treatment is recorded
Indicator (short title)	Consent to treatment
Data source	Mental Health Act Commission
Time period	June 1st 2005 to December 31st 2006
Rationale	<p>Under the common law valid consent is required from all patients before medical treatment can be given, except where common law or statute provides authority to give treatment without consent. The Code of Practice for the Mental Health Act 1983 (DH and Welsh Office 1999) further states that capacity to consent should be fully recorded in the patient's medical notes. Further, assessment of capacity should be undertaken whenever a specific treatment decision is proposed, as capacity can be variable over time.</p> <p>Mental capacity to consent should be assessed for all service users in relation to the arrangements made for their care, and methods of treatment being considered, to ensure they are not provided with treatment against their will unless it is in their "best interests" (TSO 2005; DH and Welsh Office 1999).</p>
Construction and scoring	
Construction	Proportion
Numerator	Number of care records which record service user consent to treatment
Denominator	Total number of care records assessed
Scoring rule	<p>1: Consent to treatment was recorded for less than 95% of service users</p> <p>2: Consent to treatment was recorded for 95% or more of service users</p>

Indicator 3.2.3

Indicator (long title)	Proportion of assessments which include identification of whether there is a carer
Indicator (short title)	Assessments identify carers
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	<p>The patient's main carers are identified and contact details are recorded (RCP 2006a). Admission and assessment protocols are clearly developed and described so that:</p> <ul style="list-style-type: none"> • carers are identified and contact details recorded • an interview is offered within three working days of admission with a named ward carer worker • the carer's views about ongoing and future involvement are recorded • carers are given an information sheet describing local arrangements • carers are offered a referral to a carers support worker • carers are provided with carers pack (by staff or carers support worker) <p>(CSIP-NIMHE 2005).</p>
Construction and scoring	
Construction	Proportion
Numerator	Total number of care records which record assessment of whether there is a carer (Q3d)
Denominator	Total number of care records audited (50)
Scoring rule	<p>1: Less than or equal to 70% of assessments identify whether there is a carer</p> <p>2: More than 70% and less than or equal to 80% of assessments identify whether there is a carer</p> <p>3: More than 80% less than or equal to 90% of assessments identify whether there is a carer</p> <p>4: More than 90% of assessments identify whether there is a carer</p>

Indicator 3.2.4

Indicator (long title)	Arrangements in place to support carers and families
Indicator (short title)	Arrangements in place to support carers and families
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers Questionnaire for trust acute care leads
Time period	2007 April 1st 2006 and March 31st 2007
Rationale	Staff who undertake assessment and care planning should have received training in how to involve patients and carers (RCP 2002b; DH 2004c; SCMH 2001). Education and training should be available for all health care personnel, which increases awareness of the patients' and or carers' individual needs (DH 2003a).
Construction and scoring	
Construction	Constructed by assigning a score to each ward as follows: 1 = Trust has less than 60% of front line ward staff trained in supporting carers and families (T12) AND the ward does not have a carer lead (W13) 2 = Trust has at least 60% of front line ward staff trained in supporting carers and families (T12) OR the ward has a carer lead (W13) 3 = Trust has at least 60% of front line ward staff trained in supporting carers and families (T12) AND the ward has a carer lead (W13) Ward level scores were then averaged and adjusted back to a three point scale.
Numerator	N/A
Denominator	N/A
Scoring rule	1: Average score is less than or equal to 1.66 2: Average score is greater than 1.66 and less than or equal to 2.34 3: Average score is greater than 2.34

Indicator 3.3.1

Indicator (long title)	Proportion of wards which use a range of methods for service user involvement
Indicator (short title)	Range of service user involvement methods used
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	2007
Rationale	Service users should be involved in planning what happens on the ward (Janner, M. 2006; DH 2002b; DH 2006c). A range of types of advocacy is provided ensuring a choice of advocacy for patients (DH 2002f). Patients' and/or carers' views or satisfaction surveys are recorded, disseminated and used in practice (DH 2003a; RCP 2002b). PALS will actively seek the views of service users, carers and the public to ensure effective services (DH 2002e). The delivery of training and education needs to be more inclusive of service user and carer training roles (DH 2002b). There should be service user representation on the PICU/low secure operational forum to promote users' views on staff recruitment and training (DH 2002d).
Construction and scoring	
Construction	Constructed by assessment of the ward use of the following methods for service user involvement: a) patient councils b) trust funded/staffed advocacy c) independent advocacy d) satisfaction questionnaire e) user audit or monitoring f) patient advice and liaison services g) patient and public involvement fora h) service user involvement in staff training i) service user involvement in recruitment Wards must use at least six out of the nine methods for service user involvement to count as a positive value in the numerator.
Numerator	Number of wards that use at least six out of nine methods for service user involvement (SU7)
Denominator	Total number of wards
Scoring rule	1: Less than or equal to 25% of wards which use a range of methods for service user involvement 2: More than 25% and less than or equal to 50% of wards which use a range of methods for service user involvement 3: More than 50% and less than or equal to 75% of wards which use a range of methods for service user involvement 4: More than 75% wards which use a range of methods for service user involvement

Indicator 3.3.2

Indicator (long title)	Proportion of wards with regular ward based community meetings to seek feedback from service users about the day-to-day running of the ward during the six months from October 1st 2006 to March 31st 2007
Indicator (short title)	Frequency of, and support for, ward based meetings to seek service user and carer feedback
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups Questionnaire for ward managers
Time period	October 1st 2006 to March 31st 2007
Rationale	There should be regular, timetabled means and forums for encouraging patient involvement in determining how the ward is run, what rules of conduct apply, and what activities are available and attended by a senior member of staff and/or PALS representative, patient advocate etc. (DH 2002b; CSIP 2005; DH 2003a; RCP 2006a). Where possible inpatients should have access to a culturally appropriate environment and advocacy (DH 2002b).
Construction and scoring	
Construction	Constructed by combined indicator using: a) Proportion of wards holding ward-based meetings at least once a week (SU5) 1 = Less than or equal to 50% of wards hold ward-based meetings at least once a week 2 = More than 50% but less than or equal to 65% of wards hold ward-based meetings at least once a week 3 = More than 65% but less than or equal to 80% of wards hold ward-based meetings at least once a week 4 = More than 80% of wards hold ward-based meetings at least once a week b) Proportion of wards that have independent facilitation 'most of the time' or 'all of the time' for ward-based meetings (SU6) 1 = Less than or equal to 25% of wards have independent facilitation 'most of the time' or 'all of the time' for ward-based meetings 2 = More than 25% but less than or equal to 50% of wards have independent facilitation 'most of the time' or 'all of the time' for ward-based meetings 3 = More than 50% but less than or equal to 75% of wards have independent facilitation 'most of the time' or 'all of the time' for ward-based meetings 4 = More than 75% of wards have independent facilitation 'most of the time' or 'all of the time' for ward-based meetings c) Proportion of wards that provide interpreters, where required, 'most of the time' or 'all of the time' for ward-based meetings (W12b) 1 = Less than or equal to 25% of wards provide interpreters where required 'most of the time' or 'all of the time' for ward based meetings 2 = More than 25% but less than or equal to 50% of wards provide

	<p>interpreters where required 'most of the time' or 'all of the time' or ward-based meetings</p> <p>3 = More than 50% but less than or equal to 75% of wards provide interpreters where required 'most of the time' or 'all of the time' for ward-based meetings</p> <p>4 = More than 75% of wards provide interpreters where required 'most of the time' or 'all of the time' for ward-based meetings</p> <p>Scores for each component (a, b and c) were averaged together then adjusted back to a four point scale.</p>
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Average score is less than or equal to 1.75</p> <p>2: Average score is greater than 1.75 and less than or equal to 2.5.</p> <p>3: Average score is greater than 2.5 and less than or equal to 3.25.</p> <p>4: Average score is greater than 3.25</p>

Indicator 3.3.3

Indicator (long title)	Involvement of service users and carers in the acute care forum
Indicator (short title)	Involvement of service users and carers in acute care forum
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	2007
Rationale	There should be an acute care forum (or equivalent), with links across the elements of the acute care system (to include intensive care) and with involvement of patients and carers to agree and regularly review the operation and co-ordination of the range of acute care services (DH 2002b; DH and Welsh Office 1999; DH 2004b).
Construction and scoring	
Construction	Constructed by assessment of regular attendance of service users and carers at acute care forum meetings (T17a and T17b). Regular is defined as attending at least half the meetings held over the year.
Numerator	N/A
Denominator	N/A
Scoring rule	1: Neither service users nor carers regularly attend ACF meetings 2: Either service users or carers regularly attend ACF meetings 3: Both service users and carers regularly attend ACF meetings

Indicator 4.1.1

Indicator (long title)	Proportion of service users who have been involved in an assault in the present patient spell, or the period January 1st to March 31st 2006, whichever is shorter*
Indicator (short title)	Service users involved in an assault
Data source	Healthcare Commission Count Me In Census
Time period	2006
Rationale	Disturbed or violent behaviour by an individual in an adult in-patient psychiatric setting poses a serious risk to that individual, other service users and staff (NICE 2005). Trusts should have zero tolerance policies towards violence (DH 1999c).
Construction and scoring	
Construction	Proportion
Numerator	Total number of service users who have been involved in an assault in the present patient spell, or period 1st January to 31st March 2006, whichever is shorter*
Denominator	Total number of service users included in the Count Me In Census 2006 for the trust
Scoring rule	1: Proportion of service users who have been involved in an assault is significantly higher than the national average proportion (unit mean) 2: Proportion of service users who have been involved in an assault is not significantly different from the national average proportion (unit mean) 3: Proportion of service users who have been involved in an assault is significantly lower than the national average proportion (unit mean)

* Please note: we made an error in the final assessment framework in the description of this indicator in that we published that the indicator was based on the the period January 1st to March 31st 2007 rather than 2006 but we had used 2006 data to calculate the results. The indicator description has therefore been revised as above.

Indicator 4.1.2

Indicator (long title)	Proportion of service users receiving medication above British National Formulary levels in the first week of admission
Indicator (short title)	Service users receiving medication above British National Formulary levels
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	Current evidence does not justify the routine use of high dose anti-psychotic medication in general adult mental health services, either with a single agent or combined antipsychotics (RCP 2006b; BNF No. 54, 2007; The Maudsley Prescribing Guidelines, 9th ed, 2007)
Construction and scoring	
Construction	Proportion
Numerator	Number of service users that received above the British National Formulary maximum dosages during the first seven days of admission (Q5)
Denominator	Total number of care records audited (50)
Scoring rule	1: More than 5% of service users received medication above BNF limits during the first seven days of admission 2: 5% or less of service users received medication above BNF limits during the first seven days of admission

Indicator 4.1.3

Indicator (long title)	Average rate of service users absent without leave from 1st October 2006 to 31st March 2007
Indicator (short title)	Service users absent without leave
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 2006 to 31st March 2007
Rationale	Inpatient services must fulfil their obligations under Section 18 of the Mental Health Act 1983 (unauthorised absence: being absent without leave, and returning) (DH and Welsh Office 1999).
Construction and scoring	
Construction	Z Score analysis (Proportion) Proportion of service users absent without leave adjusted by the number of beds and compared to the national average using Z scores.
Numerator	Number of service users absent without leave (T9a)
Denominator	Number of beds
Scoring rule	1: The average rate of service users absent without leave was significantly higher than the national average proportion (unit mean) 2: The average rate of service users absent without leave was not significantly different from the national average proportion (unit mean) 3: The average rate of service users absent without leave was significantly lower than the national average proportion (unit mean)

Indicator 4.1.4

Indicator (long title)	Average rate of bed occupancy excluding leave from October 1st 2006 to March 31st 2007
Indicator (short title)	Bed occupancy
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 1 st 2006 to March 31 st 2007
Rationale	<p>The Department of Health has not put forward recommendations for the number of acute inpatient beds required. The appropriate level of inpatient bed provision can only be properly ascertained in the context of greater clarity regarding the effective use of inpatient provision and the other national service framework acute care components (crisis resolution, respite care) and of local needs and circumstances. Service mapping, profiling information, and benchmarking exercises are needed to inform commissioning decisions on the nature of and level of future provision required and the staffing establishment and other resources required for services to operate effectively. (DH 2002b).</p> <p>The Royal College of Psychiatrists has suggested that an ideal average bed occupancy rate should be about 85%, if a safe environment is to be provided RCP 1998b). High bed occupancy rates can have a negative impact upon patients and pose a risk to patient and staff safety through higher incidents of violence and aggression (MHAC 2006; HC and RCP 2005).</p>
Construction and scoring	
Construction	Proportion
Numerator	Total number of occupied bed days from October 1st 2006 to March 31st 2007 (T5)
Denominator	Total number of available bed days from October 1st 2006 to March 31st 2007 (T6a)
Scoring rule	<p>1 = Average rate of bed occupancy without leave is less than or equal to 70% OR is greater than 100%</p> <p>2 = Average rate of bed occupancy without leave is greater than 70% and less than or equal to 75% OR is greater than 95% and less than or equal to 100%</p> <p>3 = Average rate of bed occupancy without leave is greater than 75% and less than or equal to 80% OR is greater than 90% and less than or equal to 95%</p> <p>4 = Average rate of bed occupancy without leave is greater than 80% and less than or equal to 90%</p>

Indicator 4.1.5

Indicator (long title)	Proportion of all staff who have experienced physical violence, or bullying, harassment or abuse from service users and/or relatives of service users in the last 12 months
Indicator (short title)	Staff reporting having experienced physical violence, bullying, harassment or abuse
Data source	Healthcare Commission Staff Survey
Time period	2006
Rationale	Disturbed or violent behaviour by an individual in an adult inpatient psychiatric setting poses a serious risk to that individual, other service users and staff (HC and RCP 2005). Trusts should have zero tolerance policies towards violence (DH 1999c).
Construction and scoring	
Construction	Z Score analysis (Proportion) Constructed by combined indicator using: a) Proportion of all staff who have experienced physical violence from service users and/or relatives of service users in the last 12 months b) Proportion of all staff who have experienced bullying, harassment or abuse from service users and/or relatives of service users in the last 12 months Each component was scored as follows: 1 = significantly higher than the national average proportion (unit mean) 2 = not significantly different from the national average proportion (unit mean) 3 = significantly lower than the national average proportion (unit mean) Scores for the two components (a and b) were then averaged and adjusted back to a three point scale.
Numerator	N/A
Denominator	N/A
Scoring rule	1: Average score is less than or equal to 1.66 2: Average score is greater than 1.66 and less than or equal to 2.34 3: Average score is greater than 2.34

Indicator 4.1.6

Indicator (long title)	Reviews or audits at ward level carried out (and audit cycle completed) within last year
Indicator (short title)	Audits at ward level are carried out
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	April 1st 2006 to March 31st 2007
Rationale	<p>a) levels of polypharmacy Inpatient services should audit high dose medication to monitor practice in this area (RCP 2006b). Trusts should audit use of more than one antipsychotic in accordance with NICE guidelines on schizophrenia (NICE 2002).</p> <p>b) use of rapid tranquilisation Trust should audit the use of rapid tranquillisation, seclusion and/or physical intervention to ensure that incident adequately justified the use of these interventions (NICE 2005; NICE 2002).</p> <p>c) implementation of NICE guidelines Trusts should monitor implementation of NICE guidelines in accordance with the relevant audit tools (NICE 2005; NICE 2002).</p> <p>d) use of seclusion Trust should audit the use of rapid tranquillisation, seclusion and/or physical intervention to ensure that incident adequately justified the use of these interventions (NICE 2005).</p> <p>e) levels of observation Acute care fora should monitor information on staff activity on the wards (observation, escorts, ward reviews, direct contact with service users) (DH 2002b).</p> <p>f) staffing levels/skill mix There are systems in place that ensure that all factors that will affect required staffing numbers and skill mix are taken into consideration and reviewed as and when required. Factors may include special observation, sickness and absence, training, supervision, escorts and therapeutic observation and engagement. (SCMH 2005a)</p> <p>g) training needs analysis Workforce Development Confederations (WDCs) and NHS Trusts should assess and audit training and education provision for quality, improvement, service user and carer involvement and outcome. The use of a quality improvement tool e.g. the Northern Centre for Mental Health Quality Improvement Tool, is recommended (NIMHE 2004a).</p> <p>h) provision of activities A range of activities should be developed and reviewed in consultation with patients (RCP 2006a). Services need to respond to the individual activity needs of their service users (HC and RCP 2005).</p>

Construction and scoring

Construction	<p>Constructed by a count of the following ward-based reviews and audits for which the audit cycle has been completed (ie, audit or review carried out, action plan and learning shared across all wards) (T14):</p> <ul style="list-style-type: none">a) levels of polypharmacyb) use of rapid tranquillisationc) implementation of relevant NICE guidelinesd) use of seclusione) levels of observationf) staffing levels and skill mixg) training needs analysish) provision of activities
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: Two or less types of audits or reviews had been carried out at ward level (and the audit cycle completed) within last year</p> <p>2: Three or four types of audits or reviews had been carried out at ward level (and the audit cycle completed) within last year</p> <p>3: Five or six types of audits or reviews had been carried out at ward level (and the audit cycle completed) within last year</p> <p>4: Seven or eight types of audits or reviews had been carried out at ward level (and the audit cycle completed) within last year</p>

Indicator 4.2.1

Indicator (long title)	Trust current assessment level for Clinical Negligence Scheme for Trusts
Indicator (short title)	Assessment level for Clinical Negligence Scheme for Trusts
Data source	NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST)
Time period	Date of organisation's last assessment
Rationale	Adult acute psychiatric inpatients services should provide a high standard of humane treatment and care in a safe and therapeutic setting. The physical inpatient environment and domestic arrangements must be organised to deliver a comfortable, relaxed, safe and secure environment. (DH 2002b).
Construction and scoring	
Construction	Constructed based on scores assigned by CNST, which are: 1 = CNST Level 0, the organisation has not been assessed by CNST standards 2 = CNST Level 1 which assesses whether effective risk management systems and processes have been documented (Policy). 3 = CNST Level 2 which assesses whether the systems described at Level 1 have been implemented (Practice).
Numerator	N/A
Denominator	N/A
Scoring rule	1: CNST score of 0 2: CNST score of 1 3: CNST score of 2

Indicator 4.2.2

Indicator (long title)	Proportion of clinical and administrative staff who report having received training in how to prevent or handle violence and aggression to either staff, patients or service users in the last 12 months
Indicator (short title)	Staff training in prevention or handling of violence and aggression
Data source	Healthcare Commission Staff Survey
Time period	2006
Rationale	Staff need to have the appropriate skills to manage disturbed or violent behaviour in psychiatric inpatient settings. Training in the interventions used for the short-term management of disturbed or violent behaviour safeguards both staff and service users. All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed or violent behaviour. The policy should specify who will receive what level of training, based upon risk assessment, how often they will be trained and outline the techniques in which they will be trained. All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed or violent behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed or violent behaviour (NICE 2005). The National Audit of Violence recommends that there should be a greater emphasis on the prevention of incidents within staff training for the prevention and management of violence (HC and RCP 2005).
Construction and scoring	
Construction	Proportion
Numerator	Number of clinical and administrative staff who report having received training in how to prevent or handle violence and aggression to either staff, patients or service users in the last 12 months
Denominator	Number of clinical and administrative staff respondents
Scoring rule	1: Less than or equal to 50% of staff have received training 2: More than 50% and less than or equal to 65% of staff have received training 3: More than 65% and less than or equal to 80% of staff have received training 4: More than 80% of staff have received training

Indicator 4.2.3

Indicator (long title)	Proportion of clinical staff who report having received training in assessing use of alcohol and drugs, and how to handle patients who are drunk or under the influence of drugs
Indicator (short title)	Staff training in dealing with service users who use alcohol or drugs
Data source	Healthcare Commission Staff Survey
Time period	2006
Rationale	<p>Substance misuse is a wide spread problem within acute inpatient units and psychiatric intensive care units. Inpatient staff have generally received little training in the area of dual diagnosis. Training should be available to all staff who routinely come into contact with people with a dual diagnosis, and must include medical as well as nursing, social work, psychology, occupational therapy and non-professionally qualified staff. This should include theoretical and skills based training, based upon an audit of the team's training needs. The core training needs for individuals working with people with dual diagnosis may include:</p> <ul style="list-style-type: none"> • knowledge of dual diagnosis • drug and alcohol awareness • assessment skills for substance misuse • knowledge of the management of substance misuse problems • relapse prevention for substance misuse. <p>(DH 2002c).</p> <p>The Chief Nursing Officer's report into mental health nursing (DH 2006c) recommends the need for improved training for mental health nurses in substance misuse management, both pre and post registration.</p>
Construction and scoring	
Construction	<p>Constructed as a combination of:</p> <p>a) Proportion of clinical staff who report having received training in how to ask service users about their use of alcohol or drugs (including illegal drugs)</p> <p>b) Proportion of clinical staff who report having received training in how to handle patients who are drunk or under the influence of drugs (including illegal drugs)</p> <p>Both components were scored as follows:</p> <p>1 = Less than or equal to 50% of staff have received training</p> <p>2 = More than 50% but less than or equal to 65% of staff have received training</p> <p>3 = More than 65% but less than or equal to 80% of staff have received training</p> <p>4 = More than 80% of staff have received training</p> <p>Scores for the two components were then averaged together and adjusted back to a four point scale.</p>

Numerator	N/A
Denominator	N/A
Scoring rule	1: Average score is less than or equal to 1.75 2: Average score is greater than 1.75 and less than or equal to 2.5. 3: Average score is greater than 2.5 and less than or equal to 3.25. 4: Average score is greater than 3.25

Indicator 4.2.4

Indicator (long title)	Proportion of bank and agency nursing staff from October 1st 2006 to March 31st 2007
Indicator (short title)	Use of bank and agency staff
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	October 1st 2006 to March 31st 2007
Rationale	Inpatient services should avoid high use of bank and agency staff. There should be a policy in place to ensure that bank and agency staff have the appropriate skills and induction, and that use of such staff is monitored (DH 2002b).
Construction and scoring	
Construction	Percentages were supplied by trusts in T10 Scores for acute inpatient wards and PICUs calculated separately then averaged for overall score. If the trust has no PICU, the score is based on the results for the acute inpatient wards only.
Numerator	N/A
Denominator	N/A
Scoring rule	1: More than 30% of nursing staff were bank and agency 2: More than 20% and less than or equal to 30% of nursing staff were bank and agency 3: More than 10% and less than or equal to 20% of nursing staff were bank and agency 4: Less than or equal to 10% of nursing staff were bank and agency

Indicator 4.2.5

Indicator (long title)	Proportion of service users for whom a range of risk assessments have been completed
Indicator (short title)	Range of risk assessments
Data source	Healthcare Commission bespoke data collection Care records audit
Time period	December 1st 2006 to May 31st 2007
Rationale	<p>There needs to be greater awareness of the risks of sexual vulnerability of mental health inpatients and greater protection for patients (NPSA, 2006).</p> <p>a) risk of sexual vulnerability The initial assessment of each patient's needs should include consideration of the risk of the patient being abused, or of abusing others (DH 2000).</p> <p>b) identification of predatory behaviour, potential to abuse or offend Assessment should aim to identify at an early stage any patients who may be predatory or likely to abuse or offend (DH 2000).</p> <p>c) Patterns of substance misuse Assessment of all individuals with mental health problems should actively consider the potential of substance misuse. Specialist assessments should be undertaken to determine the nature and severity of substance misuse and mental health problems, including an assessment of the service user's patterns of substance misuse, and treatment history (DH 2002c).</p>
Construction and scoring	
Construction	<p>Constructed by assessment of whether the following risk assessments are recorded in the care record (Q3e, Q3f and Q3g):</p> <p>a) assessment of risk of sexual vulnerability b) assessment of identification of predatory behaviour, potential to abuse or offend c) assessment of patterns of substance misuse</p> <p>All three risk assessments must be recorded for the care record to count in the numerator.</p>
Numerator	Number of care records with all three risk assessments recorded (Q3e, Q3f and Q3g)
Denominator	Total number of care records audited (50)

Scoring rule	<p>1: Less than or equal to 50% of service users had all three risk assessments recorded</p> <p>2: More than 50% and less than or equal to 70% of service users had all three risk assessments recorded</p> <p>3: More than 70% and less than or equal to 90% of service users had all three risk assessments recorded</p> <p>4: More than 90% of service users had all three risk assessments recorded</p>
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Indicator 4.2.6

Indicator (long title)	Proportion of ward-based nursing staff (qualified and unqualified) trained in sexual safety awareness from April 1st 2005 to March 31st 2007
Indicator (short title)	Staff trained in sexual safety awareness
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	April 1st 2005 to March 31st 2007
Rationale	There needs to be greater awareness of the risks of sexual vulnerability of mental health inpatients and greater protection for patients (NPSA, 2006). Core training for acute mental health inpatient practitioners should include awareness of women's issues/gender awareness training (DH 2003c; NIMHE 2004a).
Construction and scoring	
Construction	Percentages were supplied by trusts in T11
Numerator	N/A
Denominator	N/A
Scoring rule	1: Less than or equal to 50% of staff have received training 2: More than 50% and less than or equal to 65% of staff have received training 3: More than 65% and less than or equal to 80% of staff have received training 4: More than 80% of staff have received training

Indicator 4.3.1

Indicator (long title)	Proportion of wards which provide a range of working facilities for service users
Indicator (short title)	Range of working facilities provided for service users
Data source	Healthcare Commission bespoke data collection Questionnaire for service user groups
Time period	2007
Rationale	<p>Patients should have access to a gym and/or exercise equipment (Janner, M. 2006; NIMHE 2004b; RCP 2006a). Patients should have access to recreational, reference and self-help books, or library facilities (Janner, M. 2006; RCP 2006a). Patients should have access to a television and VCR/DVD with videos/DVDs (RCP 2006a; Janner, M. 2006). Patients should have access to the following: activities room equipped with board games, stereo, art equipment etc (NIMHE 2004b). Service users should have access to drinks and refreshments at all times (DH 2002b).</p> <p>Family friendly areas for children visitors, with a range of toys and activities, are recommended (CSIP, MHAC, Barnardos and Family Welfare Association, 2007; Janner, M. 2006). Patients should have access to the following: multi-faith prayer/worship room (NIMHE 2004b), a quiet room or areas (DH 2006c; RCP 2006a).</p>
Construction and scoring	
Construction	<p>Constructed by audit of the provision of the following facilities on each ward:</p> <ul style="list-style-type: none"> a) an area to exercise with access to exercise equipment b) current literature c) a television d) a DVD and/or video player e) a stereo and/or CD player f) games g) 24 hour access to refreshments and snacks h) toys and games for children visitors i) a quiet room <p>Wards must provide at least eight out of the nine working facilities to count as a positive value in the numerator.</p>
Numerator	Total number of wards that have eight out of nine working facilities (SU8c to SU8k)
Denominator	Total number of wards

Scoring rule	<p>1: Less than or equal to 40% of wards provide a range of working facilities for service users</p> <p>2: More than 40% and less than or equal to 60% of wards provide a range of working facilities for service users</p> <p>3: More than 60% and less than or equal to 80% of wards provide a range of working facilities for service users</p> <p>4: More than 80% of wards provide a range of working facilities for service users</p>
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Indicator 4.3.2

Indicator (long title)	Provision of an appropriate environment which maintains privacy and dignity
Indicator (short title)	Appropriate environment which promotes privacy and dignity
Data source	Healthcare Commission a) Questionnaire for trust acute inpatient leads b) Count Me In Census
Time period	a) As at March 31st 2007 b) 2006
Rationale	<p>Privacy and dignity within hospital is an important issue for patients and the public. Mixed-sex accommodation is a concern for patients, particularly women and older people (DH 2007). Mixed-sex accommodation is the Department of Health's current policy position with access to single-sex sleeping areas, bathroom and toilet, and women only day room facilities. Effective segregation on wards can be achieved which avoids either sex having to pass through (or close to) opposite sex areas (DH 2002b; DH 2007). Ward layouts should minimise the risk of overlooking or overhearing from members of the opposite gender (DH 2007). Men-only and women-only lounges are recommended (RCP 2006a).</p> <p>The Department of Health made extra funding available for 2007-08 to support improvements to estates for acute wards and psychiatric intensive care units, in accordance with the environmental safety features outlined in the NICE Management of Violence guidelines (DH 2006a; NICE 2005).</p>
Construction and scoring	
Construction	<p>Z Score analysis (Proportion)</p> <p>Constructed by combined indicator using:</p> <p>a) Proportion of single bedrooms for patients as at March 31st 2007 (bespoke data collection)</p> <p>b) Proportion of service users reported to be in single sex accommodation (Healthcare Commission Count Me In Census, 2006)</p> <p>Each component scored as:</p> <p>1 = Proportion is significantly below the national average proportion (unit mean)</p> <p>2 = Proportion is not significantly different from the national average proportion (unit mean)</p> <p>3 = Proportion is significantly above the national average proportion (unit mean)</p> <p>Scores for the two components (a and b) were then averaged and adjusted back to a three point scale.</p>
Numerator	N/A
Denominator	N/A

Scoring rule	<p>1: Average score is less than or equal to 1.66</p> <p>2: Average score is greater than 1.66 and less than or equal to 2.34</p> <p>3: Average score is greater than 2.34</p>
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Indicator 4.3.3

Indicator (long title)	Proportion of wards which provide a range of activities for service users
Indicator (short title)	Range of activities provided for service users
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	July 2nd 2007 to July 29th 2007
Rationale	<p>The National Audit of Violence (HC and RCP 2005) found that many inpatient wards/units are unable to offer service users a structured and therapeutic system of care, which has an impact upon recovery rates of service users. There is an obvious link between 'boredom' (lack of things to do) and incidents of violence.</p> <p>Inpatient services should provide structured activities. Each inpatient service needs to have a clear focus on the timetabled accommodation of therapeutic activity and engagement of service users, both on and off the ward. This may include educational, social, artistic, recreational and leisure activities (DH 2002b).</p> <p>More creative responses to service user needs for therapeutic, social and recreational activities during inpatient care need to be developed and need to be supported by inreach from multi-disciplinary teams and other community support services, including voluntary and non-statutory services (DH 2002b).</p> <p>A range of activities should be developed and reviewed in consultation with patients (RCP 2006a). Services need to respond to the individual activity needs of their service users (HC and RCP 2005).</p>
Construction and scoring	
Construction	Constructed by assessment of the provision of the following activities: <ul style="list-style-type: none"> a) art and craft activities b) cooking c) exercise d) faith and spiritual e) gardening f) music g) discussion groups h) relaxation and meditation i) social events j) community trips k) education groups l) women's groups m) men's groups
Numerator	Total number of mixed gender wards that delivered nine out of 13 activities and the total number of male-only and female-only wards that delivered eight out of the 12 activities applicable (W1)
Denominator	Total number of wards

Scoring rule	<p>1: Less than or equal to 40% of wards provide a range of activities for service users</p> <p>2: More than 40% and less than or equal to 60% of wards provide a range of activities for service users</p> <p>3: More than 60% and less than or equal to 80% of wards provide a range of activities for service users</p> <p>4: More than 80% of wards provide a range of activities for service users</p>
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Indicator 4.3.4

Indicator (long title)	Proportion of activities delivered in evenings and weekends during the four weeks from July 2nd 2007 to July 29th 2007
Indicator (short title)	Activities provided in evenings and weekends
Data source	Healthcare Commission bespoke data collection Questionnaire for ward managers
Time period	July 2nd 2007 to July 29th 2007
Rationale	According to the National Audit of Violence (HC and RCP 2005) service users reported higher level of boredom during evenings and weekends, compared to during the day, owing to a lack of available therapies and activities. Services should respond on an individual basis to service users' assessed activity needs.
Construction and scoring	
Construction	Proportion
Numerator	Total number of activity sessions delivered in the evenings and at weekends (W3)
Denominator	Total number of activity sessions delivered (W2)
Scoring rule	<p>1: Less than or equal to 20% OR more than 50% of activities were delivered in the evening or at weekends</p> <p>2: More than 20% and less than 30% OR more than 40% and less than or equal to 50% of activities were delivered in the evening or at weekends</p> <p>3: More than 30% and less than or equal to 40% of activities were delivered in the evening or at weekends</p>

Indicator 4.3.5

Indicator (long title)	Service user access to an electro-convulsive therapy (ECT) clinic/s that have enrolled with or been accredited by the Electro Convulsive Therapy Accreditation Service (ECTAS) as at July 29th 2007
Indicator (short title)	Service user access to an electro-convulsive therapy clinic that has been enrolled with and/or accredited by the Electro Convulsive Therapy Accreditation Service
Data source	Healthcare Commission bespoke data collection Questionnaire for trust acute inpatient leads
Time period	2007
Rationale	<p>NICE guidance (NICE 2003) recommends that electro-convulsive therapy (ECT) should only be used for the treatment of severe depressive illness, a prolonged or severe episode of mania, or catatonia, under particular conditions. ECT should be used to gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life-threatening.</p> <p>The ECTAS (Electro-convulsive Therapy Accreditation Service) programme enables participating clinics to assure themselves and improve the quality of the administration of ECT. The three-year accreditation process is subject to annual self-review and peer review. Accreditation provides clinics with detailed advice and support about areas in need of improvement. It also enables clinicians and managers to focus on their ECT service provision, and to continuously develop and revise current standards focusing on best practice. (RCP website: http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/electroconvulsivetherapy.aspx).</p>
Construction and scoring	
Construction	T19 and T20
Numerator	N/A
Denominator	N/A
Scoring rule	<p>1: None of the ECT clinics to which service users have access has been enrolled with ECTAS as at July 29th 2007</p> <p>2: Some of the ECT clinics to which service users have access to have been enrolled or some of the ECT clinics have been accredited with ECTAS as at July 29th 2007</p> <p>3: All of the ECT clinics to which service users have access have been enrolled with ECTAS as at July 29th 2007</p> <p>4: All of the ECT clinics to which service users have access have been accredited by ECTAS as at July 29th 2007</p>

Appendix B

Key for policy documents

British National Formulary No. 54 (2007)

Care Services Improvement Partnership (2005) *Moving On: Key Learning from Rowan Ward*

Care Services Improvement Partnership and Department of Health (2006) *A National Survey of Crisis Resolution Teams in England*

Care Services Improvement Partnership: National Institute for Mental Health In England (2005) *Our Choices in Mental Health: Improving Choice for People who Use Mental Health Services*

Care Services Improvement Partnership: National Institute for Mental Health In England (2007) *A Positive Outlook: A Good Practice Toolkit to Improve Discharge from Inpatient Mental Health Care*

Care Services Improvement Partnership, Mental Health Act Commission, Barnardos and Family Welfare Association (2007) *Parents in Hospital: How Mental Health Services Can Best Promote Family Contact When a Parent is in Hospital*

Council of Europe (2004) *Committee of Ministers Recommendation Rec (2004)10 of the Committee of Ministers to Member States Concerning the Protection of Human Rights and Dignity of Persons with Mental Disorder*

Department of Health (1994) *HSG(94)27: Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community*

Department of Health (1999a) *A National Service Framework for Mental Health*

Department of Health (1999b) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*

Department of Health (1999c) *HSC 1999/226 Campaign to Stop Violence Against Staff Working in the NHS: NHS Zero Tolerance Zone*

Department of Health (2000) *Safety, Privacy and Dignity in Mental Health Units*

Department of Health (2001a) *Improving Working Lives National Audit Tool*

Department of Health (2001b) *Mental Health Information Strategy*

Department of Health (2001c) *Mental Health National Service Framework (and the NHS Plan): Workforce Planning, Education and Training Underpinning Programme*

Department of Health (2001d) *Mental Health Policy Implementation Guide*

Department of Health (2002a) *A Sign of the Times: Modernising Mental Health Services for People Who Are Deaf*

Department of Health (2002b) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*

Department of Health (2002c) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*

Department of Health (2002d) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units and Low Secure Environments*

Department of Health (2002e) *Supporting the Implementation of PALS: A Resource Pack*

Department of Health (2002f) *Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice*

Department of Health (2003a) *Essence of Care: Patient-Focused Benchmarks for Clinical Governance*

Department of Health (2003b) *Inside Out: Improving Mental Health Services for Black and Ethnic Minority Communities in England*

Department of Health (2003c) *Mainstreaming Gender and Women's Mental Health: Implementation Guidance*

Department of Health (2003d) *Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for People With Personality Disorder*

Department of Health (2004a) *Choosing Health: Making Healthy Choices Easier*

Department of Health (2004b) *Green Light for Mental Health: How Good are Your Mental Health Services for People With Learning Disabilities. A Service Toolkit*

Department of Health (2004c) *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*

Department of Health (2005a) *Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services and the Government's Response to the Independent Enquiry into the Death of David Bennett*

Department of Health (2005b) *Valuing People: A New Strategy for Learning Disability for the 21st Century*

Department of Health (2006a) *Capital Allocation Process: £130 Million for Adult Mental Health Services*

Department of Health (2006b) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings: Guidance on the Assessment and Management of Patients with Mental Health Inpatient and Day Hospital Settings*

Department of Health (2006c) *From Values to Action: The Chief Nursing Officer's Review of Mental Health Services*

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