National Clinical Audit of Anxiety and Depression (NCAAD)

What are the experiences and perspectives of adults who are accessing secondary care psychological therapy for anxiety or depression?

Methodology

Audit governance

NCAAD is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). It is managed by the Royal College of Psychiatrists' (RCPsych) Centre for Quality Improvement (CCQI), working in close partnership with professional, service user and carer representatives including:

- Anxiety UK;
- British Psychological Society;
- Care Quality Commission;
- Carers Trust;
- Healthcare Quality Improvement Partnership;
- The McPin Foundation;
- Mind;
- Rethink Mental Illness;
- The Royal College of General Practitioners;
- The Royal College of Nursing;
- RCPsych.

Representatives from partner organisations collaborating in the audit comprise our Steering Group, together with six representatives with experiences of living or supporting someone living with anxiety and depression, and the audit Project Team.

Audit standards

Unlike the core audit and spotlight audit on secondary care psychological therapy services, performance was not measured against standards. However, the results from the analysis were cross-referenced against the standards that services were measured against in the core audit and first spotlight audit. For the spotlight audit on psychological therapies eight standards were derived from national and professional guidance, including those from the National Institute for Health and Care Excellence (NICE).

Participation in the audit

The NCAAD is applicable to all NHS-funded secondary care psychological therapy services in England that provide care to service users with a diagnosis of anxiety and depression aged 18 and over.

The following services were excluded:

- Services that are part of the national IAPT programme;
- Specialist psychosis services (e.g. Early intervention in psychosis services);
- Forensic mental health services (inpatient and community);
- Eating disorder services;
- Specialist personality disorders services.

Identification of sample and eligibility criteria

Each service was responsible for identifying their sample of service users and distributing a survey to eligible service users. Services were also responsible for explaining the purpose of the survey using a letter template provided by the NCAAD team. All service users meeting the eligibility criteria used for the spotlight audit of psychological therapies could complete the survey. The service user survey was then distributed to 30 randomly chosen service users who had ended psychological therapy with a participating service between 01 September 2017 and 31 August 2018. This included service users who completed therapy, as well as those who did not complete or dropped out.

Data Collection

Each service was provided with a code (their Trust code followed by A, B, C, etc).

A link to an online survey (SNAP) was provided to the services. The first box of the survey instructed people to enter the service code so that the NCAAD team knew which service the survey was from. Services were also sent a limited number of paper surveys that they could give directly to patients. Completed paper surveys were then sent back to the NCAAD team who then entered the data into SNAP on the service user's behalf.

There may have been some inconsistency as to who received the service user survey. Some services may have sent the survey only to service users whose casenotes were identified as being eligible for the casenote audit. Other services may have sent the survey to all service users who had a diagnosis of anxiety and/or depression and were over 18.

Data Handling and Analysis

All data were entered using Snap Survey Software via secure webpages. The first spotlight audit was an analysis of the quantitative data provided in the service user survey, whilst the second spotlight was an analysis of the qualitative data.

As the NCAAD team wanted to gain an insight into whether service users' concerns about psychological therapies were fully reflected, an inductive approach was taken to the data. This facilitated reflection on the audit and the audit process. The data was a collection of comments of varying sizes (447 comments in total). In order to create the coding framework a small amount of charting took place before coding straight from the quotes. This resulted in the varying data on each theme being in one place to allow

for analysis. An inter-rater reliability check was then conducted on the coding framework with an expert by experience (see below).

A thematic analysis was conducted on the data. The analysis team met weekly, discussing the main concepts and themes that were emerging out of the data and any reflections or questions the team were having.

Once the analysis of the original data had been conducted, a Service User and Carer Reference Group met to discuss the results. The group was led by an expert by experience and attended by six service users and carers. The group reflected on the themes found so far and fed back from their own experiences on the themes covered.

Following the reference group, an e-consultation was held with both the Service User and Carer Reference Group and the Steering Group to clarify any questions that the analysis team still had.

Data Cleaning

Data cleaning was conducted as the survey data was entered, removing identifiable information. Where words were ineligible the team would discuss before deciding to write [ineligible].

Inter-rater reliability

Inter-rater reliability checking was conducted by an expert by experience once an initial coding frame had been developed. The inter-rater reliability between the coders was 95%, in line with Miles and Huberman (1994) that 80% agreement on 95% of codes is sufficient.[1]

Coding framework

1. Accessibility

    1.1 Availability of therapy

    - 1.1.1 Duration (extent to which therapy was of an appropriate duration i.e. total no. of sessions was enough and was over a sufficiently long period of time, whether each session was appropriate length of time)
    - 1.1.2 Frequency (extent to which service user had access to treatment at an appropriate frequency)
    - 1.1.3 Threshold for access/assessment of need (extent to which this was considered appropriate, or whether threshold was set too high to enable access to treatment)
    - 1.1.4 Timeliness (extent to which service user could access therapy at the point of need without delay, whether therapy sessions were available at a suitable time of day/week)

[1] Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook (Second Edi). Sage Publications

1.2 Physical accessibility (of building where therapy took place, and extent to which geographical location/travel times were appropriate)

2. Therapist

2.1 Demographic (extent to which demographics of therapist were considered appropriate e.g. female client felt comfortable with a male therapist)

2.2 Manner/characteristics (aspects of therapist's character and manner that impacted on experience of therapy e.g. whether they were professional, supportive, flexible, non-judgemental, understanding, respectful and empathetic, whether patient and therapist 'connected')

2.3. Professional experience (extent to which therapist had appropriate professional experience e.g. experience of treating people with particular issues)

2.4 Continuity (whether person saw same therapist over course of treatment or whether were any changes of therapist)

3. Therapy content

3.1 Information on therapy approach (extent to which therapist provided information on/explained the therapy approach they would use)

3.2. Content and approach of therapy sessions (extent to which appropriate type of therapy was offered (e.g. ACT, CBT, individual or group), whether client had choice of therapy and was tailored to client's needs, whether effective techniques were used, e.g. at appropriate pace, set goals and tasks)

3.3 Onward-planning (whether therapist provided support for onward journey after end of therapy, e.g. signposting to other support sources, providing with tools to self-manage, whether same therapist provided follow-up session)

4. Communications and administration/bureaucracy

4.1 Communications from administrative system (whether communications were efficient and proactive, whether kept client informed, GP role as gatekeeper/advocate)

4.2 Continuing care pathway/re-referral (whether further treatment was offered/accessed to those who needed it after initial treatment ended, i.e. so that person did not feel abandoned/cut off/lost, extent to which care pathway was sufficiently joined-up for successful referral from one course of treatment to the next)

5. Physical environment

5.1 Environment of therapy sessions (whether physical space where sessions took place was deemed appropriate)

6. Impact on individual

    6.1 How therapy impacted on them, nature of experience

7. Other