NCAAD
NATIONAL CLINICAL AUDIT OF ANXIETY AND DEPRESSION

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

National Clinical Audit of Anxiety and Depression (NCAAD)

Core Audit of Practice Guidance 2018/2019

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About this Guidance

The Core Audit of Practice Guidance has been produced to assist local staff completing the National Clinical Audit of Anxiety and Depression (NCAAD) Core Audit. It contains detailed information on how to answer the questions and should be kept to hand for reference.

We hope that you find this guidance helpful. If you encounter any difficulties whilst completing the audit, please contact the NCAAD project team.

NCAAD Project Team Contacts

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Key Dates

Core Audit

22 January 2018	Registration for the core audit OPENS
16 March 2018	Registration for the core audit CLOSES
19 - 31 March 2018	Core audit information pack sent to registered Trusts/organisations electronically and by post
20 April 2018	Sampling deadline
4 June 2018	Online data collection for the core audit OPENS
7 September 2018	Online data collection for the core audit CLOSES
January - April 2019	Trusts/organisations receive their individualised local reports and materials for disseminating findings at an organisational level

Eligibility Criteria for Service Users

Each Trust/organisation is asked to submit a sample of casenotes for service users admitted to an inpatient mental health service between **01 April 2017** and **30 September 2017** meeting the following eligibility criteria:

Criteria for service users to be INCLUDED in the audit:

- Aged 16 years or over (no upper age limit);
- Primary diagnosis or condition of an anxiety and/or depressive disorder as identified using the International Classification of Diseases (ICD-10) coding, at the point of discharge.

A full list of eligible ICD-10 codes can be found in Appendix 1: Eligible ICD-10 Codes.

Please note that service users with the following characteristics are EXCLUDED from the audit:

- Psychosis based diagnoses (including F32.3 Severe depressive episode with psychotic symptoms);
- Bipolar affective disorder (F31), Cyclothymia (F34.0) or mania (F30);
- Those who were admitted to a forensic service or long stay ward such as a rehabilitation service.

A full list of excluded ICD-10 codes can be found in Appendix 2: Excluded ICD-10 Codes.

Core Audit of Practice Tool Guidance

All questions in the Core Audit of Practice Tool are mandatory, unless specified otherwise.

Questions marked with an asterisk in this guidance are aligned with the Mental Health Services Data Set (MHSDS).

Audit Period:

By the audit period we mean information about the service user's care and treatment from the point of admission to the inpatient service up to and including information six-months post-admission. For example, if a service user was admitted on 02 April 2017, the information submitted should be based on their casenotes between 02 April 2017 and 02 October 2017 inclusive.

Using the Online Tool:

Navigating between pages - The *Next* and *Back* buttons allow you to navigate between pages. Any questions you have answered will save automatically.

Save – The *Save* option can be used at any point. Please follow the instructions to save the data entered so far.

Resetting the page - The *Reset* button will only clear the answers on the current page.

Submitting the document - Please ensure you have checked the data before submitting. You will NOT be able to make any changes once it has been submitted.

Responses:

The following responses are applicable throughout the audit:

Service user declined to answer - Select this response if it is clear from the casenotes that effort had been made to gather this information from the service user and that they have declined to answer. If it is not clear, please select 'Unknown/not documented'.

Unknown/not documented – Select this response if information is not recorded in the casenotes, and/or it is not clear from the casenotes that the service user has been asked for this information.

Documented evidence of refusal to have (physical health tests) – Select this response if there is documented evidence of refusal to have physical health tests (e.g. blood pressure) on more than one occasion, after it is assured that the person has been given the information on which to make an informed decision.

Question Routing:

Some of the questions are NOT applicable to every service user – these questions are shaded in grey for reference on both the audit tool and this guidance document. Please note the guidance at the start of these questions to identify whether or not you need to complete them. On the online tool, these questions will be routed according to previous answers.

TRUST/ORGANISATION INFORMATION

Trust/Organisation Code

This should be auto-filled - if there is an issue with the code, please get in touch with the local audit lead from your Trust/organisation, or contact the NCAAD project team on ncaad@rcpsych.ac.uk.

Data Collector Name

We will use this information to contact you should there be any queries with the submission.

Service User ID

This is a unique code that your Trust/organisation assigned to each of the eligible service users to ensure anonymity. If the casenote is a data reliability check '-REL' will be added to the end of the ID; for example if you are re-auditing casenote ABC9, this will be ABC9-REL.

This ID should be auto-filled on the online tool. If you are completing a paper copy of the tool you will need to confirm the service user ID with your audit team and enter this manually.

If there is an issue with the code, please get in touch with the local audit lead from your Trust/organisation, or contact the NCAAD project team on ncaad@rcpsych.ac.uk.

Responsible CCG's ODS code

This ID should be auto-filled on the online tool. If you are completing a paper copy of the tool you will need to confirm the ODS code with your audit team and enter this manually.

If there is an issue with the code, please get in touch with the local audit lead from your Trust/organisation, or contact the NCAAD project team on ncaad@rcpsych.ac.uk.

Q1-6. SERVICE USER INFORMATION

1. Age on admission

2. Gender

Non-binary/other	Service user considers themselves to be: • Neither female or male; • Any other gender not listed e.g. transgender.

3. *Ethnicity

4. *Employment status at time of admission

Employed – less than 16 hours per week	Service user was working up to 15 hours per week. Also includes those were are on 'zero hours' contracts.
Employed – 16 or more hours per week	Service user was working 16 hours or more. Also includes those who were: • Self-employed (i.e. those who worked for themselves and generally pay their National Insurance); • In supported employment; • In permitted work (i.e. those who were in paid work and who were also receiving Incapacity Benefit).
Homemaker	Service user was looking after family or home, and not working or actively seeking work.
Long-term sick leave/disabled and receiving incapacity benefit, income support etc.	Service user was on long-term sick leave or disabled. Also includes those who were receiving: • Incapacity Benefit, Income Support or both; • Employment and Support Allowance.
Not receiving benefits and not working or actively seeking work	Service user was not receiving benefits, and not working or actively seeking work.
Retired	Service user withdrew from working or professional career/ceasing to work.
Student	Service user was formally engaged in learning and not working or actively seeking work.

Unemployed and seeking work	Service user was not in paid work but actively seeking employment and available to start. Also includes those who were waiting to start a paid job they have already obtained.
Unpaid voluntary work who are not working or actively seeking work	Service user was undertaking unpaid voluntary work for which they were not receiving any direct remuneration and those not in paid employment or actively seeking paid employment.

5. *Accommodation status at time of admission

Please note the below list is not exhaustive.

Mainstream housing	Examples may include service users who were: • Homeowners; • In settled housing with family/friends; • Part of a shared ownership scheme e.g. Social Home Buy Scheme; • Tenants of either the local authority/housing association or a private landlord.
Accommodation with criminal justice support	Examples may include: • Bail/Probation hostel; • Prison; • Other accommodation with criminal justice support such as ex-offender support.
Accommodation with mental health care support	Examples may include service users who were in: • Supported accommodation (accommodation; supported by staff or resident caretaker) • Supported group home (supported by staff or resident caretaker); • Mental Health Registered Care Home; • Other accommodation with mental health care and support.
Accommodation with other (not specialist mental health) care support	Examples may include: • Foyer - accommodation for young people aged 16-25 who are homeless or in housing need; • Refuge; • Non-Mental Health Registered Care Home; • Other accommodation with care and support (not specialist mental health).
Acute/long stay healthcare residential facility/hospital	Examples may include: • Specialist rehabilitation/recovery; • Secure psychiatric unit; • Other NHS facilities/hospital;

	• Other acute/long stay healthcare residential facility/hospital.
Homeless	Examples may include service users who were: • Sleeping rough; • Squatting; • In a night shelter/emergency hostel/direct access hostel; • Sofa surfing (sleeps on different friends floor each night); • Placed in temporary accommodation by Local Authority (including homelessness resettlement service) e.g. Bed and Breakfast accommodation; • Staying with friends/family as a short-term guest.
Sheltered housing	Accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary. Examples may include: • Sheltered housing for older persons; • Extra care sheltered housing (for people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.); • Nursing Home for older persons.
Other	Any other accommodation not listed.

6. Is there an identified family member, friend or carer, who is the main source of support for the service user?

Yes - There are details in the casenotes of an identified family member, friend or carer (which include name and contact number).

No - There is NO record in the casenotes of an identified family member, friend or carer.

Please also select 'No' if the service user:

- Declined to disclose details;
- Was asked for information but does not have an identified family member, friend or carer.

Q7-8. DIAGNOSIS

7. Primary diagnosis/condition at discharge

Please select only ONE primary diagnosis/condition.

The listed diagnoses and corresponding codes are taken from the ICD-10. Please c Appendix 1: Eligible ICD-10 Codes and Appendix 2: Excluded ICD-10 Codes to ensure the service user is eligible.

8. Additional diagnoses/conditions at discharge

Please select ALL that apply.

The listed diagnoses and corresponding codes are taken from the ICD-10. Items in red include diagnoses which may be excluded from the audit – please check Appendix 1: Eligible ICD-10 Codes and Appendix 2: Excluded ICD-10 Codes to ensure the service user is eligible.

Q9-14. ADMISSION

9. Date and time hospital was notified of need for a bed (DD/MM/YYYY; HH:MM, 24hr)

10. Date of admission (DD/MM/YYYY)

11. Time of admission (HH:MM, 24hr)

12. Type of admission

Planned	Examples may include: • Admission planned in advance for the initiation of medication; • Respite care.
Emergency via Crisis Resolution/Home Treatment Team (CRHT)	Service user received intensive treatment at home when the decision was made that they should be admitted to hospital, as they were experiencing a mental health crisis which could no longer be safely managed at home.
Emergency via Emergency Department	Unplanned admission – service user was admitted urgently or in an emergency after presenting at an Emergency Department (A&E). *If the service user was bought to the Emergency Department under Section 136/135 please select 'Admitted*

	via section 136/135 from a Health Based Place of Safety (HBPoS)'
Emergency via Community CAMHS or Community Mental Health Team (CMHT)	Service user received an outpatient appointment with a nurse/psychiatrist/care coordinator etc. and the decision was made that they should receive treatment in hospital for a period of time.
Transfer from other inpatient mental health service	Service user was transferred to the current service from another inpatient mental health service.
Transfer from acute hospital service	Service user was transferred to the current service from an acute hospital service (e.g. was an inpatient on a ward in an acute/general hospital).
Admitted via section 136/135 from a Health Based Place of Safety (HBPoS)	Service user was removed from a public place or private residence as they appeared to be suffering from a mental disorder to a place of safety, after which a decision was made to admit them to hospital for assessment and/or treatment.
Police custody	Service user may or may not have been detained by the Police under Section 136, but prior to admission was held in Police custody as a place of safety.

13. Was the admission voluntary?

Yes – Service user agreed to be treated in an inpatient facility.

No - Service user was admitted under the Mental Health Act - Service user was admitted for inpatient treatment under mental health legislation.

14. Mental Health Act classification

Only answer if the service user was admitted under the Mental Health Act as recorded in Q13.

Q15-20. ASSESSMENT

Please answer the following questions based on all information gathered from the service user up to the point of discharge from the inpatient service.

In this section, please only select N/A if the question was considered during the assessment and was not applicable to the service user.

15. Did the assessment include information about the service user's past responses to treatment?

Yes – Service user has previously had treatment and there is evidence in the casenotes that responses to this were considered as part of the assessment process.

Information may include:

- Did previous medication successfully reduce the symptoms that the service user was experiencing?
- Did the service user take the medication as prescribed? If not, why not?
- Has the service user previously engaged in psychological therapies?
- If so, did psychological therapies reduce the symptoms that the service user was experiencing?
- Service user's treatment preferences based on previous experiences.

No - Service user has previously had treatment but there is NO evidence in the casenotes that this was considered as part of the assessment process.

N/A – There is NO evidence in the casenotes that the service user had any previous treatment.

16. Did the assessment include information about the service user's difficulties in relation to their:

Employment and/or education	Examples may include: • Recent loss of employment; • Absenteeism; • Struggling to keep up with workload; • Relationships with colleagues; • Currently in full/part-time education.
Financial situation	Examples may include: • Debt; • Financial strain.
Social situation	Examples may include: • Homelessness/unstable accommodation; • Substance misuse issues; • Social isolation; • Lack of/no support network.

17. Did the assessment include information about the service user's dependents (e.g. children, elderly relatives)?

18. Did the assessment consider whether the service user had a history of trauma?

The definition of trauma should be defined by the service user's experience rather than the severity of the event. Examples include violent events (e.g. shooting; mugging and/or burglary; bullying; sexual, emotional and/or physical abuse; domestic violence; child abuse/neglect; natural disasters).

Consideration may be given to experiencing several smaller traumas (e.g. being teased or bullied at school; losing friends by moving schools during childhood; a teacher shouting at them in front of the whole class; the death of a pet; losing a job; divorce).

19. Was the identified family member, friend or carer provided with information about available support services and/or a support plan?

Only answer if the service user has an identified family member, friend or carer as recorded in Q6.

Information about available support services	There is evidence in the casenotes that the family member, friend or carer has been signposted to local support services such as carer support groups/forums, community support and activities, information and advisory services, and financial support
Support plan	There is evidence in the casenotes of a support plan for the family member, friend or carer which outlines how the service will help them to support their own needs. (e.g. help with housework; becoming a member of a gym to look after their own health; replacement care/respite to allow them to take a break and/or stress management).

20. Was the identified family member, friend or carer offered a carer's assessment?

Only answer if the service user has an identified family member, friend or carer as recorded in Q6.

Q21-24. CARE PLANNING

Please answer the following questions based on all information in the service user's casenotes up until the point of discharge from the inpatient service.

21. Did the service user have a care plan?

If you have selected 'No' to this question, please skip to Q25-37 Medication.

22. Is there evidence that the care plan was jointly developed between the service user and clinician?

Only answer if the service user has a care plan as recorded in Q21.

Yes - There is evidence in the casenotes that efforts have been made to engage the service user in the development of the care plan (e.g. 'John has agreed to go shopping once a week with the community occupational therapist').

No - There is NO evidence in the casenotes that efforts were made to engage the service user in the development of the care plan.

23. Was the service user given a copy of their care plan?

Only answer if the service user has a care plan as recorded in Q21.

24. Did the care plan include an agreed date for a review?

Only answer if the service user has a care plan as recorded in Q21.

Q25-37. MEDICATION

Please answer the following questions based on all information in the service user's casenotes up until the point of discharge from the inpatient service.

25. Was the service user being prescribed psychotropic medication at the point of discharge?

If you have selected 'No' to this question, please skip to Q28-36 Psychological Therapies.

If you have selected 'Yes' to this question, please specify the DAILY dosage of ALL psychotropic medication being prescribed. Please also provide details of any psychotropic medication that are not listed.

The medication list is taken from the British National Formulary (BNF). When entering data please note the dosage units, **if you exceed the expected maximum dosage, you will be asked to review the data entered.**

26. Was the service user given verbal and/or written information about their medication prior to discharge?

Only answer if the service user was being prescribed psychotropic medication at the point of discharge as recorded in Q25.

Verbal and/or written information could include a discussion with the clinician and/or the distribution of information e.g. leaflets about the following:

- The function of different medications;
- Importance of taking medication as prescribed;
- Limitations;
- Benefits;
- Side effects.

Please note: Written information provided should be beyond the patient information leaflet (PIL)/package leaflet included in dispensed medication packaging.

27. Did a review of the service user's medication(s) take place prior to discharge?

Only answer if the service user was being prescribed psychotropic medication at the point of discharge as recorded in Q25.

If you have selected 'Yes' to this question, please indicate whether the review included: response to medication and/or side effects of medication.

Q28-36. PSYCHOLOGICAL THERAPIES

Please answer the following questions using information in the service user's casenotes during the audit period.

28. Was the service user referred to psychological therapy?

Yes - There is evidence in the casenotes that the Trust/organisation has referred the service user to a psychological therapy service.

If you have selected 'Yes' to this question, please provide the dates of referral and assessment (if this information is available).

No - There is NO evidence in the casenotes that the Trust/organisation has referred the service user to a psychological therapy service.

If you have selected 'No' to this question, please skip to Q37-44 Physical Health.

29. Which type(s) of psychological therapy was the service user referred to?

Only answer if the service user was referred to psychological therapy as recorded in Q28.

30. Who was the referral for INDIVIDUAL psychological therapy made to?

Only answer if the service user was referred to INDIVIDUAL therapy as recorded in Q29.

Private	Service user is paying for a private therapist.
IAPT	Improving Access to Psychological Therapies Services
Third sector	This includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups).
Other	Any other type of service not listed.

31. Has the service user started INDIVIDUAL psychological therapy?

Only answer if the service user was referred to INDIVIDUAL therapy as recorded in Q29.

Yes - The service user has attended **at least one** treatment session.

If you have selected 'Yes' to this question, please provide the date of first treatment session.

32. Please select the reason why INDIVIDUAL psychological therapy has not yet started

Only answer if the service user has NOT yet started INDIVIDUAL therapy as recorded in Q31.

Service user on waiting list	Service user is currently on a waiting list for the required psychological therapy.
Service user chose not to participate	Service user has made the decision themselves that they do not want to engage with psychological therapies at this time.
Service user is not currently able to engage	Service user may not be well enough currently to participate in treatment but will re-engage when appropriate.
Other	Please state any other reasons not listed above.

33. Which INDIVIDUAL psychological therapy has the service user received?

Only answer if the service user has started INDIVIDUAL therapy as recorded in Q31.

34. Has the service user started GROUP/FAMILY/COUPLES therapy?

Only answer if the service user was referred to GROUP/FAMILY/COUPLES therapy as recorded in Q29.

Yes - The service user has attended **at least one** treatment session.

If you have selected 'Yes' to this question, please provide the date of first treatment session.

35. Please select the reason why GROUP/FAMILY/COUPLES therapy has not yet started

Only answer if the service user has NOT yet started GROUP/FAMILY/COUPLES therapy as recorded in Q34.

36. Which GROUP/FAMILY/COUPLES therapy has the service user received?

Only answer if the service user has started GROUP/FAMILY/COUPLES therapy as recorded in Q34.

Q37-44. PHYSICAL HEALTH

37. Current/most recent BMI

Please record BMI in the format *NN.N*.

Body Mass Index (BMI) calculation is the service user's weight (kilograms) divided by their height (meters) squared – **(Kg/m^2).**

38. Current/most recent blood pressure

Only answer if the service user is being prescribed antipsychotic medication as recorded in Q25.

Please only answer 'recorded' if you are able to find the values for their blood pressure within their case notes.

39. Current/most recent glucose level

Only answer if the service user is being prescribed antipsychotic medication as recorded in Q25.

Please only answer 'recorded' if you are able to find the values for their blood glucose within their case notes. You may find any or all of the following measures recorded in their case notes:

- **Fasting Plasma Glucose Test (FGT)**
- **Glycated Haemoglobin (HbA1c)**
- **Random Plasma Glucose**

40. Current/most recent cholesterol level

Only answer if the service user is being prescribed antipsychotic medication as recorded in Q25.

Please only answer 'recorded' if you are able to find the values for their cholesterol levels within their case notes. You may find any or all of the following measures recorded in their case notes:

- **Total cholesterol** - The sum of HDL and LDL
- **Non-HDL cholesterol -** The total cholesterol minus HDL cholesterol
- **QRISK®2** (cardiovascular disease risk calculator)

41. Smoking status at the point of admission

Current smoker	Service user smoked more than 100 cigarettes in their lifetime and currently smokes at least monthly. *If you have selected this option, please state the number of cigarettes on average the service user smokes per day in numerical digits.*
Ex-smoker	Service user has smoked more than 100 cigarettes in their lifetime but does not currently smoke.

Never smoked	Service user has never smoked, or has smoked less than 100 cigarettes in their lifetime, and does not currently smoke.

42. Alcohol intake at the point of admission

Please record service user's WEEKLY alcohol intake in UNITS. For further guidance on units of alcohol please see http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx.

43. Was the service user identified as misusing alcohol/drugs, at the point of admission?

Alcohol/drug misuse refers to the use of legal or illicit substances in a way that causes mental or physical damage. This may include low levels of drug use, using drugs for unintended purposes or using a drug in excessive quantities.

A variety of drugs can be misused, including:

- Illegal drugs (e.g. heroin, cocaine, cannabis etc.);
- Prescription medicines (e.g. tranquilisers, painkillers etc.);
- Other medicines that can be bought from supermarkets and other retailers (e.g. cough mixtures, herbal remedies etc.).

44. Which of the following interventions were offered prior to discharge?

Brief interventions are intended to trigger an attempt to alter the service user's lifestyle (e.g. give up smoking) and include advising the service user on the best way of doing this. Advising the service user to change their lifestyle should not be counted as a stand-alone intervention - it needs to be accompanied by advice on the best way of doing this and an offer of a referral or support to do this if appropriate.

Q45-52. DISCHARGE

45. Was the service user discharged from inpatient services during the audit period?

If you have selected 'Yes' to this question, please provide the date and time of discharge.

If you have selected 'No' to this question, please skip to Q57-59 Outcome Measures.

46. Was the service user given at least 24 hours notice of discharge?

Only answer if the service user was discharged during the audit period as recorded in Q45.

47. Was the identified family, friend or carer given at least 24 hours notice of discharge?

Only answer if the service user has an identified family member, friend or carer as recorded in Q6 and was discharged during the audit period as recorded in Q45.

48. At discharge, was the service user given to take home (TTOs) medication?

Only answer if the service user was being prescribed psychotropic medication as recorded in Q25 and was discharged during the audit period as recorded in Q45.

TTOs are a supply of medicines issued to service users to take home after being discharged from hospital.

If you have selected 'Yes' to this question, please state the number of days the TTOs were prescribed for.

49. Did a review of the service user's medication(s) take place between discharge and the end of the audit period?

Only answer if the service user was being prescribed psychotropic medication as recorded in Q25 and was discharged during the audit period as recorded in Q45.

If you have selected 'Yes' to this question, please indicate whether the review included: response to medication and/or side effects of medication.

50. Was a discharge letter sent to the service user's GP?

Only answer if the service user was discharged during the audit period as recorded in Q45.

If you have selected 'Yes' to this question, please provide the date discharge letter was sent to the service user's GP.

51. Did the discharge letter include?

Only answer if the service user was discharged during the audit period as recorded Q45.

52. Was a care plan sent to a nominated person in the accepting service?

Only answer if the service user has a care plan as recorded in Q21 and has been discharged as recorded in Q45.

If you have selected 'Yes' to this question, please provide the date care plan was sent to a nominated person at an accepting service.

Q53. RE-ADMISSION TO SERVICE

53. Was the service user re-admitted to hospital between discharge and the end of the audit period?

Only answer if the service user was discharged during the audit period as recorded in Q45.

If you have selected 'Yes' to this question, please state the number of re-admissions.

Q54-55. FOLLOW-UP PROCESS

54. Did the service user receive follow-up after discharge?

Only answer if the service user was discharged during the audit period as recorded in Q45.

Follow-up refers to direct contact with the service user ONLY. If the follow-up was not carried out with the service user (e.g. it was with a family member, friend or carer), please select 'No'.

If you have selected 'Yes' to this question, please provide the date and time of follow-up (if this information is available).

55. What was the mode of contact for the follow-up?

Only answer if the service user received follow-up after discharge as recorded in Q54.

Q56. CRISIS PLANNING

56. Did the service user have a crisis plan at the point of discharge?

Only answer if the service user was discharged during the audit period as recorded in Q45.

Yes – There is evidence in the casenotes that the service user's crisis plan was reviewed a week or less pre-discharge. Please note that the crisis plan may be a separate document or it may be part of the care plan.

No – There is NO evidence in the casenotes that the crisis plan was reviewed a week or less pre-discharge.

Q57-59. OUTCOME MEASURES

57. Was a Children's Global Assessment (CGAS) completed?

Only answer if the service user is aged under 18 as recorded in Q1.

If you have selected 'Yes' to this question, please enter the CGAS score.

58. Was a Health of the Nation Outcomes Scale (HoNOS) completed?

Only answer if the service user is aged 18+ as recorded in Q1.

Please only answer 'Yes' to this question if you have TWO COMPLETED MEASURES at separate points in time (i.e. at initial contact and again more recently). If only one has been recorded, please select 'No'.

59. Were there any other outcome measures completed?

If you have selected 'Yes' to this question, please select ALL outcome measures that have been completed. For service users aged under 18 this will be the CAMHS outcome measures list.

Please only answer 'Yes' to this question if you have TWO COMPLETED MEASURES at separate points in time (i.e. at initial contact and again more recently). If only one has been recorded, please select 'No'.

Appendix 1: Eligible ICD-10 Codes

F30 – F39 MOOD [AFFECTIVE] DISORDERS	
F32	**Depressive episode**
F32.0	Mild depressive episode
F32.1	Moderate depressive episode
F32.2	Severe depressive episode without psychotic symptoms
F32.8	Other depressive episodes
F32.9	Depressive episode, unspecified
F33	**Recurrent depressive disorder**
F33.0	Recurrent depressive disorder, current episode mild
F33.1	Recurrent depressive disorder, current episode moderate
F33.2	Recurrent depressive disorder, current episode severe without psychotic symptoms
F33.4	Recurrent depressive disorder, currently in remission
F33.8	Other recurrent depressive disorders
F33.9	Recurrent depressive disorder, unspecified
F34	**Persistent mood [affective] disorders**
F34.1	Dysthymia
F34.8	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F38	**Other mood [affective] disorders**
F38.0	Other single mood [affective] disorder
F38.1	Other recurrent mood [affective] disorders
F38.8	Other specified mood [affective] disorders
F39	Unspecified mood [affective] disorder
F40 – F48 NEUROTIC, STRESS RELATED AND SOMATOFORM DISORDERS	
F40	**Phobic anxiety disorders**
F40.0	Agoraphobia
F40.1	Social phobias
F40.2	Specific (isolated) phobias
F40.8	Other phobic anxiety disorders
F40.9	Phobic anxiety disorder, unspecified
F41	**Other anxiety disorders**
F41.0	Panic disorder
F41.1	Generalized anxiety disorder
F41.2	Mixed anxiety and depressive disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42	**Obsessive-compulsive disorder**
F42.0	OCD with Predominantly obsessional thoughts or ruminations
F42.1	OCD with Predominantly compulsive acts [obsessional rituals]
F42.2	OCD with Mixed obsessional thoughts and acts
F42.8	Other obsessive-compulsive disorders
F42.9	Obsessive-compulsive disorder, unspecified
F43	**Reaction to severe stress, and adjustment disorders**
F43.0	Acute stress reaction
F43.1	Post-traumatic stress disorder
F43.2	Adjustment disorders

F43.8	Other reactions to severe stress
F43.9	Reaction to severe stress, unspecified
F44	**Dissociative [conversion] disorders**
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.2	Dissociative stupor

Appendix 2: Excluded ICD-10 Codes

Service users with the following ICD-10 codes as a primary OR additional diagnosis are excluded from the audit:

F00 - F09 ORGANIC INCLUDING SYMPTOMATIC, MENTAL DISORDERS	
F06	**Other mental disorders due to brain damage and dysfunction and to physical disease**
F06.0	Organic hallucinosis
F06.2	Organic delusional [schizophrenia-like] disorder
F20 – F29 SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS	
F20	**Schizophrenia**
F20.0	Paranoid Schizophrenia
F20.1	Hebephrenic schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.4	Post-schizophrenic depression
F20.5	Residual Schizophrenia
F20.6	Simple Schizophrenia
F20.8	Other Schizophrenia
F20.9	Schizophrenia, unspecified
F21	**Schizotypal disorder**
F22	**Persistent delusional disorders**
F22.0	Delusional disorder
F22.8	Other persistent delusional disorder
F22.9	Persistent delusional disorder, unspecified
F23	**Acute and Transient psychotic disorders**
F23.0	Acute polymorphic psychotic disorder without symptoms of schizophrenia
F23.1	Acute polymorphic psychotic disorder with symptoms of schizophrenia
F23.2	Acute schizophrenia-like psychotic disorder
F23.3	Other acute predominantly delusional psychotic disorders
F23.8	Other acute and transient psychotic disorders
F23.9	Acute and transient psychotic disorder, unspecified
F24	**Induced delusional disorder**
F25	**Schizoaffective disorders**
F25.0	Schizoaffective disorder, manic type
F25.1	Schizoaffective disorder, depressive type
F25.2	Schizoaffective disorder, mixed type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	**Other nonorganic psychotic disorders**
F29	**Unspecified nonorganic psychosis**
F30 – F39 MOOD [AFFECTIVE] DISORDERS	
F30	**Manic episode**
F30.0	Hypomania
F30.1	Mania without Psychotic Symptoms
F30.2	Mania with psychotic symptoms
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31	**Bipolar affective disorder**

F31.0	Bipolar affective disorder, current episode hypomanic
F31.1	Bipolar affective disorder, current episode manic without psychotic symptoms
F31.2	Bipolar affective disorder, current episode manic with psychotic symptoms
F31.3	Bipolar affective disorder, current episode mild or moderate depression
F31.4	Bipolar affective disorder, current episode severe depression without psychotic symptoms
F31.5	Bipolar affective disorder, current episode severe depression with psychotic symptoms
F31.6	Bipolar affective disorder, current episode mixed
F31.7	Bipolar affective disorder, currently in remission
F31.8	Other bipolar affective disorders
F31.9	Bipolar affective disorder, unspecified
F32	**Depressive episode**
F32.3	Severe depressive episode with psychotic symptoms
F33	**Recurrent depressive disorder**
F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms
F34	**Persistent mood [affective] disorders**
F34.0	Cyclothymia

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