# How are inpatient mental health services for people with anxiety and depression performing?

Main findings from the National Clinical Audit of Anxiety and Depression: a report co-produced with service users and carers

NCAAD
NATIONAL CLINICAL AUDIT OF
ANXIETY AND DEPRESSION

RC PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

HQIP
Healthcare Quality
Improvement Partnership

McPin Foundation
Transforming mental
health research
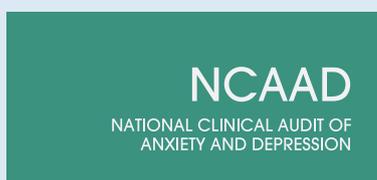
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Cover image: 'Uncertain Reflections (reeds)' by Jessie Davies - winner of NCAAD art competition

"Where the reed stems enter the water, they disturb the calm reflections. Uncertainty grows as we look more closely, with multiple intrusions and distortions causing us to question our perceptions.

In the end, we seem to be viewing the scene as if we, ourselves, are under the water."

THE PURPOSE OF THIS REPORT

This report presents the main findings of the National Clinical Audit of Anxiety and Depression carried out by the Royal College of Psychiatrists between 2017 and 2018.

It is co-produced by service users and carers, and the McPin Foundation, an independent mental health research charity, and is designed to be accessible to anybody interested in the results of the audit.

It presents the main findings of the audit along with a series of 'user friendly' abridged audit recommendations based, in part, on discussions with service users and carers. Why the findings and recommendations are important to service users and carers is also detailed throughout the report.

A full account of the audit findings is presented in a 'Technical Report' available on the audit website, which readers are encouraged to view.

The Technical Report provides a comprehensive overview of the audit methodology and findings, including how individual NHS Trusts performed and comprehensive recommendations for action. It is aimed at senior clinicians, health policy makers, commissioners, audit leads, researchers, and other relevant stakeholders to help understand and improve these services.

HOW WERE SERVICE USERS AND CARERS INVOLVED IN THE AUDIT?

People with personal experience of anxiety and/or depression and those that support them have been involved from the start of the audit process. A Service User and Carer Reference Group were involved in the development of the tools used to measure services' performance and in decisions about what data should be collected.

Once the audit had been conducted, a series of consultations was held with the Reference Group in collaboration with the McPin Foundation to discuss the findings. Service users and carers gave their responses to the results and how they related to their own experiences and discussed potential recommendations.

Quotes from these consultations and suggestions of what service users and carers would like to see in practice are included throughout the report alongside the results and formal audit recommendations.

The RCPsych used this feedback and that provided by a steering group to draw up a list of final recommendations. The recommendations contained in the body of this co-produced report are abridged for ease of reading; a full version can be found on page 38.

Jargon Buster

Service user
For the purposes of clarity, we have used the term 'service user' to describe people who use services to receive support for their own anxiety and/or depression. We acknowledge that people may have their own preferences or terms they identify with.

Carer
For the purposes of this report, this describes family members, friends and other people who support or care for a loved one with an anxiety and/or depressive disorder. We acknowledge that people may have their own preferences or terms they identify with.

Royal College of Psychiatrists (RCPsych)
This is a professional body that is responsible for setting and improving standards in psychiatry. They manage a programme of National Clinical Audits, which are commissioned by a body called the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

INTRODUCTION

The goal of the National Clinical Audit of Anxiety and Depression is to find out how services for people with anxiety and depression are performing so that the quality of care they offer can be improved. This audit focuses on inpatient services, where people are admitted to hospital and stay overnight for a period of time, run by NHS Mental Health Trusts in England. The audit was commissioned by HQIP on behalf of NHS England.

To measure how services are doing, they are assessed on 13 standards that represent best practice. The standards were drawn up in 2017 by looking at guidance, such as that provided by NICE, and by talking to service users and carers. The standards give service users and carers an idea of the sort of care they should expect from a service. They tell service providers what they need to do to provide high quality care. A list of the standards can be found on page 6, grouped into themes.

The National Clinical Audit of Anxiety and Depression is important because it will show which services and Trusts are performing at or above the expected level and which are performing below it. It will enable services and Trusts to see how they are performing compared to others locally and nationally. Improvements can then be made and lessons learned from services who are performing well.

By measuring how services are doing and helping them to improve, the audit increases the chance that people who use inpatient services for depression and anxiety will have a good experience. The hope is that this will contribute to better health and quality of life.

Jargon Buster

HQIP – Healthcare Quality Improvement Partnership
This is an independent organisation that aims to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve healthcare services.

Inpatient
A person who goes into hospital and stays there for at least one night.

NHS England
NHS England leads the National Health Service in England and supports the NHS to deliver improved care for patients.

NHS Trust
For the purposes of this report, this is a body that provides secondary health services within the NHS in England. A Trust can provide multiple services for its local population.

NICE
This stands for the National Institute of Health and Care Excellence. It is a body that provides national guidance and advice to improve health and social care.

THE STANDARDS

The standards are a way to measure how well a mental health service is performing

ACCESS

1. The Trust routinely collects data to assess equity of access.

   Guidance: This includes age, gender, ethnicity, employment and accommodation status.

2. Service users have timely access to inpatient care when required.

ASSESSMENT

3. Service users' assessments are comprehensive and include consideration of:

   - Identification of social support and/or stressors in relation to finance, education/employment and relationships;

   - Previous traumatic experiences or associated symptoms;

   - Previous treatments and response to them (if applicable);

4. Service users' physical health is considered as part of their assessment and treatment, with support, advice or onward referral offered where appropriate.

   Guidance: This includes blood pressure, heart and respiratory rates; BMI; blood tests, and lifestyle factors (e.g. diet, exercise, smoking, drug and alcohol use).

SHARED DECISION MAKING

5. The needs of service user's family members, friends or carers are considered as part of the assessment process and they are offered an assessment of their needs.

6. Care plans are jointly developed with service users and their family member, friend or carer (if applicable), and they are given a copy with an agreed date for review.

MEDICATION

7. Psychotropic medication is provided in line with the relevant NICE and BNF guidance for the service user's diagnosis/condition.

PSYCHOLOGICAL THERAPIES

8. Psychological therapies are provided in line with relevant NICE guidance for the service user's diagnosis/condition.

DISCHARGE

9. Within 24 hours of discharge a discharge letter is sent to the service user's GP and a copy of the service user's care plan is sent to the accepting service (if applicable).

10. The service user and their family member, friend or carer (if applicable), receives at least 24 hours' notice of discharge and this is documented.

11. Service users discharged from an inpatient setting receive a follow-up within 48 hours of discharge.

12. Service users have a crisis plan agreed and in place prior to discharge from an inpatient service.

OUTCOME MEASUREMENT

13. Assessments include the use of an appropriately validated outcome measure(s) (e.g. symptoms, level of functioning and/or disability) which are used to monitor, inform and evaluate treatment.

ANXIETY AND DEPRESSION AS AN INPATIENT

Anxiety and depression are often referred to as 'common mental health disorders'. This is because they are common – in England, one in six adults have a diagnosis that includes one of the two. But this phrase can also be misleading. In the public's view, 'common' sometimes gets confused with meaning 'less severe'. This means that anxiety and depression are sometimes seen as being only mild mental health difficulties, something that we all experience from time to time.

In reality, both anxiety and depression can take many forms and many degrees of intensity. They often occur together. At their most severe, people can be admitted to hospital for treatment. This could include drug treatment and/or psychological therapy.

For some people, anxiety could mean a tightening of the chest that comes when a stressful event is mentioned. This feeling may go away when the person is no longer thinking about the event or when the event itself has passed. For others, anxiety can be all-consuming and long-lasting. It can be an extreme form of worry that triggers headaches, nausea, an irregular heartbeat, panic attacks, insomnia, feelings of being disconnected from your body or surroundings, and spirals of repetitive thoughts.

These are just some of the symptoms that people can experience. Post-traumatic stress disorder, obsessive compulsive disorder and phobias are types of anxiety disorders and anxiety-related conditions. (These diagnoses were eligible for inclusion in the audit.

For a list of other eligible diagnoses, see the technical report.)

Depression is also very varied. It is estimated that about 70 per cent of people with depression have mild depression, 20 per cent moderate and 10 per cent severe*. The mental health charity, Mind, has a helpful description of this spectrum on its website. "In its mildest form, depression can mean just being in low spirits.

It does not stop you leading your normal life but makes everything harder to do and seem less worthwhile. At its most severe, depression can be life-threatening because it can make you feel suicidal or simply give up the will to live."

For further sources of support for your own mental health or that of a loved one, please see page 45.

* For a full list of references, please see the NCAAD technical report.

THE AUDIT

This is the first time that the National Clinical Audit of Anxiety and Depression has been carried out. It was commissioned after an audit of the quality of psychological therapies for people with anxiety and depression, conducted between 2010 and 2014, found some "ongoing areas of concern". You can read the summary published in 2013 at https://www.hqip.org.uk/wp-content/uploads/2018/02/UiJuO5.pdf.

What happened during the audit?

Data to measure services' performance were collected using service users' **case notes**.

People's case notes were eligible to be included in the audit if:

- ✅ They were 16 or over
- ✅ They had a primary diagnosis of anxiety or depression
- ✅ They were admitted to a NHS-funded inpatient service for treatment for depression or anxiety between 1 April 2017 and 30 September 2017
- ❌ People's case notes were not eligible if they were also diagnosed with a psychosis-based disorder

JUNE 2018 JULY 2018 AUG 2018 SEPT 2018

All 54 NHS Mental Health Trusts providing inpatient care in **England** sent the RCPsych an **anonymised** list of all eligible service-users.

The RCPsych **randomly** chose 100 people from each Trust for their case notes to be analysed.

Data collection involved the Trust going through the case notes made in the six-months after these people were admitted, **looking for evidence that the standards have been met**.

All **54** NHS Trusts submitted data. Data from **3,795** people's case notes were analysed by the RCPsych to get a picture of how services are performing.

How can you be sure that a Trust's analysis was accurate and unbiased?

The case notes chosen to be analysed were randomly picked by the RCPsych, reducing the chance of bias. Trust audit departments were then responsible for organising the collection of data. Five of each Trust's case notes were audited by two separate auditors and the RCPsych then looked at these cases to ensure they matched up to confirm reliability. Three Trusts were also selected at random to be visited by an external clinician and member of the NCAAD team to check the data they submitted were accurate.

Jargon Buster

Case notes
A document that records a service user's history and which care providers update with the individual's care plan and any drug or psychological treatments prescribed.

Care plan
This explains what support and treatment should be provided by which health professionals and when. It might include what to do in a crisis or how to prevent relapse. It should be developed in collaboration with the service user.

The next part of this report presents the results from the audit, starting with five key findings and recommendations.

The results for each standard are then presented along with audit recommendations for improving the quality of care. Why each standard matters from a service user and carer perspective and what they would like to happen is also highlighted as well as further changes they would like to see.

Percentages have been rounded to the nearest whole number for ease of reading so some graphs/tables will add to 99% or 101%.

KEY AREAS FOR IMPROVEMENT

The audit found that access to inpatient mental health services was generally good with an average wait time of five hours and 81% of service users being admitted within a day of notification. However, there were key areas for improvement relating to assessment and care planning. These areas were jointly identified by the NCAAD Service User and Carer Reference Group and the NCAAD Steering Group. Future rounds of the audit will assess these key areas. Trusts will be supported through Quality Improvement Workshops to identify suitable local systems for assessing performance in meeting these recommendations.

KEY FINDINGS

Key information is not routinely being recorded during assessments. This was particularly noticeable for physical health data, demographic information, comorbidities, history of trauma, and responses to previous treatment.

Although 91% of service users had a care plan, **shared decision making needs to be improved**. Service users are not always given a copy of their care plan and key information is not routinely being shared with service users and carers.

Psychological therapies were only offered to 39% of service users.

Outcome measures are not routinely being used to assess change; 39% of service users were not assessed using an outcome measure.

Although a majority of people received a follow-up after discharge, **26% of service users did not have a crisis plan** at the point of discharge and sufficient notice was not always given.

KEY RECOMMENDATIONS

NHS Trusts should: provide effective systems that enable **clinicians** to routinely collect and record key information from assessments for all service users, so that appropriate care plans can be developed.

Clinicians should: ensure that care plans are collaboratively developed and all service users are given a copy; and that identified carers are provided with information about support services and offered a carer's assessment. **Service managers** should: review the involvement of carers with reference to best practice guidance ('the Triangle of Care (2013)') and ensure that information about medication is available in accessible formats to all service users prescribed medication.

Clinicians should: routinely offer psychological therapies in line with NICE guidance. **Trusts** should: investigate the reasons for low referral rates.

Trusts should: agree outcome measures that can be reliably used to evaluate the treatment provided and ensure that clinicians are trained in the use of outcome measures for assessing change. **Clinicians** should: routinely use outcome measures at both assessment and review appointments.

Clinicians should: ensure that all service users and, where agreed, their carers are offered at least 24 hours' notice of discharge; that jointly developed crisis plans are in place at the point of discharge; and that all service users receive follow-up within 48 hours. **Trusts** should: provide systems to ensure discharge letters are sent to primary care services within 24 hours.

The Trust routinely collects data to assess equity of access

This includes age, gender, ethnicity, employment and accommodation status.

Results

Employment was recorded for
87% of people
It was **not recorded for 13%** of people

Accommodation was recorded for
93% of people
It was **not recorded for 7%** of people

Ethnicity was recorded for
94% of people
It was **not recorded for 6%** of people
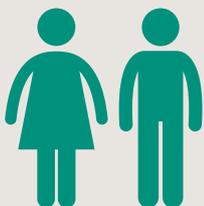
Sexuality and **religion** were not asked about as a pilot of the audit already suggested that this data was not being routinely recorded by services

What this means

Important demographic information is not being properly recorded for many service users.

Audit Recommendation 1

a) Clinicians should:

Ensure that information on employment and accommodation is collected for all service users.
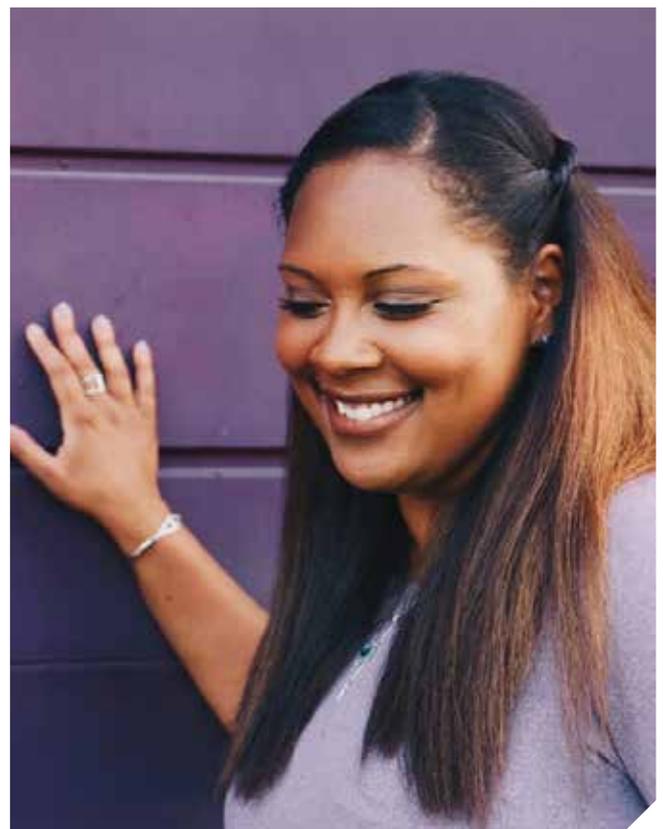
Why it matters

Services collect demographic data to see which groups of people are accessing the service and which are not, enabling them to take steps to reach those not being served. This is what equality of access means.

There is another important reason why demographic information needs to be collected – it is a key part of getting a complete picture of the person. This is essential if the clinician is to work out the best way to support the person and write a care plan that takes their current situation into account. Making time to understand a person and their situation when they are first admitted may lead to a better relationship in the future and reduce any feelings the service user has that they are "just a number".

" **You can't underestimate the impact of getting things wrong. It can lead to warning flags, a spider's web of discrimination that can lead to exclusion from some treatments. The information gets passed on in a chain – you can't get rid of it – with really serious consequences for people.** "

" **Housing is one of the big questions people should be asked on admission. Does the person live alone, in social housing? How secure is it? Are they in university accommodation? It seems odd to not ask about it – you're here tonight but where were you last night?** "

" **People make assumptions and get it wrong. I was asked whether I had a boyfriend. I have a girlfriend of 5 years but I didn't say anything about them because it had already been framed in such a way. Then this information gets replicated wherever you go.** "

" **The clinician asking for this information should give the context of why capturing this information is important. It should be done in such a way that it doesn't feel like a tick box exercise even if it is. There is a huge difference between an engaged and interested practitioner and a bored and disinterested one.** "

What would service users and carers like to happen?

For service managers

Service users must be told why demographic information is being collected and what it will be used for. Service users can then choose not to provide it but any information given must be recorded and assumptions about people's demographics must not be made. A standardised form could be used to support this.

For clinicians

The use of a standardised form cannot replace a proper conversation where the person's background is fully explored. The form should merely be a tool to make sure all the data points are gathered, and no assumptions are made.

STANDARD 2
Service users have timely access to inpatient care when required

Results

81% of people referred to hospital for anxiety and/or depression were **admitted within a day**

The **time of the admission** was unknown or not documented for **11% of people**

83% of admissions were voluntary. The average waiting time from **referral to admission was 5 hours**

Young people aged **16-17** experienced longer waits, with an average waiting time of **17 hours**

For **27% of people** it was unknown or not documented what **date and time** the hospital was notified of the need for a bed

What this means

The audit found that access to inpatient mental health services was generally good with an average wait time of five hours and 81% of service users were being admitted within a day. However, details about when services were notified of the need for a bed and dates and times of admissions were not recorded for a large number of cases.

Audit Recommendation 1

b) Trusts should:

Ensure timely access for inpatient service users. To achieve this, they need to have systems that accurately capture the date and time they are notified of the need for a bed.

c) Commissioners should:

Take action to ensure that there is adequate provision for adolescents who require inpatient care.

Why it matters

Not collecting access data means that service level and national level data on waiting times will be unreliable. Accurate recording of dates and times also enables services to predict when demand is likely to be highest so they can ensure the right numbers and rank of staff are available to ensure people's safety.

As well as information about timely access, data should be gathered on how far from home people are being sent. Being sent far away could impede recovery as it makes it harder for carers to support them.

This is hugely important from a patient safety point of view. Someone is likely to have a very different experience if they are admitted to a ward out of hours as opposed to during office hours.

Location was really important to me and should always be a consideration.

From my experience as a carer, there is a minimum of staff and resources available evenings and weekends. You often have to 'jump through hoops' to get to the correct person for a referral. It is not straightforward and very stressful.

Poor access time for someone who is suicidal could be fatal.

What would service users and carers like to happen?

For service managers

Times and dates of notification and admission, as well as distance travelled to the service, must be recorded.

STANDARD 3

Service users' assessments are comprehensive and include consideration of:

- Identification of social support and/or stressors in relation to finance, education/employment and relationships
- Previous traumatic experiences or associated symptoms
- Previous treatments and response to them (if applicable)

Results

79% of assessments considered whether the person had a history of trauma, **21% did not**

81% of assessments included details about the person's past response to treatment, **19% did not**

What this means

A significant proportion of people are not being asked about their history of trauma and past experiences of treatment.

Audit Recommendation 2

a) Clinicians should:

Ensure the assessment of all service users includes information about social stressors, financial circumstances, previous traumatic experiences, and previous response to treatment.

Did the assessment include information about the service user in relation to their:

| Employment and/or education?	Difficulties relating to financial situation?	Dependents?	Difficulties relating to social situation?
Yes 84% No 16%	Yes 71% No 29%	Yes 89% No 11%	Yes 97% No 3%
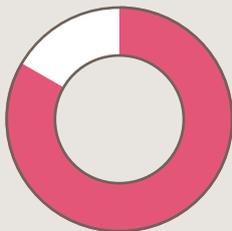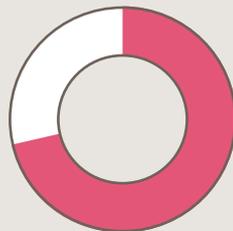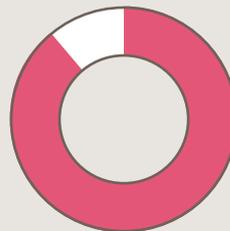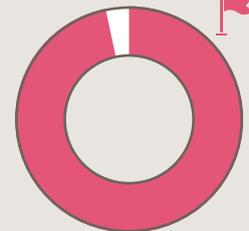
Indicates results that may be less reliable. This is because there were discrepancies between how the first and second auditors interpreted the information recorded in the case notes (see page 8 for details of how NCAAD checked data accuracy).

Why it matters

People who are admitted to a service may have come into contact with it or another service on previous occasions. Their past experiences and preferences are valuable information about what worked for them and what did not.

If these are not asked about, clinicians are starting from scratch every time, something that is frustrating, and potentially distressing, for the service user.

> **These are sensitive matters. People need to be engaged in conversation and given the opportunity to tell the narrative of their past experiences. This should not be about box ticking.**

People who are admitted may have past experience of trauma. This is essential for staff to know about as actions may need to be taken to make sure the ward environment is a safe space for them. This could make a real difference to people's inpatient experience.

> **It is extremely important for the ward environment and staff behaviour not to retraumatise people. If someone is traumatised by sexual abuse or a physical attack, they are not going to deal well with being restrained, for example.**

> **In my unit, some people couldn't cope with hospital alarms but staff knew this so they were able to minimise that person's stress, which minimised everyone else's.**

> **I still have nightmares of people looming over my bed. No one thought about how close they came to me when they were doing night-time suicide checks. They could have done it better by being trauma-aware.**

What would service users and carers like to happen?

For clinicians

On admission, service users must be engaged in a conversation about their past experiences – both in relation to past treatments and interactions with services but also their trauma history. If the individual is unable to communicate this information, where a carer is present and there is consent, carers should be involved to gather such information. Any preferences should be taken into account and steps must be taken to avoid retraumatising people.

For service managers

People's individual needs and preferences should be recorded on their care and crisis plans and all staff – clinicians, nurses, support staff and agency workers – should be briefed on them and act accordingly.

STANDARD 4

Service users' physical health is considered as part of their assessment and treatment, with support, advice or onward referral offered where appropriate

This includes blood pressure, heart and respiratory rates; BMI; blood tests, and lifestyle factors (e.g. diet, exercise, smoking, drug and alcohol use)

Results

BMI was documented for
70% of people
29% of people who required an intervention were offered one

Smoking status was documented for
84% of people
47% of people who required an intervention were offered one

Alcohol intake was documented for
83% of people
35% of people who required an intervention were offered one

Substance misuse was documented in
91% of people
34% of people who required an intervention were offered one

What this means

Information about BMI, smoking, drinking and drugs is either not asked for or is not being recorded for some people. The majority of people who require an intervention to improve these aspects of their physical health were not offered one.

Audit Recommendation 2

b) Clinicians should:

Ensure that full consideration is given to the physical health of all service users. This includes diagnosis of coexisting physical health conditions, measuring BMI and assessing the need for interventions to address smoking, excessive use of alcohol and substance misuse.

Why it matters

Mental health and physical health are closely linked. As a group, people with mental health problems have a higher risk of physical problems including diabetes, certain types of cancer and coronary heart disease. Side effects of medications for mental health difficulties can often impact upon people's physical health, for example, by making them put on weight. This is important for staff to be aware of.

> **I am often asked about smoking and drinking but not much else. This is a shame. There is a need for a conversation about physical exercise, diet and the dangers of a sedentary lifestyle.**

> **I have found 'lifestyle advice' very unhelpful as there is an element of 'blaming and shaming' rather than addressing the root causes. I would not want to feel this pressure during admission nor be signposted to smoking cessation or be told what a 'healthy BMI' looks like. This would exacerbate my mental distress at a difficult time and I would be more concerned about being admitted but not being able to smoke. I think having a more holistic assessment at a more appropriate time might be more helpful with follow-up support if required.**

> **I was admitted for depression but I also had an eating disorder. The medication I was prescribed made me put on weight so then I wasn't eligible for eating disorder services even though my eating disorder was still there.**
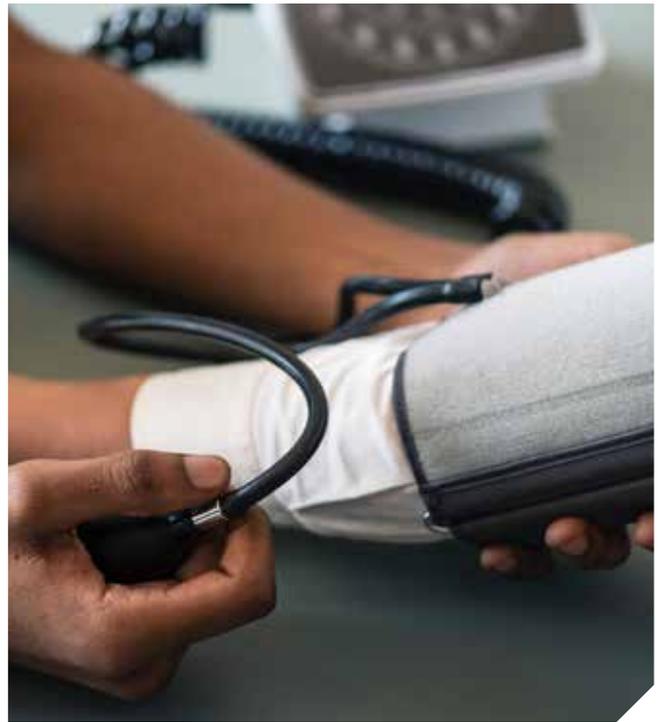
What would service users and carers like to happen?

For clinicians

Non-judgemental conversations about physical health, diet and exercise should occur at an appropriate time and be tailored to the needs and wishes of the individual. Where desired, support to address these issues should be included in a person's care plan.

For service managers

Information about BMI, smoking, drugs and alcohol must be recorded. This data must be gathered at an appropriate time, not necessarily on admission.

The potential for physical side effects to hinder recovery and reduce treatment options should be taken into account when reviewing or prescribing further medications.

STANDARD 5

The needs of service users' family members, friends or carers are considered as part of the assessment process and they are offered an assessment of their needs

Where a family member, friend, or carer was identified as the main source of support to the service user:

62% were provided information about support services and/or support plan but **38% were not**

25% were offered a carer's assessment but **75% were not**

What this means

A significant proportion of the people are not given information about support they are entitled to. The majority of people were not offered a carer's assessment.

Audit Recommendation 3

a) Clinicians should:

Ask all service users whether they wish to nominate someone as their named main support. Offer this named person a carer's assessment and document if this is declined.

Why it matters

Supporting someone with mental health problems is difficult. In order to give support to someone else, people need to be in good mental and physical health themselves. Since social support is vital to an individual's recovery, services should consider the wellbeing of the service user's carer.

> **For a carer, a loved one's illness can be very bewildering, stressful and emotional. It is imperative that carers' needs be assessed, if they agree. If they aren't, it could lead to problems with the mental health of the carer and a breakdown of relationships. Carer's assessment should commence when the patient is admitted, which will also give staff an idea of the background circumstances.**

> **I think it is a great idea for family/friends/carers to have their own separate assessment to talk about their needs. Caring for or helping a loved one with a mental illness can have a big impact on that individual's mental health. Carers can often be overwhelmed and 'forgotten'.**

> **Only a quarter of supporters are being referred for a carer's assessment, which suggests that people carrying out assessments are either not aware of the criteria for the carer's assessment or do not feel that family members are carers. It seems to suggest that there is a lack of clarity about support for family members.**

What would service users and carers like to happen?

For service managers and clinicians

People who provide support need to be engaged in a conversation about their wellbeing and support needs. People who are eligible for a carer's assessment should be offered one and the support required provided.

STANDARD 6

Care plans are jointly developed with service users and their family member, friend or carer (if applicable), and they are given a copy with an agreed date for review

Results

91% of people
had a care plan,
9% did not

There is evidence that:
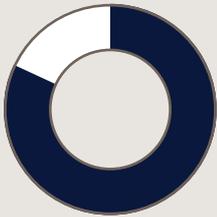
The care plan was jointly developed between the service user and clinician in **82% of cases** but not in **18% of cases**
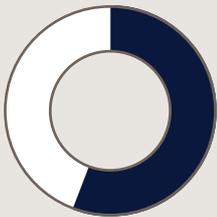
The service user was given a copy of their care plan in **59% of cases** but not in **42% of cases**
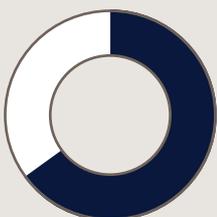
The care plan included an agreed date for a review in **65% of cases** but not in **35% of cases**

What this means

Most, but not all, service users have a care plan. Given how important the care plan is, the fact that some people do not have one is a problem. The finding that a significant proportion of people are not given a copy and have no review date agreed, suggests that the care plan is not meaningful.

Audit Recommendation 3

b) Clinicians should:

Offer all service users a copy of a jointly developed, person-centred care plan, with a documented review schedule.

Why it matters

The care plan is the keystone of someone's support and recovery. If someone does not have one it implies that the service has not thought about how they are going to support them, and that support is either not being offered, or is not being offered in any systematic way.

The care plan must be tailored to the individual and developed alongside them, otherwise people are unlikely to engage with it.

> " I have never been given a copy of a care plan or been involved in writing one, despite all the rhetoric about it being 'person centred'. I was told by the care coordinator that it was a 'compliance document' for staff primarily.

> " As a carer, I have not had the opportunity to help develop a care plan over the last 20 years. I have been given a completed copy. The care plan must primarily be about the person not the illness.

> " The audit data doesn't tell us anything about whether service users remember signing their care plan or what is in it. If it was signed at a time of extreme distress, there is no way that they will have absorbed that information.

> " If your care plan hasn't been co-developed, you aren't given a copy and there is no date for review, what is the point? You might as well not have one.

What would service users and carers like to happen?

For clinicians

Service users must have a jointly developed care plan that is tailored to them. It should take into account their current situation, including employment and accommodation as well as any other relevant demographic information and information about their physical health (see Standards 1 & 4).

Service users must know what is in their care plan and must have a copy of it. If the care plan was developed during a period of crisis, clinicians should have follow-up conversations about it when the individual is no longer in extreme distress. A review date must be agreed and the review must be carried out.

Who should information about a service user's care be shared with?

The terms 'next of kin' and 'nearest relative' are both used to describe the points of support for people in inpatient services, although they do not have to be the same person. A 'nearest relative' is a legal term that is important when someone is involuntarily detained under the Mental Health Act. There are strict rules about who someone's nearest relative can be and what rights it confers. 'Next of kin' has no legal definition. Who this person is and what information staff are allowed to share with them should be up to the service user. It should not be assumed that service users have people in their lives that can support them.

> **Supporting carers or friends is vital to get right because sometimes it is not safe to have their involvement. I had an experience when an abusive boyfriend was included in a discussion with nurses about my whereabouts.**

> **Recording of who carers/supporters are is not a cut and dried question. The preferred point of contact can change over time and depend on the family dynamics of the moment.**

> **A frank conversation with the service user must be had, in which a decision is made about who, and to what extent, others should be involved in their care. Once this is done, a conversation should be had with the third party as to the nature and extent of their involvement.**

> **It should be the service user who decides how much involvement friends and family have in their care. In my experience it was really important to me to have my mum and boyfriend involved but there were some things that I didn't want to discuss in front of them, such as suicidal thoughts, as I thought it might hurt them to hear.**

What would service users and carers like to happen?

For clinicians

Services should privately ask the service user what information they want shared with who, and if there is anyone they do not want involved. Even with the people nominated, there may be topics the individual does not want discussed with them. There should be the flexibility for this to change over time.

For more information about the term 'nearest relative', visit **https://www.rethink.org/advice-information/rights-restrictions/mental-health-laws/nearest-relative/**

STANDARD 7

Psychotropic medication is provided in line with the relevant NICE and BNF guidance for the service user's diagnosis/condition

Results

87% of people were prescribed medication when they were discharged

Of these, **73%** were given verbal and/or written information about their medication prior to discharge. **27% were not**

87% had their medication reviewed prior to discharge but **13% did not**

What this means

A significant proportion of people are not being given information about medication. Some people are being discharged without having their existing medication reviewed.

Audit Recommendation 4

Prescribers should:

In collaboration with service users who are started on new medication, review and document at one week the degree of response and any side effects experienced. Particular attention should be paid to all those under 30 years of age and those considered to be at risk of suicide.*

If they underwent a review, did it include:

Response to medication?

Yes 80%

No 20%
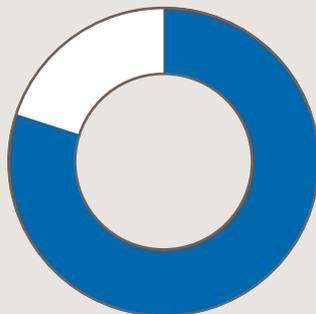
Side effects of medication?

Yes 62%

No 38%
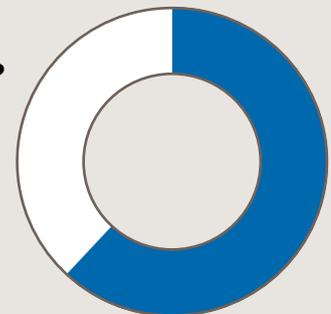
Unknown/not documented 17%

*Younger service users and those at increased risk of suicide appeared to be less likely than the sample overall to have their medication reviewed within the timeframes recommended by NICE. Please refer to the NCAAD Technical Report for more information.

Why it matters

It is essential that people are given good information about any drug they are advised to take. People have a right to know what they are consuming and what the potential side effects might be. Not being given any information about the drug suggests that there was no conversation about the service user's choices and preferences.

People who are admitted to services may already be taking a number of medications. New medication should not be prescribed without a clinician considering how it might interact with the existing drugs they are taking.

> **Being given only verbal or written information is not good enough – we need both and information about how likely side effects are, not just a list of what they are. Suggestions could be made about how to ameliorate the side effects e.g. with diet or exercise.**

> **This information needs to be written in plain English and the clinician should check whether the person properly understands the side effects. This should include both physical and emotional side effects – what feelings might come up as a result of taking it.**

What would service users and carers like to happen?

For clinicians

Medication should be reviewed regularly and certainly before discharge or before prescribing anything new. Service users need clear verbal and written information about medication, particularly on the side effects and interactions with other drugs.

This information needs to be given in the context of service user choice and shared decision-making about which medication is most suited to the individual.

Jargon Buster

BNF
This stands for the British National Formulary. It provides information about all medicines available on the NHS.

It includes guidance on what conditions medication can be prescribed for, recommended dosing, side effects, contraindications and any other safety considerations.

It is used by doctors, pharmacists and any other professionals who prescribe medications.

STANDARD 8

Psychological therapies are provided in line with relevant NICE guidance for the service user's diagnosis/condition

Results

39% of people were referred to psychological therapy but **61% were not**.

**54% of people** referred for individual therapy had started

72% referred for group therapy had started

Of those who had started therapy,

47% were receiving a type that was **recommended by NICE** for their diagnosis

Where were people referred to?
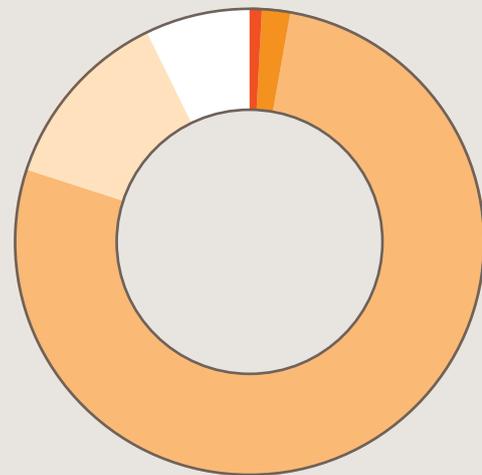
🟥	Private	**1%**
🟧	Third Sector	**2%**
🟧	NHS secondary care	**77%**
🟧	IAPT	**13%**
⬜	Other	**7%**

It was only possible to calculate waiting times between referral and the onset of therapy for 515 people. This means the data are not sufficiently reliable to present here. More robust data will be available after an audit focusing on psychological therapies is completed in 2020.

Of the people who had been referred to individual therapy, 33% had not started and it was unknown/not documented for 13% of people.

Why had they not started?
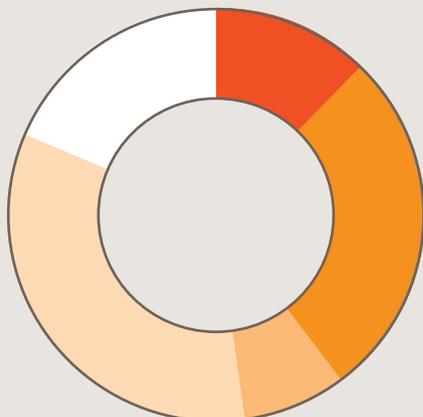
🟧	**Service user is on waiting list**	**14%**
🟧	Service user chose not to participate	**31%**
🟧	Service user is not currently able to participate	**9%**
⬜	Unknown/not documented	**25%**
⬜	Referral not appropriate/Other	**21%**

Of the people who had been referred to group therapy, 17% had not started and it was unknown /not documented for 11% of people.

Why had they not started?
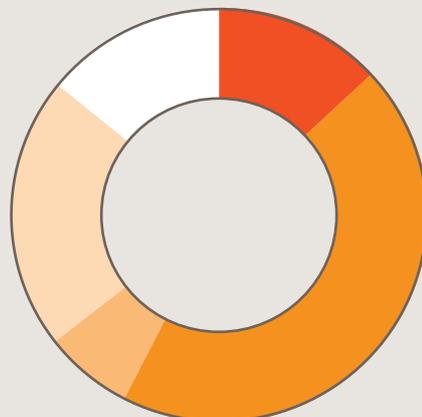
🟧	**Service user is on waiting list**	**13%**
🟧	Service user chose not to participate	**44%**
🟧	Service user is not currently able to participate	**7%**
⬜	Unknown/not documented	**21%**
⬜	Referral not appropriate/Other	**14%**

What this means

A minority of people admitted to hospital with anxiety and depression are referred for psychological therapy. For those individuals who are referred, there are challenges to accessing treatment such as waiting lists and referral criteria not being met.

Why it matters

People who are admitted to inpatient services are typically severely distressed. They could deteriorate further while they wait for therapy to start. Low referral rates to psychological therapy for service users admitted to hospital with anxiety and/or depression, indicate that this group is not accessing therapy easily. This may be for a variety of reasons, including strict criteria for accessing certain services.

Audit Recommendation 5

a) Clinicians should:

Ensure that all service users are offered an assessment for psychological therapy in line with NICE guidance and record the outcome of these discussions including details of shared decisions.

b) Trusts should:

Investigate low referral rates to psychological therapy.

> **My frustration is with secondary care services and the very patchy provision of therapies except for a lucky few, and the very long waits for many. This is unacceptable, unfair and definitely not parity with physical healthcare and maybe not even parity with mental healthcare for people with milder difficulties who can access IAPT.**

> **I'm a student and IAPT won't take me because I have multiple traumas. I'm too complex so I'm not able to get treatment on IAPT but I'm not complex enough for inpatient treatment. This means I was offered an appointment with a nurse every 6 weeks who checked I was still alive but not much else.**

> **I'm surprised that a third of people have been referred to therapy as I have found trying to access psychological therapy impossible. There is a total mismatch between the standard and my real-life experience. My experience has been that it is totally unobtainable.**

> **I'm using private trauma therapy funded by my parents. What will I do if that is cut off? The system shouldn't rely on private services to prop up the NHS. This is a source of health inequalities.**

What would service users and carers like to happen?

Commissioners and service managers

Managers should ensure that the needs of all service users can be addressed within the range of options in NHS primary and secondary clinical care. No group of people should fall into a 'treatment gap', finding themselves in between services' eligibility criteria, or have to wait for extended periods for therapy.

Jargon Buster

IAPT
Improving Access to Psychological Therapies (IAPT) is an NHS England programme which began in 2008. It provides NICE-recommended psychological therapies for adults with anxiety and depression. It is usually suitable for people whose needs can be managed safely and effectively in primary care services. Types of therapy offered might include cognitive behavioural therapy (CBT), mindfulness and counselling depending on the severity of the problem, personal preference, and on what is available locally.

NHS secondary care psychological therapy
This may be provided when service users are inpatients, for example, whilst they are on a ward, or when they are outpatients, for example, whilst being supported by a Community Mental Health Team (CMHT). This support is usually offered to people with more severe and complex needs which cannot be managed safely and effectively in primary care. A range of psychological therapies might be available and offered depending on the person's needs and what is available locally.

Third sector therapy services
This is psychological therapy offered by community and charity organisations.

STANDARD 9

Within 24 hours of discharge a discharge letter is sent to the service user's GP and a copy of the service user's care plan is sent to the accepting service (if applicable)

Results

Of the people who were discharged during the audit (who had a registered GP):

99% had a discharge letter sent to their GP. In **1% of cases**, it was **unknown/ not documented** whether a letter had been sent

Only **45%** of letters were sent **within 24 hours**

What this means

In a few cases it was not possible to tell if the person's GP had been informed of their discharge. For people whose GP was informed, there were cases when they were not provided with essential information. Of the people who were discharged into the care of another service, the care plan was not transferred, or it is not possible to tell if it was, in over half of cases.

Audit Recommendation 6

a) Trusts should:

Ensure systems are set up to facilitate discharge letters to primary care services within 24 hours.

We asked whether the discharge letter included:

Contact details for the team/service responsible for the service user's care:
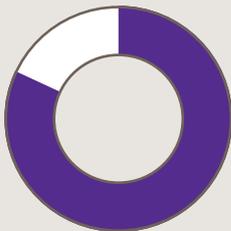
Yes 82%   No 18%

Medications including dosage and frequency:
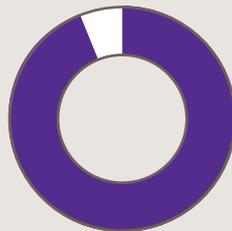
Yes 94%   No 6%

Risk to and from self and/or others:
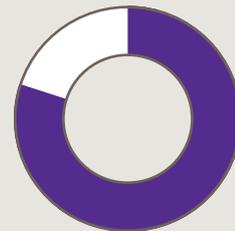
Yes 80%   No 20%

A care plan was sent to a nominated person in an accepting service in **46% of cases**. **In 15% of cases it was not, and in 39% of cases it was unknown or not documented.**

Why it matters

If a GP is not informed of discharge or is not provided with information about their patient's current mental health, treatment received, medications prescribed and level of risk, the GP will struggle to meaningfully follow up and support the person. If they have not been informed about changes to medication, they will not be able to issue repeat prescriptions or enquire about treatment response.

If the accepting service is not provided with the person's care plan, they will not know what approach or interventions were previously tried. This means they are starting from scratch, which duplicates effort and is frustrating for the individual.

Like care plans, where desired, discharge plans should be made available to the service user so they can be involved in decisions about their own care. This does not happen in my experience, processes are vague and not transparent.

What would service users and carers like to happen?

For service managers

Meaningful information about an individual's treatment at the service must be passed onto their GP and the accepting service to ensure continuity of care. A template letter of discharge can be used to ensure all necessary information is passed on.

It is unacceptable that letters are sometimes sent to GPs more than 3 days after discharge and completely unacceptable that no letter was sent. This will lead to long delays in care and a lack of coordination.

STANDARD 10

The service user and their family member, friend or carer (if applicable), receives at least 24 hours' notice of discharge and this is documented

Results

Of the people discharged during the audit, **77%** were **given at least 24 hours' notice** of discharge, **23% were not**

70% of identified families, friends or carers were **given at least 24 hours' notice** of discharge but **30% were not**

What this means

Almost a quarter of service users and their carers were not given advance notice of discharge.

Audit Recommendation 6

b) Clinicians should:

Give all service users, and where agreed a carer, at least 24 hours' notice of discharge. Notification of discharge should be documented in clinical records.

Why it matters

Transitions into and out of services are usually stressful times. People and their support networks need to know in advance when a person is coming out of the service to enable them to prepare emotionally and practically.

Potential explanations for 23% of people not being given 24 hours' notice might be that people are discharging themselves or alternatively that there is a bed shortage and unmet service requirement.

We do not currently know the reasons for this and is potentially something that the audit will undertake more focused work on in future. Please see page 42 for more information on what NCAAD are doing next.

> **If someone says 'I've had enough, I'm going', it is a very different scenario to the psychiatrist saying 'you are free to go'. It highlights something amiss about the ward environment.**

> **The data make me wonder whether patients are being discharged within 24 hours because of a bed shortage.**

The rushed discharge also implies that the service is not working with the individual to prepare them for discharge...

> **Conversations about self-management before discharge are essential. For example, I have been taking medication for 4 years but I still often forget. There could have been more support for this while I was on the ward.**

...or considering where they will be going and what their social situation will be.

> **Where are people who aren't being given notice going? What happens if the housing they are returning to is insecure, unsafe or non-existent? This is only going to worsen their distress and impede recovery.**

> **They assumed I was fine because my mum visited me every day. But I didn't live with my mum. My situation was much more precarious but it wasn't considered.**

What would service users and carers like to happen?

For service managers and clinicians

The living conditions and social situation that people are returning to need to be considered when drawing up a discharge plan. This is another reason why it is so important to gather good demographic and social information on admission (see Standard 1).

Individuals and their carers must have at least 24 hours' notice of discharge, but ideally for however long is required for necessary provisions to be in place.

If a service has a high proportion of self- discharges, the reasons behind this should be considered and action taken to make the service more tolerable to people.

STANDARD 11

Service users discharged from an inpatient setting receive a follow-up within 48 hours of discharge

Results

90% of people received a follow-up, **10% did not** or it was not possible to tell if they had or not

For people who had a follow-up, for **82%** it was face-to face and for **18% it was over the telephone**

57% of people were followed up **within 48 hours**

What this means

The majority of people received a follow-up after discharge, with this being face to face in most cases. However, a fifth of people's follow-up was over the phone and in 10% of discharges, a follow-up was not conducted or it is unknown if it was or not.

Audit Recommendation 6

c) **Clinicians should:**

Offer all service users a follow-up within 48 hours of their discharge from hospital.

Indicates results that may be less reliable. This is because there were discrepancies between how the first and second auditors interpreted the information recorded in the case notes (see page 8 for details of how NCAAD checked data accuracy).

Why it matters

The first 48-hours after discharge is known to be a time of higher risk. Services should check on people's wellbeing within this time period in a meaningful way.

> **If you are going home to an empty house with no food in, this is the time when you are most vulnerable and in need of support.**

> **The data doesn't tell us anything about the quality of the follow-up or what it constitutes. Does face to face mean the patient has to come back to the hospital, which might be distressing, or will the crisis team visit them at home?**

> **There should not be a telephone follow-up unless the patient requests it or there are extreme circumstances that mean face to face is not possible.**

What would service users and carers like to happen?

For service managers and clinicians

All service users should be followed up. This must happen within the first 48 hours after discharge. A prior conversation should be had with the service user about what they want their follow-up to look like.

> **The follow-up should include ensuring that the GP has received the discharge letter and that the person is settled and knows what their situation is re. medication and further support.**

STANDARD 12

Service users have a crisis plan agreed and in place prior to discharge from an inpatient service

Results

74% of people had a crisis plan at the point of discharge but **26% did not**

What this means

Over a quarter of people did not have a crisis plan when they were discharged.

Audit Recommendation 6

d) Clinicians should:

Ensure that all service users have an agreed, jointly developed crisis plan in place at the point of discharge.

Why it matters

People who are admitted to services are vulnerable to crises not only during their stay but also afterwards. Having a crisis plan suggests that a conversation has been had about what to do if this happens. It is an essential part of a person's care.

> I have never had a crisis plan agreed or if I have, I have never been informed. It's an important document that must be done in consultation with service users but it needs to be meaningful and not a tick-box exercise.

> I didn't have a crisis plan. I felt very much on my own when I left services and that it was a case of trying to clear beds as quickly as possible. I was given a number for Samaritans, but I already knew about this service. It was only when I left that I found out about other services through my own research. There are many excellent services out there that can help in a crisis, which can avoid having to present to A&E. These services should be promoted in inpatient services.

> The data collected for this standard doesn't say anything about the quality of the crisis plan. Is it a leaflet? I once got a business card.

What would service users and carers like to happen?

For clinicians

A crisis plan should be developed with the service user and should be consistent with their care plan.

For service managers

Service managers should ensure that a copy of the crisis plan is given to the service user, their nominated supporter and their GP.

STANDARD 13

Assessments include the use of an appropriately validated outcome measure(s) (e.g. symptoms, level of functioning and/or disability) which are used to monitor, inform and evaluate treatment

Results

61% of people were assessed using some kind of standardised assessment measure. **39% were not**

42% of young people were assessed using the **Children's Global Assessment Scale (CGAS)**
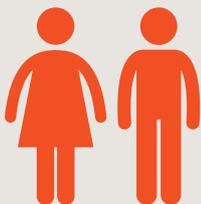
55% of adults were assessed using the **Health of the Nation Outcome Scale (HoNOS)**

What this means

In a large proportion of people, standardised measures were not used when assessing them. There is no single outcome measure routinely used nationally. This may also mean that some people are not being assessed at all.

The data captured for this standard do not reflect the experience of the assessment process or how beneficial service users find it.

Audit Recommendation 7

Trusts should:

a) Agree and implement reliable systems for assessing the effects of treatment offered to service users.

b) Ensure that clinicians are trained in the use of reliable outcome measures for assessing change, and key clinical outcome measures should be reviewed regularly.

Why it matters

If service users are not assessed with reliable measures when admitted, as well as throughout treatment and at the end of it, it will not be possible to describe what improvement, if any, has been made. As well as being essential for evaluating service performance, an assessment may also be useful for individuals who appreciate being able to track how they are getting on.

> **I like outcome measures. I find it quite helpful to see how you've progressed, especially if it is a big score difference. They can make you ask questions of yourself that you may not otherwise.**

> **I didn't mind doing outcome measures but I felt my mood varied week on week depending on what had happened that day so sometimes it isn't an accurate representation of your progression in therapy. I found my progress really came after I had been out of therapy for a while and had time to practise what I had learnt.**

> **I was never given my scores after I'd filled the questionnaires in. They should be used to spur a discussion, not to be filed away never to be seen again. Otherwise, it is just ticking boxes.**

What would service users and carers like to happen?

For clinicians

An initial assessment and review that includes the use of a standardised outcome measure should always be carried out. The review should be seen as an opportunity to have a conversation about how the service user is getting on. It should not be a tick-box exercise.

Where appropriate, service users should be given their scores and this information should be put in context.

FULL LIST OF RECOMMENDATIONS

1

a) Clinicians should:

Ensure that information about employment and accommodation is collected for all service users admitted to hospital with anxiety and depression.

b) Trusts should:

Ensure timely access for service users with anxiety and depression admitted to inpatient mental health services. To achieve this, Trusts need to have systems that accurately capture the date and time they are notified of the need for a bed, and action needs to be taken to improve access to inpatient care for adolescents.

c) Commissioners should:

Act to ensure there is adequate provision and access to inpatient care for adolescents admitted to hospital for anxiety and depression.

2

a) Clinicians should:

Ensure that clinical assessment of all inpatients with anxiety and depressive disorders includes information about social stressors, financial circumstances, previous traumatic experiences, and previous response to treatment in keeping with NICE CG123 (1.3.2.2./1.3.2.6) and CG136 (R1.3.3).

b) Clinicians should:

Ensure that full consideration is given to the physical health all people who are admitted to hospital for anxiety and depression, including:
- Diagnosis of coexisting physical health conditions
- Measurement of Body Mass Index
- Assessment and interventions for smoking, excessive use of alcohol and substance misuse.

3

a) Clinicians should:

Ask all people accessing inpatient mental health services for anxiety and depressive disorders whether they wish to nominate someone as their named main support. Offer this named person a carer's assessment and document if this is declined.

b) Clinicians should:

Offer all people with anxiety and depressive disorders a copy of a jointly developed, person-centred care plan, with a documented review schedule.

4

a) Prescribers should:

Review at one week following commencement all people who are started on new medication during an episode of inpatient treatment for anxiety and depressive disorders in collaboration with the service user.

The review must document the degree of response and any side effects experienced.

Particular attention should be paid to ensure all individuals aged <30 years and all those considered to be at risk of suicide are having their medication reviewed.

5

a) Clinicians should:

Ensure that all those admitted to hospital for treatment of anxiety and depression are offered an assessment for psychological therapy in line with NICE guidance and record these discussions.

b) Trusts should:

Investigate reasons for low referral rates to psychological therapy.

6

a) Trusts should:

Ensure systems are set up to ensure discharge letters are sent to primary care services within 24 hours for all people who are discharged from hospital following inpatient treatment for anxiety and depression.

b) Clinicians should:

Give all service users, and where agreed a carer, at least 24 hours' notice of discharge following inpatient treatment for anxiety and depression.

Notification of discharge must be documented in clinical records.

c) Clinicians should:

Offer all service users a follow-up within 48 hours of their discharge from hospital following inpatient treatment for anxiety and depression.

7

a) Trusts should:

Agree and implement reliable systems for assessing the effects of treatment offered to people with anxiety and depressive disorders. Consideration should be given to aligning these with the ICHOM Standard Set for Depression & Anxiety.

b) Trusts should:

Ensure that clinicians are trained in the use of outcome measures for assessing change; key clinical outcome measures should be reviewed regularly, and acted upon by relevant Trust Assurance Committees where and when necessary.

WHAT HAPPENS NEXT?

For Trusts and services

Trusts are asked to examine the technical report for further details on how they are performing against national data. In addition to the publicly available reports, individual Trusts will be sent a report with local data that will enable them to see how their services are performing against the national average. Topic areas that are identified as needing improvement will be the focus of quality improvement workshops held by the RCPsych that all Trusts are invited to attend.

If there are more serious cases where services are identified as performing below the accepted level (known as a negative outlier), the overseeing Trust will be informed. The Trust will be asked to explain the poor performance or provide data to show that there was an error in the previous submission. If they can't, the RCPsych will ask the Trust to respond with a plan of how they and the service are going to improve care. The RCPsych will support them to implement the plan.

The Care Quality Commission (CQC), the regulator for all health and social care services in England, will be notified of all positive (services performing better than average) and negative outliers. You can find more information about the NCAAD Outlier Policy and other core resources online at www.rcpsych.ac.uk/ncaad.

For service users and carers

There are several ways for people to voice their concerns about their local mental health services. They may also wish to get involved in how services are run in order to help make them better.

Concerns and complaints

- People who want to report concerns about performance should initially approach their local **Patient Advice and Liaison Service (PALS)**. You can find your local PALS by visiting https://www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-(PALS)/LocationSearch/363

- **Healthwatch** is an independent "national champion" for people who use health and social care services in England. They focus on "ensuring that people's worries and concerns about current services are addressed". You can find your local Healthwatch by visiting https://www.healthwatch.co.uk/your-local-healthwatch/list

Shaping services locally and nationally

Local involvement

Opportunities to get involved locally vary between areas.

- To shape how services are run from the ground up, consider getting involved with your local **Clinical Commissioning Group (CCG)**. These are the bodies that plan and buy healthcare services for people in their area. More information about how to get involved is available at https://www.england.nhs.uk/participation/get-involved/local/

- Some other suggestions to discover what is available in your area include contacting your hospital Trust to find out if they have an active service user and carer involvement group or a disability forum, speaking to someone involved in your care, and contacting any local mental health charities or patient organisations.

- You may also find that PALS or your local Healthwatch may be able to provide further information.

National involvement

- To get involved specifically with mental health services, consider becoming a "participating stakeholder" for a mental health **Clinical Reference Group (CRG)**. CRGs are groups of clinicians, commissioners, public health experts, service users and carers who use their knowledge and expertise (including that gained through lived experience) to advise NHS England on the best ways that specialised services, such as mental health services, should be provided.

- You can read more about CRGs and how to register as a stakeholder at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/

- For more information about getting involved in NHS England mental health services generally, visit https://www.england.nhs.uk/commissioning/spec-services/get-involved/

For the RCPsych

Two 'Spotlight Audits' of services providing care to service users with anxiety and depression are underway or planned. Of these, one is a more focused look at secondary care psychological therapy services.

LIMITATIONS OF THE AUDIT

This audit was a 'retrospective case note audit'. This means that data were collected from the case notes of service users who had been discharged from inpatient services within a certain time frame.

The data capture information that was recorded in people's notes or can be inferred from them. The information is then used to decide whether a service is meeting the required standard. There is a possibility that activities might have taken place but they weren't recorded in the case notes.

For example, if a GP was notified of a service user's discharge within 24 hours but this was not recorded in the case notes, the audit would count this as not being done.

Although case notes are written by clinicians and service staff, this judgement does not reflect service users' perspectives or capture how they feel about the service.

As a service user, you've got a different perspective. The way things are recorded doesn't reflect what has happened, for example, the anger you may sometimes feel.

The audit also summarises how well a service is doing by converting this information into numerical data about how often criteria are asked about or fulfilled.

This tells us whether something has happened but it does not say anything about how well it happened or what the experience was like for the service user. It does not tell us anything about the quality of the interaction.

What would service users and carers like to see in future audits?

It was recommended that for future audits interviews with service users and carers are carried out alongside the audit to collect richer information about their experiences, their thoughts and feelings about the service.

I feel we have seen lots of numbers about what services are doing well and what they could improve, but there is a whole other side to my experience of mental health services that the numbers don't show. How you are treated by staff and whether you feel you have been involved in your care is so important for recovery and we should be looking at this.

What NCAAD is doing next

For the next 'Spotlight Audit', NCAAD will collect qualitative feedback from service users to expand on some of the issues that have been identified in this report, and to gain further insights into people's experiences of accessing mental health services in secondary care. This report will be published in 2020.

WHO WAS INVOLVED?

- Nick Barber, *NCAAD Service User Representative*

- Professor David S. Baldwin, *NCAAD Clinical Lead, RCPsych*

- Paul Basset, *Statistician, Statsconsultancy Ltd*

- Kat Berry, *former Senior Operations Manager, McPin Foundation*

- Jessica Bond, *Communications Specialist, McPin Foundation*

- H F Borscha Azmi, *former NCAAD Project Officer, RCPsych*

- Francesca Brightey-Gibbons, *former NCAAD Programme Manager, RCPsych*

- Professor Mike Crawford, *Director of the Centre for Quality Improvement, RCPsych*

- Dr Lorna Farquharson, *Clinical Advisor to the Psychological Therapies Spotlight Audit, RCPsych*

- Naomi Fitzpatrick, *NCAAD Project Officer, RCPsych*

- Emily Lesnik, *former NCAAD Deputy Programme Manager, RCPsych*

- Natasha Lindsay, *NCAAD Project Officer, RCPsych*

- Aimee Morris, *former NCAAD Project Officer, RCPsych*

- C. Newton, *NCAAD Carer Representative*

- Amy Peabody, *former Senior Communications and Policy Officer, McPin Foundation*

- Dr Alan Quirk, *CCQI Senior Programme Manager (Audits and Research), RCPsych*

- Ellen Rhodes, *NCAAD Deputy Programme Manager, RCPsych*

- Prisha Shah, *NCAAD Service User Advisor*

- Imogen Voysey, *NCAAD Young Person Representative*

- Dr Ryan Williams, *CCQI Clinical Fellow, RCPsych*

For details of the professional partners involved and members of the steering group, please see the technical report available at www.rcpsych.ac.uk/ncaad. On this webpage, you will also be able to find other resources such as a list of diagnoses eligible for the audit, a list of references used to develop the standards, and a link to the British National Formulary.

Thank you to all the service users and carers who contributed to the audit, and to those who gave their time and insight to co-create this report.
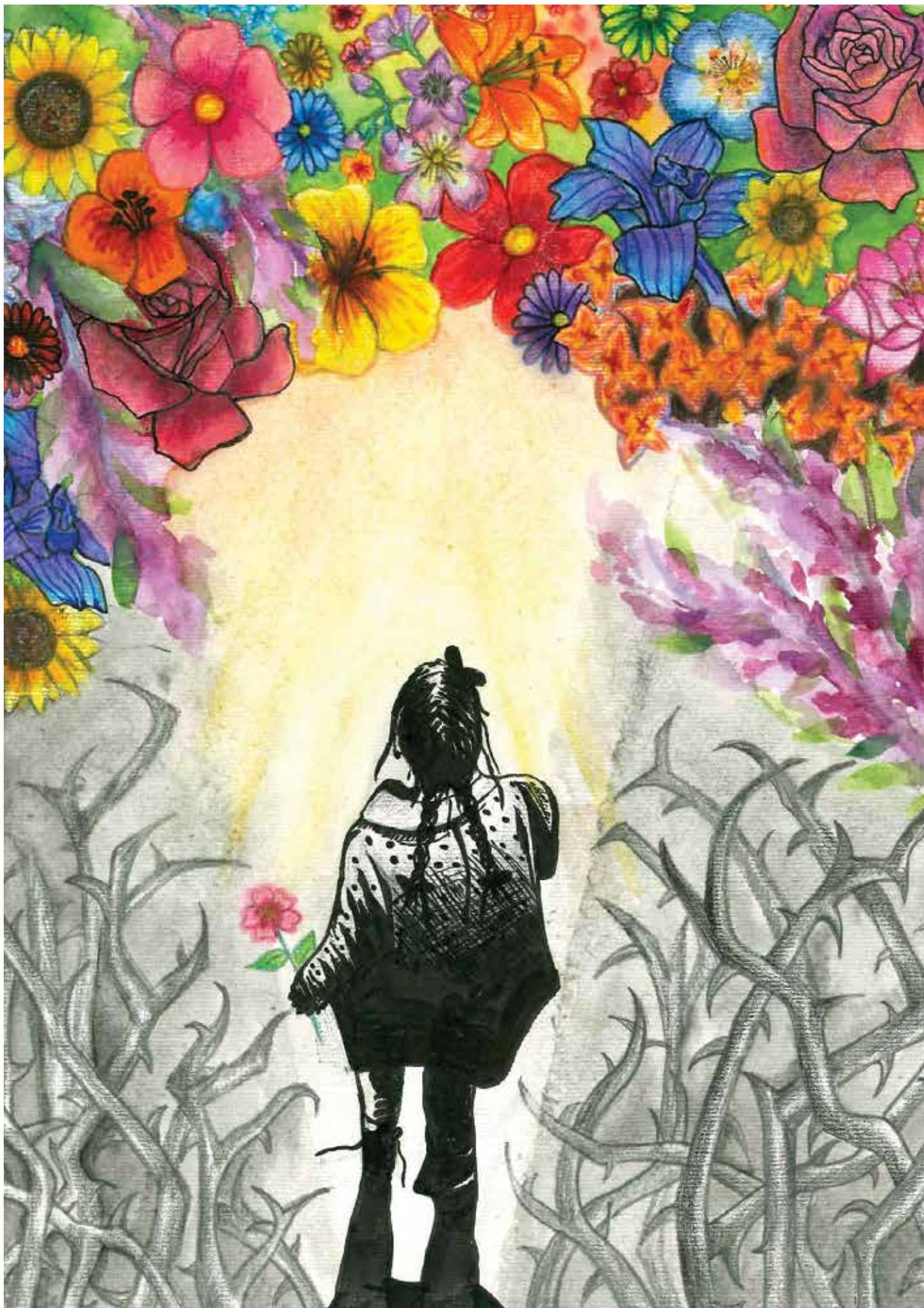
This image is by Manahil Masood (age 14). Manahil was awarded 2nd place in an art competition run by the National Clinical Audit of Anxiety and Depression in 2018. The theme was 'overcoming anxiety and depression'.

SOURCES OF SUPPORT

If you need support for your own mental health or that of a loved one, the following organisations may be able to assist you:

- www.mind.org.uk

- www.sane.org.uk

- www.thecalmzone.net/help/get-help

- www.samaritans.org

- www.anxietyuk.org.uk

- www.nopanic.org.uk

- www.carersuk.org

- www.carers.org

- www.youthaccess.org.uk

- www.youngcarerstogether.org.uk

- www.youngminds.org.uk

- www.rethink.org

- www.disabilityunited.co.uk
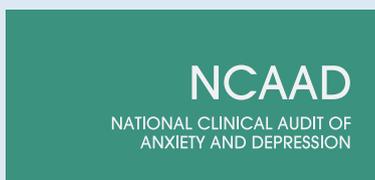
Royal College of Psychiatrists

We work to secure the best outcomes for people with mental illness, learning difficulties and developmental disorders by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

www.rcpsych.ac.uk

The McPin Foundation

We are a mental health research charity. We champion experts by experience in research so that people's mental health is improved in communities everywhere.

Research matters because we need to know a lot more about what works to improve the lives of people with mental health difficulties, their families and communities. We believe better mental health research is done by involving experts by experience. We work collaboratively with others sharing our values.

www.mcpin.org
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