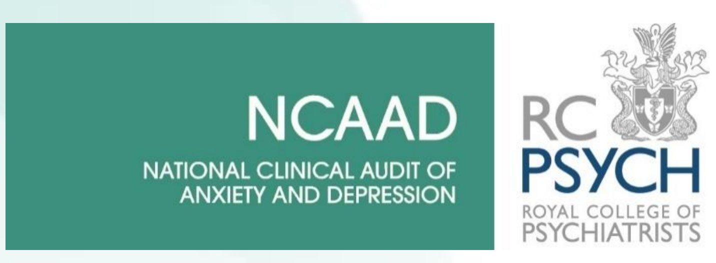
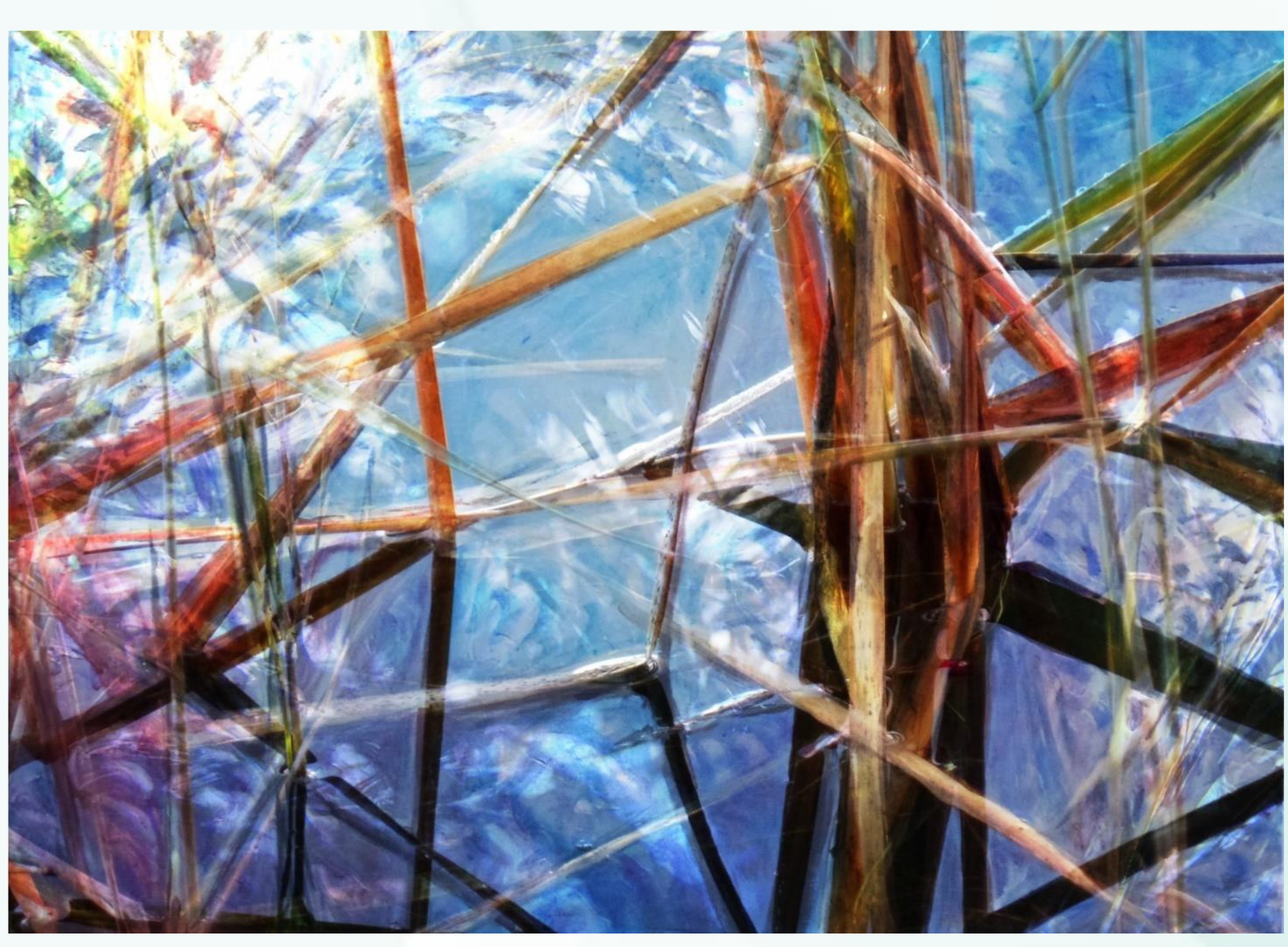


National Clinical Audit of Anxiety and Depression

Technical Report for the Core Audit
2017 - 2018



The purpose of this report

This report is a full account of the background, methodology, and findings of the core audit of the National Clinical Audit of Anxiety and Depression. It provides a detailed overview of the current state of NHS psychiatric inpatient care. The report is designed for the use of senior clinicians, health policy makers, commissioners, audit leads, researchers, and other relevant stakeholders to help understand and improve these services. The Technical Report contains a comprehensive list of recommendations for action.

The main audit findings have been published in an accessible report co-produced with service users and carers alongside this technical report and is aimed at anybody interested in the results of the audit. It provides insight into why the findings and recommendations are important to service users and carers and should be read in conjunction with this report.

Cover image: *Uncertain Reflections (Reeds)*, by Jessie Davies - "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." Winner of NCAAD Art Competition 2018.

PUBLICATION DATE: 10 October 2019
Publication Number: CCQI 308

Correspondence: NCAAD@rcpsych.ac.uk
If citing this report, please reference it as: Royal College of Psychiatrists (2019). *National Clinical Audit of Anxiety and Depression – Technical Report for the Core Audit 2017-2018*. CCQI 308. Healthcare Quality Improvement Partnership

The audit was commissioned by the Healthcare Quality Improvement Partnership (HQIP). The report is produced and published by the Royal College of Psychiatrists' Centre for Quality Improvement.

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Compiled by

The National Clinical Audit of Anxiety and Depression Project Team

H F Borscha Azmi, *former* NCAAD Project Officer
Professor David S. Baldwin, NCAAD Clinical Lead
Paul Basset, Statistician, Statsconsultancy Ltd
Francesca Brightey-Gibbons, *former* NCAAD Programme Manager
Professor Mike Crawford, Director of the Centre for Quality Improvement
Dr Lorna Farquharson, Clinical Advisor to the Psychological Therapies Spotlight Audit
Naomi Fitzpatrick, NCAAD Project Officer
Emily Lesnik, *former* NCAAD Deputy Programme Manager
Natasha Lindsay, NCAAD Project Officer
Aimee Morris, *former* NCAAD Project Officer
Dr Alan Quirk, CCQI Senior Programme Manager (Audits and Research)
Ellen Rhodes, NCAAD Deputy Programme Manager
Prisha Shah, NCAAD Service User Advisor
Dr Ryan Williams, CCQI Clinical Fellow

Acknowledgements

Development of standards and recommendations

We thank all members of the Steering and Service User and Carer Reference Groups, along with our partner organisations. For full details of the Steering Group members and the Project Team, please see Appendix 3: Steering Group and Project Team Members.

Support and input

We thank the Healthcare Quality Improvement Partnership (HQIP) for their support and encouragement, and staff in participating Trusts and organisations for their hard work and engagement in this audit.

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Executive Summary

This report presents key findings from the core audit of the National Clinical Audit of Anxiety and Depression (NCAAD). NCAAD is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), funded by NHS England.

Background

NCAAD is a three-year quality improvement programme, established to improve the quality of mental health care for people who are admitted to hospital for the treatment of anxiety and depression in England.

Audit Themes

Thirteen standards were developed based on NICE guidelines and quality standards, a literature review and feedback from a Steering Committee of service users and providers. These standards are further grouped into seven themes: access, assessment, shared decision making, medication, psychological therapies, discharge and outcome measurement.

Methodology

All NHS Trusts in England that provide inpatient mental health services agreed to take part in this audit. Each Trust was asked to submit data on a sample of people who were admitted to hospital between April and September 2017 and received inpatient care for anxiety and depression. Data were collected regarding the care of 3,885 service users, an 87% return rate on expected submissions. Following data cleaning, data from 3,795 records were analysed for this report. This represented an 85% return against the numbers expected. Appendix 2, page 40-41, shows the number of returns for each Trust.

Audit Themes

Access considers whether access to inpatient services is timely and equitable.

Assessment examines whether people admitted to a mental health inpatient service receive a comprehensive assessment of their mental and physical health needs.

Shared Decision Making considers whether the needs and preferences of people with anxiety and depression, and their family members, friends or carers are considered in assessments and care plans.

Medication examines whether people with anxiety and depression are provided psychotropic medication in line with relevant National Institute for Health and Care Excellence (NICE) and British National Formulary (BNF) guidance.

Psychological Therapies considers whether people with anxiety and depression are provided psychological therapies in line with relevant NICE guidance.

Discharge investigates whether people with anxiety and depression and their family members, friends or carers are given adequate notice of discharge from the ward with relevant crisis plans and follow-ups in place.

Outcome Measurement examines the use of validated measures to monitor and evaluate the outcome of treatment of people with anxiety and depression.

Key Findings and Recommendations

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 Recommendations
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.	➡	**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.
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.	➡	**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.
Psychological therapies were only offered to 39% of service users.	➡	**Clinicians** should: routinely offer psychological therapies in line with NICE guidance. **Trusts** should: investigate the reasons for low referral rates.
Outcome measures are not routinely being used to assess change; **39%** of service users were not assessed using an outcome measure.	➡	**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.
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 of discharge was not always given.	➡	**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.

Audit Background and Development

The National Clinical Audit of Anxiety and Depression is a three-year improvement programme, established to improve the quality of NHS-funded secondary care provided to service users with an anxiety and/or depressive disorder in England.

The NCAAD measures the performance of secondary care mental health services against criteria relating to care and treatment of people with anxiety and depression during and following an admission to hospital.

Most people who ask for help with anxiety or depressive symptoms are managed within services (such as Improving Access to Psychological Therapy [IAPT]) that are closely linked to primary care: only a small proportion will undergo inpatient care and treatment within mental health services. The findings from this audit are focussed on care provided to people with anxiety and depression who have an admission to hospital.

Anxiety and Depression in Secondary Care Mental Health Services

One in six adults in England have a common mental health problem such as anxiety or depression (McManus et al., 2016). Anxiety and depression are often unrecognised and undiagnosed, and many people who might benefit from treatment do not receive it. These disorders are associated with significant long-term disability and high level of morbidity and mortality, depression being the most common disorder contributing to suicide.

Depression is a broad and diverse diagnosis, presenting symptoms may include but are not limited to: continuous low mood, low self-esteem, disturbed sleep, loss of pleasure in most activities, isolation and avoidance of social situations. Mild depression accounts for 70%, moderate depression 20% and severe depression 10% of all cases. It is estimated that the number of people needing treatment for depression will increase to 1.45 million by 2026 and that the annual cost of treating depression is £1.7 billion (NICE, 2011).

Anxiety disorders include generalised anxiety disorder (GAD), social anxiety disorder (social phobia), specific phobia, panic disorder, agoraphobia and separation anxiety disorder. Anxiety-related conditions include post-traumatic stress disorder and obsessive-compulsive disorder (NICE, 2014). Common symptoms of anxiety disorders include excessive worrying, heightened tension, restlessness, difficulty concentrating, irritability and withdrawal from feared situations. The number of people needing treatment for anxiety is estimated to increase to 2.56 million by 2026. The annual cost of treating anxiety disorders was £1.2 billion in 2007 and this is expected to rise to £2.0 billion by 2026 (McCrone et al., 2008).

Objectives of the Audit

- To enable Trusts and other organisations to improve the quality of inpatient care for people who are admitted to hospital for treatment of anxiety and depression;
- To provide comparative data on the quality of care provided by Trusts to service users with anxiety and depression;
- To provide comparative data on service user outcomes following treatment;
- To improve the quality of care received by people with anxiety and depression by generating data that support local quality improvement initiatives, and by identifying and sharing examples of best practice.

Audit Governance

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

- Anxiety UK;
- British Psychological Society;
- Care Quality Commission;
- Carers Trust;
- Healthcare Quality Improvement Partnership;
- The McPin Foundation;
- Mind;

- Rethink Mental Illness;
- The Royal College of General Practitioners;
- The Royal College of Nursing;
- RCPsych.

Representatives from partner organisations collaborating in the audit comprise our Steering Group, together with four representatives with experiences of living or supporting someone living with anxiety and depression, and the audit Project Team. See Appendix 3: Steering Group and Project Team Members for a full list of Steering Group members.

Conflicts of Interest

Members of the Steering Group are asked to declare any conflict of interest at the outset and prior to each meeting. This is included as a standing item on the agenda. Should a conflict of interest affecting the conduct or results of the audit be declared, the member may be asked to absent themselves from all or part of the discussion, at the meeting and subsequently.

Notes on Terminology

- This audit is referred to as NCAAD.

- When using the phrase 'anxiety and depression' we are referring to people who have been given one or more diagnoses of an anxiety or depressive disorder at the time of their admission to hospital.

- Throughout the report, we use the term 'Trust' to refer to all organisations providing inpatient mental health services for people with anxiety and depression. Most of the organisations that took part in the audit were Trusts, but two were third sector organisations providing inpatient services for NHS service users.

- Representatives with lived experience of anxiety and depression or experience of supporting and caring for someone who has anxiety and depression draw upon their experiences to provide feedback into the Steering Group which advises on all aspects of the audit.

- Throughout this report, we use the term 'service user' to describe those who receive support for their own anxiety and depression, and 'carer' to describe family members, friends and significant others who support or care for someone with anxiety and depression.

Quality Improvement Workshops

Following publication of the national and local reports, audit leads can attend a series of workshops in November and December 2019.

These workshops will support the development and implementation of a range of approaches aimed at addressing the shortfalls identified by the audit.

Methodology

Audit Standards

NCAAD measures the performance of secondary care mental health services against thirteen quality standards. These standards were derived from national and professional guidance, including those from the National Institute for Health and Care Excellence (NICE), and guidance such as the 'triangle of care' published by the Carers Trust. A full list of the standards and associated references can be found in the Appendices.

Participation in the Audit

The NCAAD is applicable to all NHS-funded inpatient mental health services in England that provide care to service users with a diagnosis of anxiety and depression aged 16 and over.

All NHS Trusts that provide inpatient mental health services in England and were eligible to participate took part in the audit.

Identification of Sample

Participating Trusts were asked to generate a list of all eligible service users within their Trust and submit this list to the NCAAD team.

The maximum sample per Trust/organisation was 100, with a minimum sample of 20.

Inclusion and Exclusion Criteria

Service users were eligible for inclusion in the audit if they met the following criteria:

- Aged 16 years or above (no upper age limit);

- Admitted to an inpatient mental health unit between 01 April 2017 and 30 September 2017;
- Given a primary diagnosis of an anxiety or a depressive disorder, identified using ICD-10 coding, at the point of discharge.

Service users were excluded if they:

- Had a diagnosis of a non-affective (F20, F22, F24, F25, F28, F29) or affective (F30 F31, F32.3) psychosis, or cyclothymia (F34.0);
- Were admitted to a forensic unit or long stay ward such as a rehabilitation service.

Data Collection

Staff working in secondary care mental health services were asked to complete tools for each of their sampled service users, using data from their case notes.

The audit of practice tool included items on demographics, diagnosis, admission, assessment, care planning, medication, psychological therapies, physical health, discharge, re-admission, follow-up, crisis planning and outcome measures. The audit of practice tool is available on the audit website.

Where service users had more than one admission during the data collection period, only the first admission was used.

Data were submitted directly to the NCAAD project team via a secure online version of the audit of practice tool between June and September 2018.

A total of 3,885 returns were received, following the selection of an appropriate random sample from the eligible population provided by the 54 Trusts that took part in the audit. This represented a return of 87% of the numbers expected. The response rate for each participating Trust can be found in Appendix 2.

Data Handling and Analysis

All data were entered using Snap Survey Software via secure webpages. Data were analysed using IBM SPSS Statistics 21, Stata, or Microsoft Excel 2016.

Data Cleaning

The NCAAD team checked submitted cases against the eligibility criteria, as well as for duplicate cases, missing data and unexpected values. Data which appeared to have been entered in error were followed up by asking audit staff in Trusts to check if correct data had been submitted.

Following initial analysis, a second round of data cleaning was undertaken to clarify any potential data entry errors.

Changes Made to the Data

During the process of data management, the following changes were made:

- When it was possible to identify data entry errors with a high degree of confidence, responses were amended. Where it was not possible to identify an error with a high degree of confidence, no change was made;
- Where there were clear errors, for example, the follow-up date falling before referral date, and Trusts did not respond to the query, the data were changed to 'unknown/not documented'.

Quality Assurance

Inter-rater Reliability

We asked all services to re-audit five case notes from the submitted sample using a second auditor, so that matching case notes could be compared for reliability. The results of this analysis are published on the audit website.

Quality Assurance Visits

Three Trusts were randomly selected to take part in quality assurance visits, during which members of the NCAAD team carried out a random check of ten sets of the case notes submitted for the audit. Further information about this process can be found on the audit website.

Outliers

The outlier policy can be found on the NCAAD website. It has been informed by the Healthcare Quality Improvement Partnership and Department of Health guidance on outliers (2011).

We contacted all mental health services that were outliers prior to the publication of this report.

Methodological and Data Limitations

- Data returns were not evenly spread across Trusts

- Estimates of the performance of Trusts become less reliable when data were returned on fewer service users. Caution should be used when interpreting the performance of Trusts that returned data on fewer than 20 service users.

- The results are a snapshot reflecting the performance of a Trust at the point of data collection. It should also be considered that the standards can only be assessed as being met if the information is 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.
- Case notes are written from the perspective of clinicians and do not capture all aspects of treatment and care.

How the Audit Findings are Presented

National Results

This report contains overall results from Trusts in England taking part in the audit.

Audit Themes

All standards are measured within the audit of practice tool and data submitted are presented thematically:

1. **Access**
2. **Assessment**
3. **Shared Decision Making**
4. **Medication**
5. **Psychological Therapies**
6. **Discharge**
7. **Outcome Measurement**

Recommendations

Our key messages and recommendations can be found within the Executive Summary. Each results chapter contains detailed recommendations relating to the associated theme. A full list of our recommendations can be found on page 45.

Results

54 Trusts submitted a total of 3,885 cases. The complete NCAAD sample after data cleaning comprised 3,795 cases.

Guidance

- For clarity, most percentages in the text, Tables and Figures are rounded to the nearest integer, without decimal places. Percentages that are lower than 1% are rounded to one decimal place. Thus, the total percentages of some Tables or Figures may not add up to exactly 100%.
- Most Figures and Tables are accompanied by the number used to generate the depicted analysis. Occasionally, where a specific sub-group of service users is involved, this is described in the text.
- Much of the information is presented as bar charts, where each Trust is represented by a vertical bar. These bars are identified by a Trust code (see Appendix 2, page 40, for the corresponding Trust names) and are divided into coloured sections according to the key underneath the Figure. The percentages shown on the vertical axis indicate the percentage of service users in each Trust who met each item described in the key. In most Figures the higher performing Trusts are towards the left and lower performing towards the right.
- We have included a bar labelled 'TNS' in each figure. This represents the level of performance across England; the Total National Sample. These mean values represent an average of current practice and should not be considered as optimal practice.

- Access
- Assessment
- Shared Decision Making
- Medication
- Psychological Therapies
- Discharge
- Outcome Measurement

Access

In this section, we present and discuss findings for standards 1-2, covering demographic characteristics and inpatient service accessibility for service users with an anxiety and depressive disorder.

Standard 1: The Trust/organisation routinely collects data to assess equity of access.

Tables 1 and 2 show the demographic characteristics of the complete NCAAD audit sample.

Table 1 shows the ethnic background of service users in the audit, using the categories defined in the Office for National Statistics (ONS)' National Census. Comparison with data describing the ethnicity of the England population in the 2011 census suggests the NCAAD sample is broadly similar to the national population. Data on ethnicity were not recorded for 212 cases (6%).

Table 2 shows the number of service users in each age band. The split between males and females is similar across age bands.

Table 1: Ethnic profile of the NCAAD sample compared to the overall population of England (2011 census)

Ethnic Group*	Percentage in NCAAD Population (n)	Percentage in England Population
White *(British, Irish, Other)*	89 (3,194)	85
Mixed/Multiple Ethnic Group	2 (69)	2
Asian/Asian British	4 (155)	8
Black/African/Caribbean/Black British	2 (81)	4
Other Ethnic Group	2 (66)	1
Unknown/Not Documented	n=212	-

*18 service users declined to answer

Table 2: Proportion of the NCAAD sample in each age band by gender

Age band (years)	n (%) in each age band	Male n (%) in each age band	Female n (%) in each age band
16-17	95 (3)	22 (1)	73 (4)
18-25	481 (13) *	250 (13)	229 (12)
26-35	671 (18)	383 (20)	288 (16)
36-45	621 (16)	358 (18)	263 (14)
46-55	703 (19) *	375 (19)	327 (18)
56-65	473 (13) *	241 (12)	230 (12)
>65	751 (20) *	315 (16)	435 (24)

*<6 service users gender recorded as non-binary/other

Some diagnoses were recorded infrequently and for this reason we constructed four broad categories of psychiatric diagnoses with certain similarities, sufficient in size to permit comparisons and to prevent potential identification of individuals when audit findings were returned to participating Trusts.

Table 3: Proportion of the NCAAD sample in each diagnostic group (ICD-10) showing age and gender

Diagnosis (ICD-10 code)	n (%) in each diagnostic group	Mean age (years)	Age range (min-max)	Male n (%) in each diagnostic group	Female n (%) in each diagnostic group
Complete sample	**3,795**	**47**	**16 – 98**	**1,944 (51)**	**1,845 (49)**
Depressive episode (F32)	1,289 (34) *	**47**	16 – 92	673 (35)	615 (33)
Recurrent depressive disorder (F33); persistent mood [affective] disorders (F34); other mood [affective] disorders (F38, F39)	657 (17) *	**49**	16 – 98	287 (15)	370 (20)
Phobic anxiety disorders (F40); other anxiety disorders (F41); obsessive-compulsive disorder (F42)	801 (21) *	**43**	16- 97	363 (19)	436 (24)
Reaction to severe stress, and adjustment disorders (F43)	1,048 (28) *	**40**	16 - 98	621 (32)	424 (23)

*<6 service users gender not recorded or reported as non-binary/other

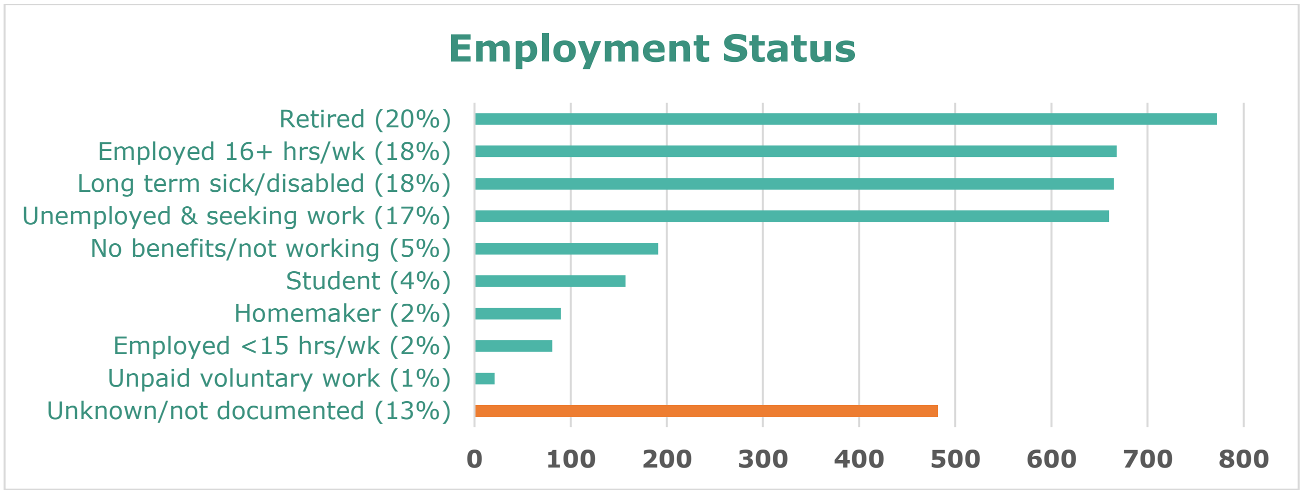
There was a higher proportion of females with a diagnosis of recurrent depressive disorder (F33), persistent mood [affective] disorders (F34), or other mood [affective] disorders (F38, F39); and a higher proportion of males with a diagnosis of a reaction to severe stress, and adjustment disorders (F43).

Table 4: Comorbid diagnoses

Number of Additional Diagnoses	Percentage (n)
Either no additional diagnoses OR presence/absence of additional diagnoses is uncertain	58 (2,182)
1 additional diagnosis	36 (1,349)
2 additional diagnoses	6 (229)
3 or more additional diagnoses	0.9 (35)
Type of Additional Diagnosis	
Organic, including symptomatic, mental disorders (F00 - F09)	2 (60)
Mental and behavioural disorders due to psychoactive substance use (F10 - F19)	14 (543)
Mood [affective] disorders (F30 - F39)	4 (164)
Neurotic, stress-related and somatoform disorders (F40 - F48)	9 (338)
Behavioural syndromes associated with physiological disturbances and physical factors (F50 - F59)	1 (47)
Disorders of adult personality and behaviour (F60 - F69)	11 (416)
Mental retardation [learning disabilities] (F70 - F79)	1 (36)
Disorders of psychological development (F80 - F89)	1 (951)
Behavioural/emotional disorders with onset usually occurring in childhood and adolescence (F90 - F98)	0.8 (32)
Unspecified mental disorder (F99)	0.6 (23)
Long term physical health disorder (e.g. motor neuron disease, multiple sclerosis, COPD)	6 (210)

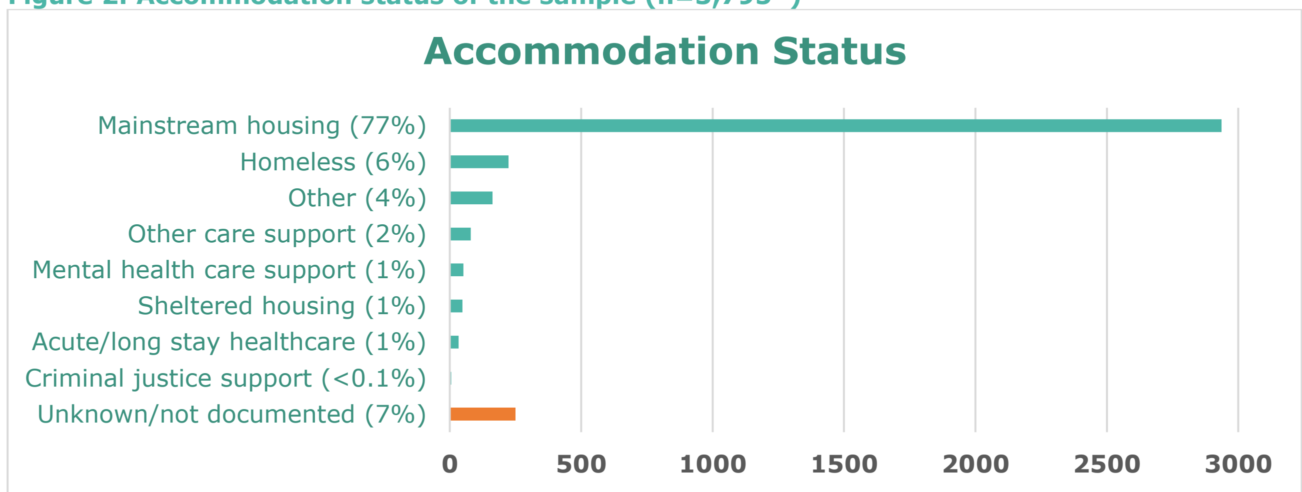
Approximately 43% of service users had a comorbid diagnosis. The most common additional diagnoses were mental and behavioural disorders due to psychoactive substance use and personality disorder, both of which can influence service provision, treatment choice and clinical outcomes. Of the service users who were recorded as having a comorbid diagnosis, the majority had only one additional condition.

Figure 1: Employment status of the sample (n=3,795*)



*8 service users declined to answer

Figure 2: Accommodation status of the sample (n=3,795*)



*<6 service users declined to answer

One in five service users in the audit were retired (n=772) and this is reflected in the age range (see Table 2). Employment status was not recorded for 13% of cases (n=482). Most service users were resident in mainstream housing (n=2,936). Accommodation status was not recorded in 7% of cases (n=250). Six percent of service users in the sample were documented as being homeless, with the proportion varying by region; Figure 3 shows that 12% of the service users in London-area Trusts were documented as homeless, compared to 4% in Trusts in the South West or Midlands.

Figure 3: Percentage of sample split by region documented as homeless

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

There are significant disadvantages associated with delays in the process of admission to a psychiatric hospital, particularly when these admissions are via emergency departments (Nicks and Manthey, 2012). Longer wait times for inpatient beds have been associated with certain service user demographic characteristics, including age (Warren et al., 2016).

NICE guidelines do not include specific recommendations for wait times involved in arranging inpatient care. However, they recommend that service users should have 'timely access' to appropriate interventions for mental health issues (CG136, 1.4.8), and specify that those referred in emergency situations should be assessed by appropriate specialist services within four hours (CG136, 1.5.5).

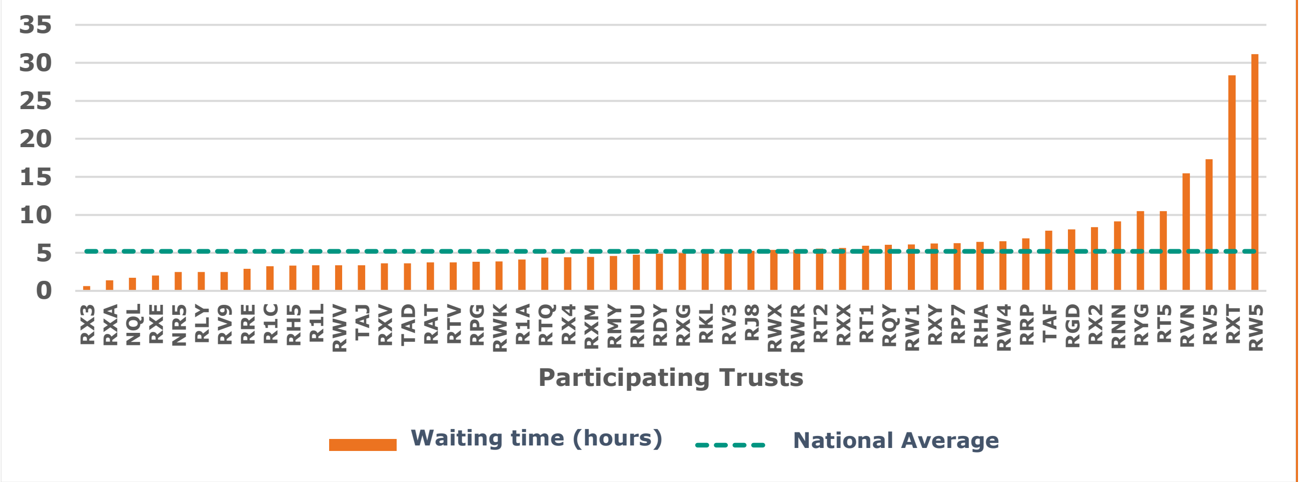
Trusts submitted details of the dates and times that hospitals were notified of a need for a bed, and the dates and times of admission. The completeness of date/time variables relating to notification and admission were assessed. Just over a quarter of service users had no data recorded on the date/time that the hospital was notified of a need for a bed (n=1,031). The date of admission was recorded in all service users, with a smaller proportion showing no record of time of admission (n=422).

Table 5: Time from notification to admission*

Time from notification to admission	Percentage (n)
< 0.5 days	72 (1,643)
0.5 – 1 days	9 (207)
1 – 2 days	8 (184)
2 – 7 days	7 (167)
7+ days	3 (69)

*based on 2,270 available cases

Figure 4: Average Trust level waiting times



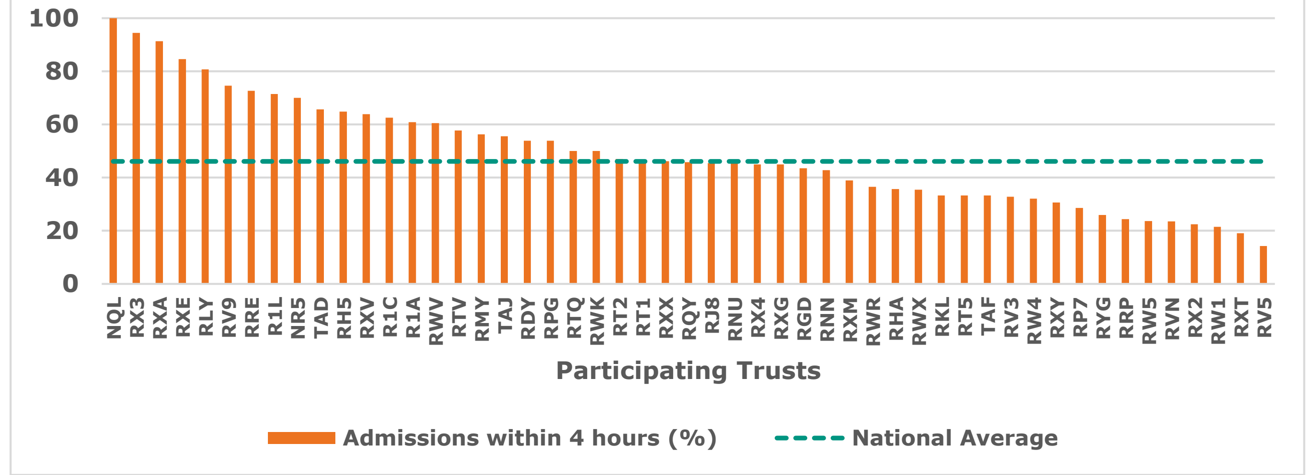
The time from notification to admission was available for only 60% of the sample (n=2,270). The data suggested a median time between the two events of approximately five hours, with an inter-quartile range from five to fifteen hours. The median delay between 'notification of the need for an inpatient bed', and 'admission' was highly variable, and significantly associated with service user age. Young service users aged 16-17 years waited much longer on average than other age groups, with an average waiting time for this age group of seventeen hours.

Table 6: Admission Information

Type of Admission	Percentage (n)
Voluntary (informal)	83 (3,165)
Under Mental Health Act	17 (630)
Section 2	91 (574)
Section 3	5 (33)
Section 4	1 (9)
Section 35, Section 36, or 'Other'	2 (14)
Figures for service users with non-voluntary admissions	
Planned	11 (412)
Transfer from acute hospital service	12 (461)
Transfer from another inpatient MH service	2 (84)
Emergency via Crisis Resolution/Home Treatment Team	29 (1,109)
Emergency via Community CAMHS or Community Mental Health	7 (251)
Emergency via Emergency Department	27 (1,031)
Admitted via Section 136/135 from a Health Based Place of Safety	6 (228)
Police custody	1 (55)
Other	3 (124)
Unknown/not documented	1 (40)

Information on the type of admission is reported in Table 6. Most admissions were characterised as 'emergencies', and were either via emergency departments or crisis resolution/home treatment teams. The national average for emergency referrals admitted within four hours was 46%. Over 80% of admissions were informal (n=3,165).

Figure 5: Percentage of Trusts meeting the national target of emergency admissions within four hours



Summary

This sample of service users with anxiety and depressive disorders is broadly representative of the UK population in terms of gender and ethnicity.

Data on employment and accommodation status were not recorded for a large number of service users. This suggests that questions about employment status and accommodation are not being routinely included in assessments. It is essential to record these key aspects of the social context of service users with anxiety and depression to develop appropriate care plans. The Homelessness Reduction Act (2017) means that there is now a statutory duty to notify local authorities of any service user who is homeless or at risk of homelessness.

While the waiting times for inpatient admission seem generally satisfactory (81% of service users were admitted within 24 hours), they were highly variable and associated with service user age. Further work is needed to standardise this process, ideally to reduce waiting times.

Recommendation 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.

Assessment

In this section, we present and discuss findings for standards 3-4, addressing aspects of the assessment process for service users with anxiety and depressive disorders. Details of each of the relevant standards are described at the beginning of each subsection.

Standard 3: Service user's assessments are comprehensive and include consideration of:

- **Identification of social support and stressors in relation to finance, education/employment and relationships;**
- **Previous traumatic experiences or associated symptoms;**
- **Previous treatments and response to them.**

Thorough assessment is essential for service users who are admitted to hospital with a mental health problem. As well as informing the diagnosis, information from a comprehensive assessment is crucial for formulating an appropriate care plan and targeting areas for intervention. Research demonstrates the benefits of implementing comprehensive standardised assessment procedures (Valenstein et al., 2009).

NICE guidelines recommend that assessments should review the service user's social and interpersonal difficulties, as well as their previous experiences of treatment (CG123, 1.3.2.2). Consideration of historical traumatic experiences is particularly important with service users who have symptoms of an anxiety or stress-related disorder, and this is also reflected in NICE guidance (CG123, 1.3.1.2).

Figure 6: Items identified as being included in assessments [where considered and applicable]

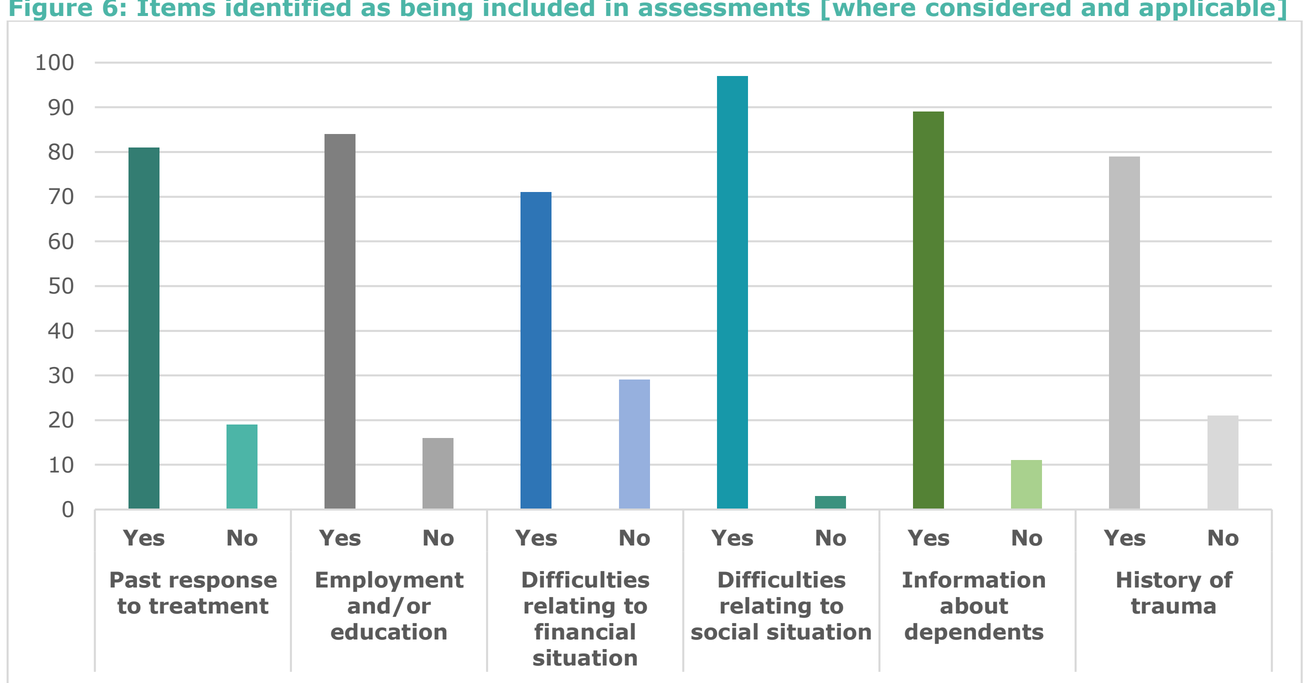


Figure 6 shows the proportion of assessments which included information relevant to Standard 3. Although most assessments included the relevant information, a sizeable proportion did not. While the data indicate that assessments were most likely to consider difficulties relating to the service users' social situation, this item was shown to have poor reliability after inter-rater reliability analysis was performed. Assessments were least likely to consider difficulties relating to their finances or their possible history of traumatic experiences.

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

Many service users with severe mental illness have poor physical health, with increased rates of cardiovascular disease and higher risk of premature mortality, when compared to the general population (De Hert et al., 2009).

Research in this area has largely focussed on associations with psychotic illness; however service users with depressive and anxiety disorders also have increased cardiovascular morbidity and mortality (Wulsin, et al., 1999). Physical health monitoring in this population has also been found to be variable and often inadequate (Lack et al., 2015).

NICE guidelines state that physical health problems should be assessed alongside mental health (CG123, 1.3.2.6). Services should establish clear links to treatment pathways for physical health needs (CG123, 1.5.1.8), and treatment options should be discussed with service users (CG 123, 1.4.1.1).

The potential for alcohol and other drugs to exacerbate symptoms of anxiety and depression, and for serious interactions between pharmacological interventions and alcohol and other drugs, means alcohol and substance misuse should be discussed as part of all assessments for service users admitted to hospital with anxiety and depression.

Table 7 shows the proportion of service users for which various parameters relating to physical health were recorded.

Table 7: Percentage of service users in the NCAAD sample where a need for an intervention for a physical health problem was identified and percentage where there was evidence that this was offered

Physical health indicator	Percentage of service users screened (n)	Percentage requiring an intervention (n)	Percentage requiring an intervention and offered
BMI* ≥ 25	70* (2,590)	53 (1,375)	29 (404)
BMI* ≥ 30	70 (2,590)	24 (615)	36 (218)
BMI* ≥ 23 (South Asian & Chinese only)	70** (102)	58 (59)	31 (18)
Blood pressure	19 (714)	9.1 (65)	45 (29)
Glucose control	12 (451)	11.1 (50)	16 (8)
Cholesterol	10 (388)	3 (13)	15 (2)
Smoking status	84*** (3,155)	44 (1,387)	47 (646)
Alcohol consumption	83****(3,084)	46 (1,431)	35 (507)
Alcohol consumption above 14 units	-	13 (407)	67 (271)
Substance misuse	91 (3,468)	29 (1,011)	34 (345)

*Three thresholds for intervention are used for BMI:

- BMI ≥ 25 kg/m2 is used as this corresponds to being overweight and above. This includes any South Asian or Chinese people with BMI ≥ 25 kg/m2.
- BMI ≥ 30 kg/m2 corresponds to obesity (NICE CG189, 2014) in which people are regarded as being at increased risk of long-term health problems.
- A separate threshold for analysis of data from all people whose ethnicity was South Asian or Chinese.

*136 documented refusal; **10 documented refusal; ***22 declined to answer; ****72 declined to answer

The data indicate that over half of service users were recorded as overweight, almost half were recorded as current smokers and consuming alcohol, and almost 30% were recorded as misusing drugs or alcohol. In all physical health categories, less than half of those requiring an intervention were offered one.

Summary

Most assessments included the information specified in the audit standards. However, information relating to service users' financial difficulties and history of traumatic experiences was less likely to be recorded.

A substantial minority of service users did not have documented evidence of receiving an assessment of their physical health. When physical health problems were identified there was limited evidence that people had been offered appropriate interventions aimed at improving their physical health. Further work is needed to improve this process as part of comprehensive assessments and ensuring parity of esteem.

Recommendation 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.

Shared Decision Making

In this section, we present and discuss findings for standards 5-6, addressing collaborative decision-making with service users and those supporting them.

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.

There is substantial evidence that service users with support networks composed of family, friends and formal/informal carers can achieve superior outcomes to those without (Avison WR, 1996). However, the care-giving role can impact negatively on carer health and wellbeing, which may in turn compromise a carer's ability to provide effective support (Department of Health, 1999).

NICE guidelines recommend that family members and carers involved in supporting a service user should be offered an assessment of their own caring, physical and mental health needs (CG113, 1.1.2). They should also be assisted with accessing appropriate support from groups and voluntary organisations.

In 62% of cases (n=2,339), an identified family member, friend, or carer was recorded as the main source of support. The audit asked if these identified individuals were offered information about available support services, and a support plan, and whether they were offered a carer's assessment.

Figure 7: Percentage of family member, friend or carers provided with information about available support services and a support plan, and percentage offered a carer's assessment

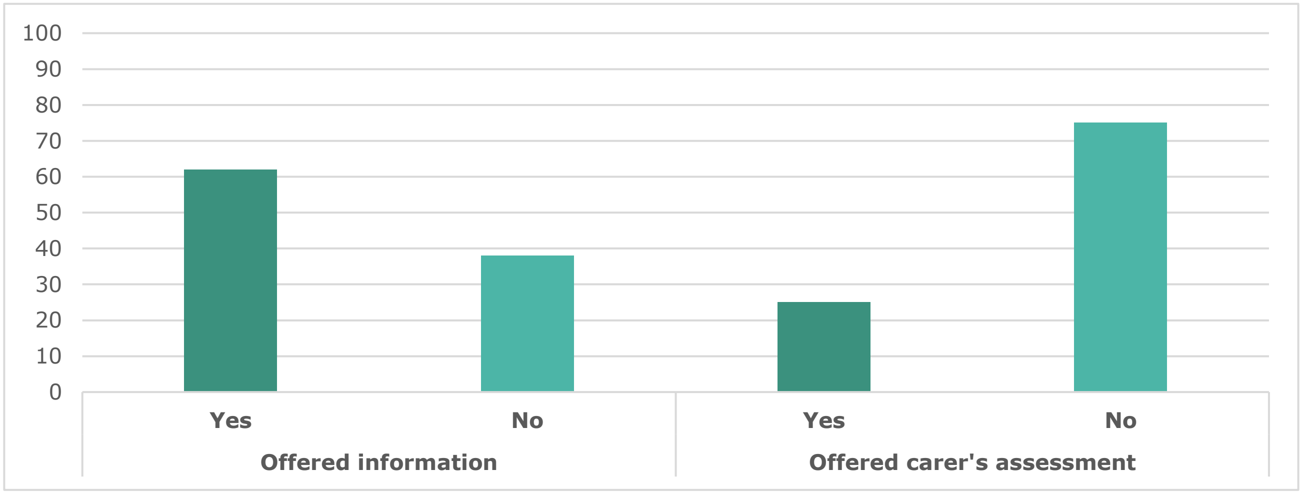


Figure 7 shows that where it was recorded that service users had a family member, friend or carer identified as the main source of support, a carer's assessment was only documented as being offered in approximately one-quarter of cases (n=579). Information about available support services, and/or a support plan were provided in 62% of cases (n=1,458).

The likelihood of information about available support services, and a carer's assessment being offered varied markedly. Carers assessments were more likely to be offered to carers of older, retired service users from white backgrounds. Assessments were less likely to be offered to carers of young or homeless service users. Information about support was more commonly provided to carers of those at the extremes of age, students, and those in residential healthcare facilities or mainstream housing.

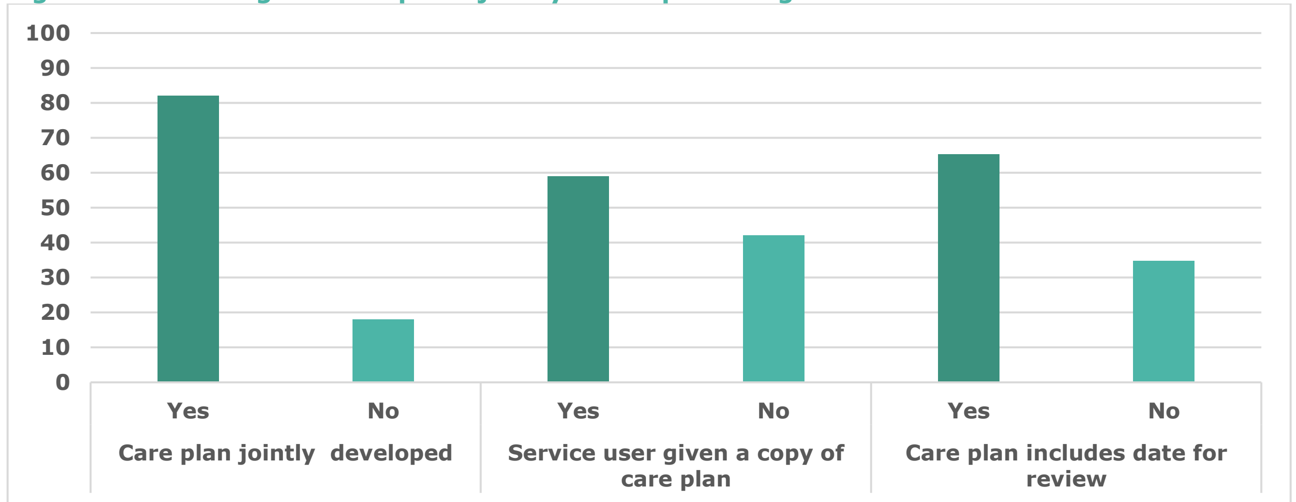
Standard 6: Care plans are jointly developed with service users and their family member, friend or carer (if applicable), and they are given a copy with an agreed date for review.

Empowering service users to contribute to their treatment is central to delivering patient-centred care, and approaches emphasising shared decision-making are strongly promoted by UK health policy (Department of Health, 2012). Personalised care planning is a nationally mandated strategy, whereby service users and their carers have the opportunity to work collaboratively with clinicians in discussing and documenting their plan of care (Dean and Wakefield, 2011).

This process should produce a written document, which should be jointly developed and accessible to the service user and include up-to-date information, to ensure high-quality care based on an individual's current needs and choices. NICE guidelines state that NHS mental health services should develop care plans jointly with service users, provide an up-to-date written copy, and agree a suitable time to review it (CG136, 1.4.2).

The vast majority (91%) of service users included in this audit were documented as having a care plan in place (n=3,445). These were jointly developed with the service user and their family member, friend or carer (if applicable) in 82% of cases (n=2,826). However, a documented review date was included in only 65% (n=2,251), and fewer service users received a copy of their care plan (59% n=2,016).

Figure 8: Percentage of care plans jointly developed and given to service users



Summary

Most carers of service users admitted to hospital with anxiety and depressive disorders were not offered a carer's assessment. It is not possible to make a distinction in the data between whether this is poor record keeping of carers declining the offer of an assessment or whether an assessment was not offered. Over a third of carers were not offered information about available support services.

The likelihood of either of these provisions being offered varied considerably with patient demographic characteristics, and carers for some vulnerable service user groups (such as the homeless) were less likely to receive them. Further work is needed to standardise this process and ensure appropriate support is available.

In general, care plans were formulated with input from service users and carers. However, copies were only provided to the service user in around half of cases, and a large proportion did not include review dates to ensure that they were kept current.

Recommendation 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.

Medication

In this section we present and discuss findings relating to standard 7, addressing psychotropic medications prescribed to inpatients with anxiety and depressive disorders.

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

Comprehensive NICE guidance is available regarding pharmacological management of depression (CG90) and anxiety/stress-related disorders (CG31, CG113, CG116, CG123).

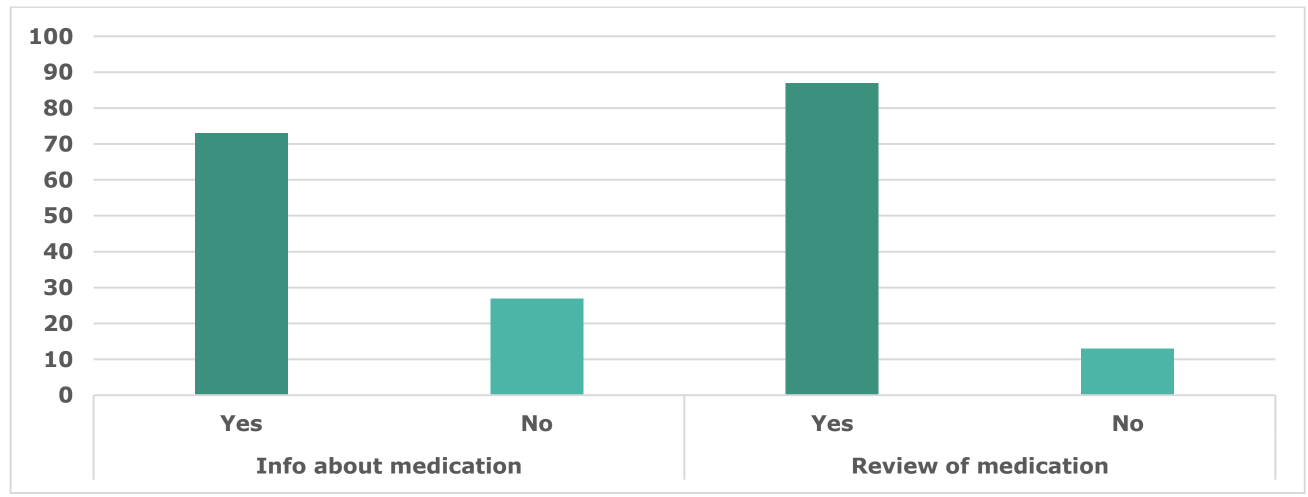
Choice of medications in specific cases is a complex process which may be influenced by a number of factors (including symptom severity, comorbidity, previous response to treatment and service user choice). NICE guidance allows for a wide range of treatment options for the same diagnoses, particularly where symptoms are refractory to treatment. The choice of specific agents in relation to diagnosis is beyond the scope of this report, which will focus on broader principles in prescribing.

The data presented in this section are based on the 87% of the NCAAD sample that were prescribed at least one psychotropic medicine (n=3,317).

All NICE guidelines applicable to this standard specify that service users who are offered pharmacological treatment should receive verbal or written information about the medication in question. The guidelines also specify that medications should be reviewed regularly.

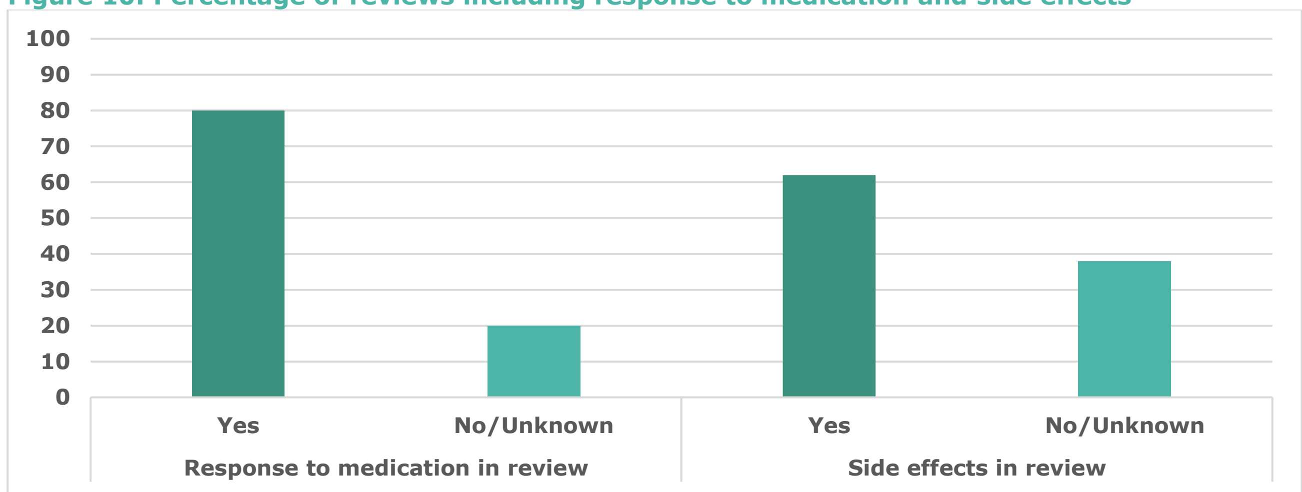
Figure 9: Percentage of service users given verbal and/or written information about their medication, and a review of their medication prior to discharge*

*of those prescribed psychotropic medication <u>and</u> discharged in the audit period (n=3,285)



Approximately three-quarters (73%, n=2,416) of those who were prescribed pharmacological treatments were provided with verbal or written information about their medication. In the majority of cases (87%, n=2,861), medication was reviewed prior to discharge. Within these reviews, 80% (n=2,294) included a review of the response to the medication, and 62% (n=1,775) included a review of side effects (Figure 10).

Figure 10: Percentage of reviews including response to medication and side effects



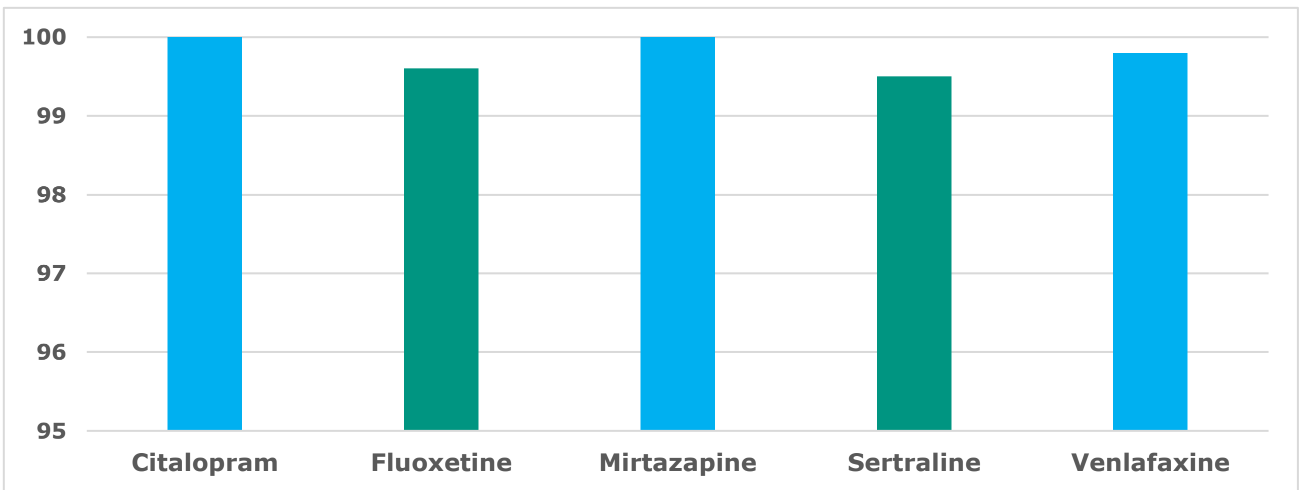
Younger service users (<30 years) appeared less likely to have their medication reviewed. Within this sub-group, service users who were prescribed antidepressant medication accounted for 20% of the sample (n=596). According to NICE guidance 1.5.2.5 and 1.5.2.7 for depression, service users in this sub-group should be followed up within one week, because of an increased risk of attempted suicide. Only 23% (n=102) of service users in this sub-group were recorded as having been followed up within a week of admission, and a review of the of medication was documented in only 64% of these service users (n=60).

The data were analysed to assess the percentage of service users with an increased risk of suicide documented as having a review within one week. Although emergency admissions can be for reasons other than suicide risk, and not all service users at risk of suicide are admitted as emergencies, emergency admissions, Section 136/135 admissions, and admissions from police custody were analysed as a proxy marker for heightened suicide risk. Within this sub-group, 7% were taking an antidepressant drug (n=2,052). Of the 306 service users that were discharged and followed up within a week of emergency admission, 69% (n=192) were documented as having a review of their medication.

The *British National Formulary* (BNF) provides guidelines for the use of individual agents, including maximum dosage limits and monitoring requirements. The maximum daily dosage differs for some indications for some drugs.

Service users who were receiving the most commonly prescribed medications (medicines that were prescribed in $\geq$5% of cases) were examined to check that prescribed doses did not exceed BNF limits (for any indication). The vast majority of cases (99.8%) accorded with BNF guidance, as shown in Figure 11.

Figure 11: Percentage of prescribed medications within BNF limits



Service users prescribed antipsychotic medications were examined to check whether appropriate physical health monitoring had taken place. As monitoring involves looking at physical health parameters more than once, this was not possible using this dataset. There was variable evidence of assessment of a measure of physical health: in 73% of cases BMI was recorded; in 46% of cases cholesterol was recorded; and in 85% of cases glucose was recorded.

BNF guidance also specifies that hypnotic/ anxiolytic agents such as benzodiazepines and Z-drugs should only be offered as short-term treatment for severe symptoms, and prescription of these agents should not exceed two weeks.

The dataset does not allow accurate information on the duration of treatment prescriptions. However, 93% of service users who were discharged on hypnotic/anxiolytic medications received a review of their medication within two weeks of discharge.

Summary

A significant minority of those who receive pharmacological treatment were not given information about their medication. Services should aim to ensure appropriate information is provided to all service users.

Most service users' pharmacological treatment was reviewed during their hospital admission, although only 62% of these included a review of the side effects of medication. Younger service users and those at risk of suicide were also less likely to receive a review within the timeframes recommended by NICE guidance. Further work is required to standardise this process.

Recommendation 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 all individuals aged <30 years and all those considered to be at risk of suicide are having their medication reviewed.*

Psychological Therapies

In this section we present and discuss findings for standard 8, addressing psychological therapy for service users with anxiety and depressive disorders.

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

Different forms of psychological therapy have many features in common, and factors associated with good outcomes (such as therapeutic alliance) may be universal to different treatments (Martin et al., 2000).

However, evidence indicates that certain therapies are particularly effective for service users with difficulties related to specific diagnoses, and this is reflected in NICE guidelines. Comprehensive guidance is available regarding psychological interventions for depressive illness (CG90) and a number of anxiety/stress-related disorders (CG31; CG113; CG116; CG123).

Only 39% of service users (n=1,478) who were admitted to hospital for anxiety and depression, were referred for psychological therapy. Of those who were referred and specified which therapy type was received, 70% were referred for individual therapy, 20% for group therapy and 11% for both.

Figure 12: Percentage of NCAAD Sample Referred for Psychological Therapy across Trusts

Of the service users referred for individual therapy, 54% had started therapy within the audit period. In service users referred for group therapy, 72% had started therapy within the audit period. The reasons for therapy not starting are detailed in Table 8, the most common reason for service users not starting both individual and group therapy being that they chose not to participate.

Waiting times were only available for calculation for 515 service users, and were found to have poor reliability after inter-rater reliability analysis was performed. More detailed analysis of waiting times for psychological therapy will be detailed in the NCAAD Spotlight Audit of Psychological Therapies due to be published in January 2020.

Table 8: Reasons for not starting therapy

Reason Therapy Not Started	Individual Therapy	Group Therapy
On waiting list	14% (53)	13% (9)
Chose not to participate	31% (115)	44% (31)
Not able to participate	9% (33)	7% (5)
Referral not appropriate/Other	21% (77)	14% (10)
Unknown/not documented*	25% (91)	21% (15)

Table 9: Where service users were referred

Referral	Percentage
NHS Secondary care	77
IAPT	13
Third sector	2
Private	1
Other	7

For those who had started therapy, where the referrals were made is detailed in Table 9; most referrals were made to NHS secondary care services. The type of therapy is summarised in Tables 10 and 11. The figures indicated that CBT was the most common type of individual therapy, with 39% of service users who had started individual therapy receiving this type of treatment. Arts therapies were the most common group therapy type (21% of those who had started group therapy), followed by mindfulness-based approaches (19%).

Table 10: Modality of individual therapy received

Type of Individual Therapy*	Number of service users
Cognitive Behavioural Therapy (CBT)	221
Counselling	63
Guided/Supported Self-help	45
Mindfulness	37
Dialectical Behavioural Therapy (DBT)	31
Cognitive Analytic Therapy (CAT)	27
Arts Psychotherapies (e.g. Art, music)	25
Short-term Psychodynamic/Psychoanalytic Psychotherapy	22
Eye Movement Desensitisation & Reprocessing (EMDR)	21
Behavioural Activation	20
Applied Relaxation	18
Acceptance and Commitment Therapy (ACT)	17
Problem Solving Therapy	17
Integrative Psychotherapy	15
Solution-Focussed Therapy	14
Interpersonal Psychotherapy (IPT)	11
Compassion Focussed Therapy	10
Humanistic/Person Centred Therapy	6
Dynamic Interpersonal Therapy (DIT)	0
Narrative Exposure Therapy (NET)	0
Other	86

*<6 receiving Mindfulness Based Cognitive Therapy (MBCT), Mindfulness Based Therapy (MBT) and Systemic Therapy.

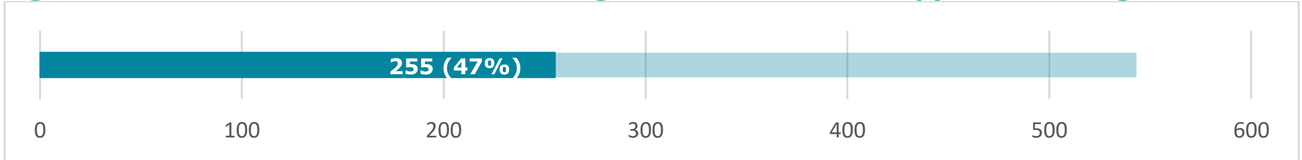
Table 11: Modality of group therapy received

Type of Group Therapy*	Number of Service users
Arts Psychotherapies (e.g. Art, music)	62
Mindfulness	55
Psycho-education	27
Cognitive Behavioural Therapy (CBT)	25
Systemic Therapy	21
Dialectical Behavioural Therapy (DBT)	18
Counselling	15
Applied Relaxation	14
Compassion Focussed Therapy	11
Problem Solving Therapy	7
Cognitive Analytic Therapy (CAT)	0
Dynamic Interpersonal Therapy (DIT)	0
Other	109

*<6 receiving Behavioural Couples Therapy, Humanistic/Person centred therapy, Integrative Therapy, Interpersonal Therapy, Mentalisation Based Therapy, MBCT, short-term Psychodynamic/Psychoanalytic Psychotherapy, Solution-Focussed Therapy, or Systemic Therapy.

Types of individual therapy in the 'other' categories included emotional coping skills, anxiety management, and one-to-one therapy without detailing the type. The 'other' types of group therapy, accounting for the largest proportion, included coping skills groups, recovery groups, and self-esteem groups, all of which had unspecified modalities.

Figure 13: Number of service users receiving a recommended therapy for their diagnosis



To assess whether service users were receiving a psychological therapy in line with NICE guidance, individuals with a secondary diagnosis that could impact on the type of psychological treatment they should be offered were excluded from the analysis of this standard. This included 543 service users with mental and behavioural disorders due to psychoactive substance use (F10 – F19); 359 individuals with a diagnosis of personality disorder (F60-69); and 32 individuals with learning difficulties (F70-79).

NICE makes no specific recommendations for the psychological treatment of disorders F43.0-, F43.2, F43.8, F43.9, F40.0, F40.2, F40.8 & F40.9; therefore, individuals with these diagnoses were also excluded from the analysis (n=513). The remaining 2348 individuals were included in the analysis. NICE recommends CBT for all anxiety disorders and a wider range of therapies are recommended for depression, including interpersonal therapy, CBT, counselling, behavioural couples therapy, behavioural activation and short-term psychodynamic therapy. A total of 884 (38%) individuals in this sub-group had been referred for therapy and 543 had started therapy by the end of the audit period. Of the 543 individuals who had started, 255 (47%) were receiving a type of therapy in line with NICE guidance for their diagnosis/condition.

Summary

There was considerable variation across Trusts in the percentage of service users being referred for psychological therapy. Overall a minority of service users were referred for therapy with an even smaller percentage starting therapy within the audit period.

Recommendation 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.

Discharge

In this section we present and discuss findings for standards 9-12, regarding discharge or transfer of care. Details of each of the relevant standards will be described at the beginning of each sub section. The following data are derived from the notes of the 87% (n=3,301) of service users who were discharged during the audit period.

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

Handing over care to an appropriate community service is a crucial part of the discharge process. Timely communication between the discharging service and community services (primary and secondary) is essential to ensure continuity of care, and the quality of this process has been linked to risk of adverse events such as unplanned readmission and medication errors (Olfson and Walkup, 1997).

NICE guidance indicates that inpatient services should ensure that a care plan is sent to all parties involved in a service user's ongoing care within 24 hours of their discharge (NG53, 1.6.3). This process should include sending a discharge letter to the service user's GP and any appropriate secondary care services.

For services users recorded as having a GP, a discharge letter was sent in 99% of cases (n=2,831). The letters contained contact details for the team/service responsible for the service user's care in 82% of cases; details of medications, including dosage and frequency, in 94% of cases; and risk to and from self and/or others in 80% of cases. However, as shown in Figure 14, this was only achieved within 24 hours in 45% of cases (n=1,270).

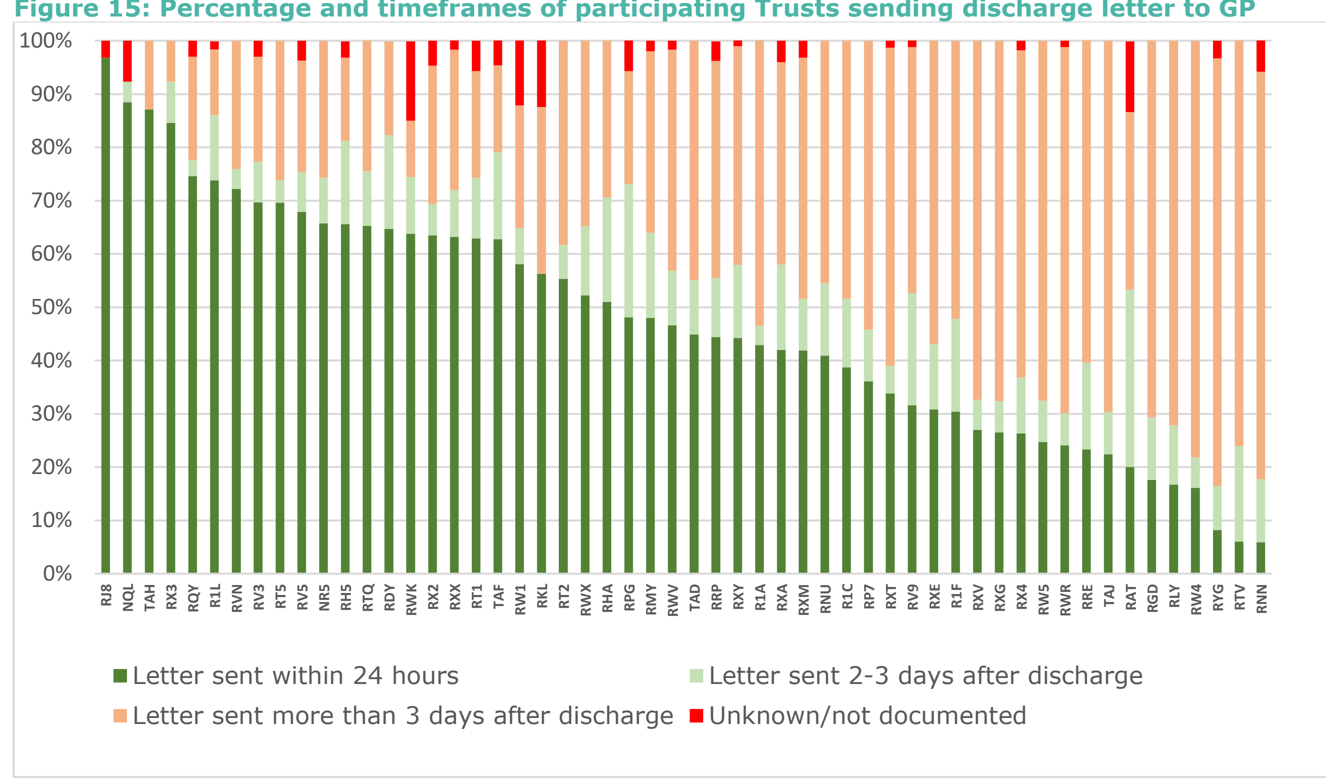
In contrast, only 46% (n=1,526) of discharged service users had a care plan sent to an accepting service, with the majority of these (77%, n= 1,167) sent within 24 hours. These 77% of cases included care plans that were sent to the accepting service before the service user was formally discharged.

There was considerable variation across Trusts as to the timeframe that discharge letters were sent in, as shown in Figure 15.

Figure 14: Percentage of cases where discharge documents were sent within 24 hrs

*Includes cases where care plan was sent before discharge

Figure 15: Percentage and timeframes of participating Trusts sending discharge letter to GP

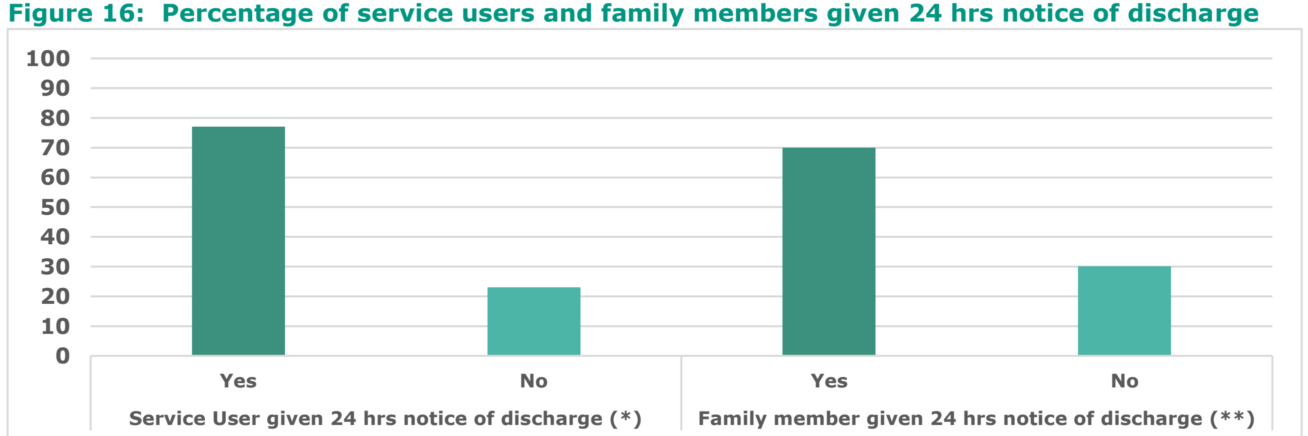


Standard 10: The service user and their family member, friend or carer (if applicable), receives at least 24 hours' notice of discharge.

The transition from a hospital environment to the community can cause considerable distress for service users with anxiety and depressive disorders. Providing adequate notice of discharge enables service users to prepare themselves (both mentally and in practical terms) for this process. It also allows other individuals in their immediate support network (family members, friends, and carers) to make any necessary arrangements to facilitate their integration back into the community.

Mental health service users should be involved in treatment decisions, including those relating to discharge, and this is recommended in NICE guidelines (NG53, 1.5.23). Figure 16 shows that 77% (n=2,546) of service users, and 70% (n=1,401) of family/carers, received 24 hours' notice of their date of discharge.

Figure 16: Percentage of service users and family members given 24 hrs notice of discharge



*Figures of those discharged only; **figures for those discharged with an identified family member/friend or carer

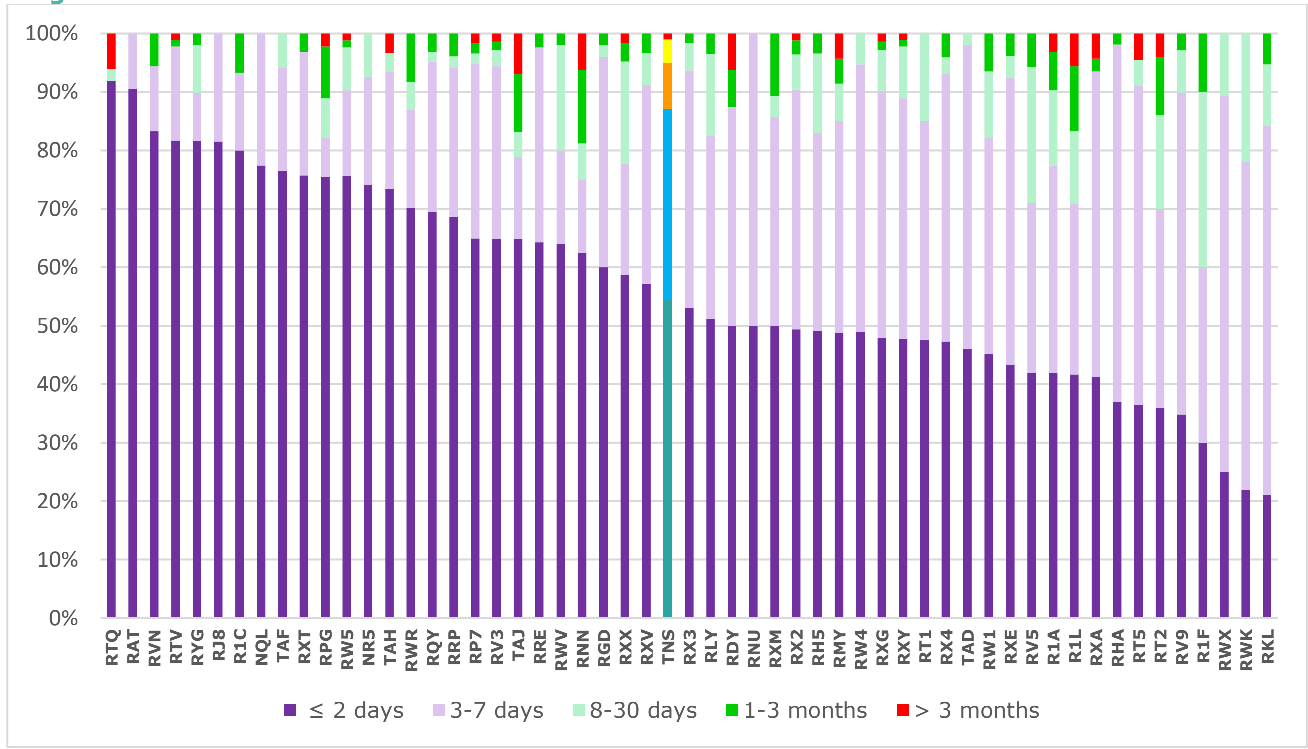
Standard 11: Service users discharged from an inpatient setting receive a follow-up within 48 hours of discharge.

Follow-up arrangements should be in place for all service users at the point of discharge, including a clear plan for the responsible service and the time and modality of next contact.

NICE guidance specifies that such follow-up arrangements are particularly important for those who may be at risk of suicide or self-harm and should be carried out within 48 hours for these individuals (NG53, 1.6.4). However, the audit did not make this distinction in light of evidence that early follow-up may be associated with better outcomes (including fewer unplanned readmissions) irrespective of suicide risk (Sfetcu et al., 2017).

The majority of service users (90% n=2,962) were followed-up after discharge. 82% were followed up face-to-face, and 18% over the phone. However, where the dates were known, follow-up appointments were within 48 hours in just over half of these cases (57% n=1,628) (see Figure 17).

Figure 17: Percentage of service users receiving follow-up within 48 hours of discharge or longer



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

Service users with anxiety/stress-related disorders are particularly vulnerable to acute deterioration in their symptoms or 'crises', which may require urgent management. NICE guidelines advise that for those at risk of crisis, a specific 'crisis plan' should be developed with input from the service user, prior to discharge (NG53, 1.29). This may include coping strategies, treatment preferences, and a contingency plan for accessing 24-hour services urgently if required.

74% (n=2,448) of service users included in this audit had a crisis plan in place at the time of discharge

Summary

Inpatient services communicated with primary care via a discharge summary letter in almost all cases. Most people also received follow-up after their discharge from hospital. However, further

work is needed to ensure that these processes occur within an appropriate timeframe.

Involvement of service users and those supporting them in the community (family, carers etc.) in the discharge planning process can be crucial for a successful discharge. However, a significant proportion of service users do not have a crisis plan in place at discharge, and do not receive adequate notice in advance of their discharge date.

Recommendation 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.

d) Clinicians should:

Ensure that all service users admitted to hospital for anxiety and depression have a jointly developed and agreed crisis plan in place at the point of discharge.

Outcome Measurement

In this section we present and discuss findings for standard 13, addressing the use of validated outcome measures for service users admitted to hospital with anxiety and depressive illness.

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

The use of routine outcome measures is common practice across a variety of mental health services (Trauer, T., 2010). There is good evidence that various outcome measures, such as the Health of the Nation Outcome Scale (HoNOS), perform well in terms of sensitivity, specificity and predictive validity when used accurately and consistently in inpatient settings (Webster et al., 2013).

NICE guidance specifies that local care pathways should have robust and universal systems in place for the reporting and aggregation of outcome measures (CG123, 1.5.1.10). Specific guidelines for depressive illness (CG90) and various anxiety/stress-related disorders (CG31, CG113, CG116, CG123) also advise the use of 'formal validated outcome measures' for monitoring response to treatment.

Table 12: Primary outcome measures

Outcome Measure	Percentage Completed (n)
Children's Global Assessment Scale* (CGAS)	42 (40)
Health of the Nation Outcome Scale** (HoNOS)	55 (2,049)
Other outcomes completed***	15 (561)

*Figures for children (<18) only; **Figures for adults *(18+) only; ***Figures for all service users (children + adults)

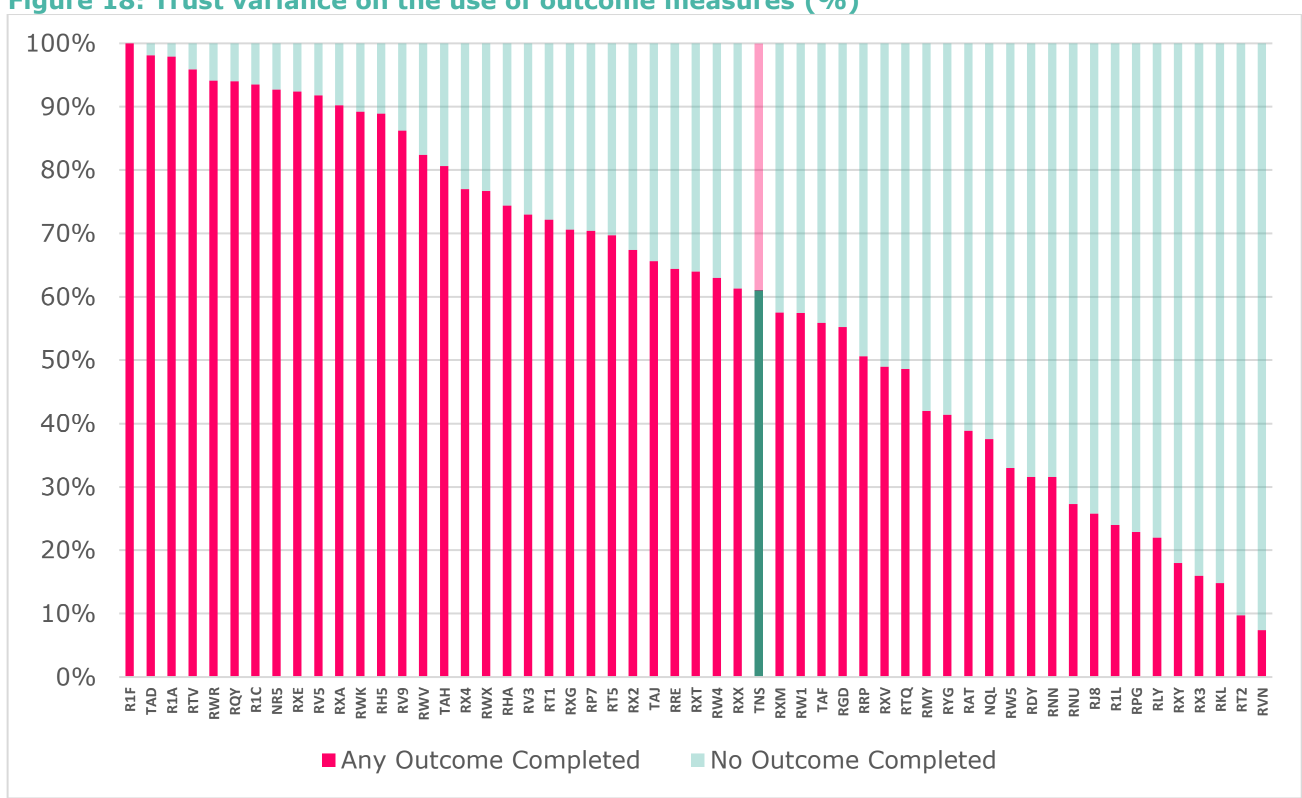
Table 12 shows that around half of adults included in the audit sample had a HoNOS completed, and less than half of children had a CGAS completed. For a small proportion of service users, there was documented evidence of an alternative outcome measure being used on assessment, but no single measure was used consistently, and data were not collected to see whether these were used serially, to evaluate the effects of treatment. Table 13 shows the range of outcome measures that were used.

Table 13: Most frequently used alternative outcome measures

Outcome measure - adult	Percentage Completed (n)
Beck Depression Inventory (BDI)	2 (82)
Generalised Anxiety Disorder Assessment (GAD-7)	2 (82)
Hospital Anxiety and Depression Scale (HADS)	2 (79)
Patient Health Questionnaire-9 (PHQ-9)	2 (65)
Warwick-Edinburgh Mental Wellbeing (WEMWBS)	1 (53)
Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)	1 (51)
Hamilton Depression Rating Scale	1 (28)
Clinical Outcomes in Routine Evaluation (CORE-10)	1 (23)
Geriatric Depression Scale (GDS)	1 (21)
Montgomery-Asberg Depression Scale (MADRS)	1 (18)
Yale-Brown Obsessive Compulsive Scale (Y-BOCS)	0.2 (7)
Other	6 (212)
Outcome measure - child	**Percentage Completed (n)**
Moods and Feelings Questionnaire (CAMHS)	11 (10)
Strengths & Difficulties Questionnaire (SDQ) - Child	7 (7)
Other	34 (32)

Overall, there was evidence of at least one outcome measure being used in 61% of cases. The use of outcome measures varied considerably across Trusts, as shown in Figure 18, ranged from 100% of cases having documented evidence of at least one outcome measure, to just 7% of cases.

Figure 18: Trust variance on the use of outcome measures (%)



Summary

The data show that across England, no single outcome measure is being routinely used. Outcome measures are important for services to evaluate the treatments they provide, but also for service users to see the progress they have made and to support meaningful discussions between clinicians and service users.

The International Consortium for Health Outcomes Measurement has developed a Standard Set for Depression & Anxiety, detailing outcome measures that should be used to monitor response to treatments provided by mental health services.

Recommendation 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.

Appendix 1

Table 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

Table 2: Ineligible ICD-10 Codes

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

Appendix 2

Participating Trusts

Trust Code	Trust Name	Expected Sample	Final case submission	Completion rate (%)	Sample after cleaning
RTQ	2gether NHS Foundation Trust	83	74	89	74
RVN	Avon and Wiltshire NHS Trust	54	54	100	54
RRP	Barnet, Enfield and Haringey Mental Health NHS Trust	90	80	100	79
RWX	Berkshire Healthcare NHS Foundation Trust	73	73	100	73
RXT	Birmingham and Solihull Mental Health NHS Foundation Trust	100	100	100	100
TAJ	Black Country Partnership NHS Foundation Trust	98	96	100	96
TAD	Bradford District Care Trust	52	52	100	52
RT1	Cambridgeshire and Peterborough NHS Foundation Trust	54	54	100	54
TAF	Camden and Islington NHS Foundation Trust	100	76	100	59
RV3	Central and North West London NHS Foundation Trust	100	100	100	100
RXA	Cheshire and Wirral Partnership NHS Foundation Trust	88	84	100	82
RJ8	Cornwall Partnership NHS Foundation Trust	34	34	100	31
RYG	Coventry and Warwickshire Partnership NHS Trust	70	70	100	70
RNN	Cumbria Partnership NHS Foundation Trust	78	19	24	19
RXM	Derbyshire Healthcare NHS Foundation Trust	85	40	100	40
RWV	Devon Partnership NHS Trust	100	100	100	74
RDY	Dorset Healthcare University NHS Foundation Trust	20	19	99	19
RWK	East London NHS Foundation Trust	100	65	100	65
R1L	Essex Partnership University NHS Foundation Trust	100	99	99	96
RXV	Greater Manchester Mental Health NHS Foundation Trust	100	100	100	100
RWR	Hertfordshire Partnership University NHS Foundation Trust	100	101	100	101
RV9	Humber NHS Foundation Trust	80	80	100	80
R1F	Isle of Wight NHS Trust	100	39	39	39
RXY	Kent and Medway NHS and Social Care Partnership Trust	100	100	100	100
RW5	Lancashire Care NHS Foundation Trust	100	100	100	100

RGD	Leeds and York Partnership NHS Foundation Trust	58	58	100	58
RT5	Leicestershire Partnership NHS Trust	100	33	33	33
RP7	Lincolnshire Partnership NHS Foundation Trust	100	81	81	81
NR5	Livewell Southwest CIC	41	41	100	41
RW4	Mersey Care NHS Foundation Trust	100	100	100	100
NQL	NAViGO Health and Social Care CIC	40	40	100	40
RMY	Norfolk and Suffolk NHS Foundation Trust	100	83	83	81
RAT	North East London NHS Foundation Trust	94	37	100	36
RLY	North Staffordshire Combined Healthcare NHS Trust	100	100	100	100
RTV	North West Boroughs Healthcare NHS Foundation Trust	100	100	100	97
RX4	Northumberland, Tyne and Wear NHS Foundation Trust	100	100	100	100
RHA	Nottinghamshire Healthcare NHS Trust	100	82	82	82
RNU	Oxford Health NHS Foundation Trust	25	24	96	22
RPG	Oxleas NHS Foundation Trust	100	97	97	83
RT2	Pennine Care NHS Foundation Trust	100	93	93	93
RXE	Rotherham Doncaster and South Humber NHS Foundation Trust	100	100	100	92
TAH	Sheffield Health and Social Care NHS Foundation Trust	31	31	100	31
R1C	Solent NHS Trust	34	32	94	31
RH5	Somerset Partnership NHS Foundation Trust	78	72	100	72
RV5	South London Maudsley NHS Foundation Trust	100	100	100	98
RRE	South Staffordshire and Shropshire NHS Foundation Trust	100	59	59	59
RQY	South West London and St George's Mental Health NHS Trust	100	84	84	84
RXG	South West Yorkshire Partnership NHS Foundation Trust	100	88	100	85
RW1	Southern Health NHS Foundation Trust	100	95	100	94
RXX	Surrey and Borders Partnership NHS Foundation Trust	96	76	100	75
RX2	Sussex Partnership NHS Foundation Trust	96	95	100	95
RX3	Tees Esk and Wear Valleys NHS Foundation Trust	100	100	100	100
RKL	West London Mental Health NHS Trust	100	27	27	27
R1A	Worcestershire Health and Care NHS Trust	52	48	92	48
Total		4,442	3,885	87	3,795

Appendix 3

Steering Group

Chair

David S. Baldwin, Clinical Advisor to the NCAAD, Professor of Psychiatry University of Southampton Faculty of Medicine

Members

Ruth Allen, Chief Executive - British Association of Social Workers

Tom Ayers, Associate Director – National Collaborating Centre for Mental Health (NCCMH)

Thomas Barnes, POMH Clinical Lead and Emeritus Professor of Clinical Psychiatry (Imperial College London)

Kat Berry, *former* Operations Manager - McPin Foundation

Alison Brabban, Expert Advisor to the Adult Mental Health Programme - NHS England

James Campbell, Associate Director for Quality & Development - Healthcare Quality Improvement Partnership

Linda Chadburn, Clinical Effectiveness & Quality Improvement Lead – Pennine Care NHS Foundation Trust

David Clark, Clinical Lead for the National IAPT Programme - NHS England

Esther Cohen-Tovée, Director of AHPs and Psychological Services (Northumberland, Tyne and Wear NHS Foundation Trust) - British Psychological Society

Jenny Edwards, Chief Executive - Mental Health Foundation

Dave Ekers, Clinical Senior Lecturer (Durham University) - Royal College of Nursing

Elizabeth England, Royal College of General Practitioners

Lorna Farquharson, Clinical Advisor to the NCAAD Spotlight Audit on Psychological Therapies (3rd NAPT)

Anna Garrod, Head of Health Influencing – Rethink Mental Illness

Wendy Harlow, Head of Clinical Audit - Sussex Partnership Trust

Sam Harper, Project Manager - Healthcare Quality Improvement Partnership

Sandra Harrild, Associate Director of Primary Care and Specialist Psychology Services (East London NHS Foundation Trust) - British Psychological Society

Saffron Homayoun, CAMHS St5 (South London and Maudsley NHS Foundation Trust)

Rebecca Jarvis, General Practitioner and Clinical Lead for Mental Health (Brighton and Hove CCG)

Tim Kendall, National Clinical Director for Mental Health - NHS England

Gary Lamph, Royal College of Nursing, Senior Research Fellow (University of Central Lancashire)

Andrea Malizia, Consultant Psychiatrist - Royal College of Psychiatrists' General Adult Faculty

Sue Mizen, Faculty Chair and Consultant Psychiatrist in Psychotherapy (Devon Partnership NHS Trust), Royal College of Psychiatrists' Medical Psychotherapy Faculty

Jonathon Moore, Social Policy Manager - Rethink Mental Illness

Sarah Murray, Mental health Policy Manager - Carers Trust

Vicki Nash, Policy and Campaigns Manager - Mind

Kira Osborne, Royal College of General Practitioners

Carol Paton, POMH Clinical Lead and Chief Pharmacist (Oxleas NHS Foundation Trust)

David Paynton, National Clinical Commissioning Lead – Royal College of General Practitioners

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

Wendy Preston, Head of Nursing Practice - Royal College of Nursing

Felicitas Rost, President - Society for Psychotherapy Research UK (SPR UK)

Prisha Shah, NCAAD Service User Advisor

Dave Smithson, Therapy Services Manager - Anxiety UK

Jill Stoddard, Director of Operations - Healthcare Quality Improvement Partnership

Toby Sweet, Chief Executive (Sunderland Counselling Service) - British Association for Counselling and Psychotherapy

Hitesh Taylor, Senior Policy Officer - Rethink Mental Illness

Keiko Toma, Analytics Manager for Clinical Effectiveness - Care Quality Commission

Nicola Vick, Regulatory Policy Manager - Care Quality Commission

Emily Waller, *former* Senior Policy and Campaigns Officer - Mind

Kirsten Windfuhr, Associate Director of Quality and Development - Healthcare Quality Improvement Partnership

Sarah Walker, Project Manager - Healthcare Quality Improvement Partnership

The National Clinical Audit of Anxiety and Depression Project Team

Mike Crawford, Director of the Royal College of Psychiatrists' Centre for Quality Improvement

Alan Quirk, Senior Programme Manager (Research and Audit)

Ellen Rhodes, Deputy Programme Manager

Naomi FitzPatrick, Project Officer

Natasha Lindsay, Project Officer

Jessica Butler, Project Administrator

Appendix 4

Standards

1	The service 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
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)*
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
7	Psychotropic medication is provided in line with the relevant NICE and BNF guidance for the service user's diagnosis/condition
8	Psychological therapies are provided in line with relevant NICE guidance for the service user's diagnosis/condition
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
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

Appendix 5

Full List of Recommendations

1. Access

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. Assessment

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. Shared Decision Making

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. Medication

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 all individuals aged <30 years and all those considered to be at risk of suicide are having their medication reviewed.*

5. Psychological Therapies

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. Discharge

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.

d) Clinicians should:
Ensure that all service users admitted to hospital for anxiety and depression have a jointly developed and agreed crisis plan in place at the point of discharge.

7. Outcome Measurement

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.

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Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London
E1 8BB

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www.rcpsych.ac.uk/ncaad

ncaad@rcpsych.ac.uk