HQIP
Healthcare Quality Improvement Partnership

Addressing Parity of Esteem in National Clinical Audit – A Guide

October 2017

"For years, mental health has been stigmatised, swept under the carpet and barely acknowledged. Thankfully these attitudes are now receding and there is an increasing realisation that mental health problems are universal and strong determinants of health outcomes. This wonderful piece of work identifies ways of looking at physical health that pay full regard to mental health problems and vice versa. It should be read by everyone!"

Professor Tim Kendall, national clinical director for mental health
NHS England and NHS Improvement

'Physical and mental health should be treated in tandem for the wellbeing of the whole person. You cannot have one without the other and so parity of esteem is essential.'

HQIP Service User Network (SUN) representatives

HQIP Healthcare Quality Improvement Partnership

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1 Executive summary

Parity of esteem essentially means valuing mental and physical health equally, including equity in measurement of health outcomes. The Healthcare Quality Improvement Partnership (HQIP) is committed to supporting national clinical audit providers to ensure that this vitally important topic is being addressed in audit and other measurement driven quality improvement initiatives.

There is an inseparable and bidirectional relationship between physical and mental health and for optimal patient care and outcomes, we must address both aspects. The direction of travel of healthcare in the UK is for more integrated services and the national clinical audit community has a duty to follow suit to reflect and enable the continuation of this movement.

This guide includes an exploration of the term parity of esteem and its relevance to national clinical audits in the national healthcare context, including reports, policies, guidelines and commissioning incentives. It offers a practical guide for how to address parity of esteem in the planning, execution and report writing of national clinical audits. Recommendations are featured in blue boxes throughout the main body of the guide and listed below, numbered for ease of reference, not magnitude of importance. They are intended to be considered by all national clinical audits, although HQIP acknowledges that not all will be relevant or possible for each audit. Appendices are also available online at *www.hqip.org.uk/resources/parity-of-esteem-clinical-audit-guide/* to provide further support in implementing these recommendations.

Recommendations to address parity of esteem by valuing mental and physical health equally in national clinical audit

1. Reflect parity of esteem in the specific audit objectives and align where possible with national commissioning initiatives and other levers of change
2. Ensure that patient and clinician expert input to the audit design reflects both mental and physical health aspects of the condition topic
3. Enable audit participation of all types of healthcare providers relevant to the topic pathway
4. Consider undertaking a spotlight audit on a mental health issue in a primarily physical health topic and vice versa
5. Incorporate relevant NICE Clinical Guidelines and Quality Standards that encompass both physical and mental health aspects of the condition being audited
6. Consider capturing information at the organisational level that indicates the extent of integration of both mental and physical healthcare in trusts
7. Investigate any risk factors that span both mental and physical health within the audit topic and consider possible implications for the audit design
8. Ensure information captured on comorbidities reflect both mental and physical illnesses, as appropriate
9. Consider including results of mental health screening in physical health audit topics and conversely, physical health checks for patients included in a predominantly mental health audit
10. Consider looking at the influence of mental health when reporting physical health outcomes and vice versa for the impact of physical health on mental health outcomes

2 Introduction

2.1 Scope and purpose of the guide

The aim of this guide is to offer practical recommendations for how to address parity of esteem in the planning, execution and report writing of national clinical audits, in pursuit of optimal patient outcomes. It includes an exploration of the term parity of esteem and its relevance to national clinical audits in the national healthcare context, including reports, policies, guidelines and commissioning incentives.

Appendices are also available online at *www.hqip.org.uk/resources/parity-of-esteem-clinical-audit-guide/* to provide further support in implementing the suggestions in the main body of the guide. These include a selection of national literature from a wide variety of relevant organisations as well as national commissioning incentives and examples of where integrated physical and mental healthcare has already been addressed in the national clinical audits managed by HQIP. National Institute for Health and Care Excellence (NICE) Clinical Guidelines and Quality Standards which overlap physical and mental healthcare and examples of condition-specific research on the inextricable links between mental and physical health are also included, as well as best practice examples of where this has been achieved in the NHS.

The guide is designed so that providers of national clinical audits can use the main text and appendices as and when needed, for inspiration and to overcome barriers that may arise as to 'how' and 'why' parity of esteem should be addressed.

The author would like to thank all those involved in discussions to help shape the content of this guide, many of which have kindly agreed for readers to contact them if they can be of assistance (see Acknowledgements). This has included a wide spectrum of stakeholders who have an influence on, and are influenced by national clinical audits, particularly those with an interest or role in integrating mental and physical healthcare. Across 2016/17, steering group meetings with HQIP staff and Service User Network representatives took place, as well as pilots across several audits managed by HQIP, to test the feasibility and acceptance of the recommendations to optimise patient care in this area. The recommendations have been presented throughout in blue boxes and numbered for ease of reference, not magnitude of importance.

2.2 Who is this guide for?

This guide is aimed at those involved in national clinical audits, whether they are clinical leads, programme or project managers, or others that help shape the audit, be they Chairs, national clinical directors, clinicians or patient representatives. Although written with primarily the national clinical audits currently managed by HQIP in mind, the principles in this guidance are intended to be applicable to all national clinical audits and other measurement driven quality improvement initiatives.

2.3 About HQIP

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies.

3 Background

3.1 Defining parity of esteem

The Royal College of Psychiatrists define parity of esteem as 'valuing mental health equally with physical health' and 'when compared with physical healthcare, mental healthcare is characterised by:

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes'[2]

The term became more commonly used following the Department of Health 2011 coalition government report 'No Health without Mental Health.[3]' This argued that 'mental health is everyone's business' and one of its six shared objectives was that 'fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health'.

NHS England recognises the fundamental importance of parity of esteem, as outlined in the foreword to their Five Year Forward View for Mental Health:[4]

'For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths'.

A stigma remains around mental health however, amongst the public and health professionals, that mental illness is somehow less 'real' than physical health.[5] There is an epidemic of diagnostic overshadowing where someone with a mental illness has their symptoms put down to this, rather than consideration of an additional physical cause and vice versa. These issues must be challenged and rectified for true parity of esteem to ever be achieved.

3.2 Key facts

- Mental health problems are the greatest single cause of UK disability[4]
- One in four UK adults has a diagnosable mental health problem in a year but this is left untreated in three quarters[4]
- People with serious mental illnesses die approximately 20 years younger, mainly because of physical health problems[4]
- Total health costs for a person with a chronic physical condition are increased by at least 45% if they also have a mental health condition[4]
- There is a large overlap between physical and mental health conditions as 30% of people with a long term condition have a mental illness and 46% of people with a mental health problem have a long term condition (see Figure 1)[6]

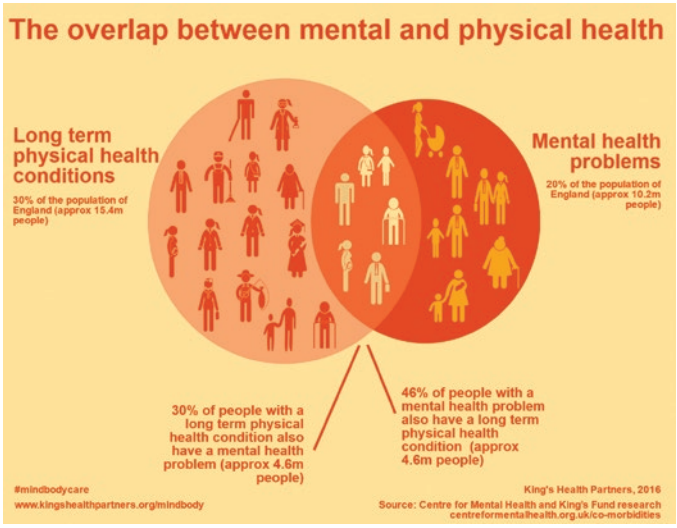

Figure 1: The overlap between physical and mental health, reproduced with kind permission of the Centre for Mental Health and King's Fund (original image) and King's Health Partners (adapted image)[7]

3.3 What are mental illnesses?

Mental illness, just like physical illness, encompasses a wide range of diagnoses that include depressive and eating disorders, autistic spectrum disorders, and anxiety conditions such as obsessive compulsive disorder, phobias and panic attacks. Psychotic disorders are characterised by a disturbance in a person's experience of reality and include schizophrenia and sometimes bipolar affective disorder, which are also known as serious/severe mental illness. A full classification is listed under Chapter V of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)[8] and a diagnosis often rests on the functional impairment of symptoms on a person's life.

3.4 Current representation of mental health in national clinical audits

HQIP undertakes an annual scoping exercise to update a directory of all known national clinical audits and enquiries in the forthcoming and previous financial years. This National Clinical Audit and Enquiries Directory can be accessed via the HQIP website[9] and stood at a total of 84 total active audits and registries at the time of writing, of which four (4.8%) had a mainly mental health focus. Overall, three of the approximately 30 national clinical audits currently managed by HQIP focus on a primarily mental health condition (10%), namely the National Audit of Dementia, the National Audit of Psychosis, and the National Audit of Anxiety and Depression – see *www.hqip.org.uk/national-programmes/mental-health-programmes/.*

As well as the overall topic level within these audits, when looking for examples of current inclusion of mental health in primarily physical health topics and vice versa, the results are varied. Approximately half the programmes include at least some consideration for the mental health needs of patients in physical health topics/collect physical health data in the mental health focussed programmes. Some examples of the ways parity of esteem is currently addressed in the national clinical audits managed by HQIP are shown in Appendix V.

4 Recommendations for addressing parity of esteem in national clinical audits

This section is intended to provide a structured approach of where and how parity of esteem can be best addressed in national clinical audits. The Appendices offer further support in the implementation of these suggestions and recommendations and overcoming any potential barriers.

4.1 Audit design

In reference to the HQIP Guide for Clinical Audit Leads,[10] parity of esteem can be considered at each of the audit design steps below:

- **Subject or topic:** within the condition topic, is there a physical or mental health condition that is particularly prevalent or impacting on quality of care? Is there alignment with national policies and commissioning incentives (examples in Appendix I and II)?

> **Recommendation 1:** Reflect parity of esteem in the specific audit objectives and align where possible with national commissioning initiatives and other levers of change

- **Objective(s):** ensure consideration of how to address parity of esteem is included as an audit objective
- **Stakeholders:** consider contacting clinicians and those with personal experience of mental health conditions in a predominantly physical health audit and vice versa for audits focusing on mental health conditions, to give their input into the design of the audit. People to consider contacting for advice/inviting to involve in the design, implementation and report writing of an audit (including those detailed in the Acknowledgments) could include:
  - Other national clinical audit providers in mental health/physical health
  - NHS England mental health team members
  - Royal colleges
  - Charities
  - Local clinicians in mental/physical health as appropriate

> **Recommendation 2:** Ensure that patient and clinician expert input to the audit design reflects both mental and physical health aspects of the condition topic

- **Population or sample:** will the sampling method assure equity of inclusion of those patients with comorbid mental and physical health conditions so as to not discriminate them from those without? Is it possible to accurately record pre-existing and new diagnoses for mental and physical health conditions? Is there consideration of any common areas of overlap between mental and physical health, for instance smoking in cardiovascular disease and dementia in physical conditions affecting mainly older adults (see examples in Appendix III)?
- **Time period:** does the sampling period take into consideration that the natural history of a mental/physical health condition may take time to develop after the acute physical/mental health presentation? Is there an opportunity to capture past mental/physical health diagnoses from the patient history? For example, it may be some months before depression develops after a life-changing fracture or for diabetes to be diagnosed after the initiation of antipsychotic medication
- **Data collection strategy:** consider collecting data from the full range of healthcare settings where patients with the condition being audited may present and be treated, including mental health hospitals, community teams and acute trusts. For example a patient with postnatal depression may be treated in a general hospital and someone with diabetes may be an inpatient on a ward in a mental health trust. Again, is there equity of inclusion in the audit for patients with comorbid mental and physical health conditions compared to those without?

Recommendation 3: Enable audit participation of all types of healthcare providers relevant to topic pathway

- **Quality of care measures:** can the data collected be used to stimulate quality improvement in terms of parity of esteem? For instance, rather than simply collecting data on whether a screen for mental health conditions was completed or not, also collect the score on the screening tool so that this information can be used to measure any associations with outcomes for patients

Figure 2: Incorporating parity of esteem into audit design

4.2 Components of national clinical audit

4.2.1 Clinical component

Another way of thinking about how to address parity of esteem is in the components of national clinical audit. As well as considering both mental and physical health in the design of the main component of the clinical audit, is there any scope for a spotlight audit/focus on a mental health or physical health issue depending on the main topic of the audit? Are there relevant NICE Clinical Guidelines or Quality Standards for the condition being audited that encompass physical and mental health, such as the examples in Appendix IV? If the audit includes patient captured measures on patient reported outcome and experience measures (PROMs and PREMs), is there scope for enquiring about how integrated their healthcare experience was, and outcomes based on integration and holistic treatment of their physical and mental healthcare?

Recommendation 4: Consider undertaking a spotlight audit on a mental health issue in a primarily physical health topic and vice versa

Recommendation 5: Incorporate relevant NICE Clinical Guidelines and Quality Standards that encompass both physical and mental health aspects of the condition being audited

4.2.2 Organisational component

At the organisational audit level, questions could be asked about the degree of need and availability of access to liaison psychiatry teams in acute hospitals and to physical health advice and resources available in mental health trusts.

Other suggestions could be auditing the provision of mandatory mental health training for physical health clinicians and vice versa. A recent report by the Medical and Surgical Clinical Outcome Review Programme entitled 'Treat as One' aimed to identify and explore remediable factors in the quality of mental health and physical health care provided to patients with significant mental health conditions who were admitted to a general hospital with physical illness. They found that only 45.7% of healthcare professionals in acute trusts stated they had undergone mandatory training in the management of mental health patients in general hospital.[11]

The above points are highlighted in a number of national policies and levers of change detailed in Appendices I and II, such as questions in the Provider Information Requests for NHS trusts from the CQC[12] relating to the care of people with mental health needs in acute trusts and vice versa for physical health checks of patients with a mental illness in mental health trusts. The Five Year Forward View for Mental Health also aims that by 2020/21, all acute hospitals will have access to mental health liaison services for patients of all ages in emergency departments and inpatient wards.[4]

Additionally, do acute trusts have clear protocols for the use of the Mental Health Act (1983), Mental Capacity Act (2005) and identification and management of dementia in their hospital? Do mental health trusts have standardised ways of addressing the physical health needs of their patients such as physical health protocols, policies or committees? Do trusts include standardised clerking proformas to remind clinicians to collect relevant information on physical/mental health conditions and complaints? Are there pathways in place for escalating concerns to on-call doctors such as the National Early Warning Score[13] and referral to acute trusts if necessary in terms of physical health concerns of mentally unwell patients?

Recommendation 6: Consider capturing information at the organisational level that indicates integration of both mental and physical healthcare in the trust

4.3 Stages of the patient journey

A third way of breaking down how to address parity of esteem in national clinical audit is to think of each stage of the patient journey and where consideration of both their mental and physical health needs might be most important.

4.3.1 Prevention

Consider whether the condition being audited has an association with a particular mental or physical illness as a risk factor or precursor to the index illness, reviewing relevant scientific research as necessary (a selection of which is shown in Appendix III). For example, depression has been quoted as a risk factor for several physical health conditions[14] as well as patients with physical illness being at higher risk of developing depression.[15] There is a theory of vascular depression in light of the multiple bidirectional links between depression and cardiovascular diseases, for example, hypertension and thromboembolisms affecting the circulation in areas of the brain associated with depressive symptoms.[16]

Tobacco smoking is known to be a risk factor for the development of a wide array of physical illnesses, but there is also a recognised higher incidence of smoking in people with a mental illness. The National Centre for Social Research paper from the 2007 Adult Psychiatric Morbidity Study concluded that 33% of people with a mental illness were regular smokers (seven or more cigarettes a week), compared to 22% of people without a mental illness.[17] In addition, a joint Public Health England and NHS survey revealed that 64% of patients on secure mental health wards were current smokers.[18] The Royal College of Physicians and the Royal College of Psychiatrists also produced a joint report[19] on smoking and mental health, recognising the enormous impact it has on this group of patients' physical health and quality of life.

If a national clinical audit includes smoking, a more complete picture could be gained by also including mental health screening and diagnosis as a group of people who make up a disproportionate amount of this population. A common misconception is that people with mental illness do not want to quit smoking and that they and even healthcare staff believe that nicotine helps them cope with their symptoms. However, a report by the Kings' Fund entitled 'Clearing the Air'[20] disputed this idea, with studies showing that more than 50% of patients with mental illness did want to quit.

Alcohol misuse, obesity, poor oral health and infectious diseases such as HIV and hepatitis B and C are also more common in people with a mental illness and these are also in turn risk factors for a number of other physical problems.[21] The Department of Health dashboards[22] leading on from the report 'No Health Without Mental Health'[3] can be used to clearly show the adverse clear links between smoking, obesity, alcohol misuse and mental illness.

> **Recommendation 7:** Investigate any risk factors that span both mental and physical health within the audit topic and consider possible implications for the audit design

4.3.2 Acute assessment

At the point of an acute presentation to an Accident and Emergency Department, and perhaps a subsequent admission, are both mental and physical components of patient health being considered? The 'Treat as One' report mentioned earlier found that in terms of the overall care of patients with a significant mental illness who were admitted to a general hospital with a physical health problem, only 46.0% of the 548 case notes reviewed were thought to have demonstrated good practice.[11]

4.3.2.1 Past history of mental/physical illness

During the assessment of the condition which is the main focus of the national clinical audit, is there a record of both existing relevant past physical and mental health illness, which can often be taken from the initial clinician admission clerking and/or Hospital Episode Statistics (HES) data?[23]

> **Recommendation 8:** Ensure information captured on comorbidities reflect both mental and physical illnesses, as appropriate

4.3.2.2 Screening

Screening for physical illness in people with mental illness

The Royal College of Psychiatrists recognise the importance of psychiatrists taking responsibility for their patients' physical as well as mental health, as demonstrated in an occasion paper on the topic.[24] This includes an expectation of an assessment for the presence of physical illness from a routine physical

health examination for all new inpatients, and investigations such as blood screening and electrocardiograms.

For patients with serious mental illness, the physical health requirements are further detailed in the report by the Academy of Medical Royal Colleges and eight partner colleges and bodies entitled 'Improving the Physical Health of People with Serious Mental Illness: Essential Actions'.[21] Elsewhere, the Lester tool[25] is a well recognised resource for screening physical health issues in people with schizophrenia which was developed as a response to findings from the National Audit of Schizophrenia. The charity Rethink Mental Illness has also combined this tool with NICE Clinical Guidelines on psychosis and schizophrenia in adults[26] and the Maudsley Prescribing Guideline's[27] recommendations on a single page to be displayed on inpatient psychiatric wards.[28]

Screening for mental illness in people with physical illness

Screening for a common mental illness in patients with a chronic physical condition could be undertaken at several points during an admission, either on admission clerking, during an inpatient stay, or prior to discharge as appropriate. Self-help material for common mental illnesses such as patient information leaflets could be offered in hospital and the results could be sent to the patient's GP, who may recommend further assessment via the Adult Improving Access to Psychological Treatments (IAPT) programme,[29] or perhaps refer to a Community Mental Health Team for secondary care.

It is estimated that two thirds of NHS beds are occupied by people more than 65 years of age and that approximately 60% have, or will develop a mental illness during a general hospital admission, mainly depression, dementia and delirium. Mental health comorbidities in this age population independently predict poor outcomes and increased costs of care and mortality.[30] It may therefore be appropriate to conduct cognition screening such as the Mini Mental State Examination[31] and Abbreviated Mental Test[32] amongst others to help detect these symptoms for further management.

In acute physical illnesses, screening for a mental illness may be relevant when the condition is likely to lead to life changing adaptations needing to be made, or perhaps when they occurred in a particularly traumatic way such as a road traffic accident or a particularly long hospital stay. In these patients there may be a referral to the hospital liaison psychiatry team if possible and needed, as well as passing on results of screening to their GP for further follow up if needed.

In regards to chronic physical health illnesses, NICE has produced Clinical Guidelines on screening for depression in this patient group,[33] due to the recognition that it is approximately two to three times more common in people with a chronic health problem, at a rate of about 20%. It recommends that:

'Any patient who may have depression (especially those with a past history of depression or who suffer from a chronic physical illness associated with functional impairment) should be asked the following two questions:

1. During the last month have you been feeling down, depressed or hopeless?
2. During the last month have you often been bothered by having little interest or pleasure in doing things?

If a patient with a chronic physical health problem answers 'yes' to either…but the practitioner is not competent to perform a mental health assessment, they should refer the patient to an appropriate professional. If this professional is not the patient's GP, inform the GP of the referral.'

These questions are the first two of the nine featured in the Patient Health Questionnaire- 9 (PHQ-9)[34] and also known as the PHQ-2 or the Whooley questions,[35] which have been found to be particularly sensitive in identifying the need for further screening and are routinely used for identifying perinatal depression.

In order to enhance the possibility for quality improvement of patient outcomes, as well as recording whether screening was performed or not, the score could also be collected (for instance 0, 1, 2 in terms of the PHQ2) as well as the outcome, such as self help material given such as patient information leaflets, referral to their GP or referral to the liaison psychiatry team. This information could then be used to correlate the degree of condition severity as indicated from the screening with outcomes for patients.

The NICE Clinical Guidelines for generalised anxiety disorder[36] recommend consideration of this diagnosis in patients with a chronic physical health problem who present with anxiety and significant worry. Similar to the PHQ-2, there is a two item Generalised Anxiety Disorder scale (GAD-2) which consists of the first two questions of the GAD-7.[37] There has been some criticism however that these scales have an over-reliance on common somatic symptoms of anxiety and depression such as fatigue and sleep problems. The Hospital Anxiety and Depression Scale (HADS) was therefore designed as an alternative combined tool for use in screening people with physical illness for these conditions.[38]

Recommendation 9: Consider including results of mental health screening in physical health audit topics and conversely, physical health checks for patients included in a predominantly mental health audit

Recommendation 10: Consider looking at the influence of mental health when reporting physical health outcomes and vice versa for the impact of physical health on mental health outcomes

4.3.3 Follow-up

As well as the acute episode component of the audit, is there an appreciation of outcomes after discharge from hospital and uptake of rehabilitation services such as cardiac or lung rehabilitation if relevant, which may be affected by the social isolation associated with depression for example? Is your audit able to identify those patients in the follow-up stage who had an existing mental or physical illness or screened positive for a common physical or mental illness during their admission? Is it then possible to determine whether outcomes are different for this group of patients, for instance in regard to time to readmission or mortality?

5 Conclusions

This guidance, and the recommendations it contains, is designed to support national clinical audits to promote parity of esteem through a comprehensive approach which fully integrates mental and physical healthcare in the design and delivery of audits and other forms of measurement driven quality improvement initiatives. In doing so it aims to promote alignment with national policies, reports, standards and commissioning incentives, to ultimately, and most importantly, achieve improved outcomes for patients.

Whereas the guide so far has covered practical ways to incorporate parity of esteem into national clinical audit, the Appendices provide additional sources of inspiration and support that can be tailored to provider needs in tackling potential barriers that may be encountered when attempting to implement these changes.

6 Acknowledgments

The author would like to thank everyone who has been involved in discussions to help shape the content of this guide and kindly agreed for readers to contact them if they can be of assistance. This has included a wide spectrum of stakeholders who have an influence on, and are influenced by national clinical audits, particularly those with an interest or role in integrating mental and physical healthcare.

A non-exhaustive list includes: Professor Tim Kendall, the national clinical director for mental health and his teams[39] at NHS England and NHS Improvement; Professor Dame Sue Bailey, the president of the Academy of Medical Royal Colleges;[40] the president of the Royal College of Psychiatrists, Professor Sir Simon Wessely as well as various Faculty leads,[41] the College Centre for Quality Improvement (CCQI)[42] and the National Collaborating Centre for Mental Health (NCCMH).[43]

Also, Professor Mark Baker, the Centre for Guidelines director and other team members at the National Institute for Health and Care Excellence (NICE),[44] the Clinical Effectiveness and Evaluation Unit (CEEU) at the Royal College of Physicians,[45] the Mental Health Policy Team and others at the Care Quality Commission (CQC),[46] several members of the National Quality Improvement and Clinical Audit Network (NQICAN),[47] hospital clinical audit teams and clinicians with examples of best practice in integrated physical and mental healthcare.

Thank you also to HQIP's Service User Network[48] representatives who have contributed their input, as well as the several audits managed by HQIP which were involved in pilots to help shape and test the feasibility and acceptance of this guide's recommendations to optimise patient care in this area.

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42. *www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx*

43. *www.rcpsych.ac.uk/workinpsychiatry/hccmh.aspx*

44. *www.nice.org.uk/get-involved/contact-us*

45. *www.rcplondon.ac.uk/clinical-effectiveness-and-evaluation-unit-ceeu*

46. *www.cqc.org.uk/contact-us*

47. *www.nqican.org.uk/index.php?p=1_2_Contact-Us*

48. *www.hqip.org.uk/involving-patients/service-user-network/*

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