NCAP
NATIONAL CLINICAL AUDIT
OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

HQIP
Healthcare Quality
Improvement Partnership

National Clinical Audit of Psychosis

National report
Early Intervention in Psychosis Audit

2020/21

The National Clinical Audit of Psychosis (NCAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). 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 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 https://www.hqip.org.uk/national-programmes

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Cover image ‘The Teal Tiger’ by Veenu Gupta

Designed and typeset by Helen Greenwood.

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Foreword

Ten years ago, I was trying to time travel in my hut on the beach in Thailand. I experienced hallucinations, delusions and paranoia as I was not eating, drinking or sleeping properly and I had stopped taking my medication. This meant that I became consumed by my psychosis and thought I was uncovering the mysteries of the universe in a hammock on the beach, watching the moon on the horizon and the formation of waves crashing the shore, that I attributed to the forces of gravity. When I got back to England, Early Intervention in Psychosis (EIP) services brought me back down to reality and supported me in my recovery, to better understand my early warning signs and triggers, and taught me methods to manage and remain well.

Ten years on, I have come a long way and I am now part of the team that conducts NCAP, as a service user advisor. I apply my lived experience to ensure the audit focuses on the needs of the service user, and I am currently realising my dreams doing a PhD in psychology. Recovery is possible and most likely looks different for all service users. EIP services support people to shape this and provide tools to living alongside psychosis or moving on from it.

My experience of EIP services was a good one, and services have come a long way since then. They have evolved over time, and adapted and changed with the needs of the service users and the contexts they are rooted in. The audit is designed to capture EIP provision, which includes a combination of interventions, including medication, cognitive behavioural therapy for psychosis, Family Intervention, physical health intervention and monitoring, social, housing and employment support.

The results of this and previous audits provide evidence of the good work being done by EIP services. As a service user advisor, I guide and support the team in collecting the audit data and developing recommendations based on the results. EIP services have done a lot to enhance service user involvement in guiding and informing service provision, and should strive to do more. I feel that more could also be done to challenge stigma and ensure that services support people who experience stigma in the future. Moreover, psychosis disproportionately affects people from minority backgrounds and greater effort needs to be made to understand this and its causes. Mental health professionals also need to do more to challenge the discrimination and racism that can trigger psychosis.

Travelling through time, and to our current context, there have been recent challenges along the way. Since the previous round of the national audit, COVID-19 has had a huge impact on the lives of people who provide and use mental health services. People have had to find ways to provide services while maintaining social distancing, and had to find ways to work more flexibly and creatively. This report highlights some of the good practice and innovative work that EIP teams have been doing to support people with psychosis during the pandemic. Services have had to adapt rapidly during this time, while maintaining quality and compassion towards their service users throughout.

I wanted to say thank you to the NCAP team for suggesting I write this foreword and for their dedicated hard work on the audit. Another big thank you to services that supported me in my times of need, and to the many other teams that are helping others with psychosis, too. The work you do makes a difference, so thank you. You have a lasting impact on the many lives you touch, and you stay with us wherever we go. Finally, a big thank you to all the service users and service providers who allow us to learn from their experiences through the data. The experiences and stories of psychosis are never the same but the quality of care and compassion from services can be.

As I have grown through the years, I feel a need to reconnect with the roots of my psychosis. I'm hoping to return to Thailand in the future and create new memories associated with it, like travelling back in time and reimagining it.

Veenu Gupta, Service User Advisor NCAP audit

Appendices are available online**:**
Appendix A: Acknowledgments
Appendix B: Steering group members
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1. Introduction

This report provides national and organisation-level findings on the treatment of people by EIP teams in England, collected as part of NCAP. EIP services are specialised services that aim to provide prompt assessment and evidence-based treatments to people with first-episode psychosis (FEP).

The aim of NCAP is to improve the quality of care that NHS mental health trusts in England, Health Boards in Wales and the Health Service Executive in Ireland provide to people with psychosis. Services are measured against criteria relating to the care and treatment they provide, so that the quality of care can be improved.

The audit is a 5-year programme, commissioned by HQIP on behalf of NHS England and NHS Improvement. The first year of the audit examined care provided to people with psychosis by inpatient and outpatient services; in years 2 (2018/2019), 3 (2019/2020) and 4 (2020/2021), the audit examined care provided by EIP services. All reports and their associated documents can be found on the College Centre for Quality Improvement (CCQI) audit reports web page.

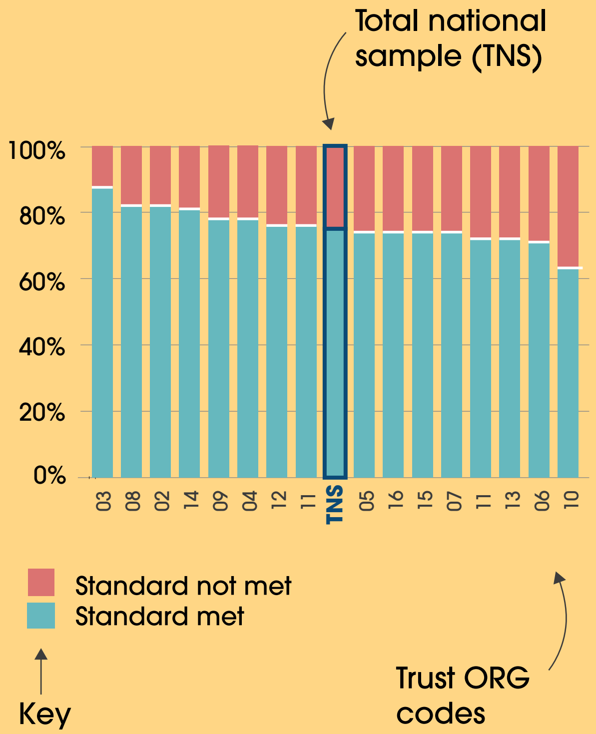
EIP services in Wales and Ireland are in an earlier developmental stage than those in England. This report provides the findings of the audit for England. Separate national reports are being produced for Wales and Ireland.

The standards for the EIP audit are based on the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard guidance (NHS England, NICE & NCCMH, 2016), which details a National Institute for Health and Care Excellence (NICE) recommended package of EIP care for treating and managing psychosis (NICE Quality Standard [QS] 80, 2015; NICE QS102, 2015).

How to read this report

Bar charts

The bar charts in this report provide a breakdown of the Trust-level data and allow for comparisons across Trusts. Each bar represents the performance of an individual Trust, which can be identified by its unique ORG ID number, found along the x-axis of the chart. The total national sample (TNS) is indicated by a bolded bar.



Total national sample (TNS)

Key

Trust ORG codes

Percentages

In this report whole number percentages have been rounded off (0.5 has been rounded up), therefore some total percentages may not add up to 100%.

2. Case-note audit: key findings

EIP
Teams

Congratulations

to all EIP teams across England for maintaining service delivery at a high level in spite of COVID-19 restrictions and the demand to move to digital interventions

2020/21 55%

Recording of **outcome measures up**

14%

2019/20 41%

👍 Commendation for commissioners

51% of services reported an **increase** in the number of **staff posts**

Increases in
6 out of 7
physical health interventions

👍 Impressive in the context of COVID-19

25% 2019/20

14%

39% 2020/21

Increase in **children and young people** receiving **Family Interventions**

A **decrease** in the number of services with **CBT for ARMS provision**

Percentages of services without CBT for ARMS provision by age range:

43%	41%	68%
under 18s	18-35s	36 and over

Acronyms: EIP - Early intervention in psychosis; COVID-19 - Coronavirus disease 2019; CBT - Cognitive behavioural therapy; ARMS - At risk mental state

3. Executive summary

This report presents the findings from the NCAP EIP 2020/2021 audit, collected via a case-note audit and a service-level questionnaire. The report provides national and organisation-level findings on the treatment of people by teams in England. There are separate national reports for Wales and Ireland. All services will receive local reports for each of their EIP teams in 2021.

Background

In 2019, NHS England published the NHS Long Term Plan (NHS England, 2019) and the NHS Mental Health Implementation Plan 2019/2020 – 2023/2024 (NHS England, 2019). These plans detailed targets for access to a NICE-approved care package within 2 weeks of referral for people experiencing FEP and achievement of NICE-concordant treatment by EIP services, and built on the requirements of the original Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016).

Method

All NHS-funded EIP teams in England were expected to take part in the audit. Data were collected via a case-note audit and service-level questionnaire completed by EIP teams.

Teams were asked to submit case-note data on a random sample of up to 100 people per team. To provide context about the impact of COVID-19, teams were invited to complete an additional questionnaire about how they have adapted their practice in response to the pandemic.

Response rate

Case-note audit data were submitted by all 55 service providers in England with eligible cases, which included mental health trusts and other organisations providing NHS services to people with FEP (referred to as 'Trusts' in the remainder of this report).

A total of 10,491 case notes were submitted for people from 154 EIP services in England; 10,033 were used in the final analysis (96% of the number expected). During the data cleaning process, 129 cases were excluded because they were duplicate entries or not eligible. A further 329 cases were excluded due to people in the sample choosing to opt out via the national data opt-out process. The case-note returns represented between 27% and 100% of eligible cases from Trust's EIP teams. A breakdown of Trust returns can be found in Appendix D (page 12). 150 teams in England submitted a contextual questionnaire, a median of 2 teams per service provider (97% of the number expected).

The survey about the impact of COVID-19 was optional, and responses were received from 33 teams in England (21%).

Key findings

Table 1 provides an overview of Trusts' performance against standards and indicators. Findings for both the entire audit sample and those for people aged under 18 are shown alongside comparison data from the NCAP EIP 2019/2020 audit.

Table 1: Key comparisons between NCAP EIP 2020/2021 audit and NCAP EIP 2019/2020 audit

Standard/indicator	NCAP 2020/2021 % (n = 10,033)	NCAP 2019/2020 % (n = 10,560)	NCAP 2020/2021 Under-18s % (n = 228)	NCAP 2019/2020 Under-18s % (n = 194)
Standard 1: Timely access				
Treatment started within 2 weeks of referral[1]	72%	74%	-	-
Standards 2 & 3: Take-up of psychological therapies				
Cognitive behavioural therapy for psychosis (CBTp)	46%	49%	42%	46%
Family intervention (FI)	21%	21%	39%	25%
Standard 4: Prescribing				
Offered clozapine[2,3]	50%	52%	58%	65%
Standard 5: Take-up of supported employment and education programmes				
Supported employment and education programmes[4]	31%	31%	37%	33%
Standard 6: Physical health monitoring[5]				
All 7 screening measures	70%	75%	62%	71%
Smoking	91%	93%	88%	91%
Alcohol use	91%	94%	87%	91%
Substance misuse	91%	94%	86%	91%
Body mass index (BMI)	84%	87%	81%	87%
Blood pressure	84%	89%	82%	90%
Blood glucose	79%	84%	77%	84%
Lipids	79%	82%	73%	82%
Standard 7: Physical health interventions[6]				
Smoking	92%	91%	90%	81%
Harmful/hazardous use of alcohol	95%	93%	100%	67%
Substance misuse	93%	90%	96%	87%
Weight/obesity	85%	83%	87%	79%
Elevated blood pressure	70%	65%	58%	46%
Abnormal glucose control	77%	75%	40%[7]	75%
Abnormal lipids[8]	69%	75%	-	-

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[1] A breakdown for under-18s is not available as this data is not collected by NCAP as part of this audit.

[2] Of those who had not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs.

[3] See NICE guidance for more information on the unlicensed use of clozapine for under-16s.

[4] Of those not in work, education or training at the time of their initial assessment.

[5] Taken up or refused.

[6] Of those who were identified as requiring an intervention based on their screening for each measure.

[7] Please note that this finding is based on very small numbers (n = <5).

[8] There were no cases requiring an intervention for abnormal lipids in the 2019/20 or 2020/21 under-18s sample.

Table 1 continued:

Standard 8: Take-up of carer-focused education and support programmes[9]				
Carer-focused education and support programmes[10]	53%	58%	58%	65%
Clinical outcome measurement				
2 or more outcome measures were recorded at least twice[11]	55%	41%	36%	38%

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[9] Data for 2019/20 includes take-up and referral to carer-focused education and support programmes.

[10] Of those with an identified carer.

[11] Health of the Nation Outcome Scale (HoNOS)/HoNOS for Children and Adolescents (CA), DIALOG, Questionnaire about the Process of Recovery (QPR) (and ‘other’ for under 18 year olds).

Discussion

In the context of COVID-19, it is commendable that EIP team performance against the audit standards was largely maintained. For the second year running, an improvement was seen in the recording of outcome measures (from 41% in 2019/2020 to 55% in 2020/2021). There were also modest improvements on 6 out of 7 of the physical health intervention standards. Take-up of FI and supported education and employment programmes also remained the same as the previous year overall. Wide variations continue to be seen between Trusts especially in the proportion of people starting treatment within 2 weeks of referral (from 14% to 96%), and in the proportion of people who were recorded as declining the offer of different interventions.

This year, 2 Trusts (compared with 1 last year) were performing below level 2 (25% or more) and 7 Trusts (compared with 5 last year) were performing below level 3 (60% or greater) on the national waiting time standard, according to performance levels set by NHS England. This may reflect the impact of COVID-19 on timely engagement and assessment and allocation processes, but these Trusts should identify factors contributing to delays and work with stakeholders to remove or reduce barriers to timely access to treatment which is a critical factor influencing longer term outcome for individuals with psychosis.

Conclusion

It has been a challenging year for healthcare, including EIP services, with many aspects of delivery impacted by COVID-19. Yet in spite of this, data from the 2020/2021 round of the audit show improvements or maintenance at the same levels as last year’s 2019/2020 audit findings for several audit standards. This was both heartening and commendable in the context of the many challenges that COVID-19 has created for staff and individuals with FEP and their families. It is unclear from the audit data whether the reduction in number of Trusts meeting the access and waiting time (AWT) standard and the marked increase in the care co-ordinator caseload range reflect local COVID-19-related pressures on EIP teams as it was not a universal finding across all EIP teams nationally. This needs to be reviewed at a local level for those Trusts where this is the case, to understand and problem-solve factors contributing to these changes. This may include learning from other EIP teams about adaptations they have made in response to COVID-19 pressures (see page 49), identifying ways to protect EIP care co-ordinator caseloads and capacity locally and ensuring adequate local investment in care co-ordinator capacity, in line with the NHS commitment to EIP delivery in the NHS Long Term Plan.

➡ *A full discussion and conclusion are included later in this report. See page 52*

➡ *Findings for children and young people (CYP) with FEP under 18 years are discussed on pages 46 to 48.*

4. Commendations and Recommendations

Key recommendations

In consultation with the NCAP EIP steering group, 4 key recommendations were identified, which are listed below.

1. Equality of access to early intervention in psychosis (EIP) service provision

NHS England/Improvement should:

- work with commissioners to ensure there are no health inequalities in early intervention in psychosis (EIP) provision and access to different interventions, to ensure equal access to the full range of early intervention in psychosis (EIP) care for all people with first episode psychosis (FEP), or who are identified as having an at-risk mental state (ARMS), aged 14–65 across England.

➡ Results for the contextual data questionnaire can be found in Appendix F page 17).

2. At-risk mental state (ARMS)

NHS England/Improvement should:

- work with local commissioners to ensure adequate investment in early intervention in psychosis (EIP) team staffing and capacity to assess and provide appropriate interventions to individuals identified as at-risk-mental state (ARMS).

➡ Results for the contextual data questionnaire can be found in Appendix F (page 17).

3. Children and young people (CYP) with first episode psychosis (FEP) under 18 years

NHS England/Improvement should:

- work with local commissioners to ensure children and young people (CYP) with first episode psychosis (FEP) under 18 have timely access to specialist early intervention in psychosis (EIP) expertise and care co-ordination from children and young people mental health (CYPMH) trained and experienced practitioners and the full range of evidence-based early intervention in psychosis (EIP) interventions.

➡ Results for CYP from the contextual data questionnaire can be found in Appendix F (page 17) and the case-note audit results can be found on page 46.

4. Physical healthcare

Early intervention in psychosis (EIP) clinicians should ensure that:

- the appropriate interventions are received in response to identified risk when screened for cardiovascular disease (smoking, hypertension, diabetes, dyslipidaemia), and that all interventions in response to identified risk are clearly documented in patient health records.

➡ Results for physical health screening and interventions can be found on pages 27 to 41.

5. Commendations

a) Early intervention in psychosis (EIP) teams:

- we commend early intervention in psychosis (EIP) teams across England for maintaining service delivery at a high level in spite of the impact of COVID-19 over this past year. Particularly, we note evidence for continued delivery of physical health which requires face-to-face contact, in the context of COVID-19 constraints.

b) Early intervention in psychosis (EIP) teams and Audit Leads:

- we thank early intervention in psychosis (EIP) teams and Audit Leads across England for co-operation with this year's early intervention in psychosis (EIP) audit in spite of considerable demands placed on services in dealing with the impact of COVID-19.

c) Commissioners:

- we commend commissioners for evidence of investment in early intervention in psychosis (EIP) team staffing in line with the NHS commitment to early intervention in psychosis (EIP) delivery in the NHS Long Term Plan.

➡ Results for investment in EIP staff posts are in the contextual data questionnaire which can be found in Appendix F (page 17).

Further recommendations

6. Caseload size

a. Managers of early intervention in psychosis (EIP) teams should:

- review caseloads of early intervention in psychosis (EIP) care co-ordinators and keep them at an appropriately low level to ensure care co-ordinators have capacity to deliver interventions and sufficient time to engage with complex individuals and their families.

b. Directors of operations in Trusts should:

- with managers of early intervention in psychosis (EIP) teams, review caseload sizes of early intervention in psychosis (EIP) care co-ordinators and reasons why for some early intervention in psychosis (EIP) teams these have risen and seek to ensure that they are protected and kept at an appropriately low level to ensure that care co-ordinators have sufficient time to engage with complex individuals and their families and the capacity to deliver interventions as required.

c. NHS England/Improvement should:

- work with commissioners to ensure adequate investment in early intervention in psychosis (EIP) team staffing and sufficient care co-ordinator capacity to deliver the full range of early intervention in psychosis (EIP) interventions to all age groups and to ensure care co-ordinator caseloads are kept at an appropriately low level to allow care co-ordinators sufficient time to engage with complex individuals and their families and provide the capacity to deliver interventions as required.

➡ Results for the contextual data questionnaire can be found in Appendix F (page 17).

7. Children and young people (CYP) with first episode psychosis (FEP) under 18 years

a. Early intervention in psychosis (EIP) and children and young people mental health (CYPMH) services should ensure:

- Children and young people (CYP) with first episode psychosis (FEP) under 18 years old are accessing evidence-based treatment for early psychosis from practitioners who have the requisite training and experience to deliver NICE recommended interventions and who are also trained and experienced in working with children and young people (CYP).
- robust shared care protocols are in place to manage care and transition between children and young people (CYP) and early intervention in psychosis (EIP) services
- access to reciprocal specialist children and young people (CYP) and early intervention in psychosis (EIP) support when prescribing for and intervening with under-18s with first episode psychosis (FEP) are made available/ provided
- regular joint training opportunities between early intervention in psychosis (EIP) and children and young people mental health (CYPMH) services to improve practice and outcomes for children and young people (CYP) with first episode psychosis (FEP) are made available/ provided

b. Clinicians should ensure that:

- Children and young people (CYP) with first episode psychosis (FEP) aged under 18 receive appropriate physical health screening to identify physical health risks
- outcome data is collected routinely and used to inform routine care planning, monitor progress and review outcomes for children and young people (CYP) with first episode psychosis (FEP).

Results for CYP from the contextual data questionnaire can be found in Appendix F (page 17) and the case-note audit results can be found on page 46.

8. Access and waiting times (AWT)

a. Early intervention in psychosis (EIP) teams should:

- continue to focus on the importance of engaging individuals with first episode psychosis (FEP) to ensure timely access to early intervention in psychosis (EIP) services.

b. Directors of Operations in Trusts should:

- work with early intervention in psychosis (EIP) team managers to identify and problem-solve obstacles to achieving 60% of individuals with first episode psychosis (FEP) accessing NICE-concordant care within 2 weeks of referral in those early intervention in psychosis (EIP) teams currently not meeting the access and waiting time standard (AWT) standard.

c. NHS England/Improvement should:

- work with local commissioners to ensure adequate investment in early intervention in psychosis (EIP) team staffing and sufficient assessment capacity to ensure 60% of individuals with first episode psychosis (FEP) access NICE-concordant care within 2 weeks of referral in those early intervention in psychosis (EIP) teams currently not meeting the access and waiting time standard (AWT) standard.

Results for Access and Waiting Times can be found on page 17.

9. Clozapine

a. Medical Directors should:

- work with early intervention in psychosis (EIP) team prescribers to identify and problem-solve obstacles to prescribing clozapine to people with first episode psychosis (FEP) who may benefit from it.[3]

b. Mental health pharmacists should:

- work with early intervention in psychosis (EIP) team prescribers to identify people who may benefit from clozapine and ensure that they are offered it and reasons for not offering/refusal are recorded in patient health records.[3]

Results for clozapine prescribing can be found on page 23.

10. Variation in intervention take-up and refusal rates

a. NCAP, in collaboration with NHS England and NHS Improvement, should encourage best practice sharing to:

- offer a quality improvement webinar programme for early intervention in psychosis (EIP) teams across England to:
    - highlight and share good practice in how interventions are offered and how higher take-up is achieved in early intervention in psychosis (EIP) teams with higher take-up rates, to address the wide variation in take-up of interventions across early intervention in psychosis (EIP) teams
    - explore why some people with first episode psychosis (FEP) and their carers refuse interventions, and problem-solve solutions that early intervention in psychosis (EIP) teams have identified to overcome barriers to address wide variation in refusal rates for interventions across early intervention in psychosis (EIP) teams.

➡ Results for take-up and refusal of interventions can be found on pages 32 to 41.

11. Outcome measurement

a. NHS England and NHS Improvement should:

- work with NHS Digital to use Mental Health Services Data Set early intervention in psychosis (EIP) outcome data (specifically the repeat outcome data entered on MHSDS for clinical outcomes (HONOS/HONOSCA), satisfaction with life domains and treatment (DIALOG), and recovery (QPR)) to assess the impact of early intervention in psychosis (EIP) care for individuals with first episode psychosis (FEP) on early intervention in psychosis (EIP) team caseloads.

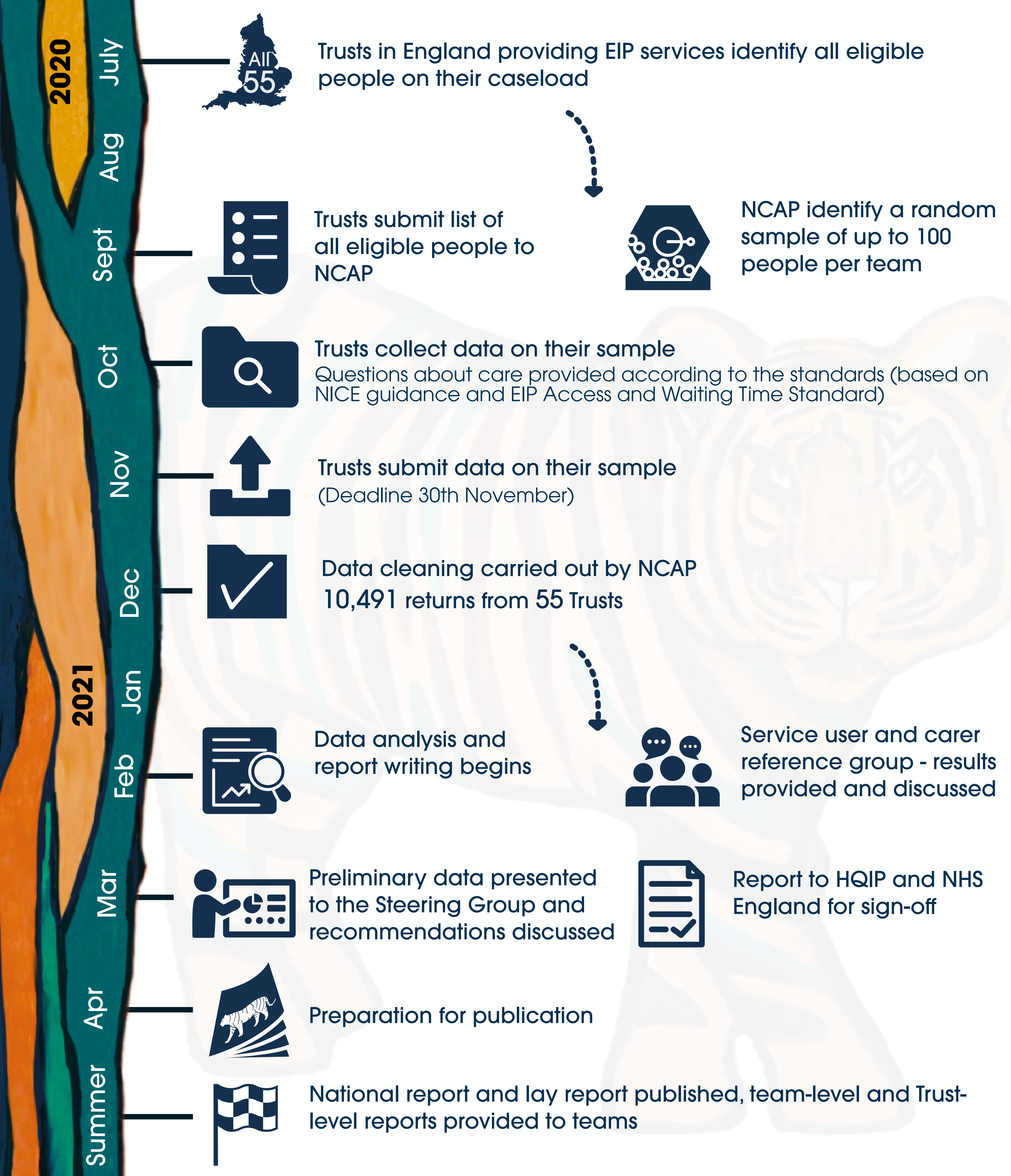
b. Quality improvement leads in Trusts should work with early intervention in psychosis (EIP) team staff to:

- develop ways to use outcome data to monitor and improve the quality of care they provide to people with early psychosis
- consider how routine outcome data collection can be used to inform routine care planning, monitor progress and review outcomes for individuals with first episode psychosis (FEP).

➡ Results for clinical outcome measurements can be found on page 44.

5. Methodology

Case-note audit method



2020

July Trusts in England providing EIP services identify all eligible people on their caseload

Aug NCAP identify a random sample of up to 100 people per team

Sept Trusts submit list of all eligible people to NCAP

Oct Trusts collect data on their sample
Questions about care provided according to the standards (based on NICE guidance and EIP Access and Waiting Time Standard)

Nov Trusts submit data on their sample
(Deadline 30th November)

Dec Data cleaning carried out by NCAP
10,491 returns from 55 Trusts

2021

Jan Service user and carer reference group - results provided and discussed

Feb Data analysis and report writing begins

Mar Preliminary data presented to the Steering Group and recommendations discussed

Report to HQIP and NHS England for sign-off

Apr Preparation for publication

Summer National report and lay report published, team-level and Trust-level reports provided to teams

A more detailed methodology can be found in Appendix E.

Standards and outcome indicator

The audit standards and outcome indicator were developed by the NCAP team in collaboration with members of the steering group, and remain the same as the 2018/2019 spotlight audit and the EIP 2019/2020 audit, except for an adaptation to standard 8 which now specifies take-up of carer-focused support and education rather than offer and referral.

The standards have remained consistent to allow for meaningful comparison and enable identification of real changes in individual standards across the audit cycles. The standards are based on the NICE quality standards in relation to treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015), and the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016).

Standards

S1*	Service users with first-episode psychosis (FEP) start treatment in early intervention in psychosis services within 2-weeks of referral (allocated to, and engaged with, an Early Intervention in Psychosis (EIP) care co-ordinator)
S2	Service users with FEP take up cognitive behavioural therapy for psychosis (CBTp)
S3	Service users with FEP and their families take up Family interventions (FI)
S4	Service users with FEP who have not responded adequately to or tolerated treatment with at least two antipsychotic drugs are offered clozapine
S5	Service users with FEP take up supported employment and education programmes
S6	Service users receive a physical health review annually. This includes the following measures: smoking status; alcohol intake; substance misuse; body mass index; blood pressure; glucose; cholesterol
S7	Service users are offered relevant interventions for their physical health for the following measures: smoking cessation; harmful alcohol use; substance misuse; weight gain/obesity; hypertension; diabetes/high risk of diabetes; dyslipidaemia
S8	Carers take up or are referred to carer focused education and support programmes

Outcome indicator

I1	Clinical outcome measurement data for service users (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) are recorded at least twice (assessment and one other time point)

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* Data for this standard were not collected through the NCAP EIP 2020/2021 audit tool; instead, the Early Intervention in Psychosis Waiting Times data published by NHS Digital were used (NHS Digital, 2020).

6. Timely access

Standard 1

Service users with first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral

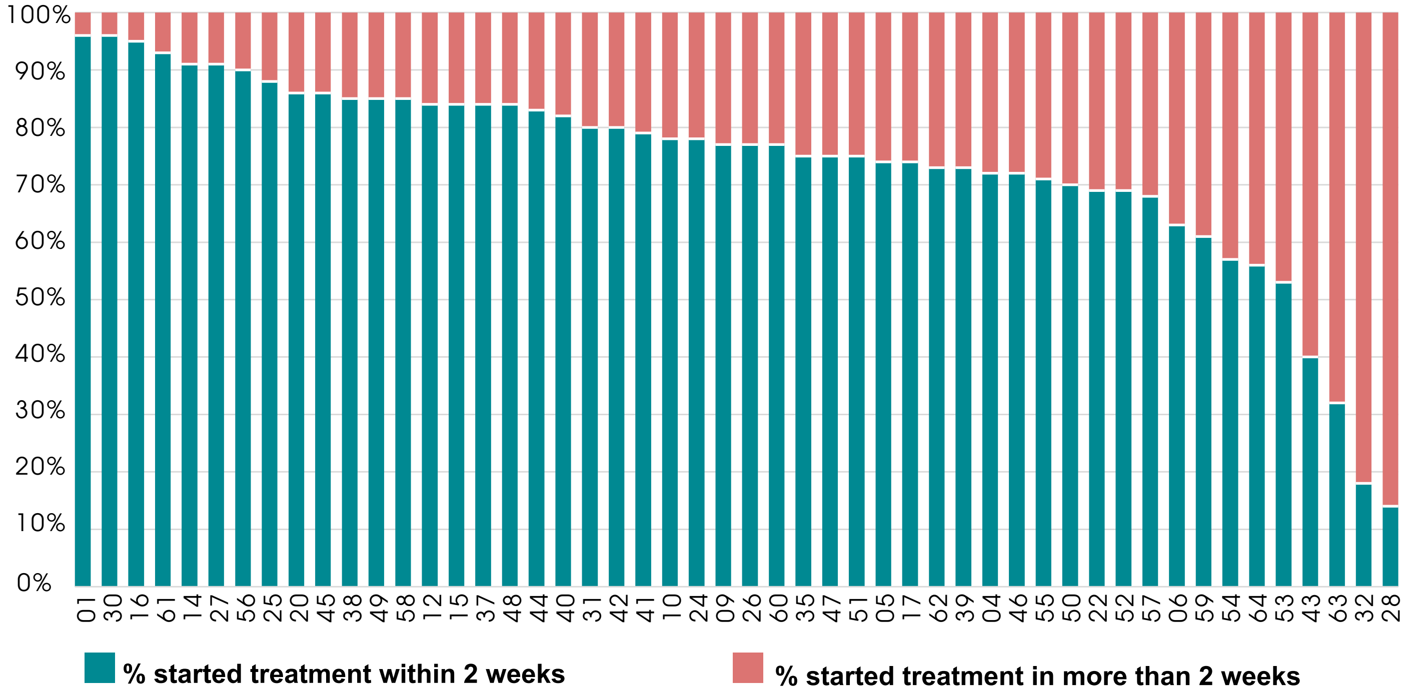
The Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016) requires that, from 1 April 2016, more than 50% of people with FEP should be treated with a NICE-approved care package within 2 weeks of referral.

To have met this standard, people must have been allocated to and engaged with an EIP care co-ordinator within 2 weeks of referral. Analysis was carried out using the Early Intervention in Psychosis Waiting Times data for September 2020 to November 2020 (NHS Digital, 2020; 2021)[12]. All people referred to services during this period were included in the analysis (n = 3,896), of which 72%[13] of people (2,795) started treatment within 2 weeks. As shown in Figure 1, the proportion of people starting treatment within 2 weeks of referral varied from 14% to 96% across Trusts.

Data for this standard were collected over a different time period this year (September 2020 to November 2020) in comparison with last year (October 2019 to December 2019). Since 2019/2020, there has been a 2% decrease (from 74% to 72%) in the proportion of people with FEP who started treatment within 2 weeks of referral.

Data for 5 Trusts (ORG08, ORG11, ORG21, ORG34 and ORG36) were not included in the Trust comparison chart because their waiting times data included small numbers (i.e. <5 people) so were not published by NHS digital.

Figure 1: Proportion of people with FEP who started treatment within 2 weeks of referral between September 2020 and November 2020 (n = 3,896)[13]



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[12] Data is classified as 'performance' data and is not final due to the introduction of the multiple submission window model which allows providers to go back and resubmit previous months of data for the current financial year.

[13] TNS is the national average of all people with FEP who started treatment within 2 weeks of referral between September 2020 and November 2020 published by NHS Digital, therefore, may include a small number of people who were not under services audited as part of the NCAP EIP 2020/21 audit.

Why it matters to people with first episode psychosis (FEP) and their carers

The consensus in the service user and carer reference group facilitated by Rethink[14] was that early intervention in psychosis is vital, as the quote below illustrates. Generally, participants agreed that the audit results reflected their experience. One service user said that their EIP service had met this standard, but they wished they had been referred sooner because it had only happened when they were severely unwell.

> “The most important part of Early Intervention in Psychosis is the ‘EARLY’ for service users and family. Witnessing trauma is really scary. EIP services come in and say, ‘We’ve got it from here’. They become the scaffolding that comes around your family and supports them” (Carer)

> “For me, I think I was seen by EIP in just over 2 weeks from the referral. Although, looking at the graph, I am shocked at how much access within the 2-week period can vary throughout England” (Service user)

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[14] The NCAP team commissioned Rethink Mental Illness to set up and run a service user and carer reference group to gather reflections on the audit data from people with a lived experience of first episode psychosis. The case-note audit findings relating to the standards were presented by the NCAP team, and the discussion was facilitated by Rethink. Quotes are presented throughout the report to offer insight into how the attending service users and carers felt about the results. For further detail, see Appendix E.

7. Cognitive behavioural therapy for psychosis (CBTp)

Standard 2

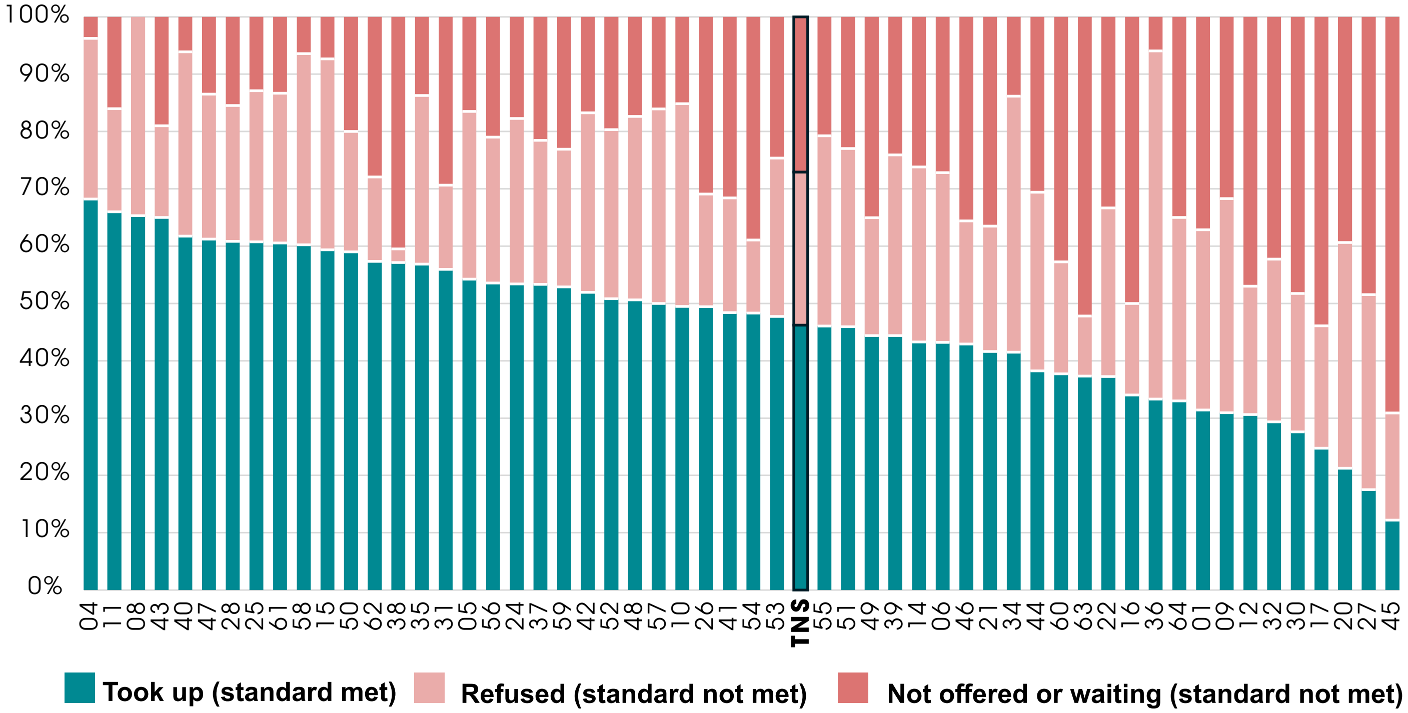
Service users with first episode of psychosis take up cognitive behavioural therapy for psychosis

The NICE quality standards in relation to treating and managing psychosis (QS80, quality statement 2; QS102, quality statement 3) recommend that CBTp is offered to people with psychosis.

For Trusts to have met this standard, people had to receive at least 1 session of a course of CBTp delivered by a person with the relevant skills, experience and competences to deliver CBTp (see guidance, question 7).

This analysis was carried out on the entire national sample (n = 10,033), of which 46% (4,637) received 1 or more sessions of CBTp. As shown in Figure 2, the proportion of people taking up CBTp varied from 12% to 68% across Trusts. The proportion of people not taking up CBTp included 27% (2,680) who refused this intervention, which varied from 2% to 61% across Trusts. Since 2019, there has been a 3% decrease (from 49% to 46%) in the proportion of people with FEP who took up CBTp.

Figure 2: Proportion of people with FEP who took up CBTp (n = 10,033)



Why it matters to people with first episode psychosis (FEP) and their carers

While some in the service user and carer reference group were clear about the value of CBTp, others were unsure about the difference between CBT and CBTp, questioned why they had been offered CBTp before seeing a psychologist, and commented on having started CBTp when unwell and not being able to remember it at all.

One carer commented on the creative ways her son’s EIP team had used to engage him in CBTp, while they were having to adapt their practice due to the pandemic. She spoke appreciatively of how the team had made home visits and changed therapists when the first one did not match the service user’s needs. The group agreed with her view about how important it was to have the right person coming in at the right time.

A few service users suggested that the refusal rates could be due to people being offered CBTp too early, commenting on how they had felt unable to start CBTp when they were still very unwell.

> “My experience was that CBTp was too rigid to do when you are straight off the ward… People will be more likely to refuse as they won’t feel it is meeting their needs” (Service user)

> “Accepting the need for CBTp is not easy. Many practitioners have not been trained in the ‘p’ of CBTp, which means they cannot train other clinicians. It’s a chicken and egg situation. The more clinicians that are trained, the more the ‘p’ will be understood and discussed, experiences shared and stigma lessened” (Carer)

8. Family intervention

Standard 3
Service users with first episode psychosis and their families take up FI

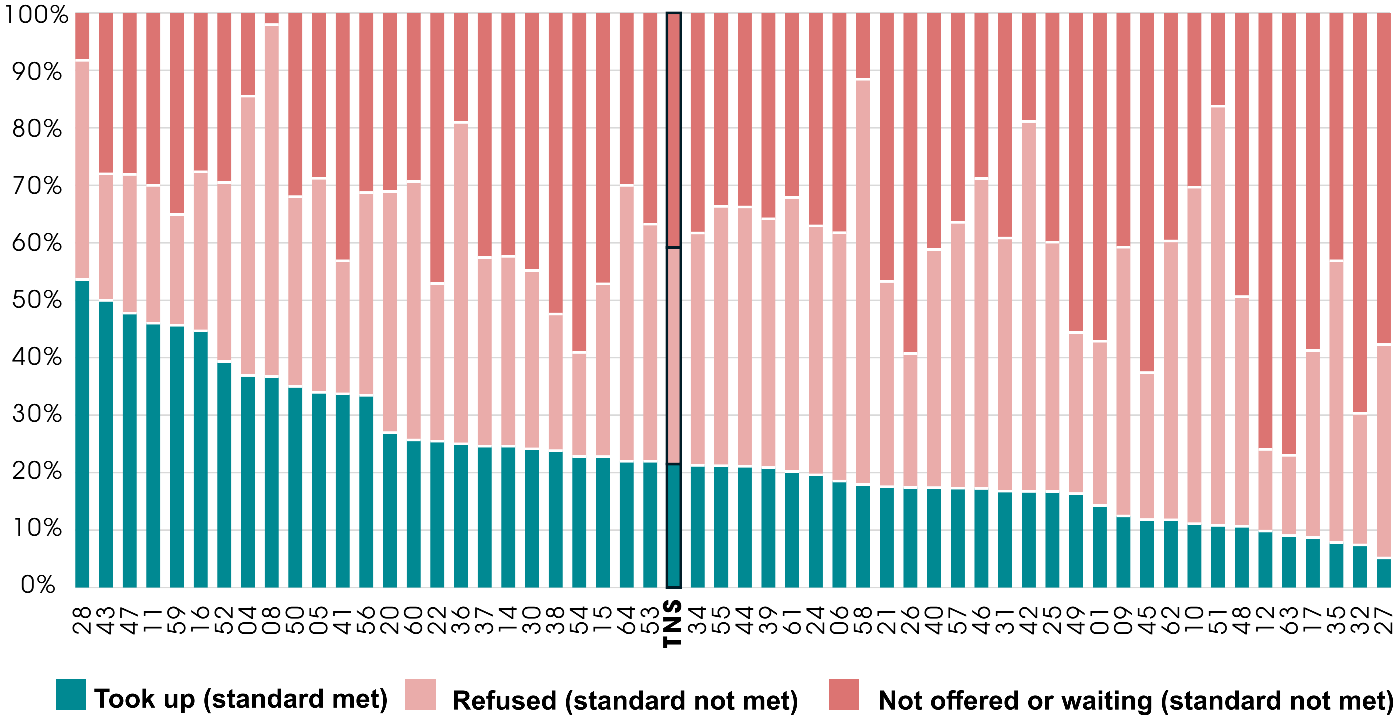
The NICE quality standards in relation to treating and managing psychosis (QS80, quality statement 3; QS102, quality statement 2) recommend that family members of people with psychosis should be offered FI.

For Trusts to have met this standard, people had to have received at least 1 FI session delivered by a person with the relevant skills, experience and competences in delivering FI (see guidance, question 7).

This analysis was carried out on the entire national sample (n = 10,033), of which 21% (2,157) received 1 or more sessions of FI. As shown in Figure 3, the take-up of FI ranged from 5% to 54% across Trusts. The proportion of people not taking up FI included 38% (3,782) who refused this intervention, which varied from 14% to 73% across Trusts. Since 2019, there has been no change in the proportion of people with FEP and their families who took up FI.

Data collected on FI may include digital FI during COVID-19. However, it is important to note that there is currently no supporting evidence for delivering FI in this way and the impact on outcomes is unknown.

Figure 3: Proportion of people with FEP and their families who took up FI (n = 10,033)



Further analysis for this standard was carried out on people who had an identified carer, excluding those who did not wish this person to be contacted (n = 7,444).

27% (1,980) of 7,444 people who had an identified carer and did wish for this person to be contacted, had received 1 or more sessions of FI. For this smaller sample, the proportion of people meeting the standard ranged from 6% to 76% across Trusts. The proportion of people who refused to take up FI in this smaller sample was 37% (2,755), which ranged from 13% to 75% across Trusts. See Figure 1 in Appendix G (page 23).

Why it matters to people with first episode psychosis (FEP) and their carers

There was surprise among the group that the take-up of FI was so low, because most of them had undertaken it and had a positive experience. One carer said the word ‘therapy’ can be off putting and that ‘Family Intervention Support’ should be used instead. Another commented that some families do not feel in a position to take on board support as they are already dealing with so much.

> When my daughter was unwell, we [herself, her daughter and other children] would all be sitting in separate rooms. All upset and feeling our emotions separately. EIP and Family Intervention helped to knock these brick walls down and bring us together” (Carer)

> [FI] creates a feeling that we are all in this together” (Carer)

> “Sadly my teenage daughter [who is the sister to someone in EIP] isn’t really wanting to engage with Family Intervention therapy as she constantly says she doesn’t need therapy – I think the way it is explained is key and I agree the word therapy does not help” (Carer)

> The service went above and beyond and I really valued the experience. It felt like a luxurious offer” (Service user)

9. Prescribing of clozapine

S4

Standard 4

Service users with first episode psychosis who have not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs are offered clozapine

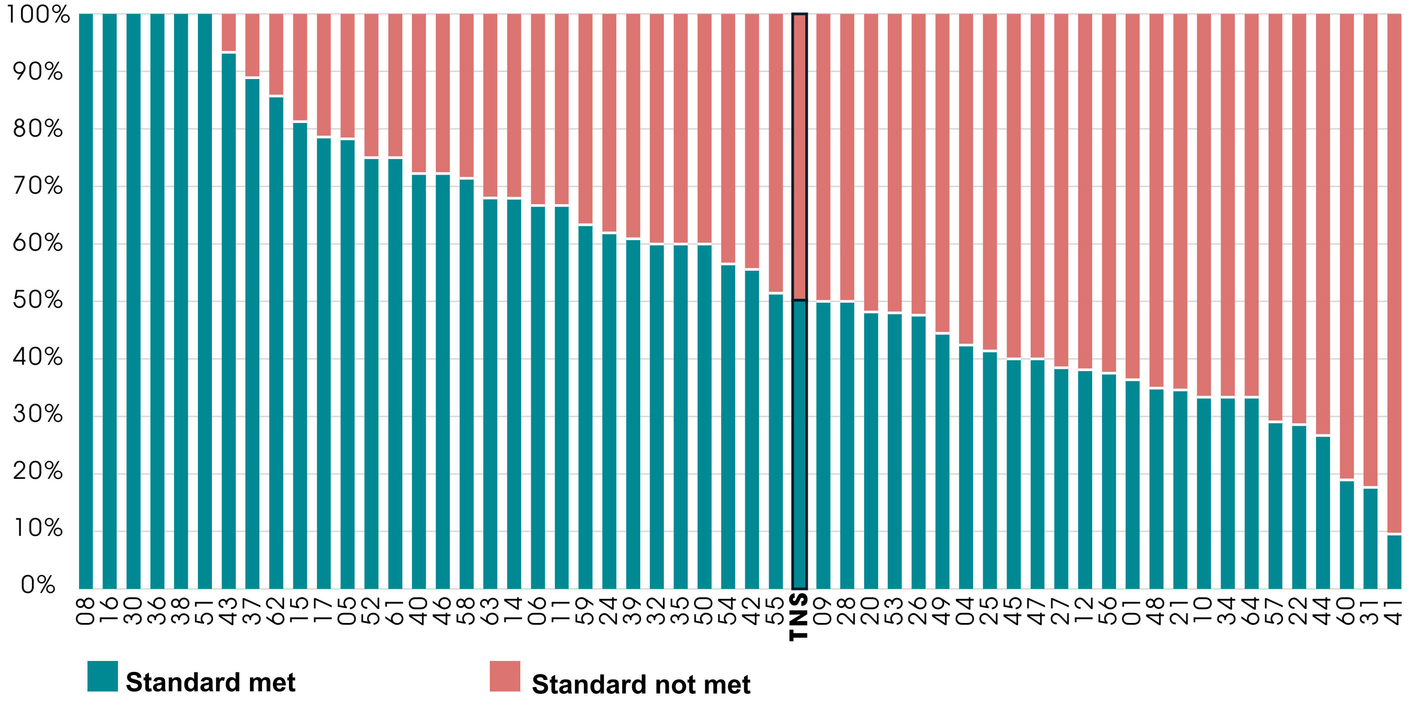
The NICE quality standard for psychosis and schizophrenia in adults QS80, quality statement 4) recommends that people who have not responded adequately to at least 2 trials of antipsychotic drugs (at least 1 of which should be a non-clozapine second-generation antipsychotic) should be offered clozapine[3].

Analysis for this standard was conducted on people who were identified from their case notes as having had treatment with at least 2 antipsychotic drugs and not having responded adequately to or tolerated them (n = 1,143).

As shown in Figure 4, 50% (574) of 1,143 people in the national sample were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs.

The proportion of people whose treatment met this standard ranged from 10% to 100% across Trusts. Since 2019, there has been a 2% decrease (from 52% to 50%) in the proportion of people being offered clozapine after 2 unsuccessful trials of antipsychotics.

Figure 4: Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs (n = 1,143)



Why it matters to people with first episode psychosis (FEP) and their carers

There was a consensus in the service user and carer reference group that you can feel more hopeful if you have the right EIP team and the right drugs. For some, there was a perception that clozapine is a ‘big step’, and participants agreed that it should only be offered after other drugs have been tried. One service user said they were surprised that only half of the people in the audit had been offered clozapine because, for him, it was the ‘best drug ever’.

> I was on clozapine for 6 months before EIP even started. I have now been on it for a really long time and it has really helped me” (Service user)

10. Supported employment and education programmes

S5

Standard 5

Service users with first episode psychosis take up supported employment and education programmes

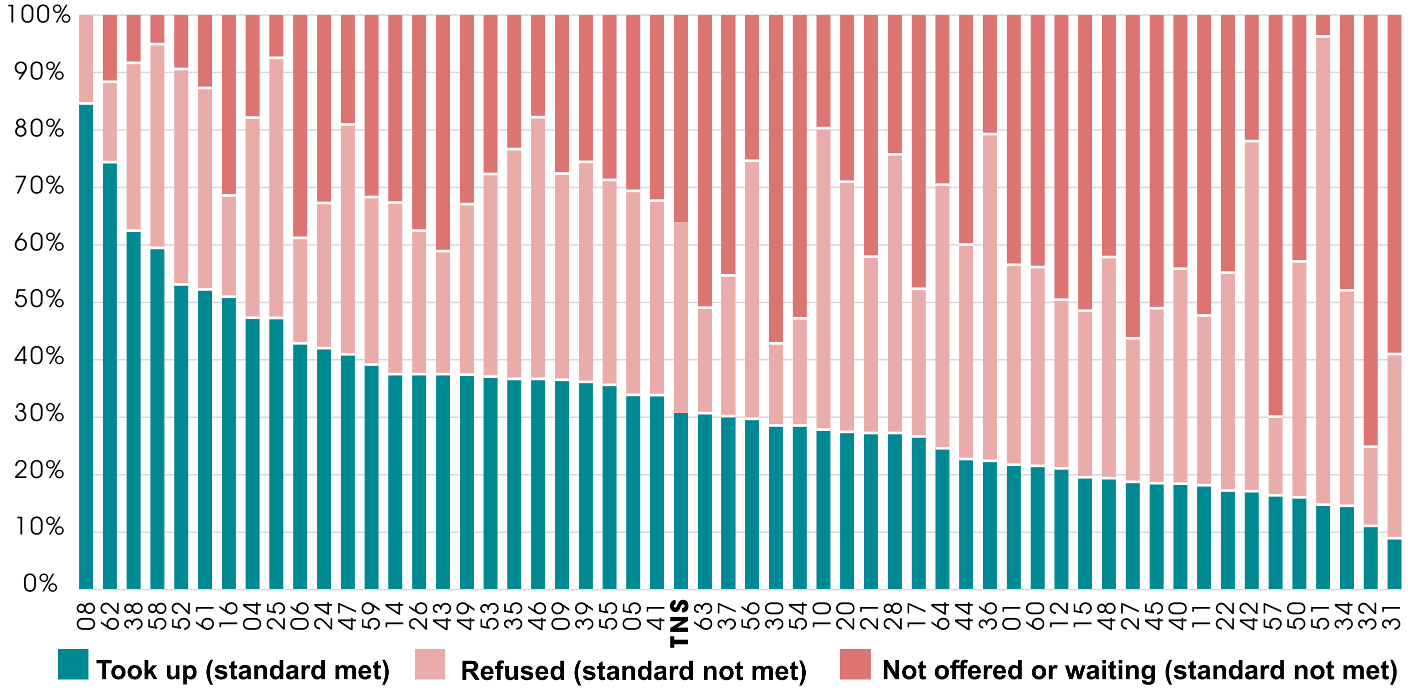
The NICE quality standards in relation to treating and managing psychosis (QS80, quality statement 5; QS102, quality statement 8) recommend that supported education and employment programmes should be offered to people if they wish to find or return to education or work.

For Trusts to have met this standard, people had to have received at least 1 session of a supported employment or education programme, delivered by a person who had the relevant skills, experience and competences to deliver an education and employment programme (see guidance, question 7).

This analysis was carried out on responses from people who were identified from their case notes as not being in work, education or training at the time of their initial assessment (n = 5,921). 31% (1,820) of 5,921 people identified as not being in work, education or training attended 1 or more sessions of a supported employment or education programme.

As shown in Figure 5, the proportion of people taking up supported employment and education programmes ranged from 9% to 85% across Trusts. The proportion of people not taking up supported employment and education programmes included 33% who refused this intervention, which varied from 14% to 81% across Trusts. Since 2019, there has been no change in the proportion of people with FEP taking up supported employment and education programmes.

Figure 5: Proportion of people with FEP who were not in work, education or training who had taken up supported employment and education programmes (n = 5,921)



Further analysis for this standard was carried out on the entire national sample (n = 10,033), because supported employment and education programmes may help people stay in their current employment or education, change work or take up other training/education programmes. 32% (3,183) of 10,033 people in the national sample attended 1 or more sessions of a supported employment or education programme. The proportion of people who refused to take up supported employment and education programmes was 29% (n = 2,896), which varied between 10% and 66% across Trusts. For this larger sample, the proportion of people meeting the standard ranged from 9% to 86% across Trusts. See Figure 2 in Appendix G (page 23).

Why it matters to people with first episode psychosis (FEP) and their carers

One service user in the reference group commented that she had ‘consistently asked for [employment and education] support and it was consistently not provided’. By the time it was offered, she had become unwell again, so it was no longer a priority to her. One carer noted how hard it was getting back into work after a first episode of psychosis, and that there needs to be support and training on how to re-enter the job market. The group agreed that there appeared to be a gap between EIP and employability support and that service users needed more structured offers and should not have to reach out for such support.

It was pointed out that the audit results do not show a service user’s whole journey of employment, e.g. if they had been employed before becoming unwell and if they had managed to stay employed or had lost their job once starting EIP. One carer wanted to know more about why some service users ‘refused’ this support – e.g., was the relationship with the service user properly developed before the support had been offered?

Reflecting on the audit results, one participant commented it was a ‘postcode lottery’ as to whether good links existed locally between EIP services and employers or education schemes in the community and whether support is structured or more ad hoc.

> I am really independent and want to work to support myself” (Service user)

> [Within] the offer of supportive education for younger people are there any exploratory programmes for helping them explore interests and learn pleasurably? How do you reach the hopes and aspirations they had before becoming unwell? These education and employment programmes do not appear to be the right vehicle to get a young person’s identity back” (Carer)

11. Physical health screening

Standard 6

Service users receive a physical health review annually. This includes the following measures:

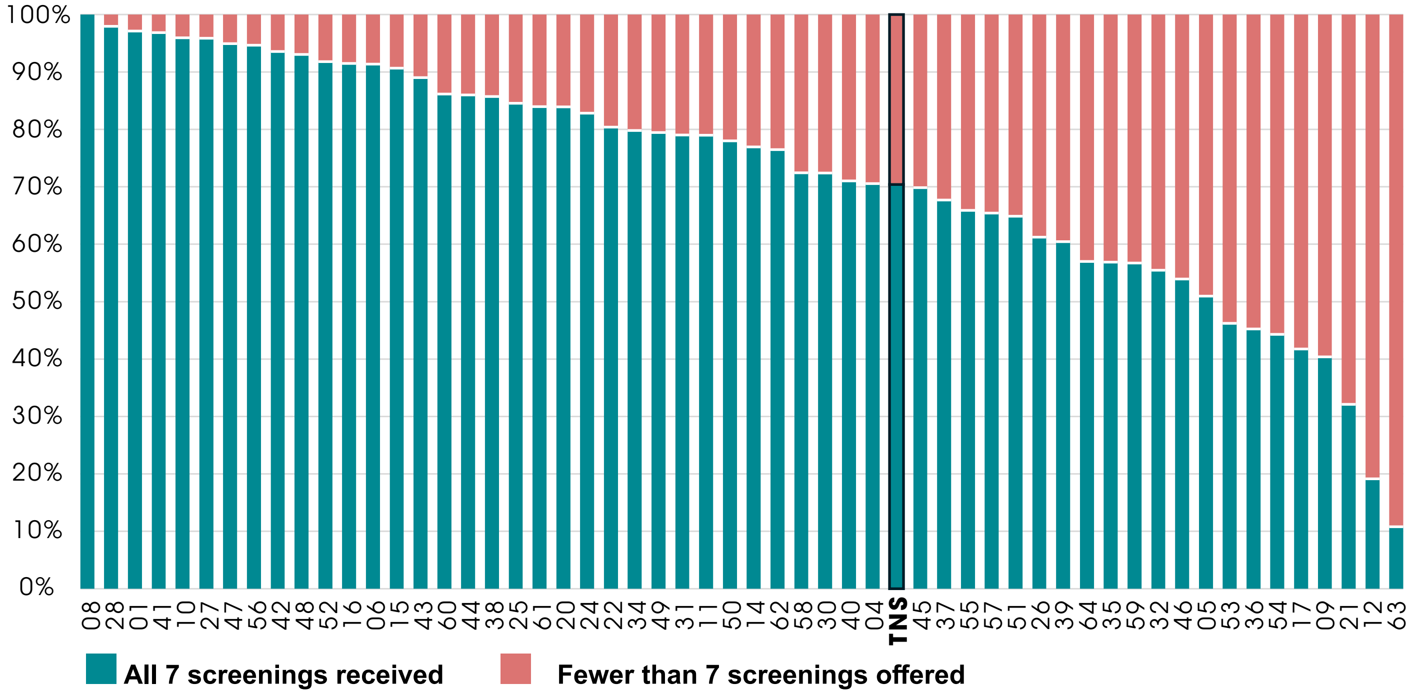
- smoking status
- alcohol intake
- substance misuse
- BMI
- blood pressure
- glucose
- cholesterol

The NICE quality standards in relation to treating and managing psychosis (QS80, quality statement 6; QS102, quality statement 6) recommend that people with psychosis should receive comprehensive physical health assessments. Physical health should be assessed within 12 weeks of starting treatment, at 1 year and annually thereafter.

For Trusts to have met this standard, people must have been screened on all 7 physical health measures within the last 12 months. As in the 2019/2020 audit, these data were analysed in the same way as the Commissioning for Quality and Innovation programme implemented between 2017-19 on improving the physical health of people with severe mental illness. 'Received screening' includes those people who were offered but refused screening.

All people (n = 10,033) were included in this analysis, and it was found that 70% (7,063) had been screened on all 7 physical health measures. Across Trusts, the proportion of people meeting the standard ranged from 11% to 100%. Figure 6 shows the proportion of people who were screened on all 7 physical health measures. This is a 5% decrease from the previous year, in which 75% received screening on all 7 physical health measures.

Figure 6: Proportion of people with FEP who were screened on all 7 physical health measures across Trusts in the past 12 months (n = 10,033)[15]



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[15] 'Screened' includes those people who were offered but refused screening.

Smoking status

Figure 7 shows that smoking status was monitored for 91% (9,099) of people. This is a 2% decrease from the previous year, where 93% received screening for their smoking status. 5% (465) of people in total refused to provide their smoking status; refusal rates varied from 0% to 28% across Trusts. Smoking status was not documented in 9% (934) of cases. Monitoring of smoking status ranged from 45% to 100% across Trusts.

Alcohol intake

Figure 8 shows that screening of alcohol intake was monitored for 91% (9,155) of people. This is a 3% decrease from the previous year, where 94% received screening for their alcohol use. Screenings were refused by 5% (467) of people; refusal rates varied from 0% to 28% across Trusts. Alcohol use was not documented in 9% (878) of cases. Monitoring of alcohol use ranged from 45% to 100% across Trusts.

Figure 7: Proportion of people with FEP monitored for cigarette smoking across Trusts in the past 12 months (n = 10,033)

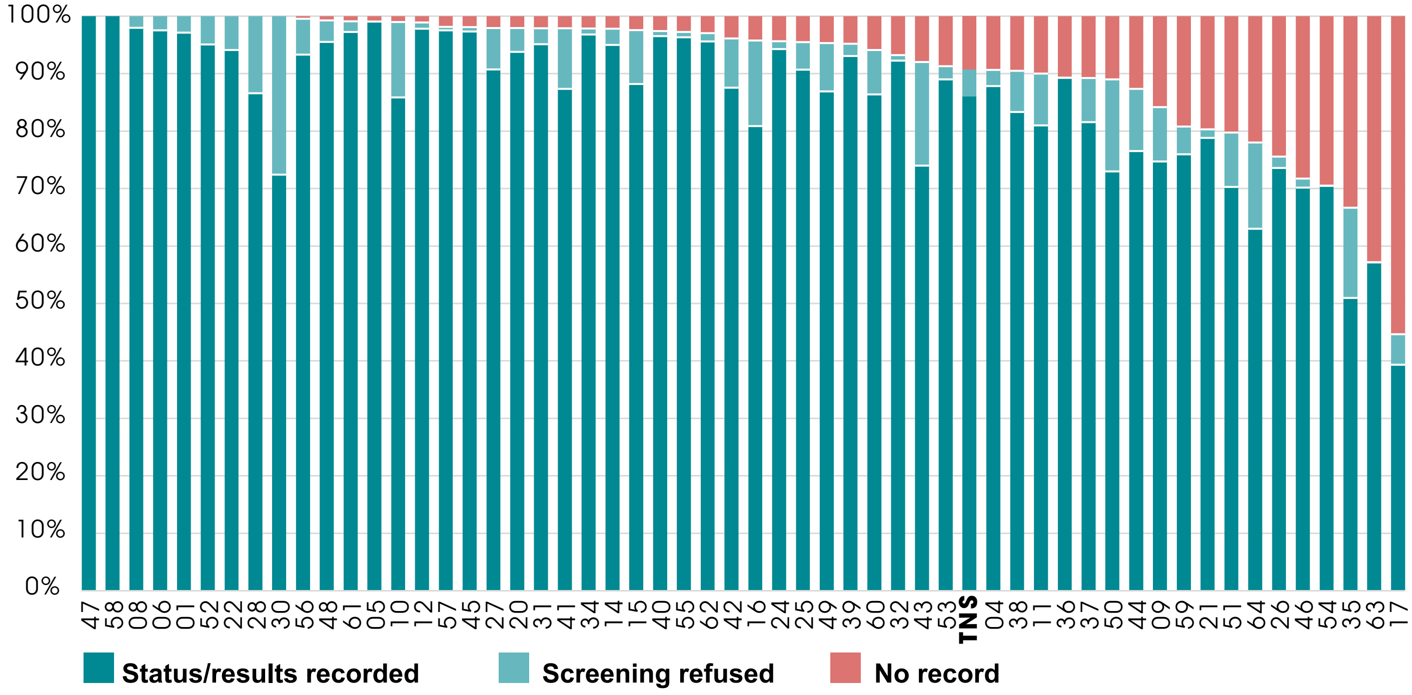
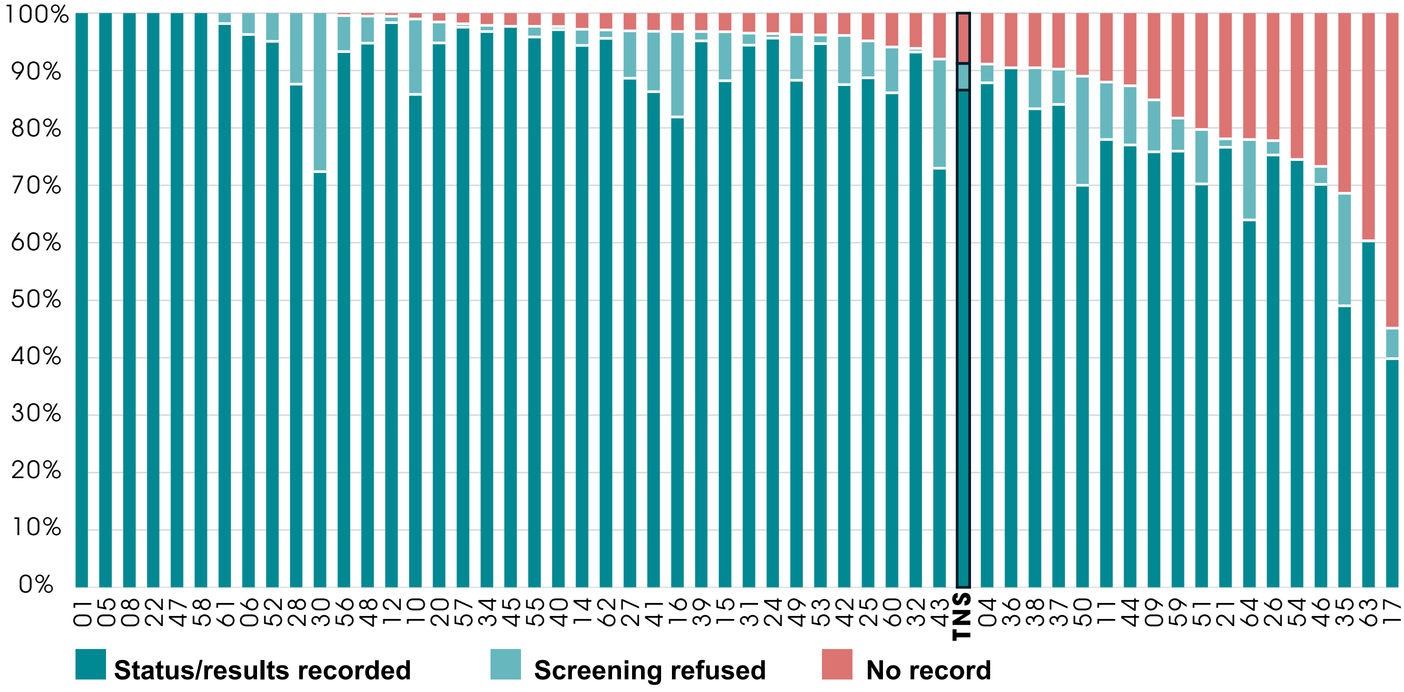


Figure 8: Proportion of people with FEP monitored for alcohol consumption across Trusts in the past 12 months (n = 10,033)



Substance misuse

Figure 9 shows that screening for substance misuse was monitored for 91% (9,146) of people. This is a 3% decrease from the previous year, where 94% received screening for substance misuse. Screenings were refused by 5% (485) of people; refusal rates varied from 0% to 28% across Trusts. Substance misuse was not documented in 9% (887) of cases. Monitoring of substance misuse ranged from 45% to 100% across Trusts.

Body mass index

Figure 10 shows that BMI was monitored for 84% (8,384) of people. This is a 3% decrease from the previous year, where 87% had their BMI monitored. BMI measurement was refused by 9% (863) of people; refusal rates varied from 0% to 35% across Trusts. BMI was not documented in 16% (1,649) of cases. Monitoring of BMI ranged from 27% to 100% across Trusts.

Figure 9: Proportion of people with FEP monitored for substance misuse across Trusts in the past 12 months (n = 10,033)

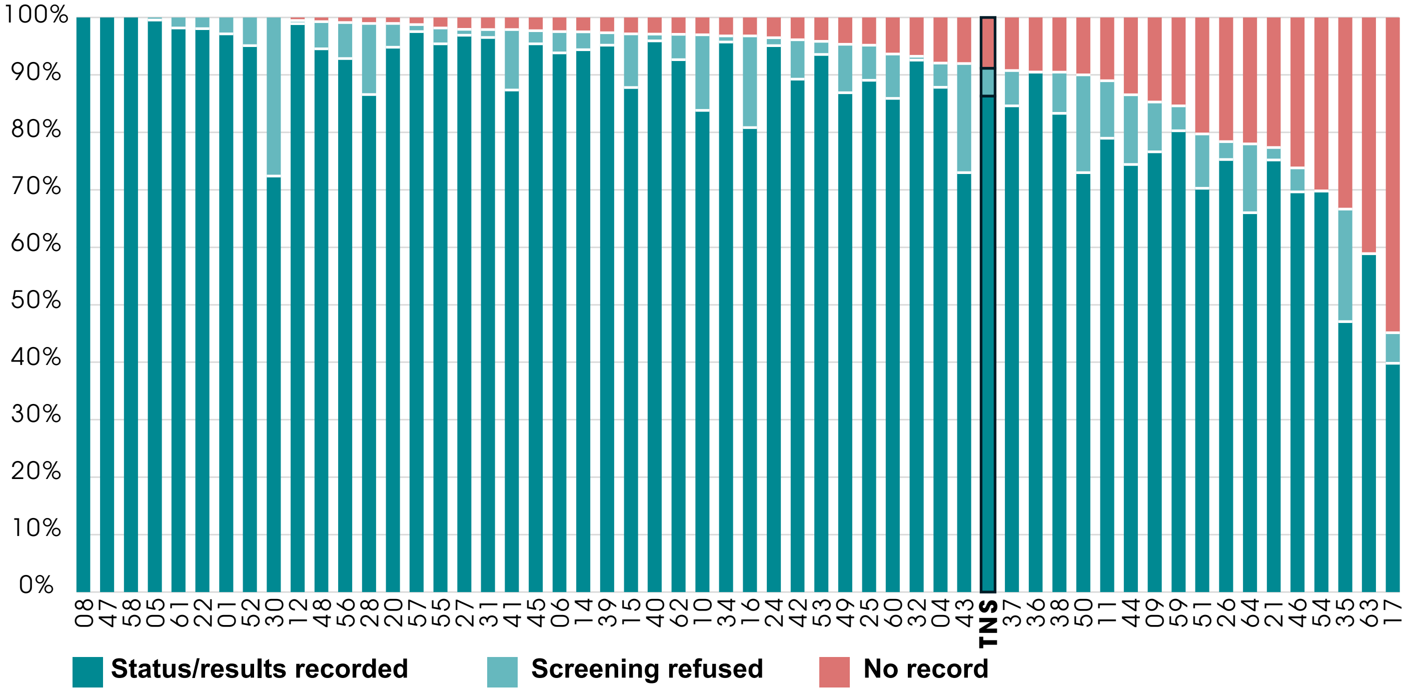
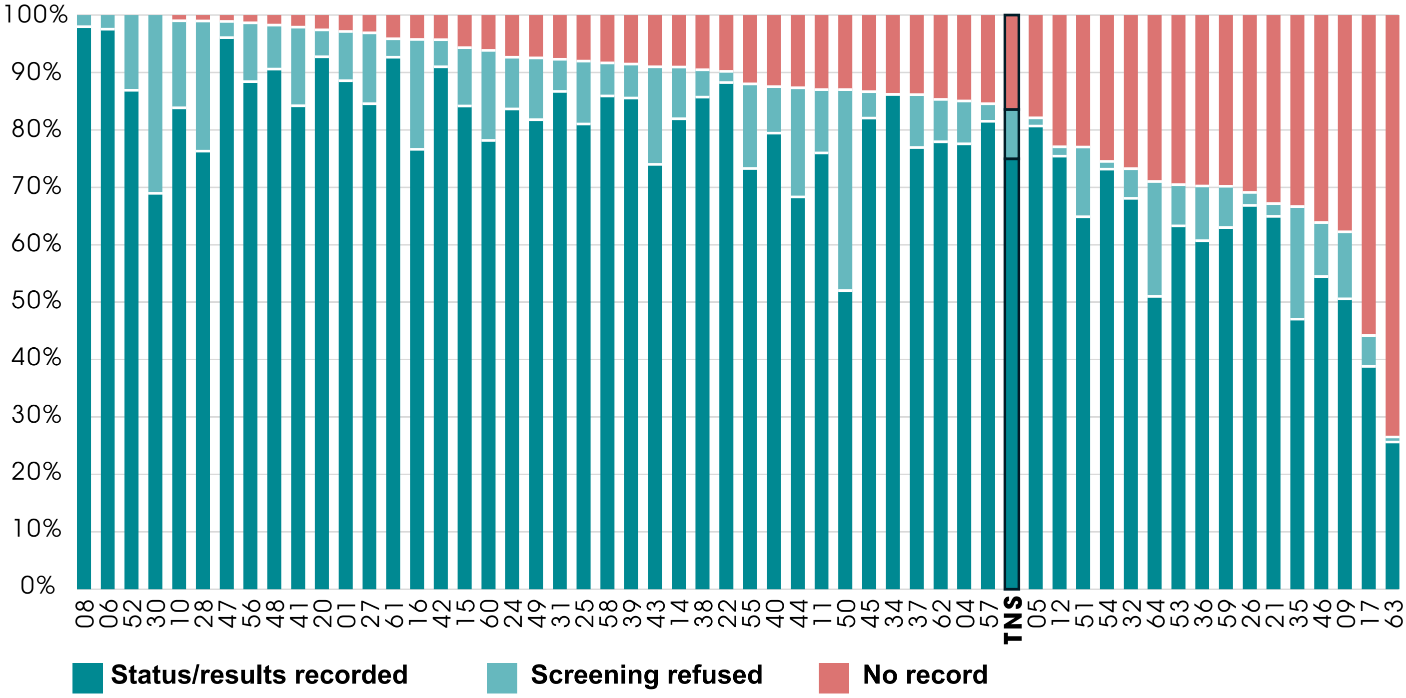


Figure 10: Proportion of people with FEP monitored for BMI across Trusts in the past 12 months (n = 10,033)



Blood pressure

Figure 11 shows that blood pressure was monitored for 84% (8,404) of people. This is a 5% decrease from the previous year, where 89% of people were monitored for blood pressure. Blood pressure screenings were refused by 8% (823) of people; refusal rates varied from 0% to 31% across Trusts. Blood pressure was not documented in 16% (1,629) of cases. Monitoring of blood pressure ranged from 28% to 100% across Trusts.

Blood glucose control

Figure 12 shows that glucose control was monitored for 79% (7,959) of people. This is a 5% decrease from the previous year, where 84% were monitored for glucose control. Screening was refused by 14% (1,394) of people; refusal rates varied from 0% to 33% across Trusts. Glucose control was not documented in 21% (2,074) of cases. Monitoring of glucose control ranged from 31% to 100% across Trusts.

Figure 11: Proportion of people with FEP monitored for blood pressure across Trusts in the past 12 months (n = 10,033)

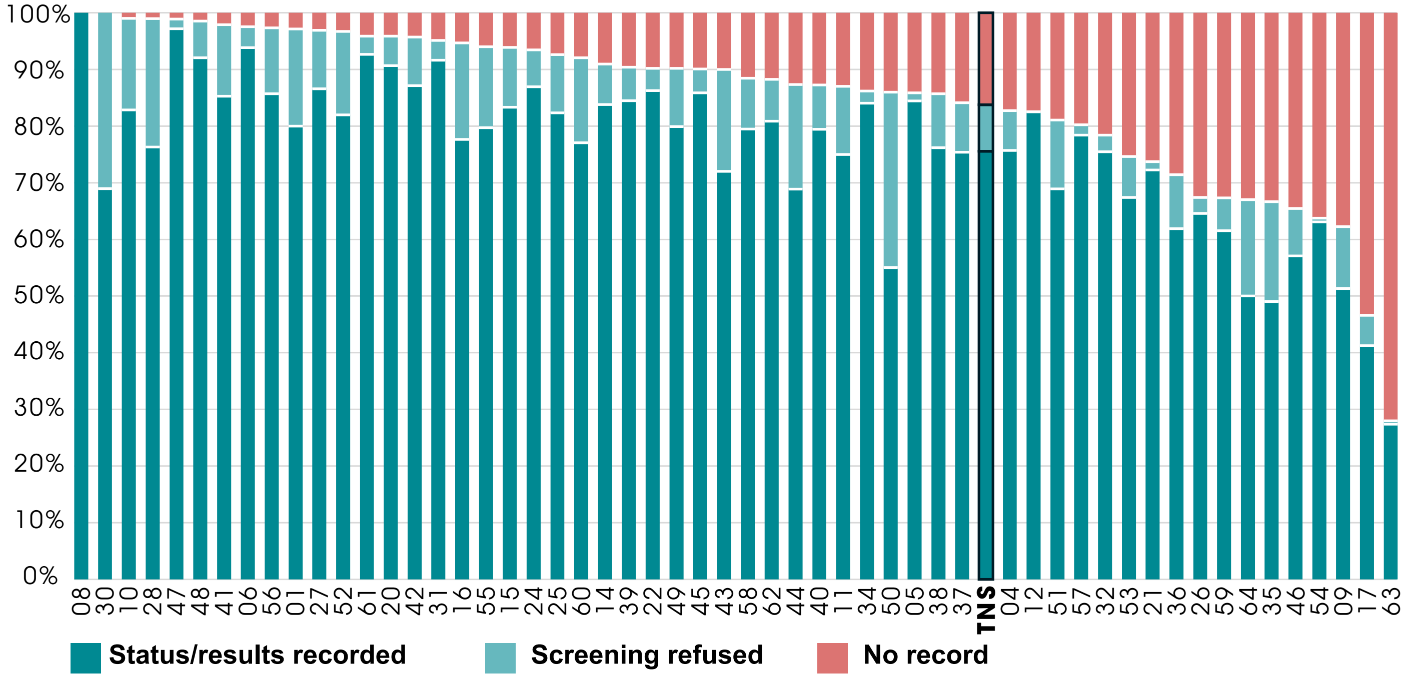
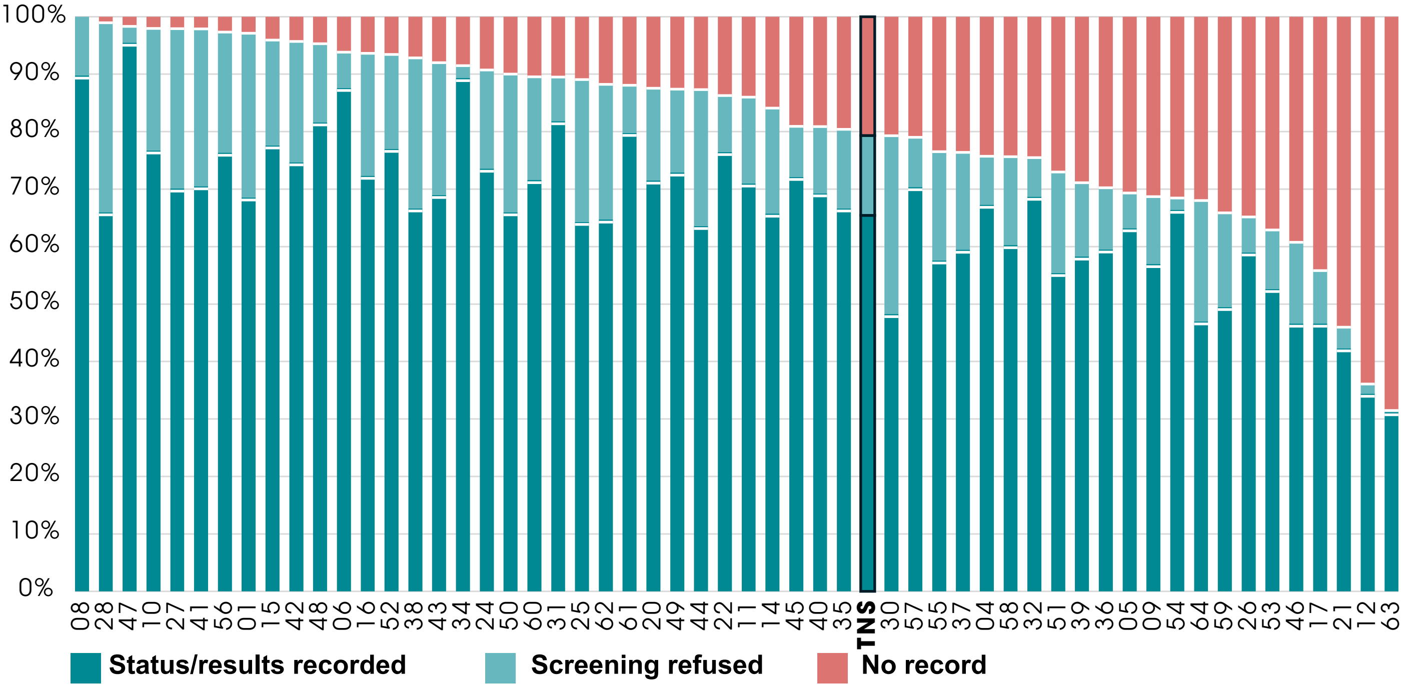


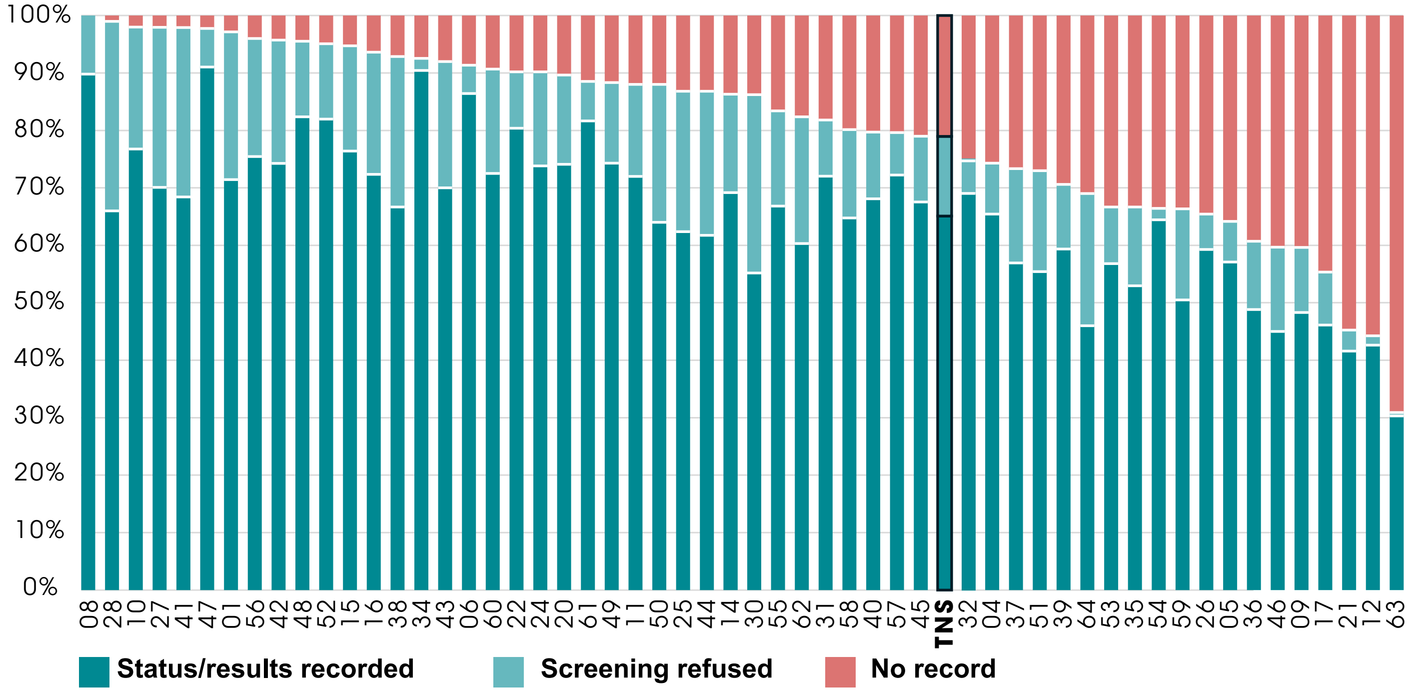
Figure 12: Proportion of people with FEP monitored for blood glucose control across Trusts in the past 12 months (n = 10,033)



Cholesterol

Figure 13 shows that cholesterol was monitored for 79% (7,922) of people. This is a 3% decrease from the previous year, where 82% were monitored for cholesterol. Screening was refused by 14% (1,391) of people; refusal rates varied from 1% to 33% across Trusts. Cholesterol was not documented in 21% (2,111) of cases. Monitoring of cholesterol ranged from 31% to 100% across Trusts.

Figure 13: Proportion of people with FEP monitored for cholesterol (blood lipids) across Trusts in the past 12 months (n = 10,033)



Why it matters to people with first episode psychosis (FEP) and their carers

The service user and carer reference group recognised the importance of physical health monitoring, as the quotes below illustrate. It was understood that some screenings like taking blood would have been difficult to do while social distancing.

> “It was a really good thing, to focus on the physical aspect of my condition, it provided me with a lot of help” (Service user)

> “I’m a clinician but had no level of expertise with regards to antipsychotics, [and] one of the first things I’ve learned is that it impacts physical health. We worked hard as a family to understand these impacts” (Carer)

> “70% [being screened for all physical health measures] is acceptable given the pandemic – well done EIP teams” (Carer)

12. Physical health interventions

Standard 7
Service users are offered relevant interventions for their physical health for the following measures:

- smoking cessation
- harmful alcohol use
- substance misuse
- weight gain/obesity
- hypertension
- diabetes/high risk of diabetes
- dyslipidaemia

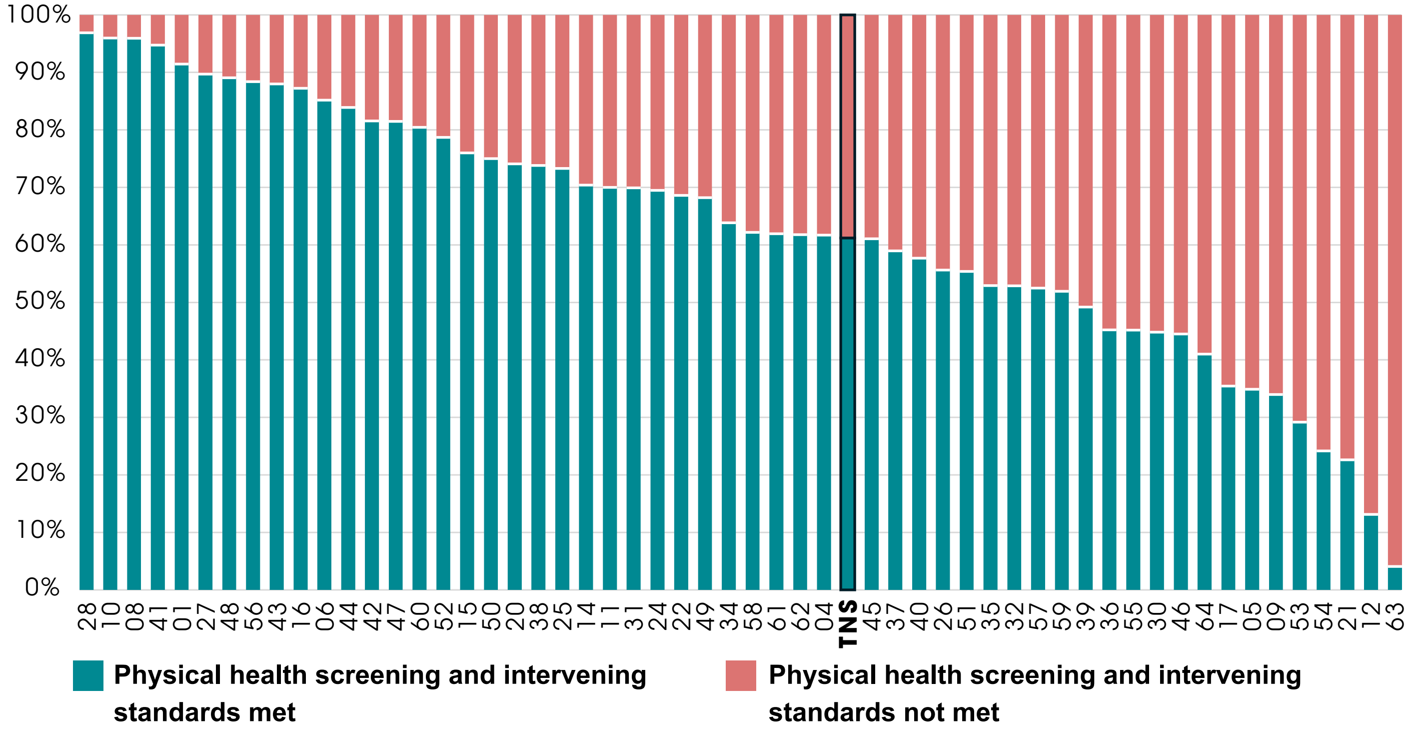
To define need for intervention, the Lester Resource (Shiers et al., 2014) was used to assess thresholds for smoking status, BMI, blood pressure, glucose and cholesterol. Thresholds for alcohol intake and substance misuse are defined by NICE guidelines CG115 and CG120. These thresholds reflect those implemented within the national Mental Health Commissioning for Quality and Innovation analysis conducted between 2017-19.

The criteria applied to determine need for intervention were as follows:

- **Cigarette smoking: Records documenting person as current smoker.**
- **Alcohol use: Records indicating harmful or hazardous use of alcohol.**
- **Substance misuse: Records indicating substance misuse.**
- **BMI: BMI recorded as ≥25 kg/m^2 (for South Asian and Chinese people, ≥23 kg/m^2).**
- **Blood pressure: Systolic >140 mm and/or diastolic >90 mm.**
- **Glucose control: At least 1 of: Fasting plasma glucose ≥5.5 mmol/l; random plasma glucose ≥11.1 mmol/l; haemoglobin bA1c ≥42 mmol/mol.**
- **Lipid abnormality: Total cholesterol >9 mmol/l, non-high-density lipid cholesterol >7.5 mmol/l and/or Q-Risk score >10%.**

For Trusts to meet the standard, people must have been offered all relevant interventions where screening indicated a risk level requiring intervention, within the last 12 months. As shown in Figure 14, 61% (6,141) of people were offered (and received or refused) all screenings and relevant interventions across all 7 measures. This is a decrease of 2% from the previous year, where 63% of people were offered (and received or refused) all screenings and relevant interventions across all 7 measures. The proportion of people offered screenings and interventions (where required) varied across measures, ranging from 95% for harmful alcohol use to 69% for dyslipidaemia.

Figure 14: Composite measure of standards 6 & 7: All 7 physical health screenings offered and interventions offered where applicable (n = 10,033)



Interventions for smoking

As shown in Figure 15, 39% (3,878) of people were identified from their case notes as requiring an intervention for smoking cessation. Of this sample, 92% (3,572) were offered a smoking cessation intervention. A further breakdown of this showed that 64% (2,471) of people received an intervention and 28% (1,101) refused the intervention. Refusal rates varied across Trusts, from 0% to 93%. Since 2019, there has been a 1% increase (from 91% to 92%) in the proportion of people with FEP who were offered a smoking cessation intervention.

Brief intervention (n = 2,047, 83%) was the most common intervention provided to the 2,471 people who received a smoking cessation intervention where required. Individual or group behavioural support was the least common (n = 30, 1%). A further breakdown of the interventions provided is displayed in Table 2.

Table 2: Breakdown of interventions received by those requiring smoking interventions across Trusts (n = 2,471)

Type of intervention received	n (%) of people who received intervention*
Brief intervention	2,047 (83%)
Smoking cessation education	619 (25%)
Referral to smoking cessation service	321 (13%)
Smoking cessation therapy	133 (5%)
Individual or group behavioural support	30 (1%)

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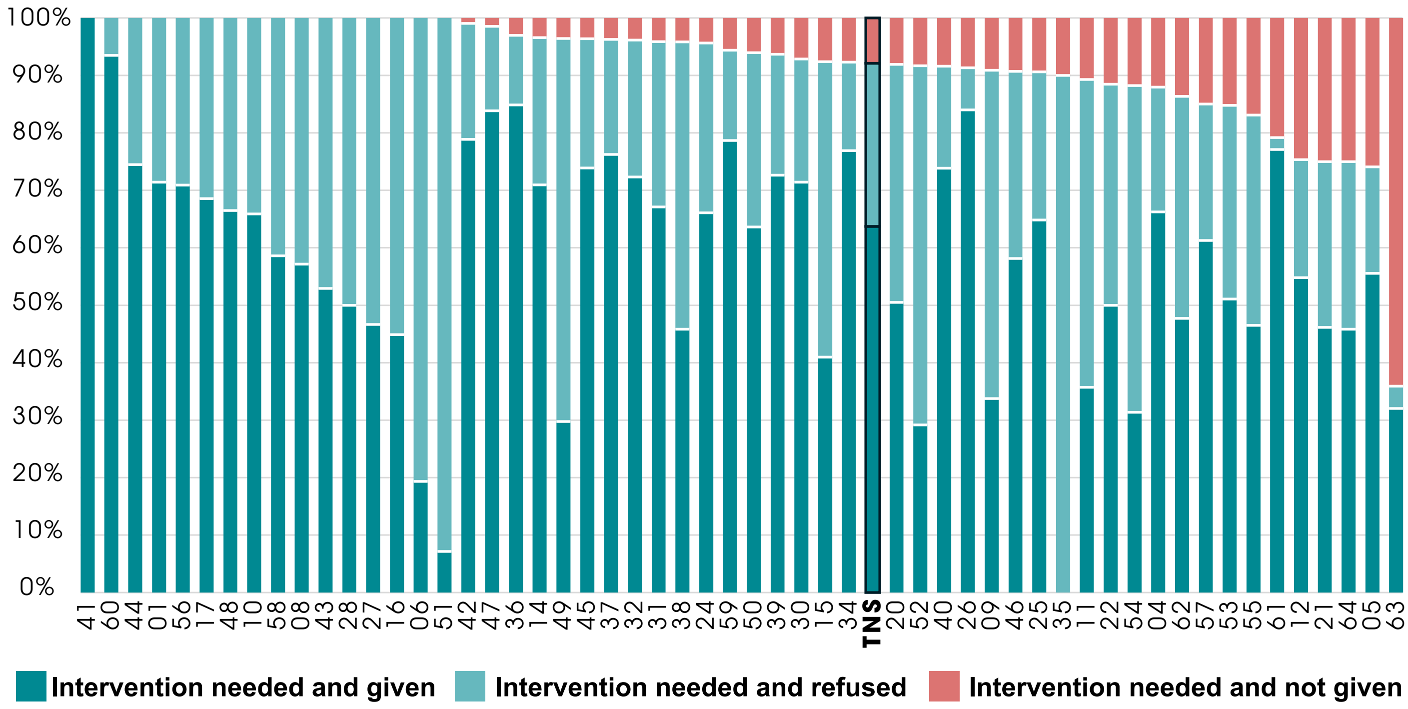
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 15: Proportion of people with FEP offered intervention for cigarette smoking across Trusts (n = 3,878 with this risk)



Interventions for harmful or hazardous alcohol use

As shown in Figure 16, 8% (783) of people were identified from their case notes as requiring an intervention for harmful or hazardous alcohol use. Of this sample, 95% (747) were offered an intervention. A further breakdown of this showed a total of 74% (581) of people received an intervention and 21% (166) refused the intervention. Refusal rates varied across Trusts from 0% to 67%. Since 2019, there has been a 2% increase (from 93% to 95%) in the proportion of people with FEP who were offered an intervention for harmful or hazardous alcohol use.

Brief intervention and advice (n = 424, 73%) was the most common intervention provided to those 581 people who received an intervention for alcohol use where required, and pharmacological intervention was the least common (n = 5, 1%). A further breakdown of interventions provided is displayed in Table 3.

Table 3: Breakdown of interventions received by those requiring harmful or hazardous alcohol use intervention across Trusts (n = 581)

Type of intervention received	n (%) of people who received intervention*
Brief intervention and advice	424 (73%)
Education about alcohol consumption	239 (41%)
Referral to alcohol misuse service	179 (31%)
Motivational interviewing	61 (10%)
Referral to psychoeducation programme	23 (4%)
Individual or group behavioural support	22 (4%)
Pharmacological intervention for harmful use of alcohol commenced or reviewed (acamprosate, disulfiram or naltrexone)	5 (1%)

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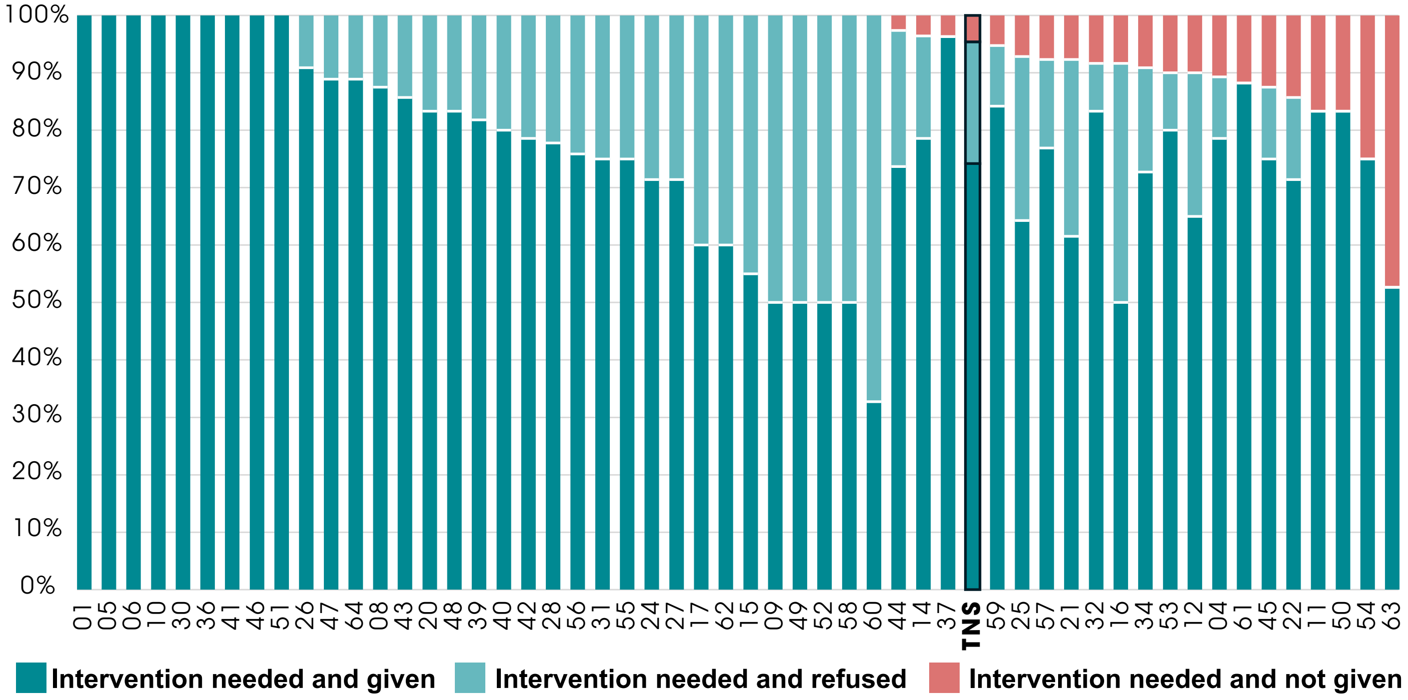
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 16: Proportion of people with FEP offered intervention for harmful or hazardous use of alcohol use across Trusts (n = 783)



Interventions for substance misuse

As shown in Figure 17, 21% (2,085) of people were identified from their case notes as requiring an intervention for substance misuse. Of this sample, 93% (1,935) were offered an intervention. A further breakdown of this showed a total of 74% (1,535) of people received an intervention and 19% (400) refused the intervention. Refusal rates varied across Trusts from 0% to 89%. Since 2019, there has been a 3% increase (from 90% to 93%) in the proportion of people with FEP who were offered an intervention for substance misuse.

Brief intervention/advice (n = 1,119, 73%) was the most common intervention provided to those 1,535 people who received an intervention for substance misuse where required and referral to a detox programme was the least common (n = 33, 2%). A further breakdown of interventions provided is displayed in Table 4.

Table 4: Breakdown of interventions received by those requiring substance misuse intervention across Trusts (n = 1,535)

Type of intervention received	n (%) of people who received intervention*
Brief intervention/advice	1,119 (73%)
Substance use education	500 (33%)
Referral to substance misuse service	457 (30%)
Motivational interviewing	119 (8%)
Referral to psychoeducation programme	35 (2%)
Referral to detoxification programme	33 (2%)

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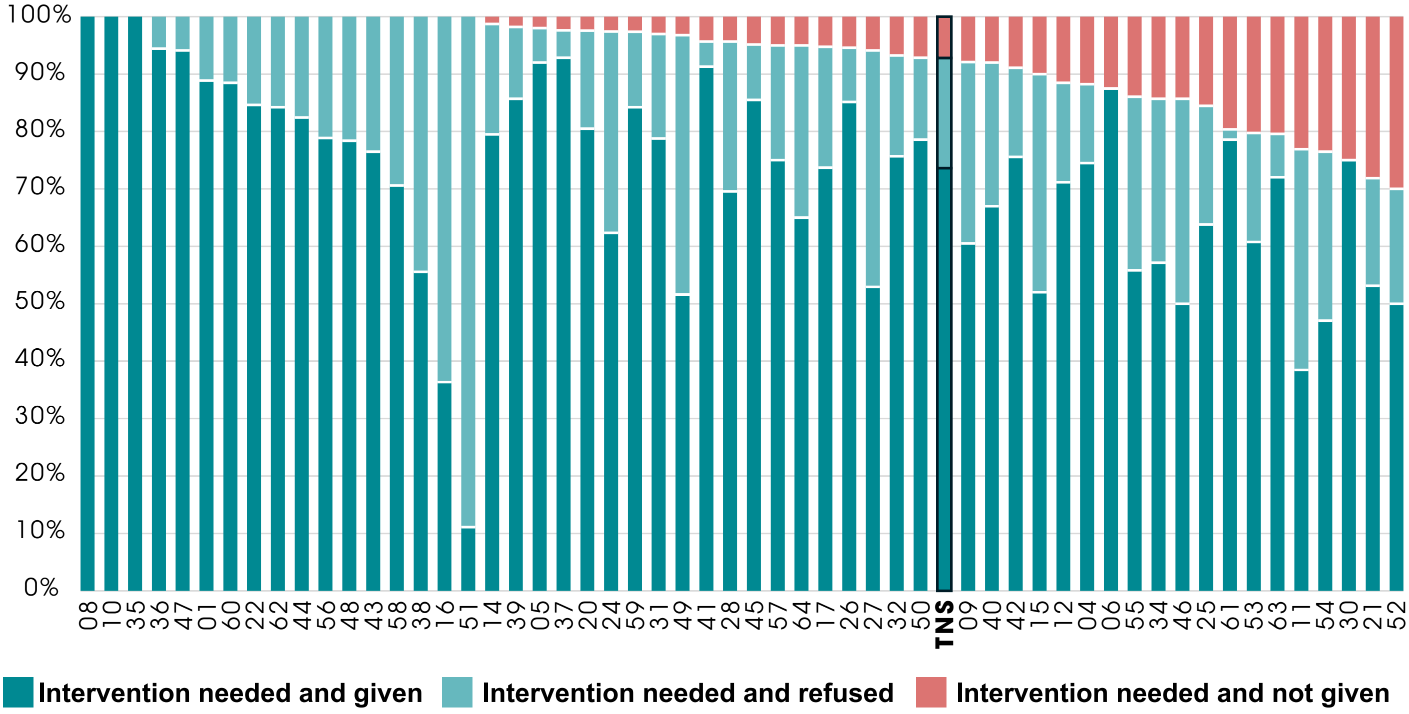
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 17: Proportion of people with FEP offered intervention for substance misuse across Trusts (n = 2,085)



Interventions for elevated BMI/ weight gain

As shown in Figure 18, 47% (4,752) of people were identified from their case notes as requiring an intervention for weight gain or obesity. Of this sample, 85% (4,058) were offered an intervention. A further breakdown of this showed a total of 79% (3,764) of people received an intervention and 6% (294) refused the intervention. Refusal rates varied from 0% to 39%. Since 2019, there has been a 2% increase (from 83% to 85%) in the proportion of people with FEP who were offered an intervention for weight gain or obesity.

Advice or referral about diet (n = 3,244, 86%) was the most common intervention provided to those 3,764 people who received an intervention for weight loss where required, and pharmacological intervention was the least common (n = 33, 1%). A further breakdown of interventions provided is displayed in Table 5.

Table 5: Breakdown of interventions received by those requiring weight loss intervention across Trusts (n = 3,764)

Type of intervention received	n (%) of people who received intervention*
Advice or referral about diet	3,244 (86%)
Advice or referral about exercise	2,978 (79%)
Mental health medication review with respect to weight (e.g. antipsychotic)	863 (23%)
Lifestyle education regarding risk of diabetes	499 (13%)
Referral for weight management programme	126 (3%)
Weight management programme	99 (3%)
Referral for lifestyle education regarding risk of diabetes	91 (2%)
Referral for lifestyle education	84 (2%)
Combined health eating and physical education programme	83 (2%)
Referral for combined healthy eating and physical education programme	67 (2%)
Pharmacological intervention for obesity commenced or reviewed	33 (1%)

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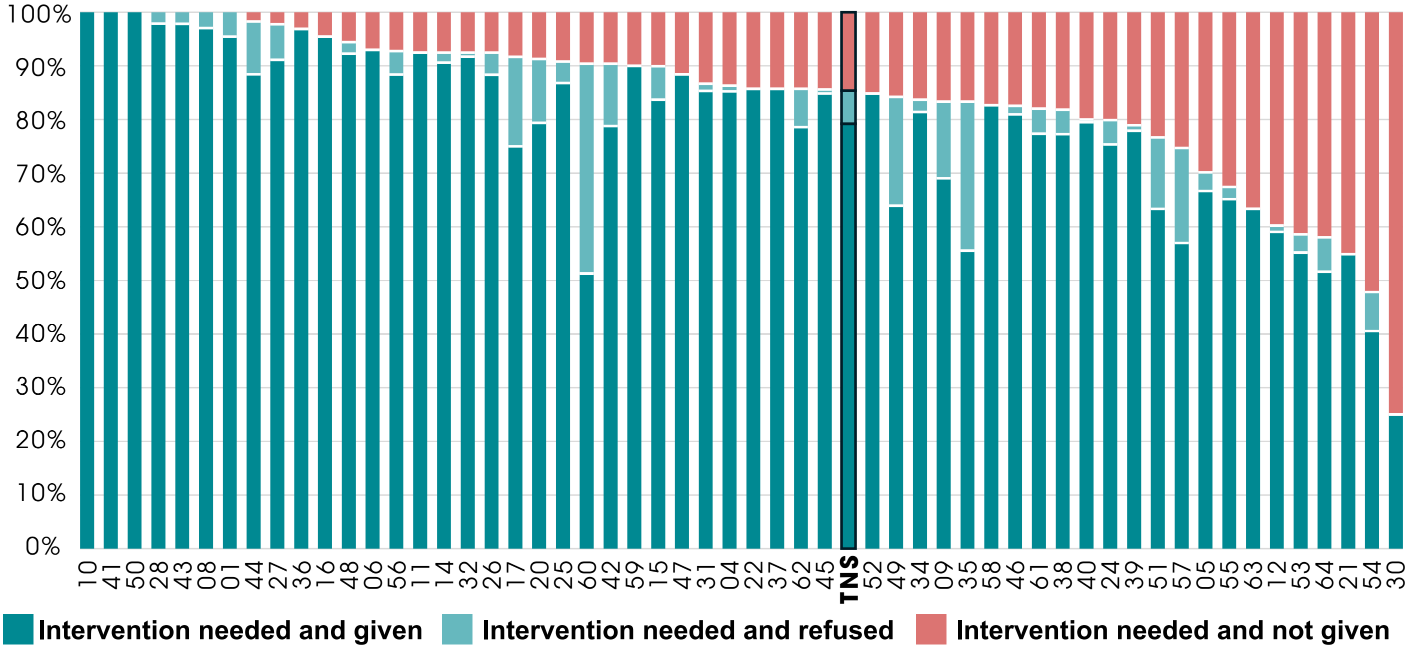
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 18: Proportion of people with FEP offered intervention for elevated BMI across Trusts (n = 4,752)



Interventions for hypertension

As shown in Figure 19, 12% (1,272) of people were identified from their case notes as requiring an intervention for hypertension. Of this sample, 70% (846) were offered an intervention. A further breakdown of this showed a total of 64% (819) of people received an intervention and 2% (27) refused the intervention. Additionally, a further 3% (44) of people did not require an intervention due to a result within the normal range on a repeat blood test. Refusal rates varied across Trusts from 0% to 20%. Since 2019, there has been a 5% increase (from 65% to 70%) in the proportion of people with FEP who were offered an intervention for hypertension.

Advice or referral about diet/salt intake (n = 491, 60%) was the most common intervention provided to those 819 people who received an intervention for elevated blood pressure where required, and referral for antihypertensive therapy was the least common (n = 10, 1%). A further breakdown of interventions provided is displayed in Table 6.

Table 6: Breakdown of interventions received by those requiring blood pressure intervention across Trusts (n = 819)

Type of intervention received	n (%) of people who received intervention*
Advice or referral about diet/ salt intake	491 (60%)
Advice or referral about exercise	458 (56%)
Referral to general practice service	337 (41%)
Mental health medication review with respect to high blood pressure (e.g. antipsychotic)	128 (16%)
Referral to secondary care physician	69 (8%)
Antihypertensive therapy	42 (5%)
Referral for antihypertensive therapy	10 (1%)

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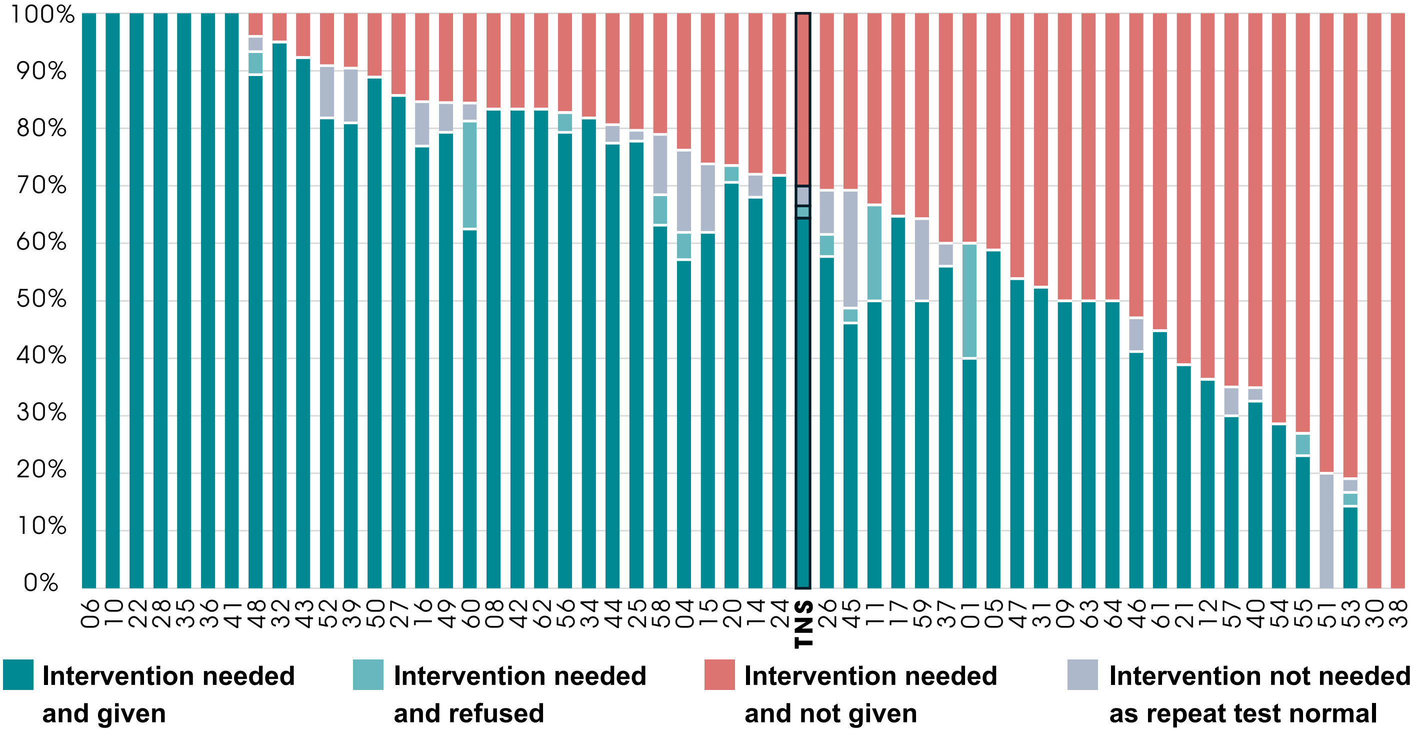
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 19: Proportion of people with FEP offered intervention for elevated blood pressure across Trusts (n = 1,272)



Interventions for diabetes/high risk of diabetes

As shown in Figure 20, 6% (598) of people were identified from their case notes as requiring an intervention for diabetes or pre-diabetes risk. Of this sample, 77% (462) were offered an intervention. A further breakdown of this showed a total of 75% (450) of people received an intervention and 2% (12) refused the intervention. Refusal rates varied across Trusts from 0% to 25%. Since 2019, there has been a 2% increase (from 75% to 77%) in the proportion of people with FEP who were offered an intervention for diabetes or pre-diabetes risk.

Referral to general practice service (n = 233, 52%) was the most common intervention provided to those 450 who received an intervention for glucose control where required, and referral to structured lifestyle education programme was the least common (n = 14, 3%). A further breakdown of interventions provided is displayed in Table 7.

Table 7: Breakdown of interventions received by those requiring glucose control intervention across Trusts (n = 450)

Type of intervention received	n (%) of people who received intervention*
Referral to general practice service	233 (52%)
Advice or referral about exercise	201 (45%)
Diet modification	133 (30%)
Mental health medication review with respect to glucose regulation (e.g. antipsychotic)	71 (16%)
Diabetic care	70 (16%)
Metformin therapy	59 (13%)
Referral to secondary care physician	36 (8%)
Referral for diabetic care	29 (6%)
Referral to structured lifestyle education programme	14 (3%)

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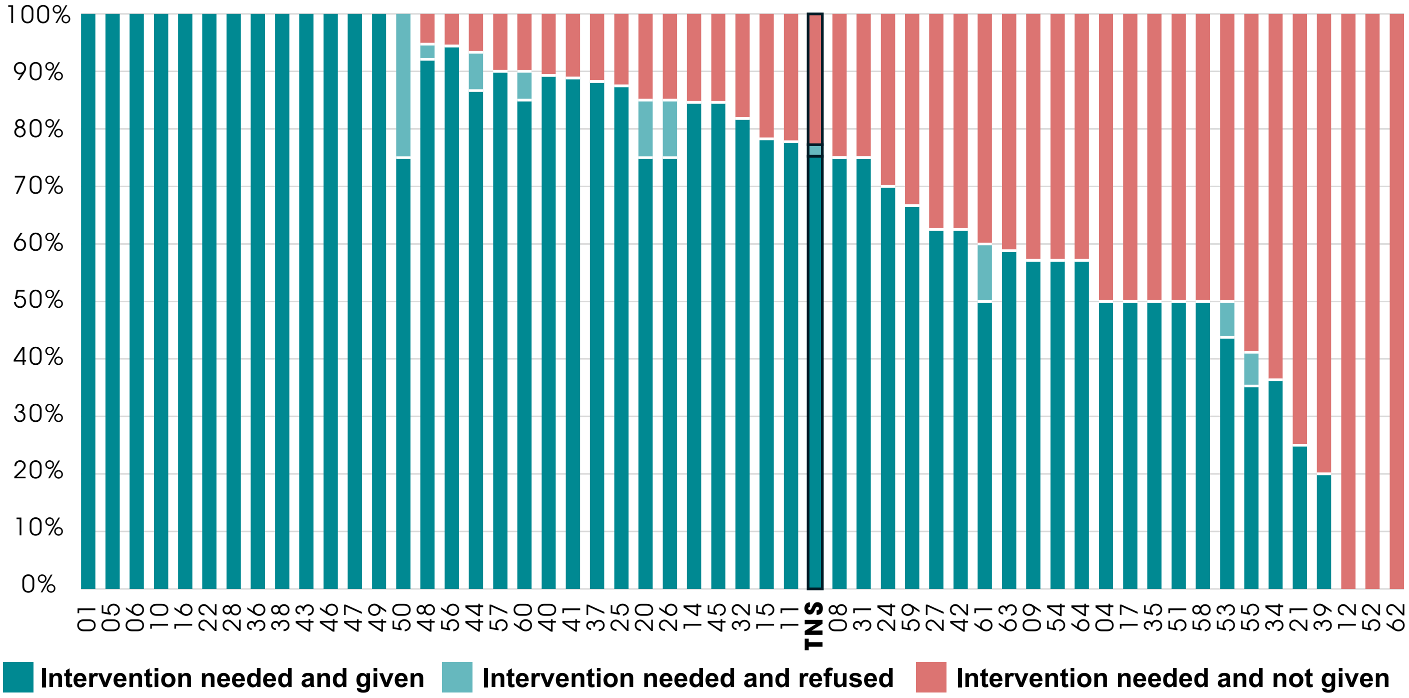
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 20: Proportion of people with FEP offered intervention for abnormal glucose control across Trusts (n = 598)



Interventions for dyslipidaemia

As shown in Figure 21, 1% (58) of people were identified from their case notes as requiring an intervention for dyslipidaemia. Of this sample, 69% (40) were offered an intervention. A further breakdown of this showed a total of 64% (37) received an intervention and 5% (3) refused the intervention. Since 2019, there has been a 6% decrease (from 75% to 69%) in the proportion of people with FEP who were offered an intervention for dyslipidaemia.

Advice or referral about diet (n = 30, 81%) was the most common intervention provided to those 37 people who received an intervention for dyslipidaemia where required, and referral for lipid lowering therapy was the least common (n = 4, 11%). A further breakdown of interventions provided is displayed in Table 8.

Table 8: Breakdown of interventions received by those requiring an intervention for dyslipidaemia across Trusts (n = 37)

Type of intervention received	n (%) of people who received intervention*
Advice or referral about diet	30 (81%)
Advice or referral about exercise	29 (78%)
Referral to primary or secondary care physician	23 (62%)
Mental health medication review to lower blood lipids (e.g. antipsychotic)	7 (19%)
Lipid lowering therapy	7 (19%)
Referral for lipid lowering therapy	4 (11%)

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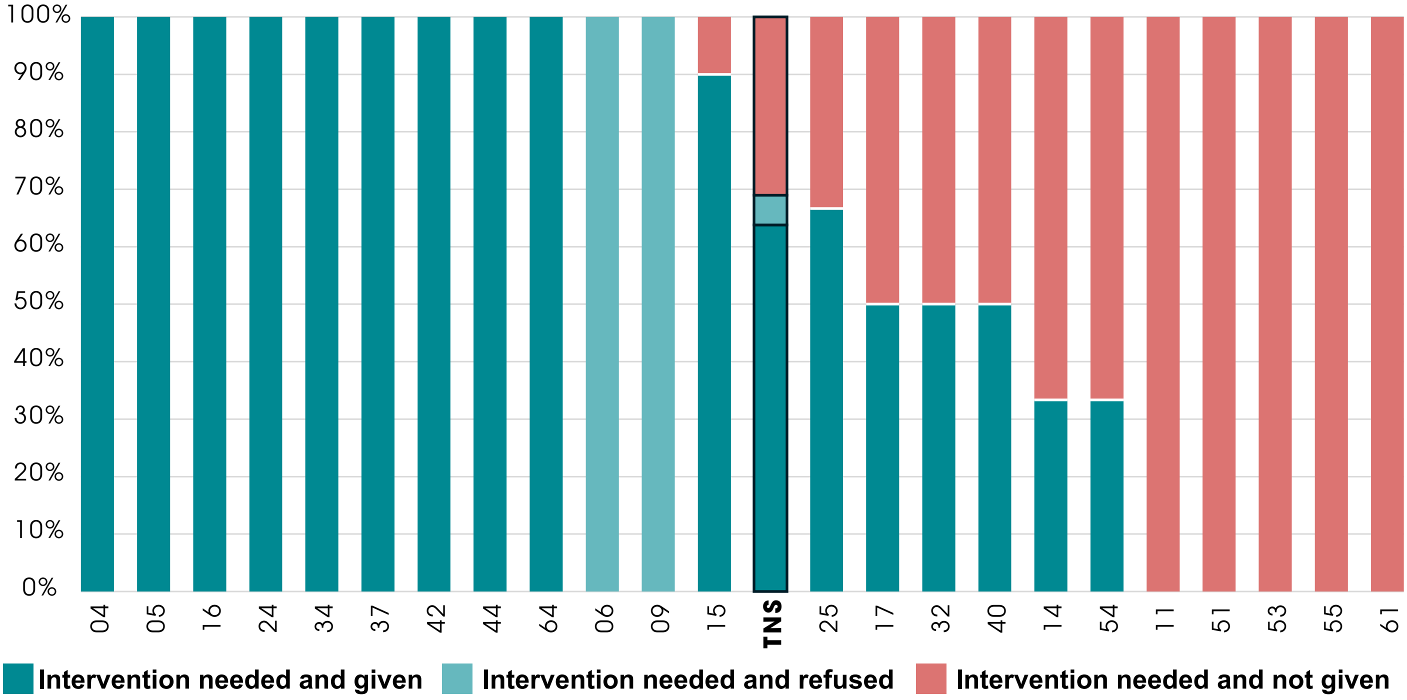
* Total percentage may be >100% due to some people receiving multiple interventions

Figure 21: Proportion of people with FEP offered intervention for abnormal lipids across Trusts (n = 58)[16]



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[16] Only those Trusts who had patients identified as requiring this intervention are represented in this chart.

Why it matters to people with first episode psychosis (FEP) and their carers

In the service user and carer reference group, participants acknowledged the importance of physical health screening and intervention as part of EIP but commented that they had had to be proactive with making lifestyle changes and interventions themselves, either as a service user or carer.

> “The screening happened, but a lot of the work afterwards was driven by me. There could be so much done on this issue – more support for healthy alternatives and how to make lifestyle changes” (Carer)

> “[Our family] had thrown ourselves into learning about the impact of the medication – it’s because of the hard work we’ve done – what about patients that don’t have a carer or they are living on their own? There is a gap in doing early work with a carer around and preventing certain lifestyle behaviours. There is a need for early intervention work. Once you start taking the medication, it can then be more difficult to change your behaviour” (Carer)

> “[While in an EIP service] we started a physical health group and it was really great, we would talk about our nutrition, go for walks together” (Service user)

13. Carer-focused education and support programmes

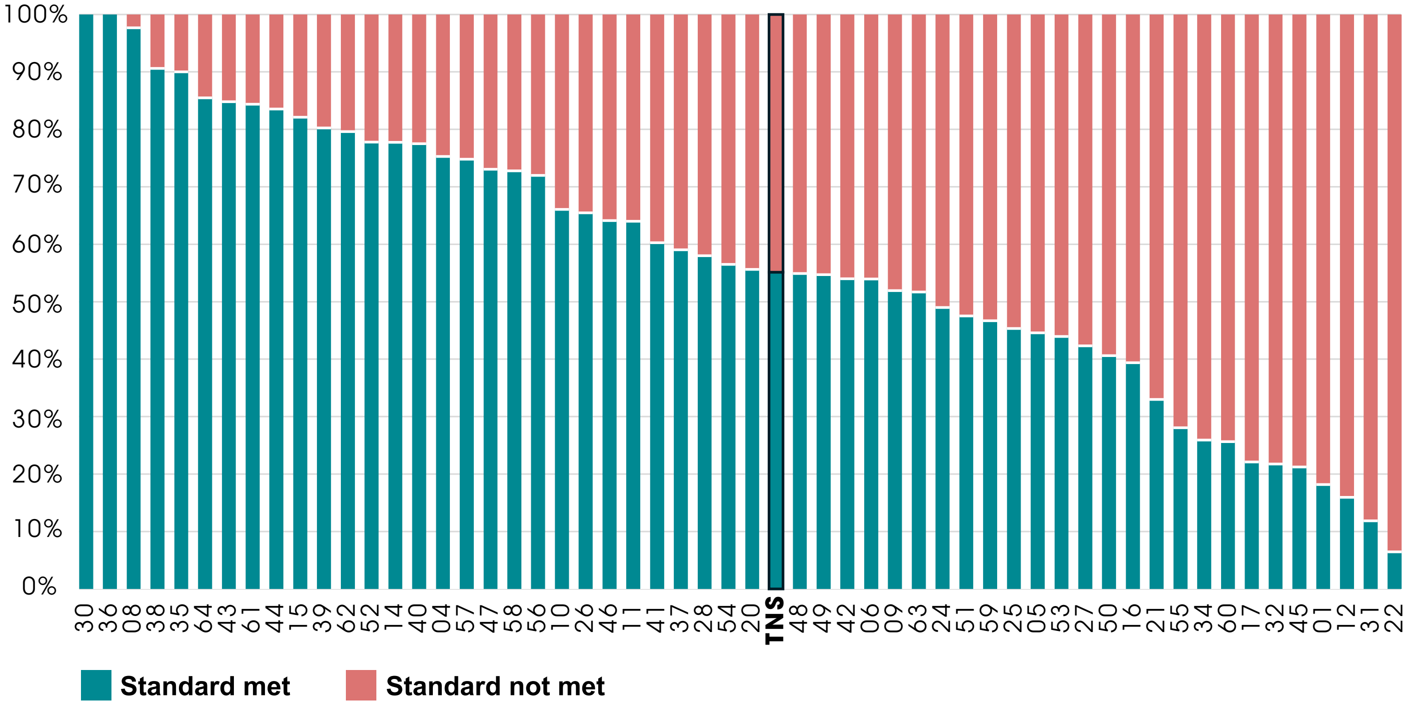
Standard 8
Carers take up carer-focused education and support programmes

The NICE quality standards in relation to treating and managing psychosis (QS80, quality statement 8; QS102, quality statement 4) recommend that carers of people with psychosis should be offered carer-focused education and support programmes.

For Trusts to have met this standard, the person's identified carer must have taken up an education and support programme. For the EIP 2020/2021 audit, there was an adaptation to standard 8 which now specifies take-up of carer-focused support and education rather than offer and referral.

This analysis was carried out on all people in the sample who had an identified carer (n = 7,842). 53% (4,171) of 7,842 carers had taken up carer-focused education and support programmes. As shown in Figure 22, the proportion of people meeting this standard ranges from 8% to 100% across Trusts. Since 2019, there has been a 5% decrease (from 58% to 53%) in the proportion of people whose carers took up or were referred to carer education and support programmes. As mentioned, it is important to note that 2019/2020 comparison data for this standard includes take-up and referral, whereas data for the EIP 2020/2021 audit specifies take-up alone.

Figure 22: Proportion of people with FEP whose identified family member, friend or carer has taken up carer-focused education and support programmes (n = 7,842)



Further analysis for this standard was carried out on people who had an identified carer, excluding those who did not wish this person to be contacted (n = 7,444).

55% (4,104) of 7,444 carers had taken up or been referred to education and support programmes. For this smaller sample, the proportion of carers that took up carer education and support programmes ranged from 8% to 100% across Trusts. See Figure 3 in Appendix G (page 24).

Why it matters to carers of people with first episode psychosis (FEP)

The quotes below from carers in the reference group indicate both why carer-focused education and support is so important and why only 53% of carers in the audit sample had taken it up.

> “When EIP came into my home, I didn’t want them to focus on me, and that went on for quite a while, then all of a sudden I realised EIP are the good guys and they are bringing my daughter back. I could hear laughter in my house again. If anyone is going to understand mental health it’s them, so I picked up the phone to the Manager and I said, ‘I need to talk to you’, and at that point I had an honest conversation about how I wasn’t sleeping right and eating right” (Carer)

> “I have been involved in a virtual carer group [in the last year] with people who have children at a similar age, that has been so powerful… [The team] have listened to what changes we wanted made in the group and they’ve done really well and been really creative” (Carer)

> “The word carer is so big it means so many things, and might put people off [carer support or education]… I prefer the term family member or mum” (Carer)

> “I had so much to do with my own work, to actually to take on the ‘carer’ label outside of the home was daunting” (Carer)

> “Everyone is in a different place, and some carers’ experiences can be worrying to hear about if your child is at the beginning of their recovery journey” (Carer)

14. Outcome indicator

Outcome Indicator

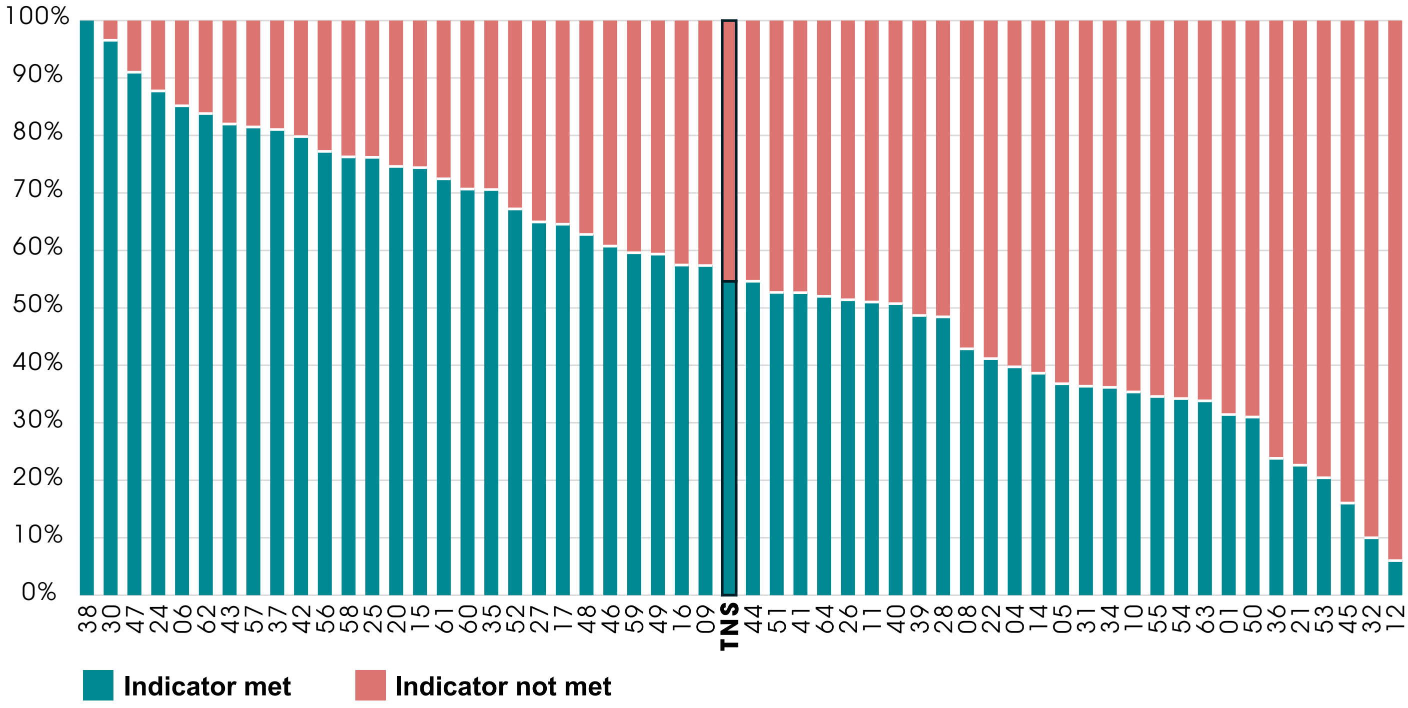
Clinical outcome measurement data for service users (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) are recorded at least twice (assessment and one other time point)

For Trusts to have met this standard, people had clinical outcome measurement data (2 or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR[17]) recorded at least twice. This had to be at baseline assessment and repeated at one other time point between 1 November 2019 and 31 October 2020. For people aged under 18 only, the following outcome measures were accepted: HoNOS/HoNOSCA, DIALOG, QPR, Other.

This analysis was carried out on the entire national sample (n = 10,033). 55% (5,480) of 10,033 people in the national sample had 2 or more outcome measures recorded at least twice. As shown in Figure 23, the proportion of Trusts that met this standard ranged from 6% to 100%. Since 2019, there has been a 14% increase (from 41% to 55%) in the proportion of people with 2 or more outcome measures recorded at least twice.

For a further breakdown of measures recorded for the Trusts who met the outcome indicator, see Appendix G (page 25).

Figure 23: Proportion of people with FEP with clinical outcome measurement data (2 or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) recorded at least twice (at assessment and at one other time point) (n = 10,033)



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[17] HoNOS/HoNOSCA: Health of the Nation Outcome Scales/ Health of the Nation Outcome Scales for Children and Adolescents. DIALOG: a patient-reported outcome measure for people with psychosis. QPR: Process of Recovery Questionnaire.

Why it matters to people with first episode psychosis (FEP) and their carers

The experience of some in the service user and carer reference group was that they had not been asked to complete a second follow-up outcome measure, so were understandably not clear of the value of such measures. There was a perception that EIP teams had become better at recording such information and that it could be useful for helping people's transition from EIP services to CMHTs.

> EIP teams have gotten much better at recording the data, now they have accepted how it impacts them as a team, more and more EIP services have become better at recording the information" (Carer)

> It would be good if this outcomes data could be transmitted to the community mental health teams – that would be useful for transitions from EIP" (Carer)

15. Children and young people

Case-note audit data were analysed for a subsample of all people with FEP in England under the age of 18 (on 1 November 2020) for whom data were collected in the NCAP EIP 2020/2021 audit (n = 228).

Care for under-18s with first episode psychosis (FEP)

Performance against EIP 2019/2020 case-note audit results for under-18s

In comparison with last year's NCAP EIP 2019/2020 audit findings for under-18s, EIP performance against the audit standards showed improvements in take-up of FI (39% vs 25%), supported employment and education programmes (37% vs 33%) and for 5 out of 7 of the physical health interventions; most notably harmful/ hazardous use of alcohol with all people requiring an intervention receiving one (67% to 100%); substance misuse (87% to 96%) and elevated blood pressure (46% to 58%).

Performance in a number of standards for under-18s had declined in comparison with the 2019/2020 audit results for under-18s. Notable differences include provision of CBTp (46% to 42%), offer of clozapine[18] (65% to 58%), clinical outcome measurement (38% to 36%) and provision of carer support (65% to 58%), however the change in standard 8 from take-up and referral to take-up must be taken into consideration. Provision for physical health screening on all 7 measures had also declined (71% to 62%). There was a decline in provision for abnormal glucose control (75% to 40%), although the small sample sizes for these analyses must be considered.

Performance against EIP 2020/2021 case-note audit results for the full sample

EIP care for under-18s with FEP was largely similar to that received by the full sample, although take-up was higher for FI (39% vs 21%), clozapine[18] (58% vs 50%), supported employment and education programmes (37% vs 31%), carer education and support (58% vs 53%) and 3 physical health interventions for alcohol intake (100% vs 95%), substance misuse (96% vs 93%) and obesity (87% vs 85%). Areas showing lower provision included take-up of CBTp (42% compared with 46%), physical health screening (62% compared with 70%), and most notably, use of clinical outcome measurement (36% compared with 55%). The provision of physical health interventions was largely similar to that received by the full sample, with higher provision of interventions for harmful/ hazardous use of alcohol (100% compared with 95%), substance misuse (96% compared with 93%) and weight/obesity (87% compared with 85%). Poorer provision was seen in relation to interventions for elevated blood pressure (58% compared with 70%) and abnormal glucose control (40% compared with 77%). The small numbers of people under the age of 18 who were screened and required interventions for individual physical health measures must be noted when interpreting these results.

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[18] See NICE guidance for more information on the unlicensed use of clozapine for under-16s.

Performance against EIP 2019/2020 contextual questionnaire results for under-18s

As in the EIP 2019/2020 audit, information was collected on the provision of services to CYP in the contextual questionnaire. Consistent with the 2019/2020 audit, most teams (97%) provided EIP services for people under 18 with the most frequently chosen model (52%) being an adult EIP service with joint protocols with CYP mental health (CYPMH) services. The audit data shows a range of models providing support to under-18s, including CYP staff embedded in EIP teams, dedicated CYP EIP teams or EIP teams embedded in CYPMH services. The wide range of models illustrates the relatively low number of under-18s (2.2%) within the case-note audit sample.

Improvements were seen in comparison with the EIP 2019/2020 audit in the number of teams that had shared protocols between the EIP and CYPMH service (87% compared with 82%); similarly there were improvements in the number of teams that had joint or reciprocal training events (35% compared with 26%).

Nearly all teams offered psychological therapies to under-18s, with 98% providing CBTp and over 99% providing FI. These were either provided within the team or by community mental health teams, CYPMH or ‘Other’ services. There was a decline in the number of teams that had care co-ordinators specifically for under-18s (36% compared with 42%), either within the EIP or CYPMH team.

79% (n = 119) of teams had EIP/CYP trained and experienced prescribers to manage medication or provide advice on medication management for under-18s.

Table 9: Performance against NCAP standards for under-18s within the English national sample EIP 2020/2021 audit (n = 228)

Standard/indicator	NCAP English national sample (under-18s) 2020/2021		NCAP English national sample 2020/2021	NCAP English national sample (under-18s) 2019/2020
	n	%	%	%
Standards 2 & 3: Take-up of psychological therapies				
CBTp	95	42%	46%	46%
FI	88	39%	21%	25%
Standard 4: Prescribing				
Offered clozapine[19,20]	11	58%	50%	65%
Standard 5: Take-up of supported employment and education programmes				
Take-up of supported employment and education programmes[21]	15	37%	31%	33%
Standard 6: Physical health monitoring[22]				
All 7 physical health measures	142	62%	70%	71%
Smoking	200	88%	91%	91%
Alcohol use	198	87%	91%	91%
Substance misuse	197	86%	91%	91%
BMI	184	81%	84%	87%
Blood pressure	188	82%	84%	90%
Blood glucose	176	77%	79%	84%
Lipids	166	73%	79%	82%

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[19] Of those who had not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs.
[20] See NICE guidance for more information on the unlicensed use of clozapine for under-16s.
[21] Of those not in work, education or training at the time of their initial assessment.
[22] Taken up or refused.

Standard 7: Physical health interventions[23]				
Smoking	37	90%	92%	81%
Harmful/hazardous use of alcohol	6	100%	95%	67%
Substance misuse	25	96%	93%	87%
Weight/obesity	80	87%	85%	79%
Elevated blood pressure	7	58%	70%	46%
Abnormal glucose control	2	40%	77%	75%
Abnormal lipids[24]	-	-	69%	–
Standard 8: Take-up of carer-focused education and support programmes[25]				
Carer-focused education and support programmes[26]	124	58%	53%	65%
Clinical outcome measurement				
2 or more outcome measures were recorded at least twice[27]	82	36%	55%	38%

A breakdown of the demographics for under-18s can be found in Appendix H.

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[23] Of those who were identified as requiring an intervention based on their screening for each measure.

[24] There were no cases requiring an intervention for abnormal lipids in the 2019/20 or 2020/21 under-18s sample.

[25] Data for 2019/20 includes take-up and referral to carer-focused education and support programmes.

[26] Of those with an identified carer.

[27] Health of the Nation Outcome Scale (HoNOS)/HoNOS for Children and Adolescents (CA), DIALOG, Questionnaire about the Process of Recovery (QPR) (and ‘other’ for under 18 year olds).

16. How EIP teams have adapted practice during the pandemic

The NCAP team wanted to ensure that this year's audit report provided context about the impact of COVID-19 and the way that EIP teams have adapted their practice in response to the pandemic. The NCAP team developed a short questionnaire asking about adapting practice due to COVID-19. The survey was optional, and responses were received from 28 (18%) teams in England.

Adaptations to practice

Since the start of the pandemic most staff have been working from home where possible. The biggest change reported by teams was moving services online and the introduction of videoconferencing and telephone appointments. Teams have been using a variety of platforms to facilitate this including Microsoft teams, Zoom, Accurex and Attend Anywhere and have been supporting service users access these platforms. Services delivered via video conferencing include:

- patient consultations/appointments
- physical health screening
- group sessions:
    - art therapy
    - behavioural family therapy
    - carer support groups
    - CBTp
    - friends and family group
    - hearing voices group
    - mindfulness
    - multiple family group
    - psychology group
    - social groups
- staff team meetings, MDTs, safeguarding meetings

Although many teams transitioned to providing virtual services, there were some that were unable to do this, and these teams reported having to stop some group work and physical health checks. Reasons for this were not provided.

In some instances, there was still a need to offer face-to-face appointments, and these were generally offered based on the individual needs of service users particularly if there were active concerns about their mental health, they were vulnerable individuals or were unable to engage virtually. To ensure these appointments were safe for both staff and service users, COVID-19 risk assessments took place, social distancing was observed, and personal protective equipment was utilised.

Another adaptation reported by teams related to how they facilitated social support to service users throughout the pandemic. Some teams that had previously offered group 'healthy walks' changed to one-to-one sessions, and some teams were able to provide service users with fitness aids (e.g. hula hoops) and fitness trackers so they could keep active while gyms were closed. Others provided e-Readers, and one team secured funding to buy a PlayStation console with a membership, to run online gaming groups for service users.

Feedback about experience of staff, people with first episode psychosis (FEP) and carers

Few teams had the opportunity to formally evaluate the impact of these adaptations, so it is not possible to gauge the effect that they may have had on teams' audit results. Teams were able to provide an overview of some of the benefits and challenges that had been encountered by staff, and people with FEP and their carers. These are summarised in Table 10 and 11, below.

Table 10: Benefits of adaptations to practice for staff members

Benefits to staff	Number of teams reporting each benefit (n=28)
Virtual meetings are more efficient, e.g. easier to facilitate/attend, fewer resources required	19
Staff spend less time travelling	15
Developed new/improved way for working	15
More opportunities for staff development	8
Staff had positive experiences of working from home, e.g. better work–life balance	7
Better access to technology	4
Staff safety – risk of violence from patient reduced when appointments are virtual	2
Benefits to people with FEP and carers	
Virtual groups/appointments/support are more accessible to service users, carers, friends and family	14
More choice/flexibility around interactions, e.g. face-to-face or online contact options	12
Positive experiences of virtual meetings/increased engagement	8
Positive impact on person’s wellbeing	7
Less time spent travelling to appointments	3

Table 11: Challenges of adaptations to practice for staff members

Challenges for staff	Number of teams reporting each benefit (n = 28)
Difficult to complete assessments virtually/quality compromised	14
Isolating working from home	12
Lack of peer support when working remotely	12
Appointments generally more difficult virtually, e.g. difficult to build therapeutic rapport	10
Problems with technology, e.g. Internet connection causing delays	5
Low team morale	3
Difficulties working from home, e.g. unexpected interruptions, invasion of privacy if service user is being challenging/abusive	3
Challenges for people with FEP and carers	
Preference for face-to-face contact/do not want to engage virtually	19
Negative effect on person’s wellbeing, e.g. increased stress/anxiety, low mood	14
Less support for carers	13

Negative impact on carer wellbeing, e.g. increased stress/worry about the person they care for	11
Digital exclusion (no/limited access to technology/Not IT literate)	11
Reluctance to use technology due to mental state, e.g. paranoia, delusional beliefs	10
Reduced physical health screening	9
Social activities stopped/less available	8
FI groups stopped/reduced	8

Both staff and service users felt that the shift to online services has some benefits and agreed that these should continue to be offered alongside face to-face appointments in the future. As part of the questionnaire, Mersey Care EIP team told us that they had carried out a survey with service users and carers about the transition to online working, and helpfully shared comments with us to illustrate their experience, which can be seen below.

> It appears to work very well. Our experience is better than initially envisaged. Prior to first family meeting we were very skeptical but now happy with progress and open friendly constructive discussion” (service user)

> We feel as a family that the transition from attending a building to attending online has worked really well” (service user)

> *“I have found the online platform to be a positive experience and has meant that we can include family members who may live many miles away. This has meant that we have been able to broaden who we can offer our family work to and I feel they may not have been able to have access this work previously” (staff)*

> “Generally, it has been good, but not as good as personal contact” (service user)

Five top tips from teams

1. Ensure staff feel supported and connected with the rest of the team while working at home
2. Adopt a quality improvement approach - continually review new practices and work in collaboration with service users
3. Make sure service users and carers are kept informed about why and how their care will be delivered.
4. If individuals are unable to access virtual services or do not know how, alternative contact modes should be offered and/or guidance about how to use the technology
5. Check whether family members are in a confidential space rather than assuming they are free to talk

17. Discussion

Performance against EIP 2019/2020 case-note audit results

In the context of COVID-19, it is commendable that EIP team performance against the audit standards was largely maintained. For the second year running, an improvement was seen in the recording of outcome measures (from 41% in 2019/2020 to 55% in 2020/2021). Improvements were also seen for 6 out of the 7 physical health interventions: cigarette smoking (91% to 92%), harmful alcohol use (93% to 95%), substance misuse (90% to 93%), BMI (83% to 85%), hypertension (65% to 70%) and abnormal glucose control (75% to 77%).

Take-up of FI remained the same at 21% for the whole patient sample but had increased slightly from 25% to 27% when the sample excluded carers whom patients did not wish to be contacted. Similarly, supported employment and education programmes remained at 31% when only including those patients not in work, education or training, but increased from 30% to 32% when including the whole patient sample.

Small reductions were seen in timely access (74% to 72%), provision of CBTp (49% to 46%) and those offered clozapine3 (52% to 50%). Physical health screening for all 7 measures dropped from 75% to 70%, as did monitoring in relation to: cigarette smoking (93% to 91%), alcohol (94% to 91%), substance misuse (94% to 91%), BMI (87% to 84%), blood pressure (89% to 84%), blood glucose (84% to 79%) and blood lipids (82% to 79%). The percentage of people offered all 7 physical health screenings and relevant physical health interventions (a composite measure of standards 6 and 7) also dropped from 63% to 61%. Physical health intervention for dyslipidaemia showed one of the biggest drops (from 75% to 69%). This may reflect an impact of COVID-19, particularly those measures and interventions that require face-to-face contact. However, physical health screening and intervention are important to maintain because of the increased risk of later morbidity and mortality for this FEP group, related to cardiovascular disease, diabetes and smoking.

Carer-focused education and support programmes, similarly, showed big drops from 58% to 53% for patients with an identified family member, friend or carer and from 61% to 55% when excluding those family, friends and carers whom patients did not wish to be involved. This may reflect changes made to the auditing of this standard this year which now only includes 'take-up' rather than 'take-up and referral' of carer-focused education and support programmes. However, this finding is of concern as carer involvement is important, especially during times of COVID-19, to ensure service users are adequately supported by their family but also that carers continue to be supported too.

Variation in the EIP 2020/2021 case-note audit results

Wide variations between Trusts' performances were seen in intervention offer, take-up and refusal rates across all individual standards. The smallest difference in offer of interventions across standards was for substance misuse (from 70% to 100%) and the greatest in the offers of physical health interventions for diabetes/high risk of diabetes and dyslipidaemia (which both varied from 0% to 100%). It is a serious health and safety concern that there were 3 Trusts where none of the individuals identified as having abnormal blood glucose control were offered relevant interventions for diabetes/high risk of diabetes, and 5 Trusts where none of the individuals identified as having abnormal lipid levels were offered relevant interventions for dyslipidaemia. It is important that we do not just screen but also proactively intervene when potential risk for diabetes/pre-diabetes and cardiovascular disease are identified. These Trusts should identify reasons why interventions were not offered in response to identified risk as this is a critical factor if we are to successfully reduce longer term adverse physical health outcomes for individuals with psychosis. The smallest difference in take-up across standards was for FI (5% to 54%) and the greatest in outcome measurement recording (from 6% to 100%). The smallest difference in refusal rates across standards was in the offer of physical health intervention for hypertension (from 0% to 20%) and the greatest in offer of intervention for dyslipidaemia (from 0% to 100%). This wide variation between Trusts on individual standards shows opportunities for learning and sharing good practice between EIP teams while also emphasising the importance of equitable commissioning and resourcing of EIP teams.

Timely access

Although it is acknowledged that some individuals may not wish to engage with EIP services or may take longer to come forward, this year's national sample average of 72% indicates that approximately 1 in 4 individuals with FEP do not start treatment within this 2-week window. However, the proportion of people starting treatment within 2 weeks of referral varied from 14% to 96% across Trusts. Of concern, was that there was an observed reduction in number of Trusts meeting this standard compared with last year's NCAP EIP 2019/2020 audit findings. This year, 2 Trusts (compared with 1 last year) were performing below level 2 (25% or more) and 7 Trusts (compared with 5 last year) were performing below level 3 (60% or greater) on the national waiting time standard, according to performance levels set by NHS England. This may reflect the impact of COVID-19 on timely engagement and assessment and allocation processes but these Trusts should identify factors contributing to delays and work with stakeholders to remove or reduce barriers to timely access to treatment which is a critical factor influencing longer term outcome for individuals with psychosis.

Commissioning

The service contextual questionnaire audit data revealed further inequities in commissioning and resourcing of EIP provision across the age range where 5 teams (3%) were reporting no EIP provision for under-18s with FEP and 13 (9%) where there is no EIP provision for 36 years and over presenting with FEP. In relation to CBT for ARMS provision, inequities were greater and more widespread across all age groups with no CBT for ARMS for 43% of under-18s, 41% of 18-35s and 68% of 36 years and over. 51% of EIP teams reported an increase in staff posts in 2020. The average EIP care co-ordinator caseload was 17.08 but, of concern, is that caseload size ranged up to a maximum of 54.5 (compared with the maximum of 34.47 reported in the 2029/2020 audit and previously highlighted as an area of concern in last year's audit recommendations). Caseloads above 25 will adversely impact on team capacity to deliver NICE-concordant interventions and patient and carer outcomes. Those teams where care co-ordinator caseloads are 25 or above require urgent review and adequate resourcing to ensure sufficient care co-ordinator capacity to ensure individual caseloads do not exceed 25.

Children and young people data

It is important to note that the CYP audit data describes EIP care to under-18s predominantly delivered by all age adult EIP services in conjunction with young people's services who either employ staff with expertise in CYPMH (34%) or have joint care and treatment protocols with CYPMH services (52%). There are still 5 EIP teams (3%) where there is no CYP EIP provision and 11% where CYP EIP provision is described as 'other'. The onset of psychosis in adolescence typically tends to be associated with poorer long-term outcomes so under-18s are a critical FEP subgroup who should be prioritised to receive intensive early intervention but due to low numbers, do not always receive optimal EIP care. In this year's audit, 13 teams (9%) reported that they did not have CYP prescribing training or a protocol or access to specialist CYPMH prescribing advice, 3 teams (2%) were describing no CBTp provision and 1 team (<1%) no FI provision for under-18s with FEP and 64 teams (43%) were reporting no CBT for ARMS provision for under-18s. Further work is required to understand access to NICE-compliant care and the experience of all under-18s with FEP and those with an ARMS, particularly those under the care of generic CYPMH teams.

18. Conclusions

Maintaining service in the face of challenge

It has been a challenging year for healthcare, including EIP services, with many aspects of delivery impacted by COVID-19. Yet in spite of this, data from the 2020/2021 round of the audit show improvements or maintenance at the same levels as last year's 2019/2020 audit findings for several audit standards. This was both heartening and commendable in the context of the many challenges that COVID-19 has created for staff and individuals with FEP and their families. It is unclear from the audit data whether the reduction in number of Trusts meeting the AWT standard and the marked increase in the care co-ordinator caseload range reflect local COVID-19-related pressures on EIP teams as it was not a universal finding across all EIP teams nationally. This needs to be reviewed at a local level for those Trusts where this is the case to understand, and problem-solve factors contributing to these changes. This may include learning from other EIP teams about adaptations they have made in response to COVID-19 pressures (see page 69), identifying ways to protect EIP care co-ordinator caseloads and capacity locally and ensuring adequate local investment in care co-ordinator capacity, in line with the NHS commitment to EIP delivery in the NHS Long Term Plan.

Continuing increase in outcome measurement

The massive year on year improvement in outcome measurement recording is encouraging and reflects the efforts of EIP teams to improve practice in relation to this standard where we have observed outcome measurement improvements from 9% to 55% of individuals with FEP over a 3-year audit period. National and regional teams have supported work on improving outcome measurement and included outcome measurement and using data to drive clinical improvement in EIP services as a specific topic focus in regional EIP webinar training programmes. Last year, outcome measurement was also identified by the national audit team as the quality improvement focus for a webinar series which identified and shared good practice examples. This provided an opportunity for EIP teams to share learning and skills in relation to improving routine outcome measurement and using outcome data that is collected to review clinical outcomes of individuals with FEP and evaluate the impact and experience of EIP services on a range of recovery outcomes important to service users. It was interesting to see that this was the standard where the greatest improvement was observed this year, and which supports the value of a data-driven quality improvement cycle and measuring the impact of quality improvement initiatives over time.

At-risk mental state (ARMS) provision

As outlined in the NHS Mental Health Implementation Plan, as part of a comprehensive EIP service, people identified as ARMS for psychosis should receive treatment locally. Typically, for this ARMS group, many protective social and family supports are intact and they are often still engaged in education or work. With the onset of distressing symptoms of psychosis and without early intervention, deterioration in family and social life and functioning can occur very rapidly. Local ARMS provision needs to be adequately resourced and supported as a key element of a core EIP service, to identify people even earlier and offer preventive strategies with the potential to avoid or reduce some of the impact of transitioning to a full-blown psychosis. This requires investment in additional capacity and specialist training to undertake ARMS assessment and offer appropriate interventions (CBT with or without FI as well as interventions for coexisting mental health problems) for those identified as requiring an ARMS support pathway. While evidence for ARMS interventions is well established for people aged under 35 years, commissioners and Trusts should consider access to ARMS services for people aged up to 65 years, in line with the EIP standards guidance (NHSE, 2020). Across all age groups, the absence of ARMS provision was widespread affecting 41-68% of EIP teams nationally. Commissioners and providers need to work jointly with service users, carers and families, to ensure there is appropriately resourced ARMS service provision that is based on and able to respond the needs of the local population.

Reducing variation in EIP care

There was pervasive evidence of wide variations and inequities in provision suggesting there remains a ‘postcode lottery’ in terms of access and wait times, EIP, CYP under 18 and ARMS service provision across England. There are still many EIP teams reporting no ARMS provision and several areas with no EIP provision for under-18s with FEP, 18-35s and 35-65s. More needs to be done to ensure equitable and uniform commissioning and provision of evidence-based EIP care across England in line with NICE quality standards. There is also wide variation in offer, take-up and refusal rates of NICE interventions across EIP teams nationally. We need to understand what may be contributing to these variations in processes and outcomes and create opportunities for sharing good practice examples to learn from EIP teams who are successfully achieving high take-up and very low refusal rates to share strategies and skills with all teams to maximise take-up and minimise refusal outcomes when interventions are offered to individuals with FEP and their carers.

19. Next steps

Addressing the variation in the EIP 2020/2021 case-note audit results

The national audit team will focus on reducing variations in offer, take-up and refusal rates across NICE interventions observed in this year's audit data, as their quality improvement focus for this year's quality improvement webinar series. The webinars will invite EIP teams who are successfully achieving high take-up and very low refusal rates to share their learning and skills across EIP teams. By focusing on unexplained variations and sharing potential strategies to address these, teams will be able to start to identify potential factors that may be contributing to variation and take steps to plan and study the impact of changes aimed at maximising intervention offer and take-up and minimising refusal rates.

Next steps for clinical outcome measurement

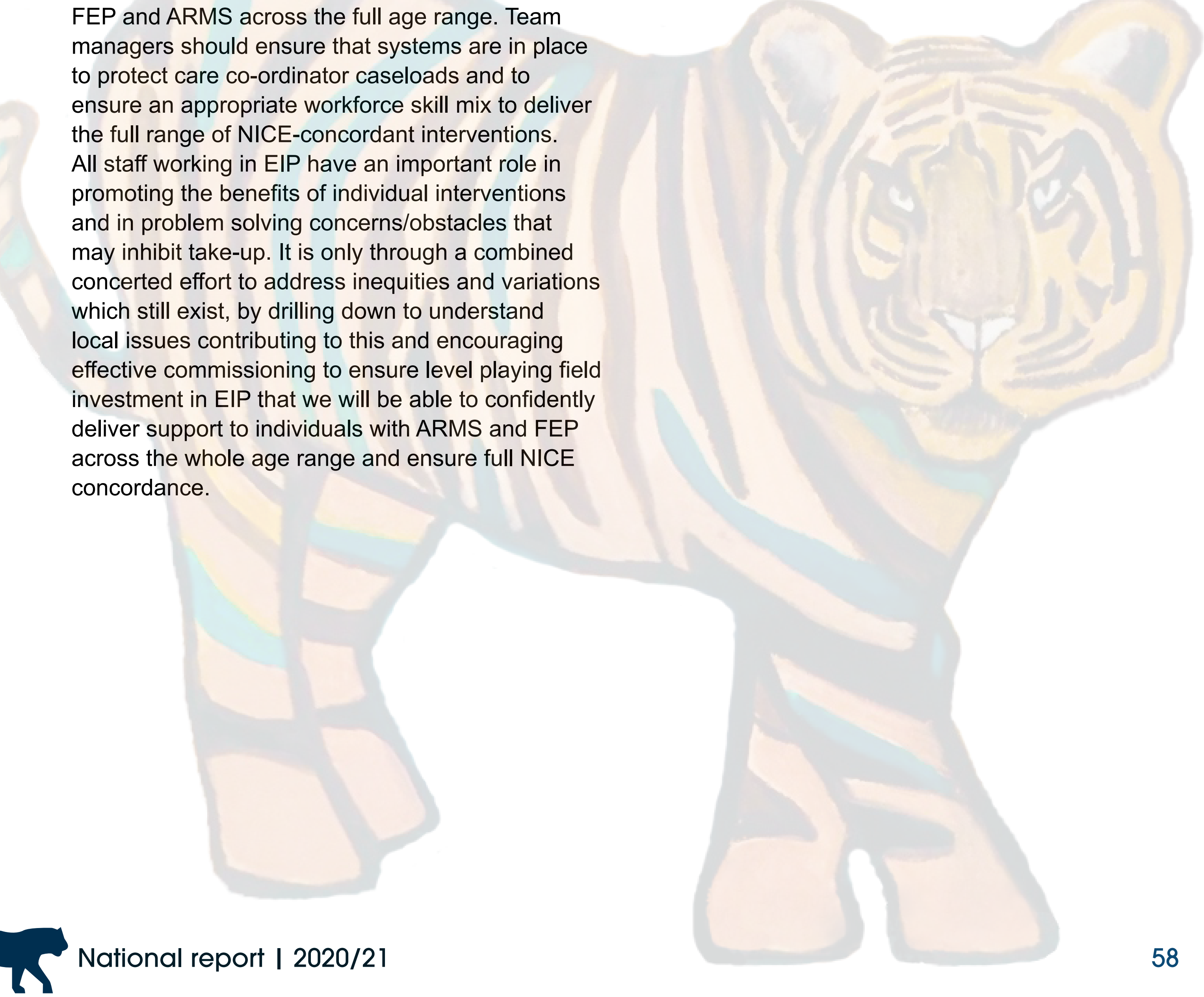
Rapid progress has been made in the collection of routine clinical outcome data in early intervention services, which now provides an opportunity to start reviewing this important data. At a local level, Trusts should work with their teams to facilitate use of clinical outcome data in routine care planning and local service evaluation. It also feels timely with over 50% of individuals with FEP having repeat outcome measure data, to propose that a next step for this particular audit standard would be to move from 'process' measurement auditing recording to 'outcome' measurement using routine outcome data collected through Mental Health Services Data Set to evaluate and demonstrate EIP impact.

Focus on care for under -18s

Access to EIP services and provision of evidence-based interventions for under-18s should be given increased focus by commissioners and providers. The national audit team are collaborating with NHS England CYP colleagues to survey all CYPMH teams in England in early summer 2021 to explore access to NICE-compliant care for all under-18s with FEP and those with ARMS. This will include identifying caseload numbers, models of service provision, skills and training deficits that may exists in the generic CYPMH workforce and the nature of relationships with adult EIP teams locally. Survey data will be compared with CYP under-18s data from the 2020/21 audit to gain a fuller picture of provision and gaps/needs which will form the basis for a quality improvement programme as well as providing clearer information on which to base commissioning investment to improve access to EIP services and provision of evidence-based interventions for under-18s with ARMS and FEP.

Investment in EIP

Implementation of the NHS Long Term Plan commitment to increase investment in EIP services requires the equitable provision of EIP and access to the full range of interventions, if the full benefits of EIP are to be realised. Commissioners, Trusts, team managers and frontline EIP staff all have a role to play in increasing access to evidence-based EIP and ARMS care. Commissioners should ensure a level playing field in terms of EIP investment to ensure that all teams receive investment to support adequate staffing levels and ensure sufficient numbers of trained staff to deliver EIP and ARMS NICE-concordant services. This requires Health Education England to ensure sufficient training programmes which are equitably available across all regions for EIP staff to access in CBTp, FI, IPS and assessment and interventions for ARMS. Trusts should monitor delivery of interventions by early intervention teams to individuals with FEP and ARMS across the full age range. Team managers should ensure that systems are in place to protect care co-ordinator caseloads and to ensure an appropriate workforce skill mix to deliver the full range of NICE-concordant interventions. All staff working in EIP have an important role in promoting the benefits of individual interventions and in problem solving concerns/obstacles that may inhibit take-up. It is only through a combined concerted effort to address inequities and variations which still exist, by drilling down to understand local issues contributing to this and encouraging effective commissioning to ensure level playing field investment in EIP that we will be able to confidently deliver support to individuals with ARMS and FEP across the whole age range and ensure full NICE concordance.



20. Compiled by

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21. List of figures and tables

22. Limitations of methodology and data

As an audit of care provided to people treated by EIP teams this report provides an account of the treatment received by most people with FEP. However, as noted in Appendix F some people with FEP aged below 18 or above 35 years are treated by other services and this report does not contain information about the quality of care that these people received.

Aggregate data presented in this report provide information about the quality of care provided by Trusts as a whole. However, these data may mask important differences in the quality of care provided by individual EIP teams within the same Trust. Local reports should be checked to assess variation in the performance of individual teams within each Trust.