RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

HQIP
Healthcare Quality Improvement Partnership

National report for England
Early Intervention in Psychosis Audit

2021/22

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.
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Key Findings

Key findings of this audit should be considered in context of the COVID-19 pandemic over the last two years. Teams are commended for maintaining Early Intervention in Psychosis (EIP) service delivery at high level in the context of the pandemic.

66%
of teams had an increase in staff in post last year

Children and Young People (CYP) improvements in:

- ☑ Clozapine prescribing
- ☑ Physical health screening and interventions
- ☑ Carer focused education and support programmes

80%
of people with first episode psychosis (FEP) received all 7 physical health screens

10% INCREASE FROM PREVIOUS

71%
of people with FEP received all relevant interventions for their physical health

10% INCREASE FROM PREVIOUS

Recording of outcome measures increased by **5%** to **60%**

Health of the Nation Outcome Scale (HoNOS) scores on all 3 targeted items showed improvements from baseline to repeat assessment for the following % of individuals:

44%
psychotic symptoms

29%
activities of daily living

19%
drinking or drug-taking

Contents

1. Overview

What is NCAP?

The National Clinical Audit of Psychosis (NCAP) aims to improve the quality of care that NHS mental health trusts in England and Health Boards in Wales 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 which runs until July 2022, commissioned by HQIP on behalf of NHS England and Improvement.

Early Intervention in Psychosis (EIP) 2021/22 audit

This report presents national and organisation-level findings on the treatment of people by teams in England. Early Intervention in Psychosis (EIP) services are specialised services that aim to provide prompt assessment and evidence-based treatments to people with first-episode psychosis (FEP).

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)**.

All NHS-funded EIP teams in England were expected to take part in the audit and data were collected via a case-note audit.

COVID-19 pandemic

The findings of this audit report need to be interpreted in context of the COVID-19 pandemic which has severely impacted the functioning of the health sector over the last two years.

What happened during the audit?

All **54 Trusts** in **England** providing EIP services took part in the audit.

Trusts identified **all eligible casenotes** and sent an anonymised list to the NCAP Team who selected a random sample of up to **100 people per team.**

Trusts **submitted data** online from **10,557** casenotes.

Results discussed at a focus group with **service user and carers** and feedback included in report.

Data analysed and **reports produced.**

EIP 21/22

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

- ✓ They had first episode psychosis (FEP)
- ✓ Aged 65 years and under
- ✓ On the caseload of the EIP team or receiving treatment for FEP and open to CYPMH teams
- ✓ On the team's caseload for 6 months at the census date (1 April 2021)
- ✗ Experiencing psychotic symptoms due to an organic cause (see Appendix A)
- ✗ Spending most of their time residing in a different locality due to attendance at university

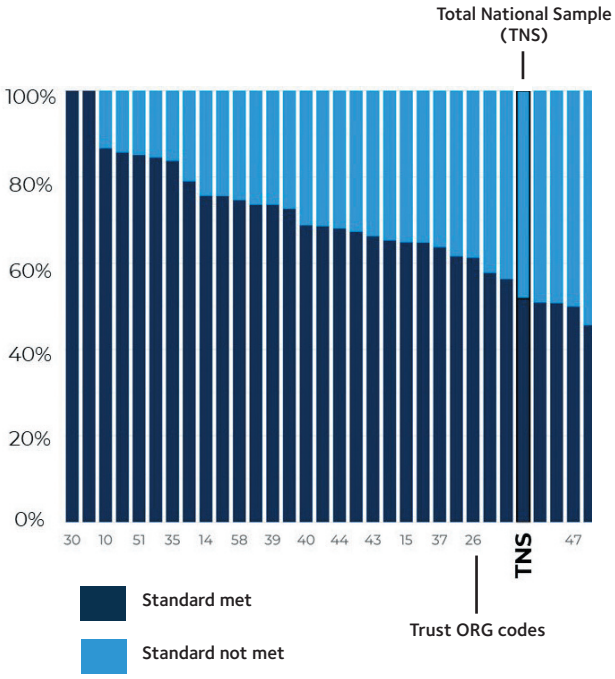
2. How to read this report

Percentages in this report may not add up to 100% as they have been rounded (0.5 has been rounded up).

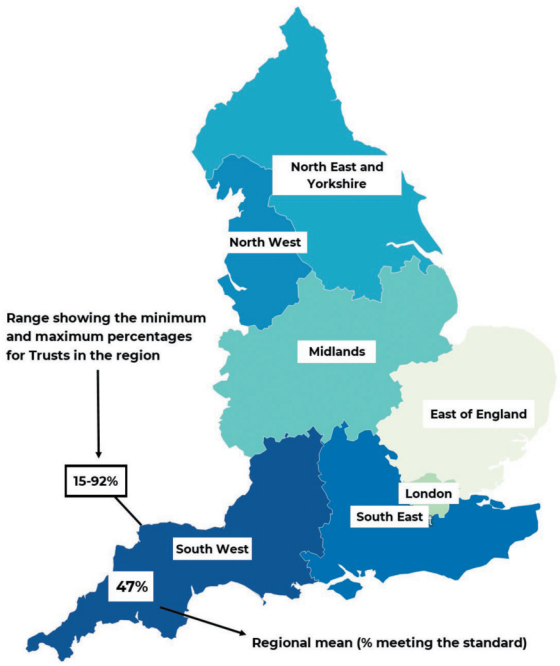
The **bar charts** in this report provide a breakdown of the Trust-level data and allow for comparisons across Trusts. Each bar represents the performance of an individual Trust, which can be identified by its unique ORGID number, found along the x-axis of the chart. The total national sample (TNS) is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

The **maps** provide an overview of regional performance in England. The regions correspond to NHSE's 7 regions: East of England (4 Trusts), London (9 Trusts), Midlands (12 Trusts), North East and Yorkshire (9 Trusts), North West (5 Trusts), South East (8 Trusts) and South West (7 Trusts). The darker colours illustrate the regions with a higher percentage of people with FEP that meet a given standard, while the lighter colours show those with a lower percentage of people that meet the standard.

Feedback from experts by experience 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 lived experiences of psychosis. Feedback and quotes are included throughout the report (see Appendix A for further information).



Illustrative figure for the variation graphs used throughout the report.



Illustrative figure for the NHS regions maps in the report.

3. Change over time

As this is the fourth year of the EIP audit, the table below shows the national performance against the audit standards over time. The greatest improvements can be seen within areas of supported employment and education programmes, physical health screening, physical health interventions and outcome measures, as indicated by the dark blue line.

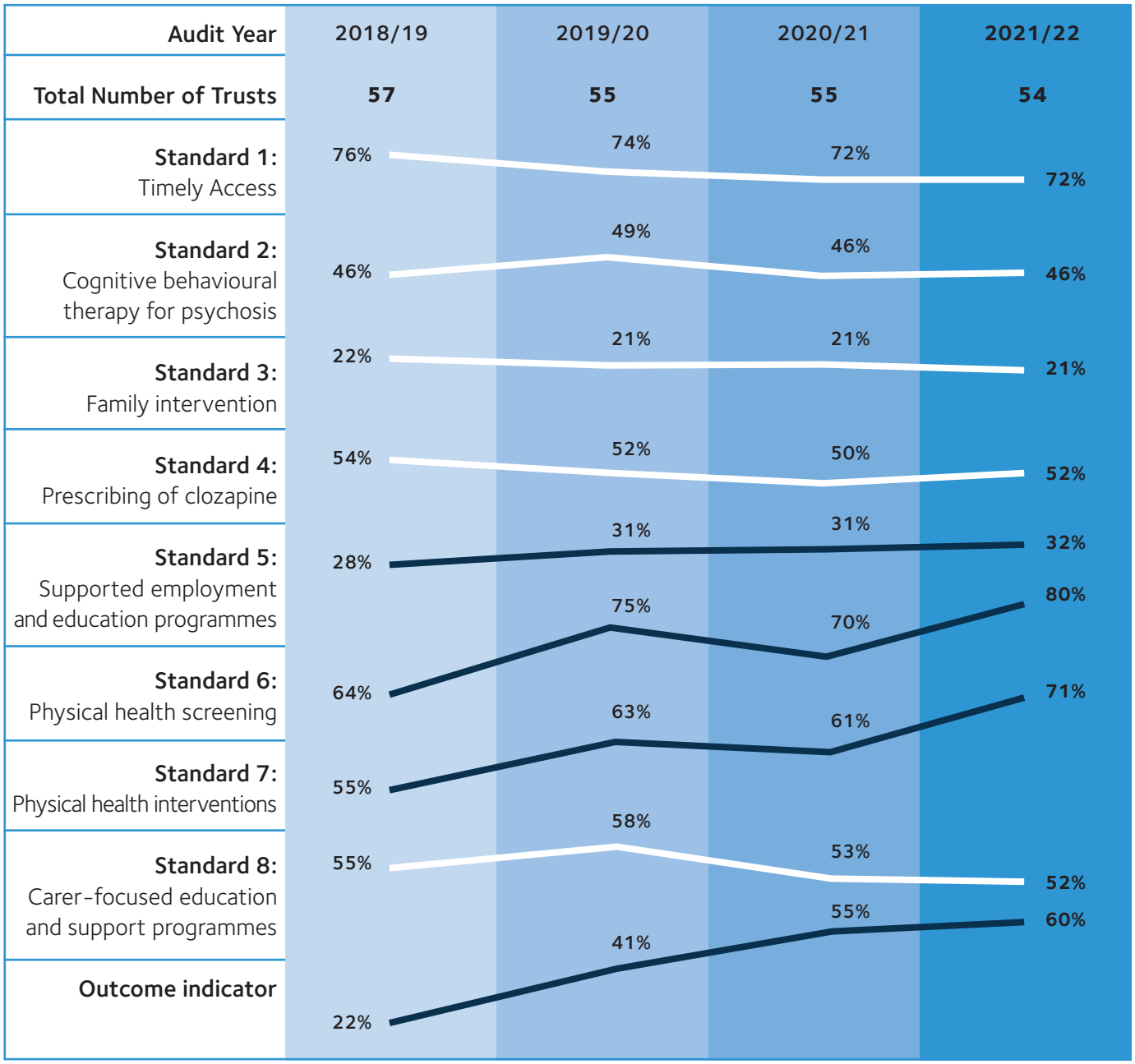


Figure 1. Audit standards and outcome indicator performance data over a four-year period

4. Trust and regional variation

This section of the report highlights variation in performance against the standards at Trust and regional level. These data aim to support networks in identifying areas for quality improvement (QI).

Staffing & workload

66% of EIP teams reported an increase in staff in post over the last 12 months and the average number of whole time equivalent (WTE) EIP care co-ordinators per team increased by 1.0 WTE in the same year. On average each WTE EIP care coordinator had a caseload of 16, but this ranged from 1-59.

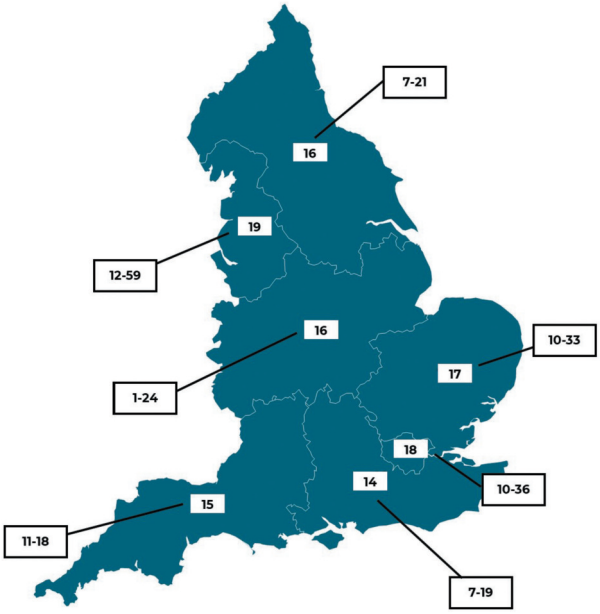


Figure 2. Regional mean and range of total caseload per whole time equivalent care coordinator at team level

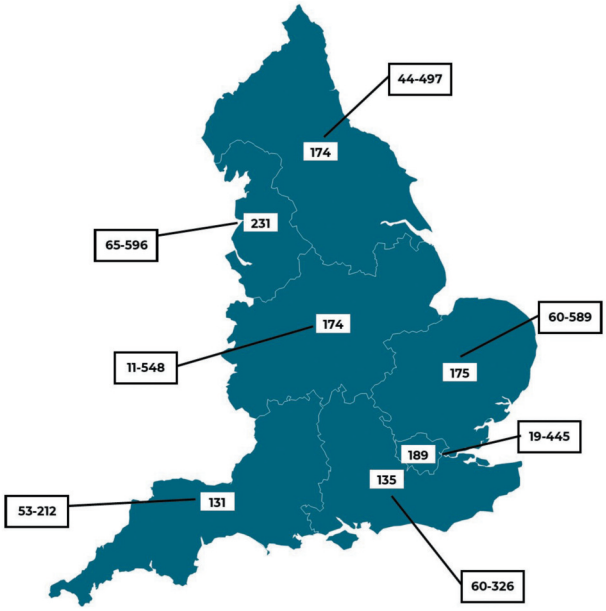


Figure 3. Regional mean and range of total caseload at team level

WHAT THIS MEANS

In regions where caseloads are higher, they also have more EIP care coordinators.

IDEAS FOR LOCAL QI

- What is the optimal caseload for a case manager?
- Would staff benefit from having regular caseload reviews during supervision?

Standard 1: Timely access

People with FEP should start treatment in EIP services within 2 weeks of referral (**NHSE, 2016;2020**). Analysis against the access and waiting times (AWT) standard was carried out using the EIP waiting times data submitted onto the Mental Health Services Dataset (MHSDS) from April to September 2021 (**NHS Digital, 2021**[1]) on **all** people referred to services during this period.

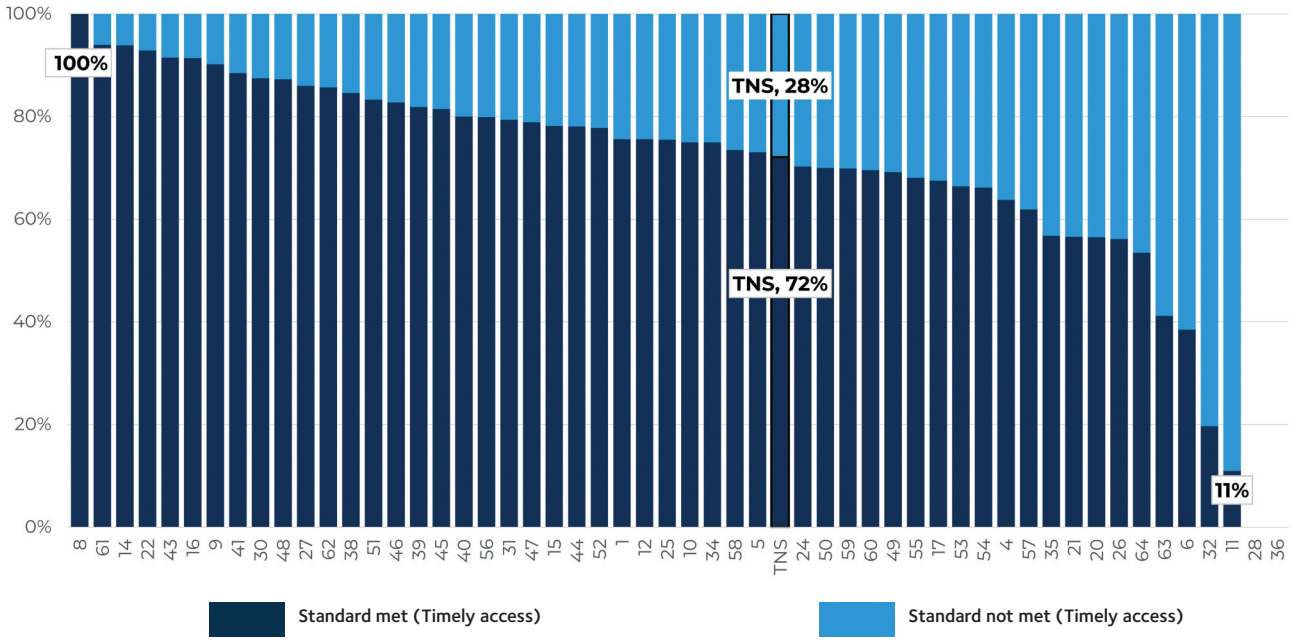


Figure 4. People with FEP who started treatment in EIP services within two weeks of referral (allocated to, and engaged with, an EIP care coordinator) (n =7,615)[2]

WHAT THIS MEANS

Improving access is a priority for NHSE with targets that at least 60% of people with FEP should meet this standard. Most Trusts are achieving this, but 10 Trusts are falling below this target.

IDEAS FOR LOCAL QI

- Would reviewing the processes in place to check AWT data submitted to NHS digital improve quality?
- Can hold ups and barriers to timely access be identified by completing a 'care pathway' assessment on a sample of new FEP cases?
- Does collecting feedback from people with FEP and carers about access improve a team's understanding of the barriers?

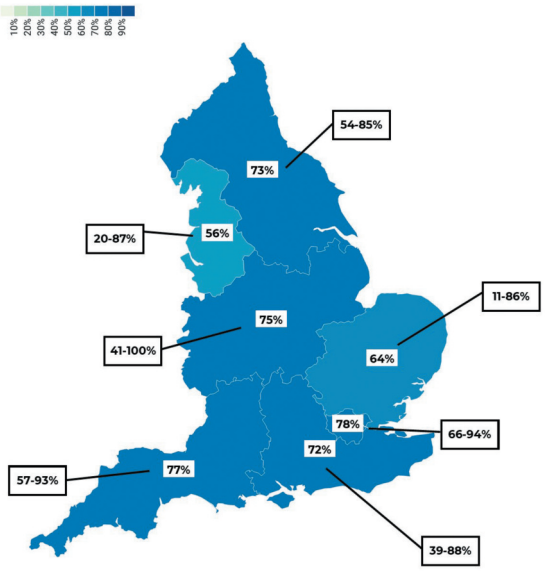


Figure 5. Regional mean and range for Standard 1 (Timely access)

1 Please note a few Trusts highlighted issues with the quality of their AWT data due to electronic patient record (EPR) migration and problems with the processing of their data.

2 Data for two Trusts (ORG28 and ORG36) were not included in figure 4 as their waiting time data included small numbers (<5 people) and were not published by NHS Digital. Data for one Trust (ORG37) was not included in figure 4 due to an organisational merger which meant that data for the newly merged Trust could not be processed correctly.

Standard 2: Cognitive behavioural therapy for psychosis (CBTp)

People with FEP should take up cognitive behavioural therapy for psychosis (CBTp) (**NICE QS80, NICE QS102**). To meet this standard people had to receive at least one session of a course of CBTp delivered by a person with the **relevant skills, experience and competencies.**

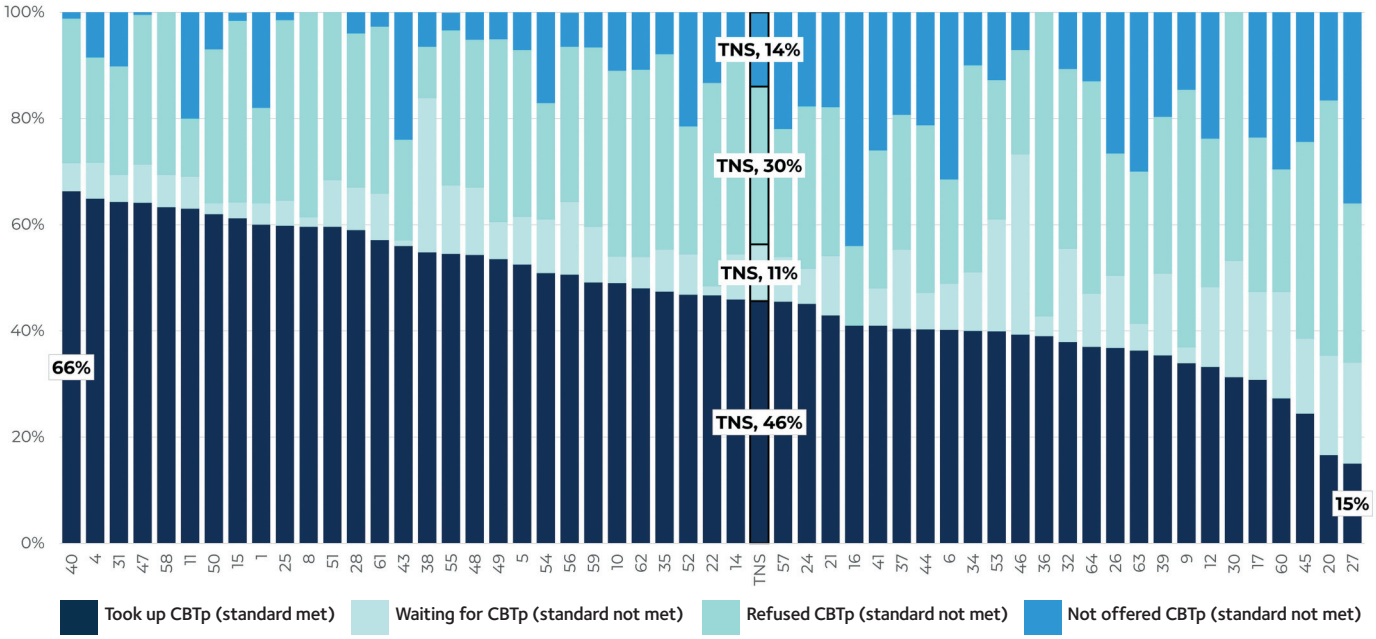


Figure 6. Proportion of people with FEP who took up CBTp (n=10,557)

WHAT THIS MEANS

Most people with FEP are being offered CBTp but on average 30% are refusing this offer.

FEEDBACK FROM EXPERTS BY EXPERIENCE

CBTp is not always suitable and the timing of this intervention is important.

"You can't always think yourself out of psychosis".

"I have autism and found it difficult to engage with CBTp".

IDEAS FOR LOCAL QI

- Does offering CBTp more than once improve uptake?
- Can including the offer of CBTp in the care planning reviews increase uptake?
- Would more/better promotion of CBTp involving people with FEP who found it helpful talking about their experiences increase engagement of those who are hesitant?

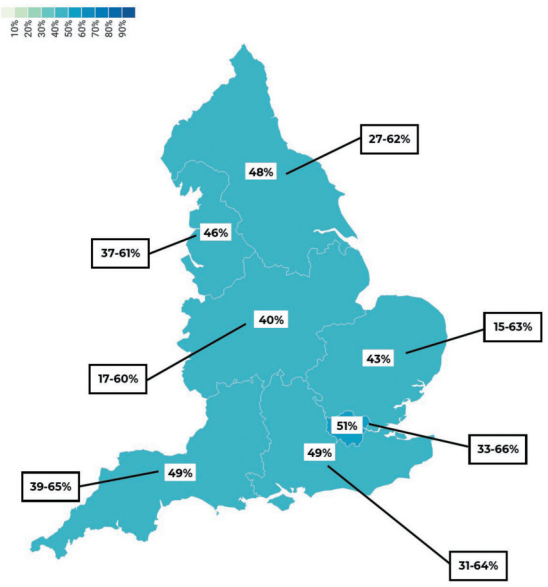


Figure 7. Regional mean and range for Standard 2 (CBTp)

Standard 3: Family intervention (FI)

People with FEP and their families should take up FI (NICE QS80, NICE QS102). To meet this standard people had to have received at least one FI session **delivered by a person with the relevant skills, experience, and competences.**

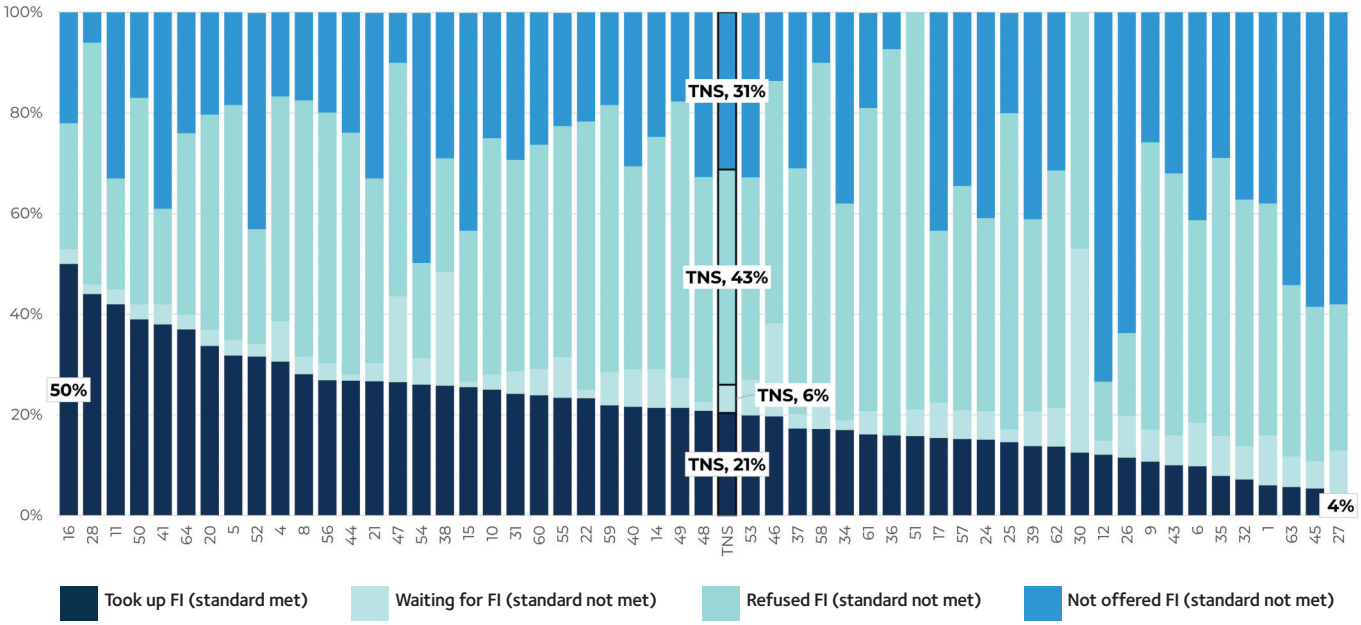


Figure 8. Proportion of people with FEP and their families who took up family intervention (FI) (n=10,557)

WHAT THIS MEANS

High proportion of people with FEP refusing FI.

FEEDBACK FROM EXPERTS BY EXPERIENCE

"[Family intervention] was offered but I was in the middle of a psychotic episode, so I was like no. It was never offered again...."

IDEAS FOR LOCAL QI

- Does offering FI more than once improve uptake?
- Would including the offer of FI in the care planning reviews increase uptake?
- Would having a champion on FI improve uptake of family interventions?

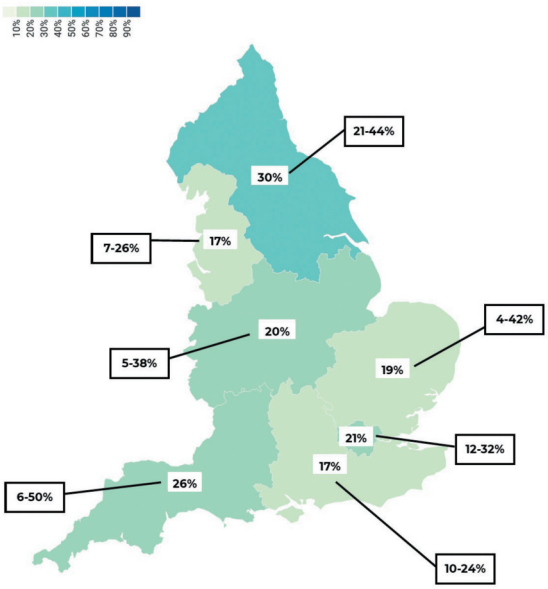


Figure 9. Regional mean and range for Standard 3 (FI)

Standard 4: Prescribing of clozapine

People with FEP who have not responded adequately to or tolerated treatment with at least two antipsychotic drugs should be offered clozapine (NICE QS80). This analysis was conducted on people who were identified as having had treatment with at least two antipsychotic drugs and not having responded adequately to or tolerated them (n=1,058).

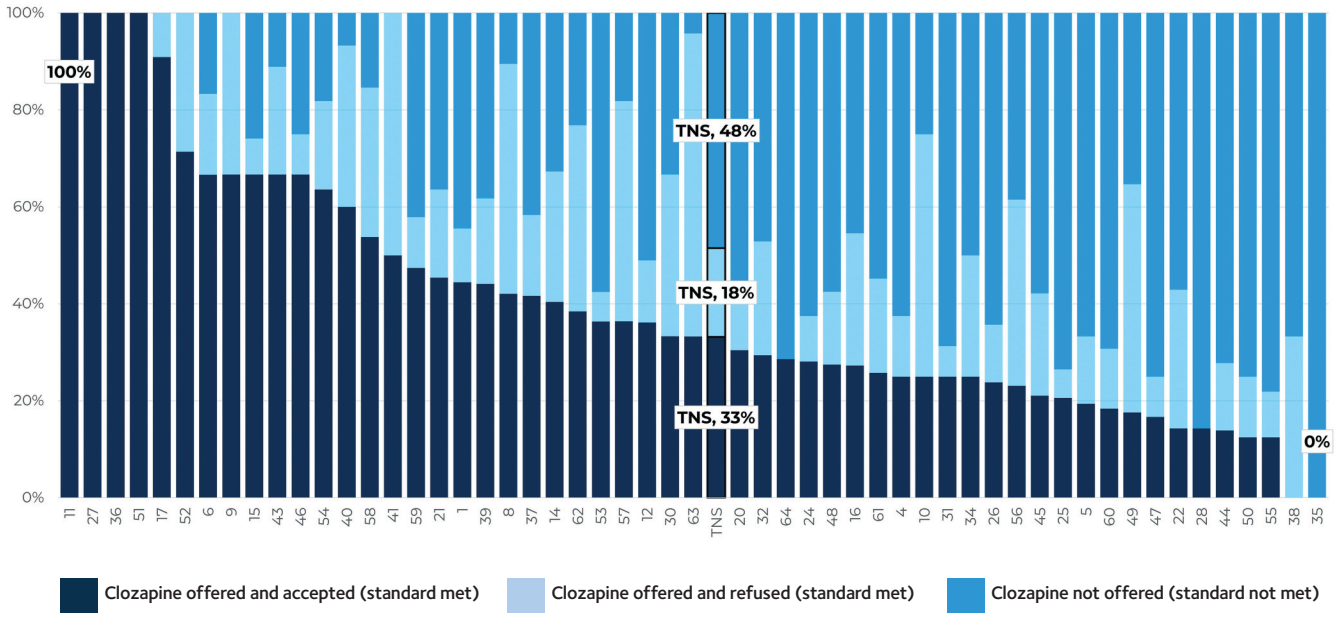


Figure 10. Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs (n=1,058)

WHAT THIS MEANS

Wide variation in the offer of clozapine between Trusts in all regions. Variations are apparent at a regional level as observed in Figure 11.

IDEAS FOR LOCAL QI

- Would involving a mental health pharmacist to identify individuals who may be eligible for clozapine increase the number who may be offered clozapine where appropriate?
- If clozapine consideration was routinely included as a prompt question in medical and care planning reviews, does this increase the number of offers?

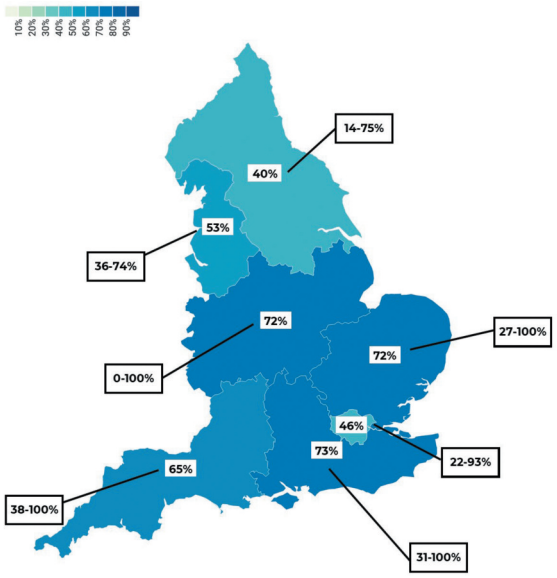


Figure 11. Regional mean and range for Standard 4 (clozapine)

Standard 5: Supported employment and education programmes

People with FEP should take up supported employment and education programmes (NICE QS80, NICE QS102). This analysis was carried out on responses from people who were identified from their casenotes as not being in work, education, or training at the time of their initial assessment (n=6,220).

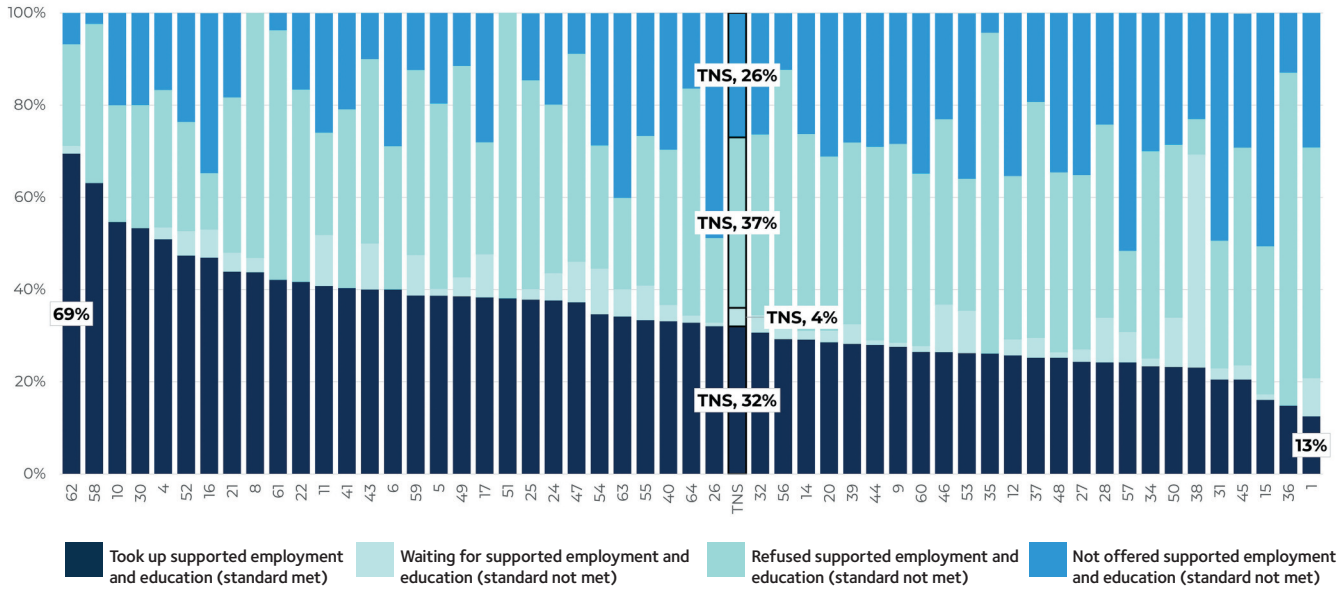


Figure 12. Proportion of people with FEP who were not in work, education or training who had taken up supported employment and education programmes (n=6,220)

WHAT THIS MEANS

A considerable proportion of people with FEP are not being offered or are refusing supported employment and education programmes.

FEEDBACK FROM EXPERTS BY EXPERIENCE

"Employment stats rest heavy with me as these are crucial elements to work with an individual to help them rebuild their life, albeit it may be a different life following psychosis."

IDEAS FOR LOCAL QI

- How can support be offered to everyone who is not in education, work, or training?
- Would including this on the agenda in clinical team meetings increase take up?
- Does including this as a routine question to be asked in care planning and medical reviews increase uptake?

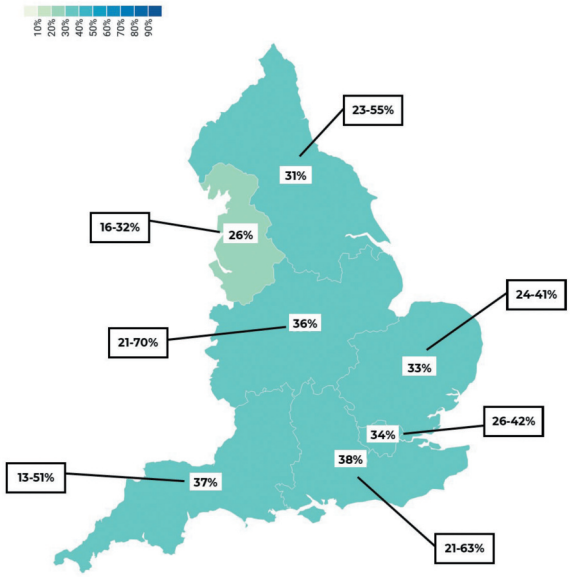


Figure 13. Regional mean and range for standard 5 (supported employment and education programmes)

Standard 6: Physical health screening

People should receive a physical health review annually which includes smoking status; alcohol intake; substance misuse; BMI; blood pressure; glucose and cholesterol (**NICE QS80, NICE QS102**). To meet this standard people must have been screened on all seven measures, this includes people who were offered but refused screening[3].

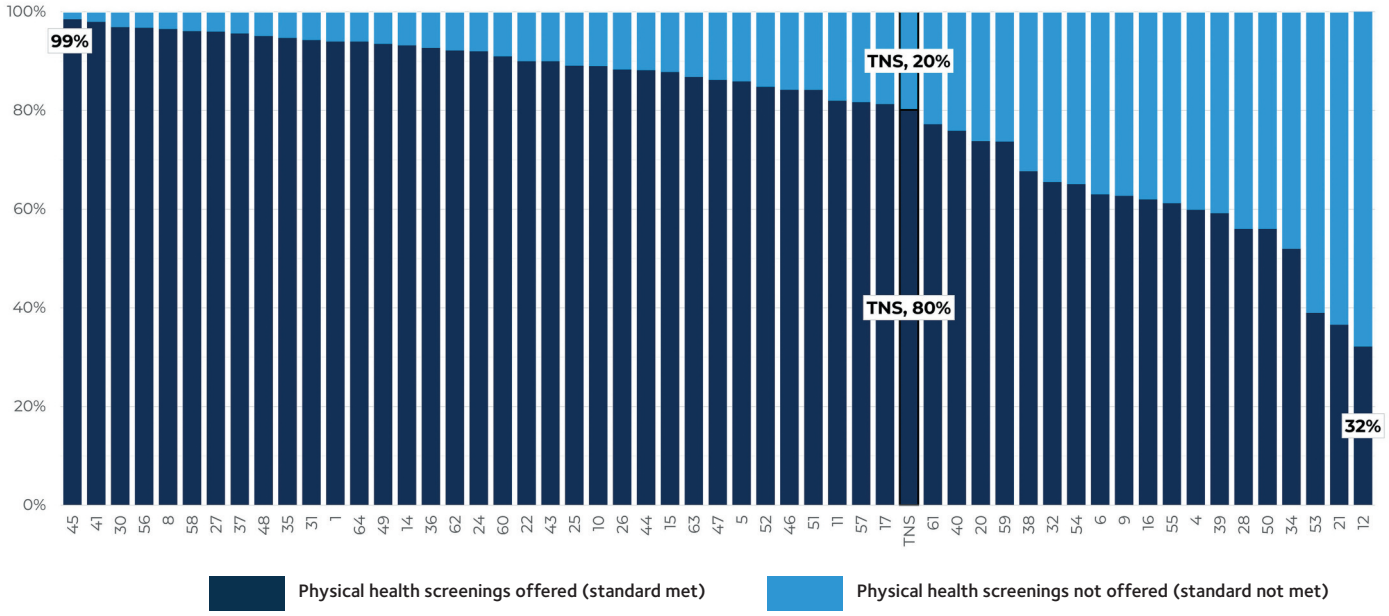


Figure 14. Proportion of people with FEP who were offered all 7 physical health measures across Trusts in the past 12 months (n=10,557)

WHAT THIS MEANS

Most people with FEP are offered all 7 physical health screenings.

IDEAS FOR LOCAL QI

- Do prompts built into the initial assessment, medical review, and care planning processes increase the number of routine physical health screens carried out?

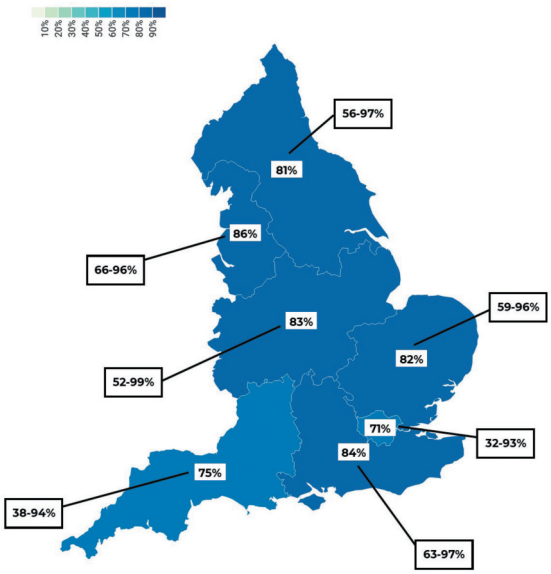


Figure 15. Regional mean and range for Standard 6 (Physical health screening)

3 Physical health tests for cholesterol and glucose may have been impacted by the global shortage of blood specimen tubes which was announced by NHSE in August 2021.

Standard 7: Physical health interventions

People must have been offered all relevant interventions where screening indicated a risk level requiring intervention, within the last 12 months (**Lester UK Adaption Tool, Shiers et al., 2014; NICE CG115** and **NICE CG120**).

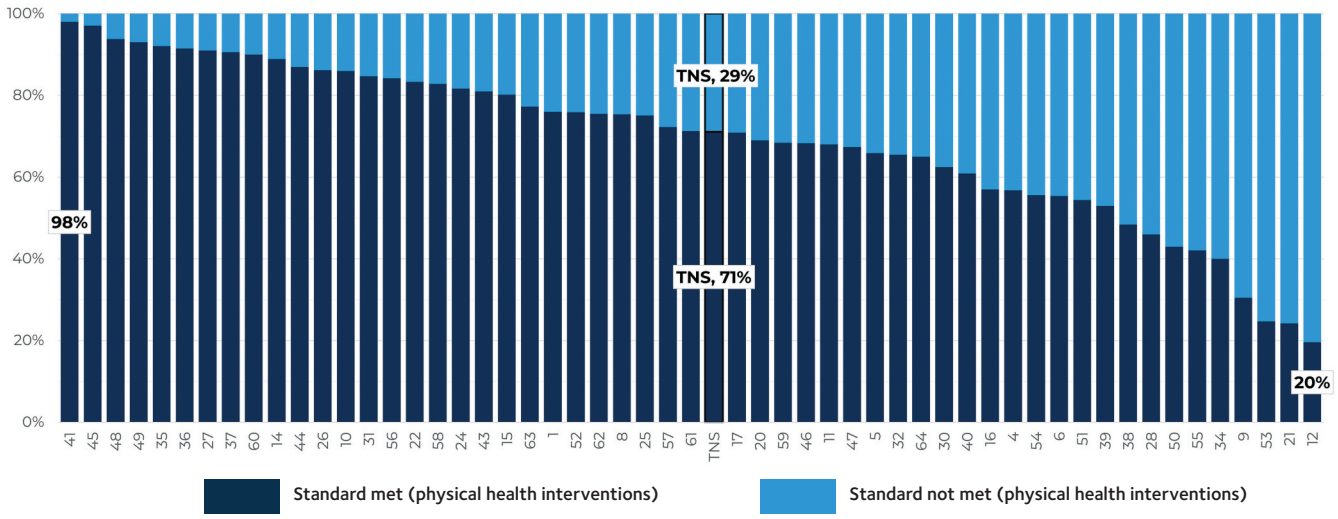


Figure 16. All 7 physical health screenings offered, and interventions offered where applicable (n=10,557)

WHAT THIS MEANS

A large proportion of people with FEP receiving physical health screenings are also receiving the corresponding intervention.

'Don't just screen - intervene!' *(The Lester UK Adaption Tool, 2014)*

IDEAS FOR LOCAL QI

- Would reviewing the process for how, when and by whom screening data for an individual is examined lead to more interventions being offered when a risk is identified?
- Can the offer of relevant interventions be increased by improving the process for review of blood results.
- Does having the Lester tool easily available for team members increase the number of physical health interventions offered?

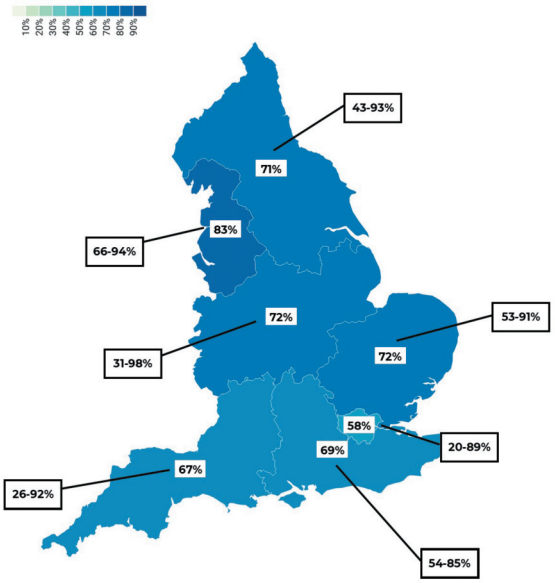


Figure 17. Regional mean and range for Standard 7 (Physical health intervention)

Standard 8: Carer-focused education and support programmes

Carers should take up carer-focused education and support programmes (CESP) (NICE QS80, NICE QS102). This analysis was carried out on all people in the sample who had an identified carer (n=8289).

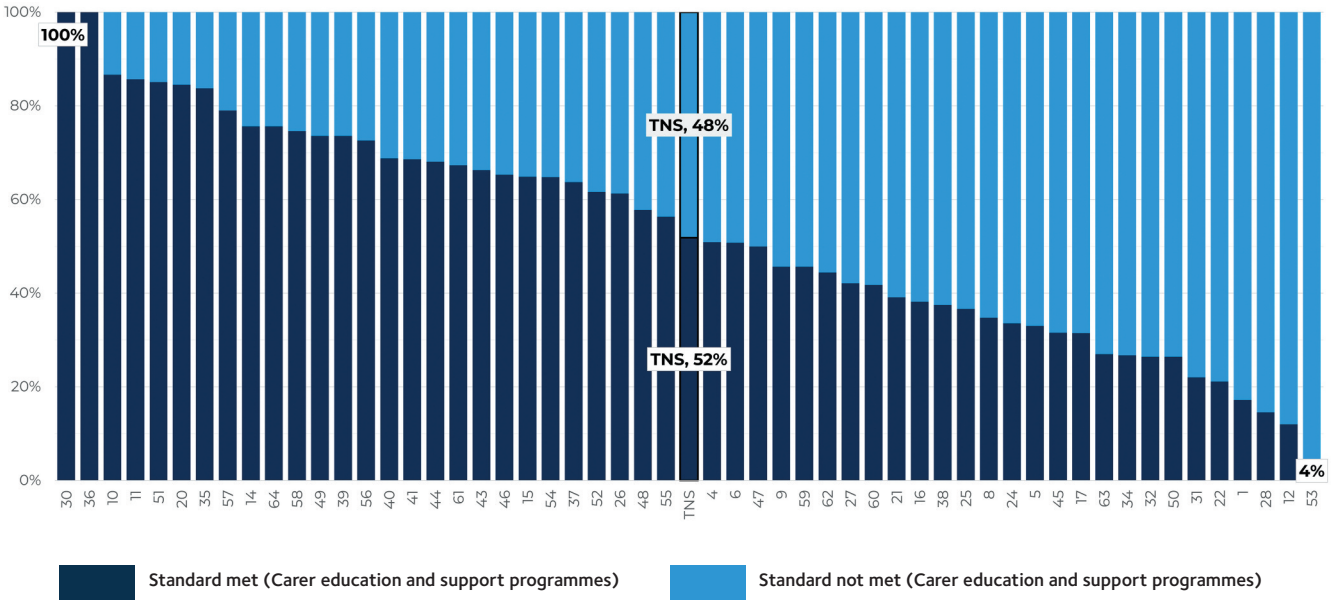


Figure 18. Proportion of people with FEP whose identified family member, friend or carer has taken up carer-focused education and support programmes (n=8289)

WHAT THIS MEANS

Only just over half of eligible carers are taking up CESP.

FEEDBACK FROM EXPERTS BY EXPERIENCE

"We're always left out of it; we don't know how to deal with things" (Carer).

IDEAS FOR LOCAL QI

- Would take up of CESP interventions be increased through promotional leaflets for carers listing what support is available and how to access it?
- Does partnering with another organisation improve local CESP available to EIP carers?
- Would reviewing carer support needs in case formulations, clinical team meetings and routine care planning review processes improve take up of CESP?

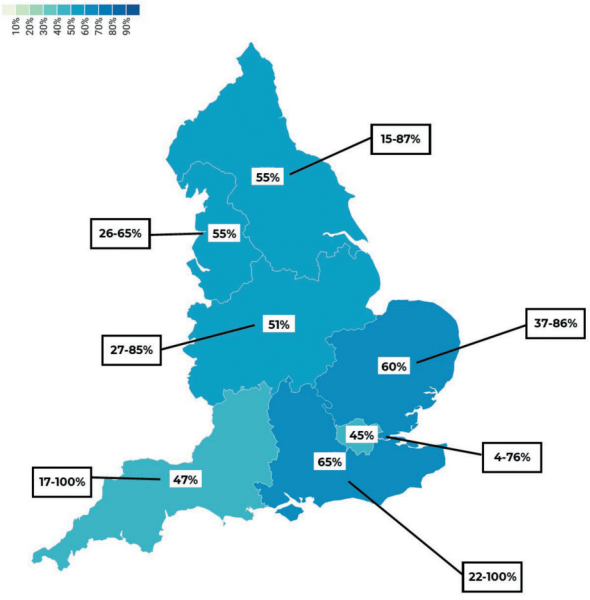


Figure 19. Regional mean and range for Standard 8 (Carer education and support programmes)

Outcome indicator

For people with FEP, two or more nationally mandated clinical outcome measures (HoNOS/HoNOSCA, DIALOG, QPR[4]) should be recorded at least twice, once on assessment and one other time point. The HoNOS was the most reported measure (95% of people had this at least once) followed by DIALOG (71%) and QPR (66%) however, 24% of people never had a QPR and 25% never had DIALOG (see Appendix C for further information).

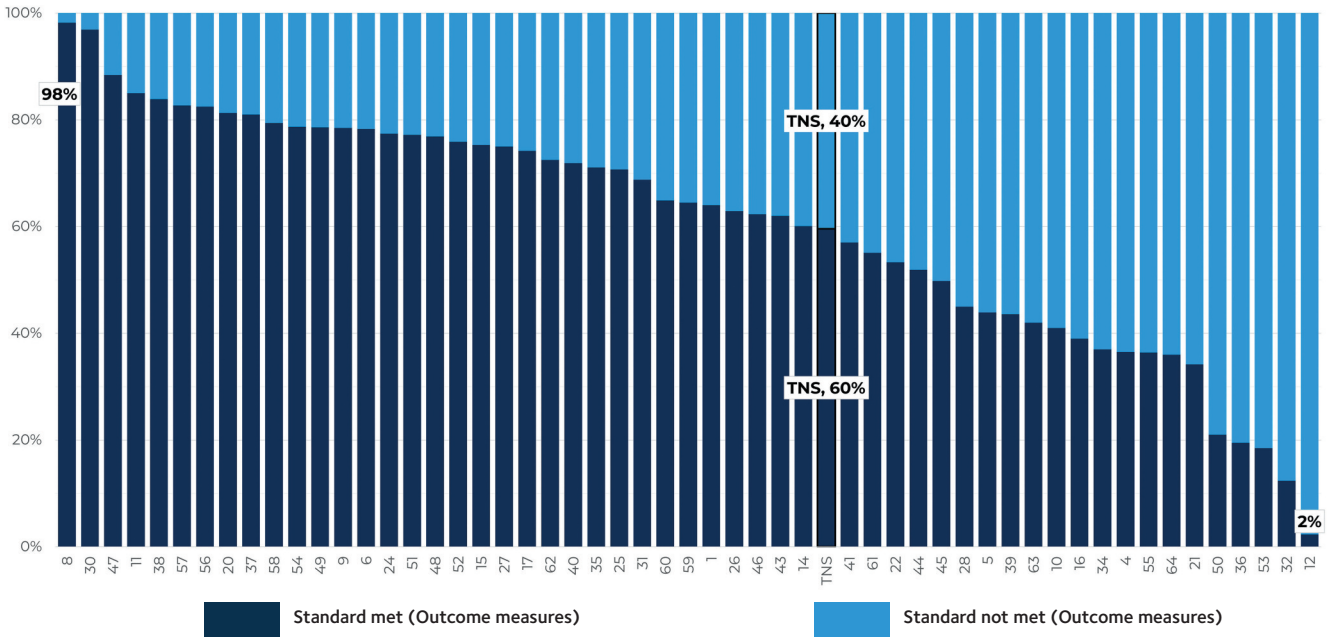


Figure 20. Proportion of people with FEP with clinical outcome measurement data recorded at least twice (n=10,557)

WHAT THIS MEANS

60% of people with FEP now have initial and repeat assessments on at least two of the three nationally mandated outcome measures.

IDEAS FOR LOCAL QI

- Would monitoring who has or has not completed outcome measures at baseline and at 12-month reviews increase recording of outcome measures?
- Is baseline and follow up data routinely collected and used to support a review of the impact of EIP on symptoms, functioning, life domains and satisfaction and the experience of EIP at an individual level?
- Does including outcome measure data within care planning reviews increase recording of outcome measures?

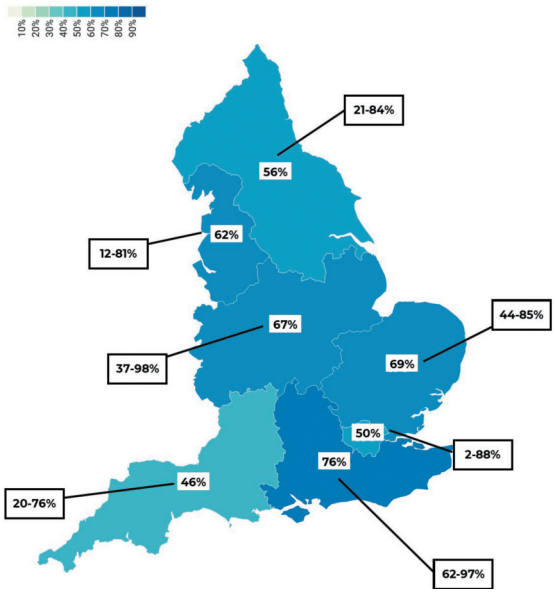
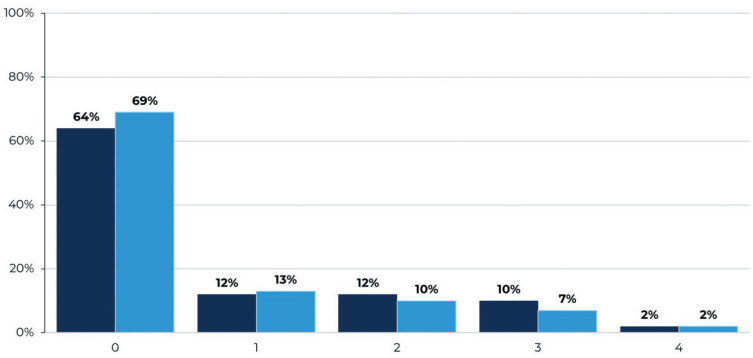


Figure 21. Regional mean and range for outcome measures

4 For people aged under 18 only the following outcome measures were accepted: HoNOS/HoNOSCA DIALOG, QPR, other.

5. EIP Impact/Outcomes[5]

This is the first year that the audit collected data on individual HoNOS scores for three items, and we asked teams to submit scores from the initial and follow-up assessment. These items were selected as they assess target symptoms for interventions (hallucinations and delusions) and are proxy indicators of Complex Psychosis and could be used to support EIP teams to identify individuals who may benefit from rehabilitation services[6].



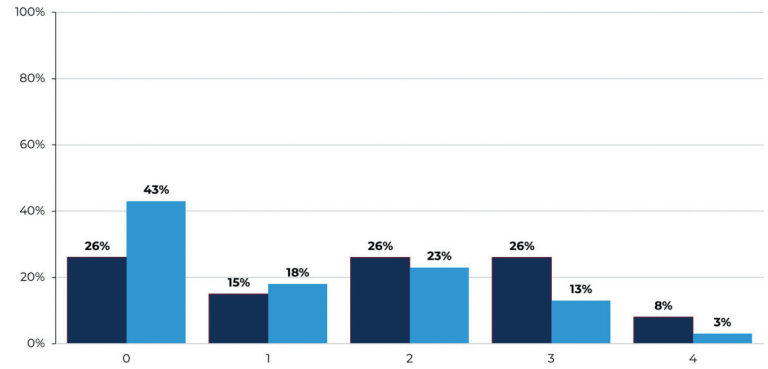
Initial Follow up

HoNOS scores

0= No problem
1= Minor problem - no action
2= Mild problem
3= Moderately severe problem
4= Severe problem

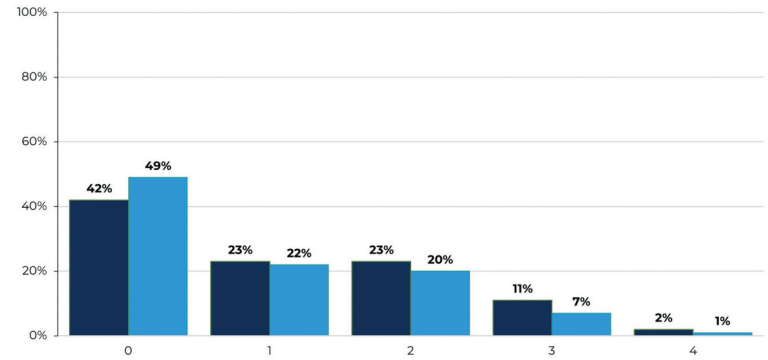
Change in score % (n)	
Improvement observed	19% (1309)
No change observed	70% (4805)
Decline observed	11% (729)

Figure 22. Proportion of people with HoNOS scores for problem with item 3 (drinking or drug-taking) at the time of initial and follow-up assessment with accompanying table displaying change in scores



Change in score % (n)	
Improvement observed	44% (3064)
No change observed	45% (3072)
Decline observed	11% (755)

Figure 23. Proportion of people with HoNOS scores for problem with item 6 (hallucinations and delusions) at the time of initial and follow-up assessment with accompanying table displaying change in scores



Change in score % (n)	
Improvement observed	29% (2014)
No change observed	53% (3670)
Decline observed	17% (1179)

Figure 24. Proportion of people with HoNOS scores for problem with item 10 (activities of daily living) at the time of initial and follow-up assessment with accompanying table displaying change in scores

WHAT THIS MEANS

The number of people with FEP with severe hallucinations and delusions halved, and the number with no or few symptoms increased by over 50%.

5 Please note that NHSE is also in the process of publishing broader guidance on the use of ouctomes in CMHS which should be forthcoming in Q4 2022/23.

6 The bar charts are representative of only those reporting scores of 0-4 for initial and follow-up assessments for item 3 (initial n=8894 and follow-up n=7536), item 6 (initial n=8933 and follow-up=7562) and item 10 (initial n=8903 and follow-up=7560). A subpopulation composed of only those reporting both initial and follow-up assessment scores from 0-4 are shown in the tables (people with missing scores for follow-up were excluded). People with scores 9 (insufficient information to make a HoNOS rating) and 10 (not applicable) were excluded from all analyses.

6. Antipsychotic commencement and weight gain

Of those who commenced antipsychotic medication within the last 6 to 12 months (n=965):

- 56% had their weight recorded.
- 33% did not have their weight recorded.
- 11% declined to have their weight recorded.
- <1% weight was not measured as they were pregnant.

Of those where weight was recorded:

- 76% had a weight increase (>0kg).
- There was a significant increase in weight identified from pre to post commencing antipsychotic medication. The average weight before was 75kg (36–184kg) and this increased to 82kg (40–180kg).

FEEDBACK FROM EXPERTS BY EXPERIENCE

"It really rested heavy with me, knowing the side effects of antipsychotics...Antipsychotics have been brilliant...but the side effects – particularly weight gain – is problematic. Why aren't we linking them in with nutritional support straight away, exercise on referral (when prescribing antipsychotics)?"

"about not having any support about side effects. I had CBTp before for an [eating disorder] ED. I went from 11 to 19 stone in 4 years [during EIP services]. My psychiatrist was adamant it was nothing to do with antipsychotics".

IDEAS FOR LOCAL QI

- Could a range of personalised strategies be used, including monitoring weight, switching antipsychotics if required, and offering interventions to help with diet exercise, and education?

7. Health inequalities

This section of the report looks at disparities in EIP care between different groups of people with FEP to highlight inequalities where there is a significant difference and to guide EIP services in addressing them (please see Appendix F for a full breakdown of significance). The audit highlighted that over a third of teams (37%) still do not have a written strategy to identify and address mental health inequalities.

Additionally, there are still some teams who do not provide EIP services to all age groups:

- **4%** of teams had no children and young people (CYP) EIP services for under 18's.
- **1%** of teams had no EIP services for those aged 18-35.
- **8%** of teams had no EIP services for those aged 36 and over.

Age

CBT for At Risk Mental State

Prior to an episode of psychosis many people will experience a period of symptoms/experiences described as having an 'at risk mental state' (ARMS). The 2020 NHSE implementing EIP AWT standard guidance prioritised ARMS and states that services should provide access to evidence-based care and support. However, there are still a high number of teams who do not provide CBT for ARMS either within or outside the team across all age groups.

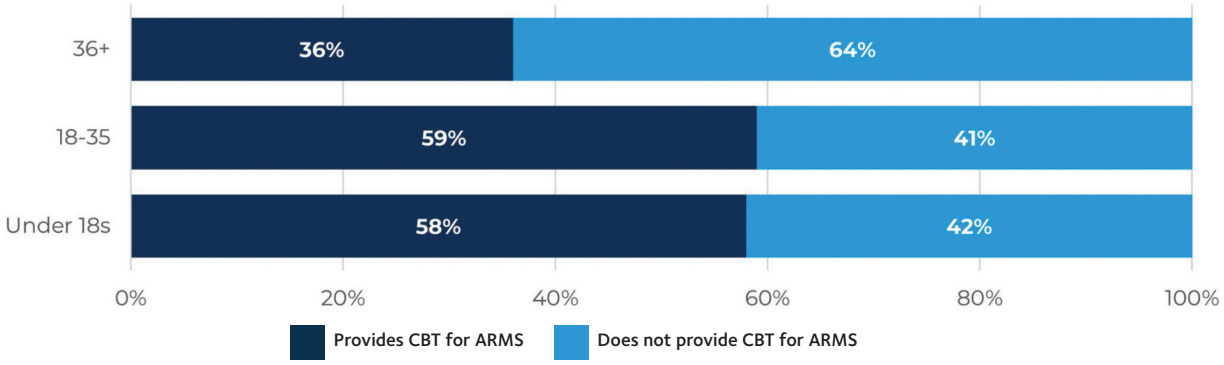


Figure 25. Proportion of teams that provide cognitive behavioural therapy (CBT) for At-Risk Mental States (ARMS), either within or outside the team, in different age groups (n = 151)

CBTp

Under 18s were less likely to be offered CBTp in comparison to older age groups and were also less likely to take up CBTp when offered. Additionally, there was a higher proportion of under 18s on a waiting list compared to older age groups (standard 2).

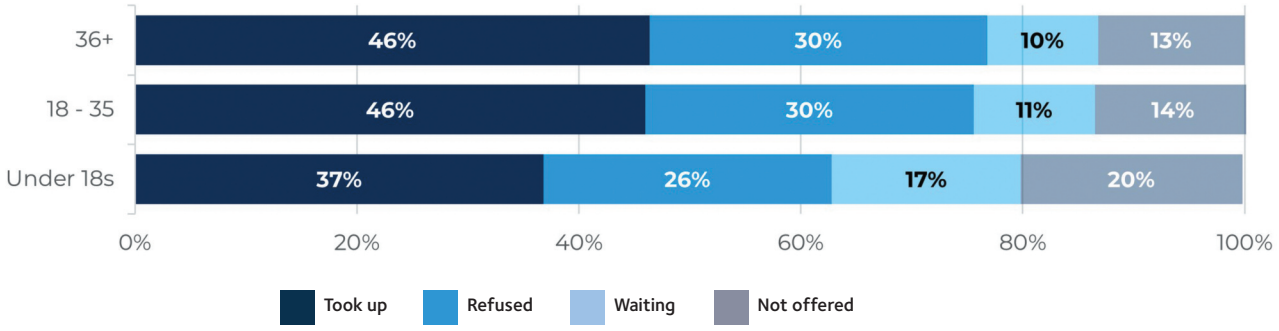


Figure 26. Proportion of people in different age groups that had taken up, refused, were waiting for or had not been offered CBTp (n = 10,557)

Family Interventions (FI)

People aged 36 plus were less likely to be offered FI and when it was offered the take-up was significantly lower (17%) compared to under 18's (33%) (standard 3).

Carer education and support programmes

Carers of people with FEP were more likely to commence a support programme if the person they care for was under 18 (61%) in comparison to those who cared for someone aged 18-35 (53%) and 36 and over (49%) (standard 8).

Supported education and employment programmes

People aged 18-35 years who were not in work education or training (NEET) at the time of their initial assessment were more likely to take up an education and employment support programmes (37%) than those aged over 36 (24%) (standard 5).

People under 18 were less likely to be offered a supported education and employment programme (47% not offered) compared to those 18-35 years (22%) and 36 plus (33%).

Clozapine

Younger age groups were more likely to be offered clozapine after two unsuccessful trials of other antipsychotic medication in comparison to those aged 36 and over (standard 4).

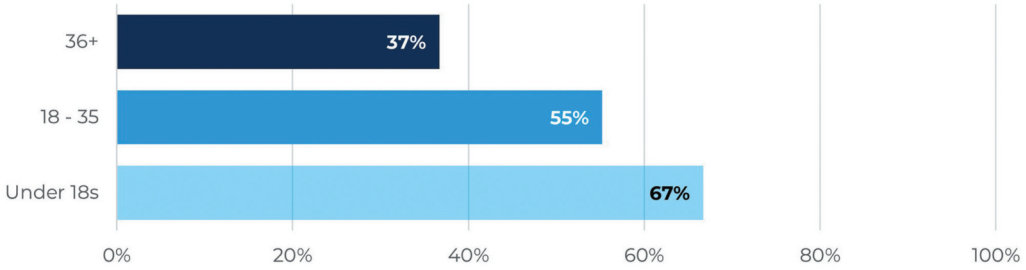


Figure 27. Proportion of people in different age groups that were offered Clozapine after 2 unsuccessful trials of other antipsychotic medication (n = 1058)

FEEDBACK FROM EXPERTS BY EXPERIENCE

"I was given various different antipsychotics that appeared...not to be working... yet if Clozapine can be offered after 2 unsuccessful trials, why was it not offered to me between the ages of 20-24?"

Outcome measures

People with FEP aged 18 and over were more likely to have two or more outcome measures recorded, more than once compared to under 18s (outcome indicator).

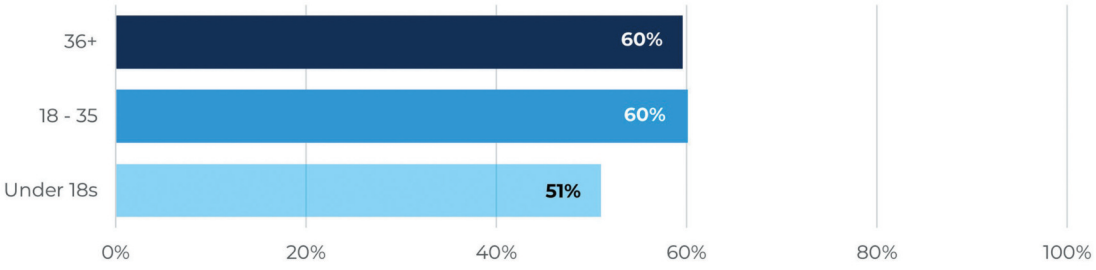


Figure 28. Proportion of people in different age groups that had 2 or more outcome measures recorded more than once (n = 10,557)

CYP subsample

When looking at the under 18s as a subsample (n=204) of this year's audit in comparison to last year (2020/21) it shows improvements for CYP with regards to:

- Offer of clozapine (standard 4) (+13%).
- Take up of carer education and support programmes (standard 8) (+7%).
- Physical health monitoring (standard 6) (+16%).
- Physical health interventions (standard 7) (+12%).
- Outcome measures (outcome indicator) (+13%).

However, there are some areas where performance has decreased for CYP, including take up of CBTp (-5%) and take up of supported education and employment programmes (-12%).

Additionally, when comparing the performance of the CYP subsample against the whole audit sample results for the current year, there were three areas where CYP had lower levels of provision than the total sample (a full analysis can be found in appendix F):

- Take up of CBTp (-9%).
- Take up of supported employment and education programmes (-7%).
- Outcome measures (-11%).

Gender

CBTp

The proportion of people who took up and were not offered CBTp differed depending on gender, with 9% more females taking up CBTp in comparison to males (standard 3).

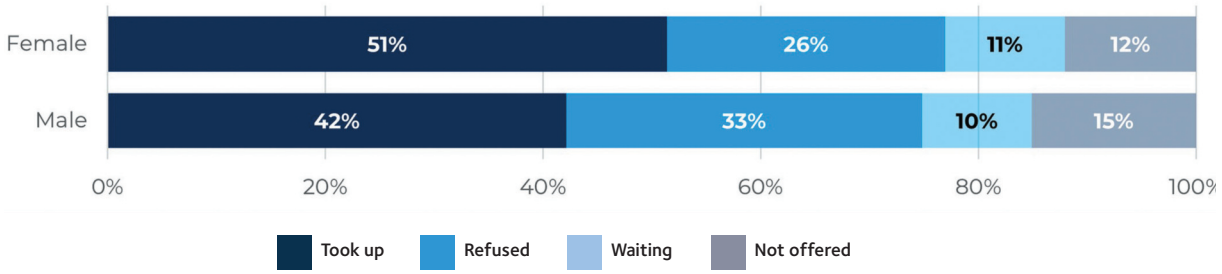
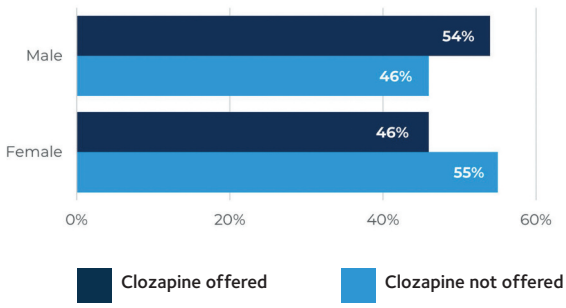


Figure 29. Proportion of people with FEP in different gender groups that had taken up, refused, were waiting for or were not offered CBTp (n=10,536)

Clozapine



FEEDBACK FROM EXPERTS BY EXPERIENCE

"I've experienced issues with medication because I am of child-bearing age. I've been refused meds because of that... bearing in mind I am a lesbian and do not want kids...".

Figure 30. Proportion of males and females who were offered clozapine after 2 unsuccessful trials of other antipsychotic medication (n= 1058)

Ethnicity

Carer education support programme

Carers of people with FEP who identify as black were less likely to have started a carer education support programme (42%) than carers of those who identify as white (55%) (standard 8).

FEEDBACK FROM EXPERTS BY EXPERIENCE

"There's lots of assumptions and misunderstanding around psychosis when it comes to Black and Asian communities and people."

Physical health

People who identified as black were less likely to receive all seven physical health screenings (standard 6) than other ethnic groups and subsequently were less likely to receive relevant health interventions (standard 7).

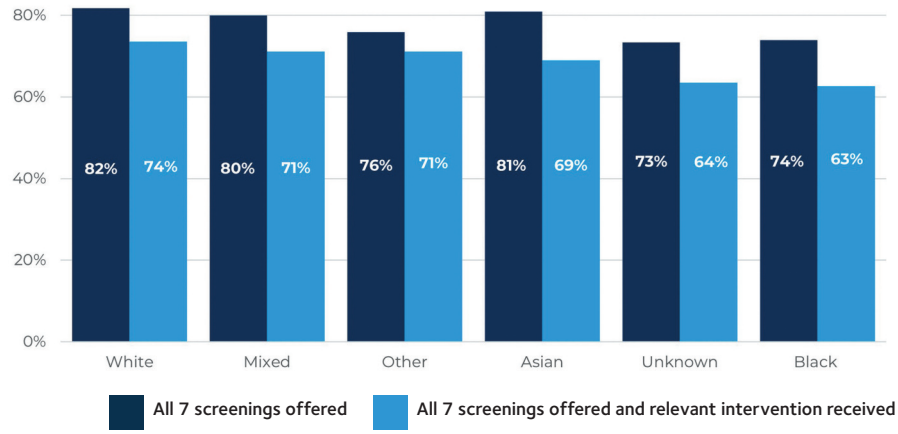


Figure 31. Proportion of people with FEP from different ethnic backgrounds that received all 7 physical health screenings (n=10,557) and were subsequently offered the required intervention (n=10,557)

Outcome measures

People who identified as black were less likely than their white counterparts to have two or more outcome measurements recorded more than once (outcome indicator).

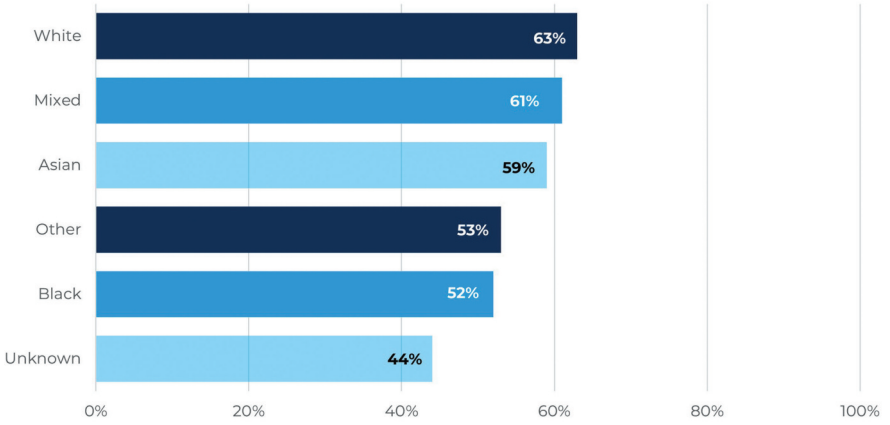


Figure 32. Proportion of people with FEP from different ethnic backgrounds that had 2 or more outcome measurements recorded more than once (n=10,557)

8. Recommendations

1. Equitable access

As part of a wider agenda to address health inequalities, **all Trusts** should review the Mental Health Inequalities Strategy alongside local and national data. Trusts should develop a strategy to identify and address mental health inequalities that influence access to or uptake of interventions for people with first episode psychosis (FEP) and work with **commissioners** and **regional networks** to ensure equitable access, experience, and outcomes. This includes:

- Unmet need in areas where there is no EIP provision, or no EIP provision for specific age groups (e.g., under 18s).
- The shortfall in EIP provision and CBT for ARMS between age groups.
- Understanding and addressing gender and ethnicity differences in intervention take up and adherence.
- Sharing learning and good practice between high and low performing Trusts within regional networks and identifying areas for local quality improvement to redress disparities in provision by postcode.

2. Think Family

EIP teams should develop quality improvement activities to understand the barriers for people with FEP and their families/carers to engage with family intervention and carer education support programmes. This includes:

- Ensuring that communication about support options available to families and carers is understandable and accessible.
- Ensuring that the offer of interventions to families and carers is an ongoing process and not a single event.

3. Outcomes focused

EIP teams should use FEP outcome measures to discuss progress and experience for individuals on caseload within care planning reviews and to report on team outcomes annually.

4. Physical health screening

EIP teams should monitor side effects of medication, in particular changes in weight when screening.

9. List of figures and tables

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