

National report for Wales Early Intervention in Psychosis Audit



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 in the context of the pandemic.

85%



of people with first episode psychosis (FEP) who had not responded adequately to treatment with at least 2 antipsychotic drugs were offered clozapine

36%



of people with FEP who were **not** in work/education took up a supported employment and education programme

51%

of people with FEP received all 7 physical health screens

27%

INCREASE FROM PREVIOUS AUDIT

30%

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

17%

INCREASE FROM PREVIOUS AUDIT

Children and Young People (CYP) improvements in:

- ✓ All teams have CYP EIP provision (44% increase)
- ✓ 66% of teams have a shared protocol between the EIP team and CYP mental health service
- ✓ Improvements in medication management and prescribing arrangements for CYP

Recording of outcome measures **increased by 8%** to 15%

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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

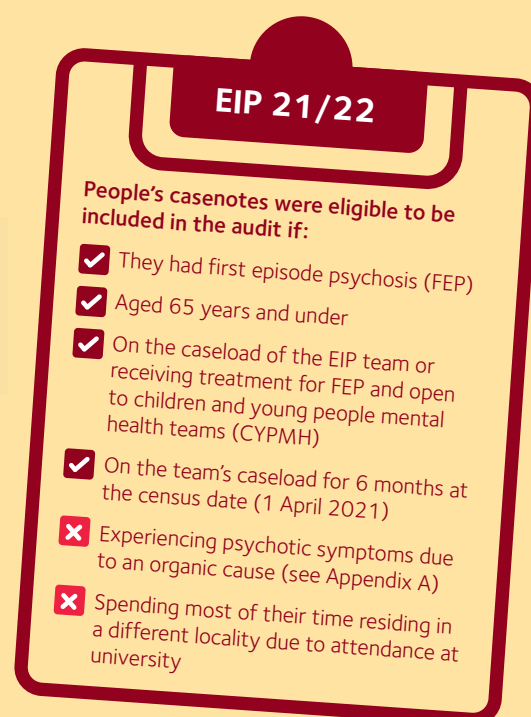
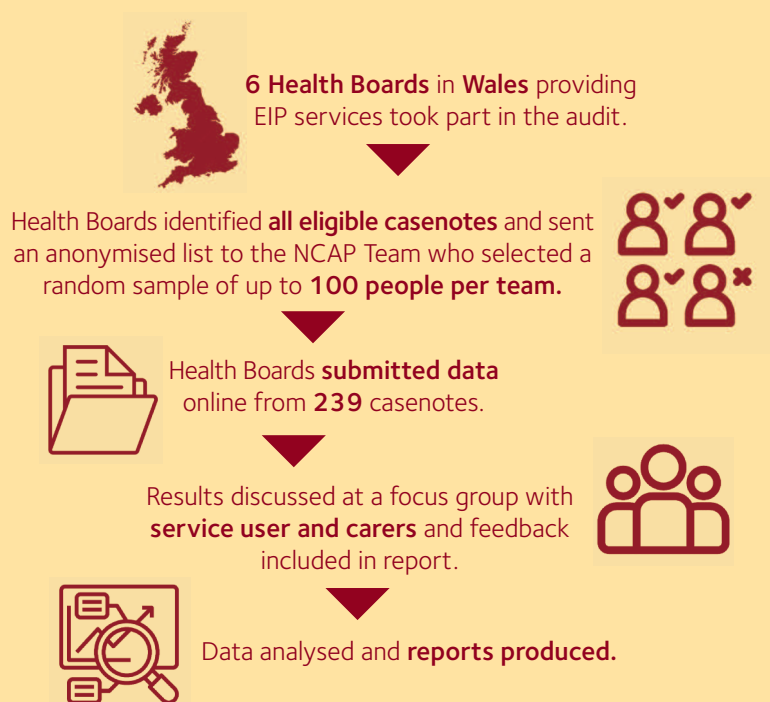
This report presents national and Health Board-level findings on the treatment of people by Early Intervention in Psychosis (EIP) teams in Wales. EIP services are specialised services that aim to provide prompt assessment and evidence-based treatments to people with first-episode psychosis (FEP).

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).

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?

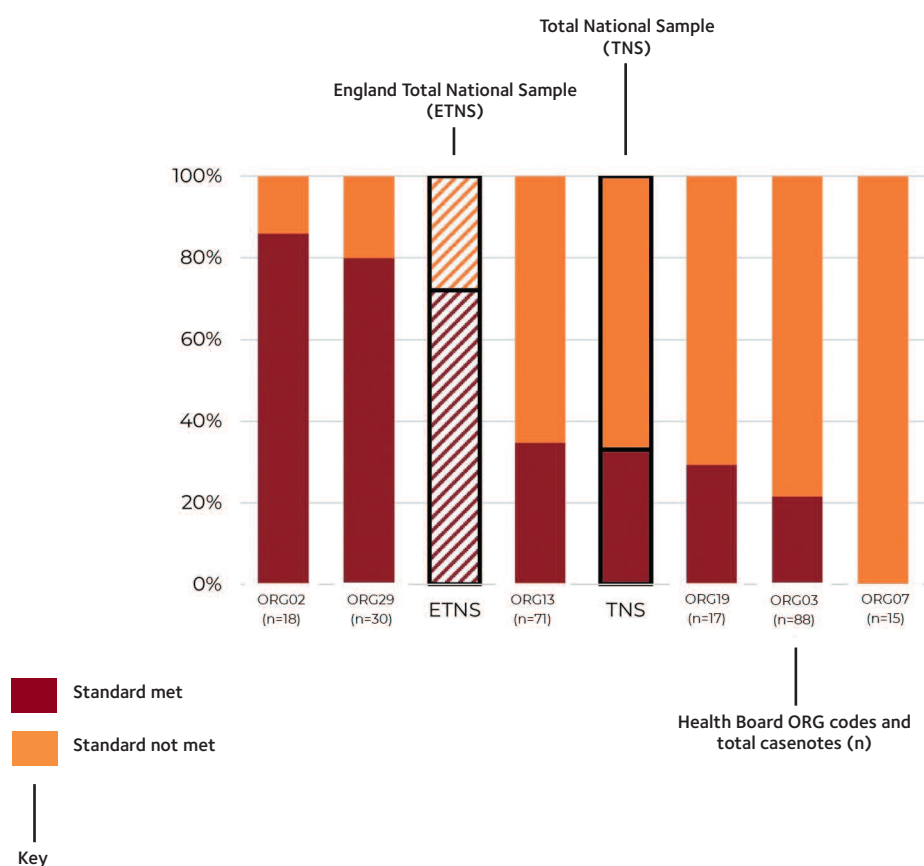


2. How to read this report

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 Health Board-level data and allow for comparisons across Health Boards. Each bar represents the performance of an individual Health Board, which can be identified by its unique ORGID number, found along the x-axis of the chart. The total national sample (TNS) for Wales is indicated by the bold bar with block colour and is displayed alongside the England total national sample (ETNS) which is indicated by the bold bar with stripes.

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.

3. Change over time

As this is the fourth year of the EIP audit, the table below shows the national performance for Wales against the audit standards over time. Improvements in performance since the spotlight audit in 2018/19 can be seen for all the standards, except for Standard 1 and 8, as indicated by the white lines.



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

4. Health Board variation

This section of the report highlights variation in performance against the standards at Health Board level.

Staffing & workload

67% 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 WTE in the same year. On average each WTE EIP care coordinator had a caseload of 15, and this ranged from 8–25¹.

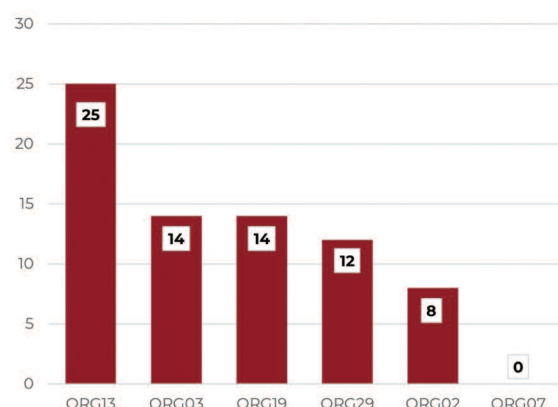


Figure 2. Caseload per whole time equivalent care coordinator for each Health Board

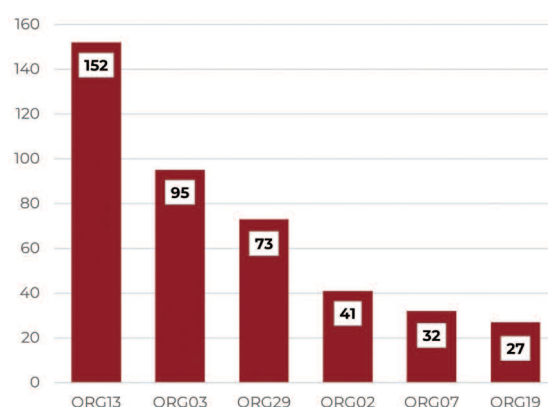


Figure 3. Total caseload for each Health Board

WHAT THIS MEANS

Care coordination is essential for EIP care and lower care coordinator caseloads support more effective delivery. There is wide variation in overall EIP caseload totals across Health Boards.

IDEAS FOR LOCAL QI

- Does allocation of identified care coordinators improve the offer and uptake of evidence-based interventions?
- Would staff benefit from having regular caseload reviews during supervision to ensure caseload size allows for the effective delivery of EIP care?
- Do total EIP caseload figures reflect the expected incidence of FEP in your Health Board?



¹ ORG07 have 0 whole-time equivalent care coordinators at the service and therefore have a caseload of 0 per whole-time equivalent care coordinator as indicated on the chart in figure 2.

Standard 1: Timely access

People with FEP should start treatment in EIP services within 2 weeks of referral (NHSE, 2016;2020)².

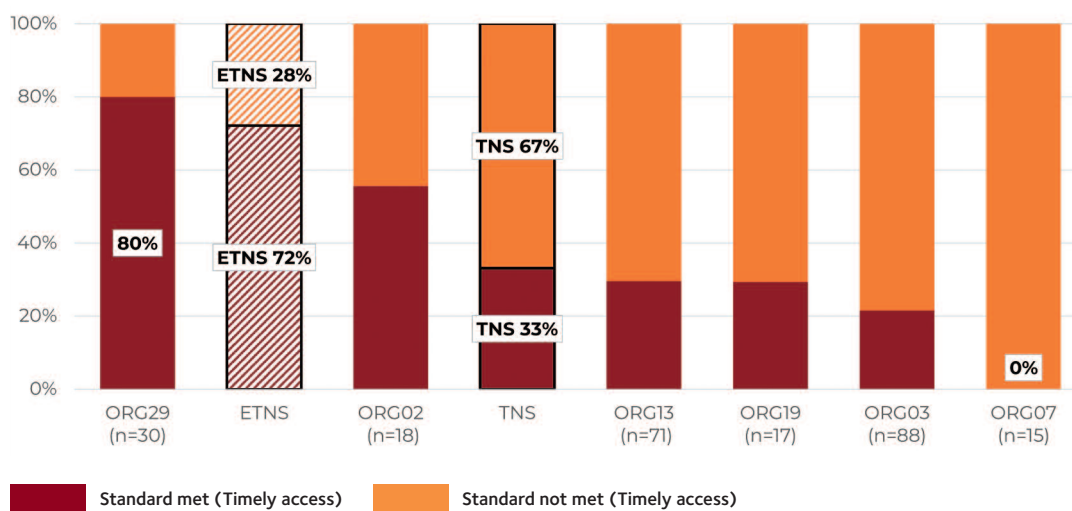


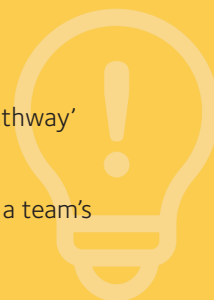
Figure 4. People with FEP who started treatment in EIP services within two weeks of referral (allocated to, and engaged with, an EIP care coordinator) (n=239)

WHAT THIS MEANS

Only one third of people with FEP are starting treatment in EIP services within 2 weeks of referral.

IDEAS FOR LOCAL QI

- Can obstacles 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 potential obstacles and barriers?



² For this standard data from England, included for comparison in figure 4 was from the Early Intervention in Psychosis Waiting Times data on the Mental Health Services Dataset (MHSDS) (NHS Digital, 2021).

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.

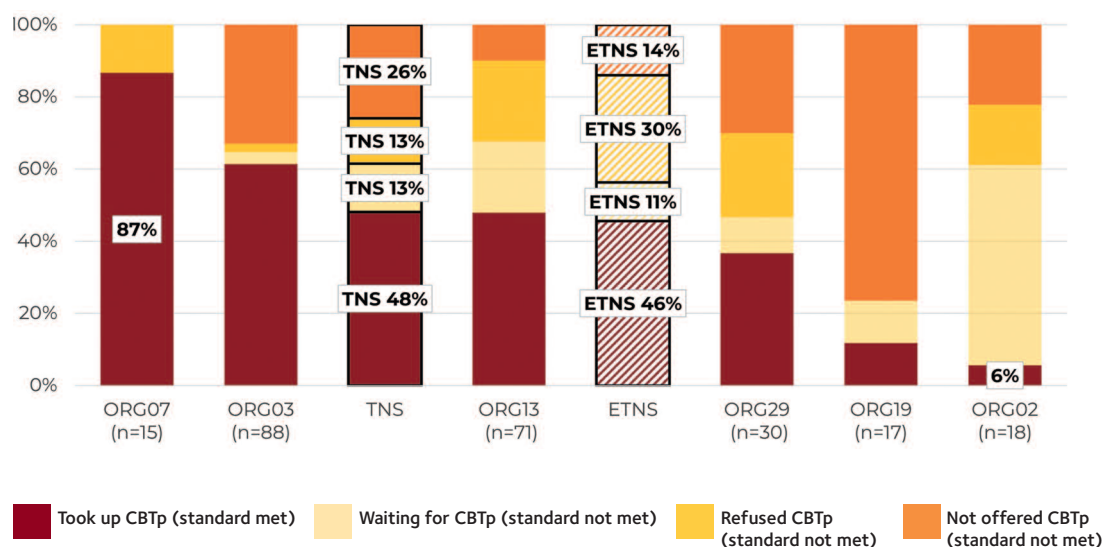


Figure 5. Proportion of people with FEP who took up CBTp (n=239)

WHAT THIS MEANS

There is wide variation in the offer, take up, waiting and refusal of CBTp between Health Boards.

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

- Do staffing models and staff skills allow for CBTp to be offered where appropriate?
- 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?



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.

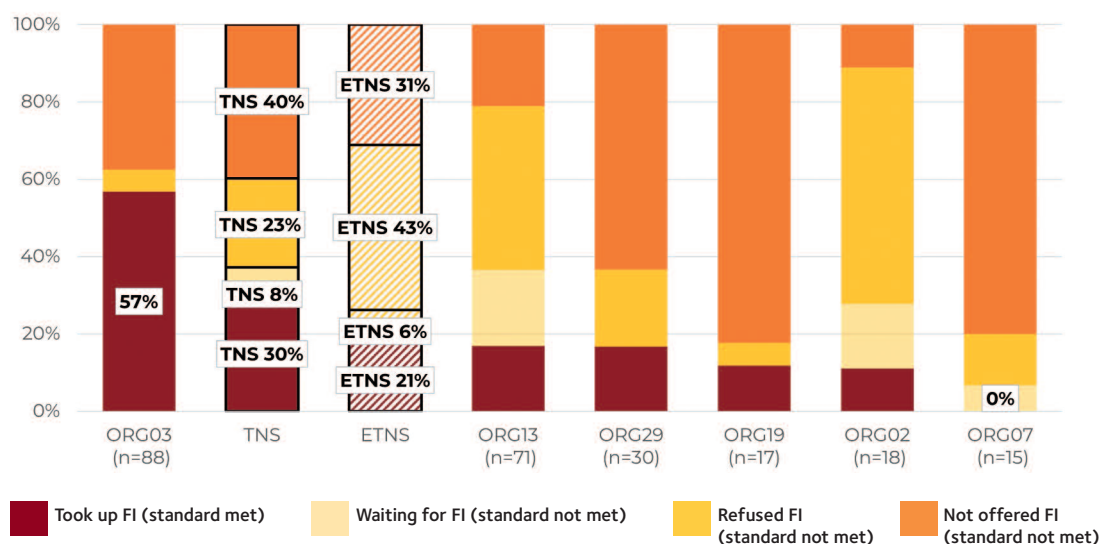


Figure 6. Proportion of people with FEP and their families who took up family intervention (FI) (n=239)

WHAT THIS MEANS

There is wide variation in the offer, take up, waiting and refusal of FI between Health Boards, with most having low FI take up and high rates of FI not being offered.

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 the uptake of family interventions?
- Would involving families who found FI beneficial help to engage families who may be hesitant to try it?



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=26).

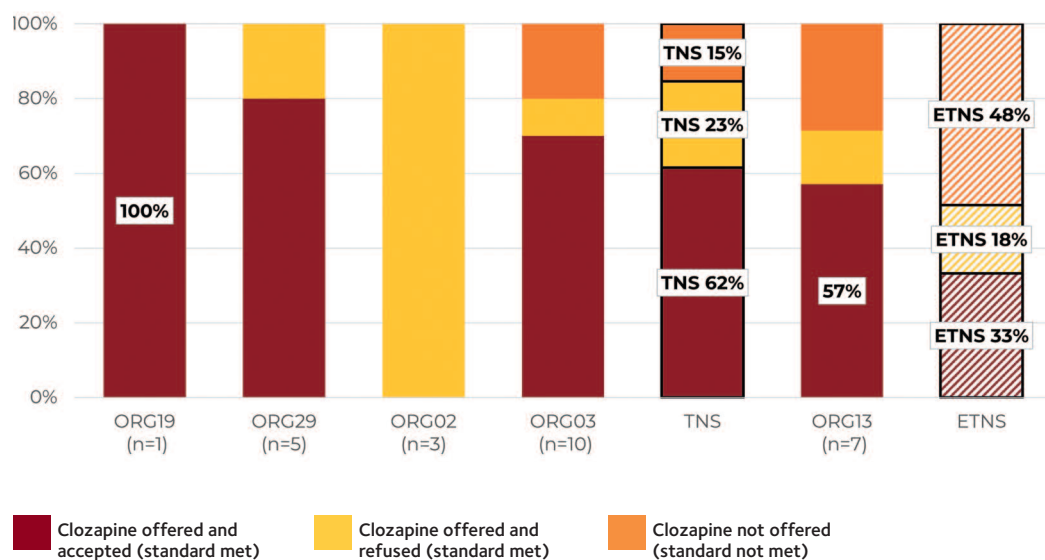


Figure 7. Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs (n=26)³

WHAT THIS MEANS

There is high offer and take up in 4/5 Health Boards however, this data is based on very small sample sizes.

IDEAS FOR LOCAL QI

- How would you know if you were missing individuals who should be considered for clozapine? Would routinely including clozapine consideration as a prompt question in medical and care planning reviews help to identify individuals who may be eligible to be offered clozapine?
- Would involving people with FEP who found the switch to clozapine beneficial help to engage those who may be hesitant to try it?

³ 3 ORG 7 had no eligible casenotes for this standard and therefore were not included in this analysis.

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=140).

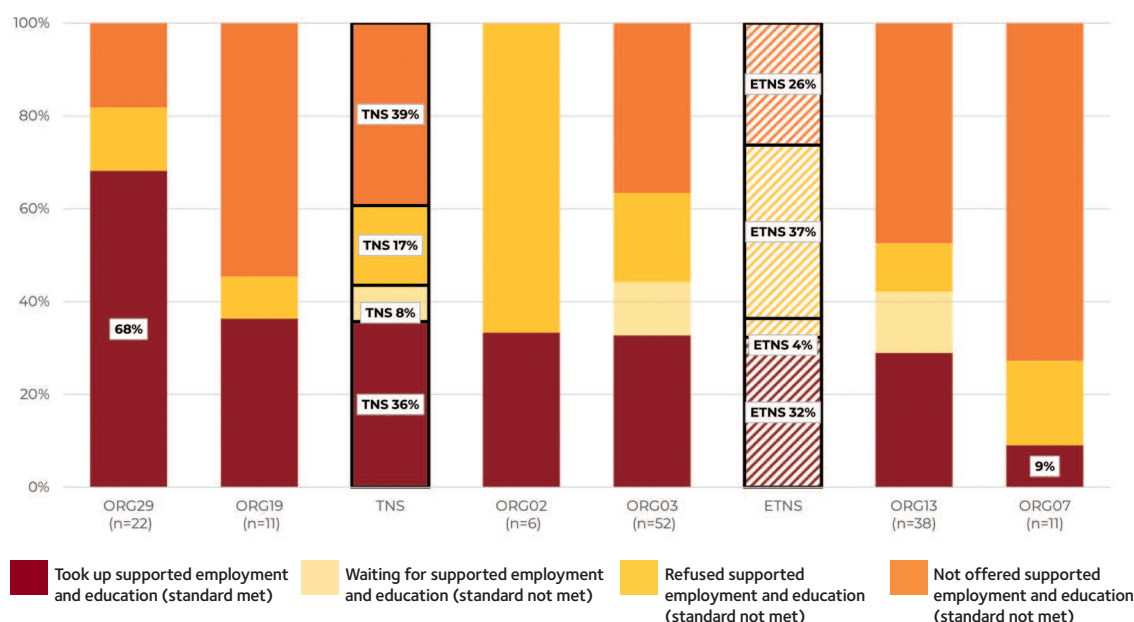


Figure 8. Proportion of people with FEP who were not in work, education or training who had taken up supported employment and education programmes (n=140)

WHAT THIS MEANS

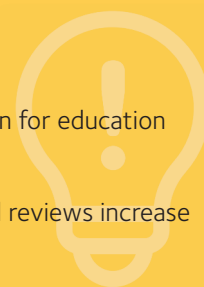
A considerable proportion of people with FEP are not being offered or are refusing supported employment and education programmes.

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

- Would including this on the agenda in clinical team meetings or having a champion for education and employment support increase offer and take up rates?
- Does including this as a routine question to be asked in care planning and medical reviews increase offer and take up?



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 screening⁴.

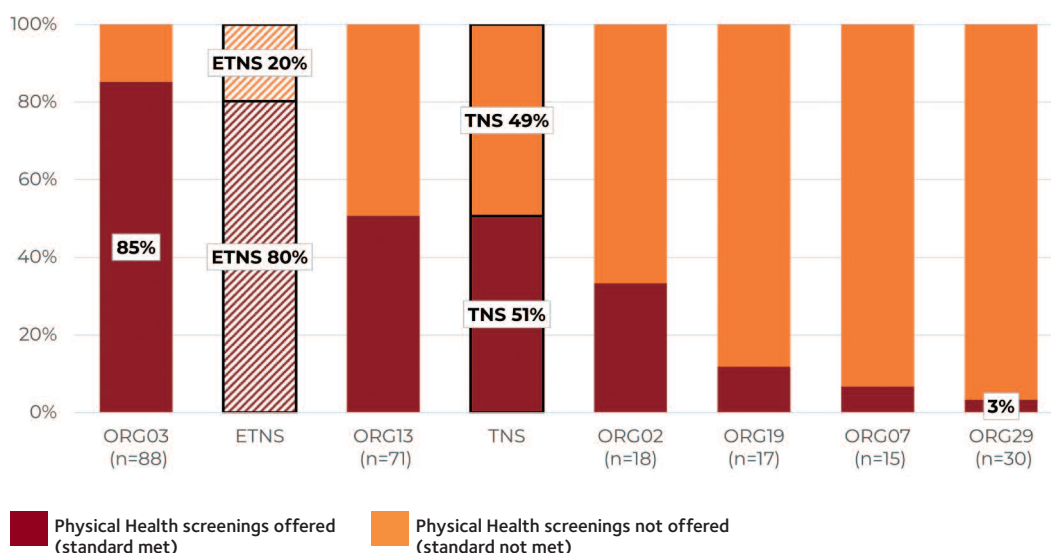


Figure 9. Proportion of people with FEP who were offered all 7 physical health measures across Health Boards in the past 12 months (n=239)

WHAT THIS MEANS

In most Health Boards, more than 50% of people with FEP received all seven 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?
- Would ensuring that there is portable equipment for carrying out physical health screening ('lab in a bag' kits) increase the number of people who are screened on all seven screening measures?
- Would having an identified team lead for physical health improve the screening rates?

⁴ 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).

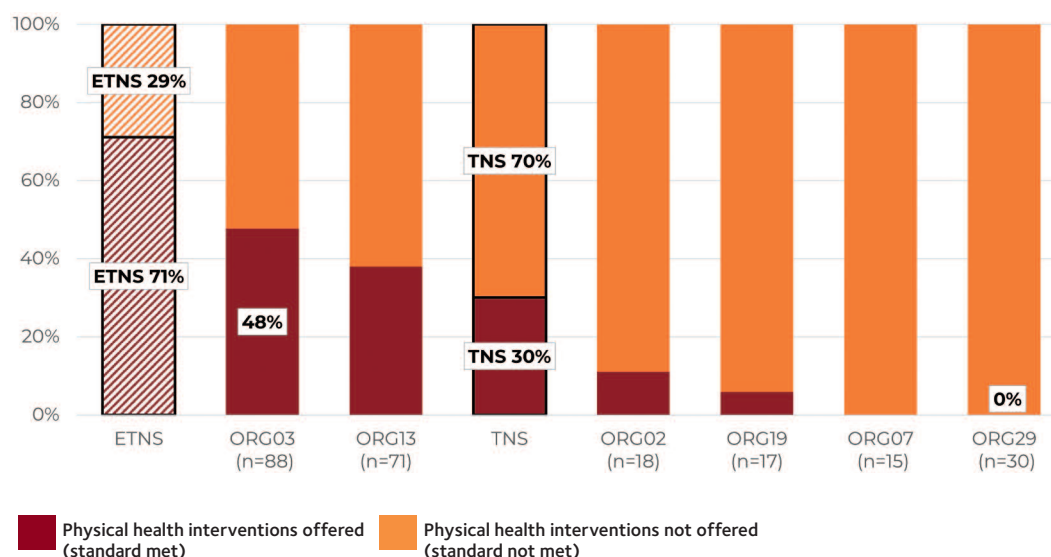


Figure 10. All 7 physical health screenings offered, and interventions offered where applicable (n=239)

WHAT THIS MEANS

On average only 30% of people with FEP identified as a risk received all the required physical health interventions.

'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 UK Adaption tool easily available for team members to access increase the number of physical health interventions offered?

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=202).

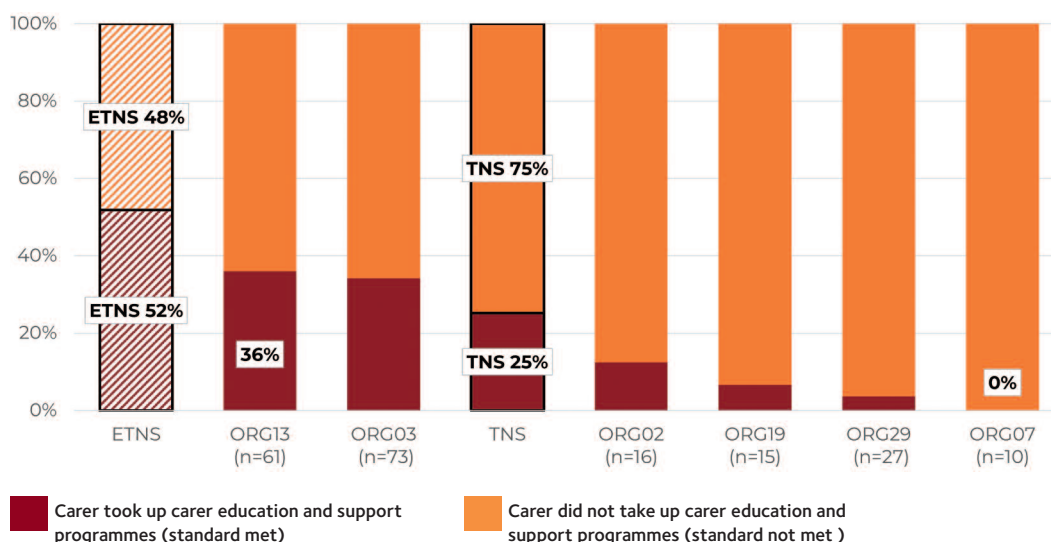


Figure 11. Proportion of people with FEP whose identified family member, friend or carer has taken up carer-focused education and support programmes (n=202)

WHAT THIS MEANS

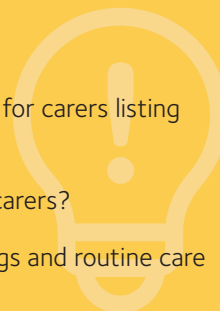
On average only a quarter of eligible carers are taking up CESP.

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?



Outcome indicator

For people with FEP, two or more clinical outcome measures (DIALOG, other) should be recorded at least twice, once on assessment and one other time point. DIALOG (73%) was the most reported measure (36% of people had this at least once) followed by the Positive and Negative Syndrome Scale (PANSS) (39%) and the Clinical Outcomes in Routine Evaluation- 10 item (CORE-10) (19%). For a full breakdown of all other outcome measures please see appendix D⁵.

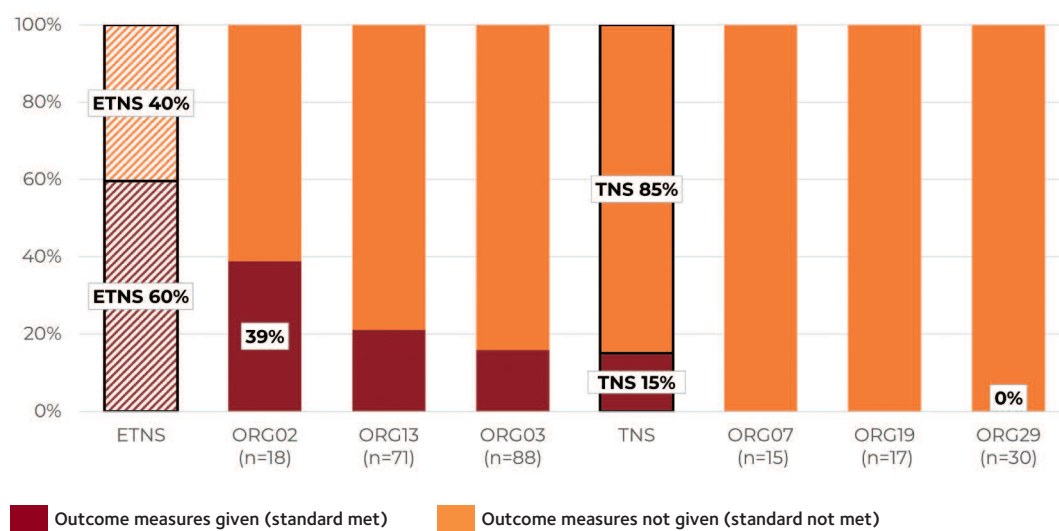


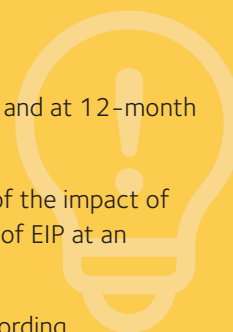
Figure 12. Proportion of people with FEP with clinical outcome measurement data recorded at least twice (n=239)

WHAT THIS MEANS

There are 3 Health Boards where no one with FEP had two or more outcome measures recorded at least twice.

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?



⁵ Data for this standard in England included for comparison in figure 12 included nationally mandated outcome measures; HoNOS, HoNOSCA, DIALOG and QPR.

5. Health inequalities

This section of the report looks at disparities in EIP care between different groups of people with FEP to highlight inequalities and to guide EIP services in addressing them⁶. The audit highlighted that:

- 5/6 teams still do not have a written strategy to identify and address mental health inequalities.
- 5/6 teams do not provide EIP services to those aged 36 and over.

The audit reports findings on the provision of EIP care for over 35s however, we acknowledge that Wales EIP policy guidance does not specifically identify the need for EIP services to be commissioned for this age group.

Age

Length of EIP treatment packages

Those aged 36 and over have an average EIP treatment length of 6 months which is considerably shorter than younger age groups who have an average length of 36 months.

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). Most teams do not provide CBT for ARMS either within or outside the team across all age groups.

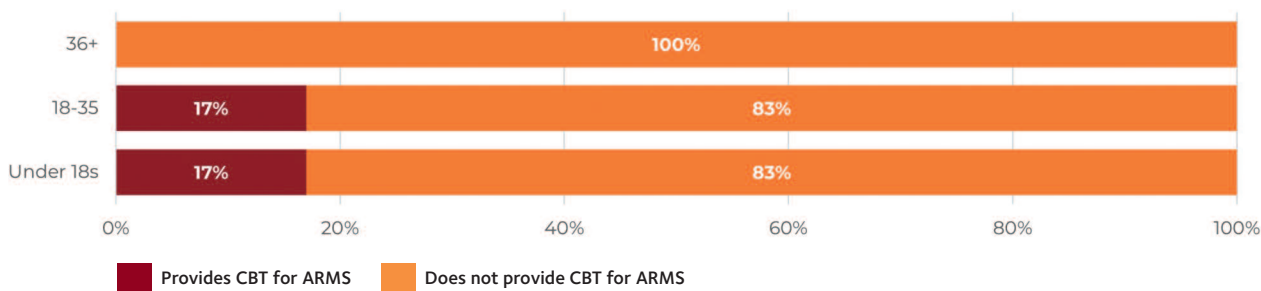


Figure 13. Proportion of teams that provide cognitive behavioural therapy (CBT) for At-Risk Mental States (ARMS), either within or outside the team, in different age groups (n=6)

CBTp and FI for CYP

Half of teams still do not have access to CBTp and nearly a fifth of teams do not have access to FI for CYP.

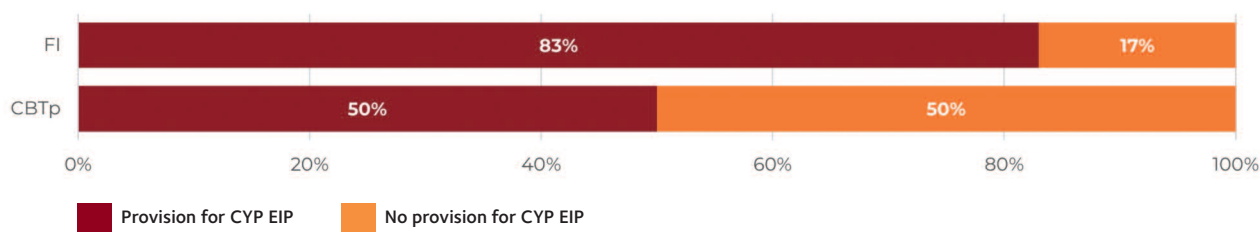


Figure 14. Proportion of teams that provide cognitive behavioural therapy for psychosis (CBTp) and family intervention (FI) for children and young people under 18 (CYP), either within or outside the team (n=6)

⁶ Statistical analyses were performed on each standard to identify any existing inequalities. There were no significant differences in relation to gender and due to small sample sizes, we were unable to draw accurate conclusions in relation to age and ethnicity.

8. Recommendations

1. Screen and intervene

EIP teams should review physical health processes to ensure people are screened and relevant interventions are offered where required as this is a health and safety issue.

2. Think Family

EIP teams should develop quality improvement activities to understand the barriers for people with first episode psychosis (FEP) and their families/carers to engaging 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 repeated and not a single event.

3. Equitable access

Health Boards should review local and national data to develop a strategy to identify and address mental health inequalities in access to or uptake of interventions for people with FEP and to ensure equitable access to EIP care.

Welsh Government should review EIP policies in relation to:

- Improving access and waiting times.
- Addressing unmet need in areas where there is no EIP provision, or no EIP provision for specific age groups.
- Addressing shortfalls in EIP provision and CBT for ARMS.
- Sharing learning and good practice between high and low performing Health Boards within regional networks and identifying areas for local quality improvement to redress disparities in provision by postcode.

4. Outcomes focused

EIP teams should use FEP outcome measurements in care planning and reviews to assess progress in achieving treatment goals and experience of EIP care for all individuals on caseload as well as using routine outcome data to demonstrate EIP team outcomes.

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