

State of the Nation Report 2026

Reducing variation and
improving access to
early intervention in
psychosis (EIP) services
in England and Wales

This report details routine
data provided from
England (March 2023 to
February 2026) and Wales
(May 2023 to April 2026)



About the NCAP

The National Clinical Audit of Psychosis (NCAP) is commissioned by the **Healthcare Quality Improvement Partnership (HQIP)** and funded by NHS England and the Welsh Government as part of the **National Clinical Audit and Patient Outcomes Programme**.



Cover image: 'Gestures in two halves' by Tamara.

"This painting explores two figures. It shows intimacy, estrangement, curiosity and apathy. Gesture becomes language where words fail. This painting invites the viewer to witness a connection that is felt more than understood. Forms dissolve into colour, faces fractured, bodies reimagined."

The artwork featured on this report was selected through an NCAP artwork competition, with members of the SUCRG voting for their favourite piece.

October 2026

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We have been supporting the NCAP audit since 2021 to bring lived experience expertise into the process. This ensures clinical knowledge combines with lived and living experiences from service user and carer perspectives. Our new group bring a wealth of expertise and have helped shaped this report.

Vanessa Pinfold, McPin



Acknowledgements

This report was developed collaboratively by the NCAP programme team at the Royal College of Psychiatrists, together with NCAP clinical advisors, the NCAP lived experience advisor, and representatives from the Service User Carer Reference Group (SUCRG).

We would also like to thank the NCAP steering group for their ongoing advice, guidance and support throughout the development of the audit programme.

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Data can show variation in EIP care and outcomes, but it does not always capture how care is experienced by the people who use services. The NCAP SUCRG helps interpret findings, identify issues that may otherwise be overlooked, and highlight the aspects of care and recovery that matter most to service users and carers. Their contribution complements audit data and clinical expertise, helping to place findings in the context of people's experiences of accessing, receiving and benefiting from EIP care.

Partnerships

NCAP works in partnership with the McPin Foundation to support the involvement of people with lived experience in the audit programme. This ensures that lived experience perspectives inform the audit and its outputs.

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Key messages



1. Access varies depending on where you live

Access to NICE-recommended interventions for psychosis varies widely across England and Wales. This means people's care still depends on where they live.



2. Inequalities in care persist

People's access to care for psychosis differs by ethnicity, age, gender and deprivation. People from Black and Black British backgrounds are less likely to receive key interventions such as cognitive behavioural therapy for psychosis (CBTp), family intervention and carer support.



3. Young people may not be accessing EIP services early enough

Very few people in EIP services are under-18. Almost one quarter of teams had no under-18s on their caseload, raising concerns about whether young people are being identified and getting the right care early enough.



4. Gaps in data limit what we can understand (England only)

Routine data provides a broader and more timely view of EIP services. However, missing or incomplete data still limits understanding of care delivery and inequalities.



5. Relationships matter for recovery

Improving access to care is essential, but equal access does not always translate into equal opportunities for recovery. People with lived experience emphasise the importance of trusting relationships, particularly with care coordinators, alongside peer support, social activities, meaningful involvement, and care that feels personalised. These factors help people make the most of available treatments and support positive outcomes.

Recommendations for EIP care



1. Reduce unwarranted variation in EIP care

Department of Health and Social Care (DHSC), Local Health Boards¹, commissioners and providers should support EIP services identified as requiring improvement. This includes addressing workforce capacity, service configuration, equitable access, and local barriers to delivery of NICE-recommended interventions.



2. Reduce inequalities in access and outcomes

Commissioners should ensure providers of EIP services routinely monitor access and outcomes by ethnicity, age, gender and deprivation and take targeted action where inequalities are identified. Particular attention should be given to children and young people. This includes improving referral pathways and transitions to ensure timely and equitable access to evidence-based EIP care. Providers should refer to existing national guidance on reducing health inequalities, including [NHS England Core20PLUS5](#).



3. Improve the quality and completeness of routine data

DHSC and Local Health Boards¹ should improve the completeness and



4. Establish clear leadership and accountability for EIP care

Each Integrated Care Board (ICB) in England and Health Board in Wales should identify a named lead responsible for implementing EIP standards and recommendations and improving coordination across services. This role should work across organisational boundaries to ensure consistent and equitable access to care in line with national specifications and quality standards.



5. Help people make the most of support

Commissioners should support providers of EIP services to strengthen connection and sustain engagement for the duration of EIP care. This includes recognising that people may face different barriers to accessing support depending on their age, ethnicity, culture, and personal circumstances. EIP services should adapt support to meet individual needs in all communities.

¹ Local Health Boards are the NHS organisations responsible for planning and delivering healthcare services in Wales.

About the audit

Early Intervention in Psychosis (EIP) services support people experiencing first episode psychosis (FEP) and those with at-risk mental states (ARMS). Early access to specialist teams and the assertive delivery of recommended care are linked to better recovery, improved outcomes and safety.

NCAP assesses the quality of care provided by EIP services across England and Wales against NICE-recommended standards². These standards include timely access to care, psychological and psychosocial interventions, physical healthcare, support for families and carers, and outcome measurement.

This report provides a national overview of care delivery and highlights variation, inequalities and gaps in EIP care.



The disruptive nature of psychosis impacts every aspect of your life. And so, for me, recovery was less of a return to who I was before and rather finding a new path guided by the holistic nature of support offered by EIP. This holistic quality is difficult to show through routine data, but it's deeply significant and worth reflecting in how we measure what good care looks like.

Ty, former EIP service user, North London



² NCAP standards are derived from the EIP Access and waiting time standard and NICE Quality Standards QS80 and QS102.

About the data



This report uses routinely collected data from EIP services across England and Wales.



England

English data are drawn from the Mental Health Services Dataset (MHSDS), with the most recent data taken from the **February 2026 performance month**.



Wales

Wales routine data are submitted directly to NCAP through the routine audit pathway, with analysis based on the most recent submission available (April 2026).

The cohort includes people aged 14–65 with suspected FEP or ARMS who had been on an EIP caseload for at least one year.

The dataset includes:

- **15,370 people** from **149 teams** across **49 Trusts** in England.
- **293 people** across **7 Health Boards** in Wales.

Data is collected differently in England and Wales. This should be considered when comparing results.

In England, data completeness and recording remain variable within the MHSDS. **Lower audit performance may therefore reflect gaps in data recording or data flow rather than the absence of care delivery.** These limitations are particularly relevant for areas such as clozapine and physical healthcare, where activity may be documented locally but not consistently captured within national datasets. NCAP transitioned from bespoke audit³ data collection to routine data reporting in 2025 and, as a result, **performance against standards is not directly comparable with previous audits.**

Further information about the audit methodology is available on the [NCAP website](#) and within the [UPCARE tool](#).

³ The bespoke audit involved a review of a sample of casenotes submitted by participating EIP services. Information was collected directly for the audit rather than through routine data sources.

Demographic profile of the cohort



The demographic profile of people receiving EIP care provides important context for understanding variation and inequalities in access to care.

- **58% of the cohort are male**, consistent with the bespoke 2024 audit and reflective of what is already known about who is most likely to experience psychosis.
- **44% live in the most deprived quartile** (England only⁴), highlighting the important role EIP services play in supporting those living in deprived areas.
- **The cohort is ethnically diverse**, with 53% White, 13% Black/Black British, 10% Asian/Asian British, 8% other ethnic groups and 6% mixed ethnicity.

Compared to the bespoke 2024 audit, the proportion of white people has decreased from 61% to 53%, with corresponding increases across other ethnic groups. This shows that EIP services are supporting a diverse population and highlights the importance of equitable, culturally appropriate care, particularly given the inequalities in delivery identified later in this report.

Wales has a higher proportion of white people receiving EIP care (73% vs 53% in England), while England showed greater ethnic diversity within its cohort, likely reflecting broader population differences.

Service context and distribution

- **London accounts for the largest proportion of the cohort (23%)**, consistent with the bespoke 2024 audit. This proportion is higher than would be expected based on population size alone, suggesting that the need for, or use of, EIP services may be greater in London than elsewhere in England.
- **The regional distribution of EIP caseloads remains broadly unchanged from 2024**, suggesting that the geographic spread of EIP provision is stable over time.

Larger caseloads were associated with lower delivery of several key interventions (including family intervention, supported education and employment and carer support), independent of patient characteristics, suggesting that capacity differences may contribute to variation in care. In contrast, there was no evidence of an association between caseload size and CBTp delivery.

Analysis of variation indicates that while most differences in care are driven by patient characteristics such as age, gender, ethnicity, and socioeconomic deprivation, a notable proportion is attributable to differences between teams and Trusts/Health Boards, suggesting that where a person receives care continues to influence access to interventions.

Further details are available in the [supplementary analysis](#).

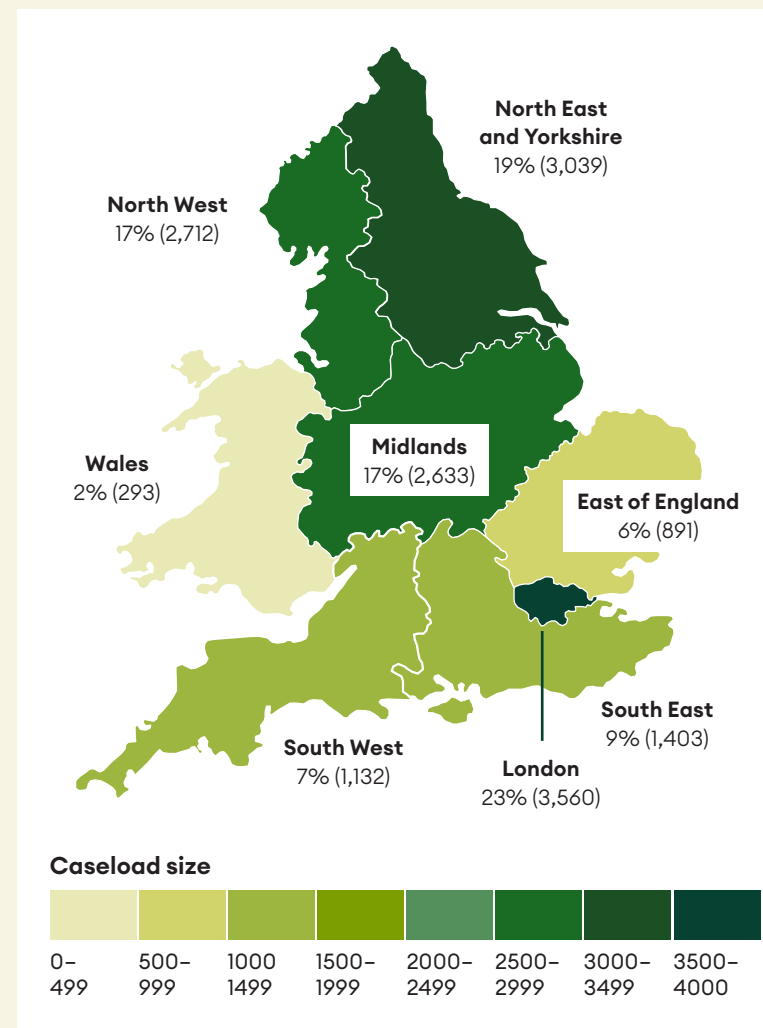


Figure 1. Heatmap showing the regional distribution of people receiving EIP care across England and Wales.

⁴ Index of Multiple Deprivation (IMD) data is not currently available within the Welsh routine audit data.



We have emerging data on inequalities and demography for under-18s and the ARMS pathway. But I would like to see more around length of untreated psychosis and the factors that contribute to this such as stigma, uninformed families, regional variations in services, GPs, schools, universities and the judicial system.

Ros Savege,
a carer from York

Age distribution

The age profile of people receiving EIP care has important implications for the delivery of early intervention. Most people are aged 18–35, with very few aged under-18 in both nations.

Across England and Wales:

- Only 3% were under-18
- 61% were aged 18–35
- 35% aged 36 and over

The age profile is **similar to previous audits** and reflects what is already known about people who develop psychosis.⁵ This suggests that limited access for under-18s is a persistent feature of EIP provision rather than a new trend.

Only around a quarter of the cohort were aged 22 and under, while a substantial proportion were aged above this range (Figure 2).

The regional distribution of under-18s varied substantially, with regions accounting for between 4% and 31% of the national under-18 cohort. North East and Yorkshire accounted for the largest proportion (31%). This suggests differences in how young people are identified, referred, and supported by services.

Wales had a markedly lower proportion of people aged 36 and over compared with England (2% vs 36%), although the number of people included from Wales was small (293 people).

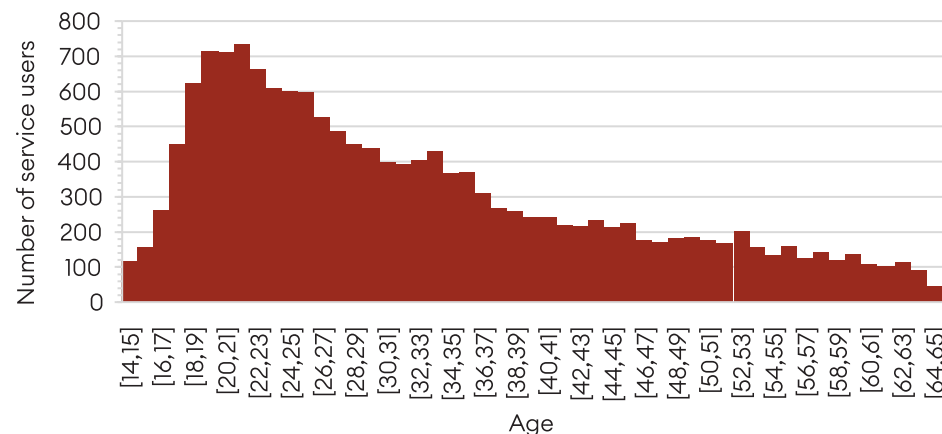


Figure 2. Age distribution of people receiving EIP care in England and Wales.

Are young people reaching EIP services early enough?

EIP services are designed to intervene early in the course of psychosis, particularly in adolescence and early adulthood. However, the national age profile suggests differences in how this care is received by younger people depending on where they live. Almost one quarter of teams had no under-18s on their caseload, and more than a third of service users are aged 36 and over. Access for younger people varied substantially between regions and services. While the number of under-18s included is an improvement compared with previous bespoke audits, in which around 40% of teams reported no cases under-18, a substantial proportion of teams still have no younger people in their care.

Together, these findings indicate that some children and young people experiencing psychosis may not be identified or be getting evidence-based EIP care in a dedicated service.⁶

Working age adults account for the majority of those receiving care, particularly in England. While EIP services support people across a broad age range, these findings raise questions about whether opportunities for earlier intervention may be missed. Without timely access to specialist support, opportunities for improved long-term outcomes may be reduced.

⁵ PsyMaptic data shows that 64% of people receiving EIP care are aged 16–35 and 36% are aged 36–64. NCAP data show a similar pattern when aligned to the same age groups (63% and 36% respectively) with a small proportion (1.1%) aged 14–16 or 65.

⁶ See Jones, P. B. (2013). Adult mental health disorders and their age at onset. *British Journal of Psychiatry*, 202(s54), s5–s10. doi:10.1192/bjp.bp.112.119164, Figure 1: Distribution of age at onset (as percentage of the whole sample, with being mean age in years) of schizophrenia (broad definition, ICD-9 codes. 295, 297, 298.3, 298.4).

National overview across standards

This section explains some of the factors that may affect how audit results are recorded and interpreted. This information helps to provide context to understand the findings of this report.

Results from routine data show lower recorded performance against the standards than those from the **2024 bespoke audit**, particularly in England. This mainly reflects differences in methodology, data recording and completeness rather than a reduction in care. Differences in data capture between England and Wales should also be considered when interpreting these findings.

The gap in performance between bespoke and routine audit results varied across standards and appears strongly influenced by how easily standards can be captured through routine national data.



Timely access has historically been collected through routine national data and is therefore comparatively well populated. Performance in this dataset appears lower than national statistics. This likely reflects differences in cohort selection and reporting at the team rather than the provider level, although a change in performance cannot be ruled out. Wider system pressures may also influence timely access, although this is not directly measured here.



Family intervention, CBTp, carer support and supported education and employment standards can each be identified using one SNOMED code.



The **clozapine** standard requires information about previous antipsychotic prescribing, which is not currently recorded within the MHSDS. Medication data is often recorded locally.



Physical health standards require multiple SNOMED codes across assessment, outcome recording and intervention stages, with some activity documented locally but not consistently flowing into MHSDS.



The **outcome measurement** standard requires two outcome measures to be recorded at two separate timepoints. This creates multiple opportunities for incomplete recording and may contribute to differences between bespoke and routine audit results.

Some standards are therefore not directly comparable with previous bespoke audits because routine national data does not currently capture all elements of the original standards.



As expected, in England, the largest differences between bespoke and routine data were seen for physical health measures and clozapine. There were also substantial differences in the recording of outcome measures across England and Wales.

Wales routine data generally reported higher levels of recorded activity across several standards, particularly for physical healthcare and clozapine. This reflects differences in data collection methods, with Wales submitting data directly through the NCAP audit pathway.

While improvements in data quality were anticipated following the introduction of SNOMED coding guidance, it is likely too early to see a consistent impact across national datasets.

NCAP quality improvement collaboratives

Some findings may reflect the impact of targeted quality improvement (QI) activity delivered through NCAP collaboratives.

Family intervention was the only routine data measure in England that showed higher levels of delivery than the equivalent bespoke audit measure. This may reflect sustained QI work undertaken through NCAP's second quality improvement collaborative during 2024–25, which focused on improving the recording and delivery of family intervention across EIP services.⁷

In early 2026, NCAP launched its **third QI collaborative** to support improvements in data recording, coding and data flow across EIP services. This work focuses on improving the quality and consistency of routine national data, particularly in areas where care may be recorded locally but not consistently captured within national datasets. Learning from this collaborative is expected to support wider improvement across EIP services.

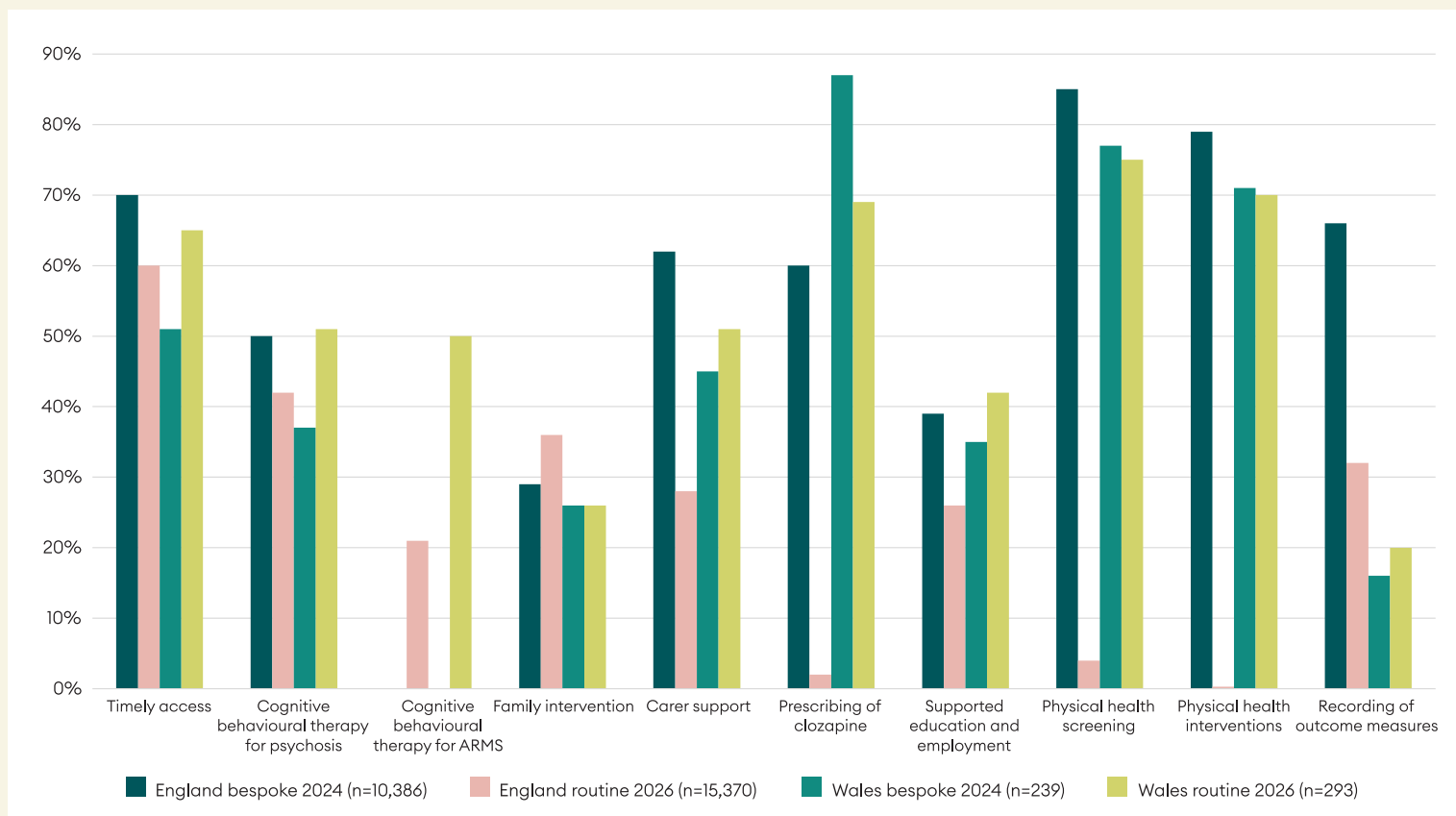


Figure 3. Comparison of performance between the bespoke 2024 and routine 2026 data in England and Wales.

Detailed definitions and specifications for all standards reported in this audit are available in the [NCAP Sampling Guidance and Eligibility Criteria document](#).



Reflecting the impact of the NCAP QI collaborative one participating service lead noted:



There has been a shift in culture around family intervention. We now regularly discuss the benefits in team meetings, and more staff are offering it as part of routine EIP care.



⁷ Routine data currently uses a proxy measure for family intervention and results are therefore not directly comparable with the original bespoke audit standard.

Health inequalities



Inequalities in access to NICE-recommended interventions were evident across gender, age, ethnicity and socioeconomic deprivation. Findings presented below focus on areas where statistically significant differences were identified between groups.

Further details on the significance analysis are available in the [supplementary analysis](#).

These findings reflect recorded delivery of care within routine data and should be interpreted with caution. Incomplete or inconsistent recording may underestimate delivery in some areas and should be considered when interpreting differences between groups.



Age

Delivery of interventions differed across age groups.

- Younger people (under 35) were more likely to receive interventions than people aged 36 and over. This included family intervention, supported education and employment, and carer support.

Outcome recording shows the opposite pattern.

- Outcome measures are more consistently recorded for people aged 36 and over (37%).
- Younger people, particularly under-18s, are less likely to have outcome measures recorded (21%).

These findings highlight the importance of understanding age-related differences in access to EIP interventions and ensuring that care remains equitable across all age groups.

Further detail, including full results across all standards is available in the [supplementary analysis](#).



Gender

- Males are less likely than females to receive CBTp (40% vs 47%)
- No consistent differences were observed across other interventions



For me, recovery was not a return to how things were before, but a process of rebuilding myself. The kindness and encouragement of my employment specialist enabled me to advocate for myself to receive the help and adjustments I needed go back to work safely, while managing my health. This gave me the chance to find a work environment where I could thrive. I believe this is what every EIP service user deserves.

Ally, former EIP service user, Brighton

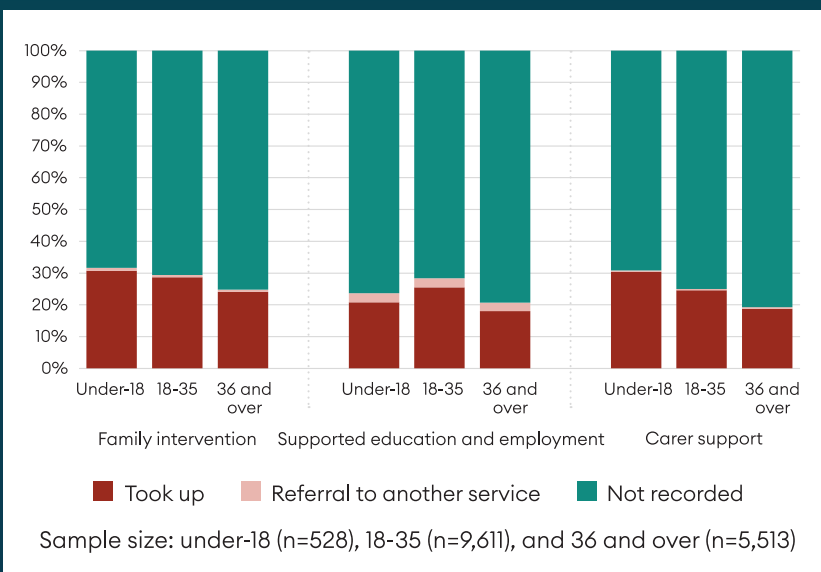


Figure 4. Comparison of selected psychosocial interventions by age group.



Consistent inequalities in the data for the treatment of black people highlight systemic problems around race. Meaningful action on staff diversity could help, as it makes a real difference when your care team can relate to your experiences, and even the first step of engaging with services can be easier when you feel accepted.

Ty, former EIP service user, North London



Ethnicity

Across England and Wales, 89% of cases had recorded ethnicity information. Clear differences in delivery of NICE-recommended interventions were evident across ethnic groups.⁸

- People from Black or Black British backgrounds were less likely to receive CBTp (39%), family intervention (23%), and carer support (18%).
- People from Asian or Asian British backgrounds were more likely to receive CBTp (50%), family intervention (26%), and carer support (27%).
- People from White backgrounds were more likely to receive family intervention (29%) and carer support (24%).

Recording of outcome measures also differed by ethnic groups.

- People from Black or Black British and Asian or Asian British groups were less likely to have two outcome measures recorded at two timepoints (25% and 29% respectively).
- People from White backgrounds were more likely to have this recorded (37%).

These findings indicate that access to and engagement with interventions are not experienced equally across all ethnic groups.



Socioeconomic deprivation (IMD – England only)

People living in the most deprived areas were less likely to receive:

- CBTp (39% vs 48% in the least deprived areas).
- Family intervention (23% vs 35% in the least deprived areas).
- Carer support (21% vs 25% in the least deprived areas).

Outcome recording also varied by deprivation:

- People in the most deprived areas were less likely to have two outcome measures recorded at two timepoints (29% vs 38% in the least deprived areas).

Taken together, these findings suggest that people in the most deprived areas may experience consistently lower access to several aspects of care, highlighting a potential inequity in delivery.

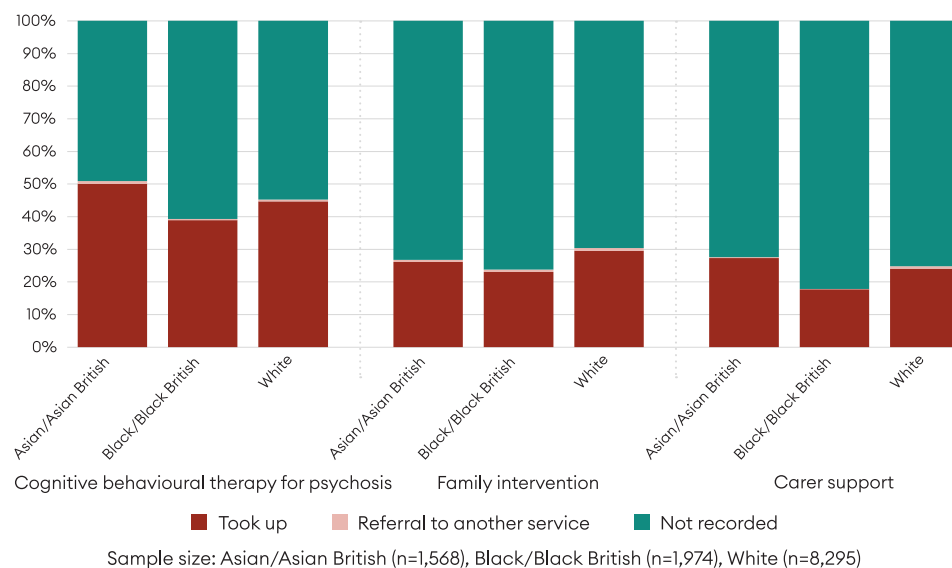


Figure 5. Delivery of CBTp, family intervention, and carer support by ethnic groups flagged in significance testing.

⁸ These findings relate to aggregated ethnic groups and may mask variation within individual communities.

Regional variation

Performance against NCAP standards varied substantially across regions in England and Wales.⁹

- The widest regional differences were seen in interventions such as family intervention, supported education and employment and carer support.
- Some regions consistently reported higher levels of recorded activity across multiple standards, including East of England and Wales, while others reported lower levels across several areas of care, including North East and Yorkshire.

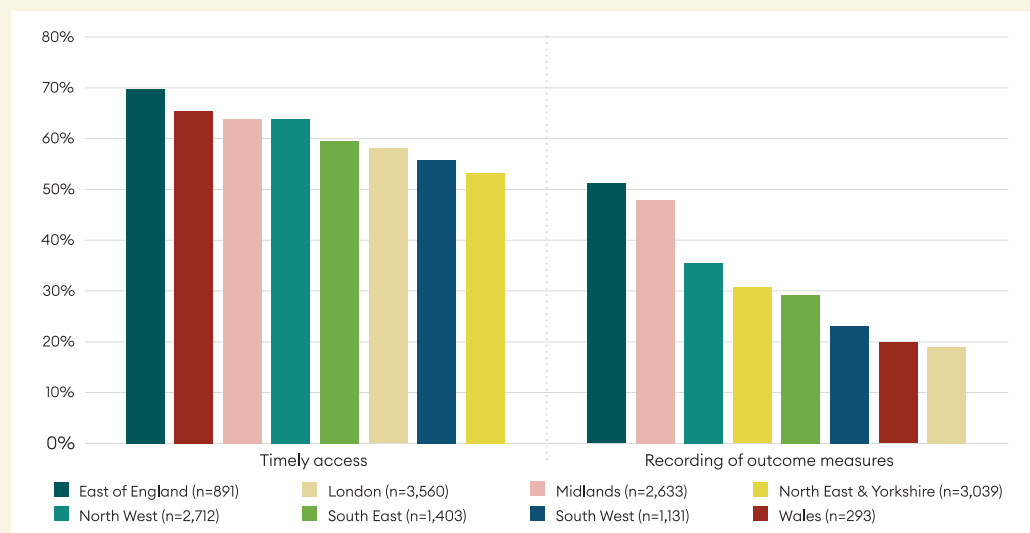


Figure 7. Standard performance by region: timely access and outcome measures.

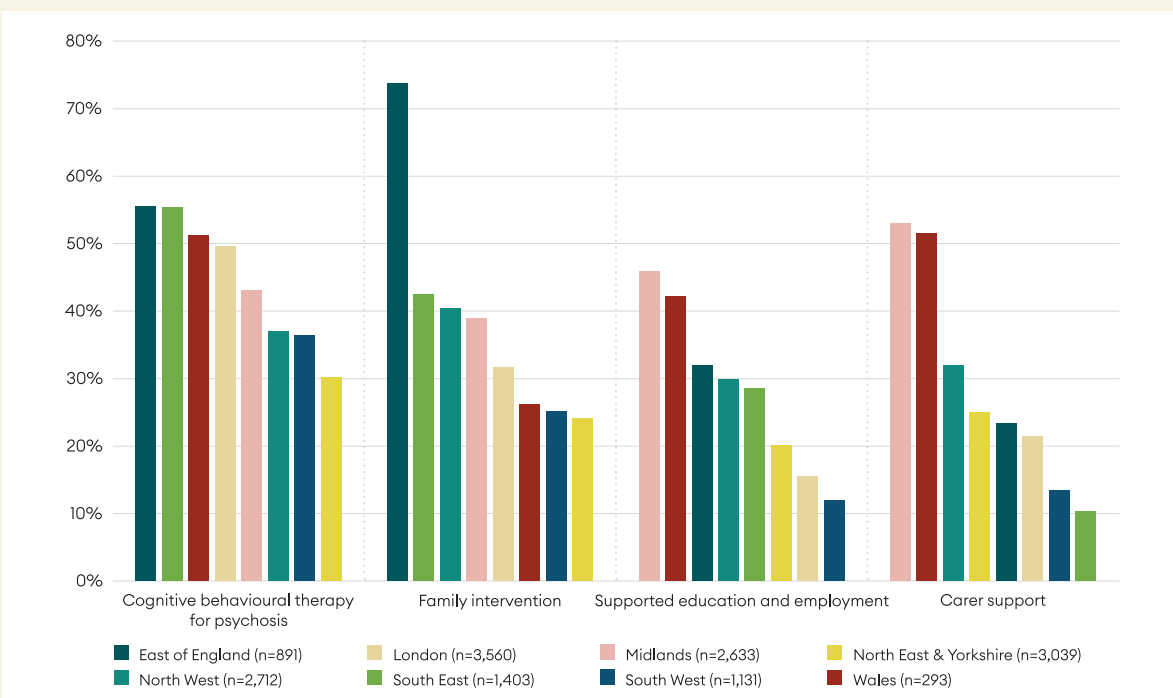


Figure 6. Standard performance by region for psychosocial interventions.

Family intervention provides one of the clearest examples of regional variation. Delivery ranged from 24% in the North East and Yorkshire to 74% in the East of England.

Lower recorded activity in England should be interpreted in the context of known limitations in routine national data recording. Despite this, the findings suggest that access to recommended EIP support continues to be influenced by where people live.

Having used several EIP services across England, I observed considerable regional variation. Access to CBTp, cultural competence and the value placed on lived experience varied significantly between services. Consistently, psychoeducation felt limited – often leaflets and signposting instead of personalised and engaging work – reducing service-user agency and capacity for informed decision-making.

Dr. K. Lawrence, Former EIP Service User, England

⁹ Clozapine and physical health haven't been included in the standard performance figures due to the data quality issues across England. All regions are performing poorly, except for Wales, which can be seen in Figure 3.

Physical healthcare

Physical health is an important part of EIP care. The data showed substantial differences between England and Wales, although these are largely reflective of differences in data recording and reporting systems rather than differences in care provided. These differences were not seen in previous audits using bespoke data.

- England showed substantially lower recorded physical healthcare activity, particularly for recording outcomes of assessments (1–8%).
- Wales showed consistently high recording across all stages of physical healthcare assessment, outcome recording and intervention (74–90%).

Recording is the main gap:

- The outcome of the assessment records important information, including smoking status, alcohol use, substance misuse, BMI, blood pressure, glucose, and cholesterol. This information helps determine whether an intervention or follow-up care is needed.
- Outcome recording was consistently lower than screening activity in England.

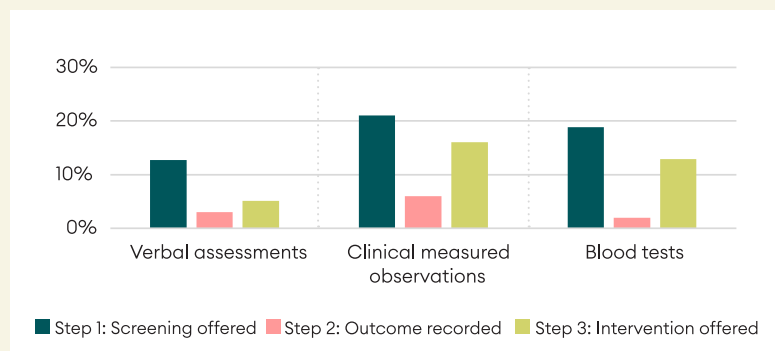


Figure 8. Physical healthcare screening, outcome recording, and intervention completion rates in England (n=15370).

¹⁰ The seven physical health assessments have been grouped as follows: verbal assessments include smoking, alcohol, and substance misuse; clinically measured observations include blood pressure and BMI; and blood tests include glucose and cholesterol.



Evidence of missing data in England:

- Intervention recording rates were sometimes higher than outcome recording rates.
- This suggests that care is being delivered but not consistently recorded in national data.

Differences reflect data systems:

- In England, physical healthcare data is often recorded across multiple local systems that do not consistently flow into national datasets.
- In Wales, direct submission through the NCAP audit pathway allows for more complete and consistent recording.

Improving data completeness and integration between local and national systems is essential to strengthen national understanding of physical healthcare delivery in EIP services.

Figures 8 and 9 show the average percentage of completion across all 7 health screenings¹⁰ for each step of the physical health check in England and Wales.

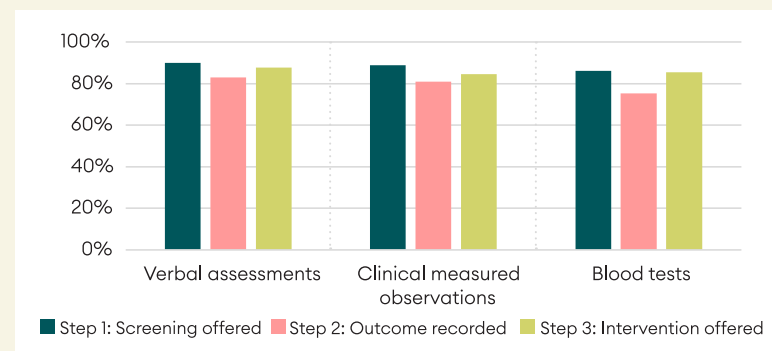


Figure 9. Physical healthcare screening, outcome recording, and intervention completion rates in Wales (n=293).



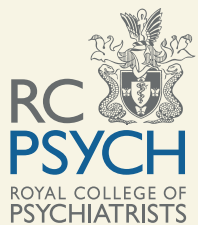
Physical health is a major factor in recovery. Given that life expectancy for those with a Severe Mental Illness diagnosis is 15 years lower than average, this is a serious issue. However, for many people, physical and mental health do not feel like separate issues. Medication side effects, symptoms, sleep, motivation, confidence, habits, metabolism, physical activity are entangled in lived experience.

Everyone knows about the benefits of exercise and the risks of obesity. However, when medication leaves you with insatiable appetite, sedation, and suppressed sense of reward (from activities), generic fitness advice can feel unrealistic and shaming.

For most of us, our experiences of physical healthcare felt siloed and generic. Some even had their concerns dismissed by professionals, leading them to seek medication support outside the system. We are aware of efforts in recent years to integrate more physical care into EIP teams. We want to underline the importance of this and emphasise that for it to be effective this needs to be patient-centred.

SUCRG





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