AEIP
EARLY INTERVENTION IN PSYCHOSIS AUDIT

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Report of the Early Intervention in Psychosis audit

HQIP
Healthcare Quality Improvement Partnership

NHS England

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The report of the Early Intervention in Psychosis Audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. 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, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP holds the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising more than 30 clinical audits that cover 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 audits, also funded by the Health Department of the Scottish Government, DHSSPS Northern Ireland and the Channel Islands.

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Executive summary

Background

Improving access to evidence-based care for people with first episode psychosis is a national priority. A new Access and Waiting Time Standard has been set and additional funding has been made available to deliver better services. As part of this initiative, NHS England commissioned an audit to establish a baseline position regarding services' ability to provide timely access to NICE recommended interventions across England.

Method

All NHS mental health providers in England with a specialist Early Intervention in Psychosis (EIP) service were expected to take part in the audit. Providers were asked to submit retrospective data on a sample of up to 100 patients accepted onto the caseload of EIP services between 30/06/2014 and 31/12/2014 and the treatment they received over the following six months. They were also asked to provide service-level information for each of their EIP teams.

Response rate

Fifty-five providers submitted data on 144 EIP teams (range 1-7, median 2 teams per provider).

Fifty-four providers, and 135 EIP teams submitted data on 2,833 patients for patient-level audit. Seventy-two cases were ineligible therefore the analysis was carried out on 2,761 patients (range 11-100, median 52 patients per provider).

Key findings

Performance against standards nationally and the variation in performance across trusts are presented in the table below.

Standard	% of patients where the standard was met	% range of provider performance
Standard 1– Allocation and engagement*		
Patients with first episode or suspected psychosis allocated and engaged within 2 weeks	33%	4% - 82%
Patients with first episode or suspected psychosis allocated and engaged but not within 2 weeks	62%	14% - 96%
Patients with first episode or suspected psychosis not engaged	5%	0% - 48%
Standard 2 – Cognitive Behavioural Therapy for psychosis (CBTp)		
Patients with first episode or suspected psychosis are offered CBTp	41%	0% - 88%
Standard 3 – Family Intervention (FI)		
FI is offered to those in contact with their families	31%	0% - 100%
Standard 4 – Clozapine prescribing		
Clozapine is prescribed to patients for whom this treatment is indicated (or valid reason is given for not prescribing clozapine)	36%	0% - 100%
Standard 5 – Offer of supported employment programmes		
Patients looking for work are offered supported employment programmes	63%	0% - 100%
Standards 6 – Physical health assessment		
Screening is offered for all seven physical health measures	22%	0% - 82%
Standard 7 – Physical health interventions		
All interventions are offered where required	13%	0% - 64%
Standard 8 – Carer-focused educational and support programmes		
Carers are offered support programmes	50%	0% - 90%

These standards are derived from the NICE quality standard for the care of people with psychosis and schizophrenia in adults 2015 (QS80)

**Expected to be achieved for more than 50% of patients by April 2016, see page 39 for further details*

Discussion

Participation in the audit was excellent with 55 (98%) of 56 eligible providers in England providing some data, showing considerable variation in performance across the country. The audit found that EIP services were able to successfully engage most people referred to them, but only a third of those with first episode or suspected psychosis were engaged within the two week target period.

The extent to which services were able to deliver evidence-based psychological and medical treatments varied considerably across providers. Levels of screening and intervening for physical health problems at the time when audit data were collected fell well below nationally agreed standards of care; so too did the provision of Family Intervention (FI), Cognitive Behavioural Therapy for Psychosis (CBTp) and Individual Placement and Support programmes (IPS).

These data are based on information extracted by services retrospectively, during a time that services were preparing for standard implementation, from written and electronic records and do not reflect interventions and treatments that were delivered but not documented. They detail how services were performing in 2014/15 and do not account for improvements that may have taken place since this time.

Conclusions

Most people in England assessed as having first episode psychosis waited more than two weeks before they were allocated to and engaged by an EIP care coordinator. Marked variation across the country shows that commencement of engagement within two weeks of referral is possible. These findings also highlight areas where change is most needed to bring the treatment that people with first episode psychosis receive in line with nationally agreed standards of care, specifically the need to improve physical health screening and intervention and patients' access to psychological treatments (CBTp and FI) in keeping with NICE standards of care.

Recommendations

- Results of this audit show marked variation in access and waiting times for EIP services across England. Clinical teams should use local networks and the new EIP Network to share good practice and implement changes needed to increase the proportion of people who are engaged with services within a two week period.

- Data from this audit show that most patients do not have documented evidence that recommended screening and interventions for common physical health problems have been used. EIP services should familiarise themselves with good practice guidelines on physical health. A Toolkit published by NHS England and the Department of Health has been designed to help services improve the quality of physical health care they provide.

- Employment support services were not available to patients in approximately a fifth of teams. Providers must make sure they are able to offer supported employment programmes in line with NICE QS80. NICE guidelines emphasise the evidence-based programme of Individual Placement and Support (IPS) which is also recommended in the Mental Health Taskforce (MHTF) report. Providers must develop their provision of this type of evidence-based programme and further information can be found on the Centre for Mental Helath IPS webpage.

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Context

The Early Intervention in Psychosis (EIP) access and waiting time standard requires that, from 1 April 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved package of care within two weeks of referral.

Both elements of the standard (referral to engagement waiting time and treatment delivered in according with NICE guidelines and quality standards for psychosis and schizophrenia) must be met for the standard to be deemed to have been achieved.

This audit aimed to establish a baseline position regarding services' ability to provide timely access to the full range of interventions recommended by NICE (delivered by fully trained, qualified and supervised practitioners) in line with local demand.

In addition, all EIP services will be expected to participate in a quality assessment and improvement programme, organised and administered by the College Centre for Quality Improvement (CCQI). This will include a framework, performance assessment scale, and self-assessment tool, which all EIP services will need to complete and submit. CCQI will use the framework and self-assessment tool submissions to conduct an independent review of performance in all local EIP teams during 2016/17, and this will continue on an annual cycle to enable transparent tracking of process.

Methodology

Standards development

Patient-level audit

The audit specification was developed in collaboration with a nationally-constituted EIP Expert Reference Group (ERG), organised and facilitated by the National Collaborating Centre for Mental Health.

The standards for the patient-level audit derive from the National Institute for Health and Care Excellence (NICE) quality statements for psychosis and schizophrenia in adults 2015 (QS80) and can be found in table 2. It is acknowledged that this audit has used the NICE quality standard for psychosis and schizophrenia in adults as its focus. When the audit specification was developed and audit commissioned, the bipolar, psychosis and schizophrenia quality standard for children and young people was not finalised or published.

Assessment of compliance with standard 1 (patients with a first episode of psychosis allocated to and engaged by and EIP care coordinator within 2 weeks of referral) was based on information from NHS England on the referral to treatment waiting time pathway, linked to guidance published in February 2015.[1] The clock for the two-week pathway starts when a referral has been flagged as 'suspected first episode psychosis' or is recognised as such upon receipt. Referrals would usually be made to a central triage point ('single point of access') or directly to an EIP service. The clock starts on referral to the central triage point, unless the EIP service accepts referrals directly. The clock stops when, following assessment, the patient is:

1) Accepted onto the caseload of an EIP service
2) Allocated to and engaged by an EIP care coordinator (Engaged by an EIP care coordinator means that the care coordinator attempted to form a

[1] https://www.england.nhs.uk/2015/02/mh-standards/

therapeutic professional relationship with the patient and offered treatment to them) (NICE and NHS England, 2016).

Assessment of compliance with standard 7 (Patients are offered relevant interventions for their physical health for the following measures: Smoking cessation, Harmful alcohol use, Substance misuse, Weight gain / obesity, Hypertension, Diabetes / high risk of diabetes, Dyslipidemia) was based on the Lester tool (see appendix C). This clinical resource, endorsed by NICE, provides a simple framework for identifying and treating cardiovascular and type 2 diabetes risks in patients with psychosis receiving antipsychotic medication (NICE, November 2015); and was the basis for indicator 4a of the Mental Health CQUIN 2015/16.

All other standards are taken from the NICE quality standard for psychosis and schizophrenia in adults 2015 (QS80).

Service-level audit

The service-level component of the audit looks at contextual data on service provision and staff training. The information gathered from services is therefore not standards-based, rather its purpose is to ascertain whether the team includes the appropriate skill mix and competencies to provide a NICE approved package of care and meet the NICE quality standards within the service. The measurements to achieve this were refined with advice from the ERG sub-group.

Audit tool development

Two audit tools were developed to collect data from participating providers. A patient-level audit tool and a service-level audit tool were agreed and developed to include all items necessary to measure adherence to the audit standards and outcome indicators. Patient data were to be collected from patient case notes, alongside any other patient information available to the clinical team; the

service-level data would in addition be available to services from their service specification.

NHS England provided a list of data requirements in the specification for the audit based on the NICE quality standard for psychosis and schizophrenia in adults (QS80) and aligned with current policy (NHS England (2015) Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16; Department of Health and NHS England (2014) Achieving Better Access to Mental Health Services by 2020; NICE clinical guideline: psychosis and schizophrenia in adults (CG178) (2014)).

Initial tools were developed based on these requirements by the EIP audit project team, drawing on audit tools designed by the National Adult of Schizophrenia (NAS) and the Commissioning for Quality and Innovation (CQUIN) audit programme. However, it was clear that to establish an appropriate consensus regarding the audit standards a range of different views would be required. Thus, a preliminary version of the tools was circulated to the ERG involved in informing and supporting development of the access and waiting time standard for comment, before a pilot phase was conducted in four providers (NICE and NHS England, 2016). Following the pilot, the tools were further refined in conjunction with members of the ERG.

Table 1: EIP audit standards

	Standard
Standard 1	Patients with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral[2]
Standard 2	Patients are offered Cognitive Behavioural Therapy for psychosis (CBTp)
Standard 3	Where patients are in contact with their families, family members are offered Family Intervention (FI)
Standard 4	Patients that have not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine
Standard 5	Patients who wish to find or return to work are offered supported employment and/or education programmes
Standard 6	Patients are offered a comprehensive physical health check, which includes the following measures: • Smoking status • Alcohol intake • Substance misuse • BMI or change in weight over a 3 month period • Blood pressure • Glucose • Cholesterol
Standard 7	Patients are offered relevant interventions for their physical health for the following measures: • Smoking cessation • Harmful alcohol use • Substance misuse • Weight gain / obesity • Hypertension • Diabetes / high risk of diabetes • Dyslipidemia
Standard 8	Carers receive focused education and support

Derived from the NICE quality standard for the care of people with psychosis and schizophrenia in adults 2015 (QS80)

[2] Accepted onto the caseload of an EIP service and allocated to and engaged by an EIP care coordinator. Engaged by an EIP care coordinator means that the care coordinator attempted to form a therapeutic professional relationship with the patient and offered treatment to them. (NICE and NHS England, 2016).

All NHS mental health providers in England with a specialist EIP service were expected to take part in the audit. The EIP audit team contacted each provider and invited them to nominate an EIP audit lead for their organisation and to register online, with details of each EIP team within their service.

Sampling

Patient-level audit

Participating providers were asked to generate a sample of all patients referred to EIP services who met the eligibility criteria for the audit. Unique codes were allocated by providers to each patient to maintain anonymity to the project team (see appendix B). It was not expected that many providers would have more than 100 patients for random sampling. All providers were instructed to return their anonymised sample to the EIP audit team if they found that they had more than 100 eligible patients. A sample of 100 patients was created and returned to such providers for data collection, stratified by the EIP audit team. Providers were given a guidance document on how to identify their sample, available on application.

Inclusion and exclusion criteria

Patients would be eligible for inclusion if they met the following criteria:

- aged 14 – 65 years
- accepted onto the caseload of EIP services between 30/06/2014 and 31/12/2014, receiving treatment at six months after this.

Patients were excluded from the sample generated by providers if they were experiencing psychotic symptoms due to an organic cause, for example brain disease such as Huntingdon's and Parkinson's disease, HIV, syphilis, dementia, or brain tumours or cysts as these patients would also be excluded from the access and waiting times standard cohort (NICE and NHS England, 2016).

The sample collected by providers included patients assessed as having first

episode or suspected psychosis, At Risk Mental State (ARMS) or another condition. The following definitions were provided:

First episode of psychosis (FEP): This relates to an individual experiencing clear symptoms of psychosis typically operationalised in terms of PANSS (Positive and Negative Syndrome Scale) as below.

- Experiencing 4 or above on the hallucinations OR delusions section of the PANSS, with other items on the positive section of the scale scoring 5 or above in the context of a cluster of symptoms.
- The symptom must have lasted throughout the day for several days or several times a week, not limited to a few brief moments.
- The above symptoms must be present for a period of over seven consecutive days duration over the last 12 months (or if less than this then the improvement must be attributable to antipsychotic treatment).

At Risk Mental State (ARMS): This relates to an individual who clearly does not have FEP or a suspected psychosis but has a significantly elevated risk of developing psychosis. Two subgroups specify state risk factors, defined by the presence of either transient psychotic symptoms, called brief limited intermittent psychotic symptoms, or attenuated (subclinical) psychotic symptoms. The other subgroup comprises trait plus state risk factors, operationally defined by the presence of diminished functioning plus either a first degree relative with a history of psychosis or a pre-existing schizotypal personality disorder. Symptom profiles are evaluated on the Comprehensive Assessment of at Risk Mental States (CAARMS).

Suspected psychosis: This relates to an uncertainty which requires assessment. An initial referral from a GP may refer on the basis of suspected psychosis and when assessed by a specialist EIP team they may be able to confirm that this is a case of FEP. However, it is also possible that the team require a more longitudinal assessment in order to fully understand the complexities of someone's presentation i.e. they suspect it may be psychosis but the confirmatory evidence or complexity of the case prevents a definitive FEP diagnosis being applied. When this happens the individual is typically placed on an extended assessment pathway for 3-6 months. Outcomes can be transfer to an FEP pathway, transfer to an ARMS pathway or discharge.

Service-level audit

Each provider was asked to complete one service-level tool per team.

Response rates

Service-level audit

Fifty-five providers submitted data for 144 EIP teams for the service-level audit (range 1-7, median 2 teams per provider). One provider which had registered to take part withdrew during data collection due to losing the tender to provide Early Intervention Services.

Patient-level audit

Fifty-four providers, and 135 EIP teams submitted data for 2,833 patients for this part of the audit. One provider for which service level data is included withdrew from the patient-level audit as a proportion of its teams did not complete data collection. Some cases were identified as ineligible hence the patient-level component of this report contains data on 2,761 patients (range 11-100, median 52 patients per provider).

The return rates for each provider are shown in table 3.

Table 2: Provider return rates for the patient and service level audit

Provider name	Provider ID	Patient Form	Service Form
2gether NHS Foundation Trust	21	25	2
5 Boroughs Partnership NHS Foundation Trust	51	59	3
Avon & Wiltshire Mental Health Partnership NHS Trust	55	-	6
Barnet, Enfield & Haringey MH NHS Trust	35	60	3
Berkshire Healthcare NHS Foundation Trust	23	19	1
Black Country Partnership NHS Foundation Trust	20	39	2
Bradford District Care Trust	27	58	1
Cambridgeshire and Peterborough NHS Foundation Trust	26	55	1
Camden and Islington NHS Foundation Trust	18	73	2
Central and North West London NHS Foundation Trust	01	81	4
Cheshire and Wirral Partnership NHS Foundation Trust	49	50	3
Community Links Northern	05	52	1
Cornwall Partnership NHS Foundation Trust	53	18	1
Coventry and Warwickshire Partnership Trust	14	56	3
Cumbria Partnership NHS Foundation Trust	16	46	1
Derbyshire Healthcare NHS Foundation Trust	41	40	3
Devon Partnership Trust	25	32	5
Dorset Healthcare University NHS Foundation Trust	37	75	2
Dudley and Walsall Mental Health Partnership Trust	34	31	2
East London NHS Foundation Trust	11	64	4
Greater Manchester West Mental Health NHS Foundation Trust	40	73	3
Hertfordshire Partnership University Foundation Trust	36	79	1
Humber NHS Foundation Trust	08	27	1
Isle of Wight NHS Trust	04	17	1
Kent and Medway NHS and Social Care Partnership Trust	24	92	1
Lancashire Care NHS Foundation Trust	45	100	3
Leicestershire Partnership NHS Trust	30	52	1
Lincolnshire Partnership NHS Foundation Trust	54	38	1
Mersey Care NHS Trust	19	80	2

Provider name	Provider ID	Patient Form	Service Form
NAViGO Health and Social Care CIC	07	11	1
Norfolk & Suffolk NHS Foundation Trust	12	60	3
North East London NHS Foundation Trust	39	48	4
North Essex Partnership NHS Foundation Trust	48	56	3
North Staffordshire Combined Healthcare NHS Trust	17	25	1
Northamptonshire Healthcare NHS Foundation Trust	50	24	1
Northumberland Tyne and Wear NHS Foundation Trust	46	65	5
Nottinghamshire Healthcare NHS Trust	47	78	5
Oxford Health NHS Foundation Trust	03	58	2
Oxleas NHS Foundation Trust	02	49	3
Pennine Care NHS Foundation Trust	52	63	5
Plymouth Community Healthcare (CIC)	32	15	1
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	10	97	4
Sheffield Health & Social Care NHS Foundation Trust	09	26	1
Somerset Partnership NHS Foundation Trust	29	32	1
South Essex Partnership University NHS Foundation Trust	28	41	2
South London and Maudsley NHS Foundation Trust	31	91	4
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	38	29	2
South West London and St George's Mental Health Trust	42	100	4
South West Yorkshire Partnership NHS Foundation Trust	33	58	4
Southern Health NHS Foundation Trust	13	39	4
Surrey and Borders Partnership NHS Foundation Trust	44	42	2
Sussex Partnership NHS Foundation Trust	22	68	6
Tees, Esk and Wear Valley NHS Foundation Trust	06	100	7
West London Mental Health NHS Trust	15	44	3
Worcestershire Health & Care NHS Trust	43	23	2

Guidance on reading this document

The term ‘provider’ has been used to refer to both English NHS trusts and NHS foundation trusts and independent or third sector providers of EIP services throughout this report.

Figures in the text, data tables and charts are rounded to the nearest integer, without decimal places, for clarity of presentation. Thus, the total percentages for some tables or charts may add up to 99% or 101%.

Where the total sample is referenced, this refers to the total sample for that standard, and not to the total number of patients in the audit. Please note that the total sample number against which the percentage is measured is not the same in each table.

Further information on data handling can be found in appendix B.

Layout of the audit data sections

The subsequent sections of the report will present an overview of the data relating to the service-level data, followed by the measurement of each of the audit standards, and concluding with the use of outcome measures. The averaged data, over the total population, for each particular measure is referred to in the figures as the Total National Sample (TNS).

Each table and figure has a number and title above indicating the number of cases used for the particular analysis, and in some cases text below indicates any significant caveats. Much of the information relating to performance against the standards is presented as figures made up of bar charts with each bar representing the results for an individual provider. In the figures, the providers performing closest to the standard are on the left, with performance to the standard decreasing along to the right. Where appropriate there will be a bar in approximately the middle representing the national average for the total population and called ‘TNS’ (Total National Sample).

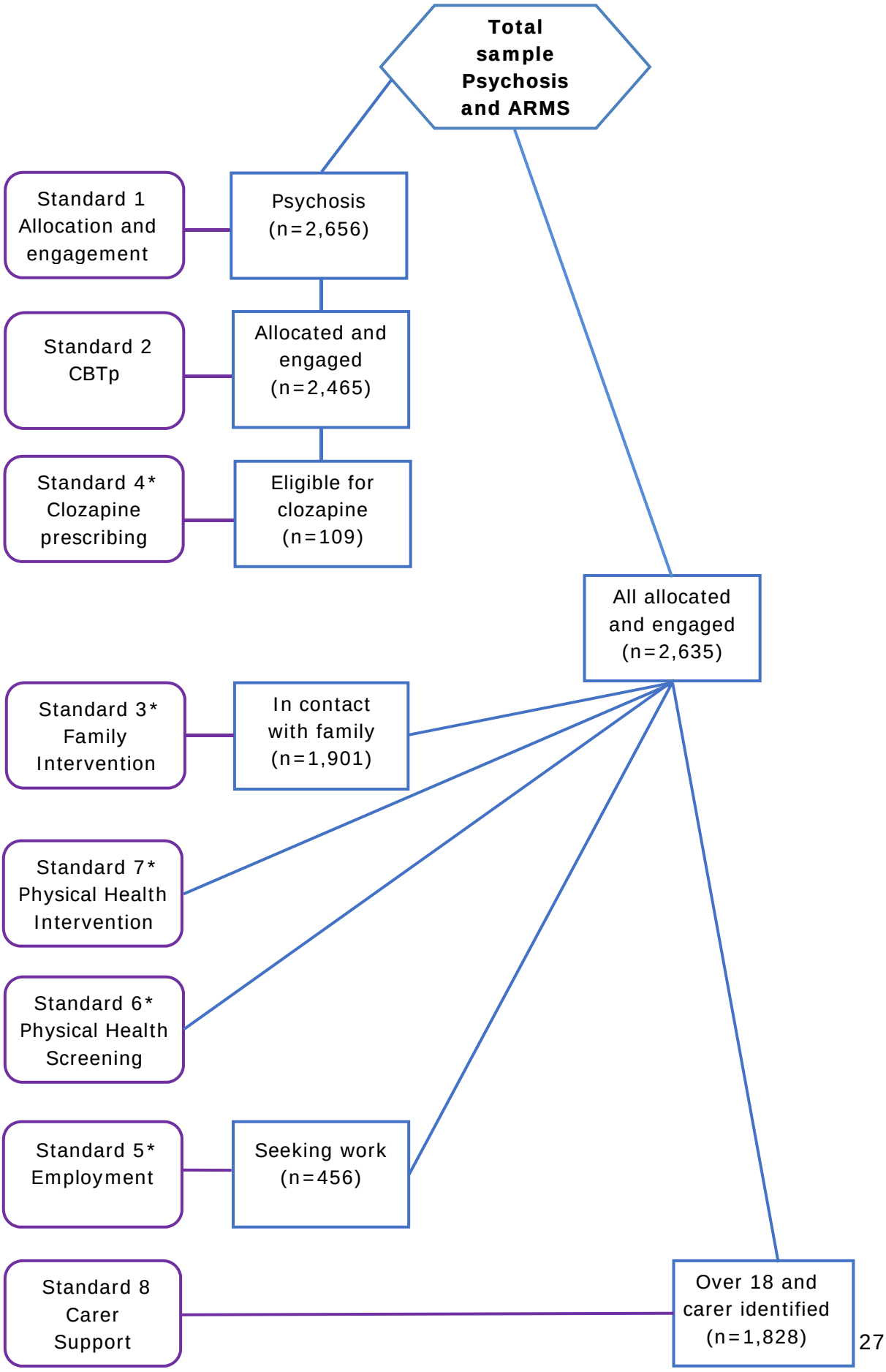
Subsamples within the analysis

The patient-level data within the report have been analysed on subsamples relevant to each standard and the flowchart in figure 1 provides an overview of these subsamples. This information is repeated at the beginning of each section of the report where measurements against standards is presented.

Provider-level data

Individual reports with a summary of provider-level analysis will be circulated after publication of the report.

Figure 1: Flowchart showing subsamples for each standard for the patient level audit



**Please note that for clarity of illustration, these standards are not shown in numerical order.*

Caveats

General caveats that apply to the report are:

- The sample only included patients who had been receiving treatment from an EIP team for six months or more.
- Some cases were deleted because the provider included patients who did not meet the initial eligibility criteria (e.g. they were not accepted onto the caseload in the period specified in the sampling guidance). Providers were informed about these cases and gave permission for their deletion from the dataset.
- Some cases were deleted because the provider did not have accurate digital records with the required details for the patient (e.g. cases were only accepted if a full dataset could be provided). Providers were informed about these cases and gave permission for their deletion from the dataset.
- Some cases were deleted because the provider was not able to confirm details during data cleaning for that patient (e.g. providers did not respond to queries regarding data cleaning). Providers were informed about these cases and gave permission for their deletion from the dataset.
- In some cases, data were only provided for BMI *or* change in weight over a three month period; systolic *or* diastolic blood pressure; fasting plasma glucose *or* glycated haemoglobin *or* random plasma glucose; and total cholesterol *or* non-HDL cholesterol *or* QRISK-2 score. These cases were still included in the analysis.

Throughout the report, several comments and caveats regarding the data for specific tables and figures are stated below each relevant table or figure.

Summary of the service-level data

The service-level audit tool was designed to gather information on how EIP teams and services were operating. The data were collected to provide context for the results of the patient-level audit. A detailed account of the service-level data is provided in appendix D.

Most EIP services (N = 125, 87%) were standalone specialist teams with their own management structure. Five (3%) services were provided by staff embedded within existing community mental health teams and one service reported being delivered through a hub and spoke model.[3]

Most EIP services reported working with people aged from 14 to 35 years (N = 90, 63%). Twenty five (17%) worked with people aged 18 or over along with eight working with those aged 16 or over. All but three services set a maximum time they worked with people for. This ranged from 15 months to 5 years. Most (n = 128, 89%) reported working with people for a maximum of 3 years.

Data on referrals, acceptances and expected incidence rates 01 January 2014 – 31 December 2014 can be found in appendix D.

Around a fifth of teams (22%) did not provide employment and education support services to patients or refer them to third parties for these services. Of the teams who did provide these services or refer patients to third party providers, a vocational support programme was the most commonly offered, by 60% of teams. 42 teams (38%) stated they offered the evidence-based Individual Placement and Support (IPS) supported employment programme.

In the 112 teams (78%) where supported employment services were provided, there was no clear division in the type of staff providing them.

Data on the reported numbers of staff in teams considered qualified to deliver FI and CBTp at the time of data submission can be found in appendix D.

[3] Based on a hub and spoke model in which EIP staff work in community teams but receive input from a central hub. The service is provided by staff who are to be embedded in 'spokes', often CMHTs, and in the central 'hub'. The hub usually provides access to leadership, specialist skills and support to the spoke workers.

Patient level audit

Referral to treatment waiting time

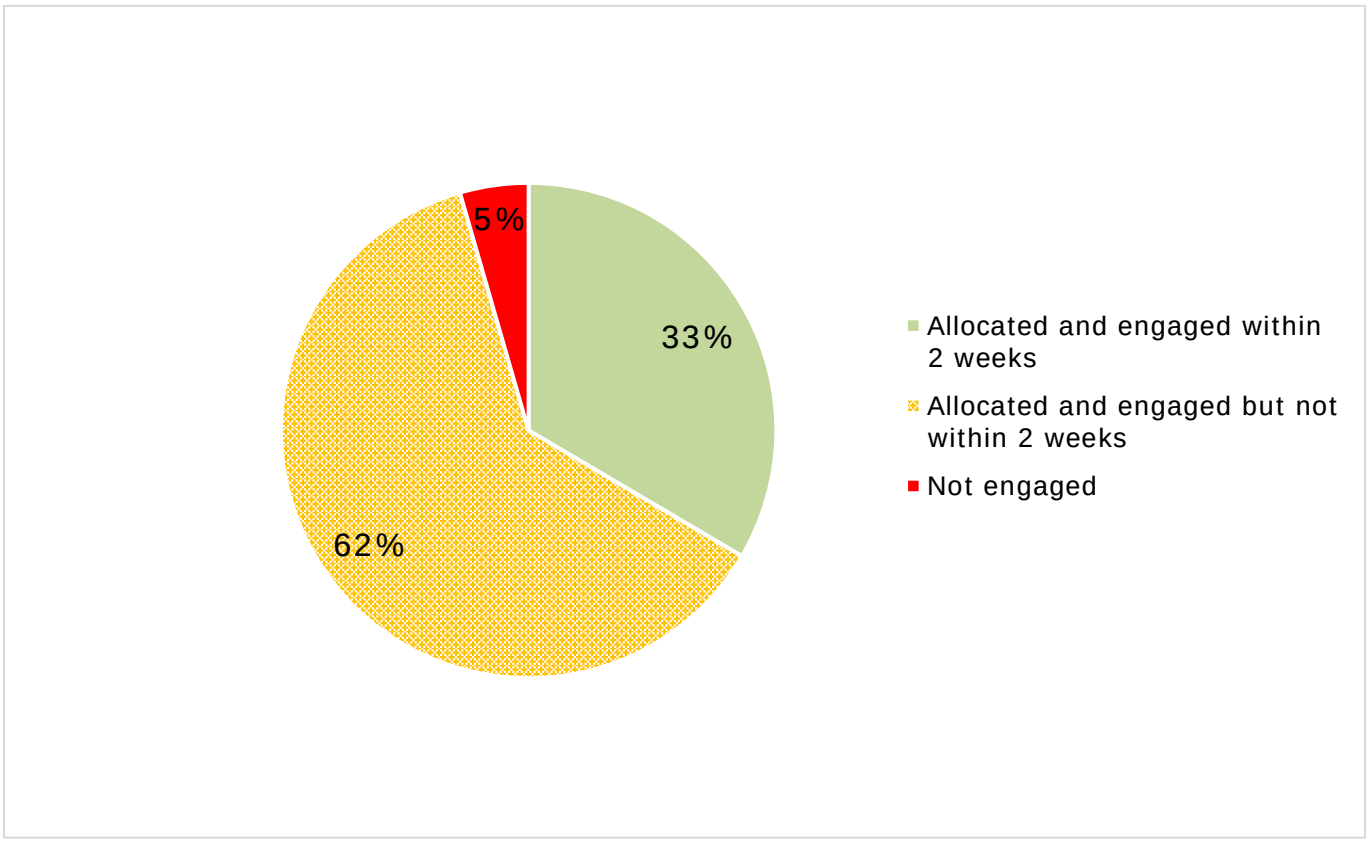
Standard 1: Patients with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral

The analysis for standard 1 has been performed separately for two groups of patients: those who, following assessment, were accepted onto the caseload of an EIP service having been assessed as experiencing first episode or suspected psychosis (n= 2,656) and those accepted onto the caseload with an at risk mental state (ARMS) (n=105).

Patients accepted onto the caseload of the EIP services for first episode or suspected psychosis:

Figure 2 shows the percentage of patients for whom standard 1 was met.

Figure 2: Percentage of patients with first episode or suspected psychosis allocated to and engaged by an EIP care coordinator within two weeks of referral. N=2,656



Patients who were not engaged include those who refused to engage with an EIP care coordinator, despite attempts by services.

Table 4 provides further analysis on the delay in engagement for those patients where engagement was not within two weeks of referral. The analysis excludes patients within this group who were engaged by the EIP care coordinator before allocation (n=25).

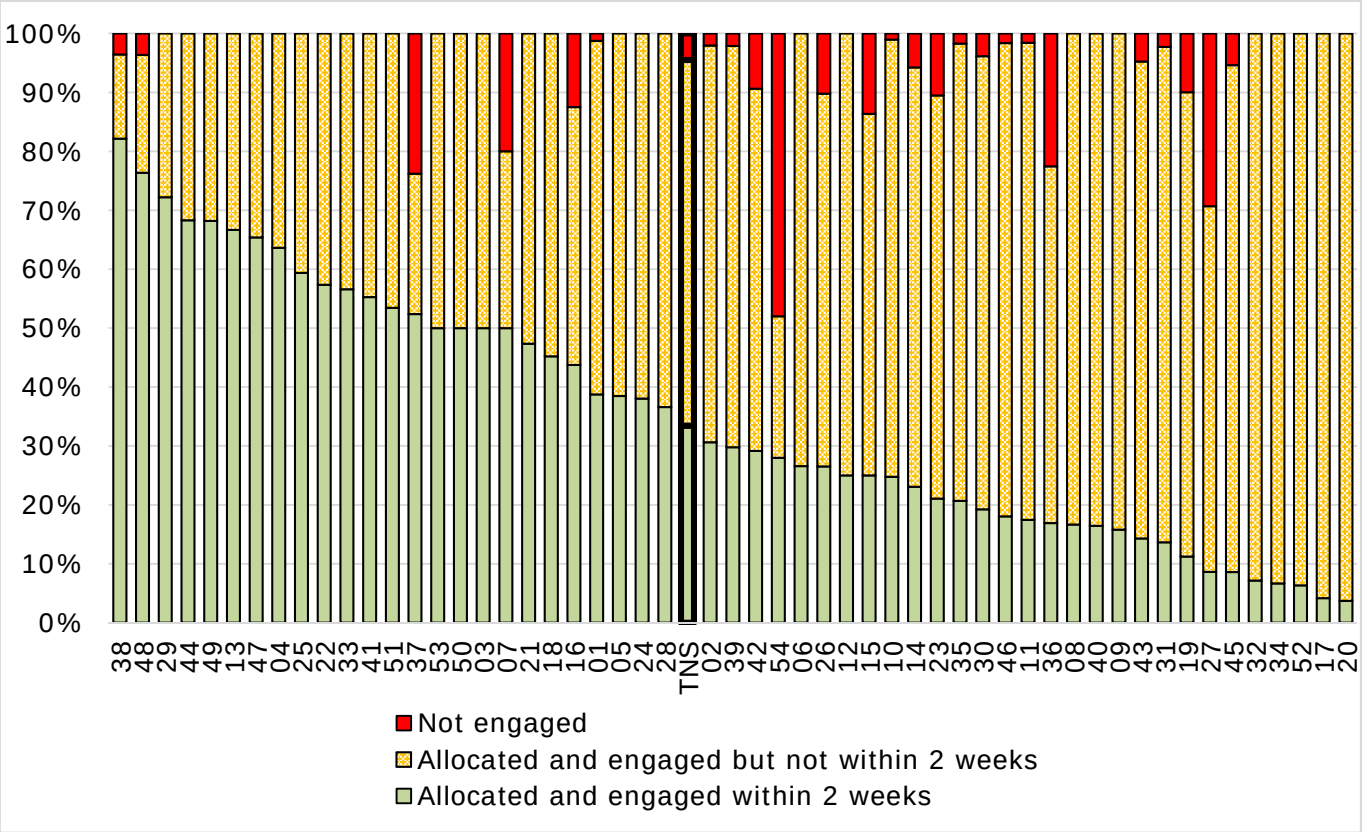
Table 3: Timescale for engagement by an EIP care coordinator for those patients where engagement was not within two weeks of referral. Patients allocated before engagement (N=1,623).

Timescale of engagement by an EIP care coordinator	N (%)	% of total sample
Between 2 weeks and 4 weeks of referral	630 (39%)	24%
Between 4 weeks and 12 weeks of referral	795 (49%)	30%
Between 12 weeks and 24 weeks of referral	135 (8%)	5%
Between 24 weeks and 36 weeks of referral	36 (2%)	1%
Between 36 weeks and 52 weeks of referral	12 (1%)	0%
Over 52 weeks from referral	15 (1%)	1%
Total patients	**1,623 (100%)**	**-**

Of the 1,623 patients allocated and engaged more than two weeks after referral where engagement was after allocation, 88% were engaged by an EIP care coordinator within 12 weeks of referral, this is 54% of the total sample.

Figure 3 presents the variation across providers for the allocation to and engagement of patients by an EIP care coordinator.

Figure 3: Provider level percentage of patients accepted onto the caseload of the EIP services for first episode or suspected psychosis, and their allocation and engagement by an EIP care coordinator. N=2,656



There is wide variation in the percentage of patients allocated and engaged within two weeks of referral, ranging from 82% to 4% with a TNS average of 33%. Please see the section Interpreting engagement below (p33).

In 25 providers not all patients were engaged. This varied from 48% to 0% of patients, with a TNS average of 5%.

It is important to note that the audit data is retrospective, referring to patients accepted onto caseloads between 30 June and 31 December 2014 and reporting treatment six months after this. However, the access and waiting times standard which requires more than 50% of patients experiencing first episode psychosis to commence a NICE-recommended package of care within two weeks of referral is expected from 1 April 2016 (NHS England, 2015). The results here illustrate where providers were at in 2014 in terms of access to treatment and waiting times for first episode or suspected psychosis patients and do not reflect current performance.

Patients referred for ARMS:

The same analysis was carried out for ARMS patients. Of the 105 patients, 26 (25%) were allocated and engaged within two weeks of their referral date; 72 (68%) were allocated and engaged outside the two week period from referral and 7 (7%) were not both allocated to and engaged by an EIP care coordinator. Thirty-six patients (34%) did not receive a specialist ARMS assessment.

Interpreting engagement

A definition of engagement was provided to providers (see page 19) and the EIP audit team offered advice throughout the data collection period in order to promote consistency across providers. However, it should be noted that this data relies on the interpretation of the term ‘engagement’ by the data collector and may vary by provider. The audit also required the understanding of the term to be applied retrospectively to clinical records.

Psychological therapies - CBTp

The NICE quality standard for psychosis and schizophrenia in adults (2015) (QS80) recommends that CBTp should be offered to all adults with psychosis or schizophrenia and should be used in conjunction with pharmacotherapy, or alone if medication is declined.[4] CBTp should follow a treatment manual and be delivered over at least 16 planned sessions.

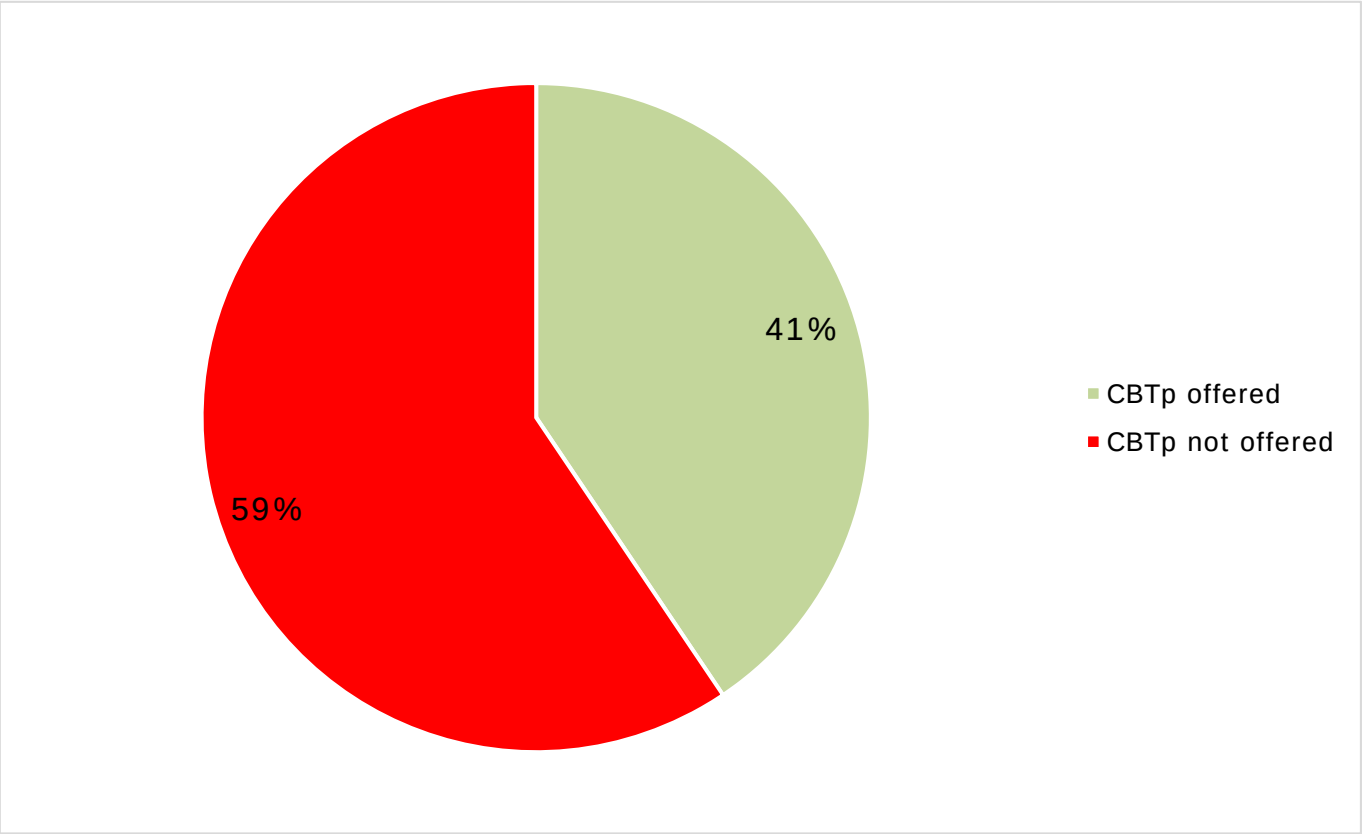
For the purpose of the audit, CBTp was only deemed to be offered where services had the capacity to deliver a minimum of 16 sessions to each patient, delivered by practitioners with appropriate CBTp training and supervision. The patient must have been referred for or offered CBTp in the first six months from when they were accepted onto the caseload of the EIP service.

Standard 2: Patients are offered Cognitive Behavioural Therapy for psychosis (CBTp).

First episode or suspected psychosis patients were excluded if they were not engaged by an EIP care coordinator (n=119). In addition, patients from one provider were excluded as they identified their data on capacity to provide CBTp was inaccurate (n=72). The analysis was carried out on 2,465 eligible patients. Figure 4 shows the percentage of patients for whom standard 2 was met.

[4] According to QS80, CBTp should be provided according to the NICE guideline CG178 Psychosis and schizophrenia in adults (2014), recommendations 1.3.9.1, 1.4.2.1 and 1.4.4.1 (key priority for implementation).

Figure 4: Percentage of patients with first episode of psychosis or suspected psychosis offered CBTp. N=2,465



Three-hundred-and-sixty-two of the patients offered CBTp had been allocated and engaged within two weeks of referral (15% of the total sample).

Take up of CBTp where it was available:

Table 5 shows the percentage of patients offered CBTp where it was available (n=1,000), who took up this therapy.

Table 4: Percentage of patients with first episode or suspected psychosis offered CBTp who took up this therapy. N=1,000

Take up of CBTp where offered	N (%)	% of total sample
Taken up	510 (51%)	21%
Not taken up	490 (49%)	20%
Total patients offered CBTp	**1,000 (100%)**	**-**

Availability of CBTp where it was not offered to patients:

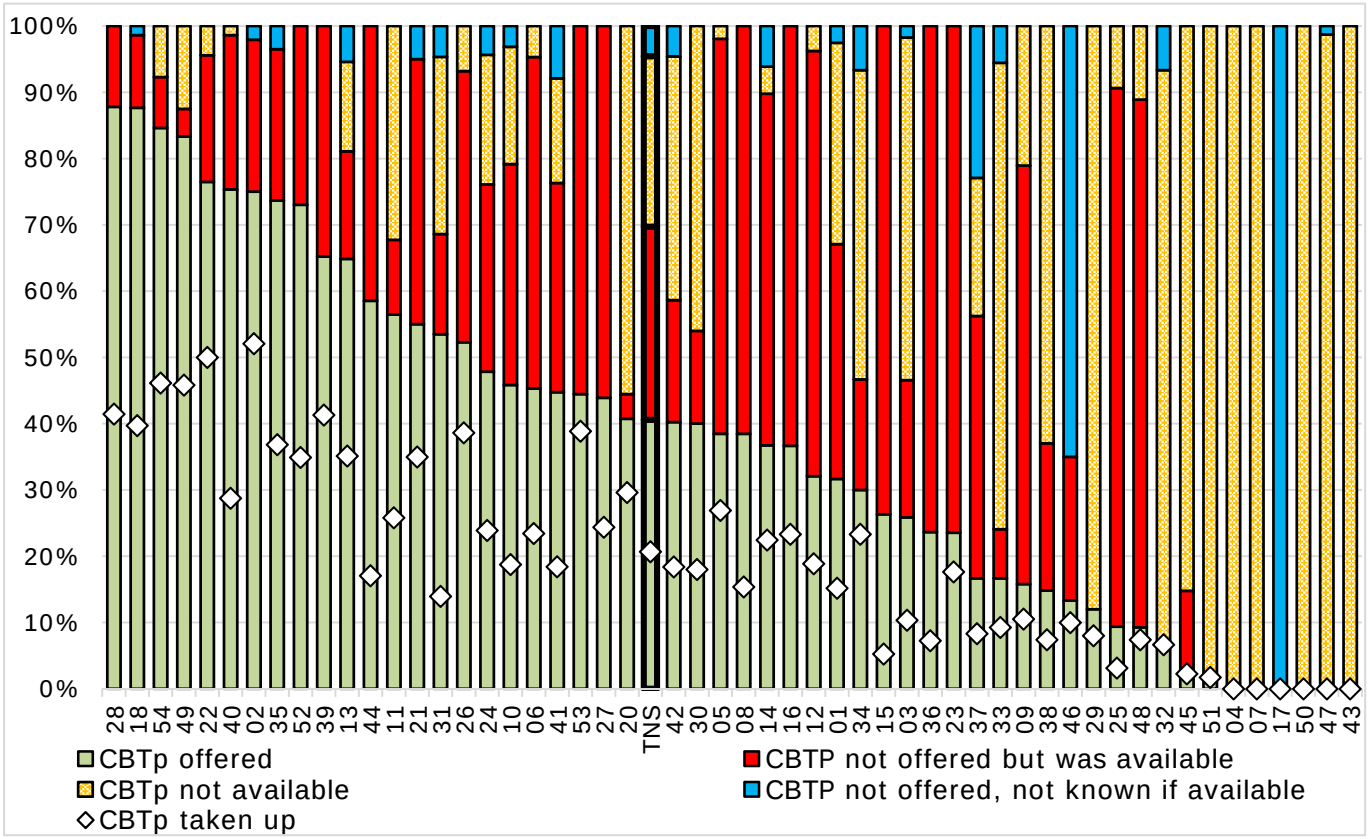
Table 6 shows whether CBTp was available where it was not offered to patients (n=1,465).

Table 5: Availability of CBTp to patients with first episode or suspected psychosis who were not offered CBTp. N=1,465

Availability of CBTp where not offered to patients	N (%)	% of total sample
CBTp not offered but was available	719 (49%)	29%
CBTp not offered and not available	634 (43%)	26%
CBTp not offered, not known if available	112 (8%)	5%
Total patients where CBTp not offered	**1,465 (100%)**	**-**

Figure 5 shows the offer and availability of CBTp to patients across each provider. Take up of CBTp where it was offered is indicated by white diamonds.

Figure 5: Provider level percentage of patients with first episode of psychosis or suspected psychosis offered CBTp; the take up of CBTp; and availability of CBTp if not offered. N=2,465



There is wide variation across providers in the number of patients offered CBTp, ranging from 88% to 0%, with a TNS average of 41%. Among those offered CBTp the take up also varied, from 52% to 2% (TNS average was 21%).

Availability of CBTp where it was not offered to patients also varied considerably, ranging from unavailable to 100% to 0% of patients with a TNS average of 26%. At 11 providers it was available to all eligible patients in the sample, whereas at four providers it was available to none.

Providers may wish to compare their performance with data on current staffing levels provided in the service-level data detailed in appendix D, bearing in mind that the data here refer to patients accepted onto their caseload in 2014.

Psychological therapies – Family Intervention (FI)

The NICE quality standards for psychosis and schizophrenia in adults (2015) (QS80) recommend that family members of adults with psychosis or schizophrenia are offered FI. Family members are defined as including carers and family members with whom the person is in close contact.

For the purpose of the audit, FI was only deemed to be offered where it was provided by practitioners who had been trained by recognised training routes to acquire the competences specified in the national framework. The patient should have been referred for or offered FI in the first six months from when they were accepted onto the caseload of the EIP service.

Standard 3: Where patients are in contact with their families, family members are offered Family Intervention.

These analyses are based on patients allocated and engaged by an EIP care coordinator who were in contact with their family. Figure 6 shows the percentage of patients for whom standard 3 was met.

Figure 6: Percentage of patients whose families were offered FI. N=1,901

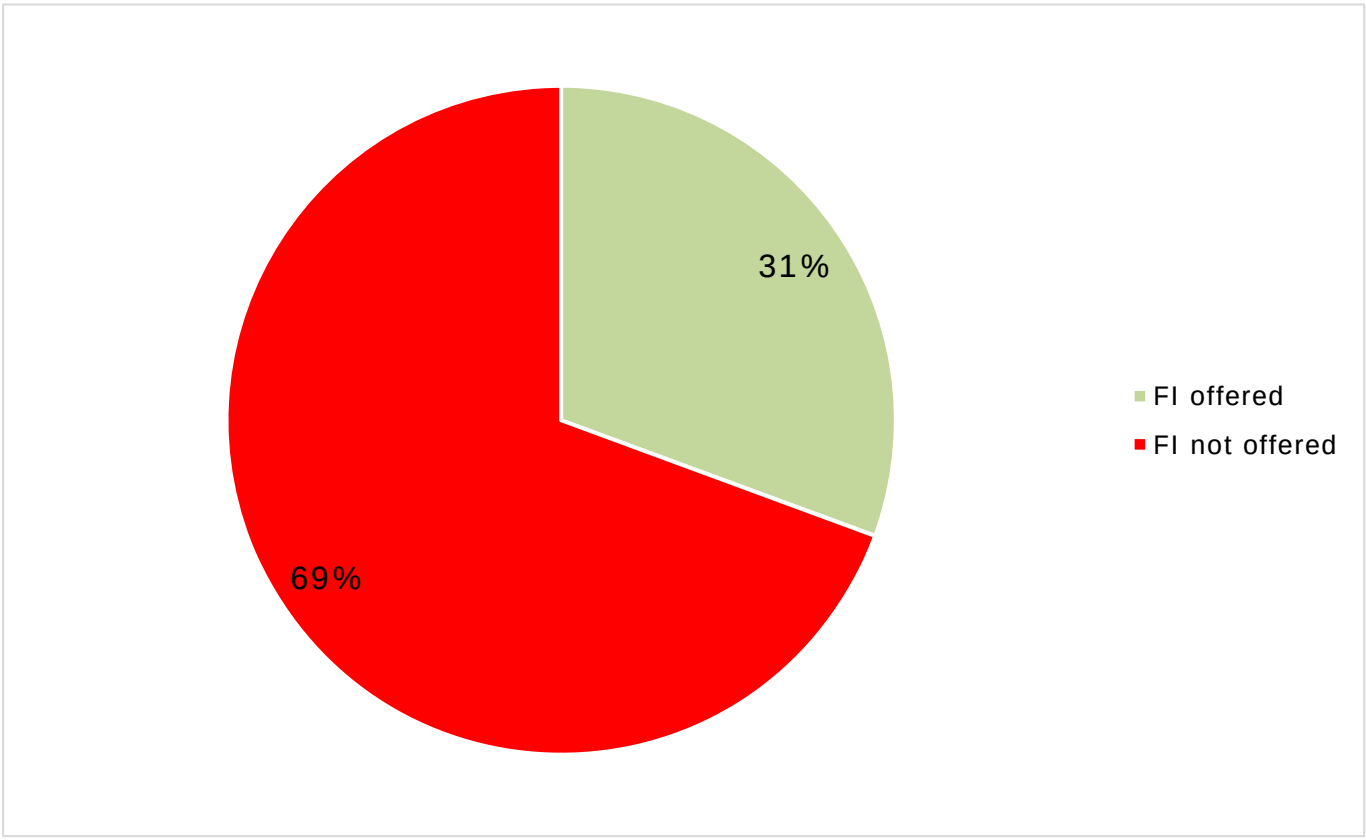


Table 7 shows the percentage of patients whose families were offered FI (n=582), who took up this therapy.

Table 6: Percentage of patients whose family was offered FI who took up this therapy. N=582

Take up of FI where offered	N (%)	% of total sample
FI taken up	224 (38%)	12%
FI offered but not taken up	358 (62%)	19%
Total patients whose family members were offered FI	**582 (100%)**	-

Availability of FI where not offered to the family members of patients:

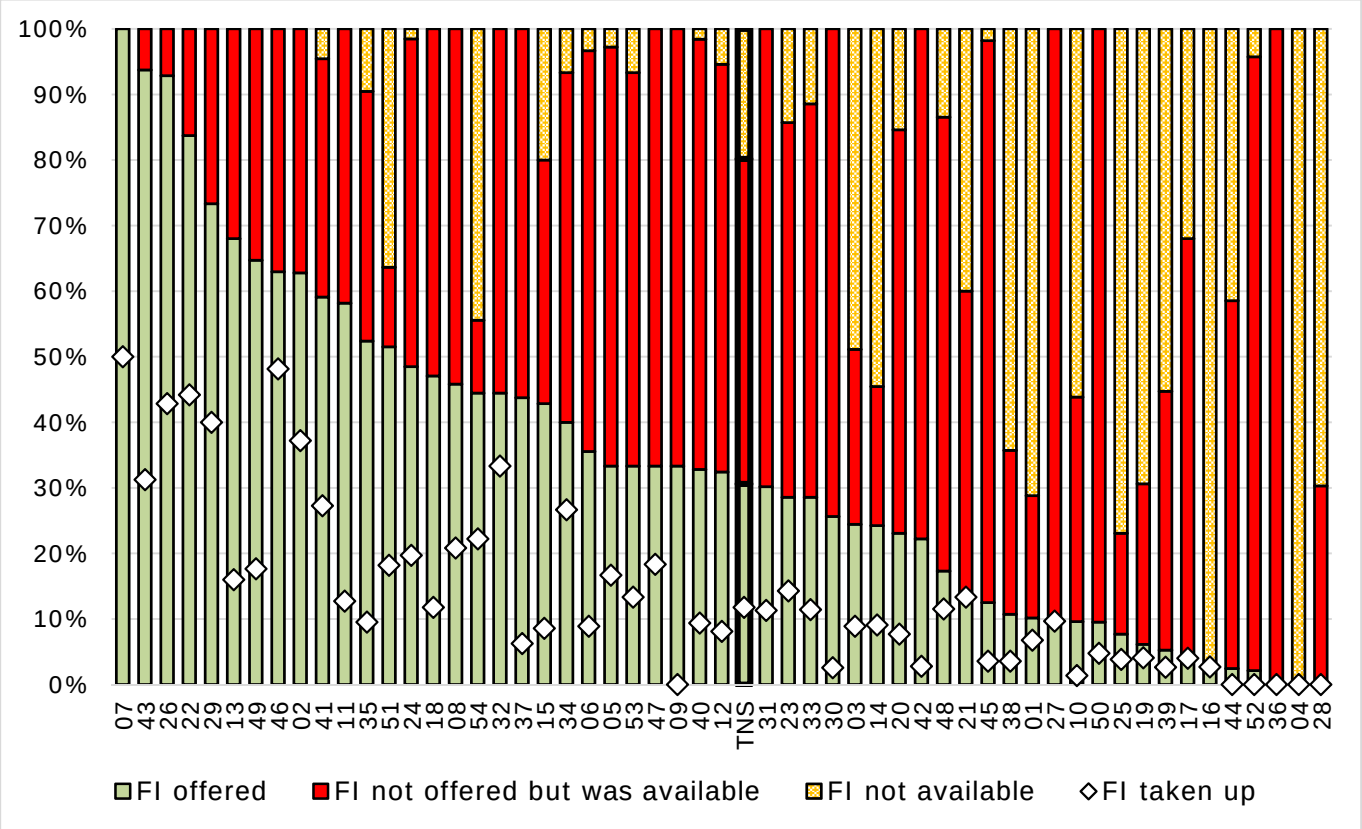
Table 8 shows whether FI was available where it was not offered to patients' families (n=1,319).

Table 7: Availability of FI to patients' families who were not offered FI. N=1,319

Availability of FI where not offered	N (%)	% of total sample
FI not offered but was available	942 (71%)	50%
FI not offered and not available	377 (29%)	20%
Total patients whose family members were not offered FI	**(1, 319) 100%**	-

Figure 7 shows the offer and availability of FI across each provider. Take up of FI where it was offered is indicated by white diamonds.

Figure 7: Provider level percentage of patients in contact with their family offered FI; the take up of FI; and availability of FI if not offered. N=1,901



There is wide variation across providers in the number of patients whose family was offered FI, ranging from 100% to 0%, with a TNS average of 31%. Among those offered FI the take up also varied from 50% to 0% (TNS average 12%).

Availability of FI where it was not offered also varied considerably, ranging from unavailable to 100% to 0% of patients, with a TNS average of 20%. At 22 providers FI was available to all eligible patients in the sample, whereas at one provider it was available to none.

Providers may wish to compare their performance with the data on current staffing levels provided in the service-level data detailed in appendix D, bearing in mind that the data here refer to patients accepted onto the caseload in 2014.

Clozapine prescribing

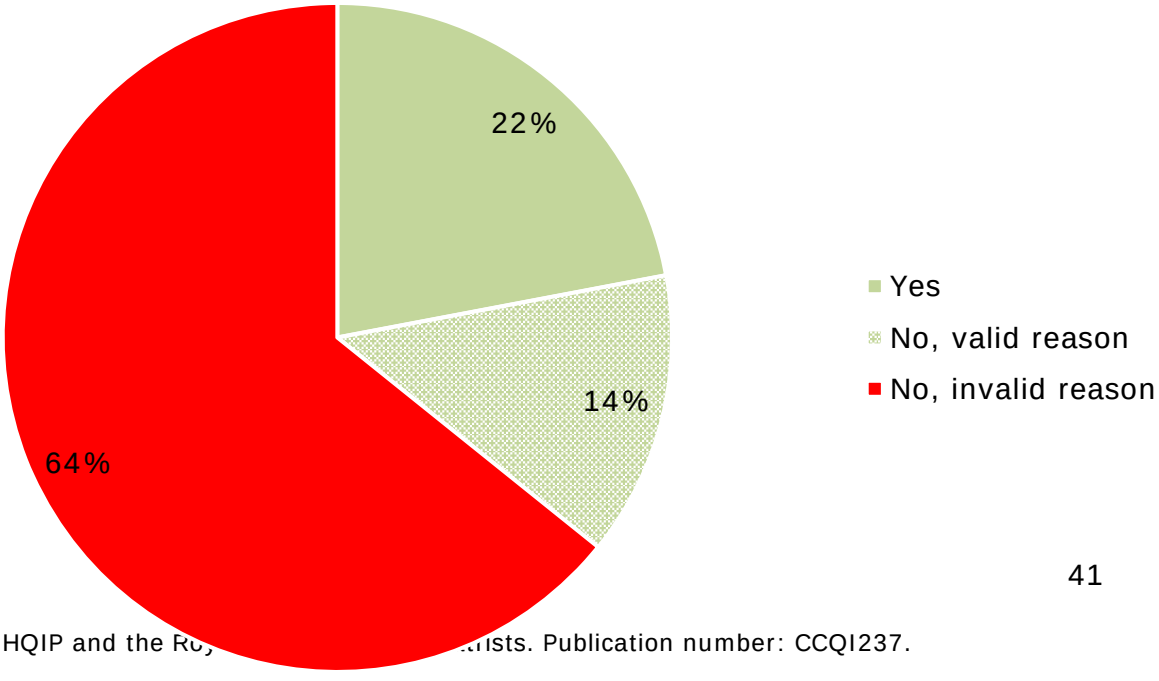
The NICE quality standards for psychosis and schizophrenia in adults (2015) (QS80) recommend that patients who have not responded adequately to treatment with at least two antipsychotic drugs should be offered clozapine.

Standard 4: Patients that have not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine.

These analyses were based on patients who, following assessment, were accepted onto the caseload of the EIP services as having first episode or suspected psychosis, who were being prescribed antipsychotic medication, who had not made an adequate response and had been given a full trial of two antipsychotic drugs (n=109).

Figure 8 shows the percentage of patients who were prescribed clozapine. Patients needed to have been prescribed clozapine or for there to have been a valid reason for them not being prescribed clozapine in order to meet standard 4. The reasons considered valid can be found in table 9 below. Those designated valid were specified by consultant psychiatrists in the sub-ERG.

Figure 8: Percentage of eligible patients who were prescribed clozapine. N=109



The standard was met for 36% of patients. Twenty-two percent of patients (n=24) were prescribed clozapine while 14% (n=15) were not prescribed clozapine for a valid reason.

Table 9 illustrates the reasons that were given for patients currently not being prescribed clozapine.

Table 8: Responses provided for not prescribing clozapine for patients where indicated. N=85

Reasons considered to be valid	**N (%)**
Clozapine contraindicated for this patient	5 (3%)
Clozapine tried but patient did not respond	1 (1%)
Clozapine offered but patient refused	9 (5%)
Total	**15**

Reasons not considered to be valid	**N (%)**
Unable to determine whether other antipsychotic doses are adequate	23 (12%)
None of the above	47 (24%)
Total	**70 (36%)**

The number of patients included in this analysis is very small (n=109), therefore a provider level performance comparison has not been carried out. Thirty-seven out of 54 providers had eligible patients for whom clozapine was indicated. Seven providers fully met standard 4 at 100%. Of the providers who met the standard to some degree (n=25), the range of performance against the standard was between 20% and 100%. Twelve providers did not meet the standard at all, performing at 0%.

Those wishing to find or return to work are offered programmes

The NICE quality standards for psychosis and schizophrenia in adults (2015) (QS80) recommend that those who wish to find or return to work are offered supported employment programmes. For the purpose of the audit, the patient must have been offered the programme(s) in the first six months after being accepted onto the caseload of the EIP service.

These analyses were based on patients recorded as unemployed and seeking work (n=456).

Standard 5: Patients who wish to find or return to work are offered supported employment and/or education programmes.

Figure 9 shows that 286 patients (63%) were offered one or more supported employment or education programme. This includes but is not limited to the evidence-based programme of Individual Placement and Support (IPS).

Figure 9: Percentage of patients offered supported employment or education programmes. N=456

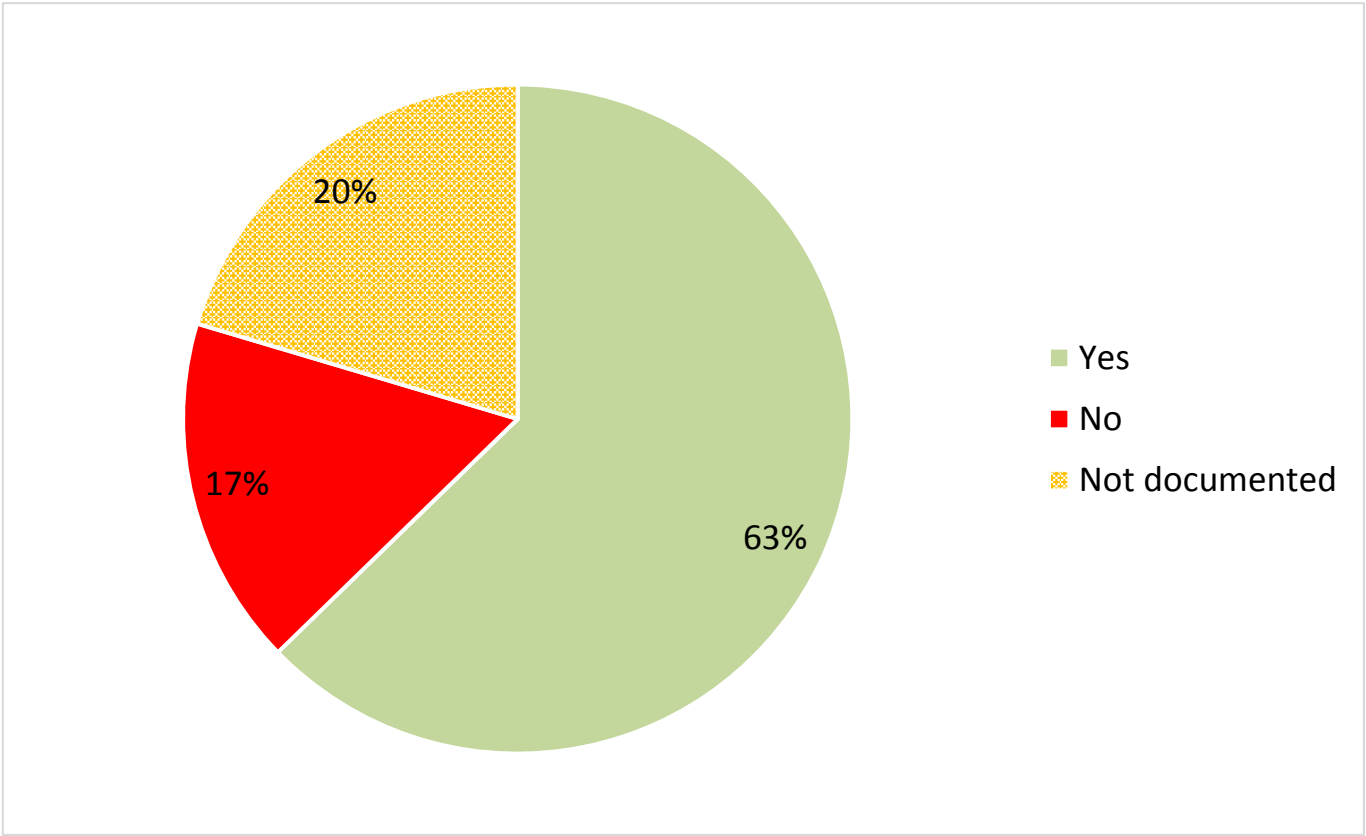


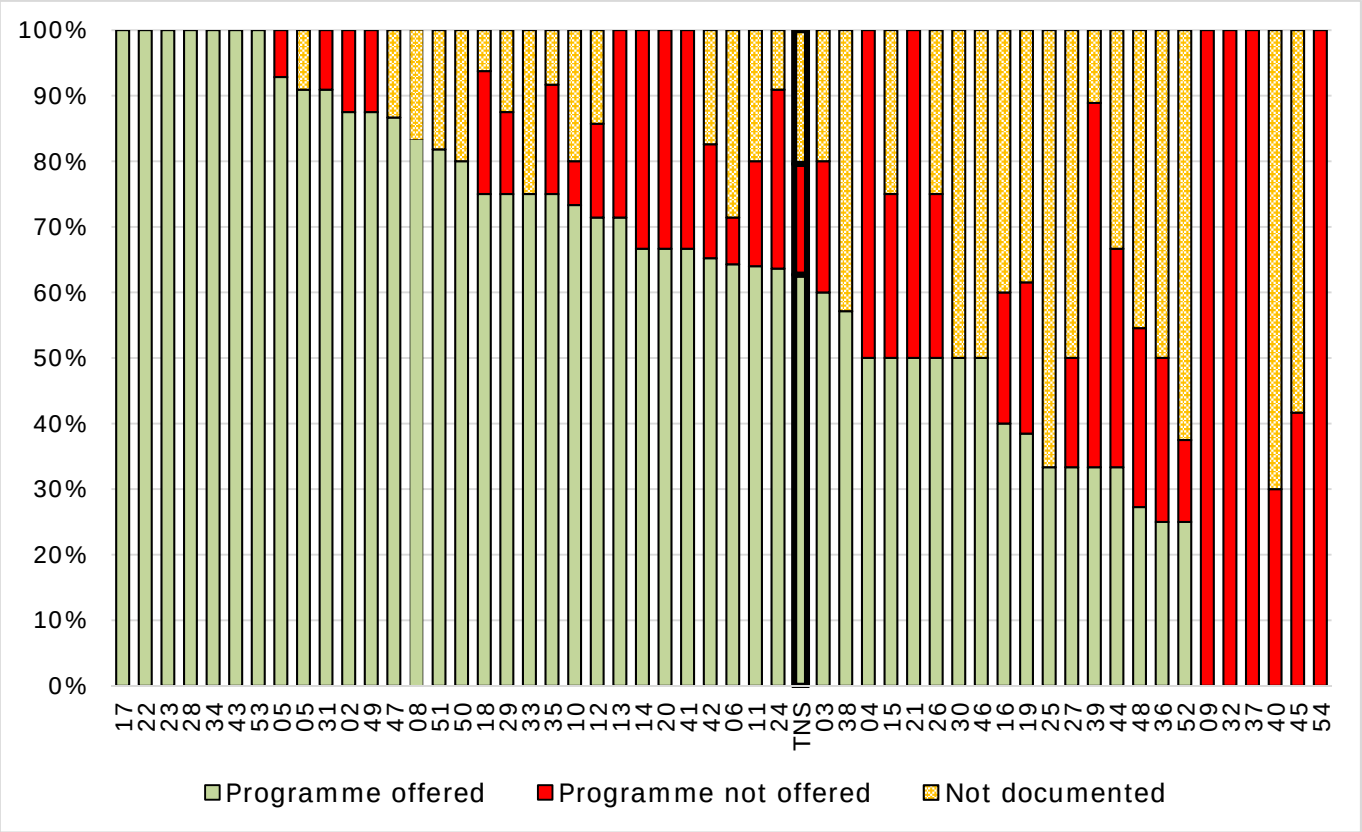
Table 10 shows the types of programmes offered to this subset of patients (multiple responses could be chosen).

Table 9: Types of support employment programmes offered to patients who were unemployed and seeking work. N=286

Type of programme offered	N (%)
Employment support programme (Individual Placement and Support)	57 (19%)
Employment support programme (other)	87 (30%)
Vocational support programme	107 (36%)
Apprenticeship programme	5 (2%)
Education programme	28 (10%)
Other	62 (21%)
Total	**346 (118%)**

Figure 10 shows performance on standard 5 at a provider level.

Figure 10: Provider level percentage of unemployed patients seeking work offered a supported employment or education programme. N=456



Fifty-three out of 54 providers had eligible patients for this analysis. Of those providers who met the standard to some degree (n=47), performance against the standard ranged from 100% to 25%. Seven providers fully met standard 5 at 100% while six providers did not meet the standard at all, performing at 0%.

Employment Support Programme (individual placement and support)

Quality statement 5 in the NICE guidelines specifies the evidence-based programme of Individual Placement and Support (IPS). IPS is an approach to vocational rehabilitation that attempts to place patients in competitive employment immediately (QS 80, 2015).

IPS was offered to just 57 patients (13% of all the 456 identified as unemployed and seeking work). At a provider level, only two providers offered IPS to all patients. Of the 23 providers who provided IPS to some patients, the range of performance varied from 4% to 100%. Thirty providers did not offer IPS to any patients identified as unemployed and seeking work. Of these, 6 providers did

not offer any programme and 24 providers offered other types of programme(s).

Physical health screening

The NICE quality standard (2015) (QS80) recommends that comprehensive physical health assessments should be received by adults with psychosis or schizophrenia. Assessments should take place within the first 12 weeks of treatment for patients being treated for first episode psychosis, and at least annually thereafter.

Physical health screening must have been carried out within 12 weeks from the patient being accepted onto the caseload in order to be included.

Standard 6: Patients are offered a comprehensive physical health check, which includes the following measures:

- Smoking status
- Alcohol intake
- Substance misuse
- BMI or change in weight over a 3 month period
- Blood pressure
- Glucose
- Cholesterol

There were 2,635 eligible patients, who had been engaged by an EIP care coordinator.

Figure 11 shows the percentage of patients who were offered screening for all seven physical health measures. The patient must have been offered screening for all seven measures for standard 6 to be considered met. 'Offered screening' means the screening was carried out or the patient was offered but refused the screening.

Figure 11: Percentage of patients offered screening for all seven physical health measures. N=2,635

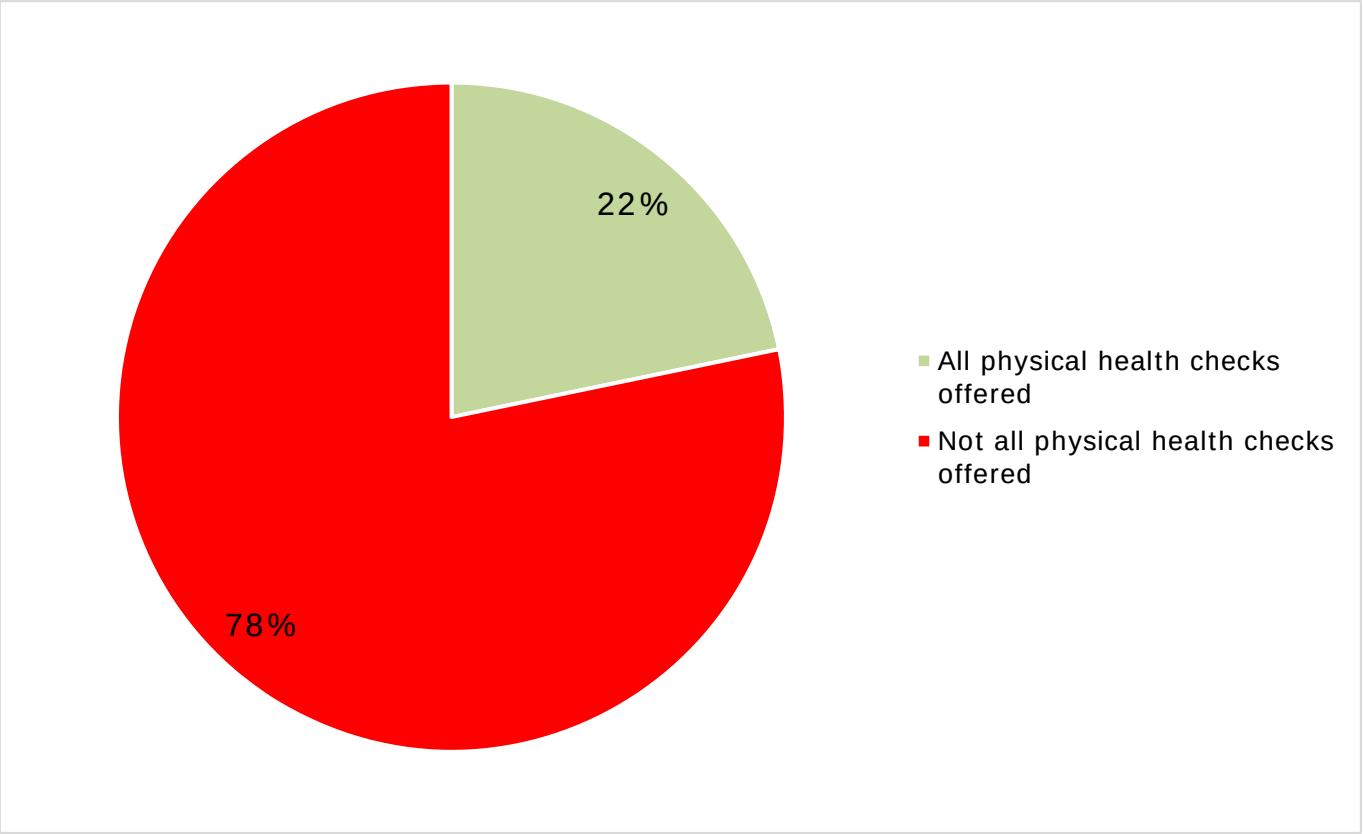


Table 11 provides information on the percentage of patients who were offered screening for each measure. The percentage of patients who refused screening for any measure ranged from 1% to 5% of the sample.

Table 10: Percentage of patients who were offered screening for each physical health measure. N=2,635

Physical health measure	N (%)
Smoking status	2,244 (85%)
Alcohol intake	2,315 (88%)
Substance misuse	2,396 (91%)
BMI or change in weight over a 3 month period	1,383 (52%)
Blood pressure	1,385 (53%)
Glucose	1,064 (40%)
Cholesterol	986 (37%)
Total patients	**2,635 (100%)**

Table 12 shows the number of physical health measures for which patients were offered screening.

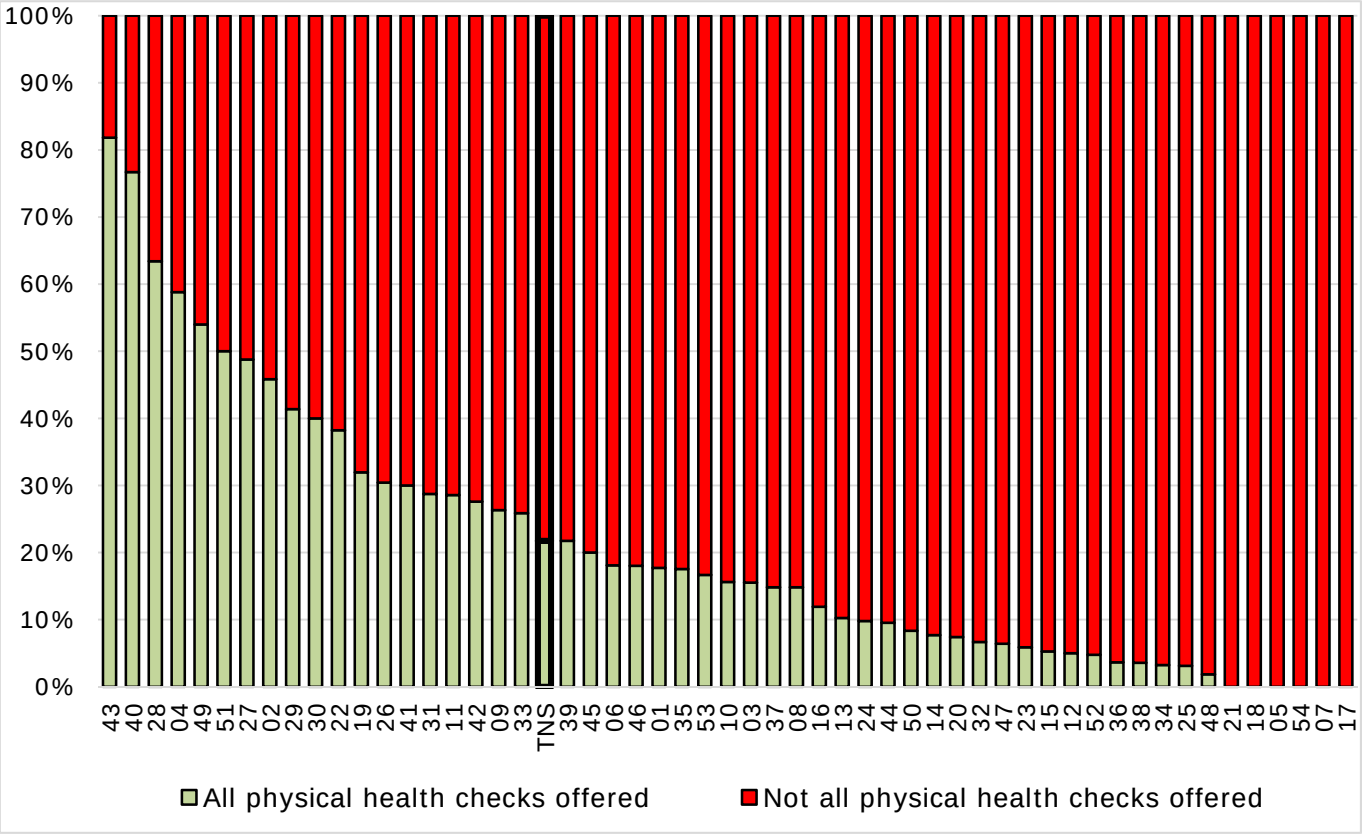
Table 11: Number of physical health measures for which patients were offered screening. N= 2,635

Number of physical health measures	N (%)
None	112 (4%)
One	82 (3%)
Two	155 (6%)
Three	626 (24%)
Four	263 (10%)
Five	504 (19%)
Six	320 (12%)
Seven	573 (22%)
Total patients	**2,635 (100%)**

Eighty-seven percent (n=2,286) of patients were offered screening for three or more physical health measures.

Figure 12 presents the variation across providers for patients offered screening for all seven physical health measures.

Figure 12: Provider level percentage of patients who were offered screening for all seven physical health measures. N=2,635



There was considerable variation across providers in the percentage of patients offered screening for all seven physical health measures, from 82% to 0%, with a TNS average of 22%. In six providers, no patients were offered screening for all seven physical health measures.

Physical health interventions

Physical health interventions are defined by the Lester tool (see appendix C) which provides parameters for interventions for tobacco smoking status, BMI or change in weight, blood pressure, glucose and cholesterol. Parameters for harmful alcohol use and substance misuse are provided by the NICE guidelines CG115 (2011) and CG51 (2007).

The patient must have been referred for or offered the intervention for these measures up until the day the data collection tool was completed.

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

- Smoking cessation
- Harmful alcohol use
- Substance misuse
- Weight gain / obesity
- Hypertension
- Diabetes / high risk of diabetes
- Dyslipidemia

There were 2,635 eligible patients, who had been engaged by an EIP care coordinator.

Figure 13 shows the percentage of patients who were offered interventions for all seven physical health measures. Patients needed to have been offered screening for each measure as well as any relevant interventions in order to meet standard 7. If the patient was screened and did not require an intervention, standard 7 was considered met.

Figure 13: Percentage of patients offered relevant interventions for all seven physical health measures. N=2,635

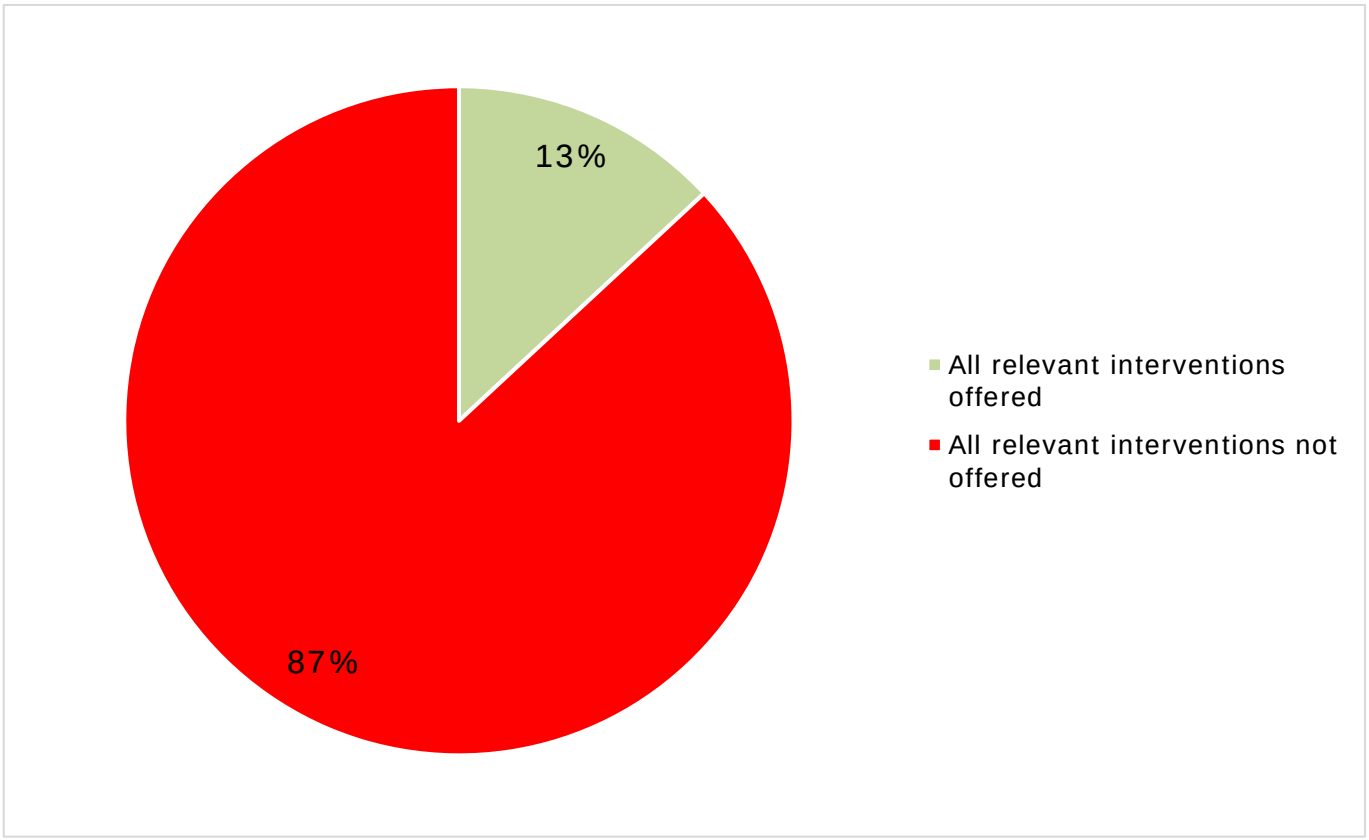


Table 13 shows the number of patients who needed and were offered an intervention for each measure. The requirement for an intervention was defined by the parameters set out in the Lester tool and NICE guidelines CG115 (2011) and CG51 (2007).

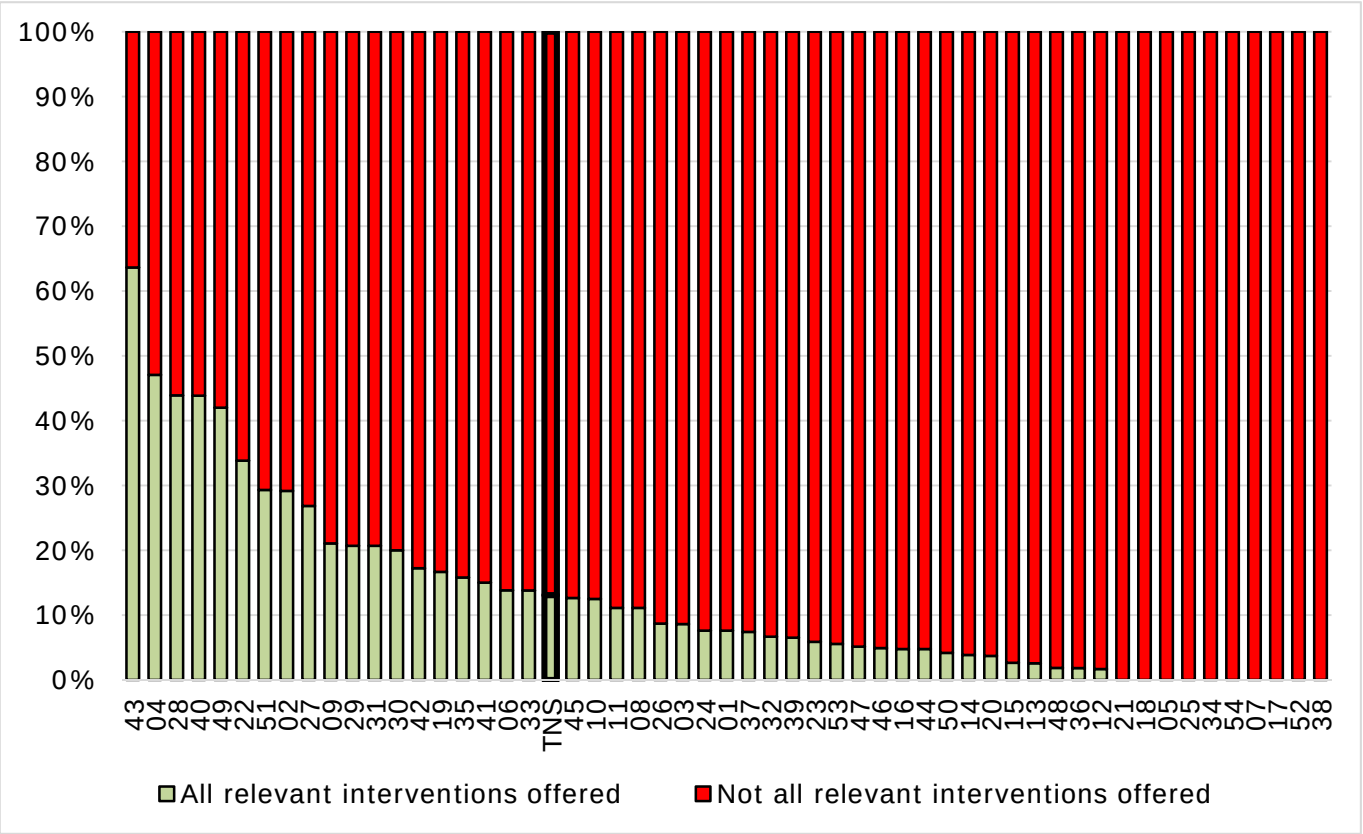
Table 12: Patients who needed and were offered an intervention for each measure. The n for each measure is provided in the table

Patients requiring an intervention	Patients requiring and offered intervention	
	N (%)	% of total sample
Smoking cessation (n=1167)	670 (57%)	25%
Harmful alcohol use (n=297)	232 (78%)	9%
Substance misuse (n=933)	696 (75%)	26%
Weight gain/obesity (n= 638)	332 (52%)	13%
Hypertension (n= 171)	58 (34%)	2%
Diabetes/high risk of diabetes (n=97)	26 (27%)	1%
Dyslipidemia (n=5)	0 (0%)	0%

The percentage of patients offered an intervention when required for each measure varied, from 78% for harmful alcohol use to 0% for dyslipidemia. The percentage of patients who needed and refused an intervention for any measure was highest for smoking, with 359 (31%) of those needing and offered an intervention refusing it. Fewer patients refused interventions for other measures: harmful alcohol use 38 (13%), substance misuse 152 (16%), weight gain/obesity 21 (3%), hypertension 2 (1%), diabetes/high risk of diabetes 1 (1%). No patients were offered and refused an intervention for dyslipidemia. When making any comparison, please note the variation in the number of patients requiring an intervention for each measure.

Figure 14 presents the variation across providers for patients offered relevant interventions for all seven physical health measures.

Figure 14: Provider level percentage of patients who were offered relevant interventions for all seven physical health measures. N=2,635



There was considerable variation across providers in the percentage of patients offered relevant interventions for all seven physical health measures, from 64% to 0%, with a TNS average of 13%. In ten providers, no patients were offered relevant interventions for all seven physical health measures.

Carers of adults with psychosis are offered education and support programmes

The NICE quality standard for psychosis and schizophrenia in adults (2015) (QS80) recommends that carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes. A carer of an adult patient can be anyone who has regular close contact with the patient, and can include advocates, friends or family members (QS 80).

Standard 8: Carers receive focused education and support.

These analyses were carried out for patients aged 17 years or over with an identified carer (n=1,828). The standard specifically refers to carers of adults. However, patients 17 years or over during the sampling period were included as it was possible that they were 17 years old at referral but turned 18 in the subsequent six months.

Figure 15 shows that carer-focused education and support programmes were offered to the carers of 50% (915) of these patients.

Figure 15: Percentage of identified carers of adult patients who were offered carer-focused education and support programmes. N=1,828

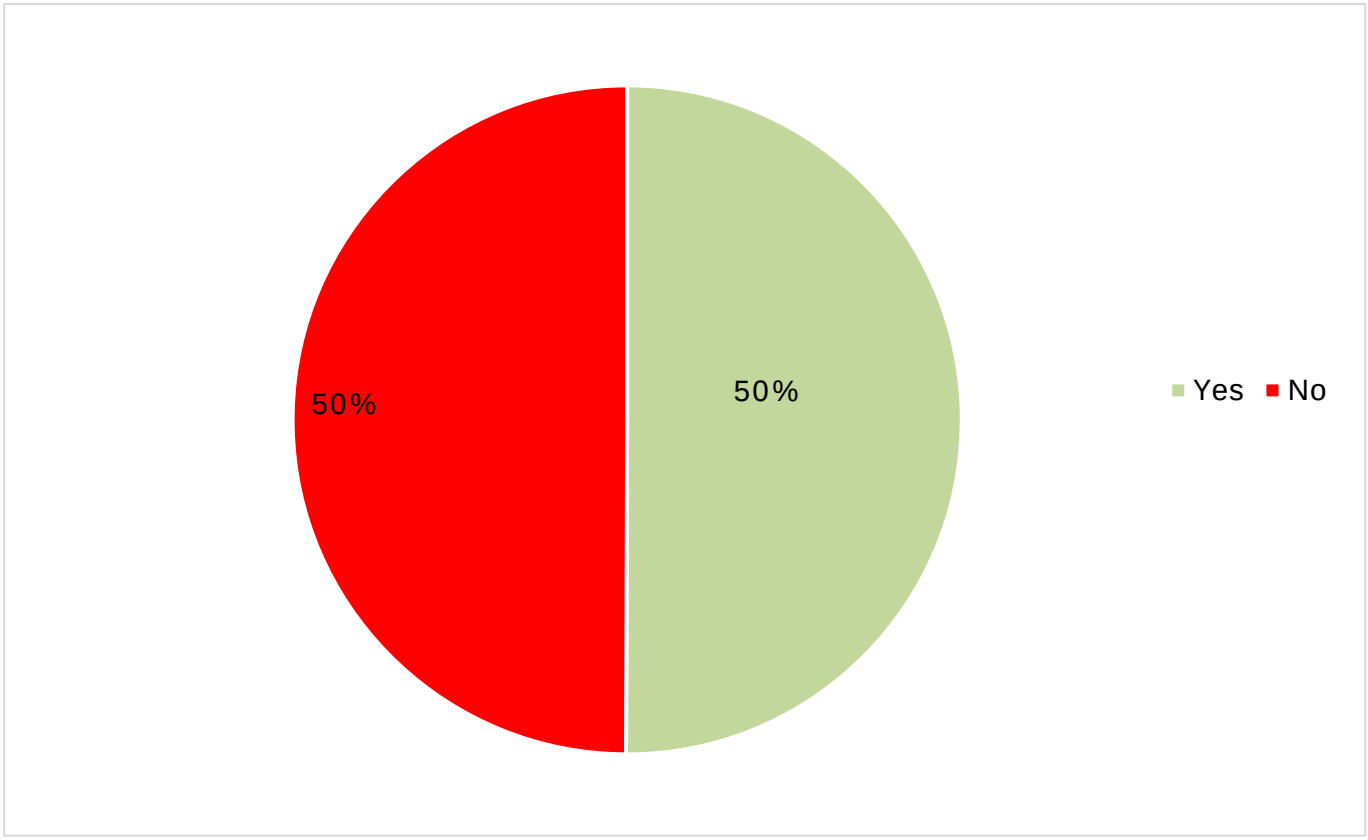
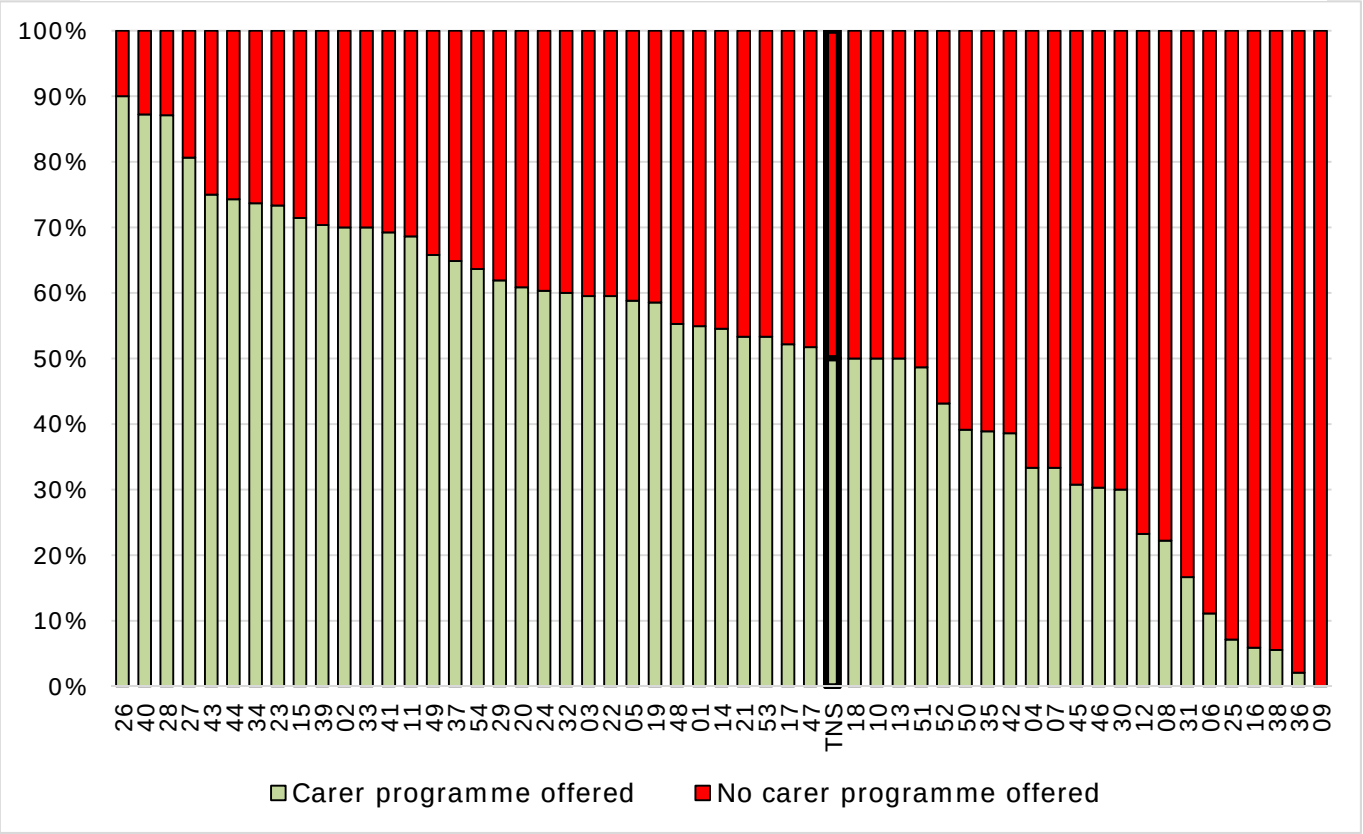


Figure 16 shows performance on standard 8 at a provider level.

Figure 16: Provider level percentage of identified carers of adult patients offered carer-focused education and support programmes. N=1,828



All 54 providers had eligible patients for this analysis and none of the providers fully met standard 8 at 100%. Of those providers who met the standard to some degree (n=53), performance against the standard ranged from 90% to 2%. One provider did not offer carer-focused education and support programmes to any carers of patients on their caseload.

Outcome measures

Nationally, three outcome measures have been recommended for routine use in EIP services by the EIP ERG and will ultimately be able to be collected and reported through the Mental Health Services Dataset. These are the Health of the Nation Outcome Scales (HoNOS) and the child and adolescent version (HoNOSCA) for under 18s (clinician rated outcome measure, CROM); DIALOG (patient rated outcome measure, PROM); and the Process of Recovery Questionnaire (QPR) (CROM). The audit also collected information on other standardised outcome measures used routinely.

There were 2,635 eligible patients who had been engaged by an EIP care coordinator.

Figure 17 shows the percentage of patients where a standardised outcome measure was used routinely.

Figure 17: Percentage of patients where HoNOS or HoNOSCA was used routinely. N=2,635

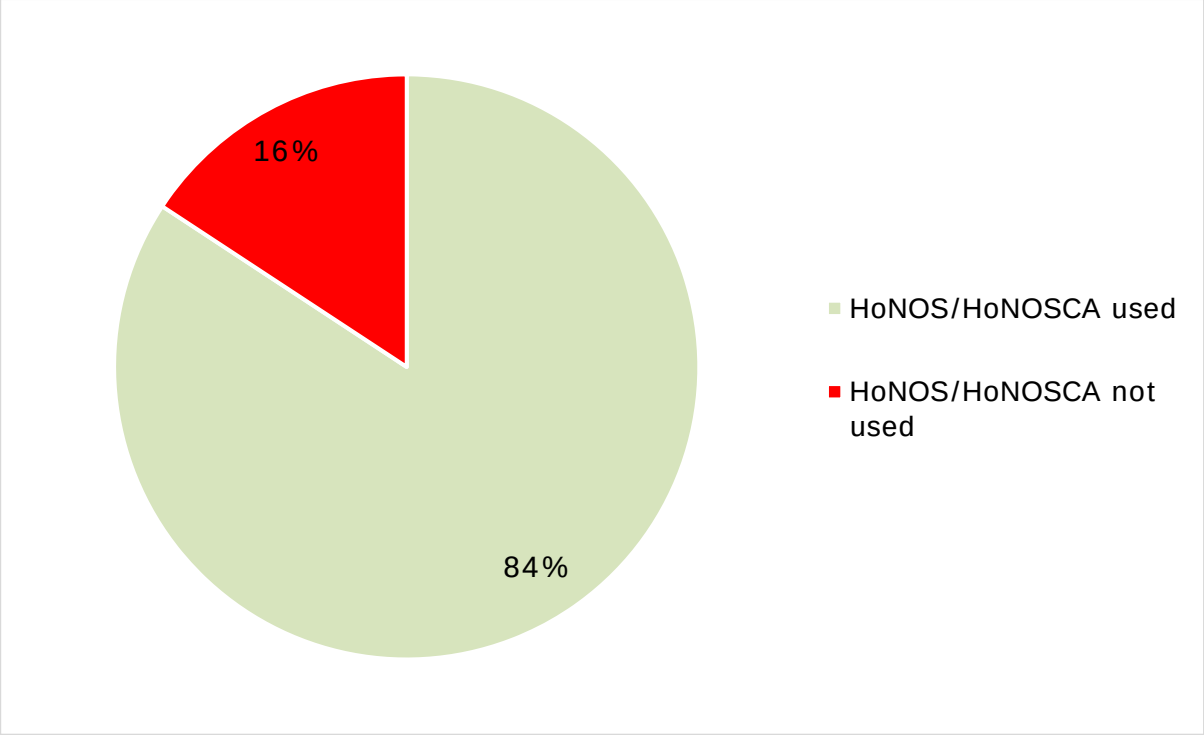


Table 14 provides information on the five most frequently used outcome measures. DIALOG is not included in this table as it was used for under 1% of patients. Please note that multiple outcome measures could be chosen.

Table 13: Percentage of patients where the five most frequently employed standardised outcome measures were used

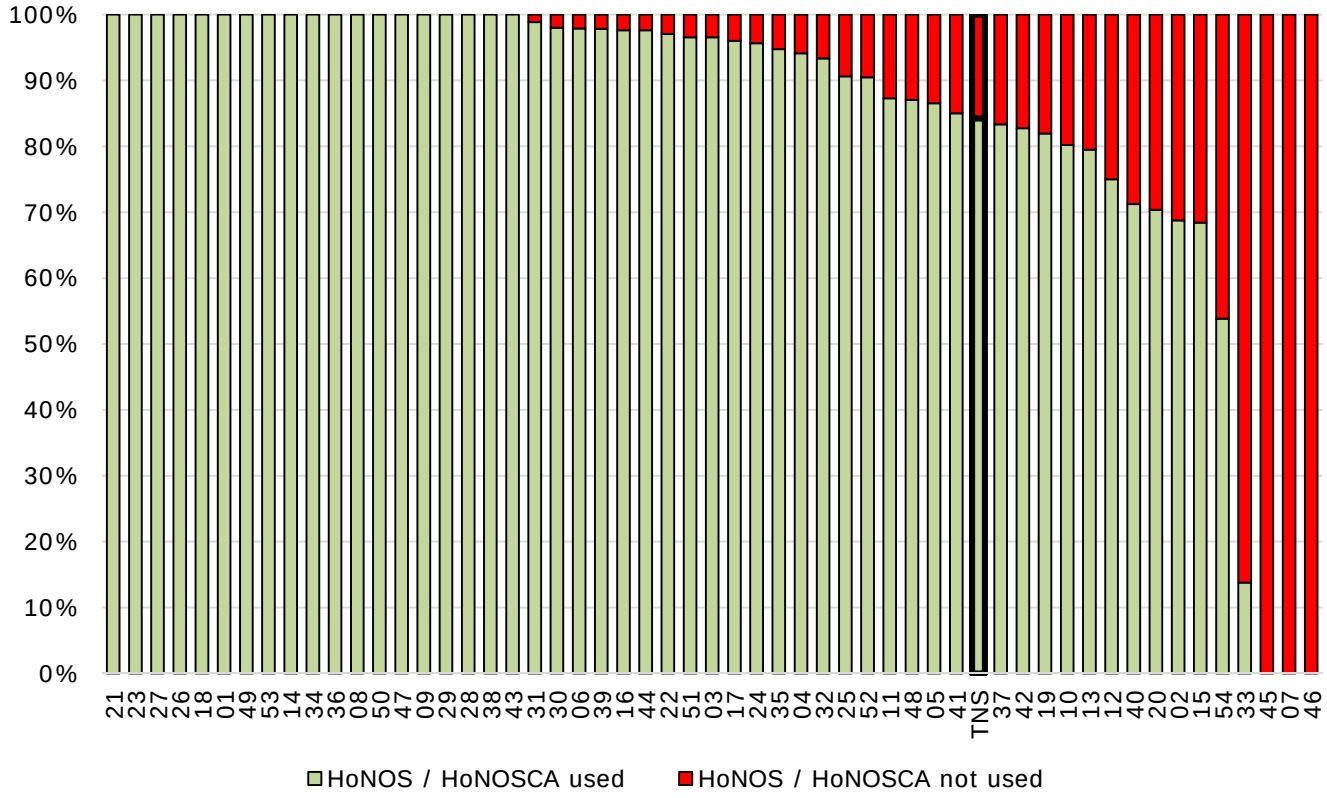
Outcome measure	N (%)
HoNOS / HoNOSCA*	2,220 (84%)
QPR*	169 (6%)
Positive and Negative Syndrome Scale (PANSS)*	124 (5%)
Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)**	103 (4%)
Clinical Global Impressions Scale (CGI)*	66 (3%)
Total patients	2,635 (100%)

** CROM; **PROM*

The HoNOS/HoNOSCA scale was used on 84% of patients. It is also notable that only one patient rated outcome measure was among the top five used routinely, and this was only reported being used for 103 (4%) patients.

Figure 18 presents the variation across providers for patients where HoNOS or HoNOSCA was used routinely.

Figure 18: Provider level percentage of patients where HoNOS/HoNOSCA was used routinely. N=2,635



The number of patients where HoNOS/HoNOSCA was used routinely varied from 100% to 0% of patients, with a TNS average of 87%. In nineteen (35%) providers one was used for 100% of patients.

Limitations of the methodology

The main limitations of the methodology were:

- Data returns were not evenly spread across providers. Reasons for this included: variation in numbers of patients accepted onto EIP team caseloads across providers; variation in numbers of EIP teams across providers
- The results are a 'snapshot' reflecting the time that data were collected. Therefore comparisons over time cannot be measured.
- Expected incidence rates of FEP for services between January and December 2014 were not available for all providers (e.g. if it was not routinely collected).
- For question 8 on the service-level data collection form ('how many people with a suspected first episode of psychosis were referred to your service 01 January 2014 – 31 December 2014') not all EIP services recorded these referrals separately. Their proxy therefore was to enter the number of all those referred to their service, which may not accurately reflect the numbers of those referred with suspects FEP specifically.
- Providers were directed to use the Psymaptic tool to determine the expected incidence of FEP for each team. They may also have used other data to estimate this figure. Please note this data is estimated and many teams had difficulties obtaining an accurate representation of this figure. This data should therefore be interpreted with caution.
- The Psymaptic tool that EIP services were referred to in order to determine their expected incidence of FEP has a lower age band of 16 years old, whereas many services operate from 14 years old.
- The definitions provided to providers to determine whether staff are CBTp/FI qualified may not fully capture all those that are, due to feedback from services to this end.
- Some patients were on the caseload of two EIP teams at the same time, for example university students. The data therefore may not accurately reflect what that specific team has provided, as for example if the university town team stated that CBTp was provided but it was actually

given by the home EIP team. However, the low numbers mean this is unlikely to be statistically significant.

- The initial definition of FEP was amended by the ERG one month after data collection started, therefore it is possible that some patients included by providers in their sample do not meet this new criteria. All providers were informed of the change.
- No data was collected on the patient uptake rates of the physical health interventions, support employment programmes or carer-focused programmes. In addition, although data on uptakes rates was collected where for CBTp and FI were offered to patients, the time period in which these therapies were taken up was not collected.
- There are some EIP patients who were not captured by the existing audit tools. These included:
    - Patients whose physical health assessments were carried out by a different team or EIP service in or outside the provider immediately prior to referral and acceptance onto the EIP caseload of the submitting provider.
    - Patients who needed an intervention for weight loss rather than obesity, as they were underweight.

Conclusion

Most people in England assessed as having first episode psychosis waited more than two weeks before they were allocated to and engaged by an EIP care coordinator The data showed marked variation across the country and whilst it is encouraging that some teams were able to begin assessment and engagement within two weeks of referral, other teams have work to do to improve their response times. The introduction of the access and waiting time standard together with other initiatives such as the EIP accreditation network and the new Mental Health Services Data Set (MHSDS), will help services to continue building on their work to deliver treatment to patients in a timely manner.

NICE quality standard QS80 state that patients should have access to psychological treatments. The data shows that only 41% of patients were offered CBTp, and under 1/3 (31%) of families were offered FI. Considerable variation across the country again suggests that teams have work to do to provide psychological treatments to all patients according to NICE standards of care. Funded Health Education England training for staff across the country will help develop staff skills in this area.

While it is encouraging that 87% of patients were offered screening in three or more physical health measures, the audit findings highlight the need to improve physical health screening and intervention in keeping with NICE standards of care. All patients should be screened and offered relevant interventions for physical health in line with NICE quality standard QS80 and other national programmes such as Commissioning for Quality and Innovation (CQUIN). The data here shows that work is still needed to provide a comprehensive programme of physical health screening and interventions for patients.

While work has been ongoing in preparation for the introduction of an EIP access and waiting time standard in April 2016, the audit findings show that access to NICE recommended care for patients with first episode psychosis varied considerably across England at the time when this baseline was conducted. Continuing work is needed to ensure that patients receive timely access to the NICE recommended package of care.

References

Achieving better access to mental health services by 2020. Department of Health 2014.

The Mandate. A mandate from the Government to NHS England: April 2015 to March 2016. Department of Health 2015.

The forward view into action: Planning for 2015/2016. NHS England, December 2014.

Implementing the Early Intervention in Psychosis Access and Waiting time standard. A commissioning guide based on NICE-recommended care. NICE and NHS England 2016.

National Institute for Health and Care Excellence (2015). Psychosis and Schizophrenia in Adults. NICE quality standard (QS80). 2015.

National Institute for Health and Clinical Excellence (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE guidelines (CG115). 2011.

National Institute for Health and Clinical Excellence (2007). Drug misuse in over 16s: psychosocial interventions. NICE guidelines (CG51). 2007.

NHS England. Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16. February 2015.

Shiers DE, Rafi I, Cooper SJ, Holt RIG. 2014 update (with acknowledgement to the late Helen Lester for her contribution to the original 2012 version) Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis and schizophrenia. 2014 update. Royal College of Psychiatrists, London.

Appendix A: Key of provider teams

The breakdown of teams in providers that participated in the national audit are listed below for use with the analysis on the service-level data in the report. In alphabetical order by provider name:

Provider name	Provider ID	Team name	Team number
2together NHS Foundation Trust	21	Herefordshire EIT	Team 1
		GRIP	Team 2
5 Boroughs Partnership NHS Foundation Trust	51	Warrington & Halton	Team 1
		St Helens & Knowsley	Team 2
		Wigan & Leigh	Team 3
Avon & Wiltshire Mental Health Partnership NHS Trust	55	North Somerset	Team 1
		South Gloucestershire	Team 2
		Swindon	Team 3
		BANES	Team 4
		Bristol	Team 5
		Wiltshire	Team 6
Barnet, Enfield & Haringey MH NHS Trust	35	Enfield EIS	Team 1
		Barnet EIS	Team 2
		Haringey EIS	Team 3
Berkshire Healthcare NHS Foundation Trust	23	Berkshire EIP Service	Team 1
Black Country Partnership NHS Foundation Trust	20	Wolverhampton Early Intervention	Team 1
		Sandwell Early Intervention	Team 2
Bradford District Care Trust	27	Bradford & Airedale EIP service (covers 3 CCG's: Bradford City, Bradford District and AWC)	Team 1
Cambridgeshire and Peterborough NHS Foundation Trust	26	CAMEO	Team 1
Camden and Islington NHS Foundation Trust	18	Camden	Team 1
		Islington	Team 2
Central and North West London NHS Foundation Trust	01	Brent EIS	Team 1
		Kensington, Chelsea and Westminster	Team 2
		Hillingdon and Harrow EIT	Team 3

Provider name	Provider ID	Team name	Team number
		Milton Keynes EIT	Team 4
Cheshire and Wirral Partnership NHS Foundation Trust	49	Wirral EIT	Team 1
		East EIT	Team 2
		CWP West	Team 3
Community Links Northern	05	aspire - Community Links	Team 1
Cornwall Partnership NHS Foundation Trust	53	Cornwall EIS	Team 1
Coventry and Warwickshire Partnership Trust	14	South Warwickshire	Team 1
		Coventry	Team 2
		North Warwickshire and Rugby	Team 3
Cumbria Partnership NHS Foundation Trust	16	EIT Cumbria (A-maze)	Team 1
Derbyshire Healthcare NHS Foundation Trust	41	Derby City EIT	Team 1
		County South Derbyshire EIT	Team 2
		County North Derbyshire EIS	Team 3
Devon Partnership Trust	25	North Devon STEP	Team 1
		Torbay STEP	Team 2
		Exeter STEP	Team 3
		East and Mid STEP	Team 4
		South and West STEP	Team 5
Dorset Healthcare University NHS Foundation Trust	37	EIS West	Team 1
		EIS East	Team 2
Dudley and Walsall Mental Health Partnership Trust	34	Dudley EIS	Team 1
		Walsall EIS	Team 2
East London NHS Foundation Trust	11	EIP Bedfordshire	Team 1
		Tower Hamlets EIS	Team 2
		Equip City and Hackney	Team 3
		Newham EIS	Team 4
Greater Manchester West Mental Health NHS Foundation Trust	40	Bolton	Team 1
		Trafford	Team 2
		Salford	Team 3
Hertfordshire Partnership University Foundation Trust	36	Hertfordshire EIP Pathway	Team 1
Humber NHS Foundation Trust	08	PSYPHER	Team 1
Isle of Wight NHS Trust	04	Early Intervention in Psychosis Team	Team 1
Kent and Medway NHS	24	Kent & Medway EIP	Team 1

Provider name	Provider ID	Team name	Team number
and Social Care Partnership Trust		Service	
Lancashire Care NHS Foundation Trust	45	Central Lancashire EIS	Team 1
		East Lancashire EIS	Team 2
		North Lancashire EIS	Team 3
Leicestershire Partnership NHS Trust	30	PIER	Team 1
Lincolnshire Partnership NHS Foundation Trust	54	Community Mental Health Team LPFT	Team 1
Mersey Care NHS Trust	19	Sefton & Kirkby	Team 1
		Liverpool	Team 2
NAViGO Health and Social Care CIC	07	Early Intervention in Psychosis and Transition Team	Team 1
Norfolk & Suffolk NHS Foundation Trust	12	Great Yarmouth and Waveney EIP	Team 1
		West Norfolk EIS	Team 2
		Central Norfolk EIT	Team 3
North East London NHS Foundation Trust	39	EIP Barking & Dagenham	Team 1
		Havering EIT	Team 2
		EIP Redbridge	Team 3
		EIP Waltham Forest	Team 4
North Essex Partnership NHS Foundation Trust	48	Early and Assertive Psychosis Team - West	Team 1
		Specialist Psychosis Team - North East	Team 2
		Specialist Psychosis Team - Mid	Team 3
North Staffordshire Combined Healthcare NHS Trust	17	Early Intervention in Psychosis Service	Team 1
Northamptonshire Healthcare NHS Foundation Trust	50	N-STEP Countywide	Team 1
Northumberland Tyne and Wear NHS Foundation Trust	46	EIP South Tyneside	Team 1
		EIP Sunderland	Team 2
		EIP Gateshead	Team 3
		EIP Newcastle & North Tyneside	Team 4
		EIP Northumberland	Team 5
Nottinghamshire Healthcare NHS Trust	47	EIP Bassetlaw	Team 1
		EIP Ashfield & Mansfield	Team 2
		EIP Newark & Sherwood	Team 3

Provider name	Provider ID	Team name	Team number
		EIP County South	Team 4
		EIP Nottingham City Team	Team 5
Oxford Health NHS Foundation Trust	03	Oxfordshire	Team 1
		Buckinghamshire	Team 2
Oxleas NHS Foundation Trust	02	Greenwich EIT	Team 1
		Bexley EIT	Team 2
		Bromley EIT	Team 3
Pennine Care NHS Foundation Trust	52	Oldham EIT	Team 1
		Bury EIT	Team 2
		Rochdale EIT	Team 3
		Tameside EIT	Team 4
		Stockport EIT	Team 5
Plymouth Community Healthcare	32	Insight Team	Team 1
Rotherham, Doncaster and South Humber Mental Health Foundation Trust	10	North Lincs EIT	Team 1
		Doncaster EIT	Team 2
		Manchester EIT	Team 3
		Rotherham EIT	Team 4
Sheffield Health & Social Care NHS Foundation Trust	09	Sheffield EIS	Team 1
Somerset Partnership NHS Foundation Trust	29	STEP	Team 1
South Essex Partnership University NHS Foundation	28	EIP East	Team 1
		EIP West	Team 2
South London and Maudsley NHS Foundation Trust	31	Croydon Early Intervention in Psychosis Service - COAST	Team 1
		Southwark Team For Early Intervention In Psychosis - STEP	Team 2
		Lewisham Early Intervention Service - LEIS	Team 3
		Lambeth Early Onset - LEO	Team 4
South Staffordshire and Shropshire Healthcare NHS foundation Trust	38	Shropshire,Telford & Wrekin Early Intervention	Team 1
		South Staffordshire EIT	Team 2
South West London and St George's Mental Health	42	Kingston EIS	Team 1
		Wandsworth EIS	Team 2

Provider name	Provider ID	Team name	Team number
Trust		Merton and Sutton EIS	Team 3
		Richmond EIS	Team 4
South West Yorkshire Partnership NHS Foundation Trust	33	Kirklees Insight Team	Team 1
		Barnsley EIT	Team 2
		Wakefield	Team 3
		Calderdale Insight EIP	Team 4
Southern Health NHS Foundation Trust	13	East Hampshire EIP	Team 1
		North EIP	Team 2
		West Hampshire EIP	Team 3
		Southampton EIP	Team 4
Surrey and Borders Partnership NHS Foundation Trust	44	EIIP East	Team 1
		EIP Service West Surrey & NE Hants	Team 2
Sussex Partnership NHS Foundation Trust	22	Bognor - West Sussex	Team 1
		Hailsham - East Sussex	Team 2
		Hastings - East Sussex	Team 3
		Worthing - West Sussex	Team 4
		Horsham - West Sussex	Team 5
		Brighton and Hove	Team 6
Tees, Esk and Wear Valleys NHS Foundation Trust	06	York & Selby EIP Service	Team 1
		Scarborough, Whitby, Ryedale EIP	Team 2
		South Durham EIP	Team 3
		North Durham EIP	Team 4
		Harrogate, Hambleton and Richmondshire EIP	Team 5
		South Tees EIP	Team 6
		North Tees EIP	Team 7
West London Mental Health NHS Trust	15	Hounslow	Team 1
		Hammersmith and Fulham EIS	Team 2
		Ealing EIS	Team 3
Worcestershire Health & Care NHS Trust	43	North Worcestershire EIT	Team 1
		South Worcestershire EIT	Team 2

In numerical order by Provider ID:

Provider name	Provider ID	Team name	Team number
Central and North West London NHS Foundation Trust	01	Brent EIS	Team 1
		Kensington, Chelsea and Westminster	Team 2
		Hillingdon and Harrow EIT	Team 3
		Milton Keynes EIT	Team 4
Oxleas NHS Foundation Trust	02	Greenwich EIT	Team 1
		Bexley EIT	Team 2
		Bromley EIT	Team 3
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		Buckinghamshire	Team 2
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Community Links Northern	05	aspire - Community Links	Team 1
Tees, Esk and Wear Valleys NHS Foundation Trust	06	York & Selby EIP Service	Team 1
		Scarborough, Whitby, Ryedale EIP	Team 2
		South Durham EIP	Team 3
		North Durham EIP	Team 4
		Harrogate, Hambleton and Richmondshire EIP	Team 5
		South Tees EIP	Team 6
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		West Norfolk EIS	Team 2
		Central Norfolk EIT	Team 3

Provider name	Provider ID	Team name	Team number
Southern Health NHS Foundation Trust	13	East Hampshire EIP	Team 1
		North EIP	Team 2
		West Hampshire EIP	Team 3
		Southampton EIP	Team 4
Coventry and Warwickshire Partnership Trust	14	South Warwickshire	Team 1
		Coventry	Team 2
		North Warwickshire and Rugby	Team 3
West London Mental Health NHS Trust	15	Hounslow	Team 1
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		Hailsham - East Sussex	Team 2
		Hastings - East Sussex	Team 3
		Worthing - West Sussex	Team 4
		Horsham - West Sussex	Team 5
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		Torbay STEP	Team 2
		Exeter STEP	Team 3
		East and Mid STEP	Team 4
		South and West STEP	Team 5
Cambridgeshire and Peterborough NHS	26	CAMEO	Team 1

Provider name	Provider ID	Team name	Team number
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		EIP Waltham Forest	Team 4
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		County South Derbyshire EIT	Team 2
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		Wandsworth EIS	Team 2
		Merton and Sutton EIS	Team 3
		Richmond EIS	Team 4
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		North Lancashire EIS	Team 3
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		EIP Sunderland	Team 2
		EIP Gateshead	Team 3
		EIP Newcastle & North Tyneside	Team 4
		EIP Northumberland	Team 5
Nottinghamshire Healthcare NHS Trust	47	EIP Bassetlaw	Team 1
		EIP Ashfield & Mansfield	Team 2
		EIP Newark & Sherwood	Team 3
		EIP County South	Team 4
		EIP Nottingham City Team	Team 5
North Essex Partnership NHS Foundation Trust	48	Early and Assertive Psychosis Team - West	Team 1
		Specialist Psychosis Team - North East	Team 2
		Specialist Psychosis Team - Mid	Team 3

Provider name	Provider ID	Team name	Team number
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		East EIT	Team 2
		CWP West	Team 3
Northamptonshire Healthcare NHS Foundation Trust	50	N-STEP Countywide	Team 1
5 Boroughs Partnership NHS Foundation Trust	51	Warrington & Halton	Team 1
		St Helens & Knowsley	Team 2
		Wigan & Leigh	Team 3
Pennine Care NHS Foundation Trust	52	Oldham EIT	Team 1
		Bury EIT	Team 2
		Rochdale EIT	Team 3
		Tameside EIT	Team 4
		Stockport EIT	Team 5
Cornwall Partnership NHS Foundation Trust	53	Cornwall EIS	Team 1
Lincolnshire Partnership NHS Foundation Trust	54	Community Mental Health Team LPFT	Team 1
Avon & Wiltshire Mental Health Partnership NHS Trust	55	North Somerset	Team 1
		South Gloucestershire	Team 2
		Swindon	Team 3
		BANES	Team 4
		Bristol	Team 5
		Wiltshire	Team 6

Appendix B: Data handling and analysis

Data entry and analysis

All data were entered using Formic Fusion Survey Software via secure webpages. Data were extracted to PASW Statistics 20/21 (SPSS) and analysed using PASW Statistics 20/21.

Anonymisation and confidentiality

During sampling, providers were asked to allocate codes to each eligible patient, which were used during data collection. It was stipulated that these should be independent codes that allowed the provider to identify patients for the purposes of data cleaning, and should not identify patients other than to those involved in data collection. The key to the patient codes was held by the provider and was not known to the EIP audit team.

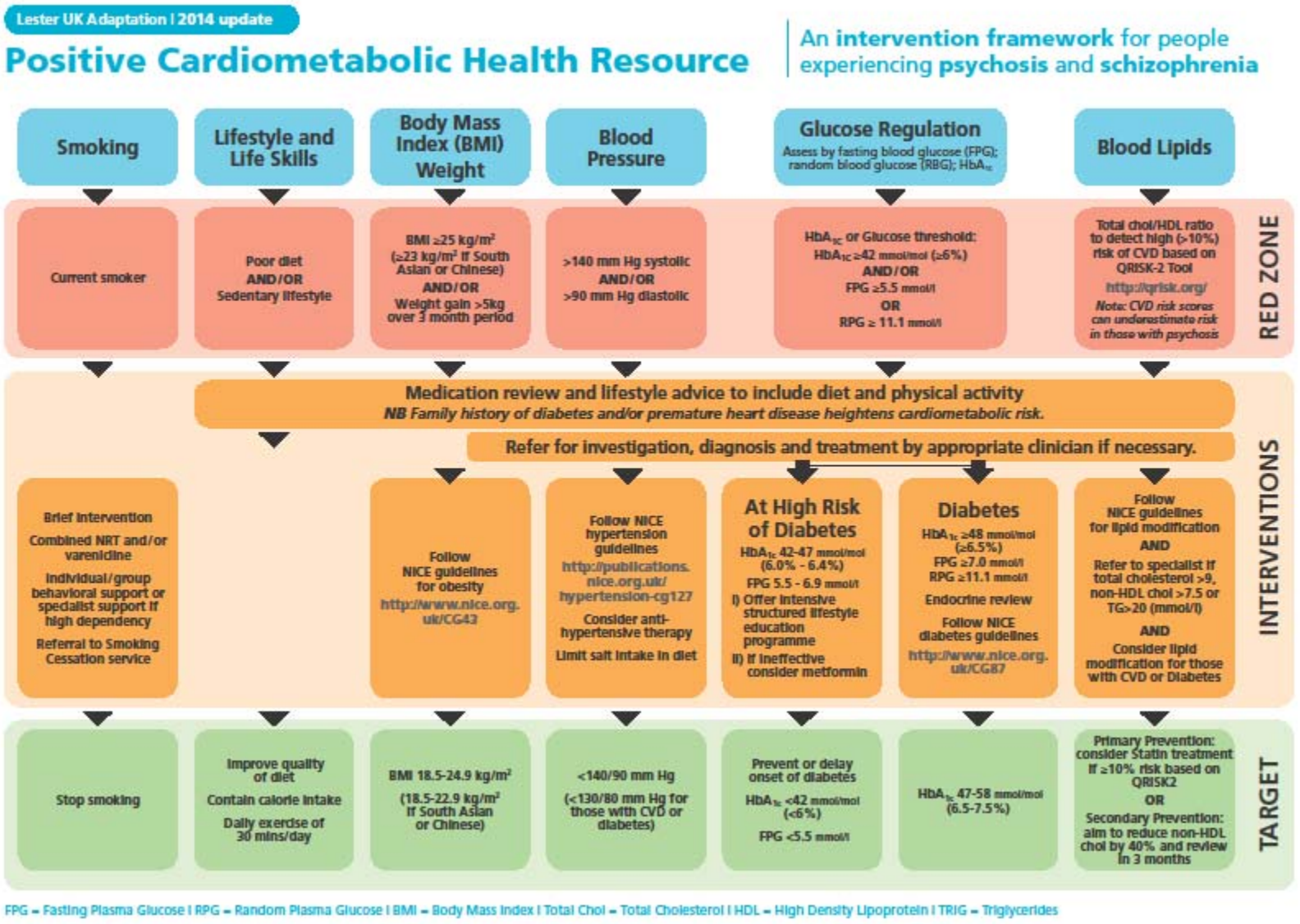
Data were submitted using the online data collection forms designed and hosted using Formic's Fusion solution. Formic abide by NHS security requirements and is ISO27001 certified and IGSoC Level 2 Compliant.

The RCPsych has a bank level end-to-end SSL/Transport Layer Security with 128 bit encryption. The online audit forms used to collect information were password protected. Each provider was provided with a username and password, also held by the EIP audit team.

Data cleaning

Data cleaning was carried out in January and February 2016. A detailed process was followed to identify cases that did not meet the sampling criteria and to check for any duplication of data, missing data, and unexpected values. Any suspected data errors were emailed back to providers on 14 January 2016 for clarification by the end of that month. Amendments were then made as necessary.

Appendix C: The positive Cardiometabolic Health resource (CMH-resource)



History and examination following initiation or change of antipsychotic medication

Frequency: Normally supervised by the psychiatrist. As a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.
Weight should be assessed weekly in the first six weeks of taking a new antipsychotic, as rapid early weight gain may predict severe weight gain in the longer term.
Subsequent reviews should take place annually unless an abnormality of physical health emerges. In these cases, appropriate action should be taken and/or the situation should be reviewed at least every 3 months.

At review

History: Seek history of substantial weight gain (e.g. 5kg), especially where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree <55 yrs male relatives and <65 yrs female relatives) and gestational diabetes. Note ethnicity.

Examination: Weight, BMI, BP, pulse.

Investigations: Fasting estimates of plasma glucose (FPG), HbA1c, and lipids (total cholesterol, non-HDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for triglycerides.

ECG: Include if history of CVD, family history of CVD; where examination reveals irregular pulse (if ECG confirms atrial fibrillation, follow NICE recommendations http://guidance.nice.org.uk/CG36); or if patient taking certain antipsychotics (See SPC) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further information).

Chronic Kidney Disease*: Screen those with co-existing diabetes, hypertension, CVD, family history of chronic kidney disease, structural renal disease (e.g. renal stones) routinely:

1. Monitor renal function: a) urea & electrolytes
   b) estimated glomerular filtration rate (eGFR)
2. Test urine: a) for proteinuria (dip-stick),
   b) albumin creatinine ratio (laboratory analysis)

*Presence of chronic kidney disease additionally increases risk of CVD: follow appropriate NICE guidelines on chronic kidney disease.

Monitoring: How often and what to do

Applies to patients prescribed antipsychotics and mood stabilizers.

	Baseline	Weekly first 6 weeks	12 weeks	Annually
Personal/FHx	■			■
Lifestyle Review[1]	■		■	■
Weight	■	■	■	■
Waist circumference	■			■
BP	■		■	■
FPG/HbA_{1c}	■		■	■
Lipid Profile[2]	■		■	■

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory
Monitoring table derived from consensus guidelines 2004, J clin. psych 65:2. APA/ADA consensus conference of 2004 published jointly in Diabetes Care and Journal of Clinical Psychiatry with permission from the Ontario Metabolic Task Force.

Specific lifestyle and pharmacological interventions

Specific lifestyle interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences:

- **Nutritional counselling:** reduce take-away and "junk" food, reduce energy intake to prevent weight gain, avoid soft and caffeinated drinks and juices, and increase fibre intake.
- **Physical activity:** structured education-lifestyle intervention. **Advise physical activity such as a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS).** For example suggest 30 minutes of physical activity on 5 days a week.

If the patient has not successfully reached their targets after 3 months, consider specific pharmacological interventions:

Anti-hypertensive therapy: Normally GP supervised. Follow NICE recommendations http://publications.nice.org.uk/hypertension-cg127.

Lipid lowering therapy: Normally GP supervised. (If total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l), refer to metabolic specialist.) Follow NICE recommendations http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf.

Treatment of diabetes: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/CG87.

Treatment of those at high risk of diabetes: FPG 5.5-6.9 mmol/l; HbA_{1c} 42-47 mmol/mol (6.0-6.4%)
Follow NICE guideline PH 38 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (recommendation 19) – http://guidance.nice.org.uk/PH38.

- Where intensive lifestyle intervention has failed **consider a metformin trial** (normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp.
  These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate).
- Start with a low dose e.g 500mg once daily and build up, as tolerated, to 1500–2000mg daily.

Review of antipsychotic and mood stabiliser medication:
Discussions about medication should involve the patient, the general practitioner and the psychiatrist. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effects:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic medication requires careful clinical judgment to weigh any benefits against the risk of relapse of the psychosis.
- An effective trial of medication is considered to be the patient taking the medication, at an optimum dosage, for a period of 4-6 weeks.
- If clinical judgment and patient preference support continuing with the same treatment, then ensure appropriate further monitoring and clinical considerations are carried out regularly.

It is advised that all side effects to antipsychotic medication are regularly monitored, especially when commencing a new antipsychotic medication (GASS questionnaire http://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/), and that any side effects, as well as the rationale for continuing, changing or stopping medication is clearly recorded and communicated with the patient.
The Psychiatrist should maintain responsibility for monitoring the patient's physical health and the effects of anti-psychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.
Discuss any non-prescribed therapies the patient wishes to use (including complementary therapies) with the patient, and carer if appropriate. Discuss the safety and efficacy of the therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.

Public Health England

NAS CCQI

NHS

This resource was co-produced by NHS England, NHS Improving Quality, Public Health England and the National Audit of Schizophrenia Team.

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Royal College of Physicians
Royal College of Nursing
Royal College of Surgeons (RC Surgeons)
UK Faculty of Public Health (FPH)
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Healthcare Quality Improvement Partnership (HQIP)
National Collaborating Centre for Mental Health (NCCMH)
Diabetes UK
Rethink Mental Illness

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Appendix D: Service-level data

Types of EIP Services

One-hundred-and-twenty-five teams (87%) classified themselves as a standalone specialist team/service with its own management structure (table 4). A minority of the teams stated being a service offered by staff embedded within existing Community Health Teams (CMHTs) (5; 3%) or based on a hub and spoke model in which EIP staff work in community teams but receive input from a central hub (1; 1%). Nine percent (13 teams) identified as being a different type of service.

Table 14: Service structure of teams

Type of service	N (%)
Standalone specialist team/service with its own management structure	125 (87%)
Service offered by staff embedded within existing community mental health teams	5 (3%)
Based on a hub and spoke model in which EIP staff work in community teams but receive input from a central hub	1 (1%)
Other	13 (9%)
Total	**144 (100%)**

Age range of patients

As can be seen in table 16, the most common combination of age limits that teams cater to for EIP services is between 14 and 35 years old (90 teams; 63%). Only 16 teams (11%) cater for patients between 14 and 65 years old. Twenty-four percent (34 teams) currently cater for patients aged up to and including 65 years of age, with 104 teams (72%) catering only for patients up to 35 years of age. Three teams (2%) have no upper age limit.

Table 15: Age limits of patients catered to by teams. N=144

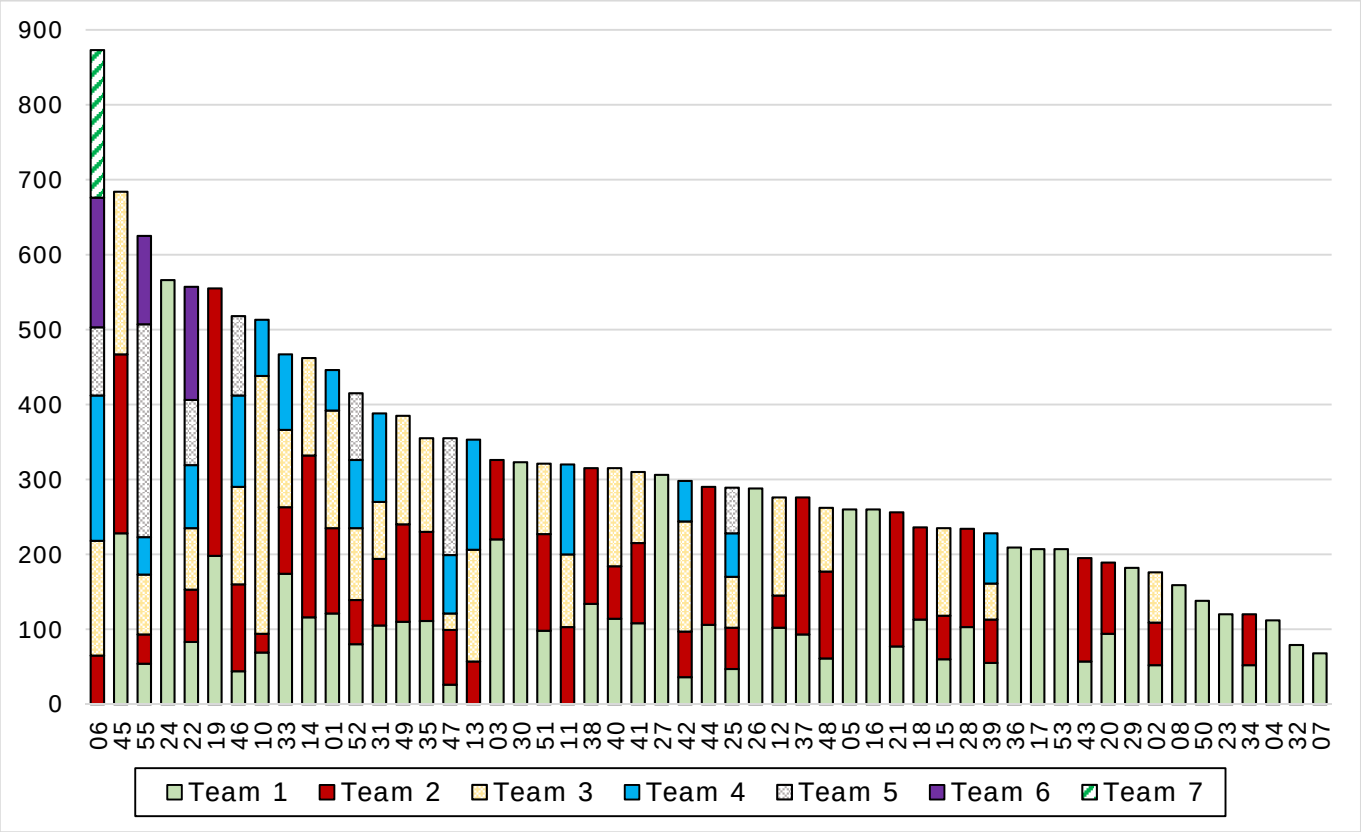
	Upper age limit	35 years	40 years	50 years	60 years	65 years	No upper limit	Total
Lower age limit	14 years	90 (63%)	0 (0%)	1 (1%)	1 (1%)	16 (11%)	3 (2%)	**111**
	16 years	2 (1%)	0 (0%)	0 (0%)	0 (0%)	2 (1%)	0 (0%)	**4**
	17 years	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (3%)	0 (0%)	**4**
	18 years	12 (8%)	1 (1%)	0 (0%)	0 (0%)	12 (10%)	0 (0%)	**25**
	Total	**104**	**1**	**1**	**1**	**34**	**3**	**144**

2014 referrals, acceptances and expected incidence rates

Large variation in these figures both between and within providers did not allow for meaningful national level analysis, so this information is shown at both provider and team level. Each provider's teams are coded as team 1, team 2 and so on. Please use the team name key provided in appendix B to identify individual teams within providers on figures 20- 25.

Suspected first episode psychosis referrals 01 January 2014 – 31 December 2014

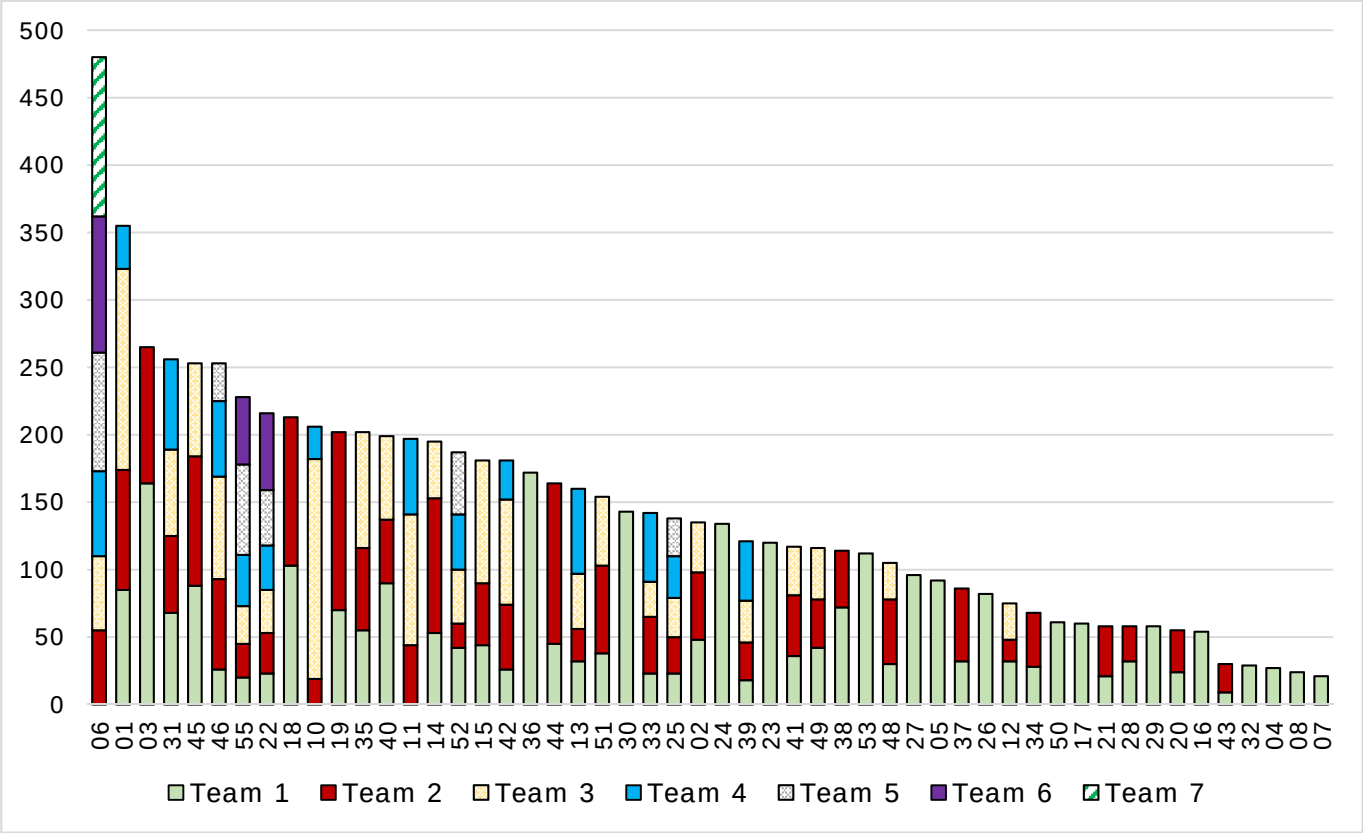
Figure 20: Numbers of teams' referrals of patients with first episode psychosis during 2014, split by teams within each provider. N=139



- Two providers are not represented in this figure as the data were unavailable for their team(s).
- Three providers are represented on the figure but did not report data for all their teams.

First episode psychosis acceptances 01 January 2014 – 31 December 2014

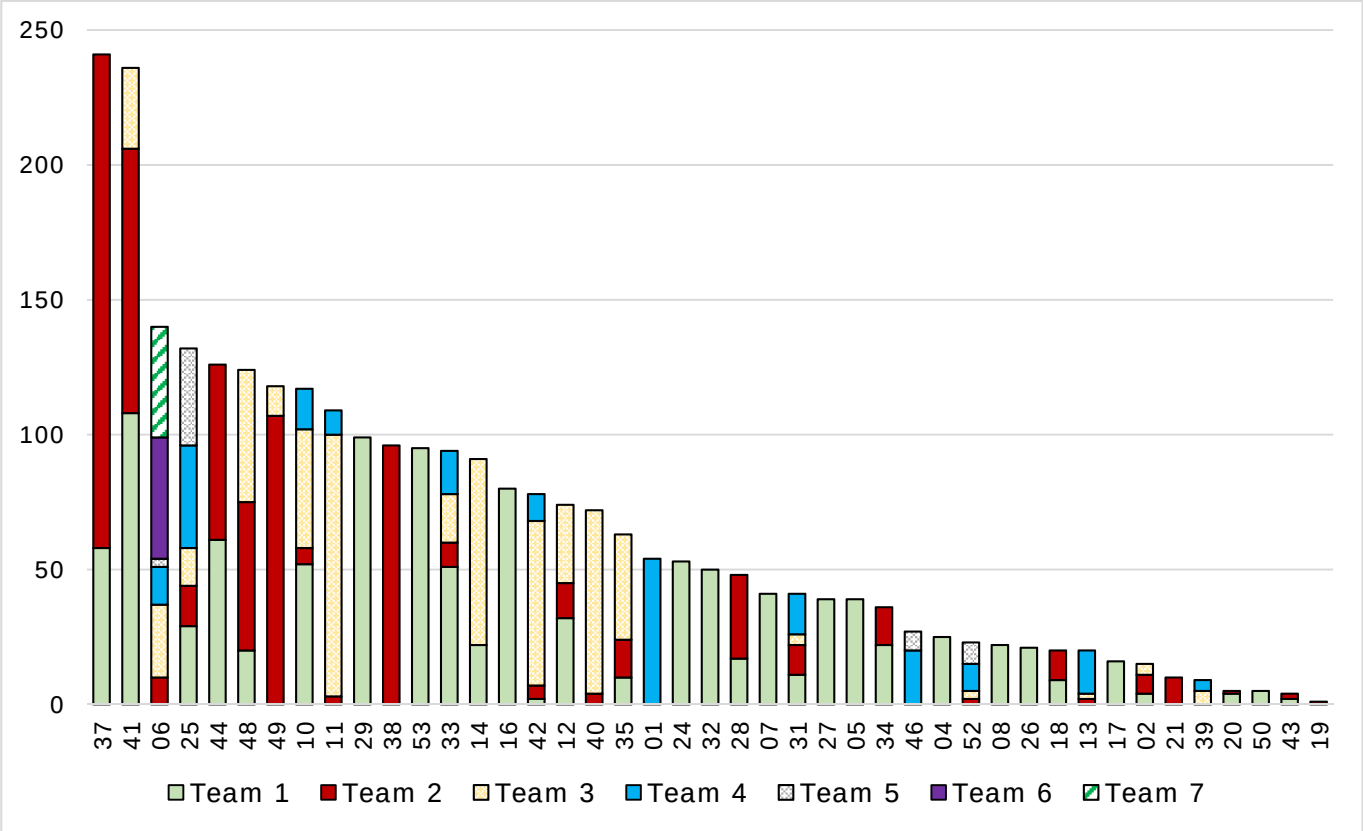
Figure 21: Numbers of teams' acceptances of patients with first episode psychosis during 2014, split by teams within each provider. N=134



- Three providers are not represented in this figure as the data were unavailable for their team(s).
- Two providers are represented on the figure but did not report data for all their teams.
- One provider is represented on the figure but reported a first episode acceptance figure of zero for one of their teams.

Suspected psychosis acceptances 01 January 2014 – 31 December 2014

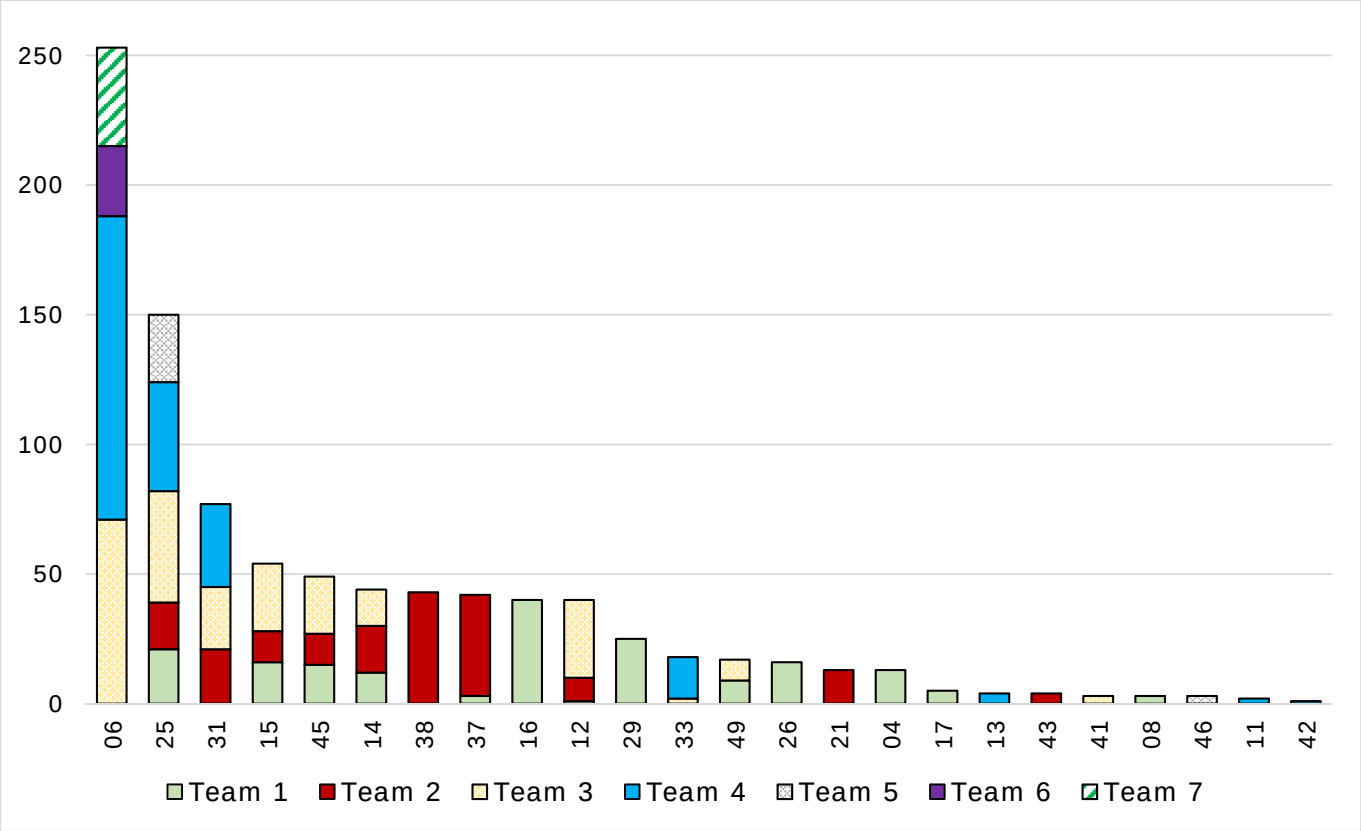
Figure 22: Numbers of teams' acceptances of patients with suspected psychosis during 2014, split by teams within each provider. N=93



- Seven providers are not represented in this figure as the data were unavailable for their team(s).
- Five providers are not represented in this figure as they reported a suspected psychosis acceptance figure of zero for their team(s).
- Six providers are represented on the figure but did not report data for all their teams.
- Seven providers are represented on the figure but reported a suspected psychosis acceptance figure of zero for a number of their teams.

ARMS acceptances 01 January 2014 – 31 December 2014

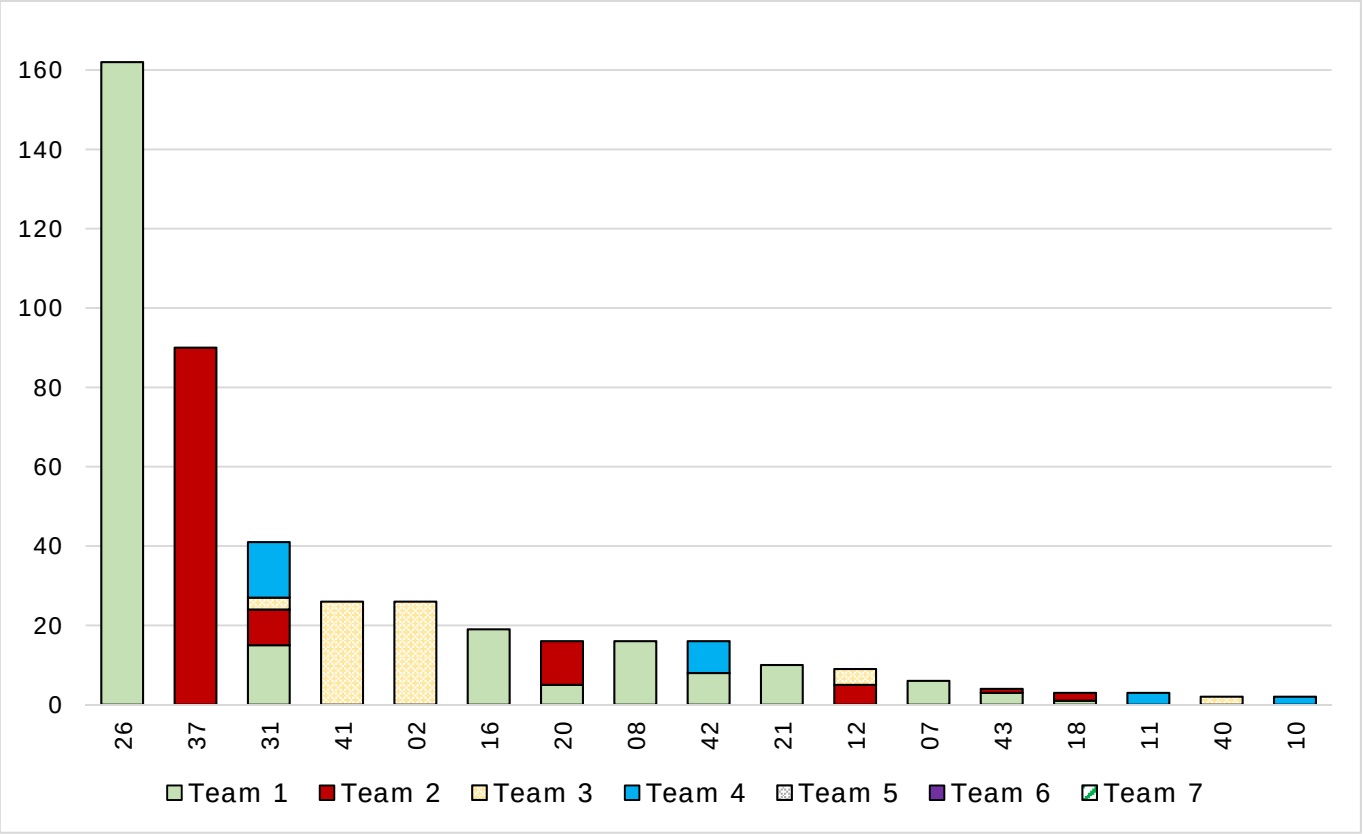
Figure 23: Numbers of teams' acceptances of ARMS patients during 2014, split by teams within each provider. N=44



- Ten providers are not represented in this figure as the data were unavailable for their team(s).
- Nineteen providers are not represented in this figure as they reported an ARMS acceptance figure of zero for their team(s).
- Two providers are not represented on this figure as they had a combination of the data being unavailable and ARMS acceptance figures of zero for their teams.
- Four providers are represented on the figure but did not report data for all their teams.
- Ten providers are represented on the figure but a number of their teams are not shown as they reported an ARMS acceptance figure of zero.

‘Other’ condition acceptances 01 January 2014 – 31 December 2014

Figure 24: Numbers of teams’ acceptances of patients with an ‘other’ condition during 2014, split by teams within each provider. N=25

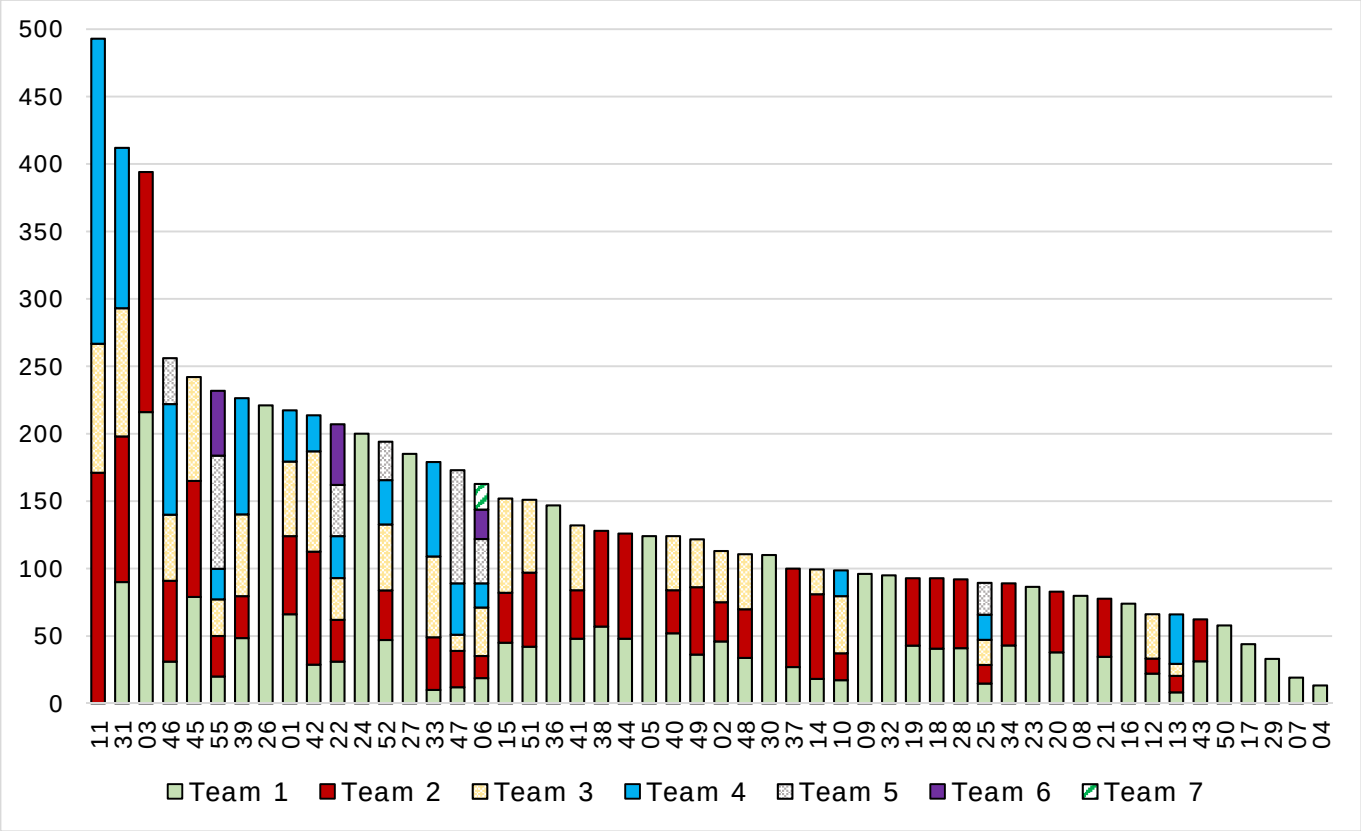


- Nine providers are not represented in this figure as the data were unavailable for their team(s).
- Twenty-five providers are not represented in the figure as they reported an ‘other’ condition acceptance figure of zero for their team(s).
- Four providers are not represented on this figure as they had a combination of the data being unavailable and ‘other’ condition acceptance figures of zero for their teams.
- Two providers are represented on the figure but did not report data for a number of their teams.
- Eight providers are represented on the figure but a number of their teams are not shown as they reported an ‘other’ condition acceptance figure of zero.

Expected incidence of first episode psychosis

Data were calculated by teams using the online Psymaptic tool with the support of their regional lead. Many teams had difficulties obtaining an accurate representation of this figure, therefore this data should be interpreted with caution.

Figure 25: Numbers of teams' annual expected incidence of patients with first episode psychosis, split by teams within each provider. N=138



- Three providers are not represented in this figure as the data were unavailable for their team(s).
- One provider is represented on the figure but did not report data for all their team(s).

Working time with patients with psychosis

A minority of teams (3; 2%) responded that their service specification did not state a maximum length of time the service should work with people with psychosis. The majority of teams (128; 89%) stated a specification to work with psychosis patients for a maximum of three years (table 17).

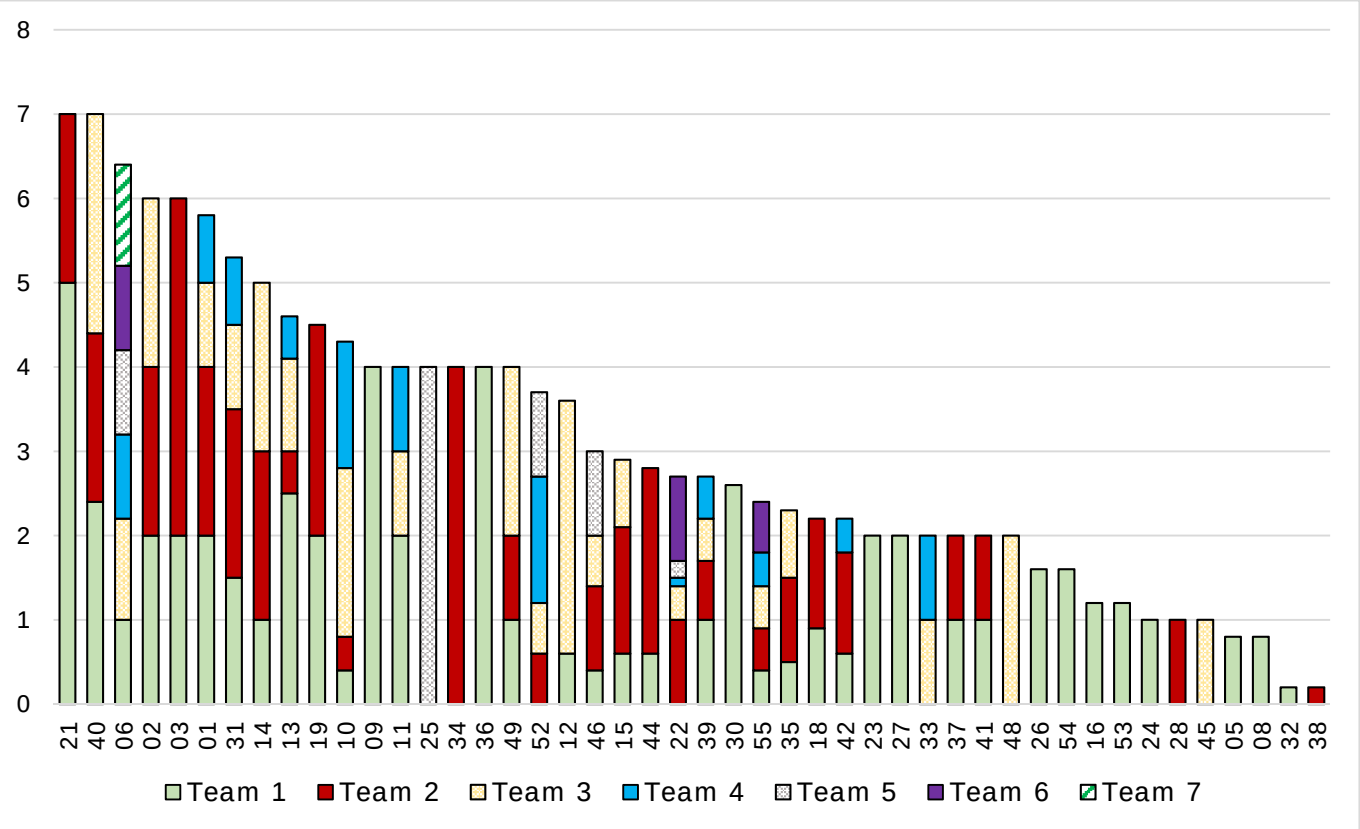
Table 16: Teams' specified maximum time to work with a patient with psychosis

Time specified	N (%)
15 months	1 (1%)
2 years	7 (5%)
3 years	128 (89%)
4 years	1 (1%)
5 years	4 (3%)
No maximum time specified	3 (2%)
Total	**144 (101%)**

Number of staff qualified to deliver Cognitive Behavioural Therapy for Psychosis (CBTp)

Teams used the guidance supplied to determine whether staff met the criteria to be considered qualified to provide CBTp. Guidance available on demand. Providers may wish to compare numbers of qualified staff with data on patient acceptances and expected incidence in 2014, shown in figures 20 - 25, bearing in mind that the data here refer to staffing levels in December 2015.

Figure 26: Number of teams' CBTp qualified staff (WTE), split by teams within each provider. N=144

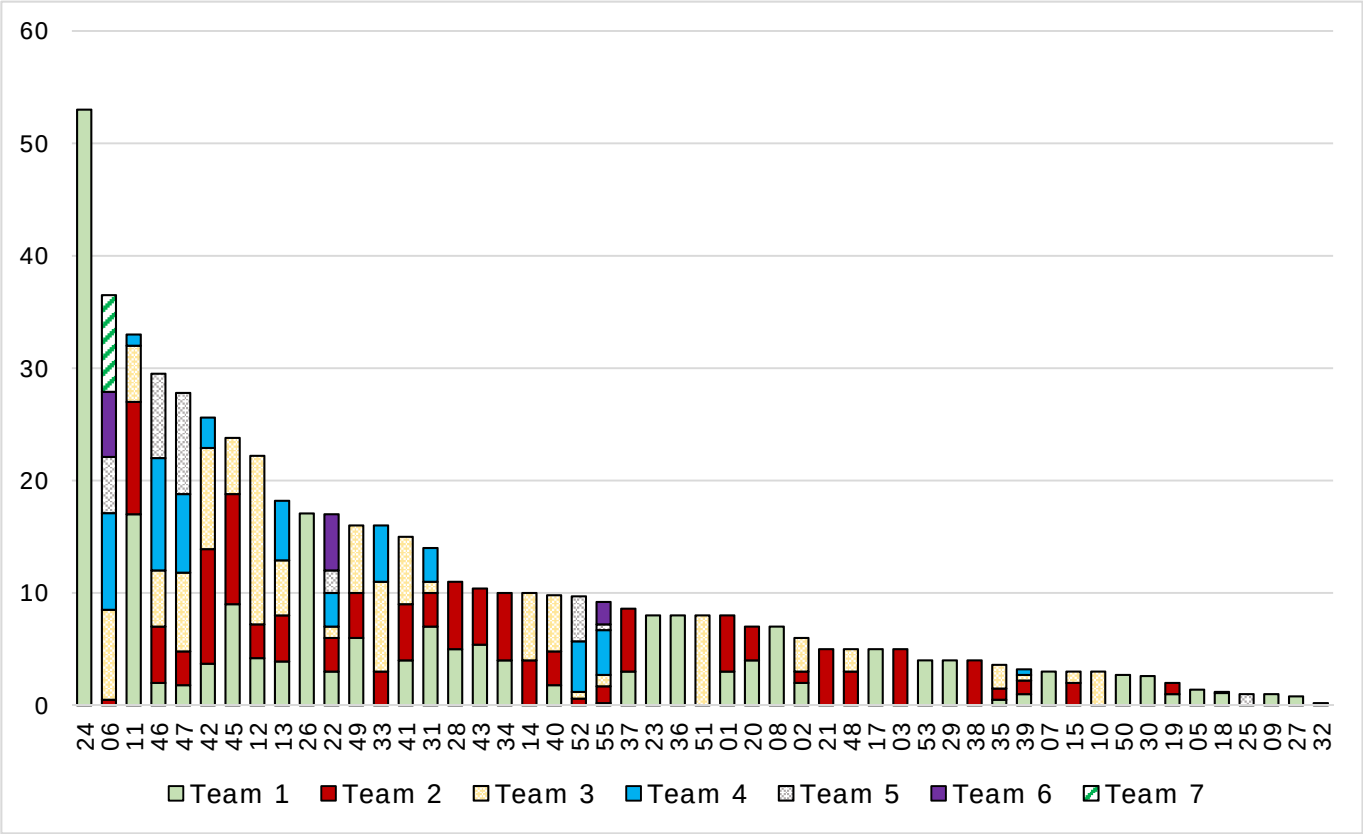


- Nine providers are not represented in this figure as they reported no CBTp qualified staff for their team(s).
- Sixteen providers are represented on the figure but reported zero CBTp qualified staff for a number of their teams.

Number of staff qualified to deliver Family Intervention (FI)

Teams used the guidance supplied to determine whether staff met the criteria to be considered qualified to provide Family Intervention. Guidance available on demand. Providers may wish to compare numbers of qualified staff with data on patient acceptances and expected incidence in 2014, shown in figures 20 - 25, bearing in mind that the data here refer to staffing levels in December 2015.

Figure 27: Number of teams' FI qualified staff (WTE), split by teams within each provider. N=119



- Four providers are not represented in this figure as they reported no FI qualified staff for their team(s).
- One provider is represented on the figure but did not report data for their team(s).
- Twelve providers are represented on the figure but reported zero FI qualified staff for a number of their teams.

Education / employment programmes provided by EIP services

Around a fifth of EIP teams (32; 22%) stated that their service did not provide employment and education support services to patients or refer them to third parties (table 18). Table 19 shows that of the 112 teams (78%) who did provide these services or referred patients to third parties providing these services, the most commonly offered to patients was a vocational support programme, offered by 67 teams (60%). A fifth of teams (22 teams; 20%) stated they offered types of support which were not listed in the audit tool. Please note that multiple responses could be chosen.

Table 17: Teams providing education and support services. N=144

Does your service or third party provide employment and support services to patients?	N (%)
Yes	112 (78%)
No	32 (22%)
Total	**144 (100%)**

Table 18: Type of education and support services offered. N=112

Type of service(s) provided	N (%)
Vocational Support Programme	67 (60%)
Supported Employment Programme (IPS)	42 (38%)
Other Supported Employment Programme	38 (34%)
Other	22 (20%)
Education Programme	20 (18%)
Apprenticeship Programme	7 (6%)
Total	**196 (175%)**

Type of staff providing education / employment support programmes

In teams where these services are provided (n=112), there is no clear division in the type of staff providing them. Occupational therapists are marginally the most commonly cited type of staff, but there is less than 10% difference between the percentage of response for them (41%) and the second from bottom most chosen staff, mental health nurses (34%). Over a quarter of teams, (26%, 29) also chose an 'other' designation of staff.

Table 19: Percentages and numbers of the designation of staff providing education and support services

Designation of staff providing employment and education support	N (%)
Occupational therapists	46 (41%)
Support and recovery workers	44 (39%)
Employment support workers	43 (38%)
Mental health nurses	40 (36%)
Vocational/employment advisors	38 (34%)
Other	29 (26%)
Social workers	18 (16%)
Total	**258 (230%)**

Appendix E: Free text responses

Service-level audit tool

Q1: Other types of EIP service

Other type of service structure	N
A stand alone specialist team/service with a shared management structure.	5
A stand alone team with shared manager with community psychosis team.	2
Currently Oldham have a standalone team for medical cover at 33 hours medical cover and 7 fte care coordinators and 1 fte support worker current case load currently 179. Psychological therapies is shared across 3 boroughs: Oldham, Rochdale and Bury boroughs this includes 1 full time cbt therapist and 1 part time psychologist 33 hours, both have supervisory and training roles in inclusive hours and cover a large radius as not based in Oldham or Rochdale boroughs but based in Bury travelling time impacts on available therapy time for Rochdale and Oldham. Following assessment from psychological therapies the client goes onto an 11 month waiting list if they wish to continue with therapy after the assessment with the psychologist or cbt therapist.	1
HPFT delivers a service to people experiencing a first episode psychosis through a pathway in Targeted Treatment Teams (these teams work with people suffering with psychosis through all parts of the recovery process) and the CAMHS service.	1
Hub & spokes managed as 1 EIP service & separate to community teams.	1
Integrated services into psychosis and recovery pathways.	1
Service with its own management structure - Based on a hub and spoke model in which EIP staff work in community teams but receive input from a central hub.	1
Standalone team within CMHT with shared management.	1

Q9: Other employment and education support services offered to patients

Other services specified	N
Offer IPS approaches, local links with employment and education, Job centres. Job retention support with current employers. Strong links with universities/colleges (Disability Workers in the Student welfare departments).	2
OT.	2
Signpost to Job Centre Plus.	2
Individual support for occupational, educational and social recovery.	1
Generic supported employment programmes.	1
OT Assessments, connecting and supporting patients with links to local colleges and local employment.	1
Remploy.	1
Signpost to partners for vocation and education support ie City Limits, Job Centre Plus.	1
Support groups in returning to mainstream employment/education.	1
Support in accessing employment/education, signposting to third parties and also used to support this process.	1
Support with CVs.	1
Support with existing employment or those seeking employment.	1
Tailored input from vocational workers.	1
Voluntary placements.	1
We use "Chapter", a locally based 3rd sector service with connections with local employers to help patients identify employment & voluntry opportunities. Sometimes our support workers add additional support during the employment seeking process.	1
Work Clinic provided by Vocational Service.	1
x 2 OTs in team trained in individual placement support and using principles in clinical work in the team. Partnership service provide by Mind Employment service with a surgery held in the team weekly to	1

advice and support service users. Quick access service for 18 - 25 year olds provided with a further service for over 25 years olds. Lead EQuip liaison worker with Mind employment worker. Partnership service provided by Hackney community college with a regular surgery for service users to gain support, advice and information re: available and suitable college courses, access to education, support when in education and gaining employment skills.

Q10: Other designation of staff providing employment and education support services

Other designation of staff	N
Provided by partner agencies/ 3rd party/sector staff/agencies; including: MIND, Talent Match and The Princes Trust.	6
Employment Specialist.	3
Vocational Specialists (one no longer in post, funding discontinued).	3
Assistant Practitioners.	3
Youth Support Workers.	2
Education programme - Recovery College.	1
EIPS Rethink MHSW - Confidence to Work Course; Access to Trust employment advisors - part of community resource team; Access to abilities, SWARC, Connexions..	1
Employment retention officer.	1
Employment specialist shared within Newham Locality with other Community Mental Health Teams.	1
Mind Employment worker; Hackney community college; Specialist mental health liaison advisor.	1
Options Recovery College Staff.	1
OT/CCO in team provide this support. HCA 0.8 WTE.	1
Outside agencies also work with our SU in supporting employment.	1
Recovery workers/professionally/non-professionally qualified staff with specific responsibility for occupational, educational & social recovery.	1
Rehabilitation Employment Specialist.	1

Rethink.	1
We have access to an Education Link worker for individual support for our clients - she offers support across all community MH services so her capacity for STEP clients is limited.	1
We have access to OTs and employment workers in the wider CMHT. Recovery workers in EI have had vocational support training. Local statutory and 3rd sector organisations.	1