NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

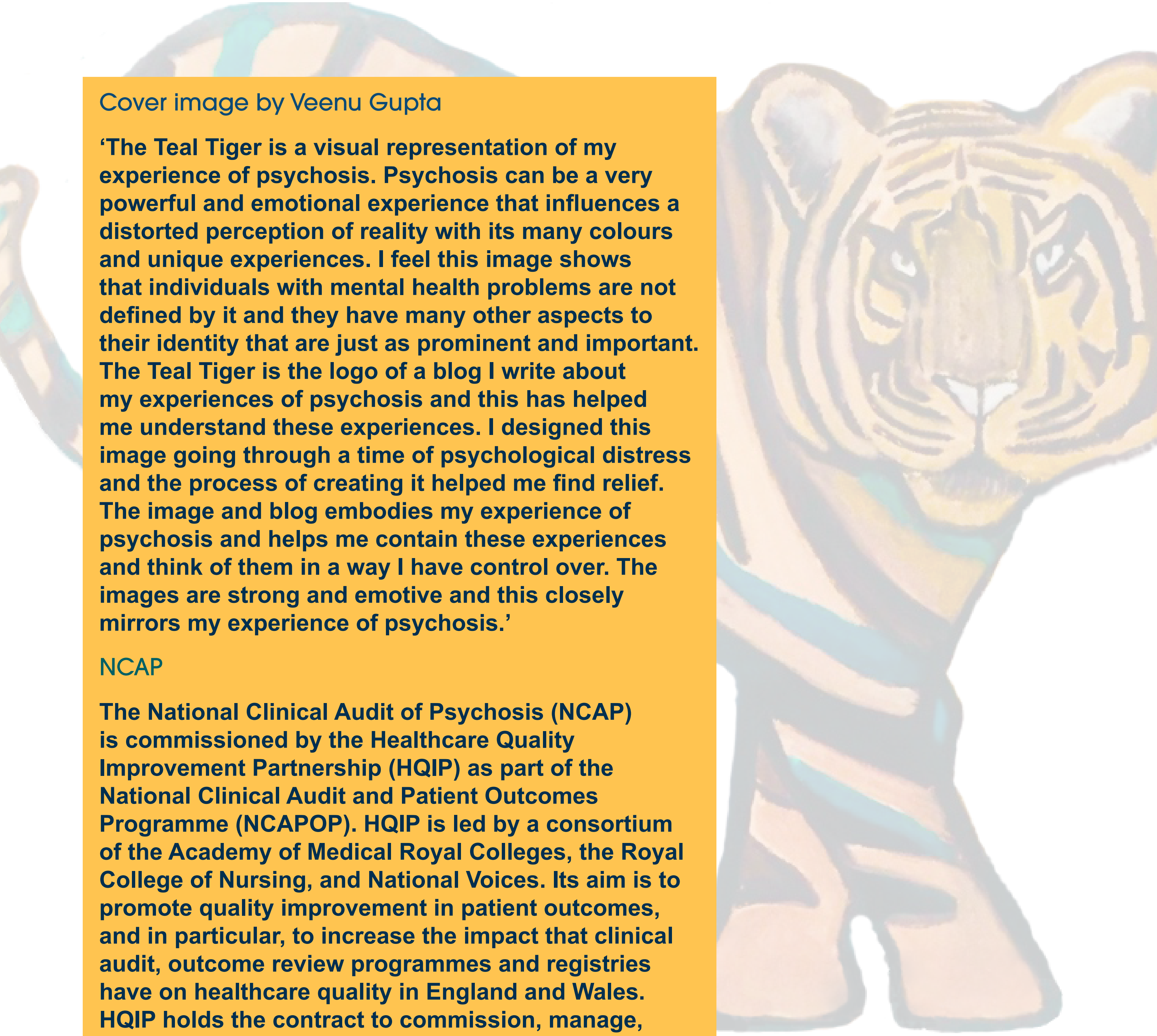
HQIP
Healthcare Quality Improvement Partnership

# National Clinical Audit of Psychosis

## Early Intervention in Psychosis Audit

2019/2020

National report



## Cover image by Veenu Gupta

‘The Teal Tiger is a visual representation of my experience of psychosis. Psychosis can be a very powerful and emotional experience that influences a distorted perception of reality with its many colours and unique experiences. I feel this image shows that individuals with mental health problems are not defined by it and they have many other aspects to their identity that are just as prominent and important. The Teal Tiger is the logo of a blog I write about my experiences of psychosis and this has helped me understand these experiences. I designed this image going through a time of psychological distress and the process of creating it helped me find relief. The image and blog embodies my experience of psychosis and helps me contain these experiences and think of them in a way I have control over. The images are strong and emotive and this closely mirrors my experience of psychosis.’

## NCAP

The National Clinical Audit of Psychosis (NCAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes

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Designed and typeset by Helen Greenwood.

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# 1. Introduction

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

For the 2019/2020 report, NCAP collected data from EIP teams on the care provided to people aged 14 – 65 (referred to in the report as the ‘case-note audit’), as well as information from people with FEP aged 14 – 65 treated by EIP teams, to understand more about their experience of care (referred to in the report as the ‘service user survey’).

The aim of NCAP is to improve the quality of care that NHS Mental Health Trusts in England and Health Boards in Wales provide to people with psychosis. Services are measured against criteria relating to the care and treatment they provide, so that the quality of care can be improved. The audit is a 3-year programme with a 2-year extension, commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and NHS Improvement. The first year of the audit examined care provided to people with psychosis by inpatient and outpatient services; in years 2 (2018/2019) and 3 (2019/2020), the audit has looked at the care provided by EIP services.

EIP services in Wales are in an earlier developmental stage than those in England. This report provides the findings of the audit for England. A separate national report is produced for Wales.

The standards for the EIP audit are based on the 2016 Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016) which details a National Institute for Health and Care Excellence (NICE) recommended package of EIP care for treating and managing psychosis (NICE quality standard [QS] 80, 2015; NICE QS102, 2015). The service user survey was developed to allow service users to feedback on their experience of EIP services. NCAP worked with people who had experience of EIP services to develop the survey, and the survey asks about elements of care they felt were important.

## How to read this report

### Icons

**These icons are used throughout this report to indicate where content relates to the case-note audit or the service user survey.**

Case-note audit icon

Service user survey icon

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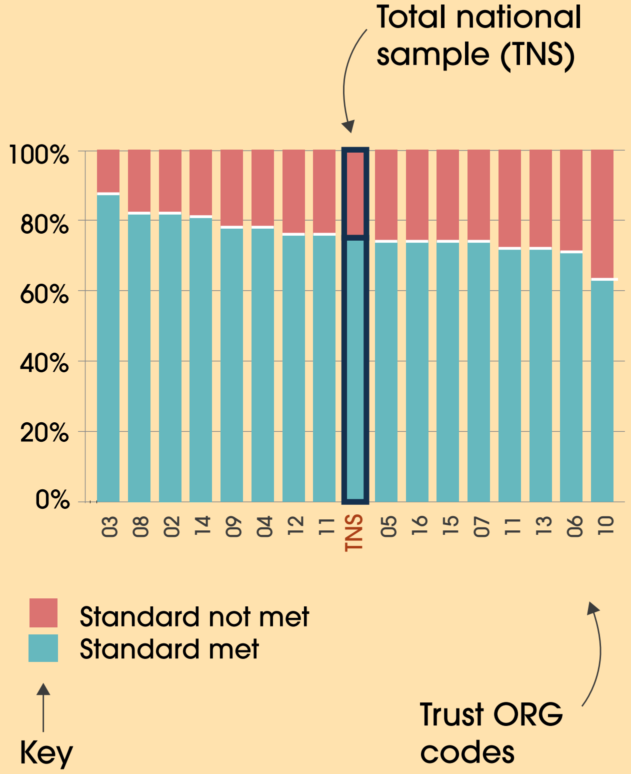
### Bar charts

**Bar charts provide a breakdown of the data at Trust level and allow for comparisons. Each bar represents the performance of an individual Trust which can be identified by its unique ORG ID. The total national sample (TNS) is indicated by a bolded bar**



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### Percentages

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

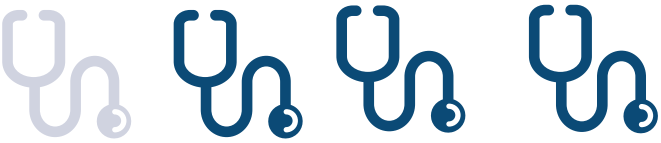
# 2. Case-note audit: key findings

## Waiting times

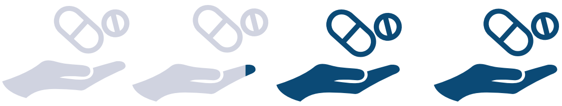
**74%** of patients began early intervention treatment within 2 weeks of referral

## Physical health

**75%** of patients received all seven physical health screenings



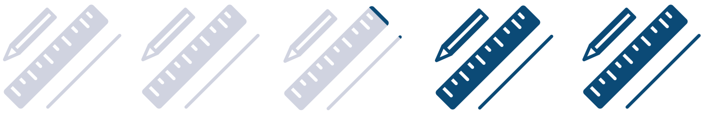
## Medication



**52%** of patients with at least 2 unsuccessful trials of antipsychotics were offered clozapine

## Outcome measures

**41%** of patients had outcomes measured 2 or more times within 12 months

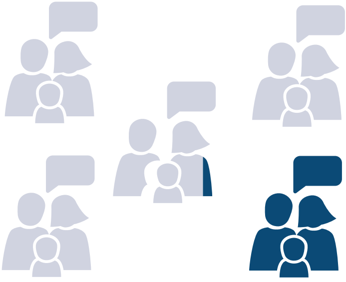


## Intervention and support

**49%** took up CBTp

**21%** took up family interventions

**31%** took up employment support



# 3. Executive summary

**This report presents the findings from the 2019/2020 NCAP EIP audit collected via a case-note audit and a survey of people who have used EIP services. The report provides national and organisation-level findings on the treatment of people by teams in England. There is a separate national report for Wales. All services including Welsh Health Boards will receive local reports for each of their EIP teams in 2020.**

## Background

In 2019, NHS England published the NHS Long Term Plan (NHS England, 2019) and the NHS Mental Health Implementation Plan 2019/20 – 2023/24 (NHS England, 2019). These plans set new targets for access to a NICE-approved care package within 2 weeks of referral for people experiencing FEP and achievement of NICE concordant treatment by EIP services, and built on the requirements of the original Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016).

## Method

All NHS-funded EIP teams in England were expected to take part in the audit. Data were collected via a case-note audit and service-level questionnaire completed by EIP teams, and a survey completed by people with FEP who have used EIP services.

Teams were asked to send a service user survey to a random sample of up to 150 people aged 14 to 65 with FEP who had been on their caseload for at least 6 months on the census date of 1 April 2019 and who remained on the caseload in June 2019. They were also asked to submit case-note data on a random sample of up to 100 people per team, taken from people who had been sent a service user survey. Each team was also asked to complete a contextual questionnaire about the type of service they deliver, which considers issues that impact on team's ability to deliver the EIP access standard.

As in the NCAP EIP Spotlight Audit 2018/19, the standards for this audit are based on the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016), which details a NICE-recommended package of EIP care for treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015).

## Response rate

Data were submitted for the case-note audit by all 57 service providers with eligible cases, which included Mental Health Trusts and other organisations providing NHS services to people with FEP (referred to as 'Trusts' in the remainder of this report). Service user surveys were received from people treated by teams in 56 Trusts.[1]

Data were submitted for 10,714 people from 155 EIP teams in England; 10,560 were used in the final analysis (97% of the number expected). Of these, 194 were aged 14-17 (aged under 18 on 1 November 2019; 1.8% of the total). 214 cases were excluded as a result of duplicate entry and data cleaning. The case-note returns represented between 32% and 100% of eligible cases from Trust's EIP teams. A breakdown of Trust returns can be found in Appendix E (page 12). 155 teams in England submitted a contextual questionnaire (median 2 teams per service provider), all of which were used in the final analysis (100% of the number expected).

2,374 service user surveys were received from people across 56 Trusts in England (18% of the total surveys that the Trusts sent out). A breakdown of Trust returns can be found in Appendix E (page 13).

## Key findings

Table 1 provides an overview of Trusts' performance against standards and indicators for the full dataset as well as those aged under 18 alongside data from the NCAP EIP Spotlight Audit 2018/2019, for comparison. Table 2 provides key findings from the service user survey, as identified by the service user and carer reference group.

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[1] One Trust were unable to send out the service user survey because they were undergoing a Trust merger at the time of survey distribution.

**Table 1: Key comparisons between NCAP EIP Audit 2019/2020 and EIP Spotlight Audit 2018/2019**

| Standard/indicator | NCAP 2019/2020 (n = 10,560) | NCAP 2018/2019 (n = 9,527) | NCAP 2019/2020 Under-18s (n= 194) | NCAP 2018/2019 Under-18s (n = 154) |
|---|---|---|---|---|
| **Standard 1: Timely access** | | | | |
| Treatment started within 2 weeks of referral[2] | 74% | 76% | - | - |
| **Standards 2 & 3: Take-up of psychological therapies** | | | | |
| Cognitive behavioural therapy for psychosis (CBTp) | 49% | 46% | 46% | 46% |
| Family intervention (FI) | 21% | 22% | 25% | 39% |
| **Standard 4: Prescribing** | | | | |
| Offered clozapine[3] | 52% | 54% | 65% | 71% |
| **Standard 5: Take-up of supported employment and education programmes** | | | | |
| Supported employment and education programmes[4] | 31% | 28% | 33% | 41% |
| **Standard 6: Physical health monitoring[5]** | | | | |
| All 7 screening measures | 75% | 64% | 71% | 55% |
| Smoking | 93% | 92% | 91% | 86% |
| Alcohol use | 94% | 92% | 91% | 89% |
| Substance misuse | 94% | 93% | 91% | 92% |
| Body mass index (BMI) | 87% | 81% | 87% | 76% |
| Blood pressure | 89% | 83% | 90% | 79% |
| Blood glucose | 84% | 75% | 84% | 68% |
| Lipids | 82% | 73% | 82% | 64% |
| **Standard 7: Physical health interventions[5,6]** | | | | |
| Smoking | 91% | 88% | 81% | 92% |
| Harmful/hazardous use of alcohol | 93% | 93% | 67% | 71% |
| Substance misuse | 90% | 85% | 87% | 74% |
| Weight/obesity | 83% | 81% | 79% | 83% |
| Elevated blood pressure | 65% | 66% | 46% | 45% |
| Abnormal glucose control | 75% | 69% | 75% | - |
| Abnormal lipids | 75% | 68% | - | - |
| **Standard 8: Take-up or referral to carer-focused education and support programmes** | | | | |
| Carer-focused education and support programmes[7] | 58% | 55% | 65% | 62% |
| **Clinical outcome measurement** | | | | |
| 2 or more outcome measures were recorded at least twice[8] | 41% | 22% | 38% | 19% |

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[2] A breakdown of these data for under 18s is not available.

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

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

[5] Taken up or refused.

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

[7] Of those with an identified carer.

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

## Key findings from the service user survey

**Table 2: Key findings from the NCAP 2019/2020 service user survey, identified by the service user and carer reference group**

| Percentage of service users who in 2019/20… | | |
|---|---|---|
| Experience of care | felt that their mental health had improved since they had been under the care of their EIP team | 89% |
| | felt heard and listened to by their EIP worker/team ‘a lot’ or ‘quite a lot’ | 83% |
| Care planning and crisis numbers | had a copy of their care plan and knew where it was | 52% |
| | had a copy of their care plan, but did not know where it was | 21% |
| | had an emergency contact number to call | 89% |
| Medication | felt that they were involved in the decision on which medication they could take | 78% |
| | felt that they were given written or online information about their medication | 72% |
| Physical health | felt that they were in good physical health | 48% |
| | felt that they were not as healthy as they wanted to be and were not receiving help[9] | 23% |
| Employment and practical help | had a job | 33% |
| | did not have any problems with housing or benefits | 84% |
| | had problems with housing or benefits but were not getting help | 7% |

### Provision for children and young people between 14 and 17 (under 18) years of age

The audit confirmed a range of models delivering support to under 18s, including CYP staff embedded in EIP teams, dedicated CYP EIP teams, or EIP teams embedded in CYPMH services. Models include joint protocols and differing age profiles. Overall, 96% of teams reported CYP EIP provision for under 18s. This complexity of service models may explain the relatively low number of under 18s (1.8%) within the caseload of the audit. Further work will be undertaken to understand better the delivery of NICE concordant care, access and experience of under 18s.

## Discussion

Performance against several standards have improved since the first NCAP EIP Spotlight Audit 2018/2019. The greatest change was seen in performance on recording outcome measures (from 22% to 41%).

Improvement was also seen in physical health screening (from 64% to 75%), interventions for abnormal glucose control (69% to 75%) and abnormal lipids (68% to 75%).

Provision of other physical health interventions remained similar, as did performance against other standards. Take-up of CBTp increased slightly from 46% to 49%, supported employment and education programmes from 28% to 31%, and carer-focused education and support programmes from 55% to 58%.

Small reductions were seen in provision of family intervention (FI) (22% to 21%), timely access (76% to 74%) and interventions received for elevated blood pressure (from 66% to 65%). There was also a drop in those offered clozapine (54% to 52%).

Variation between Trusts’ performances was seen across all individual standards, with the smallest difference in performance across Trusts found in the screening of alcohol use (from 76% to 100%) and the greatest in offer of clozapine (from 0% to 100%).

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[9] Of those who were not as healthy as they wanted to be.

Care for under 18s with FEP was largely similar to that received by the full sample although due to the small sample size, it is important that this continues to be monitored and that further work is undertaken to better understand the experience of under 18s. A full discussion of the results for under 18s with FEP can be found in Appendix I.

Results from the service user survey generally reflected the performance recorded by Trusts in the case-note audit. There were similar results for receipt of CBTp (47% compared with 49%) and carer-focused education and support programmes (60% compared with 58%), and higher numbers reporting receipt of FI (27% compared with 21%). Results for provision of interventions for smoking were lower (72% compared with 91%).

It was very encouraging to see from the service user survey that people were generally happy with the care provided by EIP services. Most people (89%) said that their mental health had improved under the care of their EIP team, and 83% said that they felt heard and listened to by their EIP worker or team. However, it is clear that there are areas where people feel less satisfied. Over one fifth (22%) of people felt that they were not involved in the decision-making around medication; nearly one quarter (23%) of those who felt that they were not as healthy as they would like to be, were not receiving help with this; and nearly half (48%) reported that they did not have access to their care plan (26% did not have a copy of their care plan and 21% had a copy of their care plan but did not know where it was).

Further work is required to understand access to NICE compliant care and the experience of under 18s with FEP.

## Conclusions

The data collected show that the provision of timely access to evidence-based treatments for people experiencing FEP has generally continued to improve, and that people treated by EIP services largely report satisfaction with the care received. However, more can be done to improve the provision of evidence-based care in line with NICE quality standards. More can also be done to improve the aspects of care that have been identified as important to those being treated by EIP services, particularly in relation to the provision of FI. Clear variation between Trusts on individual standards shows opportunities for learning, and the importance of equitable commissioning and resourcing. The low number of under 18s within the sample raises questions about access to services for this age group. There are still teams with no EIP provision for under 18s with FEP, and more must be done to ensure children and young people with FEP can access evidence-based EIP care.

# 4. Recommendations

*NCAP notes the need to take the impact of COVID-19 regulations and guidance into account when implementing these recommendations.*

## 1 Family intervention (FI)

**a. Commissioners should:**

- ensure that specifications for EIP teams include sufficient staff capacity with the required level of competence and training to offer and deliver FI to all people and their families on EIP team caseloads.

**b. Trusts should:**

- identify a lead/named individual to investigate why people are not receiving FI
- work with colleagues, service users and their families to improve access to this evidence-based intervention.

**c. The Care Quality Commission (CQC) should:**

- monitor provision of FI by EIP teams.

Results for FI can be found on pages 19-20

## 2 Equality of service provision

**a. NHS England/Improvement should:**

- work with commissioners to ensure there is equal access to EIP care for all people aged 14–65 across the country.

Results for the contextual data questionnaire can be found in Appendix G (pages 18-21).

## 3 Caseload size

**a. Managers of EIP teams should:**

- review the caseloads of care coordinators in their team. Caseloads should be at an appropriate level to ensure care coordinators have capacity to deliver interventions and ensure sufficient time to engage with complex individuals and their families. Anything beyond a caseload of 25 would typically prevent this and is likely to adversely impact on EIP outcomes.

**b. Directors of operations in Trusts should:**

- request information from managers of EIP teams on the caseload size of care coordinators and work to ensure that these are appropriate. Caseloads should ideally remain below 25.

Results for the contextual data questionnaire can be found in Appendix G (pages 18-21).

## 4

## Coordination of care

**a. Care coordinators should ensure that:**

- care plans are co-produced
- care plans are reviewed regularly and updated to reflect changing needs
- people have a copy of their care plan which should include crisis contact details.

**b. Managers of EIP teams should provide support to ensure that:**

- all care coordinators co-produce care plans
- people have a copy of their care plan, which includes crisis contact details.

Results for the distribution of care plans can be found in Appendix H (pages 30–31).

## 5

## Physical healthcare

**a. Clinicians should ensure that:**

- people identified as being at risk of cardiovascular disease (smoking, hypertension, diabetes, dyslipidaemia) when screened receive appropriate interventions in response to the risk
- all interventions are clearly documented in health records.

**b. Physical health leads in Trusts should work with EIP teams to:**

- explore why some people refuse health screening and interventions
- problem-solve ways to overcome barriers identified, to ensure EIP teams are delivering effective physical healthcare
- ensure that all staff are trained to provide brief smoking-cessation interventions for people who smoke.

Results for physical health screenings and interventions can be found on pages 24-37.

## 6

## Prescribing

**a. Medical directors should:**

- identify obstacles to prescribing people clozapine in their Trust.

**b. Mental health pharmacists should:**

- work with EIP teams to identify people who may benefit from clozapine and ensure that they are offered it and record the reasons for not offering/refusal in health records.

Results for clozapine prescribing can be found on page 21.

7

## Supported employment and education

### a. EIP teams should:

- systematically review their caseload to identify anyone who is not in education, employment or training
- offer supported education or employment programmes to anyone identified as not in education, employment or training
- record offer and uptake of supported education and employment support in health records.

Results for supported employment and education programmes can be found on pages 22 -23.

8

## Clinical outcome measurement

### a. Quality improvement leads in Trusts should work with EIP staff to:

- help them develop ways to use outcome data to monitor and improve the quality of care they deliver to people with early psychosis
- help teams think about how routine outcome data collection can also be used to inform routine care planning and monitor progress and review outcomes for individuals with FEP on the caseload.

Results for clinical outcome measurements can be found on page 40.

9

## Carer-focused education and support programmes

### a. Commissioners should work with providers to:

- ensure carer education and support programmes are being provided according to NICE guidance
- ensure carer education and support programmes meet NHS standards for equality, diversity and inclusion.

Results for carer-focused education and support programmes can be found on pages 38-39.

## 10

## Under 18s

### a. Clinicians should ensure that:

- CYP with FEP aged under 18 receive appropriate physical health interventions where screening identifies a risk.

### b. Trusts should work with commissioners for EIP and CYP services to:

- ensure CYP experiencing FEP have access to specialist EIP CYP expertise and the full range of evidence-based interventions
- hold regular joint meetings with senior managers for EIP and CYPMH services to discuss referral pathways and service delivery to CYP with FEP to ensure those under 18 years old are accessing evidence-based treatment for early psychosis
- ensure that there are robust shared care protocols in place to manage care and transition between CYP and EIP services for CYP with FEP
- ensure that EIP teams are able to access specialist CYP support when prescribing for under 18s with FEP and CYPMH teams are able to access specialist EIP support when supporting and prescribing for CYP with FEP
- ensure that there are regular opportunities for joint training and case-note audits between EIP and CYPMH services to improve practice and outcomes for CYP with FEP.

Results for under 18s can be found for the case-note audit in Appendix I (pages 47-48) and for the contextual data questionnaire in Appendix G (pages 18-21).

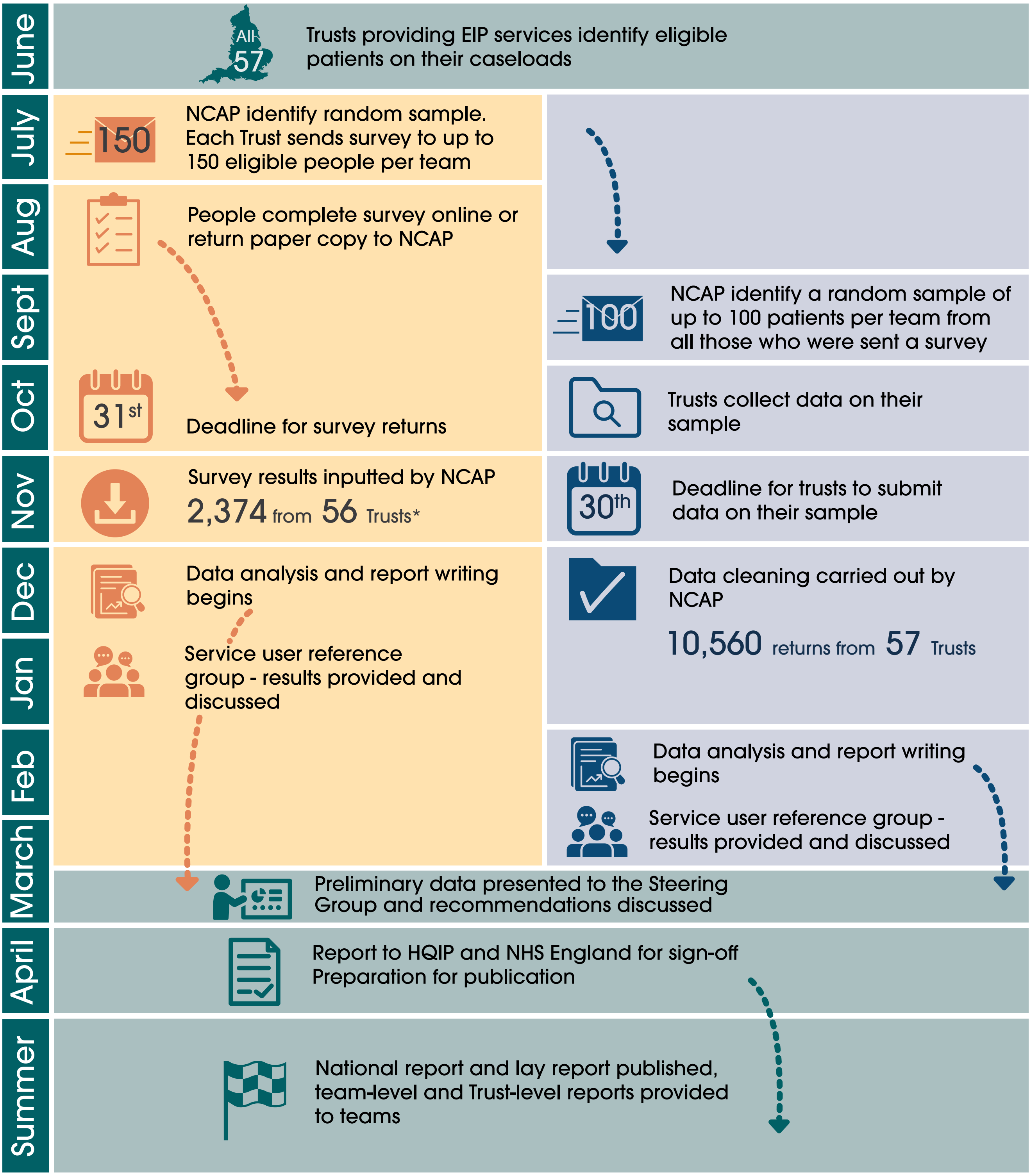
# 5. Methodology

## Service user survey

Questions about the care received by people using EIP services. Survey developed with service users.

## Case-note audit

Questions about care provided according to the standards (based on NICE guidance and the EIP Access and Waiting Time Standard).



Trusts providing EIP services identify eligible patients on their caseloads

NCAP identify random sample. Each Trust sends survey to up to 150 eligible people per team

People complete survey online or return paper copy to NCAP

Deadline for survey returns

Survey results inputted by NCAP
2,374 from 56 Trusts*

Data analysis and report writing begins

Service user reference group - results provided and discussed

NCAP identify a random sample of up to 100 patients per team from all those who were sent a survey

Trusts collect data on their sample

Deadline for trusts to submit data on their sample

Data cleaning carried out by NCAP
10,560 returns from 57 Trusts

Data analysis and report writing begins

Service user reference group - results provided and discussed

Preliminary data presented to the Steering Group and recommendations discussed

Report to HQIP and NHS England for sign-off
Preparation for publication

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

*One Trust were unable to send out the service user survey as they were undergoing a Trust merger at the time of survey distribution.

A more detailed methodology can be found in Appendix F.

## Standards and outcome indicator

The audit standards and outcome indicator (Table 3) were developed by the NCAP team in collaboration with members of the steering group, and remain the same as the 2018/2019 audit to allow meaningful comparison and enable identification of real changes in individual standards across the audit cycles. The standards are based on the NICE quality standards in relation to treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015), and the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016).

**Table 3: NCAP standards and outcome indicator**

| Standards | |
|---|---|
| S1* | Service users with first episode of psychosis start treatment in early intervention in psychosis services within two weeks of referral (allocated to, and engaged with, an EIP care coordinator) |
| S2 | Service users with first episode psychosis take up Cognitive Behavioural Therapy for psychosis (CBTp) |
| S3 | Service users with first episode psychosis and their families take up Family interventions (FI) |
| S4 | Service users with first episode psychosis who have not responded adequately to or tolerated treatment with at least two antipsychotic drugs are offered clozapine |
| S5 | Service users with first episode psychosis take up supported employment and education programmes |
| S6 | Service users receive a physical health review annually. This includes the following measures: smoking status; alcohol intake; substance misuse; BMI; blood pressure; glucose; cholesterol |
| S7 | Service users are offered relevant interventions for their physical health for the following measures: smoking cessation; harmful alcohol use; substance misuse; weight gain/obesity; hypertension; diabetes/high risk of diabetes; dyslipidaemia |
| S8 | Carers take up or are referred to carer focused education and support programmes |
| **Outcome indicator** | |
| I1 | Clinical outcome measurement data for service users (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) are recorded at least twice (assessment and one other time point) |

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*Data for this standard were not collected through the NCAP EIP 2019/2020 audit tool; rather, the Early Intervention in Psychosis Waiting Times data published by NHS Digital were used (NHS Digital, 2019; 2020).

# 6. Key findings from the service user survey

The service user survey was designed to collect feedback from people accessing services in England and Wales. The 2,374 responses were analysed and presented to the service user and carer reference group, who reflected on the results and selected the key findings presented below. The 2 service user and carer reference groups consisted of 18 people with a lived experience of psychosis (10 service users and 8 carers) who were invited via e-mail to attend by Rethink Mental Illness.

43% of survey respondents had been under the care of their EIP team for 2 years or more, with 41% between 1 and 2 years, and 16% between 6 months and 1 year. The results from the survey and feedback from the service user and carer reference group were generally positive. The total sample for each question will be less than the complete total service user survey sample, as not all people answered all questions.

### Service user experience of care

**89%** (2,091/2,350) of service users felt that their mental health had improved since they had been under the care of their EIP team.

**83%** (1,956/2,348) of service users said that they felt heard and listened to ‘a lot’ or ‘quite a lot’ by their EIP worker/team.

The service user and carer reference group highlighted that while the survey did not capture the experiences of people who had been unable to access EIP services or those not engaged with services, the service user and carer reference group’s experiences of EIP services were largely positive.

> “I have found staff to offer compassionate care”

> “[It was] such a good experience, I didn’t want to leave”

### Care planning and crisis numbers

**52%** (1,217/2,330) of service users said they had a copy of their care plan and knew where it was, and 21% (497/2,330) said they had a copy but did not know where it was.

**89%** (2,062/2,308) of service users said they had an emergency contact number to call.

Some of the service user and carer group did not have a copy of their care plan or know where it was, so were not surprised at the data. There was a strong service user sentiment that care plans are not always collaborative and co-produced but are rather a ‘tick-box’ item for practitioners.

> “I haven’t found that EIP teams use or refer to a physical care plan […] it’s all verbal, I haven’t seen it”

> “The care plan was made but I wasn’t given a copy for the person I care for – I had to ask for it”

The service user and carer reference group also said that even if they did have an emergency number, their calls may go unanswered, or if they managed to get through it was unlikely to be a person that was aware of them or their relative.

> “Emergency numbers are always hard to find out – I’m not surprised about that. A single number to call doesn’t exist”

### Medication

**78%** (1,706/2,181) of service users felt that they were involved in the decision on which medication to take.

**72%** (1,557/2,169) of service users said that they were given written or online information about their medication.

The service user and carer reference group found the data on people not always receiving information about their medication surprising. While 95% (2,226/2,351) of the sample were offered antipsychotic medication, important details about medication were in some cases not accessible, for example explanation of side effects, risks of stopping and written or online information.

> “Who is it that will help you manage the process to reduce your dosages? There seems to be a gap. What’s happening is people aren’t being given that opportunity to manage coming off the drug safely and effectively. That’s my personal experience. People don’t often want to stay on high dosages. They don’t know what sort of impact that would have if they were to reduce their dosage. Another thing about clozapine, you need monthly tests, plasma tests. I heard from people – they don’t have the plasma test, so don’t understand how it’s specifically impacting them”

### Physical health

**48%** (1,089/2,274) of survey respondents felt that they were in good physical health.

**23%** (274/1,185) of service users were not as healthy as they wanted to be and were not receiving help for this.

In the service user and carer reference group, there was a shared consensus that physical health was an important underlying factor in the ability to work, access stable housing and in recovery from psychosis in general.

> When my son was admitted to hospital, the nurses came around to do physical health checks before any psychiatric intervention. I think it’s a necessity really”

### Employment and practical help

**33%** (748/2,286) of service users said that they currently have a job.

**84%** (1,778/2,125) of service users said that they did not have any problems with housing or benefits and 7% (144/2,125) said that they did have problems but were not getting help with this.

The service user and carer group were concerned that two thirds of service users with psychosis did not have a job (67%). However, the survey did not record whether people were in education, so it is likely that some of those not in employment were students. The group indicated that there is a lack of engagement and shared decision-making for service users in employment and education, leading to misconceptions about the level of support needed, or a lack of support altogether.

> On/off claims for Jobseeker’s Allowance, in amongst periods of employment is disheartening.”

> You’re too ill to work [and] not signposted to support; this hinders recovery”

# 7. Standard 1: Timely access

**S1** Service users with first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral

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

To have met this standard, people must have been allocated to and engaged with an EIP care coordinator within 2 weeks of referral. Analysis was carried out using the Early Intervention Psychosis Waiting Times data for October 2019 to December 2019 (NHS Digital, 2019; 2020).

All people referred to services during this period were included in the analysis (n = 3,544), of which 74% of people (2,635) started treatment within 2 weeks. As shown in Figure 1, the proportion of people starting treatment within 2 weeks of referral varied from 17% to 100% across Trusts.*

Data for this standard were collected over a different time period this year (October 2019 to December 2019) in comparison with last year (November 2018 to January 2019). Since 2018/19, there has been a 2% decrease (from 76% to 74%) in the proportion of people with FEP who started treatment within 2 weeks of referral.

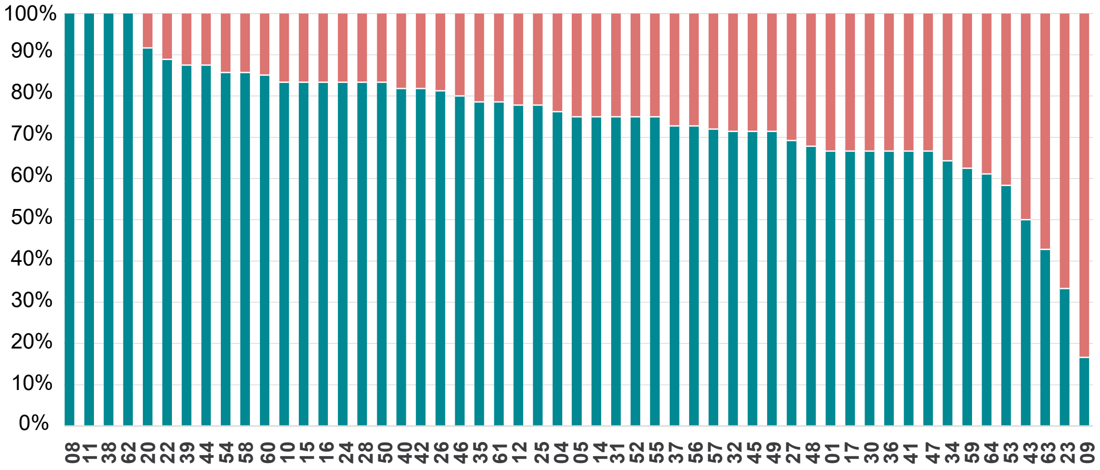


**Figure 1: Proportion of people with FEP who started treatment within 2 weeks of referral between October 2019 and December 2019 (n = 3,545)*,**,*****

🟩 **Started treatment in 0-2 weeks**

🟥 **Started treatment in >2 weeks**

---

*NHS Digital publish provider level data rounded to the nearest 5, which were used for the Trust level analysis. No TNS is therefore provided in the Trust comparison chart.

**Data for ORG18 is not included in the Trust comparison chart because management of their teams moved to ORG32 and ORG44 from October 2019.

***Data for 3 Trusts (ORG06, ORG21 and ORG51) were not included in the Trust comparison chart because their waiting times data included <5 people, so were not published by NHS Digital.

# 8. Standard 2: Cognitive behavioural therapy for psychosis

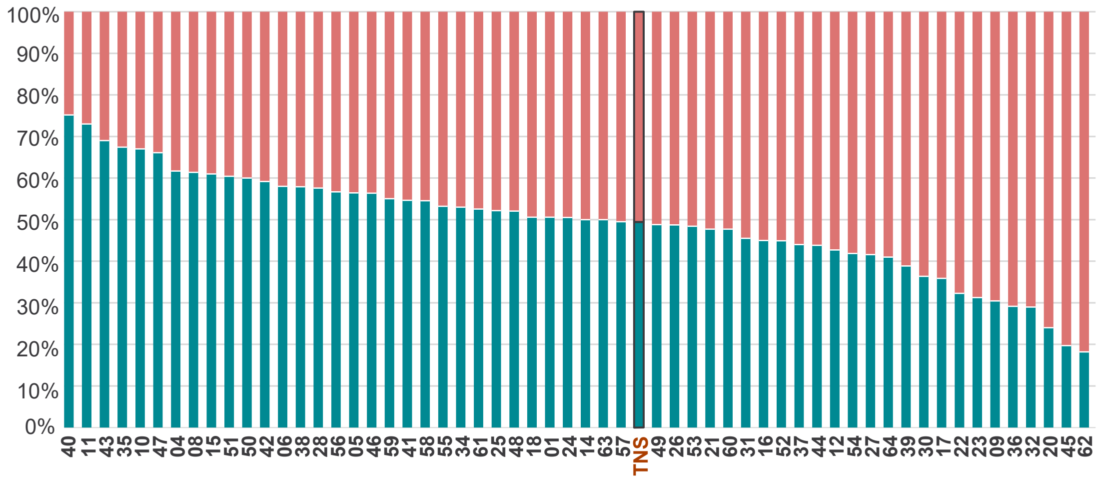
S2 Service users with first episode of psychosis take up cognitive behavioural therapy for psychosis

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

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

This analysis was carried out on the entire national sample (n = 10,560), of which 49% (5,221) received 1 or more sessions of CBTp. As shown in Figure 2, the proportion of people taking up CBTp varied from 18% to 75% across Trusts. Since 2018, there has been a 3% increase (from 46% to 49%) in the proportion of people with FEP who took up CBTp.

**Figure 2: Proportion of people with FEP who took up CBTp (n = 10,560)***



🟩 **Standard met**

🟥 **Standard not met**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

## Service user survey responses

In the service user survey, people were asked to indicate if they had received or were currently receiving CBTp.

2,280 people responded to this question, of which 47% (1,081) reported that they had received or were receiving CBTp. This figure is comparable with the case-note audit data, which reported 49%.

As shown in Figure 3, the proportion of people taking up CBTp varied from 17% to 75% across Trusts. A full breakdown of the service user survey results can be found in Appendix H.

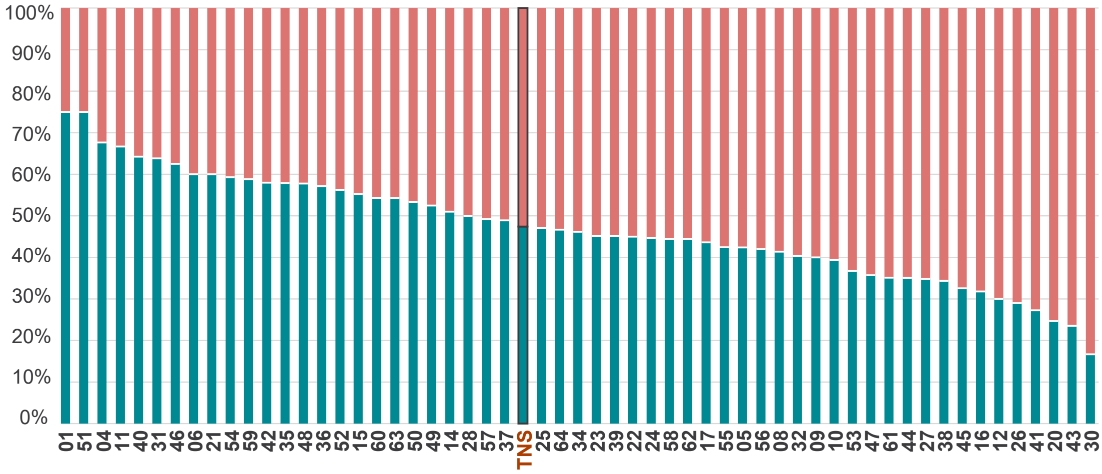

**Figure 3: Proportion of people with FEP reporting that they had taken up CBTp (n = 2,280)**

🟦 **Standard met (Yes, I have had/am having it)**

🟥 **Standard not met (Yes, I am waiting for it, Yes, but I did not want it, I have not been offered it)**

# 9. Standard 3: Family intervention

**S3** Service users with first episode psychosis and their families take up family intervention

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

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

This analysis was carried out on the entire national sample (n = 10,560), of which 21% (2,177) received 1 or more sessions of FI. As shown in Figure 4, the take-up of FI ranged from 5% to 57% across Trusts. Since 2018, there has been a 1% decrease (from 22% to 21%) in the proportion of people with FEP and their families who took up FI.

Data were collected on FI delivered in person. Services may look to providing high quality digital interventions during COVID-19. However, it is important to note that there is currently no supporting evidence for delivering FI in this way and the effects on outcomes must be better understood.

Further analysis for this standard was carried out on people who had an identified carer, excluding those who did not wish this person to be contacted (n = 7,596).

25% (1,930) of 7,596 people who had an identified carer and did wish for this person to be contacted, had received 1 or more sessions of FI. For this smaller sample, the proportion of people meeting the standard ranged from 7% to 71% across Trusts. See Figure 49 in Appendix J (page 49).

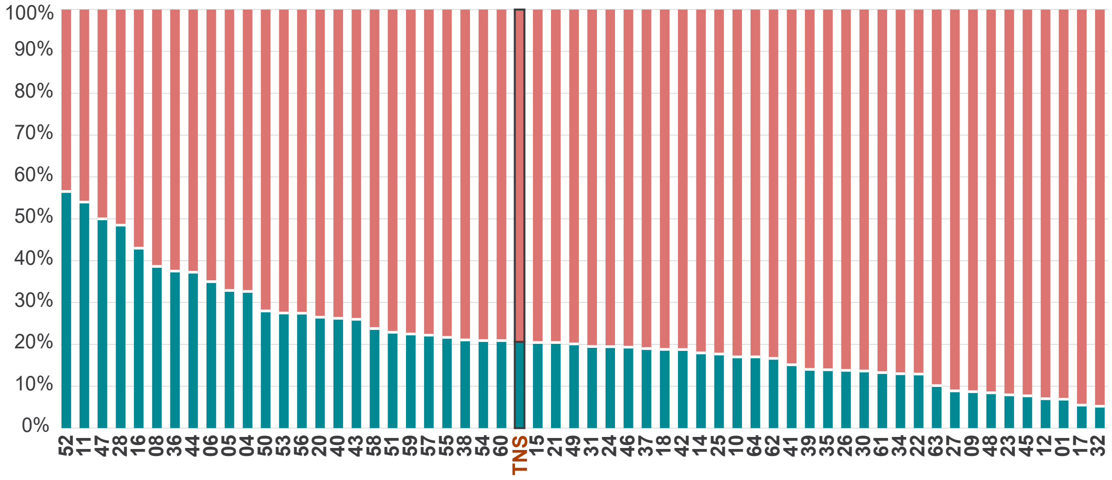

**Figure 4: Proportion of people with FEP and their families who took up FI (n = 10,560)***

🟩 **Standard met**

🟥 **Standard not met**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of 1 of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

## Service user survey responses

In the service user survey, people were asked to indicate if they had received or were currently receiving FI.

2,211 people responded to this question, of which 27% (598) reported that they had received or were receiving FI. This figure is higher than the 21% reported in the case-note audit.

As shown in Figure 5, the proportion of people taking up FI varied from 8% to 67% across Trusts. A full breakdown of the service user survey results can be found in Appendix H.

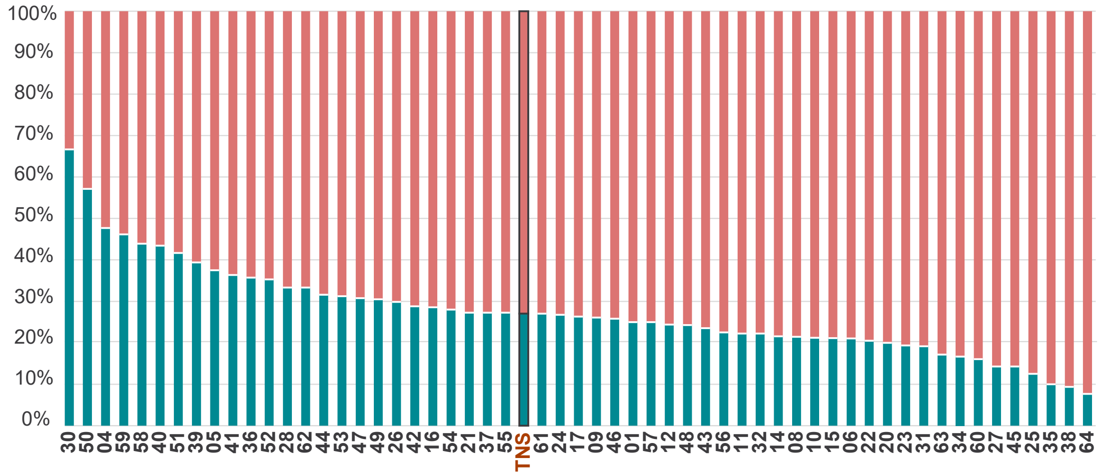

**Figure 5: Proportion of people with FEP reporting that they had taken up FI (n = 2,211)**

🟩 **Standard met (Yes, I have had/am having it)**

🟥 **Standard not met (Yes, I am waiting for it, Yes, but I did not want it, I have not been offered it)**

# 10. Standard 4: Prescribing of clozapine

**S4** Service users with first episode psychosis who have not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs are offered clozapine

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

Analysis for this standard was conducted on people who were identified from their case-notes as having had treatment with at least 2 antipsychotic drugs and not having responded adequately to or tolerated them (n = 1,296).

As shown in Figure 6, 52% (677) of 1,296 people in the national sample were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs.

The proportion of people whose treatment met this standard ranged from 0% to 100% across Trusts. Since 2018, there has been a 2% decrease (from 54% to 52%) in the proportion of people being offered clozapine after 2 unsuccessful trials of antipsychotics.

## Service user survey responses

The service user survey did not ask people about their tolerance to antipsychotic drugs or their experience with clozapine. However, people's experience of prescriptive practice was measured, including how involved they felt in decision-making and whether they were offered information about their medication and possible side effects. These findings and a full breakdown of the service user survey results can be found in Appendix H.

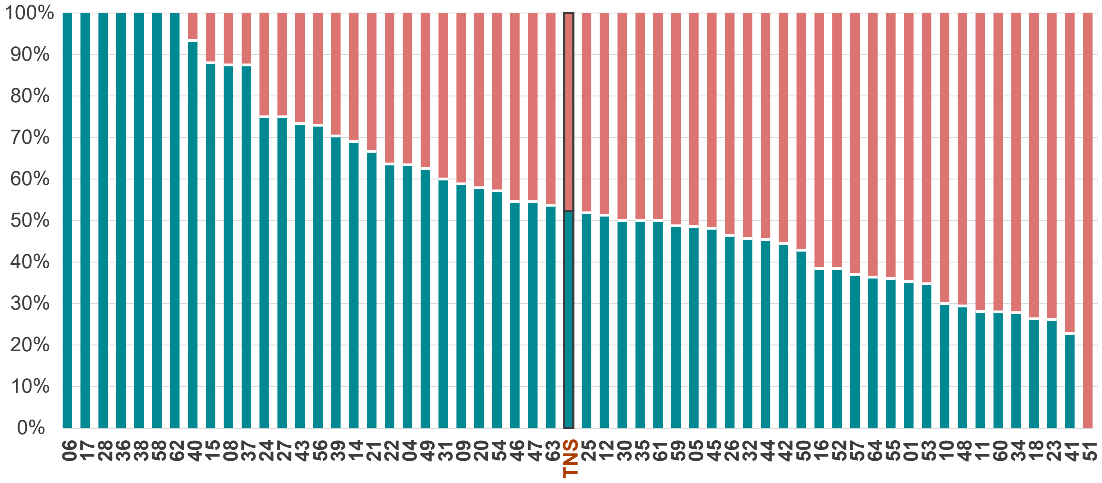

**Figure 6: Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least 2 other antipsychotic drugs (n = 1,296)***

🟩 **Standard met**

🟥 **Standard not met**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

# 11. Standard 5: Supported employment and education programmes

**S5** Service users with first episode psychosis take up supported employment and education programmes

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

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

This analysis was carried out on responses from people who were identified from their case-notes as not being in work, education or training at the time of their initial assessment (n = 6,409). 31% (1,958) of 6,409 people identified as not being in work, education or training attended 1 or more sessions of a supported employment or education programme.

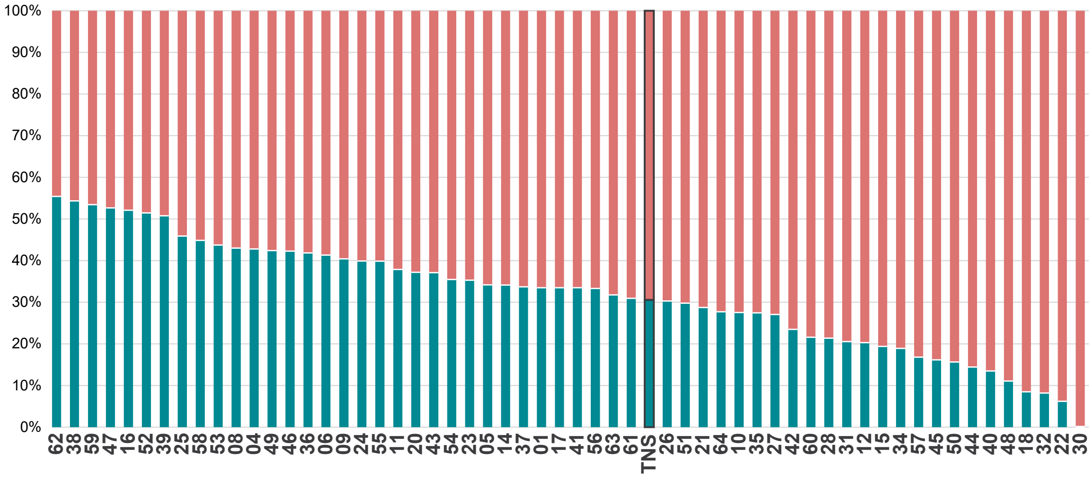
As shown in Figure 7, the proportion of people taking up supported employment and education programmes ranged from 0% to 55% across Trusts. Since 2018, there has been a 3% increase (from 28% to 31%) in the proportion of people with FEP taking up supported employment and education programmes.

Further analysis for this standard was carried out on the entire national sample (n = 10,560), because supported employment and education programmes may help people stay in their current employment or education, change work or take up other training/education programmes. 30% (3,179) of 10,560 people in the national sample attended 1 or more sessions of a supported employment or education programme. For this larger sample, the proportion of people meeting the standard ranged from 0% to 58% across Trusts. See Figure 50 in Appendix J (page 49).

**Figure 7: Proportion of people with FEP who were not in work, education or training who had taken up supported employment and education programmes (n = 6,409)***

🟩 **Standard met**

🟥 **Standard not met**



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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

## Service user survey responses

In the service user survey, service users were asked about their current employment status.

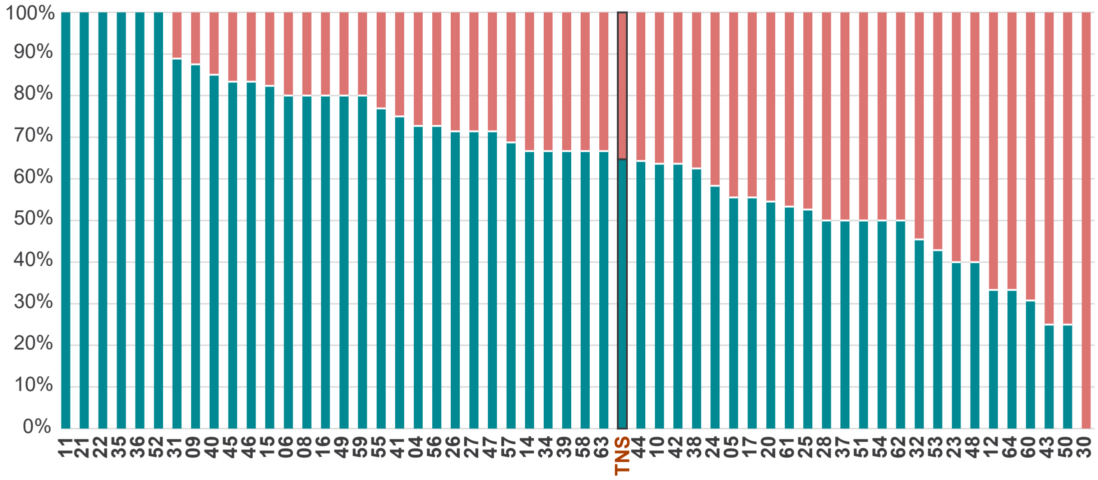
The analysis was carried out on responses from people who answered the question to say that they felt able to work but did not have a job (n = 561). Of these, 65% (363) reported that they were getting help to find a job.

As shown in Figure 8, the proportion of people who did not have a job and were getting help to find one ranged from 0% to 100% across Trusts.

It is important to note that more than one third (43%) of people answered this question to say that they did not have a job but 'did not feel able to work at the moment', so were not included in the sample for this analysis. The case-note audit did not include this response option; therefore, the results are not directly comparable. A full breakdown of the service user survey results can be found in Appendix H.

Service users responding to question 17 of the survey indicated that they had a job if they were a student, in full-time education or a full-time carer. Therefore, this question was interpreted by service users in different ways and the responses were not solely from people who had a full-time job.

**Figure 8: Proportion of people with FEP who were not in work but felt able to work, who reported that they were getting help to find a job (n = 561)**



🟩 **Standard met (I don't have a job, but I am getting help to find one)**

🟥 **Standard not met (I don't have a job, and I am not getting help to find one)**

# 12. Standard 6: Physical health screening

**S6** Service users receive a physical health review annually. This includes the following measures:

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

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

For Trusts to have met this standard, people must have been screened on all 7 physical health measures within the last 12 months. As in the 2018/19 NCAP audit, these data were analysed in the same way as the Commissioning for Quality and Innovation programme on improving the physical health of people with severe mental illness. 'Received screening' includes those people who were offered but refused screening.

All people (n = 10,560) were included in this analysis, and it was found that 75% (7,879) had been screened on all 7 physical health measures. Between Trusts, the proportion of people meeting the standard ranged from 9% to 100%. Figure 9 shows the proportion of people who were screened on all 7 physical health measures. This is an 11% increase from the previous year, when 64% received screening on all 7 physical health measures.

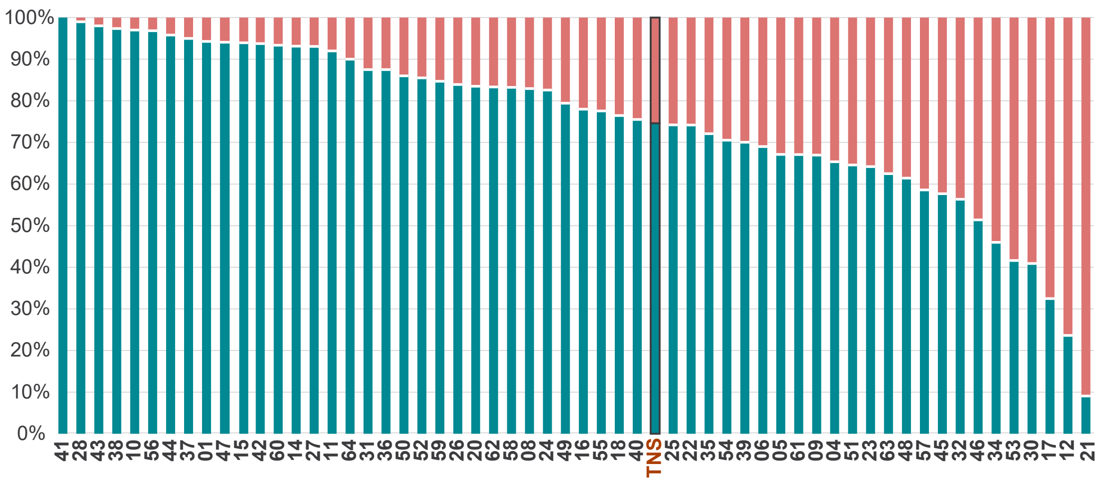


**Figure 9: Proportion of people with FEP who were screened* on all 7 physical health measures across Trusts in the past 12 months (n = 10,560)****

🟦 **All 7 screenings received**

🟥 **Fewer than 7 screenings offered**

---

*'Screened' includes those people who were offered but refused screening

**Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

## Smoking status

Figure 10 shows that smoking status was assessed for 93% (9,872) of people. This is a 1% increase from the previous year, where 92% received screening for their smoking status. 6% (652) of people in total refused to provide their smoking status; refusal rates varied from 1% to 33% across Trusts. Smoking status was not documented in 7% (688) of cases. Monitoring of smoking status ranged from 72% to 100% across Trusts.

## Alcohol intake

Figure 11 shows that screening of alcohol intake was received by 94% (9,918) of people. This is a 2% increase from the previous year, where 92% received screening for their alcohol use. Screenings were refused by 6% (668) of people; refusal rates varied from 1% to 35% across Trusts. Alcohol use was not documented in 6% (642) of cases. Monitoring of alcohol use ranged from 76% to 100% across Trusts.

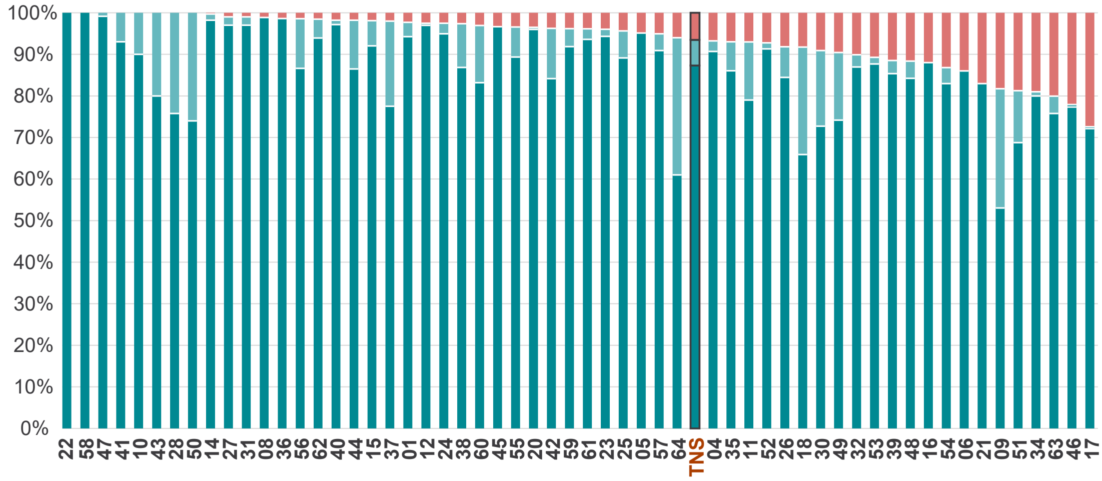


**Figure 10: Proportion of people with FEP monitored for cigarette smoking across Trusts in the past 12 months (n = 10,560)***

🟦 **Status/results recorded**

🟦 **Screening refused**

🟥 **No record**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

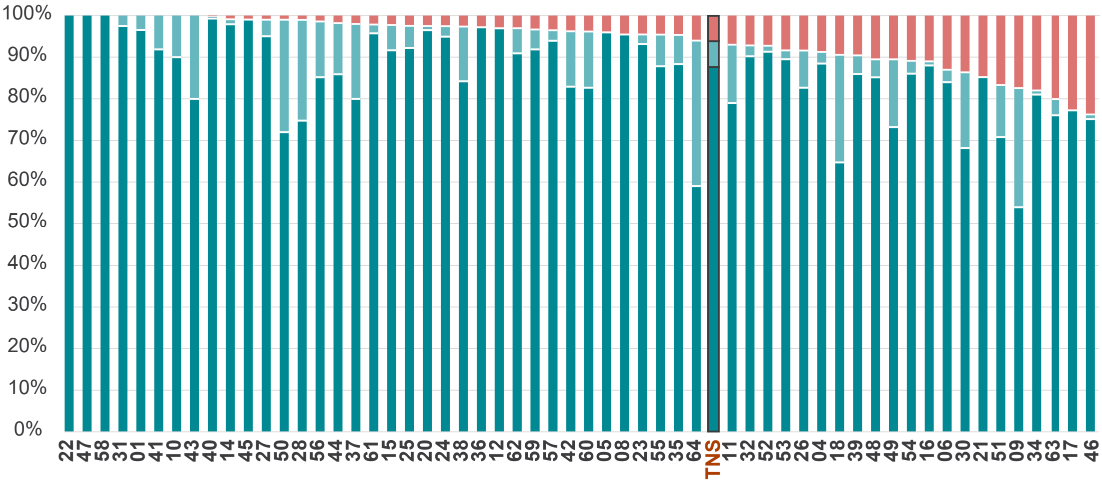


**Figure 11: Proportion of people with FEP monitored for alcohol consumption across Trusts in the past 12 months (n = 10,560)***

🟦 **Status/results recorded**

🟦 **Screening refused**

🟥 **No record**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

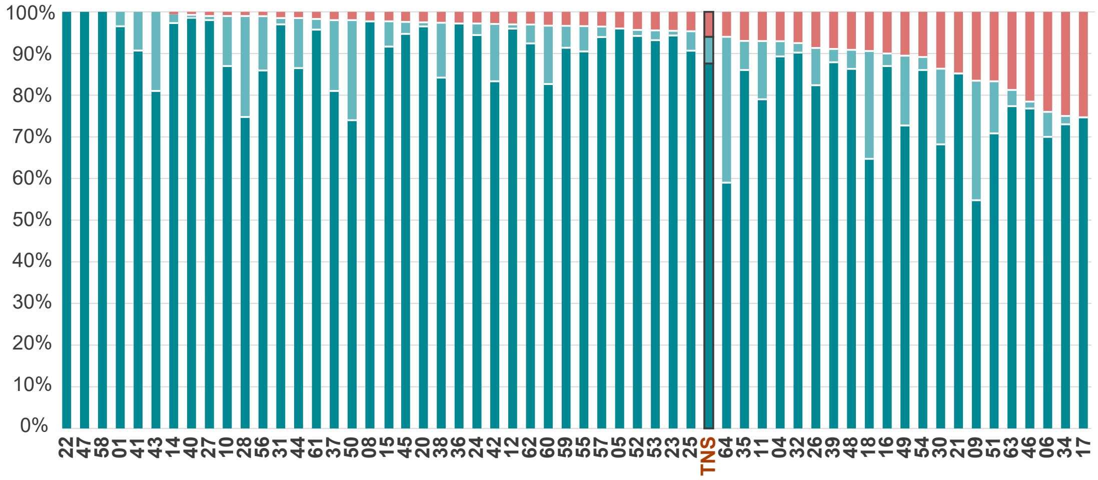
## Substance misuse

Figure 12 shows that screening for substance misuse was received by 94% (9,928) of people. This is a 1% increase from the previous year, where 93% received screening for substance misuse. Screenings were refused by 6% (677) of people; refusal rates varied from 1% to 35% across Trusts. Substance misuse was not documented in 6% (632) of cases. Monitoring of substance misuse ranged from 75% to 100% across Trusts.

## Body mass index

Figure 13 shows that BMI was monitored for 87% (9,184) of people. This is a 6% increase from the previous year, when 81% had their BMI monitored. BMI measurement was refused by 9% (985) of people; refusal rates varied from 2% to 42% across Trusts. BMI was not documented in 13% (1,376) of cases. Monitoring of BMI ranged from 48% to 100% across Trusts.

**Figure 12: Proportion of people with FEP monitored for substance misuse across Trusts in the past 12 months (n = 10,560)***



■ **Status/results recorded**

▨ **Screening refused**

🟥 **No record**

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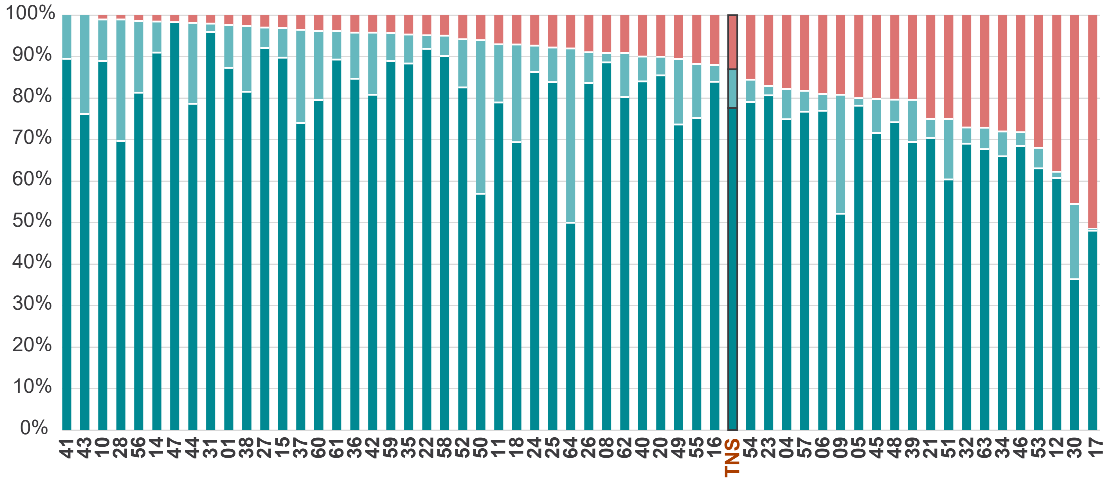
*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Figure 13: Proportion of people with FEP monitored for BMI across Trusts in the past 12 months (n = 10,560)***



■ **Status/results recorded**

▨ **Screening refused**

🟥 **No record**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

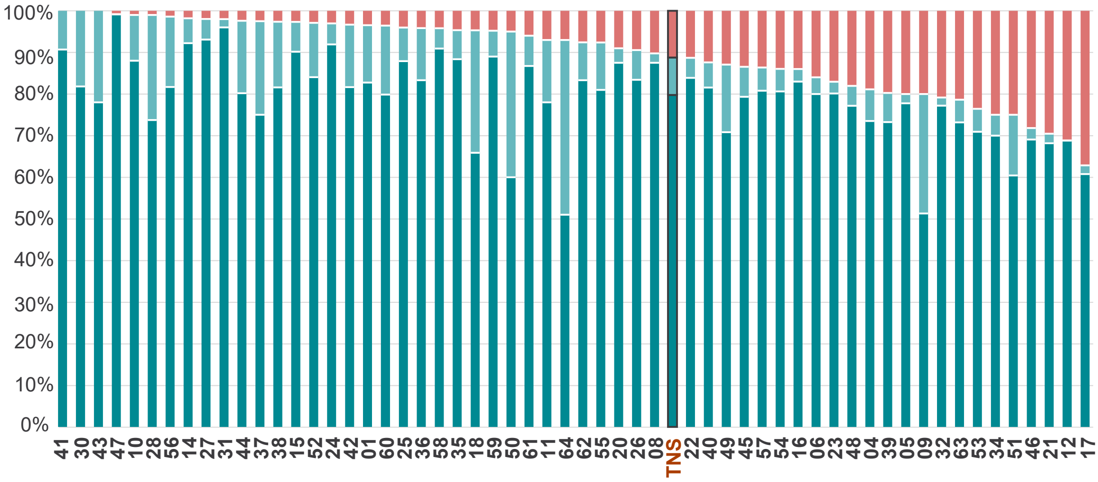
## Blood pressure

Figure 14 shows that blood pressure was monitored for 89% (9,374) of people. This is a 6% increase from the previous year, where 83% of people were monitored for blood pressure. Blood pressure screenings were refused by 9% (950) of people; refusal rates varied from 2% to 42% across Trusts. Blood pressure was not documented in 11% (1,186) of cases. Monitoring of blood pressure ranged from 63% to 100% across Trusts.

## Blood glucose control

Figure 15 shows that glucose control was monitored for 84% (8,840) of people. This is a 9% increase from the previous year, where 75% were monitored for glucose control. Screening was refused by 15% (1,538) of people; refusal rates varied from 1% to 51% across Trusts. Glucose control was not documented in 16% (1,720) of cases. Monitoring of glucose control ranged from 16% to 100% across Trusts.

**Figure 14: Proportion of people with FEP monitored for blood pressure across Trusts in the past 12 months (n = 10,560)***



🟦 **Status/results recorded**

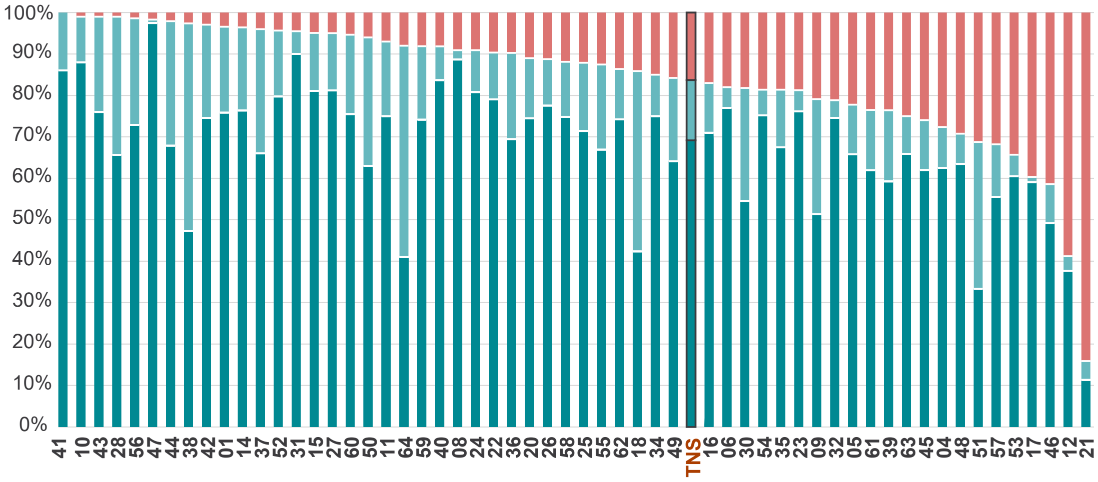
▨ **Screening refused**

🟥 **No record**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Figure 15: Proportion of people with FEP monitored for blood glucose control across Trusts in the past 12 months (n = 10,560)***



🟦 **Status/results recorded**

▨ **Screening refused**

🟥 **No record**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

## Cholesterol

Figure 16 shows that cholesterol was monitored for 82% (8,686) of people. This is a 9% increase from the previous year, where 73% were monitored for cholesterol. Screening was refused by 15% (1,552) of people; refusal rates varied from 1% to 49% across Trusts. Cholesterol was not documented in 18% (1,874) of cases. Monitoring of cholesterol ranged from 13% to 100% across Trusts.

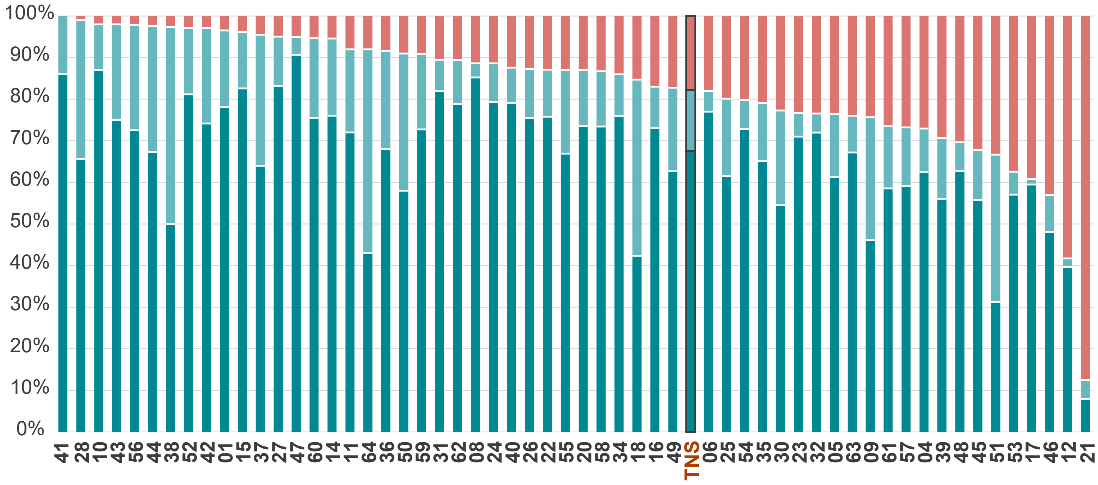

**Figure 16: Proportion of people with FEP monitored for blood lipids across Trusts in the past 12 months (n = 10,560)***

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

# 13. Standard 7: Physical health interventions

**S7** Service users are offered relevant interventions for their physical health for the following measures:

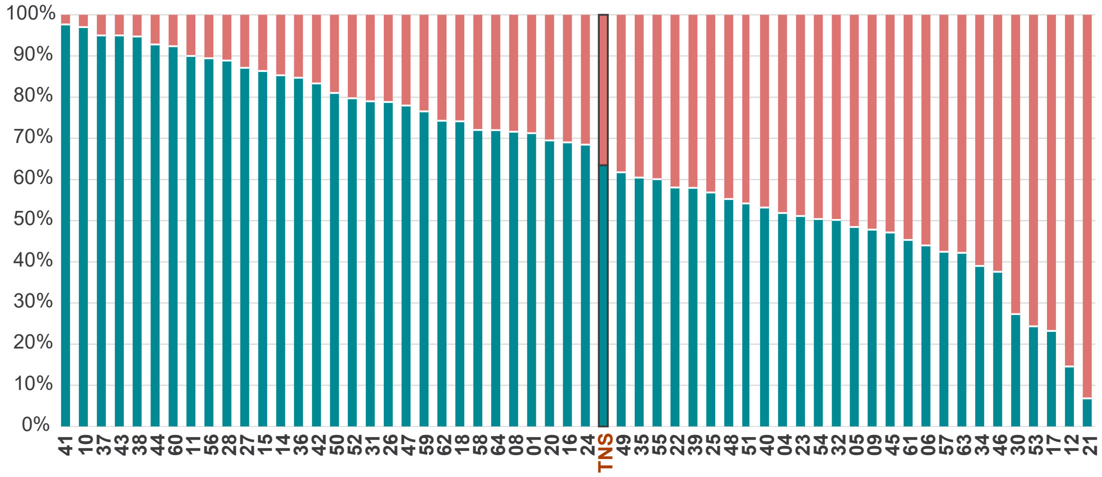
- smoking cessation
- harmful alcohol use
- substance misuse
- weight gain/obesity
- hypertension
- diabetes/high risk of diabetes
- dyslipidaemia

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

For Trusts to meet the standard, people must have been offered all relevant interventions where screening indicated a risk level requiring intervention, within the last 12 months. As shown in Figure 17, 63% (6,701) of people were offered (and received or refused) all screenings and relevant interventions across all 7 measures. This is an increase of 8% from the previous year, where 55% of people were offered (and received or refused) all screenings and relevant interventions across all 7 measures. The proportion of people offered screenings and interventions (where required) varied across measures, ranging from 93% for harmful alcohol use to 63% for hypertension. The criteria applied to determine need for intervention were as follows:

- **Cigarette smoking**: Records documenting person as current smoker.
- **Alcohol use**: Records indicating harmful or hazardous use of alcohol.
- **Substance misuse**: Records indicating substance misuse.
- **BMI**: BMI recorded as ≥25 kg/m² (for South Asian and Chinese people, ≥23 kg/m²).
- **Blood pressure (BP)**: Systolic BP >140 mm and/or diastolic BP >90 mm.
- **Glucose control**: At least 1 of: Fasting plasma glucose ≥5.5 mmol/l; Random plasma glucose ≥11.1 mmol/l; Haemoglobin bA1c ≥42 mmol/mol.
- **Lipid abnormality**: Total cholesterol >9, non-high-density lipid cholesterol >7.5 or triglycerides >20 mmol/l and/or Q-Risk score >10%.

**Figure 17: Composite measure of standards 6 & 7: All 7 physical health screenings offered and interventions offered (where applicable) – including refusals/where the person was pregnant/repeat BP test (n = 10,560)***



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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

🟩 **Physical health screening & intervening standards met**

🟥 **Physical health screening & intervening standards not met**

## Interventions for smoking

As shown in Figure 18, 40% (4,237) of people were identified from their case-notes as requiring an intervention for smoking cessation. Of this sample, 91% (3,853) were offered a smoking cessation intervention. A further breakdown of this showed that 58% (2,471) of people received an intervention and 33% (1,382) refused the intervention. Refusal rates varied across Trusts, from 4% to 100%.

Brief intervention or advice (n = 1,753, 71%) was the most common intervention provided to the 2,471 people who received a smoking cessation intervention where required. Individual or group behavioural support was the least common (n = 21, 1%). A further breakdown of the interventions provided is displayed in Table 4.

**Figure 18: Proportion of people with FEP offered intervention for cigarette smoking across Trusts (n = 4,237 with this risk)***

🟩 **Intervention needed and given**

🟦 **Intervention needed and refused**

🟥 **Intervention needed and not given**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 4: Breakdown of interventions received by those requiring smoking interventions across Trusts (n = 2,471)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Brief intervention and advice | 1,753 (71%) |
| Smoking cessation education | 964 (39%) |
| Referral to smoking cessation service | 373 (15%) |
| Smoking cessation therapy | 172 (7%) |
| Individual or group behavioural support | 21 (1%) |

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

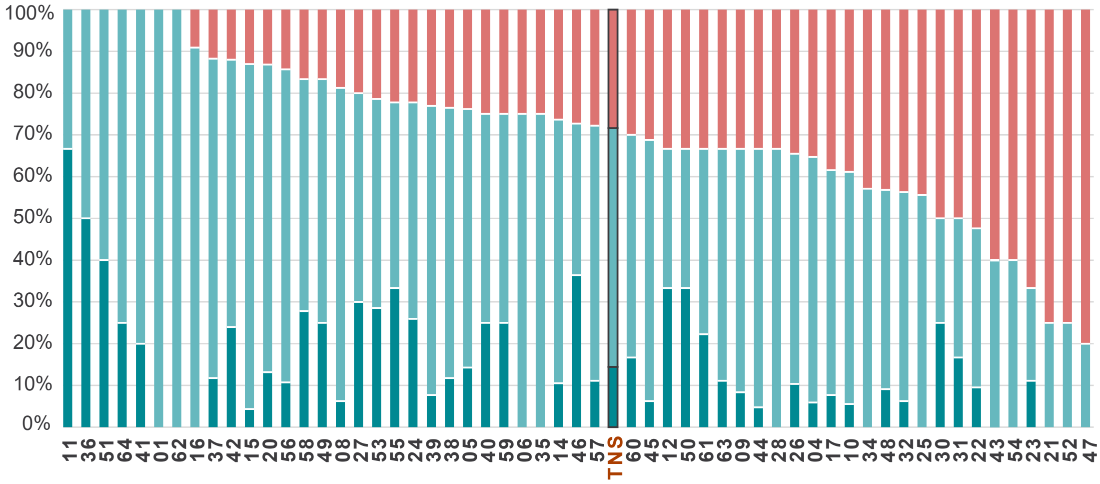
## Service user survey responses

In the service user survey, 36% (831) of people indicated that they were currently smoking. Of these, 803 people responded to a further question asking if they had been offered help to give up smoking.

Of these 803 people, 72% (575) had been offered help to stop smoking. Further analysis of these data showed 14% (116) of people received an intervention for smoking and 57% (459) refused the intervention. Figures for offer and receipt of interventions are lower than those reported in the case-note audit (91% offered, 58% received) and the percentage of refusals is higher than that reported in the case-note audit (33%).

As shown in Figure 19, the proportion of people who were currently smoking and who were offered help to give up ranged across Trusts from 20% to 100%. A full breakdown of the service user survey results can be found in Appendix H.

**Figure 19: Proportion of people with FEP who currently smoke and who are getting help to stop (n= 803)***



- 🟦 **Intervention needed and given (Yes, and I took the offer up)**
- 🟦 **Intervention needed and refused (Yes, but I did not want help)**
- 🟥 **Intervention needed and not given (No, but I did want help and No, but I did not want help)**

## Interventions for harmful or hazardous alcohol use

As shown in Figure 20, 8% (863) of people were identified from their case-notes as requiring an intervention for harmful or hazardous alcohol use. Of this sample, 93% (799) were offered an intervention. A further breakdown of this showed a total of 70% (603) of people received an intervention and 23% (196) refused the intervention. Refusal rates varied across Trusts from 4% to 75%. Brief intervention or advice (n = 391, 65%) was the most commonly provided intervention to those 603 people who received an intervention for alcohol use where required, and pharmacological treatment was the least common (n = 8, 1%). A further breakdown of interventions provided is displayed in Table 5.

**Figure 20: Proportion of people with FEP offered intervention for harmful or hazardous use of alcohol use across Trusts (n = 863)***

■ **Intervention needed and given**

□ **Intervention needed and refused**

🟥 **Intervention needed and not given**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 5: Breakdown of interventions received by those requiring harmful or hazardous alcohol use intervention across Trusts (n = 603)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Brief intervention and advice | 391 (65%) |
| Education about alcohol consumption | 249 (41%) |
| Referral to alcohol misuse service | 210 (35%) |
| Motivational interviewing | 45 (7%) |
| Referral to psychoeducation programme | 23 (4%) |
| Individual or group behavioural support | 16 (3%) |
| Pharmacological intervention for harmful use of alcohol commenced or reviewed | 8 (1%) |

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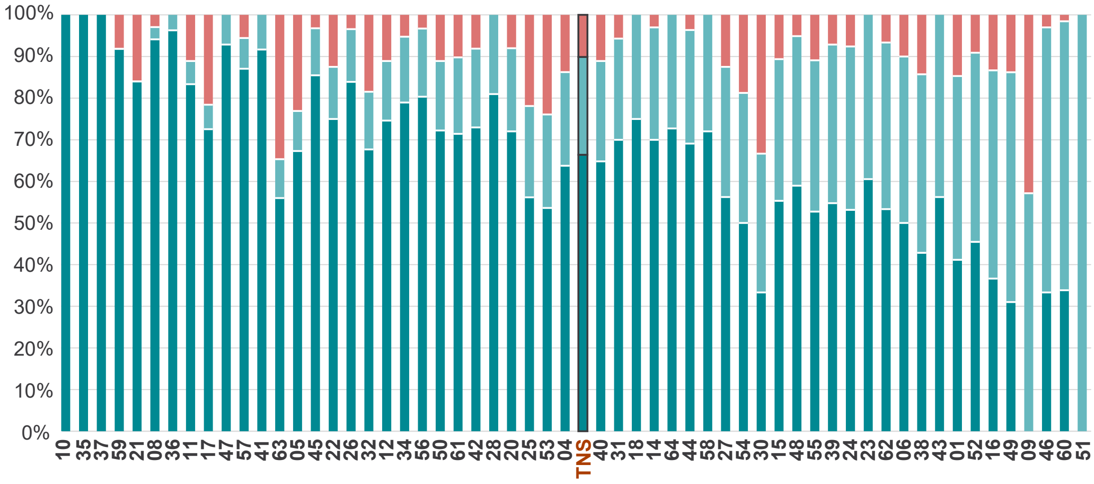
*Total percentage may be >100% due to some people receiving multiple interventions

## Interventions for substance misuse

As shown in Figure 21, 22% (2,303) of people were identified from their case-notes as requiring an intervention for substance misuse. Of this sample, 90% (2,070) were offered an intervention. A further breakdown of this showed a total of 66% (1,529) of people received an intervention and 23% (541) refused the intervention. Refusal rates varied across Trusts from 3% to 100%.

Brief intervention and advice (n = 982, 64%) was the most commonly provided intervention to those 1,529 people who received an intervention for substance misuse where required and referral to a detox programme was the least common (n = 28, 2%). A further breakdown of interventions provided is displayed in Table 6.

**Figure 21: Proportion of people with FEP offered intervention for substance misuse across Trusts (n = 2,303)***



- 🟦 **Intervention needed and given**
- 🟦 **Intervention needed and refused**
- 🟥 **Intervention needed and not given**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 6: Breakdown of interventions received by those requiring substance misuse intervention across Trusts (n = 1,529)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Brief intervention/advice | 982 (64%) |
| Substance use education | 579 (38%) |
| Referral to substance misuse service | 511 (33%) |
| Motivational interviewing | 87 (6%) |
| Referral to psychoeducation programme | 53 (3%) |
| Referral to detoxification programme | 28 (2%) |

---

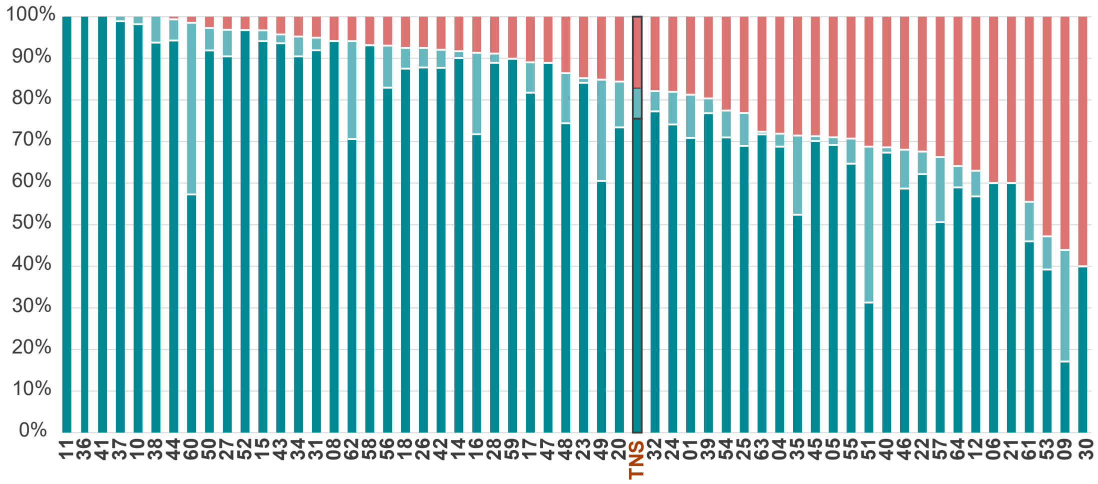
*Total percentage may be >100% due to some people receiving multiple interventions

## Interventions for elevated BMI/ weight gain

As shown in Figure 22, 48% (5,078) of people were identified from their case-notes as requiring an intervention for weight gain or obesity. Of this sample, 83% (4,211) were offered an intervention. A further breakdown of this showed a total of 75% (3,833) of people received an intervention and 7% (378) refused the intervention. Refusal rates varied from 1% to 41%.

Advice or referral about diet (n = 3,030, 79%) was the most commonly provided intervention to those 3,833 people who received an intervention for weight loss where required, and pharmacological intervention was the least common (n = 18, <1%). A further breakdown of interventions provided is displayed in Table 7.

**Figure 22: Proportion of people with FEP offered intervention for elevated BMI across Trusts (n = 5,078)***



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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 7: Breakdown of interventions received by those requiring weight loss intervention across Trusts (n = 3,833)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Advice or referral about diet | 3,030 (79%) |
| Advice or referral about exercise | 2,800 (73%) |
| Mental health medication review with respect to weight (e.g. antipsychotic) | 738 (19%) |
| Lifestyle education regarding risk of diabetes | 604 (16%) |
| Combined health eating and physical education programme | 213 (6%) |
| Referral for weight management programme | 186 (5%) |
| Weight management programme | 168 (4%) |
| Referral for combined healthy eating and physical education programme | 147 (4%) |
| Referral for lifestyle education | 101 (3%) |
| Referral for lifestyle education regarding risk of diabetes | 91 (2%) |
| Pharmacological intervention for obesity commenced or reviewed | 18 (<1%) |

---

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

## Interventions for hypertension

As shown in Figure 23, 11% (1,209) of people were identified from their case-notes as requiring an intervention for hypertension. Of this sample, 63% (763) were offered an intervention. A further breakdown of this showed a total of 58% (732) of people received an intervention and 2% (31) refused the intervention. Additionally, a further 4% (49) of people did not require intervention due to normal repeat tests. Refusal rates varied across Trusts from 2% to 20%.

Advice or referral about diet/salt intake (n = 426, 58%) was the most commonly provided intervention to those 732 people who received an intervention for elevated blood pressure where required, and referral for antihypertensive therapy was the least common (n = 24, 3%). A further breakdown of interventions provided is displayed in Table 8.

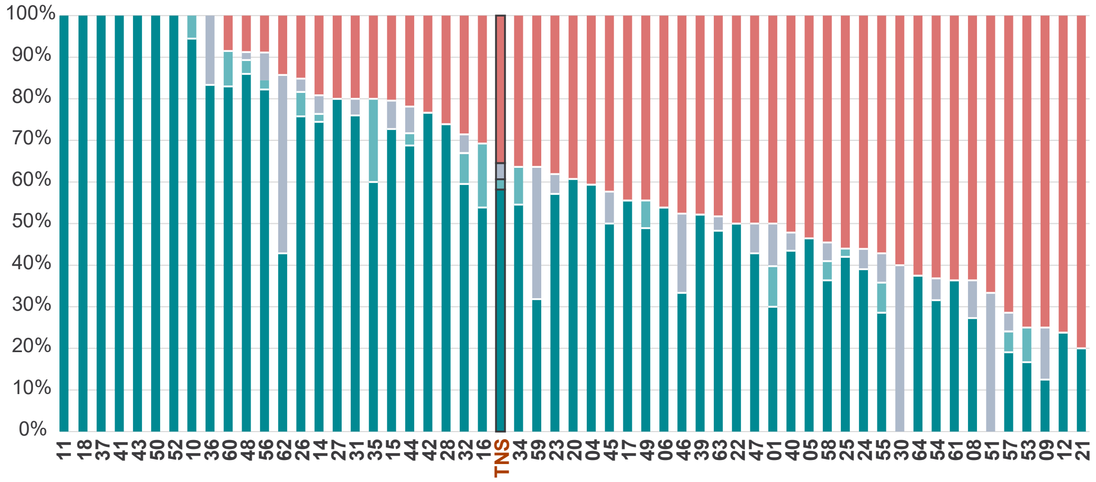

**Figure 23: Proportion of people with FEP offered intervention for elevated blood pressure across Trusts (n = 1,258)***

- 🟦 **Intervention needed and given**
- 🟦 **Intervention needed and refused**
- ⬜ **Intervention not needed as repeat test normal**
- 🟥 **Intervention needed and not given**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 8: Breakdown of interventions received by those requiring blood pressure intervention across Trusts (n = 732)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Advice or referral about diet/salt intake | 426 (58%) |
| Advice or referral about exercise | 402 (55%) |
| Referral to general practice service | 332 (45%) |
| Mental health medication review with respect to high blood pressure (e.g. antipsychotic) | 85 (12%) |
| Referral to secondary care physician | 42 (6%) |
| Antihypertensive therapy | 39 (5%) |
| Referral for antihypertensive therapy | 24 (3%) |

---

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

## Interventions for diabetes/high risk of diabetes

As shown in Figure 24, 6% (599) of people were identified from their case-notes as requiring an intervention for diabetes or pre-diabetes risk. Of this sample, 75% (447) were offered an intervention. A further breakdown of this showed a total of 73% (435) of people received an intervention and 2% (12) refused the intervention. Refusal rates varied across Trusts from 2% to 25%.

Referral to general practice services (n = 241, 55%) was the most commonly provided intervention to those 435 who received an intervention for glucose control where required, and referral to structured lifestyle education programme was the least common (n = 16, 4%). A further breakdown of interventions provided is displayed in Table 9.

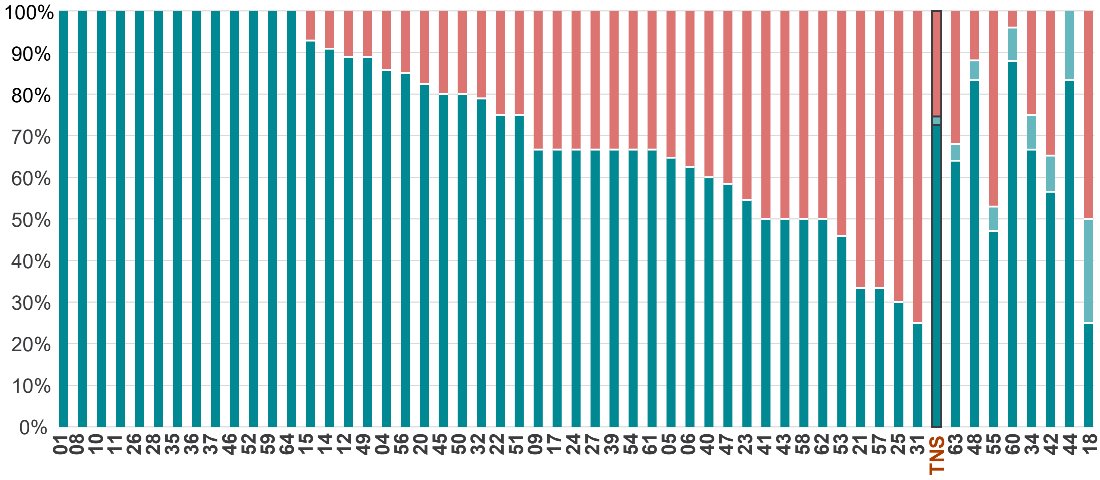

**Figure 24: Proportion of people with FEP offered intervention for abnormal glucose control across Trusts (n = 599)***

**■ Intervention needed and given**
**■ Intervention needed and refused**
**■ Intervention needed and not given**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

**Table 9: Breakdown of interventions received by those requiring glucose control intervention across Trusts (n = 435)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Referral to general practice service | 241 (55%) |
| Advice or referral about exercise | 176 (40%) |
| Diet modification | 122 (28%) |
| Mental health medication review with respect to glucose regulation (e.g. antipsychotic) | 80 (18%) |
| Diabetic care | 68 (16%) |
| Metformin therapy | 52 (12%) |
| Referral to secondary care physician | 35 (8%) |
| Referral for diabetic care | 34 (8%) |
| Referral to structured lifestyle education programme | 16 (4%) |

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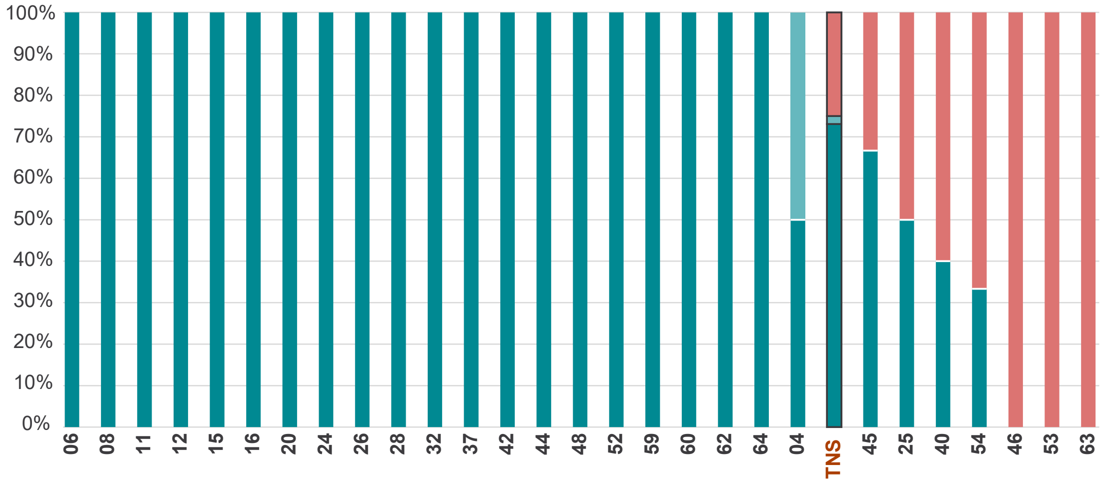
*Total percentage may be >100% due to some people receiving multiple interventions

## Interventions for dyslipidaemia

As shown in Figure 25, 0.5% (52) of people were identified from their case-notes as requiring an intervention for dyslipidaemia. Of this sample, 75% (39) were offered an intervention. A further breakdown of this showed a total of 73% (38) received an intervention and 2% (1) refused the intervention.

Advice or referral about diet (n = 25, 66%) was the intervention most commonly provided to those 38 people who received an intervention for dyslipidaemia where required, and a lipid lowering therapy was the least common (n = 4, 11%). A further breakdown of interventions provided is displayed in Table 10.

**Figure 25: Proportion of people with FEP offered intervention for abnormal lipids across Trusts (n = 52**)***



- 🟩 **Intervention needed and given**
- 🟦 **Intervention needed and refused**
- 🟥 **Intervention needed and not given**

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

**Table 10: Breakdown of interventions received by those requiring an intervention for dyslipidaemia across Trusts (n = 38)**

| Type of intervention received | n (%) of people who received intervention* |
|---|---|
| Advice or referral about diet | 25 (66%) |
| Advice or referral about exercise | 23 (61%) |
| Referral to primary or secondary care physician | 20 (53%) |
| Mental health medication review to lower blood lipids (e.g. antipsychotic) | 8 (21%) |
| Referral for lipid lowering therapy | 5 (13%) |
| Lipid lowering therapy | 4 (11%) |

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

# 14. Standard 8: Carer-focused education and support programmes

**S8** Carers take up or are referred to carer-focused education and support programmes

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

For Trusts to have met this standard, the person's identified carer must have taken up or been referred to an education and support programme.

This analysis was carried out where the person had an identified carer (n = 8,116). 58% (4,710) of 8,116 carers had taken up or been referred to carer-focused education and support programmes. As shown in Figure 26, the proportion of people meeting this standard ranges from 13% to 98% across Trusts. Since 2018, there has been a 3% increase (from 55% to 58%) in the proportion of people whose carers took up or were referred to carer education and support programmes.

Further analysis for this standard was carried out on people who had an identified carer, excluding those who did not wish this person to be contacted (n = 7,596).

61% (4,610) of 7,596 carers had taken up or been referred to education and support programmes. For this smaller sample, the proportion of people meeting the standard ranged from 12% to 98% across Trusts. See Figure 51 in Appendix J (page 50).

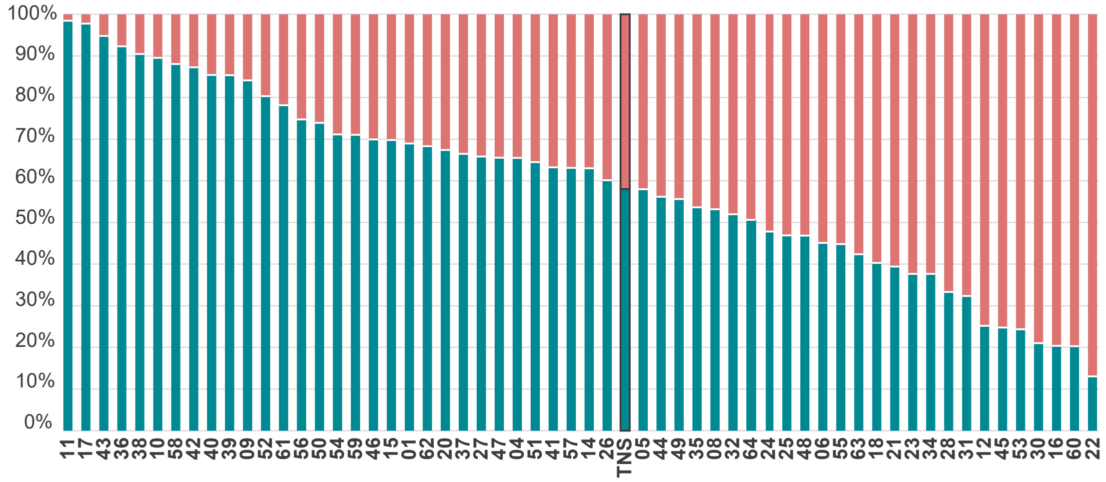


**Figure 26: Proportion of people with FEP with an identified family member, friend or carer who have taken up or been referred to carer-focused education and support programmes (n = 8,116)***

🟦 **Standard met**

🟥 **Standard not met**

---

*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

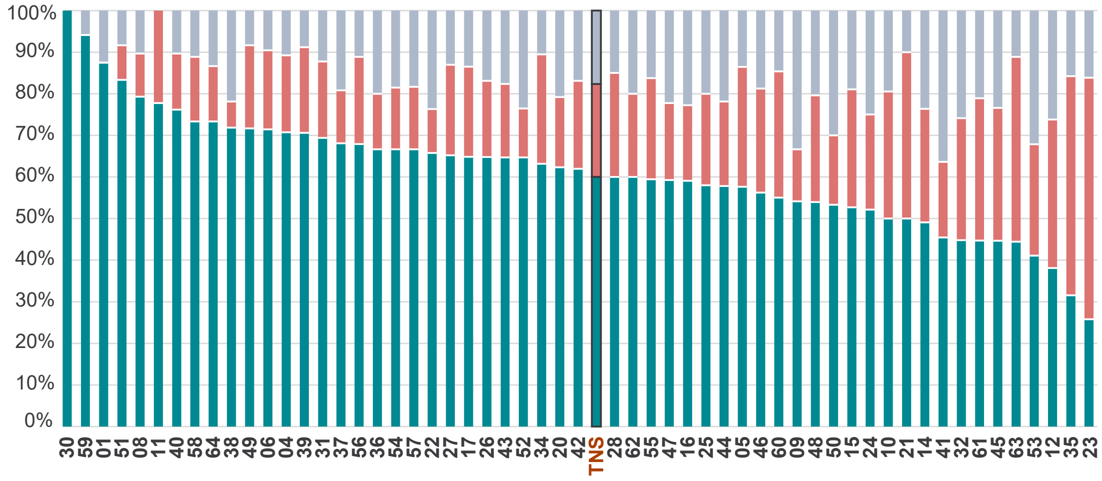
## Service user survey response

In the service user survey, people were asked if those who are important to them had been offered support from the EIP team such as carer education/support or FI.

2,329 people responded to this question. Of these, 60% (1,398) reported that those people who are important to them had been offered support from the EIP team, 22% (520) said this was not the case and 18% (411) did not know. The figure for the offer of carer support is comparable to the case-note audit data at 61%.

As shown in Figure 27, the proportion of people who reported that those who are important to them had been offered support from the EIP team ranged from 26% to 100% across Trusts. Please see Appendix H for a full breakdown of the service user survey.

**Figure 27: Proportion of people with FEP reporting that those who are important to them had been offered support from the EIP team (n = 2,329)**



🟩 **Standard met (Yes)**

🟥 **Standard not met (No)**

⬜ **Standard not met (Don't know)**

# 15. Outcome indicator

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

For Trusts to have met this standard, people had to have had clinical outcome measurement data (2 or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR[10]) recorded at least twice. This had to be at baseline assessment and repeated at one other time point between 01 November 2018 and 31 October 2019. For people aged under 18 only, the following outcome measures were accepted: HoNOS/HoNOSCA, DIALOG, QPR, Other.

This analysis was carried out on the entire national sample (n = 10,560). 41% (4,367) of 10,560 people in the national sample had 2 or more outcome measures recorded at least twice. As shown in Figure 28, the proportion of Trusts that met this standard ranged from 1% to 89%. Since 2018, there has been a 19% increase (from 22% to 41%) in the proportion of people with 2 or more outcome measures recorded at least twice.

For a further breakdown of measures recorded for the Trusts who met the outcome indicator, see Table 35 in Appendix J (page 50).

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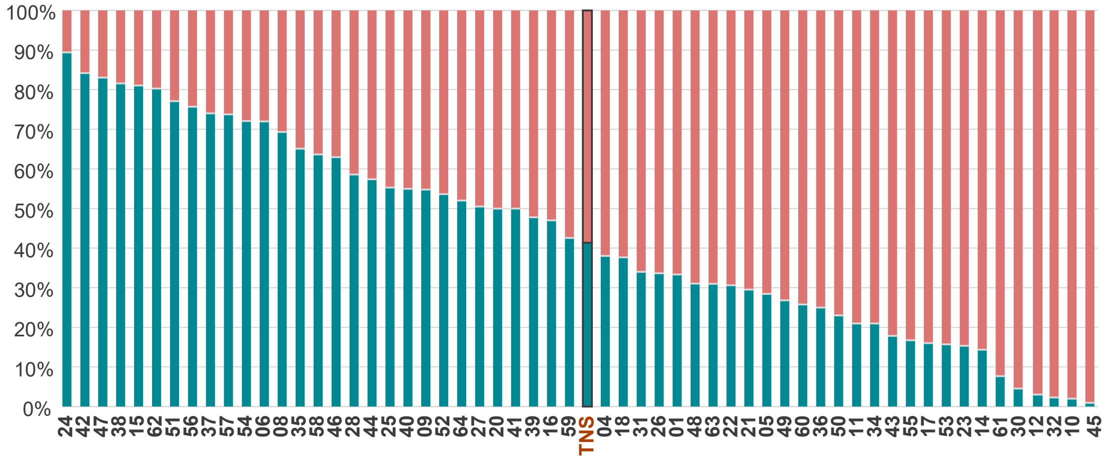
[10] HoNOS/HoNOSCA: Health of the Nation Outcome Scales/The Health of the Nation Outcome Scales for Children and Adolescents. DIALOG: a Patient Reported Outcome Measure developed for people with psychosis. QPR: Process of Recovery Questionnaire

**Figure 28: Proportion of people with FEP with clinical outcome measurement data (2 or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) recorded at least twice (at assessment and at one other time point) (n = 10,560)***



🟦 **Indicator met**

🟥 **Indicator not met**

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*Due to the reconfiguration of Trusts in October 2019, data from ORG32 includes people whose care was carried out by ORG18 until October 2019. ORG18 submitted data for people under the care of one of their teams during the period covered by the audit. This team moved to ORG44 from October 2019.

# 16. Conclusions

Data from the 2019/2020 round of this audit show improvements in a number of areas of care for people with FEP. These include better physical healthcare and increased use of clinical outcomes. Results from the service user survey show high levels of patient experience and satisfaction with care, but 1 in 4 people told us that they did not have a current care plan.

The proportion of people who start treatment within 2 weeks of referral was nearly unchanged; nationally 1 in 4 people do not start treatment within this period. (Although it should be noted that everyone would not be expected to start treatment within 2 weeks as some people may not wish to engage with services or may take longer to come forward).

The area where performance of EIP services continues to be furthest behind recommended practice is in the delivery of FI, with 3 out of 4 people in the audit with an identified carer who they wished to be involved in their care not receiving it. Levels of delivery of FI in England have never been high and progress is not being made to change this. This is of concern because FI reduce rates of relapse and hospital admission and can improve the longer-term outcomes of people with FEP.

The low number of under 18s within the sample raises questions about access to services for this age group. More representative sampling should address this in future audits but there are still teams with no EIP provision for under 18s with FEP, and more must be done to ensure that all children and young people with FEP have prompt access to evidence-based EIP care.

## Next steps

Much progress has been made to reduce delays in treatment for people with FEP. Further reductions will be more difficult to achieve. Trusts should identify factors leading to delays and work with stakeholders to remove or reduce barriers to timely access to treatment. Access to EIP services and provision of evidence-based interventions for under 18s should be given increased focus by commissioners and providers.

Commissioners, Trusts and frontline staff all have a role to play in increasing access to evidence-based FI. FI is more challenging to deliver than individual psychological or pharmacological treatments because it involves working with family members. This requires training, supervision and support to ensure that staff have the knowledge, skills and time to engage family members and people by explaining the rationale and potential benefits of this approach. Commissioners should ensure that early intervention teams have enough trained staff to deliver FI. Trusts should monitor delivery of FI by early intervention teams. Team managers should ensure that systems are in place to deliver support and supervision for staff delivering FI and that staff are regularly attending these sessions.

The rapid progress that has been made in the collection of routine clinical outcome data in early intervention services provides an opportunity to start reviewing clinical outcomes of people with FEP for the first time. By studying outcome data, teams will be able to start to identify causes of unexplained variation and take steps to plan and study the impact of changes aimed at improving them. Trusts should work with local teams to facilitate use of these outcome data. The national audit team will help to identify and share good practice to illustrate ways that teams and Trusts are beginning to use outcome data to study and improve the quality of care they provide to people with FEP.

# 17. Compiled by

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# 18. List of figures and tables

# 19. Limitations of methodology and data

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

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

2,374 people responded to the service user survey. We estimate that this was 18% of those who were sent a survey. We do not know if the views and experiences of people who responded to the survey are representative of those who did not.

The survey and supporting documents were only available in English and Welsh, so service users who were unable to read English or Welsh may have been unable to complete them.