NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

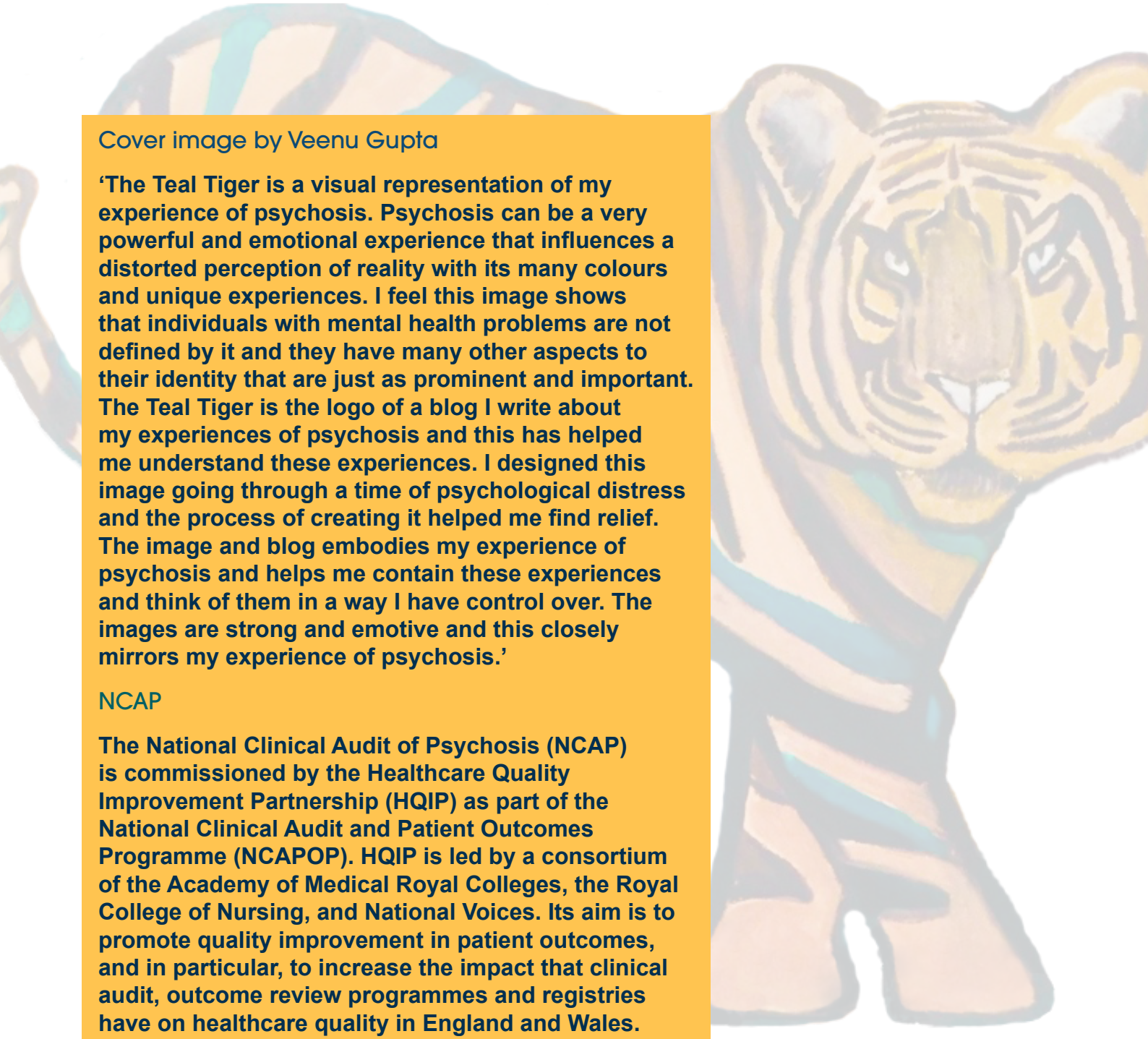
HQIP
Healthcare Quality Improvement Partnership

National Clinical Audit of Psychosis

Early Intervention in Psychosis Audit

2019/2020

National report for Wales



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

If citing this report, please reference it as: Royal College of Psychiatrists (2020) National Clinical Audit of Psychosis – Wales National Report for the Early Intervention in Psychosis Audit 2019/2020. London: Healthcare Quality Improvement Partnership. Available from: www.rcpsych.ac.uk/NCAP

Designed and typeset by Helen Greenwood.

Foreword

The National Clinical Audit of Psychosis (NCAP) has been pleased to support the development of services for people with psychosis and their families and, in recent years, has focused on early intervention in psychosis (EIP) services. Last year, we were delighted to work with Welsh colleagues to initiate the process of extending the EIP audit into Wales. This has culminated in this first national report, which is a valuable source of information about the quality of NHS mental health care, specifically for people with early psychosis and their families, across Wales.

An important aspect of the audit is to identify unwarranted variation both across and within organisations as a method of driving forward the quality of care that people receive.

EIP services have developed to provide prompt assessment, treatment and support to people with an emerging psychosis. These services offer a range of evidence based interventions shown to impact positively on outcomes for people with psychosis and their families, which have been endorsed by the National Institute of Health and Care Excellence (NICE 2014; 2015). It is these interventions that form the basis of the audit, alongside contextual service data collection.

Results from this audit indicate some real impacts across a number of key areas, which in the second year of audit, is excellent to see. However, this is against a backdrop of what are very low numbers of patients compared with numbers that would have been expected to present with a first episode of psychosis and has exposed wide variations in service delivery across EIP teams in Wales (Appendix D). This offers the opportunity for real change and service quality improvement, and an annual repeat audit process can provide a mechanism for tracking progress towards this.

There can now be a real push to focus on some of the key recommendations which will drive forward the development of EIP services for people with early psychosis and their families in Wales. To successfully achieve this, it will be vital for Welsh government, commissioners, providers and regulators in the health system to work together to ensure that people with early psychosis and their families receive the safe and effective EIP services that they deserve.

It is important to thank everyone who has contributed to data collection and analysis which has enabled us to generate this first national report for Wales. We look forward to working with you over the coming years to continue to map progress improvements against these important audit standards.

Dr Paul French and Prof. Jo Smith

NCAP Joint Clinical Advisors to the EIP Audit in England and Wales

Contents

1. Introduction

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

In 2019/2020, NCAP collected data from EIP teams on the care provided to people (referred to in the report as the 'case-note audit'), as well as information from people with FEP 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 (2017/2018) 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.

This report provides the findings of the audit for Wales and is the first time a national report has been published for Wales. A separate national report has been produced for England, because EIP services in Wales are in an earlier developmental stage than those in England. In 2012, Together for Mental Health (Welsh Government, 2012), a 10-year cross-governmental strategy to improve mental health and wellbeing, identified the development of services for the treatment of people with FEP as a priority. This strategy has been supported by 3 delivery plans. The 2016–2019 delivery plan (Welsh Government, 2016) focused on setting up EIP teams in all Health Boards, and the assessment and provision of NICE-compliant treatment to 14–25 year olds with an emerging psychosis. The most recent plan covering 2019–2022 (Welsh Government, 2020) requires the Welsh EIP National Steering Group and Community of Practice[1] to work with the Royal College of Psychiatrists (RCPsych) to develop and embed best practice service models in line with standards.

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

[1] A group of leads from each Health Board with responsibility for EIP.

2. 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).

June

All 6 Health Boards providing EIP services identify eligible patients on their caseloads

July

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

Aug

People complete survey online or return paper copy to NCAP

Sept

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

Oct

31st Deadline for survey returns

Health Boards collect data on their sample

Nov

Survey results inputted by NCAP

48 from 6 Health Boards

30th Deadline for Health Boards to submit data on their sample

Dec

Data analysis and report writing begins

Data cleaning carried out by NCAP

205 returns from 6 Health Boards

Jan

Feb

Data analysis and report writing begins

Mar

Apr

May

Data presented to Welsh stakeholders and recommendations discussed

June

Report to HQIP and Welsh Government for sign-off
Preparation for publication

Summer

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

The sampling criteria can be found on our website.

3. Findings

Table 1 provides an overview of Health Board performance against access and treatment for people experiencing FEP alongside data for Wales from the NCAP EIP Spotlight Audit 2018/19 for comparison and benchmarked against audit data from the England 2019/20 national sample.

Table 1: Key comparisons between NCAP EIP audit 2019/20 and EIP spotlight audit 2018/2019

Standard/indicator	NCAP 2019/20 Wales % (n=205)	NCAP 2018/19 Wales % (n=247)	NCAP 2019/20 England % (n=10,560)
Standard 1: Timely access			
Treatment started within two weeks of referral[2]	33%	N/A	74%
Standards 2 & 3: Take up of psychological therapies			
Cognitive Behavioural Therapy for psychosis (CBTp)	51%	43%	49%
Family Intervention (FI)	24%	22%	21%
Standard 4: Prescribing			
Offered clozapine[3]	66%	55%	52%
Standard 5: Take up of supported employment & education programmes			
Supported employment & education programmes[4]	18%	17%	31%
Standard 6: Physical health monitoring[5]			
All seven screening measures	21%	15%	75%
Smoking	80%	79%	93%
Alcohol use	83%	91%	94%
Substance misuse	91%	93%	94%
Body mass index	38%	28%	87%
Blood pressure	46%	38%	89%
Blood glucose	38%	28%	84%
Lipids	36%	27%	82%
Standard 7: Physical health interventions[5,6]			
Smoking	38%	35%	91%
Harmful/hazardous use of alcohol	74%	50%	93%
Substance misuse	52%	61%	90%
Weight/obesity	48%	69%	83%
Elevated blood pressure	17%	6%	65%
Abnormal glucose control	60%	50%	75%
Abnormal lipids	-	-	75%
Standard 8: Take up or referral to carer-focused education and support programmes			
Carer-focused education and support programmes[7]	44%	29%	58%
Clinical outcome measurement			
Two or more outcome measures were recorded at least twice[8]	5%	0%	41%

[2] Data for this standard in England are Early Intervention in Psychosis Waiting Times (NHS Digital, 2019). Data for this standard for Wales were not collected in 2018/19.
[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] Wales: DIALOG (patient reported outcome measure developed for people with psychosis) and 'Other'; England: 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).

Service user survey

Table 2: Key findings from the NCAP 2019/2020 service user survey identified by the service user and carer reference group. Total sample for Wales (n = 48) benchmarked against English national sample (n = 2,374)[9]

Percentage of service users who…		Wales national sample 2019/20 %	England national sample 2019/20 %
Experience of care	felt that their mental health had improved since they had been under the care of their EIP team	96%	89%
	felt heard and listened to by their EIP worker/team 'a lot' or 'quite a lot'	83%	83%
Care planning and crisis numbers	had a copy of their care plan and knew where it was	60%	52%
	had a copy of their care plan, but did not know where it was	17%	21%
	had an emergency contact number to call	73%	89%
Medication	felt that they were involved in the decision on which medication they could take	89%	78%
	felt that they were given written or online information about their medication	71%	72%
Physical health	felt that they were in good physical health	44%	48%
Employment and practical help	had a job	27%	33%
	did not have any problems with housing or benefits	93%	84%
	had problems with housing or benefits but were not getting help	0%	7%

[9] The total responses for each question will be less than the complete total service user sample, as not all patients answered all questions and some questions were routed.

Service level data

Table 3: Contextual questionnaire: Wales (6 teams submitted data, n = 6[10]) and England (155 teams submitted data, n = 155)

	Welsh services 2019/20 n (%)	Welsh services 2018/19 n (%)	English services 2019/20 n (%)
Q1. Routinely collected demographic data			
Protected characteristics			
Age	6 (100%)	5 (100%)	155 (100%)
Disability	4 (67%)	3 (60%)	132 (85%)
Gender reassignment	3 (50%)	2 (40%)	72 (46%)
Marriage and civil partnership	4 (67%)	3 (60%)	147 (95%)
Pregnancy and maternity	4 (67%)	2 (40%)	99 (64%)
Race	5 (83%)	4 (80%)	151 (97%)
Religion or belief	5 (83%)	3 (60%)	145 (94%)
Sex	6 (100%)	5 (100%)	153 (99%)
Sexual orientation	3 (50%)	2 (40%)	117 (75%)
Other demographic data			
Socioeconomic status	4 (67%)	2 (40%)	98 (63%)
Refugees/asylum seekers	2 (33%)	3 (60%)	55 (35%)
Migrant workers	2 (33%)	2 (40%)	37 (24%)
Homelessness	2 (33%)	2 (40%)	139 (90%)

[10] Only 6/7 Health Boards in Wales participated in the audit because one Health Board did not have an EIP team at the point of registration (Spring 2019) and were not able to easily identify eligible patients.

Table 3 continued

		Welsh services 2019/20 n (%)	Welsh services 2018/19 n (%)	English services 2019/20 n (%)
Q2. Written strategy/strategies to identify and address any mental health inequalities				
Yes		2 (33%)	2 (40%)	94 (61%)
No		4 (67%)	3 (60%)	61 (39%)
Q3. Early intervention service provided for these age ranges				
18–35 years	Stand-alone multidisciplinary EIP team	2 (33%)	2 (40%)	138 (89%)
	Hub-and-spoke model	2 (33%)	2 (40%)	6 (4%)
	Integrated community mental health trust (CMHT)	2 (33%)	1 (20%)	10 (6%)
	No early intervention service	0 (0%)	0 (0%)	1 (<1%)
36 years and over	Stand-alone multidisciplinary EIP team	1 (17%)	1 (20%)	113 (73%)
	Hub-and-spoke model	1 (17%)	1 (20%)	14 (9%)
	Integrated CMHT	0 (0%)	0 (0%)	13 (8%)
	No early intervention service	4 (67%)	3 (60%)	15 (10%)
Q4. Length of treatment packages for different age ranges				
Under 18 years	N services	5	5	139
	Mean months (SD)	36 (0)	36 (0)	35.32 (5.45)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	57 (3–60)
18–35 years	N services	6	5	154
	Mean months (SD)	36 (0)	36 (0)	35.45 (5.49)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	75 (3–78)
36 years and over	N services	2	2	140
	Mean months (SD)	36 (0)	36	32.70 (7.89)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	57 (3–60)
Q5a. Model of provision for children and young people (CYP) **Total percentage may be >100% due to some teams having multiple models*				
Specialist EIP team embedded within CYP mental health services		3 (50%)	1 (20%)	14 (9%)
Specialist CYP EIP team		1 (17%)	0 (0%)	18 (12%)
Adult and young people's EIP service with staff that have expertise in CYP mental health		2 (33%)	1 (20%)	49 (32%)
Adult EIP service with joint protocols with CYP mental health services		3 (50%)	2 (40%)	84 (54%)
No CYP EIP provision		0 (0%)	0 (0%)	6 (4%)
Other[11]		1 (17%)	1 (20%)	16 (10%)
Q5b. Is there a shared protocol between the EIP team and the children and young people's mental health (CYPMH) service?				
Yes		4 (67%)	N/A	127 (82%)
No		2 (33%)	N/A	28 (18%)
Q5c. Are joint or reciprocal training events arranged at least annually between the CYPMH and EIP teams?				
Yes		5 (83%)	N/A	41 (26%)
No		1 (17%)	N/A	114 (74%)

[11] For a breakdown of 'Other' models, please see Table 4.

Table 3 continued

		Welsh services 2019/20 n (%)	Welsh services 2018/19 n (%)	English services 2019/20 n (%)
Q5d. How is medication managed for CYP?[12] **Total percentage may be >100% due to some teams managing medication in multiple ways*				
CYP team prescribers with specific EIP training and experience prescribe for CYP		0 (0%)	N/A	41 (28%)
CYP team prescribers advise and support EIP team prescribing for CYP		1 (20%)	N/A	43 (29%)
CYP team prescribers do not have specific EIP prescribing training and experience and do not have a protocol or routine access to specialist EIP prescribing advice		2 (40%)	N/A	21 (14%)
EIP team prescribers with specific CYP training and experience prescribe for CYP		0 (0%)	N/A	38 (26%)
EIP team prescribers advise and support CYPMH team prescribing for CYP		2 (40%)	N/A	48 (32%)
EIP team prescribers do not have specific CYP prescribing training and experience and do not have a protocol or routine access to specialist CYP prescribing advice		0 (0%)	N/A	16 (11%)
Q5e. Provision from appropriately trained practitioners available for CYP, with early onset psychosis **Total percentage may be >100% due to some teams having multiple provisions*				
Provided by CYPMH service	CBTp	2 (33%)	N/A	27 (17%)
	FI	3 (50%)	N/A	40 (26%)
Provided by EIP	CBTp	3 (50%)	N/A	127 (82%)
	FI	3 (50%)	N/A	126 (81%)
Provided by CMHT	CBTp	0 (0%)	N/A	0 (0%)
	FI	0 (0%)	N/A	0 (0%)
Provided by Other	CBTp	0 (0%)	N/A	1 (1%)
	FI	0 (0%)	N/A	0 (0%)
No CYP EIP provision	CBTp	2 (33%)	N/A	7 (5%)
	FI	1 (17%)	N/A	3 (2%)
Q6. Whole-time equivalent EIP care coordinators				
Mean (SD)		3.43 (2.95)	2.8 (2.77)	9.55 (5.40)
Range (min.–max.)		7 (0–7)	7 (0–7)	30.3 (1–31.3)
Q6b. Care coordinators specifically for CYP under 18				
Yes, within EIP team		1 (17%)	N/A	48 (31%)
Yes, within **CYPMH**		1 (17%)	N/A	21 (14%)
No		5 (83%)	N/A	90 (58%)

[12] This question was multiple choice. 7 teams (1 Welsh team and 6 English teams) were identified as having input options which may be contradictory. We have removed these teams for the national analysis therefore the denominator for Wales is 5 and for England is 149.

Table 3 continued

			Welsh services 2019/20 n (%)	Welsh services 2018/19 n (%)	English services 2019/20 n (%)
Q7. Increase in number of staff posts					
Yes			4 (67%)	2 (40%)	62 (40%)
No			2 (33%)	3 (60%)	93 (60%)
Q8. Cognitive behavioural therapy (CBT) for at risk mental state (ARMS)					
Elsewhere		Under 18	0 (0%)	0 (0%)	13 (8%)
		18–35	0 (0%)		14 (9%)
		36 and over	0 (0%)		16 (10%)
Within the EIP team		Under 18	2 (33%)	3 (60%)	72 (46%)
		18–35	2 (33%)		74 (48%)
		36 and over	1 (17%)		39 (25%)
Not at all		Under 18	4 (67%)	2 (40%)	64 (41%)
		18–35	4 (67%)		62 (40%)
		36 and over	5 (83%)		100 (65%)
Separate **CBT** for ARMS team		Under 18	0 (0%)	N/A	6 (4%)
		18–35	0 (0%)		5 (3%)
		36 and over	0 (0%)		0 (0%)
Q9. Total caseload of the EIP team					
Total caseload		Mean (standard deviations [SD])	61.33 (24.58)	59.20 (26.96)	161.17 (104.20)
		Range (min.–max.)	72 (35–107)	64 (41–105)	576 (4–580)
Caseload per whole-time EIP care coordinator		Mean (SD)	13.85 (5.09)	22.13 (13.18)	16.97 (5.03)
		Range (min.–max.)	11.49 (8.85–20.33)	29.50 (11.5–41)	33.47 (1–34.47)
Q10. Total caseload by age ranges					
Under 14 years	FEP	Mean (SD)	0.00 (0)	0.00 (0)	0.02 (0.18)
		Range (min.–max.)	0 (0–0)	0 (0–0)	2 (0–2)
	ARMS	Mean (SD)	0.00 (0)	0.00 (0)	0.03 (0.21)
		Range (min.–max.)	0 (0–0)	0 (0–0)	2 (0–2)
	Suspected FEP	Mean (SD)	0.00 (0)	0.00 (0)	0.00 (0)
		Range (min.–max.)	0 (0–0)	0 (0–0)	0 (0–0)
14–17 years	FEP	Mean (SD)	1.83 (2.14)	6.00 (7.1)	5.23 (5.23)
		Range (min.–max.)	5 (0–5)	16 (0–16)	26 (0–26)
	ARMS	Mean (SD)	1.17 (2.40)	1.20 (1.8)	1.45 (2.90)
		Range (min.–max.)	6 (0–6)	4 (0–4)	14 (0–14)
	Suspected FEP	Mean (SD)	0.83 (1.17)	2.40 (3.29)	0.92 (3.09)
		Range (min.–max.)	3 (0–3)	8 (0–8)	34 (0–34)

Table 3 continued

			Welsh services 2019/20 n (%)	Welsh services 2018/19 n (%)	English services 2019/20 n (%)
18–35 years	FEP	Mean (SD)	44.33 (20.05)	39.60 (28.85)	95.99 (62.83)
		Range (min.–max.)	53 (26–79)	68 (23–91)	342 (0–342)
	ARMS	Mean (SD)	3.83 (5.60)	5.40 (9.1)	5.96 (11.34)
		Range (min.–max.)	12 (0–12)	21 (0–21)	52 (0–52)
	Suspected FEP	Mean (SD)	6.83 (7.73)	2.60 (3.96)	5.73 (14.82)
		Range (min.–max.)	17 (0–17)	9 (0–9)	150 (0–150)
36 years and over	FEP	Mean (SD)	2.00 (2.45)	1.8 (2.49)	42.65 (40.14)
		Range (min.–max.)	6 (0–6)	5 (0–5)	252 (0–252)
	ARMS	Mean (SD)	0.00 (0)	0.00 (0)	0.80 (2.96)
		Range (min.–max.)	0 (0–0)	0 (0–0)	24 (0–24)
	Suspected FEP	Mean (SD)	0.50 (0.84)	0.20 (0.45)	2.46 (5.05)
		Range (min.–max.)	2 (0–2)	1 (0–1)	27 (0–27)
Q11. Average length of treatment in months of last 10 FEP service users					
Mean (SD)			25.15 (12.42)	16.78 (14.1)	32.35 (10.45)
Range (min.–max.)			29 (10–39)	31.6 (5.8–37.4)	68.90 (0–68.90)

Table 4: 'Other' models of provision for CYP (1 team submitted data)

'Other' models of provision for CYP	Welsh services 2019/20 n (%)
No age barrier for assessment. Care coordinator from age 18. Under-18 joint-working but not CC	1 (17%)

Demographics

Tables 5 and 6 provide the demographic characteristics for the complete case-note audit sample (n = 205).

Table 5: Number of people in the case-note sample by age and gender (n = 205) benchmarked against the English national sample (n = 10,560)

		Wales 2019/20 n (%)	England 2019/20 n (%)
Total sample	n (%)	205 (100%)	10,560 (100%)
	Mean age in years (SD)	25.03 (5.84)	32.11 (11.05)
	Age range	37	51
	Age min.–max. (years)	17–54	14–65
Male	n (%)	150 (73%)	6,468 (61%)
	Mean age in years (SD)	25.17 (5.99)	30.57 (9.93)
	Age range	37	51
	Age min.–max. (years)	17–54	14–65
Female	n (%)	53 (26%)	4,082 (39%)
	Mean age in years (SD)	24.79 (5.45)	34.56 (12.24)
	Age range	21	51
	Age min.–max. (years)	17–38	14–65
Other/ undefined	n (%)	2 (<1%)	10 (<1%)
	Mean age in years (SD)	20.5 (3.54)	26.17 (7.59)
	Age range	5	26
	Age min.–max. (years)	18–23	18–44

Table 6: Number of people in the case-note sample by ethnicity (n = 205) benchmarked against the English national sample (n = 10,560)

Ethnic group	Wales 2019/20 n (%)	England 2019/20 n (%)
White	165 (81%)	6,766 (64%)
Black or Black British	8 (4%)	1,356 (13%)
Asian or Asian British	7 (3%)	1,286 (12%)
Mixed	10 (5%)	421 (4%)
Other ethnic groups	15 (7%)	731 (7%)

Tables 7 and 8 provide the demographic characteristics for the complete survey user survey sample (total sample n = 45[13]).

Table 7: Number of people in the service user sample by age and gender (total sample n = 45) benchmarked against the English national sample (n = 2,291)[13]

		Wales 2019/20 n (%)	England 2019/20 n (%)
Total sample	n (%)	45 (100%)	2,291 (100%)
	Mode age range	18–25	18–25
	Age min.–max. (years)	Under 18–50+	Under 18–50+
Male	n (%)	26 (58%)	1,184 (52%)
	Mode age range	18–25	18–25
	Age min.–max. (years)	Under 18–50+	Under 18–50+
Female	n (%)	18 (40%)	1,086 (47%)
	Mode age range	18–25	26–35
	Age min.–max. (years)	Under 18–50+	Under 18–50+
Other/ undefined	n (%)	1 (2%)	21 (<1%)
	Mode age range	18–25	18–25
	Age min.–max. (years)	Under 18–50+	Under 18–50

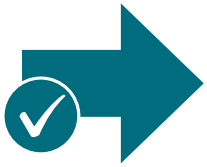
Table 8: Number of people in the service user sample by ethnicity (total sample n = 44) benchmarked against the English national sample (n = 2,260)[13]

Ethnic group	Wales 2019/20 n (%)	England 2019/20 n (%)
White	40 (91%)	1,527 (66%)
Black or Black British	1 (2%)	243 (11%)
Asian or Asian British	0 (0%)	232 (10%)
Mixed	3 (7%)	119 (5%)
Other ethnic groups	0 (0%)	139 (6%)

[13]The total sample for each demographic will be less than the complete total service user survey sample, as not all patients answered all questions.

4. Recommendations

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



1 Ensure equality of early intervention in psychosis (EIP) service provision and timely access to EIP care across Wales

a. Welsh Government should work with Health Boards and commissioners to:

- ensure there is equal access to a standardised EIP care package for all people aged 14–65 across Wales.
- ensure access to emergency and urgent assessment within 48 hours and that EIP treatment is commenced within 2 weeks of referral.
- introduce a national framework for self-assessment using EIP measurement data to inform service planning for Welsh EIP teams over a 3-year time frame, with a test framework in place by November 2020.

b. Health Boards should:

- ensure adequate provision of EIP services for all people aged 14–65 presenting with a first episode of psychosis. This should include access to cognitive behavioural therapy for psychosis (CBTp) and family intervention (FI).
- ensure that EIP teams are appropriately resourced with sufficient staff capacity, with the required level of competence and training, to deliver comprehensive EIP care to all people presenting with first episode of psychosis (FEP) and their families in their respective catchment population.

c. Welsh Government to work with Delivery Unit/Health Inspectorate Wales (HIW) to commission a review of progress during the 2020–2022 delivery period:

- monitor EIP provision, equity and timeliness of access to EIP interventions across Health Boards.
- follow a national learning/development/assurance approach for the 2020–2022 period.

d. Improvement Cymru and Quality improvement Leads for Health Boards should:

- support links between high and low-performing EIP teams across Wales to share learning, quality improvement initiatives and good practice.
- support national development according to the priorities set by the national EIP Steering Group and Welsh Government and review against the milestones set out in the Mental Health Delivery Plan.

e. National Steering Group/Health Board leads should:

- review pathways and access and develop a plan to encourage uptake of EIP services in line with prevalence data for Wales. This should be part of the work plan specified as a milestone in the 2019–2022 Delivery Plan. The plan should include raising awareness of EIP support, intervention and outcomes and involve service users, education, primary care, non-government and voluntary sector staff and other key stakeholders.

2 Psychological therapies

a. The EIP national steering group/ Health Board Leads should:

- review the training needs and the EIP workforce skill mix across the board, with a focus on the ability to deliver CBTp and FI.
- ensure that EIP staff can access relevant specialist training programmes and ongoing opportunities for supervision and continuing professional development updates.

b. Mental health workforce planning should:

- prioritise the development of dedicated specialist posts for EIP teams of staff who are appropriately trained and capable of delivering specialist evidence-based psychological interventions for psychosis.
- commission specialist training and ongoing supervision support to grow the skills of the EIP workforce to deliver specialist CBTp and FI psychological interventions.

c. Health Boards should:

- review local capacity of the EIP service to deliver specialist psychological therapies for psychosis, notably CBTp and FI according to the Matrics Cymru, to people experiencing FEP and their families, and prioritise EIP for service improvement funding to build sufficient local capacity to deliver psychological therapies for psychosis.
- ensure there are sufficient specialist staff working in or available to EIP teams with the appropriate training competences and supervision support to deliver CBTp to people experiencing FEP in concordance with the Matrics Cymru, relevant NICE guidance (NICE QS80, quality statement 2; NICE QS102, quality statement 3).
- ensure there are sufficient trained staff in EIP teams with the appropriate competences and supervision support to deliver FI to EIP families in concordance with Matrics Cymru, relevant NICE guidance (NICE QS80, quality statement 3; NICE QS102, quality statement 2).

3 Supported employment and education

a. EIP Team managers and commissioners should:

- ensure there are sufficient skilled staff in EIP teams to deliver supported education and employment programmes in line with NICE recommendations (NICE QS80, quality statement 5; NICE clinical guideline 178 1.3.3.1, 1.3.3.5; NICE QS102, quality statement 8).
- ensure that, where this is not the case, teams refer people to effective local services delivering evidence-based supported education and employment programmes.

b. 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.

4 Physical healthcare

a. Health Boards should ensure that comprehensive physical health screening can be provided by EIP teams. To do this they should:

- carry out an annual review of EIP staff skills/knowledge in relation to physical health monitoring and offer training as required.
- ensure that relevant equipment (for example, weighing scales, blood pressure monitors) are available to EIP teams.
- establish procedures that ensure physical health monitoring is a core part of service delivery and is reviewed regularly in line with NICE guidance (NICE QS80, quality statement 6).

b. EIP Clinicians should:

- ensure that routine physical health screening takes place.
- where screening indicates a risk of cardiovascular disease (obesity, smoking, hypertension, diabetes, dyslipidemia) according to the Lester UK Adaptation tool, ensure that appropriate interventions are provided in accordance with relevant NICE guidance (NICE QS80, quality statement 6; NICE QS102, quality statement 6).
- ensure all interventions are clearly documented in health records held in mental health services and primary care.

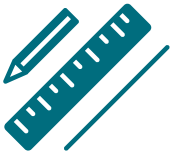
c. EIP team Managers should work with EIP care coordinators to:

- ensure allocation of appropriate time, effort and resources to ensure physical health needs of EIP service users are assessed and addressed.
- problem-solve ways to overcome barriers to routine screening and intervention to ensure EIP teams are delivering effective physical healthcare.
- ensure that all EIP staff are trained to provide brief smoking-cessation interventions for people who smoke, and simple lifestyle behaviour interventions to support healthy eating, regular exercise and health promoting lifestyle changes.
- ensure there are clear referral pathways for those risks identified which require specialist assessment and intervention either in primary or secondary care, e.g. for risks such as diabetes, dyslipidemia, high blood pressure or specialist substance-misuse support.
- ensure that patients know who is responsible for monitoring their physical health for each of the 7 physical health measures.

5 Carer-focused education and support programmes

a. Commissioners with EIP providers and local carer support workers/champions should:

- assess local capacity of the EIP service to deliver carer information, education and support on a routine basis to all carers and to ensure staff have the appropriate skills to deliver support in line with NICE guidance (NICE QS80, quality statement 8; NICE QS102, quality statement 4).
- identify individual EIP carers or an EIP carers group to involve in co-producing carer education and support opportunities that respond appropriately to the specific information and support needs of carers supporting a relative with FEP.
- ensure that carer education and support programmes specifically targeting FEP are made available for and promoted to carers to access (such as carer-focused information materials, online information programmes and e-support opportunities, FEP carer education and support groups).
- ensure that appropriate referral pathways are in place so that EIP staff know how to refer carers to existing carer support resources.



6 Clinical outcome measurement

a. Welsh Government should:

- monitor service improvement against the RCPsych standards using the Welsh EIP framework and through regular updates against the Together for Mental Health Delivery Plan 2019–22.
- Identify meaningful EIP success indicators based on routine outcome data collection to measure whether the needs of people using EIP services are being met and whether successful outcomes are being achieved.

b. Health Boards should:

- ensure digital and online resources are available to teams, to enable them to engage with service users in the use of recommended outcome tools and digital applications.

c. Quality Improvement Leads should work with EIP teams:

- to develop ways to use QPR and DIALOG outcome data to monitor and improve the quality of care they deliver to people with early psychosis.

d. EIP Teams should:

- collect data, including the EIP specific measures QPR and DIALOG (at a minimum, to be recorded in people's health records at baseline, 12 months and annually thereafter), to ensure routine outcome measurement takes place in line with the Wales Mental Health Core Dataset programme.
- use routine outcome data to inform individual care plans co-produced with the service user.

5. Compiled by

The National Clinical Audit of Psychosis project team

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6. Appendix A: Acknowledgements

Development of recommendations

We would like to thank the Welsh government and Improvement Cymru for their contributions to the recommendations in this audit report.

Support and input

We would like to thank the staff in participating trusts/organisations and Health Boards for their hard work collecting and submitting data for this audit.

We would also like to offer particular thanks to everyone who completed and returned a service user survey.

Thank you also to the team at Healthcare Quality Improvement Partnership (HQIP) for their support and encouragement throughout, and to members of our steering group for their contributions to the audit. A list of members of the steering group, together with the organisations they represent, can be found in Appendix B.

7. Appendix B: Steering group members

Table 9: Steering group members and organisations (in alphabetical order)

Name	Organisation
Dr Alison Brabban	Early Intervention in Psychosis Network, NHS England and NHS Improvement
Linda Chadburn	Pennine Care NHS Foundation Trust/local audit representative
Amy Clarke	NHS England
Dr Elizabeth Davies	Welsh Government
Dr Selma Ebrahim	British Psychological Society (BPS)
Angela Etherington	Expert by experience
Louise Forsyth	Public Affairs & Stakeholder Manager, Rethink Mental Illness
Ellie Gordon	Royal College of Nursing (RCN)
Danielle Hamm	Public Affairs & Stakeholder Manager, Rethink Mental Illness
Wendy Harlow	Sussex Partnership Trust/local audit representative
Sam Harper	Healthcare Quality Improvement Partnership (HQIP)
Sarah Holloway	NHS England and NHS Improvement
Beth McGeever	NHS England and NHS Improvement
Jay Nairn	NHS England and NHS Improvement
Peter Pratt	Prescribing expert, NHS England and NHS Improvement
Caroline Rogers	Healthcare Quality Improvement Partnership (HQIP)
Dr David Shiers	General practitioner (retired)/Carer
Dr Shubulade Smith	National Collaborating Centre for Mental Health (NCCMH)
Dr Caroline Taylor	Royal College of General Practitioners (RCGP)/ Clinical Commissioning Group representative
Hilary Tovey	NHS England and NHS Improvement
Nicola Vick	Care Quality Commission (CQC)
Dr Jonathan West	Early Intervention in Psychosis Network (London)
Dr Latha Weston	RCPsych General Adult Faculty

8. Appendix C: Participating Health Boards

Table 10: Participating Health Boards, provider IDs and EIP teams (alphabetised by trust name)

Provider name	Provider ID	Team name(s)
Swansea Bay University Health Board	ORG02	Neath Port Talbot SBUHB EIP Service
Aneurin Bevan University Health Board	ORG03	Early Intervention Service, ABUHB
Betsi Cadwaladr University Health Board	ORG07	Gwynedd and Mon EIP
Cardiff and Vale University Health Board	ORG13	Headroom: Youth Psychosis Service
Cwm Taf University Health Board	ORG19	CAMHS Cynon CMHT Merthyr CMHT Taff Ely CMHT
Hywel Dda University Health Board	ORG29	Early Intervention Service, Hywel Dda UHB

9. Appendix D: Health Board returns

Case-note audit

Health Boards were asked to send out a service user survey to 150 people using their service. If there were less than 150, all were sent a survey. Of those sent a survey, up to 100 were to be randomly selected for case note audit. Where there were less than 100 eligible cases, all were audited (see infographic p 6).

Table 11: Health Board returns of case-note audit form

Organisation ID	Total eligible cases	Expected sample	Sample submitted	Final sample after data cleaning	Final sample as % of total eligible cases	Final sample as % of expected sample
ORG02	28	28	22	22	79%	79%
ORG03	70	70	67	69*	99%	99%
ORG07	25	25	25	19	76%	76%
ORG13	56	56	55	41	73%	73%
ORG19	33	33	26	26	79%	79%
ORG29	30	30	30	28	93%	93%

**The increase in submissions post data cleaning is due to data initially being entered under the incorrect EIP team code; these were reassigned by the NCAP team during data cleaning.*

Wales began to develop and implement EIP services following the rollout of the Together for Mental Health Delivery Plan in 2016. At this earlier stage of development uptake does not yet reflect the incidence of FEP within the population. Caseload numbers can be expected to increase as the services develop in line with the Plan.

Table 12: FEP audit sample and caseload by Health Board, and as a proportion of estimated incidence of FEP

Organisation ID	Final cleaned sample	Total number of people with FEP on caseload[14]	Total number of people with FEP on caseload as a proportion of estimated 3 year incidence	Estimated FEP incidence over 3 years[15]
ORG02	22	46	25%	189.3
ORG03	69	86	50%	173.7
ORG07	19	34	16%	216.6
ORG13	41	61	28%	221.7
ORG19	26	35	32%	110.7
ORG29	28	27	23%	119.4

[14]See Table 3. People typically receive support from an EIP team for 3 years.
[15]According to www.PsyMaptic.org, which provides a prediction of annual FEP incidence. This is multiplied by 3 to estimate expected FEP cases over 3 years.

Service user survey

Table 13: Number of surveys sent out and returns from each Health Board in Wales

Organisation ID	Number of people in sample	Number of returns received	Number of returns as % of people in sample
ORG02	28	4	14%
ORG03	70	21	30%
ORG07	25	5	20%
ORG13	56	6	11%
ORG19	33	8	24%
ORG29	28	4	14%

10. Appendix E: References

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11. List of figures and tables