NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

National Clinical Audit of Psychosis

National report for the Early Intervention in Psychosis Spotlight Audit 2018/2019

'Psychosis can be a very powerful and emotional experience. This image shows that individuals with mental health problems are not defined by it and have many other aspects to their identity that are just as prominent and important'

Veenu Gupta, Service User Advisor NCAP

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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.'

Compiled by

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Acknowledgements

Development of standards and recommendations

We would like to thank the members of our Steering Group for their contributions to the NCAP standards and recommendations for this audit. A list of members of the Steering Group, together with the organisations they represent, can be found in Appendix A.

Support and input

The audit drew heavily on the work of the Royal College of Psychiatrists (RCPsych) team on the Early Intervention in Psychosis self-assessment exercises that took place in 2016/2017 and 2017/2018 and we would like to thank them for their input and advice.

We would also like to express our thanks to the Healthcare Quality Improvement Partnership (HQIP) for their support and encouragement throughout; and our particular thanks to the staff in participating Trusts/organisations and Health Boards for their hard work and engagement in submitting data for this audit.

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Foreword

Early Intervention in Psychosis (EIP) services saw the introduction of an access and waiting time standard in 2016, which aimed to ensure that people with first episode psychosis (FEP) received prompt assessment and access to the evidence-based interventions that are vital to improved mental health and recovery.

Services delivered by EIP teams have been audited annually since 2015/16. Year on year, since then, EIP services have improved the quality of care they deliver and should feel proud of what has been achieved so far. Results of this year's audit, conducted as part of the National Clinical Audit of Psychosis, provide further evidence of improvement in the quality of care that people with FEP are receiving. Results of the audit show increases in the proportion of people receiving Family Interventions, Cognitive Behavioural Therapy for psychosis (CBTp), specialist employment support and clozapine, if they have not made a good response to other antipsychotic medications.

EIP services have always been keen to evidence outcomes but, in the previous audit in 2017/18, only 9% of people with FEP had paired outcome measures which made it difficult to draw conclusions about EIP service outcomes from these data. This year, 22% of people audited had paired outcome data. We have seen great strides across the range of interventions audited and we are delighted with the potential impact this should have on patient outcomes.

However, there is more to be done. We need to challenge the system to continue to commission high quality EIP services staffed with appropriately trained, skilled staff that are able to deliver against these standards. We know some areas are struggling to provide services for people over the age of 35 and those in an 'At Risk Mental State'. Some EIP teams have insufficient access to specialist expertise needed to deliver the more complex psychological, family and vocational interventions.

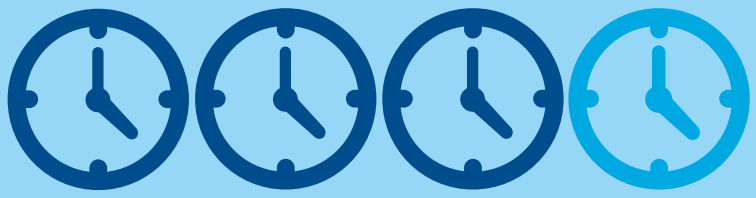
We will continue to develop the audit process, year on year, so that we can continue to track progress over time and ensure that we are asking the right questions as new issues emerge. At the same time, we will continue to look for ways to minimise data burden for clinical teams and provide data reports in a timely manner.

Finally, we would like to extend a huge thanks to everyone who has contributed to data collection and analysis which has enabled us to generate such a rich report demonstrating significant and impressive quality improvement in EIP service delivery across the country.

Dr Paul French, NCAP EIP Clinical Advisor

Professor Jo Smith, NCAP EIP Clinical Advisor

MAIN FINDINGS



76%

of patients began Early Intervention treatment within 2 weeks of referral

64%

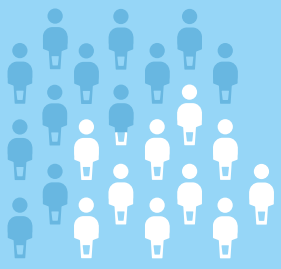
of patients received all seven physical health screenings

54%

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

22%

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

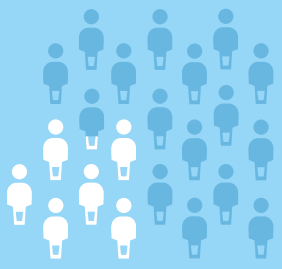


46%

took up CBTp

22%

took up family interventions



28%

took up employment support

Executive summary

This report presents the findings from the National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis (EIP) spotlight audit which took place in 2018/2019. This report provides national and organisation-level findings on the treatment of patients by Early Intervention Psychosis Teams in England. Welsh participation this year was from a learning perspective, so a Welsh national report has not been produced; we expect to publish a national report for Wales in 2020. All services including Welsh Health Boards will receive local reports for each of their teams in 2019.

Background

In 2016, NHS England introduced the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016). This is designed to improve access to EIP services for people experiencing First Episode Psychosis (FEP), ensure the provision of evidence-based treatments, and monitor patient outcomes. It also requires services to take part in a national quality assessment and improvement programme. This was initially a self-assessment exercise led in 2017/18 by the Early Intervention in Psychosis Network at the Royal College of Psychiatrists (RCPsych). In 2018/2019, it was carried out as a spotlight audit by NCAP at the RCPsych.

Method

All NHS funded EIP teams in England were expected to take part in the audit. Teams were asked to submit retrospective data on a sample of up to 100 patients with FEP who had been on their caseload for at least six months on the census date of 1 February 2018 and remained on the caseload in September 2018. Teams also answered a service-level questionnaire.

Standards were based on the Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016), which defined a package of care based on NICE quality standards in relation to treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015).

Response rate

All 57 service providers with eligible cases, which included Trusts and other organisations providing NHS services to people with FEP (referred to as 'Trusts' in the remainder of this report) submitted data for the audit. Data were submitted for 9631 patients from 154 teams in England; 9527 were used in the final analysis (99% of the number expected). All cases excluded were the result of duplicate entry. These were removed during data cleaning. A breakdown of Trust returns can be found in Appendix B (pages 39–40).

151 teams in England submitted a contextual questionnaire (median 2 teams per service provider), all of which were used in the final analysis (98% of the number expected).

Key findings

Table 1 provides an overview of performance against standards nationally with comparisons from the 2017/2018 EIP self-assessment exercise.

Table 1: Key comparisons between NCAP spotlight audit 2018/19 and EIP self-assessment 2017/18

Standard/indicator	NCAP 2018/19 %	Self-assessment 2017/18 %
Standard 1: Timely access		
Treatment started within two weeks of referral	76[1]	72[2]
Standards 2 & 3: Take up of psychological therapies		
Cognitive Behavioural Therapy for psychosis (CBTp)	46	34[3]
Family Intervention	22	18[3]
Standard 4: Prescribing		
Offered clozapine[4]	54	49[3]
Standard 5: Take up of supported employment & education programmes		
Supported employment & education programmes[5]	28	20[3]
Standard 6: Physical health monitoring[6]		
All seven physical health measures	64	Not available
Smoking	92	92
Alcohol use	92	91
Substance misuse	93	92
BMI	81	73
Blood pressure	83	76
Blood glucose	75	66
Lipids	73	65
Standard 7: Physical health interventions[6,7]		
Smoking	88	Not available
Harmful/hazardous use of alcohol	93	
Substance misuse	85	
Weight/obesity	81	
Elevated blood pressure	66	
Abnormal glucose control	69	
Abnormal lipids	68	
Standard 8: Take up or referral to carer-focused education and support programmes		
Carer-focused education and support programmes[8]	55	53[9]
Clinical outcome measurement		
Two or more outcome measures were recorded at least twice[10]	22	9[3]

1. November 2018-January 2019.
2. November 2017-January 2018.
3. Figure includes patients who were on the caseload for <6 months.
4. Of those who had not responded adequately to or tolerated treatment with at least two antipsychotic drugs.
5. Of those not in work, education or training at the time of their initial assessment.
6. Taken up or refused.
7. Of those who were identified as requiring an intervention based on their screening for each measure.
8. Of those with an identified carer.
9. Figure includes all patients who were on the caseload (i.e. not FEP exclusively) and patients who were on the caseload for <6 months.
10. HoNOS/HoNOSCA, DIALOG, QPR (and 'other' for under 18-year olds).

Discussion

Continuing improvement was found across all standards since the EIP self-assessment in 2017/2018. While recording two or more paired clinical outcome measures[a] remained low (22%), there was a marked improvement since the 9%[b] measured in 2017/2018. Improvements were also seen in the take up of CBTp (from 34%[b] to 46%), take up of supported employment and education programmes[c] (20%[b] to 28%) and offer of clozapine[d] (49%[b] to 54%). Smaller improvements were seen in take up of Family Intervention (18%[b] to 22%), timely access (72%[e] to 76%[f]) and carer-focused education and support programmes[g] (53%[h] to 55%).

Physical health interventions data cannot be compared with the previous year due to the way data were analysed. This year data were analysed according to the national Mental Health Commissioning for Quality and Innovation (CQUIN) programme on improving the physical health of people with severe mental illness. The number of patients receiving screening[i] for all seven physical health measures was lower than expected (64%). The provision[j] of physical health interventions[k] where required varied between measures, from 66% for elevated blood pressure to 93% for harmful/hazardous use of alcohol. Given the serious health implications, it is notable that only 69% of patients took up or refused an intervention for abnormal glucose control and 68% of patients took up or refused an intervention for abnormal lipids.

Conclusions

Data collected in this audit show continuing improvements in the provision of timely access to evidence-based treatments for people experiencing FEP. However, more can be done to improve the provision of evidence-based care in line with NICE quality standards. Monitoring of clinical outcome measures has improved but remains low. Variation between Trusts on individual standards shows opportunities for learning and the importance of equitable commissioning and resourcing.

[a] HoNOS/HoNOSCA, DIALOG, QPR (and 'other' for under 18-year olds).
[b] Figure includes patients who were on the caseload for <6 months.
[c] Of those not in work, education or training at the time of their initial assessment.
[d] If patient has not responded adequately to or tolerated treatment with at least two antipsychotic drugs.
[e] November 2017-January 2018.
[f] November 2018-January 2019.
[g] Of those with an identified carer.
[h] Figure includes all patients who were on the caseload (i.e. not FEP exclusively) and patients who were on the caseload for <6 months.
[i] Taken up or refused.
[j] Taken up or refused.
[k] Of those who were identified as requiring an intervention based on their screening for each measure.

Recommendations

RECOMMENDATION 1

Physical health screening and intervention

a) **Teams** should:

- Ensure that where screening indicates a risk according to the Lester Tool, that interventions are provided in accordance with relevant NICE guidance (NICE QS80, Quality statement 6; NICE QS102, Quality statement 6)
- Ensure that screening and interventions provided are accurately documented in people's health records held in mental health services and primary care.

b) **Trusts** should ensure that comprehensive physical health screening can be provided by EIP teams. To do this they should:

- Carry out an annual review of staff skills/ knowledge and offer training as required
- Ensure that relevant equipment (for example, weighing scales, blood pressure monitors) are available to EIP teams.

c) **Trusts** should:

- Ensure continued annual audit of physical healthcare screening and interventions
- Escalate inappropriate exceptions to the Trust Board with action plans for review.

d) **Trusts** should:

- Ensure that there are shared care protocols to facilitate information sharing between primary and secondary care.

Results for physical health screening and intervention can be found on pages 24–34.

RECOMMENDATION 2

Psychological therapies

a) **Trusts** and **commissioners** should:

- Ensure there are sufficient trained staff in EIP teams to deliver Cognitive Behavioural Therapy for psychosis (CBTp) in concordance with relevant NICE guidance (NICE QS80, Quality statement 2; NICE QS102, Quality statement 3)
- Ensure there are sufficient trained staff in EIP teams to deliver Family Intervention in concordance with relevant NICE guidance (NICE QS80, Quality statement 3; NICE QS102, Quality statement 2).

b) When carrying out workforce planning, **commissioners** and **Trusts** should:

- Consider the need for dedicated posts for staff delivering psychological interventions
- Consider the need for supervision for staff delivering psychological interventions.

c) **Health Education England** and **local sustainability and transformation partnerships** should:

- Review training needs and the EIP workforce skill mix at a regional level
- Ensure that EIP staff can access relevant training programmes as required.

Results for psychological therapies can be found on pages 19–20.

RECOMMENDATION 3

Prescribing

a) **Teams** should:

- Ensure that reasons for not prescribing clozapine are routinely documented in people's records.

b) **Mental health pharmacists** should:

- Work with teams to systematically identify people who may benefit from clozapine.

Results for offer of clozapine can be found on page 21.

RECOMMENDATION 4

Supported employment and education programmes

a) **Teams** should:

- Ensure that educational and occupational status is routinely documented in people's records.

b) **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 CG178 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 these programmes.

c) **Teams** should:

- Ensure appropriate emphasis is placed on educational goals as well as occupational goals.

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

RECOMMENDATION 5

Carer-focused education and support programmes

a) **Trusts** and **teams** should:

- Ensure there is the appropriate skill mix and staffing within teams to deliver carer-focused education and support programmes in line with NICE guidance (NICE QS80, Quality statement 8; NICE QS102, Quality statement 4)
- Ensure programmes are made available for carers to access (for example, online programmes)
- Ensure appropriate referral pathways are in place so that EIP staff know how to refer carers to existing programmes.

Results for carer-focused education and support programmes can be found on page 35.

RECOMMENDATION 6

Clinical outcome measurement

a) **Teams** should:

- Collect and clearly document outcome measures in people's records at baseline, 6 months, 12 months and annually thereafter
- Use outcome data to inform individual care plans co-produced with the service user.

b) **Trust Boards** should:

- Ensure systems are in place to allow outcome measurement data to be submitted to NHS Digital. This will enable this audit to report on outcome measures submitted to MHSDS in 2019/2020.

Results for clinical outcome measurements can be found on page 36.

RECOMMENDATION 7

Learning

a) In order to support equitable service access and provision, **NHS England** and **NHS Improvement regional teams** should:

- Support links between high and low performing Trusts in their region and across the country to share learning and good practice.

Trust-level results can be found on pages 18–36.

RECOMMENDATION 8

Service set-up

a) **Commissioners** and **Trusts** should, in line with NHS England guidance:

- Ensure teams are providing EIP services to under 18 year olds and over 35 year olds
- Ensure teams are providing EIP services to those people identified as having an At Risk Mental State.

Results for the contextual data questionnaire can be found in Appendix C, pages 41–43.

RECOMMENDATION 9

Recording and reporting on interventions

a) **Trusts** should:

- Work to standardise recording and reporting on interventions in patient records using SNOMED CT
- Submit information on interventions to NHS Digital. This may reduce the audit burden to teams by allowing these data to be used in future audits.

Trust-level results can be found on pages 18–36.

Context

In February 2016, the Five Year Forward View for Mental Health was published by the Mental Health Taskforce (Mental Health Taskforce, 2016). This set priorities for improving mental health services in England by 2020/21 including targets for increasing access to evidence-based treatments for people with FEP and their carers.

In April 2016, NHS England introduced the Early Intervention in Psychosis Access and Waiting Time Standard (NICE, NHS England & NCCMH, 2016). This set targets for EIP services that require that from 1st April 2016 more than 50% of those experiencing FEP will be treated with a NICE-approved care package within two weeks of referral, and that by 2020/21, more than 60% of people with FEP will be treated with this care package within two weeks of referral.

As part of the Access and Waiting Time Standard, teams were required to take part in a national quality assessment and improvement programme. A baseline position was established in the 2016 Audit of Early Intervention in Psychosis (AEIP), run by the RCPsych. Adherence in the following two years was evaluated through a self-assessment exercise run by the Early Intervention in Psychosis Network at the RCPsych. In 2018/2019 it has been carried out as a spotlight audit by NCAP, also run by the RCPsych.

Methodology

Audit development

This spotlight audit focuses on the care provided by EIP teams in relation to timely access, effective treatment and monitoring of outcome measures, consistent with previous years of the national quality assessment and improvement programme. Unlike previous years, data were collected on patients with FEP only.

Figure 1 outlines the timetable for this audit.

Standards and outcome indicators

The audit standards and outcome indicator (Table 2) were developed by the NCAP team in collaboration with members of the steering group. 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).

Development of the audit tools

Two audit tools were developed to collect data from participating Trusts: a patient-level case note audit questionnaire and a service-level contextual questionnaire. Both were designed so that data collected were comparable with the EIP self-assessment in 2017/2018, where possible.

The case note audit form was developed to collect demographic information and data on interventions provided to patients according to the audit standards (Table 2). Data were collected from patient case notes, alongside other patient information available to the clinical team.

The contextual questionnaire form was developed to collect data to assess whether teams have the appropriate infrastructure to provide a NICE approved package of care. It asked for:

- Information about the team (e.g. routinely collected demographic data, how it was set-up, length of treatment packages, provisions for children and young people, number of care coordinators and provision of CBT for At Risk Mental State).

May–June 2018	Audit standards finalised and sampling materials distributed to Trusts
June–September 2018	Trusts identify eligible patients
September 2018	Random sample lists sent to Trusts
October–November 2018	Sites collect and submit data to NCAP team
December 2018–February 2019	Data cleaning by NCAP team
February–March 2019	Data analysis and presentation of preliminary data to Steering Group
March–June 2019	Writing of report. Submission of first version and then final version to HQIP
Summer 2019	Publication of national report

Figure 1: Timetable of the National Clinical Audit of Psychosis Early Intervention in Psychosis spotlight audit

Table 2: NCAP standards and outcome indicator

Standards	
S1*	Service users with first episode 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.
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	
I.1	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).

*Data for this standard were not collected through the NCAP audit tool, the Early Intervention in Psychosis Waiting Times data published by NHS England were used (NHS England, 2018, 2019).

- Information about caseload (e.g. total caseload and length of treatment for patients who were discharged having completed a package of care).

The audit tools can be downloaded from the NCAP website.

Results of the contextual questionnaire can be found in Appendix C (pages 41–43).

Identification of the case sample

Sampling

All Trusts were asked to submit data on a random sample of a maximum of 100 patients per team. Trusts generated a full list of patients meeting the eligibility criteria and returned this to the NCAP team. Where a team had more than 100 eligible patients, the NCAP team provided them with a random sample of 100 patients from this list using an online tool. Where a team identified fewer than 100 eligible patients, teams were asked to submit data on all patients identified.

Inclusion and exclusion criteria

Patients were eligible for inclusion in the audit if they met the following criteria:

- Aged 14-65 years
- First episode psychosis
- On the caseload of an EIP team (if the service was part of a larger team, for example, integrated into a CMHT, only those people with FEP on the EIP caseload were included)
- Had been on the caseload of the team for 6 months or more at the census date (1 February 2018) and still on the caseload in September 2018 when the list of eligible patients was submitted for sampling.

Patients were excluded from the audit if they:

- Were experiencing psychotic symptoms due to an organic cause, for example, Huntington's disease or dementia.[l]

Audit participation and process

Eligibility and participation

All NHS funded EIP teams in England were expected to participate in the audit.

All 57 Trusts with eligible cases in England submitted data. A list of participating organisations can be found in Appendix D along with a unique organisation code (ORG ID) which can be used to identify each Trust through this report. (Appendix D is ordered alphabetically by Trust name, pages 44–48, and by provider ID, pages 48–50).

Data handling and analysis

Data cleaning

Data cleaning took place between December 2018 and February 2019. The NCAP team checked and queried duplicate entries, missing data and unexpected/extreme values.

Data entry and analysis

All data were entered using Formic Fusion Survey software via secure webpages. Data were extracted to IBM SPSS Statistics 21 and analysed using IBM SPSS Statistics 21 or Microsoft Excel 2016. The statistical techniques used in IBM SPSS Statistics 21 to analyse the data were frequencies, cross-tabulations and descriptive statistics.

Reading the report

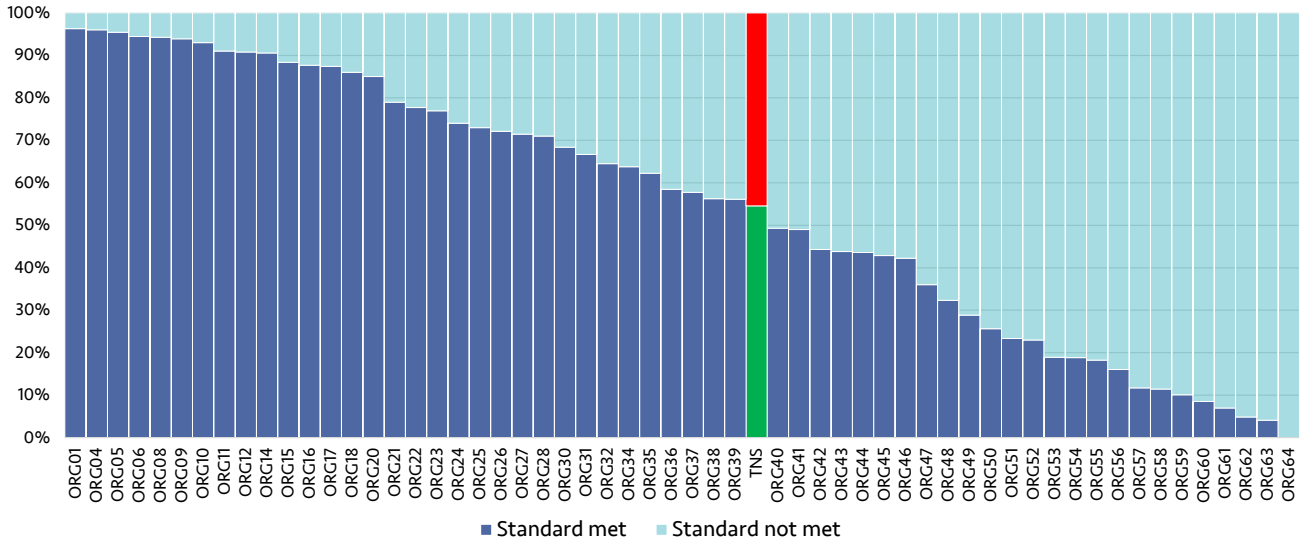
How to read the charts

Bar charts such as that shown in the example below 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 (see Appendix D. Appendix D is ordered alphabetically by Trust name, pages 44–48, and by provider ID, pages 48–50). The total national sample (TNS) is indicated by a bolded bar.

Outliers

Trusts were identified as an outlier for a standard if their performance was more than two standard deviations (SD) outside of the average performance of all Trusts. The outlier standards were chosen and agreed with the Steering Group prior to the start of data analysis.

The identification and management of outliers followed guidance prepared by HQIP.



Example bar chart

[l]These exclusion criteria are the same as those excluded from the Access and Waiting Times Standard cohort (NHS England, NICE & NCCMH, 2016).

Limitations of the methodology and data

Limitations

- As an audit of care provided to patients treated by Early Intervention in Psychosis teams this report provides a detailed account of the treatment received by most people with first episode psychosis (FEP). However, as noted in Table 12 (pages 41–43) some patients 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 patients 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.
- The results are a 'snapshot' reflecting the performance of a Trust during the period of data collection. Though comparisons can be made with the previous year's EIP self-assessment, these are different samples and not a follow up of the same patients over time.
- Sampling was based on people on the caseload of an EIP team, as this was deemed a practical way to identify cases. However, this may not provide an accurate picture of treatment to those people aged under 18 years old or over 35 years old, who may access EIP services through other services.

Caveats

Due to variances in sampling methods, EIP self-assessment 2017/18 national comparison percentages, in places, include cases which were on the caseload for less than six months at the time of data collection. Where this is the case, a specific caveat has been noted next to the relevant figure.

Quality assurance

In an effort to assure data quality, we informed Trusts that we would conduct visits to randomly selected services to compare the data they submitted against primary data in case records. Four Trusts were visited by members of the NCAP team after data collection and cleaning. Further information can be found in Appendix E (p. 51).

STANDARD 1

Timely access

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 patients with FEP should be treated with a NICE-approved care package within two weeks of referral.

Standard 1

Service users with first episode psychosis start treatment in early intervention in psychosis services within two weeks of referral.

To have met this standard, patients must have been allocated to and engaged with an EIP care coordinator within two weeks of referral. Analysis was carried out using the Early Intervention in Psychosis Waiting Times data for November 2018 – January 2019 (NHS England, 2018; 2019). All patients referred to services during this period were included in the analysis (n = 3218), of which 2446 (76%) of 3218 patients started treatment with two weeks. As shown in Figure 2, the proportion of patients starting treatment within two weeks of referral varied from 28% to 100% across Trusts.

Early Intervention in Psychosis Waiting Times data for November 2017 – January 2018 (NHS England, 2017; 2018) were analysed for comparison. Since 2017/18, there has been a 4% absolute increase (from 72% to 76%) in the proportion of patients with FEP who started treatment within two weeks of referral.

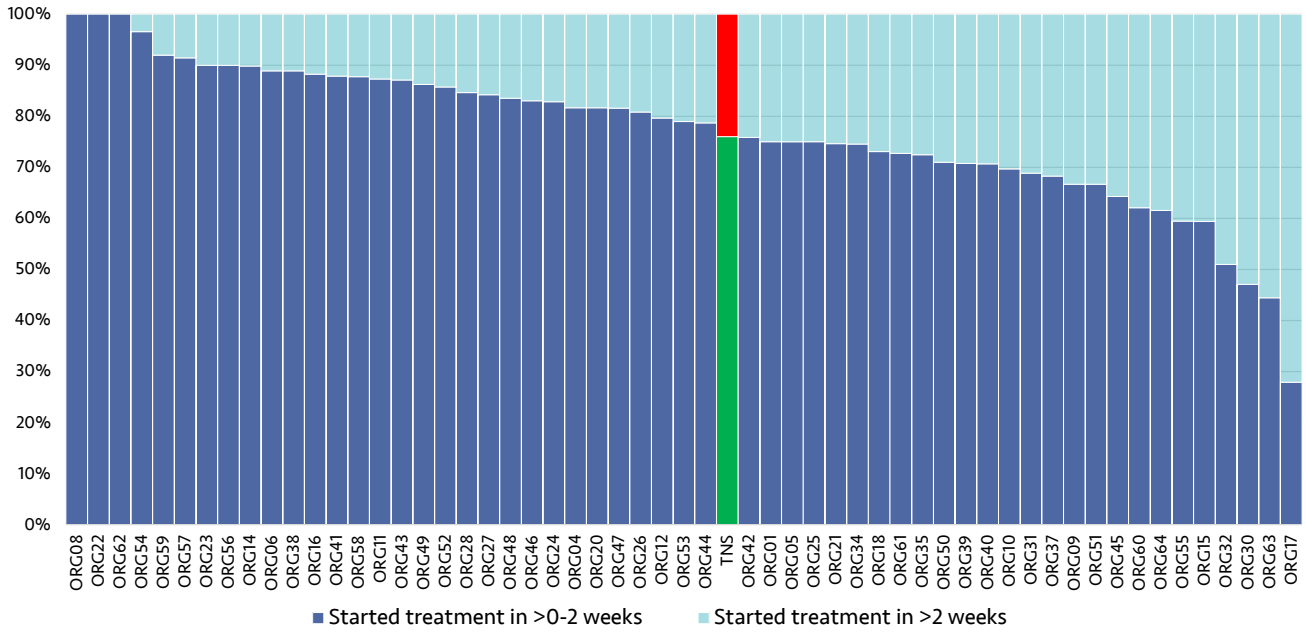


Figure 2: Proportion of people with FEP who started treatment within two weeks of referral between November 2018 – January 2019 (n = 3218)*

*NB two providers for which Waiting Times data were published are not included in the Trust comparison chart as they were not registered to NCAP. These providers' performances remain within the TNS figure for comparison. One Trust (ORG 36) registered to NCAP is not included in the above chart as their data is not published as part of the Early Intervention in Psychosis Waiting Times data.

Psychological therapies

Standard 2: 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.

Standard 2

Service users with first episode psychosis take up Cognitive Behavioural Therapy for psychosis (CBTp).

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

This analysis was carried out on the entire national sample (n = 9527), of which 4417 (46%) patients received one or more sessions of CBTp. As shown in Figure 3, the proportion of patients taking up CBTp varied from 0% to 90% across Trusts. Since 2017 there has been a 12% absolute increase (from 34%[m] to 46%) in the proportion of people with FEP who took up CBTp.

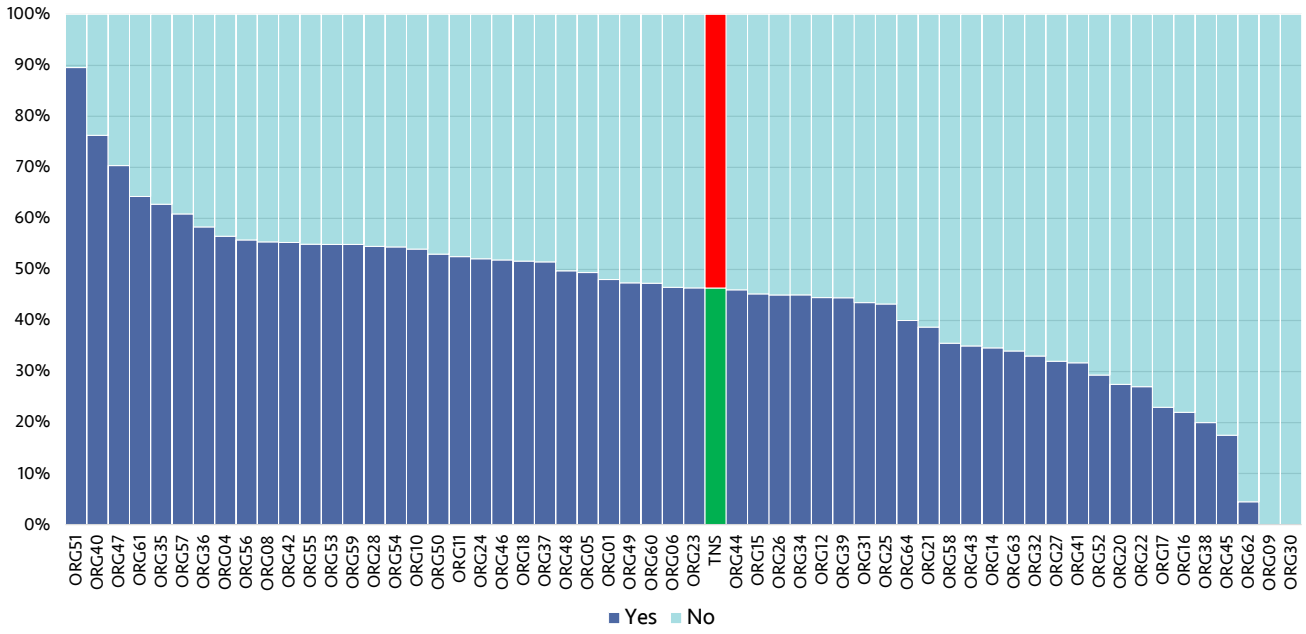


Figure 3: Proportion of people with FEP who took up CBTp (n = 9527)

[m] Compared to data from the EIP self-assessment 2017/18 for which the sample included patients who had been on the caseload for <6 months.

Standard 3: Family Interventions

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 Family Interventions.

Standard 3

Service users with first episode psychosis and their families take up Family Interventions.

For Trusts to have met this standard, patients had to have received at least one Family Intervention session delivered by a person who had the relevant skills, experience and competencies in delivering Family Interventions (see guidance, question 7).

This analysis was carried out on the entire national sample (n = 9527), of which 2049 (22%) of 9527 patients received one or more sessions of Family Intervention. As shown in Figure 4, the take up of Family Interventions ranged from 1% to 65% across Trusts. Since 2017, there has been a 4% absolute increase (from 18%[n] to 22%) in the proportion of people with FEP and their families who took up Family Interventions.

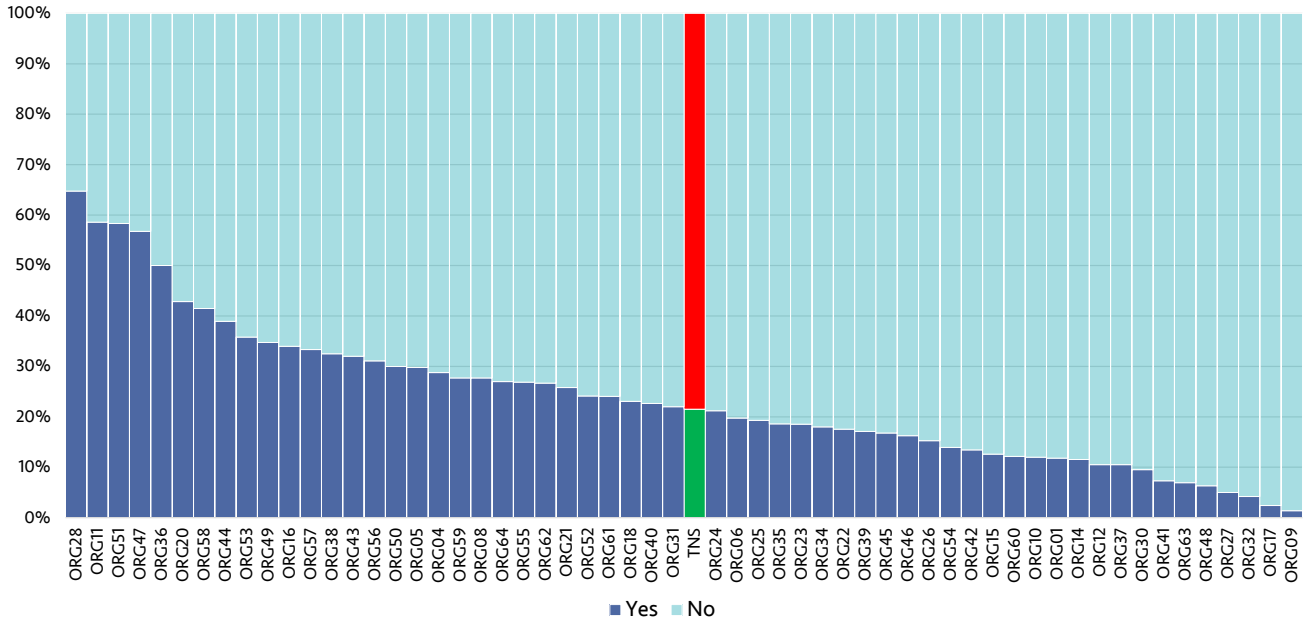


Figure 4: Proportion of people with FEP and their families who took up Family Interventions (n = 9527)

[n] Compared to data from the EIP self-assessment 2017/18 for which the sample included patients who had been on the caseload for <6 months.

STANDARD 4

Prescribing of clozapine

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

Standard 4

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

Analysis for this standard was conducted on patients who were identified as having had treatment with at least two antipsychotic drugs and not having responded adequately to or tolerated them (n = 1287). As shown in Figure 5, 690 (54%) of 1287 patients in the national sample were offered clozapine after not responding adequately to or tolerating at least two other antipsychotic drugs. The proportion of patients whose treatment met this standard ranged from 10% to 100% across Trusts. Since 2017, there has been a 5% absolute increase (from 49%° to 54%) in the proportion of patients being offered clozapine after two unsuccessful trials of antipsychotics.

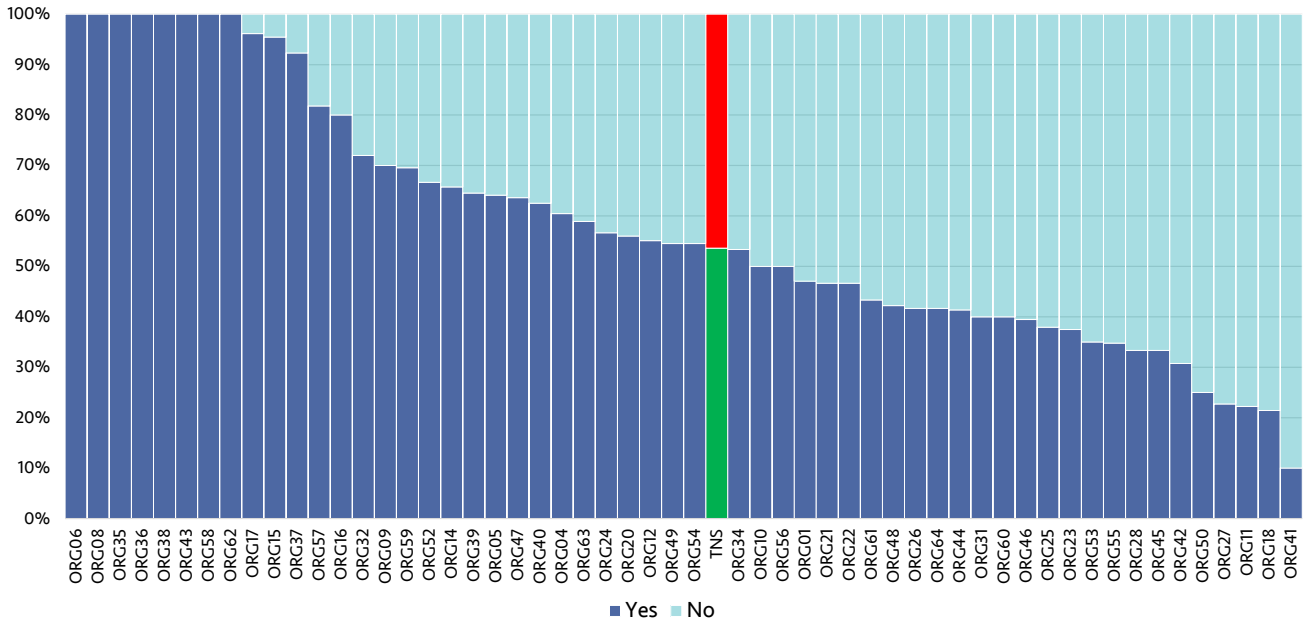


Figure 5: Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least two other antipsychotic drugs (n = 1287)

°Compared to data from the EIP self-assessment 2017/18 for which the sample included patients who had been on the caseload for <6 months.

STANDARD 5

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 patients if they wish to find or return to education or work.

Standard 5

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

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

This analysis was carried out on patients who were identified as not being in work, education or training at the time of their initial assessment (n = 5782). 1611 (28%) of 5782 patients identified as not being in work, education or training attended one or more sessions of a supported employment or education programme. As shown in Figure 6, the proportion of patients taking up

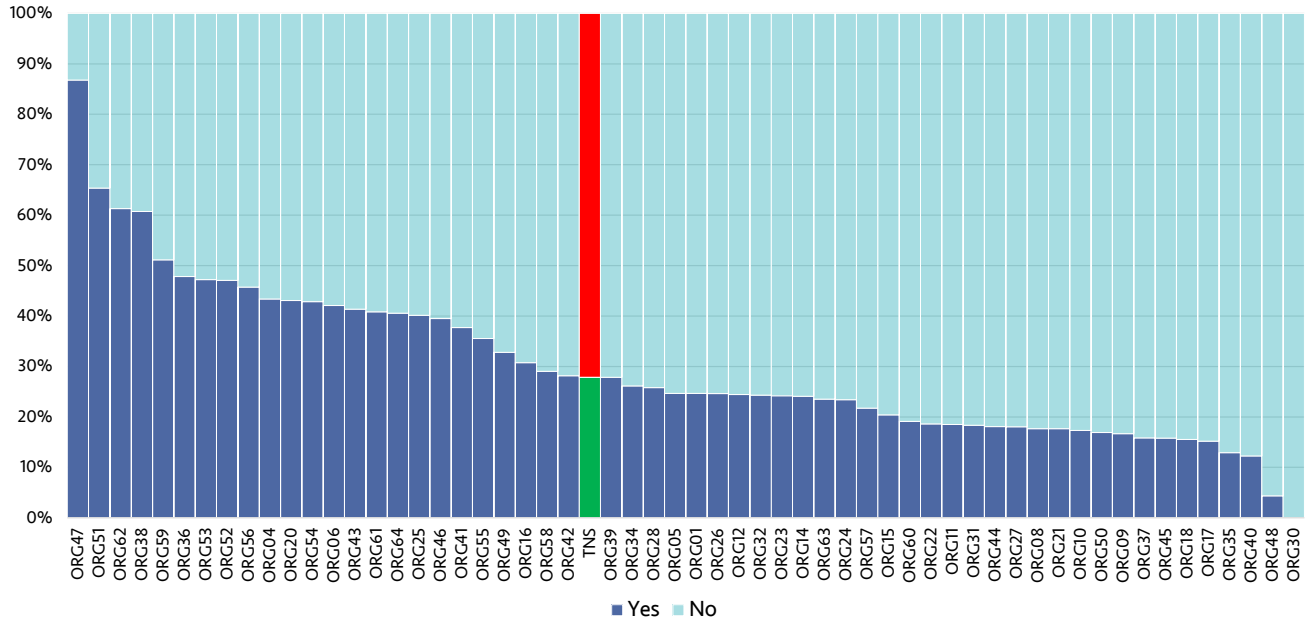


Figure 6: Proportion of people with FEP who were not in work, who had taken up supported employment and education programmes (n = 5782)

[p] Compared to data from the EIP self-assessment 2017/18 for which the sample included patients who had been on the caseload for <6 months.

supported employment and education programmes ranged from 0% to 87% across Trusts.

Since 2017, there has been an 8% absolute increase (from 20%[P] to 28%) 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 = 9527), as supported employment and education programmes may help people stay in their current employment or education, change work or take up other training/education programmes. 2626 (28%) of 9527 patients in the national sample attended one or more sessions of a supported employment or education programme. For this larger sample, the proportion of patients meeting the standard ranged from 0% to 74% across Trusts. See Figure 24 in Appendix F (page 52).

STANDARD 6

Physical health screening

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 one year, and annually thereafter.

Standard 6

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

- Smoking status
- Alcohol intake
- Substance misuse
- BMI
- Blood pressure
- Glucose
- Cholesterol

For Trusts to have met this standard, patients must have been screened on all seven physical health measures within the last 12 months. These data were analysed in the same way as the CQUIN programme on improving the physical health of people with severe mental illness. 'Received screening' includes those patients who were offered but refused screening.

All patients were included in this analysis (n = 9527), of which 6096 (64%) patients had been screened on all seven physical health measures. Between Trusts, this ranged from 0% to 100%. Figure 7 displays the proportion of patients who were screened on all seven physical health measures.

As this composite measure was not calculated for the EIP self-assessment, a comparison figure is not available. However, EIP self-assessment comparisons for individual measures can be found in the subsequent sections.

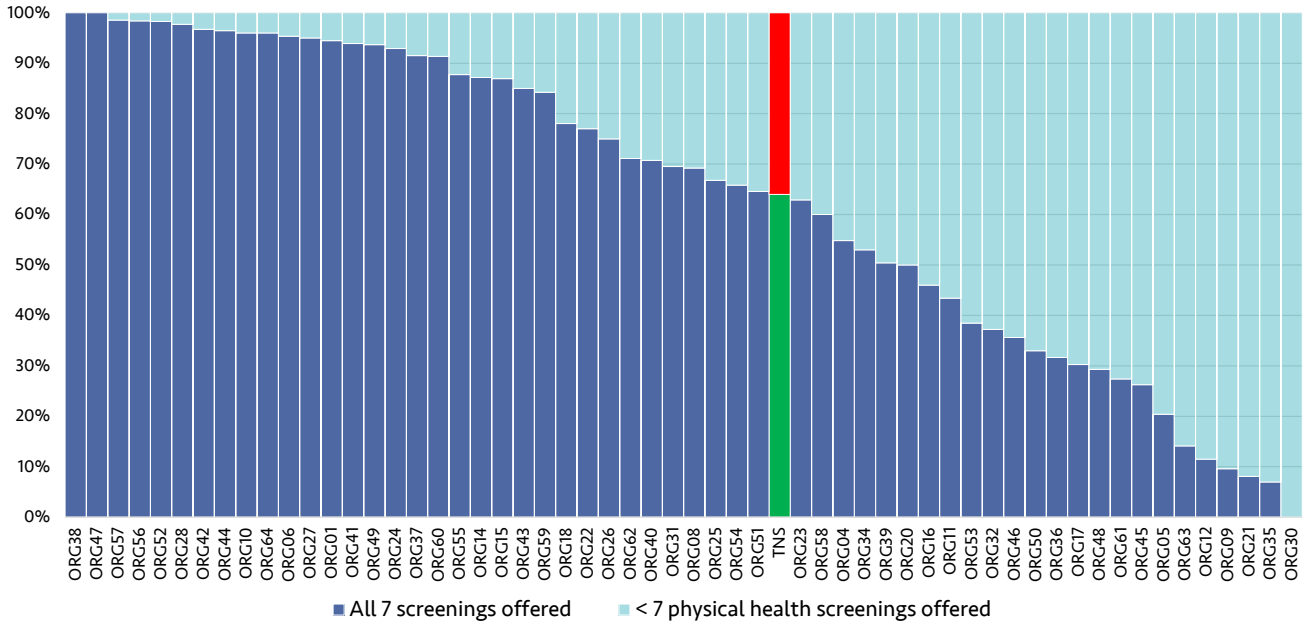


Figure 7: Proportion of people with FEP who were screened* on all seven physical health measures across Trusts in the past 12 months (n = 9527)

* 'Screened' includes those patients who were offered but refused screening.

Smoking status

Figure 8 shows that smoking status was assessed for 8776 patients (92%). This is the same as the previous year, where 92% were asked about their smoking status. 354 (4%) patients in total refused to provide their smoking status; refusal rates varied from 1% to 37% across Trusts. Smoking status was not documented in 751 (8%) cases. Monitoring of smoking status ranged from 60% to 100% across Trusts.

Alcohol intake

Figure 9 shows that screening of alcohol intake was received by 8760 patients (92%). This is a 1% absolute increase from the previous year, where 91% received screening for their alcohol use. Screenings were refused by 404 (4%) patients in total; refusal rates varied from 1% to 37% across Trusts. Alcohol use was not documented in 767 (8%) cases. Monitoring of alcohol use ranged from 58% to 100% across Trusts.

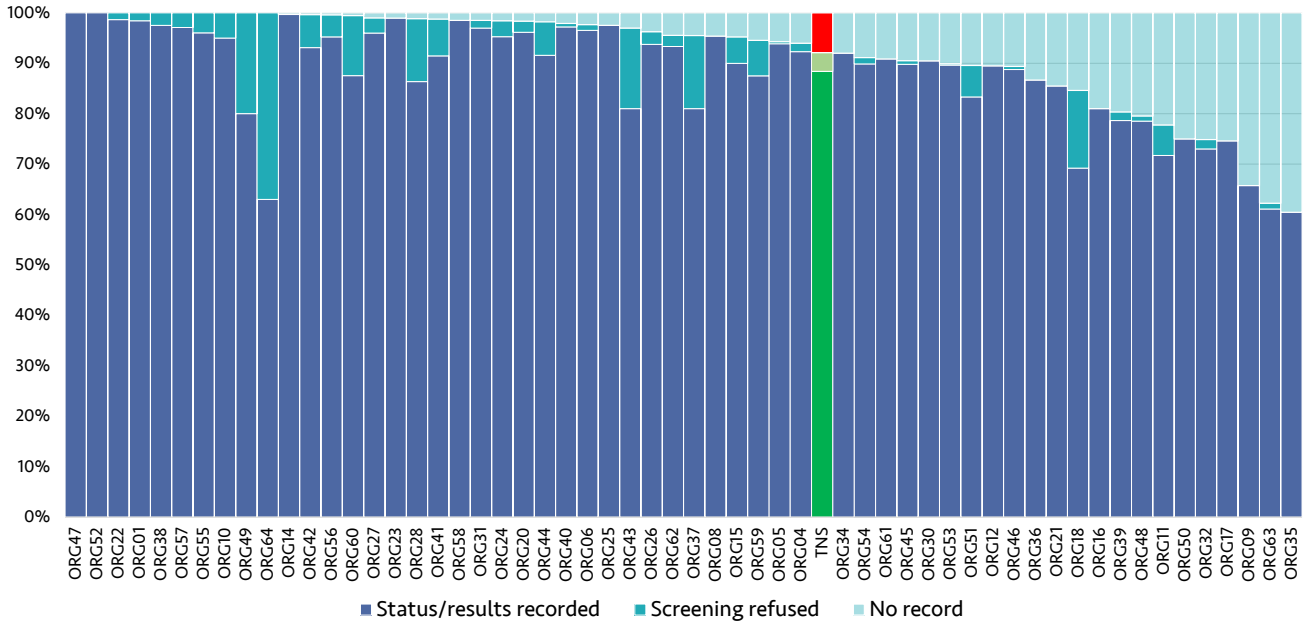


Figure 8: Proportion of people with FEP monitored for cigarette smoking across Trusts in the past 12 months (n = 9527)

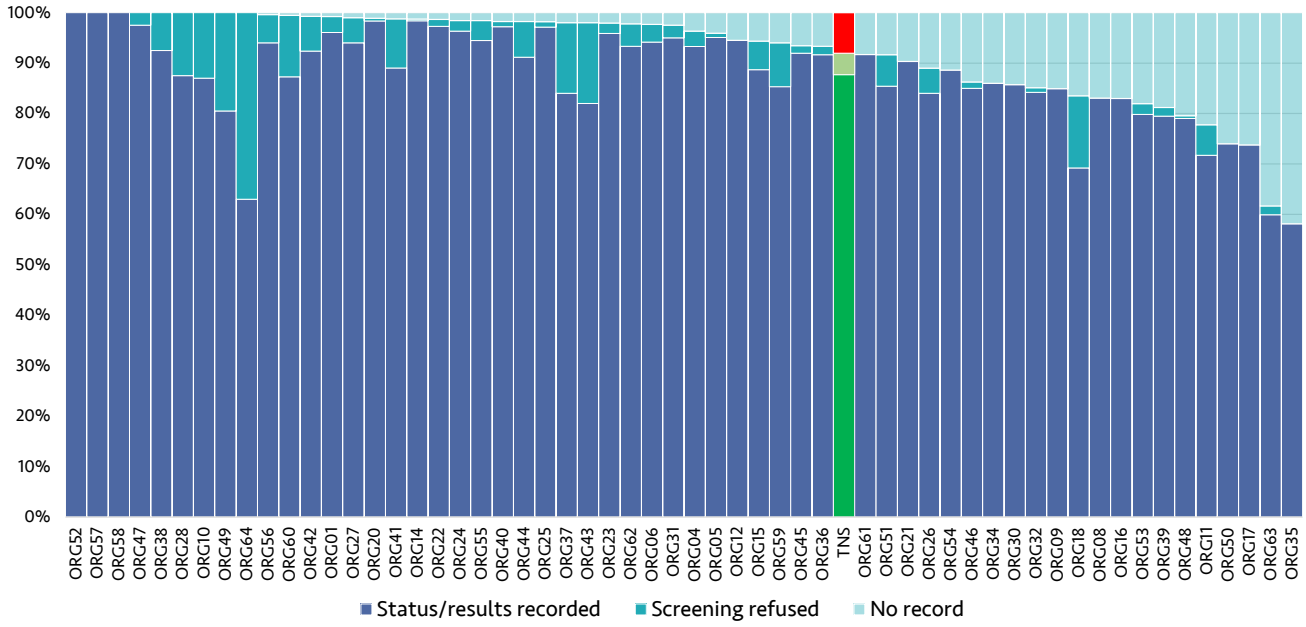


Figure 9: Proportion of people with FEP monitored for alcohol consumption across Trusts in the past 12 months (n = 9527)

Substance misuse

Figure 10 shows that screening for substance misuse was received by 8836 patients (93%). This is a 1% absolute increase from the previous year, where 92% received screening for substance misuse. Screenings were refused by 410 (4%) patients; refusal rates varied from 1% to 36% across Trusts. Substance misuse was not documented in 691 (7%) cases. Monitoring of substance misuse ranged from 60% to 100% across Trusts.

BMI

Figure 11 shows that BMI was monitored for 7755 patients (81%). This is an 8% absolute increase from the previous year, when 73% had their BMI monitored. BMI measurement was refused by 702 (7%) patients; refusal rates varied from 1% to 45% across Trusts. BMI was not documented in 1772 (19%) cases. Monitoring of BMI ranged from 19% to 100% across Trusts.

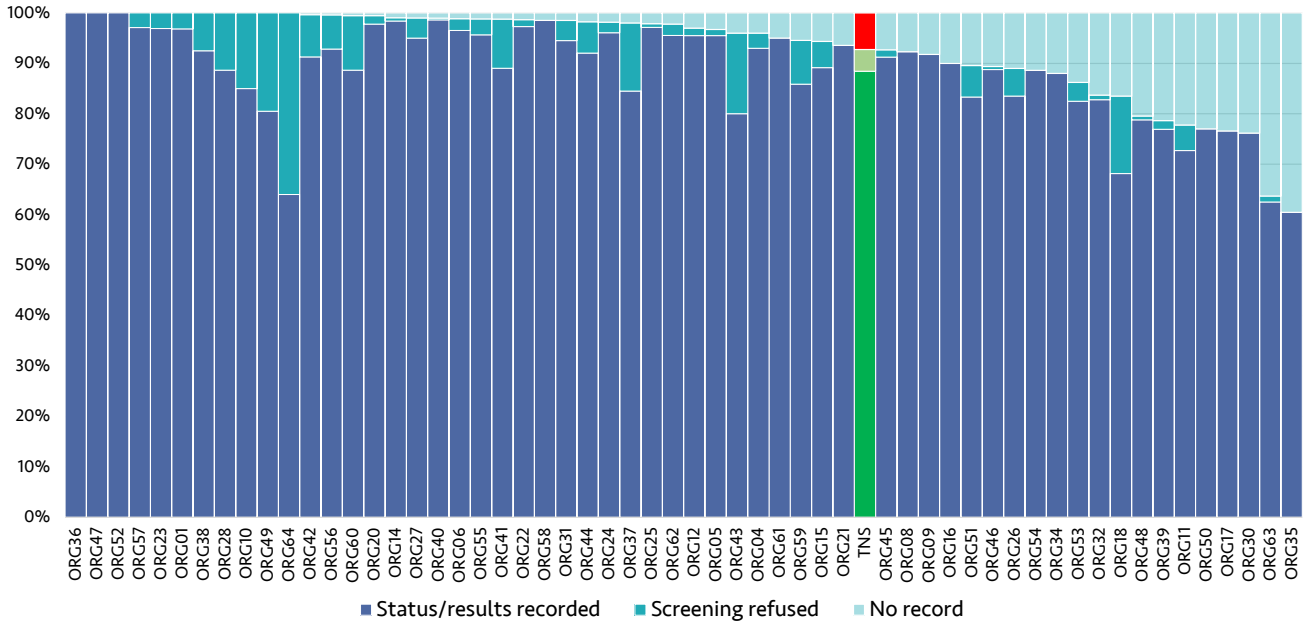


Figure 10: Proportion of people with FEP monitored for substance misuse across Trusts in the past 12 months (n = 9527)

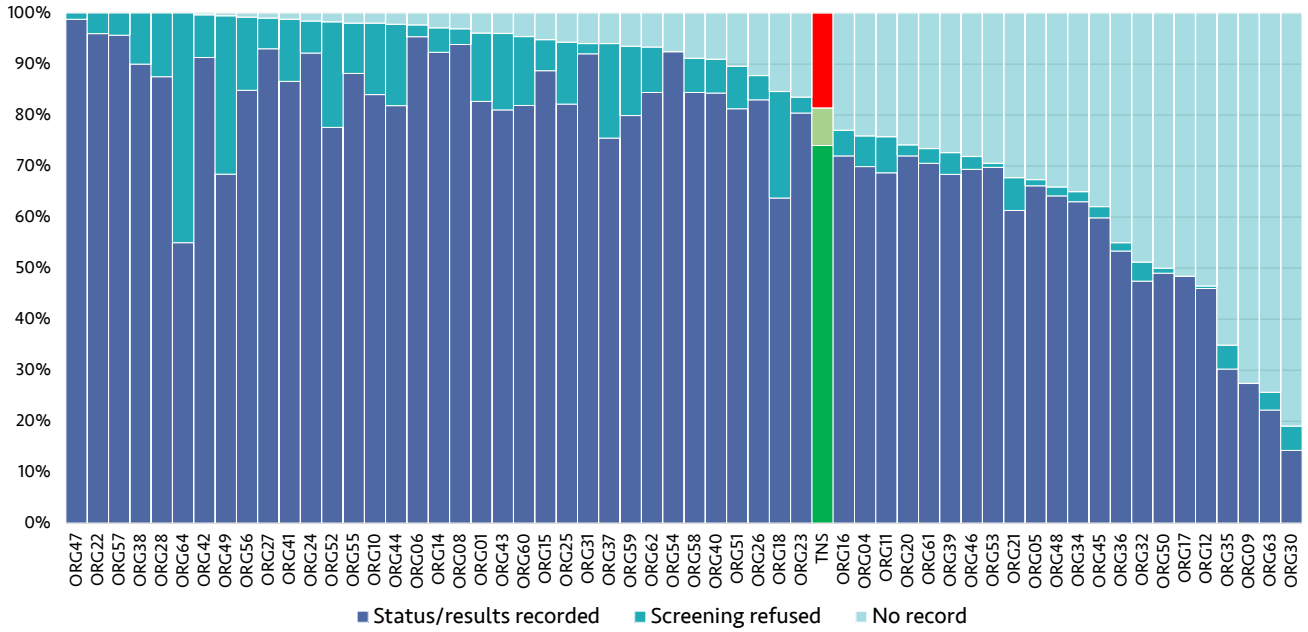


Figure 11: Proportion of people with FEP monitored for BMI across Trusts in the past 12 months (n = 9527)

Blood pressure

Figure 12 shows that blood pressure was monitored for 7873 patients (83%). This is a 7% absolute increase from the previous year, where 76% were monitored for blood pressure. Blood pressure screenings were refused by 666 (7%) patients; refusal rates varied from 1% to 42% across Trusts. Blood pressure was not documented in 1654 (17%) cases. Monitoring of blood pressure ranged from 36% to 100% across Trusts.

Blood glucose control

Figure 13 shows that glucose control was monitored for 7103 patients (75%). This is a 9% absolute increase from the previous year, where 66% were monitored for glucose control. Screening was refused by 1201 (13%) patients; refusal rates varied from 1% to 59% across Trusts. Glucose control was not documented in 2424 (25%) cases. Monitoring of glucose control ranged from 0% to 100% across Trusts.

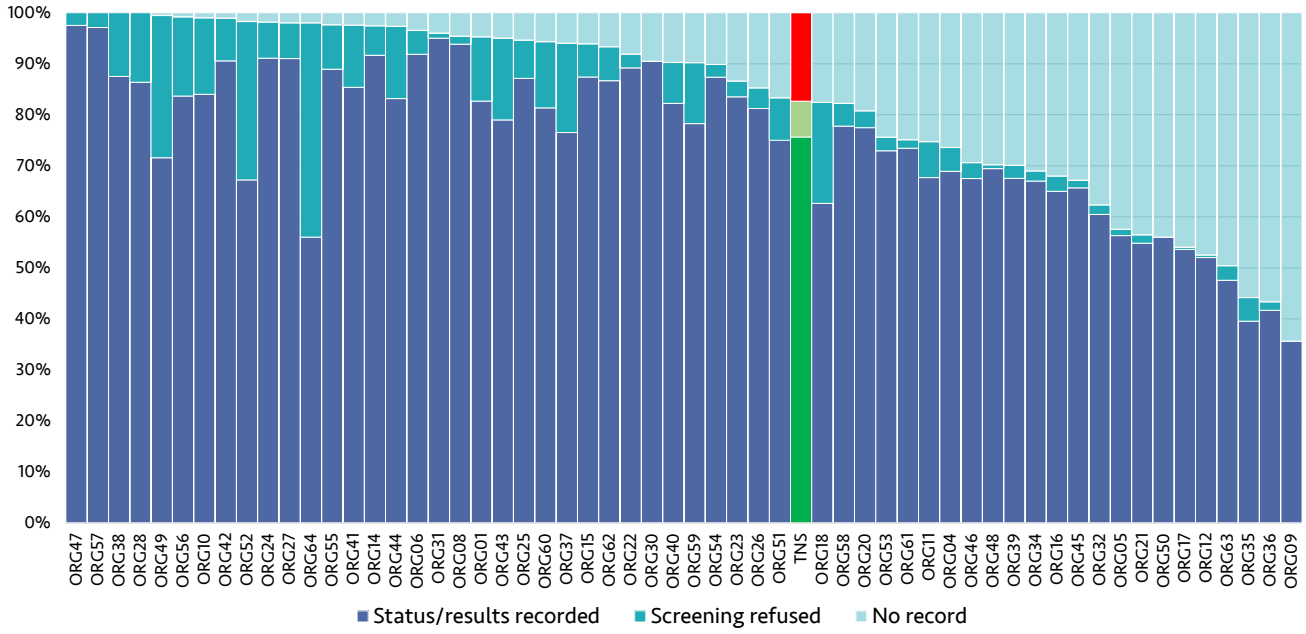


Figure 12: Proportion of people with FEP monitored for blood pressure across Trusts in the past 12 months (n = 9527)

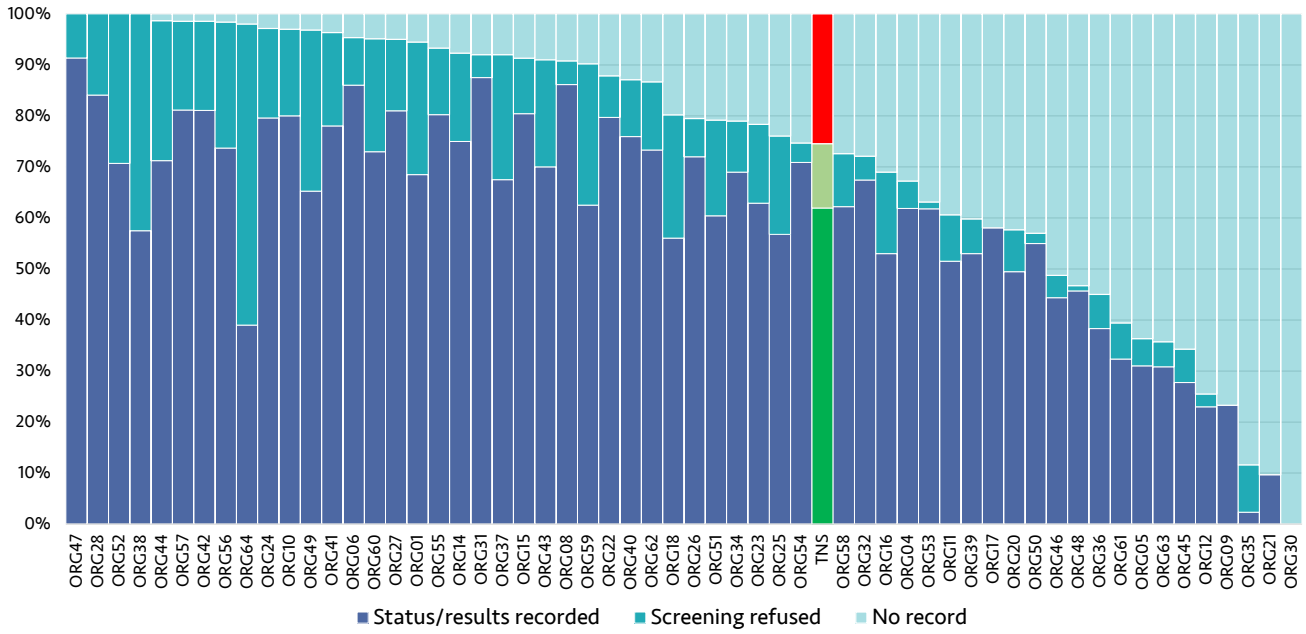


Figure 13: Proportion of people with FEP monitored for blood glucose control across Trusts in the past 12 months (n = 9527)

Cholesterol

Figure 14 shows that cholesterol was monitored for 6993 patients (73%). This is an 8% absolute increase from the previous year, where 65% were monitored for cholesterol. Screening was refused by 1224 patients (13%); refusal rates varied from 1% to 59% across Trusts. Cholesterol was not documented in 2534 (27%) cases. Monitoring of cholesterol ranged from 0% to 100% across Trusts.

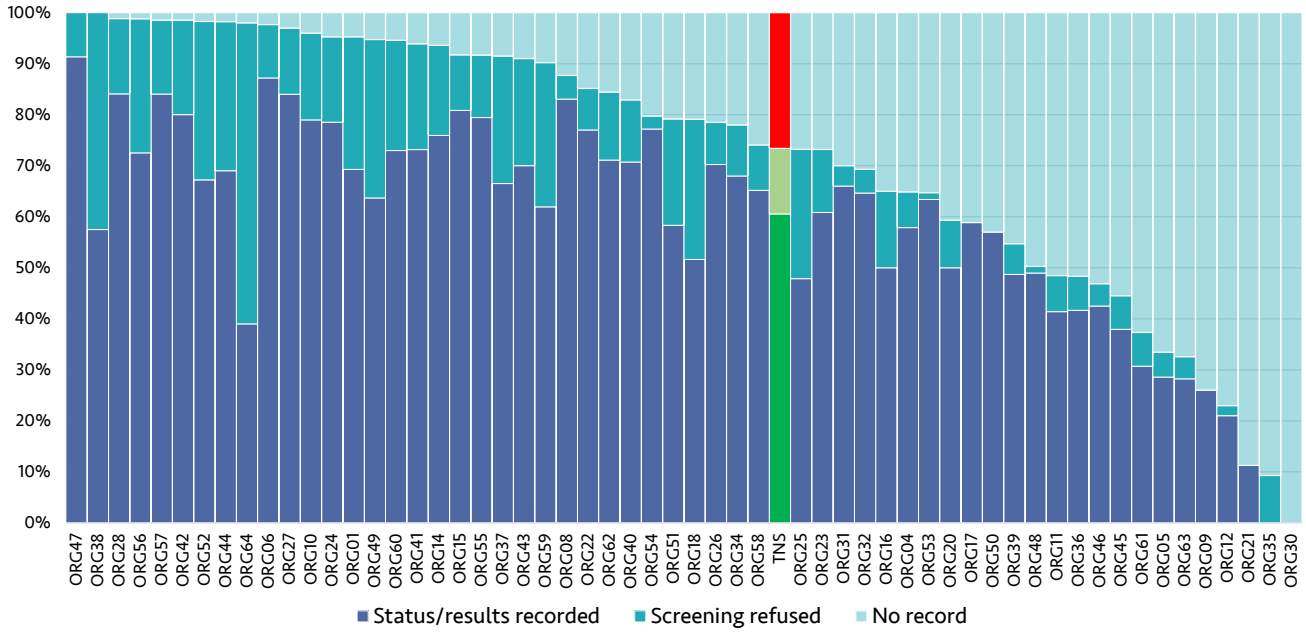


Figure 14: Proportion of people with FEP monitored for blood lipids across Trusts in the past 12 months (n = 9527)

STANDARD 7

Physical health interventions

In order 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, CG120. These thresholds reflect those implemented within the national Mental Health CQUIN analysis.

The criteria applied to determine need for intervention were as follows:

- **Cigarette smoking**: Records documenting patient as current smoker.
- **Alcohol use**: Records documenting harmful or hazardous use of alcohol.
- **Substance misuse**: Records documenting substance misuse.
- **BMI**: BMI recorded as ≥25kg/m^2 (for South Asian and Chinese patients ≥23kg/m^2).
- **Blood pressure**: Systolic BP recorded as >140 mm and/or diastolic BP recorded as >90 mm.
- **Glucose control**: At least one record of: FPG ≥5.5 mmol/l; RPG ≥11.1 mmol/l; HbA1c ≥ 42 mmol/mol.
- **Lipid abnormality**: At least one record of: total cholesterol >9, non-HDL cholesterol >7.5; Q-Risk score >10%.

For Trusts to meet the standard, patients must have been offered all relevant interventions where screening indicated a need, within the last 12 months. As shown in Figure 15, 5199 (55%) patients were offered (and received or refused) all screenings and relevant interventions across all seven measures.

Due to differences in analysis methodology, these findings cannot be compared to the previous year's EIP self-assessment.

The proportion of patients offered screenings and interventions (where required) varied across measures, ranging from 88% for smoking cessation to 63% for dyslipidaemia.

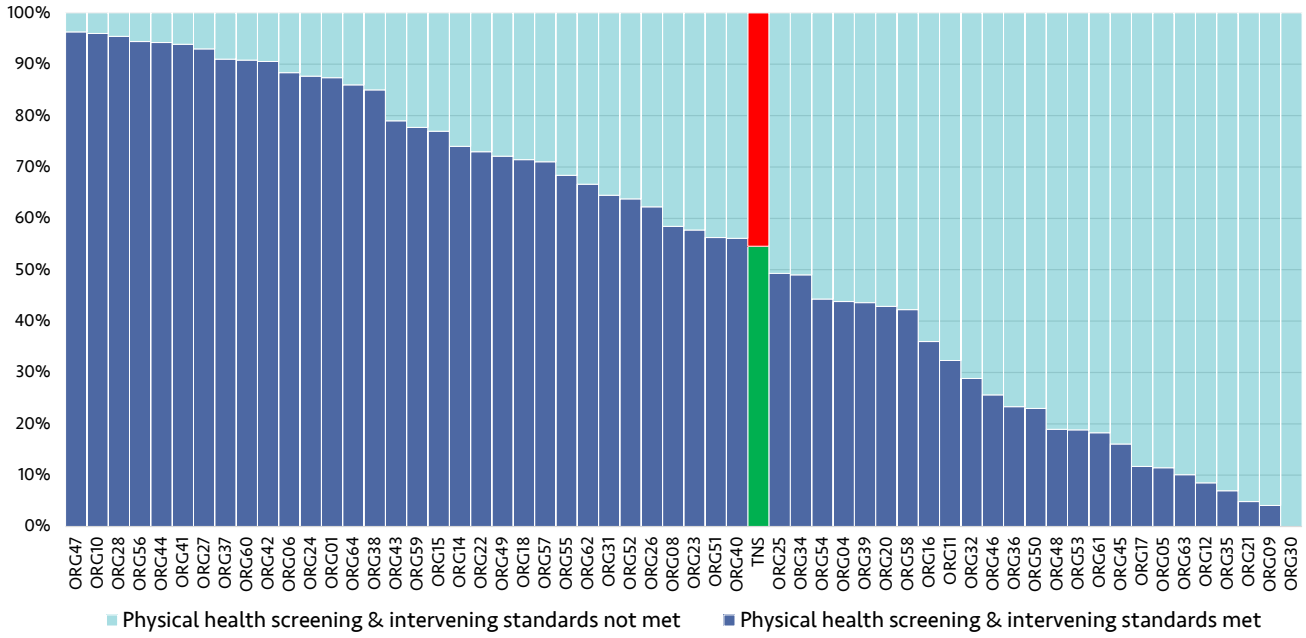


Figure 15: Composite measure of standards 6 & 7: All seven physical health screenings and relevant interventions offered in the past 12 months (n = 9527)

Intervention for smoking

As shown in Figure 16, 4093 (43%) patients were identified as requiring an intervention for smoking cessation. Of this sample, 3615 (88%) current smokers were offered a smoking cessation intervention. A further breakdown of this showed a total of 2214 (54%) patients received an intervention and 1401 (34%) refused the intervention. Refusal rates varied across Trusts from 6% to 79%.

Brief intervention (n = 1927, 87%) was the most commonly provided intervention to those 2214 patients who received a smoking cessation intervention where required and individual or group behavioural therapy was the least common (n = 50, 2%). A further breakdown of interventions provided is displayed in Table 3.

Table 3: Breakdown of interventions received by those requiring smoking intervention across Trusts (n = 2214)

Type of intervention received	N (%) of patients who received intervention*
Brief intervention	1927 (87%)
Referral to smoking cessation	424 (19%)
Nicotine replacement	164 (7%)
Individual or group behavioural therapy	50 (2%)

*Total percentage will be >100% due to some patients receiving multiple interventions

Intervention for harmful or hazardous alcohol use

As shown in Figure 17, 796 (8%) patients were identified as requiring an intervention for harmful or hazardous alcohol use. Of this sample, 738 (93%) patients were offered an intervention. A further breakdown of this showed a total of 561 (70%) patients received an intervention and 177 (22%) refused the intervention. Refusal rates varied across Trusts from 4% to 100%.

Brief intervention or advice (n = 442, 79%) was the most commonly provided intervention to those 561 patients who received an intervention for alcohol use where required, and pharmacological treatment was the least common (n = 14, 2%). A further breakdown of interventions provided is displayed in Table 4.

Table 4: Breakdown of interventions received by those requiring harmful or hazardous alcohol use intervention across Trusts (n = 561)

Type of intervention received	N (%) of patients who received intervention*
Brief intervention or advice	442 (79%)
Referral to specialist service	177 (32%)
Motivational interviewing	84 (15%)
Referral to psychoeducation	36 (6%)
Individual/group behavioural support	35 (6%)
Pharmacological	14 (2%)

*Total percentage will be >100% due to some patients receiving multiple interventions.

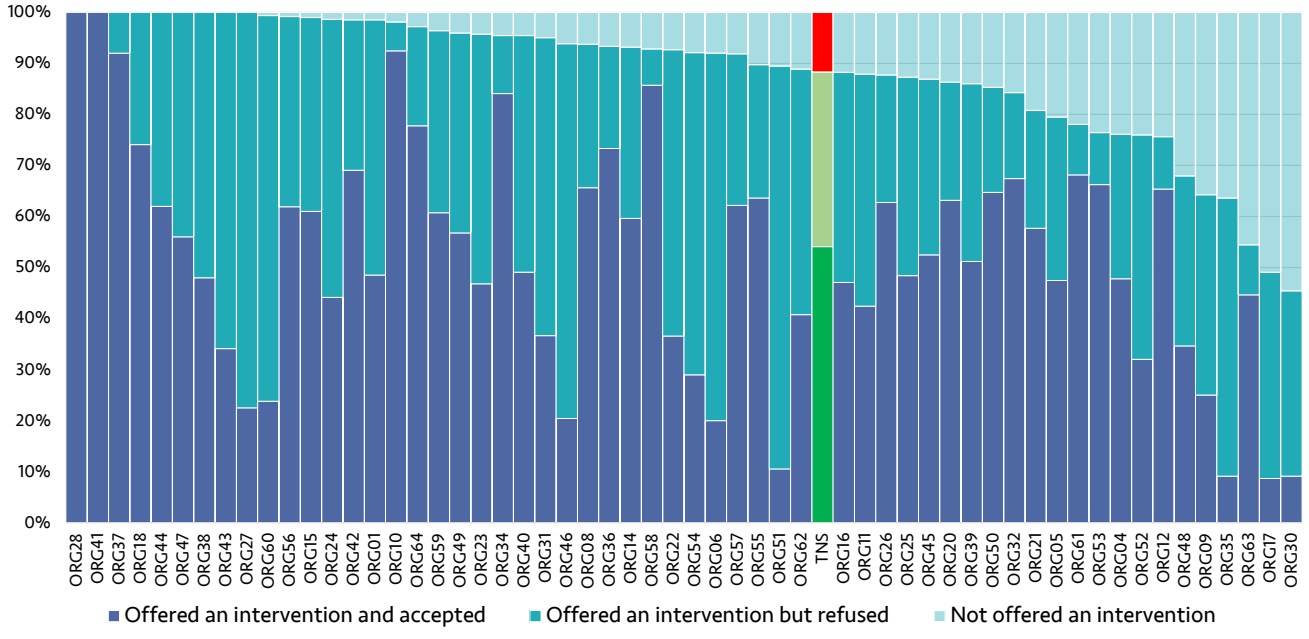


Figure 16: Proportion of people with FEP offered intervention for cigarette smoking across Trusts (n = 4093)

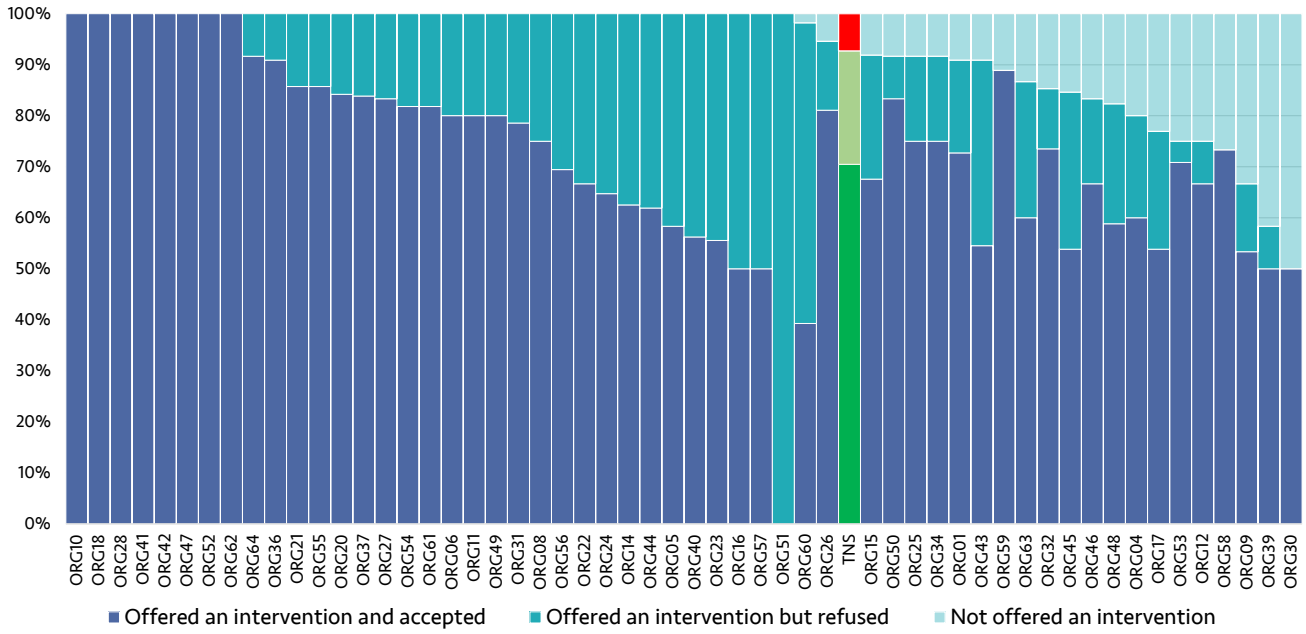


Figure 17: Proportion of people with FEP offered intervention for harmful or hazardous use of alcohol use across Trusts (n = 796)

Intervention for substance misuse

As shown in Figure 18, 2304 (24%) patients were identified as requiring an intervention for substance misuse. Of this sample, 1962 (85%) patients were offered an intervention. A further breakdown of this showed a total of 1457 (63%) patients received an intervention and 505 (22%) refused the intervention. Refusal rates varied across Trusts from 1% to 60%.

Brief intervention (n = 1119, 77%) was the most commonly provided intervention to those 1457 patients who received an intervention for substance misuse where required, and referral to a detox programme was the least common (n = 45, 3%). A further breakdown of interventions provided is displayed in Table 5.

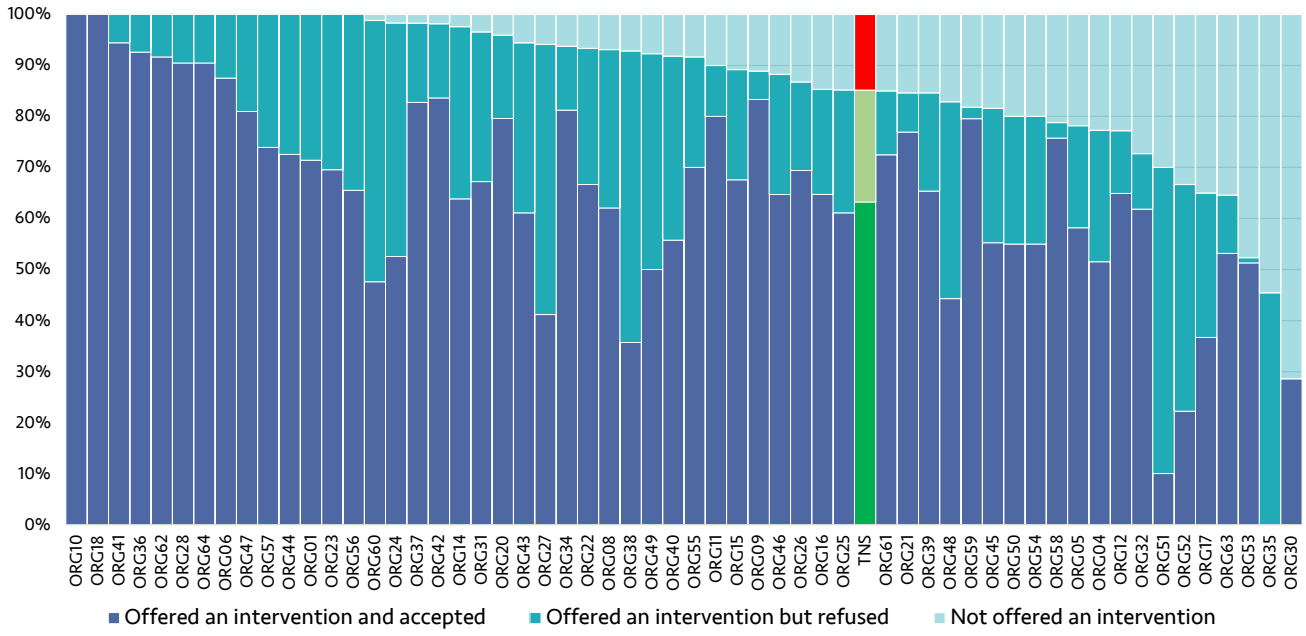


Figure 18: Proportion of people with FEP offered intervention for substance misuse across Trusts (n = 2304)

Table 5: Breakdown of interventions received by those requiring substance misuse intervention across Trusts (n = 1457)

Type of intervention received	N (%) of patients who received intervention*
Brief intervention or advice	1119 (77%)
Referral to specialist service	492 (34%)
Motivational interviewing	160 (11%)
Referral to psychoeducation	95 (7%)
Referral to detox programme	45 (3%)

*Total percentage will be >100% due to some patients receiving multiple interventions.

Table 6: Breakdown of interventions received by those requiring weight loss intervention across Trusts (n = 3302)

Type of intervention received	N (%) of patients who received intervention*
Advice or referral about diet	2844 (86%)
Advice or referral about exercise	2482 (75%)
Medication review	714 (22%)
Referral to structured lifestyle education programme	298 (9%)
Referral to primary or secondary care	253 (8%)
Pharmacological	60 (2%)

*Total percentage will be >100% due to some patients receiving multiple interventions.

Intervention for weight gain/ obesity

As shown in Figure 19, 4394 (46%) patients were identified as requiring an intervention for weight gain or obesity. Of this sample, 3577 (81%) patients were offered an intervention. A further breakdown of this showed a total of 3302 (75%) patients received an intervention and 275 (6%) refused the intervention. Refusal rates varied across Trusts from 2% to 53%.

Advice or referral about diet (n = 2844, 86%) was the most commonly provided intervention to those 3302 patients who received an intervention for weight loss where required, and pharmacological intervention was the least common (n = 60, 2%). A further breakdown of interventions provided is displayed in Table 6.

Intervention for hypertension

As shown in Figure 20, 1082 (11%) patients were identified as requiring an intervention for hypertension. Of this sample, 681 (66%) patients were offered an intervention. A further breakdown of this showed a total of 649 (60%) patients received an intervention and 32 (3%) refused the intervention. Refusal rates varied across Trusts from 2% to 20%. Additionally, a further 35 (3%) patients did not require intervention due to normal repeat tests.

Advice or referral about diet (n = 401, 62%) was the most commonly provided intervention to those 649 patients

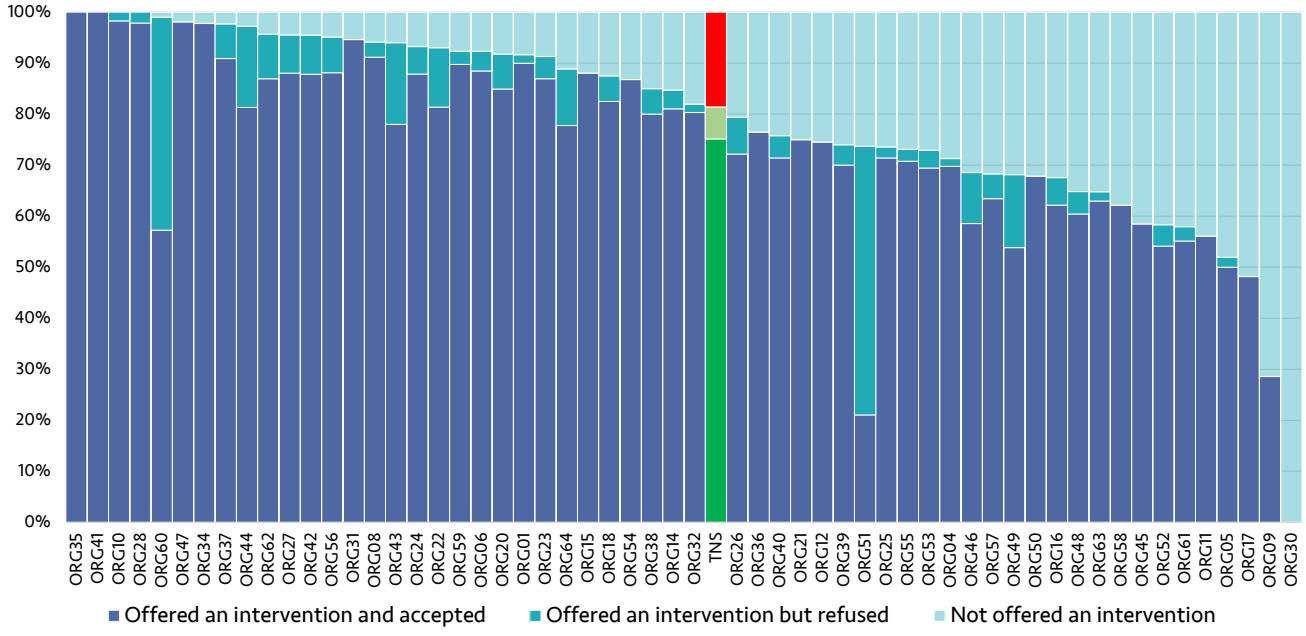


Figure 19: Proportion of people with FEP offered intervention for elevated BMI across Trusts (n = 4394)

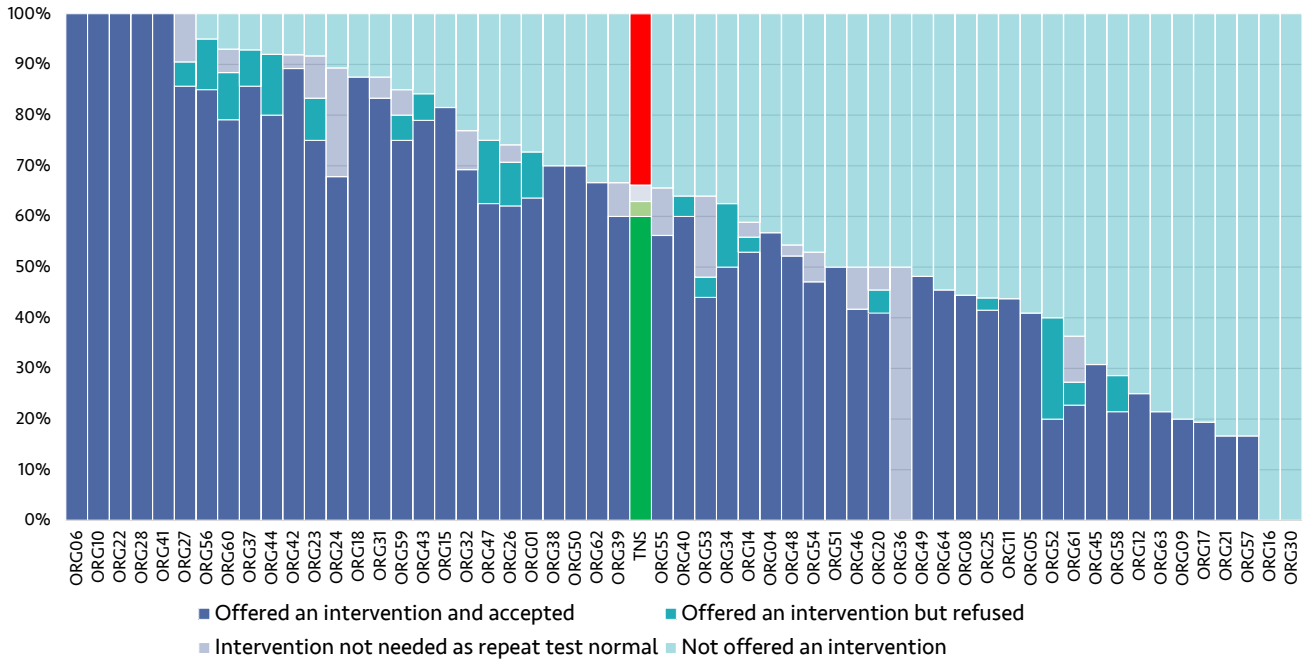


Figure 20: Proportion of people with FEP offered intervention for elevated blood pressure across Trusts (n = 1082)

who received an intervention for elevated blood pressure where required, and pharmacological intervention was the least common (n = 54, 8%). A further breakdown of interventions provided is displayed in Table 7.

Intervention for diabetes/high risk of diabetes

As shown in Figure 21, 476 (5%) patients were identified as requiring an intervention for diabetes or pre-diabetes risk. Of this sample, 327 (69%) patients were offered an intervention. A further breakdown of this showed a total of 314 (66%) patients received an intervention and 13 (3%) refused the intervention. Refusal rates varied across Trusts from 3% to 33%.

Advice or referral about diet (n = 205, 65%) was the most commonly provided intervention to those 314 patients who received an intervention for glucose control where required, and referral to structured lifestyle education programme was the least common (n = 26, 8%). A further breakdown of interventions provided is displayed in Table 8.

Table 7: Breakdown of interventions received by those requiring blood pressure intervention across Trusts (n = 649)

Type of intervention received	N (%) of patients who received intervention*
Advice or referral about diet	401 (62%)
Advice or referral about exercise	375 (58%)
Referral to primary or secondary care	291 (45%)
Medication review	93 (14%)
Pharmacological	54 (8%)
*Total percentage will be >100% due to some patients receiving multiple interventions.	

Table 8: Breakdown of interventions received by those requiring glucose control intervention across Trusts (n = 314)

Type of intervention received	N (%) of patients who received intervention*
Advice or referral about diet	205 (65%)
Advice or referral about exercise	165 (53%)
Referral to primary or secondary care	147 (47%)
Medication review	62 (20%)
Pharmacological	42 (13%)
Referral to structured lifestyle education programme	26 (8%)
*Total percentage will be >100% due to some patients receiving multiple interventions.	

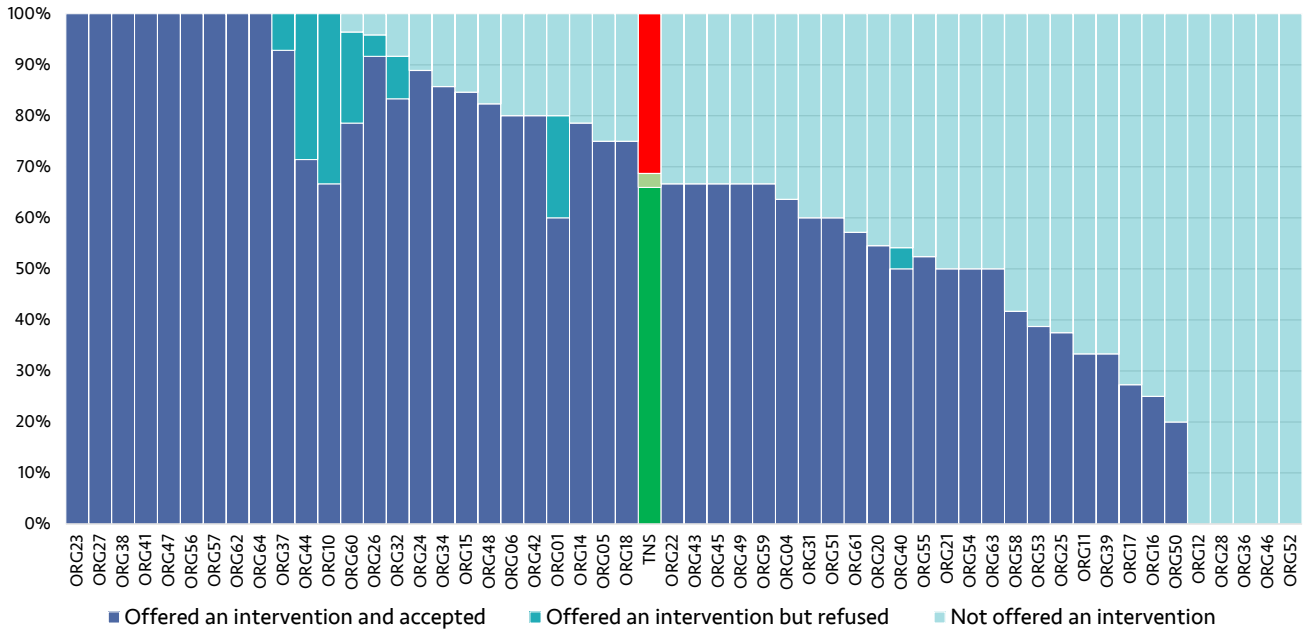


Figure 21: Proportion of people with FEP offered intervention for abnormal glucose control across Trusts (n = 476)

Intervention for dyslipidaemia

A total of 28 (0.3%) patients were identified as requiring an intervention for dyslipidaemia. Of this sample, 19 (68%) patients were offered and received an intervention, no patients refused the intervention.

Referral to primary or secondary care (n = 13, 68%) was the intervention most commonly provided to those 19 patients who received an intervention for dyslipidaemia where required, and a medication review was the least common (n = 4, 21%). A further breakdown of interventions provided is displayed in Table 9.

Table 9: Breakdown of interventions received by those requiring an intervention for dyslipidaemia across Trusts (n = 19)

Type of intervention received	N (%) of patients who received intervention*
Referral to primary or secondary care	13 (68%)
Advice or referral about diet	10 (53%)
Advice or referral about exercise	8 (42%)
Lipid modification medication	6 (32%)
Medication review	4 (21%)
*Total percentage will be >100% due to some patients receiving multiple interventions.	

STANDARD 8

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.

Standard 8

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

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

This analysis was carried out where the patient had an identified carer (n = 6980). 3871 (55%) of 6980 carers in the national sample had taken up or been referred to carer-focused education and support programmes. As shown in Figure 22, the proportion of cases meeting this standard ranges from 0% to 100% across Trusts. Since 2017, there has been a 2% absolute increase (from 53%[q] to 55%) in the proportion of patients whose carers took up or were referred to carer education and support programmes.

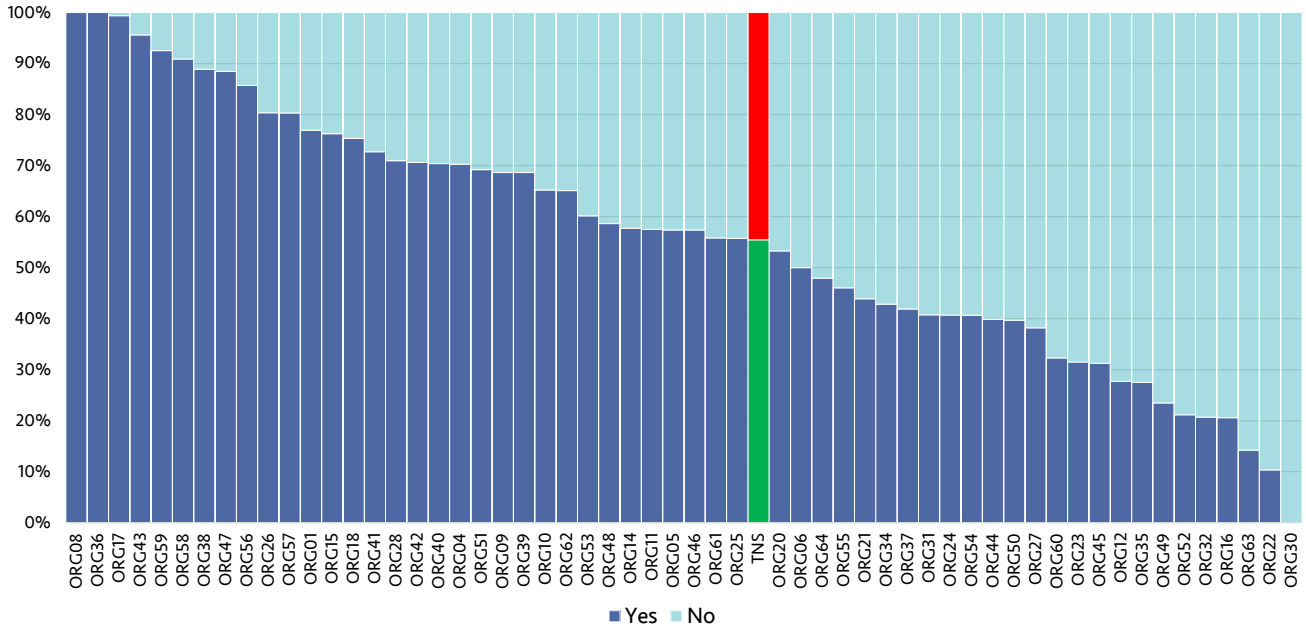


Figure 22: Proportion of people with FEP whose carers took up or were referred to carer-focused education and support programmes (n = 6980)

[q] Compared to data from the EIP self-assessment 2017/18 for which the sample contained all patients on the caseload (i.e. not FEP exclusively) and patients on the caseload for <6 months.

Outcome indicator

Outcome Indicator

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

For Trusts to have met this standard, patients had to have had clinical outcome measurement data (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR[r]) recorded at least twice. This had to be at baseline assessment and repeated at one other time point. For patients 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 = 9527). 2071 (22%) of 9527 patients in the national sample had two or more outcome measures recorded at least twice. As shown in Figure 23, the proportion of Trusts that met this standard ranged from 0% to 80%. Since 2017, there has been a 13% absolute increase (from 9%[s] to 22%) in the proportion of people with two or more outcome measures recorded at least twice.

For a further breakdown of measures recorded for the Trusts who met the outcome indicator, see Appendix F (page 52).

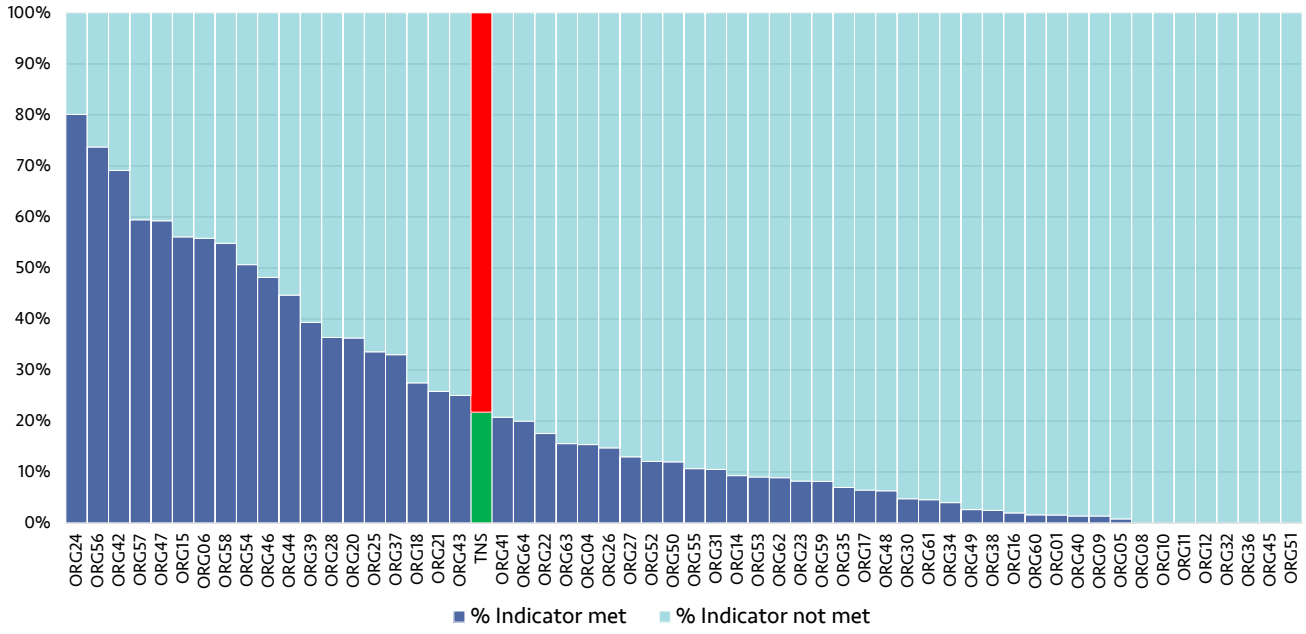


Figure 23: Proportion of people with FEP with clinical outcome measurement data (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) recorded at least twice (at assessment and at one other time point) (n = 9527)

[r] 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.
[s] Compared to data from the EIP self-assessment 2017/18 for which the sample included patients who had been on the caseload for <6 months.

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Appendix A
Steering Group members

Table 10: Steering group members and organisations (in alphabetical order)

Name	Organisation
Dr Alison Brabban	Early Intervention in Psychosis Network, NHS England
Linda Chadburn	Pennine Care NHS Foundation Trust/local audit representative
Amy Clark	NHS England
Dr Elizabeth Davies	Welsh Government
Dr Selma Ebrahim	British Psychological Society (BPS)
Angela Etherington	Expert by experience
Rebecca Gate	NHS England
Ellie Gordon	Royal College of Nursing (RCN)
Wendy Harlow	Sussex Partnership Trust/local audit representative
Sam Harper	Healthcare Quality Improvement Partnership (HQIP)
Sarah Holloway	NHS England
Jay Nairn	NHS England
Peter Pratt	Prescribing expert, NHS England
Caroline Rogers	Healthcare Quality Improvement Partnership (HQIP)
Lucy Schonegevel	Rethink Mental Illness
Dr David Shiers	GP (retired)/Carer
Dr Shubalade Smith	National Collaborating Centre for Mental Health (NCCMH)
Dr Caroline Taylor	Royal College of General Practitioners (RCGP)/CCG representative
Hilary Tovey	NHS England
Nicola Vick	Care Quality Commission (CQC)
Dr Jonathan West	Early Intervention in Psychosis Network (London)
Dr Latha Weston	RCPsych General Adult Faculty

All members of the Steering Group and the audit Implementation Group were asked to complete a Declaration of Competing Interests form. These are held on file in CCQI and are available for inspection.

Appendix B
Trust returns of case note audit form

Table 11: Expected and actual returns (post data cleaning) from each Trust

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
ORG01	127	127	127	127	100%	100%
ORG04	300	300	299	299	100%	100%
ORG05	273	245	246	245	90%	100%
ORG06	86	86	86	86	100%	100%
ORG08	65	65	65	65	100%	100%
ORG09	79	79	73	73	92%	92%
ORG10	178	100	100	100	56%	100%
ORG11	117	100	101	99	85%	99%
ORG12	297	200	200	200	67%	100%
ORG14	312	312	316	312	100%	100%
ORG15	252	232	231	230	91%	99%
ORG16	111	100	100	100	90%	100%
ORG17	248	248	248	248	100%	100%
ORG18	91	91	96	91	100%	100%
ORG20	188	180	187	182	97%	101%
ORG21	62	62	62	62	100%	100%
ORG22	74	74	74	74	100%	100%
ORG23	97	97	97	97	100%	100%
ORG24	502	396	425	382	76%	96%
ORG25	277	277	282	280	101%	101%
ORG26	963	400	401	400	42%	100%
ORG27	263	100	100	100	38%	100%
ORG28	88	88	88	88	100%	100%
ORG30	21	21	21	21	100%	100%
ORG31	271	200	200	200	74%	100%
ORG32	261	215	215	215	82%	100%
ORG34	226	100	100	100	44%	100%

Continued

Table 11 (continued)

ORG35	43	43	43	43	100%	100%
ORG36	60	60	60	60	100%	100%
ORG37	338	200	200	200	59%	100%
ORG38	40	40	40	40	100%	100%
ORG39	117	117	117	117	100%	100%
ORG40	293	293	288	287	98%	98%
ORG41	82	82	82	82	100%	100%
ORG42	308	281	281	275	89%	98%
ORG43	114	100	100	100	88%	100%
ORG44	227	227	227	226	100%	100%
ORG45	149	149	137	137	92%	92%
ORG46	163	160	161	160	98%	100%
ORG47	83	83	82	81	98%	98%
ORG48	395	395	400	396	100%	100%
ORG49	190	190	191	190	100%	100%
ORG50	159	100	100	100	63%	100%
ORG51	48	48	49	48	100%	100%
ORG52	58	58	58	58	100%	100%
ORG53	483	400	377	377	78%	94%
ORG54	80	80	79	79	99%	99%
ORG55	288	254	254	253	88%	100%
ORG56	252	252	252	251	100%	100%
ORG57	69	69	69	69	100%	100%
ORG58	149	138	147	135	91%	98%
ORG59	186	186	187	184	99%	99%
ORG60	370	370	370	370	100%	100%
ORG61	250	244	248	241	96%	99%
ORG62	45	45	45	45	100%	100%
ORG63	347	347	347	347	100%	100%
ORG64	144	100	100	100	69%	100%

Appendix C
Service-level data

All areas had an EI service working with 18–35-year olds. In 11% of areas (n = 16) there was no EI provision for patients under 18 years and in 15% of areas (n = 23) there was no EI provision for patients over 35 years.

Most services for 18–35 years were standalone multi-disciplinary EIP teams (n = 136; 90%). A minority of services for 18–35-year olds operated as an EI service integrated into a Community Mental Health Team (n = 12; 8%) or as a hub and spoke model (n = 3; 2%), in which health professionals work in the community whilst also having a central hub.

Most services offered to patients under 18 years were provided by standalone multidisciplinary EIP teams (n = 111; 74%). This was also the case for services provided to patients over 35 years (n = 117; 77%).

CBT for ARMS patients were provided within the team in seventy-five (50%) services or could be provided elsewhere in twenty-one (14%) services. Fifty-five (36%) services did not provide this intervention.

Table 12: Contextual questionnaire: England (151 teams submitted data, 3 teams did not submit data)

Q1. Routinely collected demographic data	n (%) of services
Protected characteristics	
Age	151 (100%)
Disability	127 (84%)
Gender reassignment	61 (40%)
Marriage and civil partnership	142 (94%)
Pregnancy and maternity	107 (71%)
Race	148 (98%)
Religion or belief	145 (96%)
Sex	149 (99%)
Sexual orientation	111 (74%)
Other demographic data	
Socioeconomic status	87 (58%)
Refugees/asylum seekers	66 (44%)
Migrant workers	28 (19%)
Homelessness	136 (90%)
Q2. Written strategy/strategies to identify and address any MH inequalities (8 teams ticked Y but did not submit a strategy)	
Yes	81 (54%)
No	70 (46%)

Continued

Table 12 (continued)

Q3. EI service provided for these age ranges		n (%) of services
Under 18 years	Standalone multidisciplinary EIP team	111 (74%)
	Hub and spoke model	8 (5%)
	Integrated CMHT	16 (11%)
	No EI service	16 (11%)
18–35 years	Standalone multidisciplinary EIP team	136 (90%)
	Hub and spoke model	3 (2%)
	Integrated CMHT	12 (8%)
36 years and over	Standalone multidisciplinary EIP team	117 (77%)
	Hub and spoke model	6 (4%)
	Integrated CMHT	5 (3%)
	No EI service	23 (15%)

Q4. Length of treatment packages for different age ranges	N teams	Mean (SD) months	Range months
Under 18 years	135	35.00 (7.90)	3–84
18–35 years	151	34.35 (6.35)	3–36
36 years and over	128	31.30 (9.37)	1–36

Q5. Model of provision for children and young people (CYP)	n (%) of services
Specialist EIP team embedded within CYP mental health services	14 (9%)
Specialist CYP EIP team	5 (3%)
Adult EIP service with staff that have expertise in CYP mental health	19 (13%)
Adult EIP service with joint protocols with CYP mental health services	87 (58%)
No CYP provision	8 (5%)
Other	18 (12%)

Q6. Whole time equivalent EIP care coordinators	Mean (SD)	Range
	9.68 (8.72)	1.6–96

Q7. Increase in number of staff posts	n (%) of services
Yes	43 (28%)
No	108 (72%)

Q8. CBT for ARMS	n (%) of services
Elsewhere	21 (14%)
Within the team	75 (50%)
Not at all	55 (36%)

Q9. Total caseload of the team	Mean (SD) number of patients	Range
Total caseload	158.60 (103.38)	12–620
Caseload per whole time EIP care coordinator	17.49 (6.65)	2.07–64.50

Q10. Total caseload by age ranges		Mean (SD) number of patients	Range
Under 14 years	FEP	0.01 (0.08)	0–1
	ARMS	0.01 (0.08)	0–1
	Suspected FEP	0.01 (0.16)	0–2

Continued

Table 12 (continued)

14–17 years	FEP	5.56 (6.47)	0–37
	ARMS	1.13 (2.37)	0–15
	Suspected FEP	0.85 (1.96)	0–18
18–35 years	FEP	97.73 (65.38)	1–387
	ARMS	6.05 (11.03)	0–64
	Suspected FEP	6.87 (15.80)	0–121
36 years and over	FEP	37.29 (35.15)	0–218
	ARMS	0.87 (2.81)	0–22
	Suspected FEP	2.23 (5.57)	0–52
Q11. Average length of treatment in months of last 10 FEP service users			
		30.13 (9.50)	2.10–61

Appendix D
Participating Trusts

Table 13 is a breakdown of all participating Trusts, provider IDs and registered EIP teams within each, alphabetised by Trust name. Table 14 is a breakdown of all Trusts and provider IDs, ordered by their ID number.

Table 13: Participating Trusts, provider IDs & EIP teams (alphabetised by Trust name)

Provider name	Provider ID	Team name(s)
2gether NHS Foundation Trust	ORG01	GRIP (Gloucestershire)
		Herefordshire Early Intervention Service
Avon & Wiltshire Mental Health Partnership NHS Trust	ORG04	Bristol Early Intervention Team
		North Somerset Early Intervention Team
		South Gloucestershire Early Intervention Team
		Swindon Early Intervention Team
		Wiltshire Early Intervention Team
		Banes Early Interventions Team
Barnet, Enfield & Haringey MH NHS Trust	ORG05	Barnet Early Intervention in Psychosis Service
		Enfield Early Intervention in Psychosis Service
		Haringey Early Intervention in Psychosis Service
Berkshire Healthcare NHS Foundation Trust	ORG06	Berkshire Early Intervention in Psychosis Service
Birmingham and Solihull Mental Health NHS Foundation Trust	ORG08	Solihull Early Intervention Service
Black Country Partnership NHS Foundation Trust	ORG09	Sandwell Early Intervention Team
		Wolverhampton Early Intervention Team
Bradford District Care Trust	ORG10	Bradford and Airedale Early Intervention Service
Cambridgeshire and Peterborough NHS Foundation Trust	ORG11	CAMEO
Camden and Islington NHS Foundation Trust	ORG12	Camden Early Intervention Service
		Islington Early Intervention Service
Central and North West London NHS Foundation Trust	ORG14	Brent Early Intervention Service
		Harrow & Hillingdon Early Intervention Service
		Kensington and Chelsea & Westminster EIS
		Milton Keynes Early Intervention Team
Cheshire and Wirral Partnership NHS Foundation Trust	ORG15	Central and Eastern Cheshire Early Intervention Service
		Cheshire West Early Intervention Service
		Wirral Early Intervention Team

Table 13 (continued)

Provider name	Provider ID	Team name(s)
Community Links Northern Ltd	ORG64	Aspire (Leeds)
Cornwall Partnership NHS Foundation Trust	ORG16	Cornwall Early Intervention Service
Coventry and Warwickshire Partnership Trust	ORG17	Coventry Early Intervention Team
		North Warwickshire Early Intervention Team
		South Warwickshire Early Intervention Team
Cumbria Partnership NHS Foundation Trust	ORG18	A-Maze
Derbyshire Healthcare NHS Foundation Trust	ORG20	Derby City and South County Early Intervention Service
		North Derbyshire Early Intervention Service
Devon Partnership Trust	ORG21	Exeter and East STEP
		North and Mid STEP
		South and West and Torbay STEP
Dorset Healthcare University NHS Foundation Trust	ORG22	Early Intervention Service (Dorset)
Dudley and Walsall Mental Health Partnership Trust	ORG23	Dudley Early Intervention Service
		Walsall Early Intervention Service
East London NHS Foundation Trust	ORG24	Early Intervention in Psychosis Service Bedfordshire and Luton
		Equip – City and Hackney Early Intervention Service
		Newham Early Intervention Psychosis Service
		Tower Hamlets Early Intervention Service
Essex Partnership University NHS Foundation Trust	ORG25	Mid Essex Specialist Psychosis Pathway
		North East Essex Specialist Psychosis Pathway
		West Essex Specialist Psychosis Pathway
		ESTEP East
		ESTEP West
Forward Thinking Birmingham	ORG63	Birmingham Early Intervention for Psychosis Service (West)
		Birmingham Early Intervention for Psychosis Service (East)
		Birmingham Early Intervention for Psychosis Service (North)
		Birmingham Early Intervention for Psychosis Service (South)
Greater Manchester Mental Health Services NHS Foundation Trust	ORG26	Bolton Early Intervention Team
		Salford Early Intervention Team
		Trafford Early Intervention Team
		Manchester EIT
Hertfordshire Partnership University NHS Foundation Trust	ORG27	PATH Early Intervention in Psychosis Services – Psychosis: Prevention, Assessment and Treatment in Hertfordshire
Humber NHS Foundation Trust	ORG28	Psychosis Service for Young People in Hull and East Riding (PSYPHER)
Isle of Wight NHS Trust	ORG30	Isle of Wight Early Intervention in Psychosis

Continued

Table 13 (continued)

Provider name	Provider ID	Team name(s)
Kent and Medway NHS and Social Care Partnership Trust	ORG31	Kent and Medway Early Intervention in Psychosis Service East Kent
		Kent and Medway Early Intervention in Psychosis Service West Kent
Lancashire Care NHS Foundation Trust	ORG32	Early Intervention Service – Central
		Early Intervention Service – East
		Early Intervention Service – North
Leicestershire Partnership NHS Trust	ORG34	Leicestershire Psychosis Intervention and Early Recovery (PIER) Team
Lincolnshire Partnership NHS Foundation Trust	ORG35	Early Intervention Team Lincolnshire
Livewell Southwest CIC	ORG36	Insight Team, Plymouth
Mersey Care NHS Trust	ORG37	Liverpool Early Intervention in Psychosis
		Sefton Early Intervention Team
Midland Partnership NHS Foundation Trust	ORG54	Early Intervention Team – Shropshire, Telford & Wrekin
		Early Intervention Team – South Staffordshire
NAViGO Health and Social Care CIC	ORG38	Early Intervention in Psychosis and Transition Service
Norfolk & Suffolk NHS Foundation Trust	ORG39	Central Norfolk Early Intervention Team
		Early Intervention Team – West Norfolk – Thurlow House
		Great Yarmouth and Waveney Early Intervention Team – Northgate
		Early Intervention Team – West Suffolk – Bury North
		Early Intervention Team – East Suffolk – Ipswich IDT
		Early Intervention Team – East Suffolk – Coastal – Walker Close
		West Suffolk – Bury South
North East London NHS Foundation Trust	ORG40	Barking & Dagenham Early Intervention in Psychosis
		Havering Early Intervention in Psychosis
		Redbridge Early Intervention in Psychosis Team
		Waltham Forest Early Intervention in Psychosis
North Staffordshire Combined Healthcare NHS Trust	ORG41	Early Intervention Service, North Staffordshire
North West Boroughs Healthcare NHS Foundation Trust	ORG42	Early Intervention in Psychosis Team Knowsley & St Helens
		Warrington & Halton Early intervention Team
		Wigan Early Intervention Team
Northamptonshire Healthcare NHS Foundation Trust	ORG43	Community Mental Health Adult – Early intervention N'STEP
Northumberland Tyne and Wear NHS Foundation Trust	ORG44	Gateshead EIP
		North Tyneside EIP
		Northumberland EIP
		Sunderland EIP
		Newcastle EIP
		South Tyneside EIP

Continued

Table 13 (continued)

Provider name	Provider ID	Team name(s)
Nottinghamshire Healthcare NHS Trust	ORG45	Ashfield & Mansfield Early Intervention in Psychosis Team
		County South Early Intervention in Psychosis Team
		Newark & Sherwood Early Intervention in Psychosis Team
		Nottingham City Early Intervention in Psychosis Team
Oxford Health NHS Foundation Trust	ORG46	Buckinghamshire Early Intervention Service
		Oxfordshire Early Intervention Service
Oxleas NHS Foundation Trust	ORG47	Bexley Early Intervention in Psychosis
		Bromley Early Intervention in Psychosis
		Greenwich Early Intervention in Psychosis Team
Pennine Care NHS Foundation Trust	ORG48	Early Intervention Team Bury
		Early Intervention Team Heywood, Middleton and Rochdale
		Early Intervention Team Oldham
		Early Intervention Team Stockport
		Tameside Early Intervention Team
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	ORG49	Early Intervention in Psychosis – Doncaster
		Early Intervention Team – North Lincs
		Early Intervention Team – Rotherham
Sheffield Health & Social Care NHS Foundation Trust	ORG50	Sheffield Early Intervention Service
Solent NHS Trust	ORG51	Portsmouth Early Intervention with Psychosis Team
Somerset Partnership NHS Foundation Trust	ORG52	Somerset Team for Early Psychosis
South London and Maudsley NHS Foundation Trust	ORG53	Early Intervention Service – Croydon (COAST)
		Early Intervention Service – Lambeth (LEO)
		Early Intervention Service – Lewisham (LEIS)
		Early Intervention Service – Southwark (STEP)
South West London and St George's Mental Health Trust	ORG55	Kingston Early Intervention Service
		Richmond Early Intervention Service
		Merton Early Intervention Service
		Sutton Early Intervention Service
		Wandsworth Early Intervention Team
South West Yorkshire Partnership NHS Foundation Trust	ORG56	Barnsley Early Intervention Team
		Calderdale Insight (Early Intervention in Psychosis)
		Kirklees Insight Team – North
		Kirklees Insight Team – South
		Wakefield Early Intervention in Psychosis Team
Southern Health NHS Foundation Trust	ORG57	Early Intervention in Psychosis Team – East Hampshire
		Early Intervention in Psychosis Team – North Hampshire
		Early Intervention in Psychosis Team – Southampton
		Early Intervention in Psychosis Team – West Hampshire

Continued

Table 13 (continued)

Provider name	Provider ID	Team name(s)
Surrey and Borders Partnership NHS Foundation Trust	ORG58	Early Intervention in Psychosis East Surrey
		Early Intervention in Psychosis West Surrey & North East Hampshire
Sussex Partnership NHS Foundation Trust	ORG59	Bognor Early Intervention in Psychosis Service
		Brighton Early Intervention in Psychosis Service
		Hailsham Early Intervention in Psychosis Service
		Hastings Early Intervention in Psychosis Service
		Horsham Early Intervention in Psychosis Service
		Worthing Early Intervention in Psychosis Service
Tees, Esk and Wear Valley NHS Foundation Trust	ORG60	Harrogate, Hambleton & Richmondshire Early Intervention in Psychosis Team
		North Durham & Easington Early Intervention in Psychosis Team
		Hartlepool Early Intervention in Psychosis Team
		Stockton Early Intervention in Psychosis Team
		Scarborough, Whitby & Ryedale Early Intervention in Psychosis Team
		South Durham Early Intervention in Psychosis Team
		Middlesbrough Early Intervention in Psychosis Team
		Redcar and Cleveland Early Intervention in Psychosis Team
		York & Selby Early Intervention in Psychosis Team
West London Mental Health NHS Trust	ORG61	Ealing Early Intervention Service
		FIRST Ealing Intervention Service – Hammersmith & Fulham
		Hounslow Early Intervention Service
Worcestershire Health & Care NHS Trust	ORG62	Early Intervention in Psychosis Service (Worcestershire)

Table 14: Participating Trusts & provider IDs (ordered by provider ID)

Provider ID	Provider name
ORG01	2gether NHS Foundation Trust
ORG04	Avon & Wiltshire Mental Health Partnership NHS Trust
ORG05	Barnet, Enfield & Haringey MH NHS Trust
ORG06	Berkshire Healthcare NHS Foundation Trust
ORG08	Birmingham and Solihull Mental Health NHS Foundation Trust
ORG09	Black Country Partnership NHS Foundation Trust
ORG10	Bradford District Care Trust
ORG11	Cambridgeshire and Peterborough NHS Foundation Trust
ORG12	Camden and Islington NHS Foundation Trust
ORG14	Central and North West London NHS Foundation Trust
ORG15	Cheshire and Wirral Partnership NHS Foundation Trust

Continued

Table 14 (continued)

Provider ID	Provider name
ORG16	Cornwall Partnership NHS Foundation Trust
ORG17	Coventry and Warwickshire Partnership Trust
ORG18	Cumbria Partnership NHS Foundation Trust
ORG20	Derbyshire Healthcare NHS Foundation Trust
ORG21	Devon Partnership Trust
ORG22	Dorset Healthcare University NHS Foundation Trust
ORG23	Dudley and Walsall Mental Health Partnership Trust
ORG24	East London NHS Foundation Trust
ORG25	Essex Partnership University NHS Foundation Trust
ORG26	Greater Manchester Mental Health Services NHS Foundation Trust
ORG27	Hertfordshire Partnership University NHS Foundation Trust
ORG28	Humber NHS Foundation Trust
ORG30	Isle of Wight NHS Trust
ORG31	Kent and Medway NHS and Social Care Partnership Trust
ORG32	Lancashire Care NHS Foundation Trust
ORG34	Leicestershire Partnership NHS Trust
ORG35	Lincolnshire Partnership NHS Foundation Trust
ORG36	Livewell Southwest CIC
ORG37	Mersey Care NHS Trust
ORG38	NAViGO Health and Social Care CIC
ORG39	Norfolk & Suffolk NHS Foundation Trust
ORG40	North East London NHS Foundation Trust
ORG41	North Staffordshire Combined Healthcare NHS Trust
ORG42	North West Boroughs Healthcare NHS Foundation Trust
ORG43	Northamptonshire Healthcare NHS Foundation Trust
ORG44	Northumberland Tyne and Wear NHS Foundation Trust
ORG45	Nottinghamshire Healthcare NHS Trust
ORG46	Oxford Health NHS Foundation Trust
ORG47	Oxleas NHS Foundation Trust
ORG48	Pennine Care NHS Foundation Trust
ORG49	Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
ORG50	Sheffield Health & Social Care NHS Foundation Trust
ORG51	Solent NHS Trust
ORG52	Somerset Partnership NHS Foundation Trust
ORG53	South London and Maudsley NHS Foundation Trust
ORG54	Midland Partnership NHS Foundation Trust
ORG55	South West London and St George's Mental Health Trust
ORG56	South West Yorkshire Partnership NHS Foundation Trust
ORG57	Southern Health NHS Foundation Trust
ORG58	Surrey and Borders Partnership NHS Foundation Trust

Continued

Table 14 (continued)

Provider ID	Provider name
ORG59	Sussex Partnership NHS Foundation Trust
ORG60	Tees, Esk and Wear Valley NHS Foundation Trust
ORG61	West London Mental Health NHS Trust
ORG62	Worcestershire Health & Care NHS Trust
ORG63	Forward Thinking Birmingham
ORG64	Community Links Northern Ltd

Appendix E
Quality assurance visits

A review of the quality of data collection took place at four sites, including three Trusts in England. Trusts were informed of this at the beginning of the audit and three Trusts in England were selected at random from the 57 who contributed data. The purpose of these visits was to quality assure the data collected and allow the NCAP team to gain a better understanding of the various barriers Trusts encounter during the audit process. Seven items of data relating to demographics, psychological therapies, supported employment programmes, prescribing and monitoring of physical health were chosen for verification against the case note records.

The Trusts selected were each visited for one day in February or March 2019 by an impartial clinician not connected with NCAP and at least one member of staff from the NCAP team. These Trusts were asked in advance to make a member of staff available who could access up to 25 sets of case records from those they had extracted data submitted to the audit, 15 of which were then randomly selected by the NCAP team member to be reviewed on the day of the visit. The member of Trust staff was asked to locate the data that supported each of the seven items of data selected for verification.

In total, data were reviewed for 45 case record audit of practice returns. It was possible to verify the majority of data returned. The most common reason for difficulty in verifying data was that some interventions were not clearly labelled in the patient's case notes. As such, the impartial clinician was required to make a judgment on whether the session notes qualified take up of a specific intervention (e.g. CBTp or Family Intervention) and whether the Trust staff member facilitating that intervention was suitably qualified in line with the guidance.

Overall, these reviews suggested that the data returned was of reasonable quality. There are clearly areas of Trusts' processes where improvements could be made, for example, relating to how and where information is recorded in case records and the use of headings in progress notes.

Appendix F
Additional analysis

Standard 5: Supported employment and education programmes

N.B. For this standard, the EIP self-assessment 2017/18 carried out analysis only on patients who were not in work, training or education at the time or their initial assessment therefore, we are not able to provide a comparison for the analysis undertaken on the entire sample for this standard.

Breakdown of specific outcome indicators recorded

For those patients who met the outcome indicator (had two or more outcome measures recorded on two or more occasions – at baseline assessment and repeated at one other time point), data were analysed further to determine the different types of outcome measures recorded more than once for each patient (see Table 15).

Table 15: Breakdown of outcome measures recorded more than once for people with FEP who had two or more outcome measures recorded on two or more occasions (n = 2071)

Outcome measure recorded	N (%) of people with outcome measure recorded more than once*
HoNOS/HoNOSCA	2013 (97%)
DIALOG	1770 (85%)
QPR	1585 (77%)
Other	183 (9%)

*Total percentage will be >100% due to multiple outcome indicators being recorded for all patients.

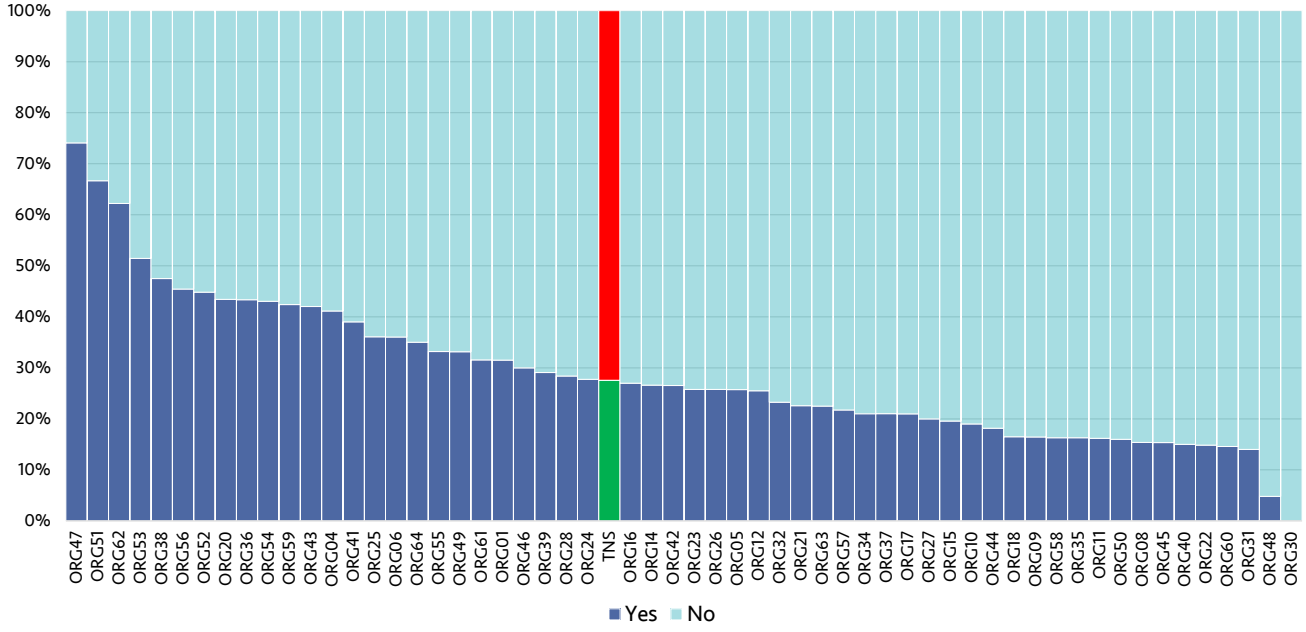

Figure 24: Proportion of people with FEP who have taken up supported employment and education programmes based on the entire national sample (n = 9527)

Appendix G Demographics

Tables 16 and 17 provide the demographic characteristics for the complete sample (n = 9527).

Table 16: Number of patients in the NCAP sample by age and gender (n = 9527)

	Number (%)	Mean age in years (SD)	Age min–max (years)
Total sample	9527 (100%)	30.57 (10.19)	14–65
Male	5892 (62%)	29.26 (9.12)	14–65
Female	3629 (38%)	32.71 (11.41)	15–65
Other/Undefined	6 (<1%)	24.67 (5.35)	18–32

Table 17: Number of patients in the NCAP sample by ethnicity (n = 9527)

Ethnic group	Number (%)
White	6173 (65%)
Black or Black British	1242 (13%)
Asian or Asian British	1191 (13%)
Mixed	401 (4%)
Other ethnic groups	520 (5%)

Appendix H Glossary

A

Antipsychotics: A group of medications that are prescribed to treat people with symptoms of psychosis.

ARMS (At Risk Mental State): A set of subclinical symptoms which do not meet threshold for a psychosis diagnosis. Symptoms may include unusual thoughts, perceptual changes, paranoia, disorganized speech and poor functioning. ARMS patients are considered at risk of developing psychosis or psychotic disorders.

Audit: Clinical audit is a quality improvement process. It seeks to improve patient care and outcomes through a systematic review of care against specific standards or criteria. The results should act as a stimulus to implement improvements in the delivery of treatment and care.

Audit standard: A standard is a specific criterion against which current practice in a service is measured. Standards are often developed from recognised, published guidelines for provision of treatment and care.

B

Benchmark: A standard result that can be used as a basis for comparison.

Blood glucose: Level of sugar in the blood. Measuring this is done to see if someone has diabetes (the term blood glucose is used in this report as a more familiar terminology for non-medical readers than the more correct plasma glucose).

Blood pressure: This gives one measure of how healthy a person's cardiovascular system is, i.e. the functioning of their heart, blood vessels and aspects of their kidney function. It is measured using two levels: systolic and diastolic blood pressure.

Body Mass Index (BMI): This is an indicator of healthy body weight, calculated by dividing the weight in kilograms by the square of the height in metres.

C

Carer: A person, often a spouse, family member or close friend, who provides unpaid emotional and day-to-day support to the service user. In this audit, service users identified their own carers.

Caveat: A factor relating to some (often unavoidable) aspect of the design of a study or problem in the collection of data that should be noted as it may (or may not) have influenced the results.

Cholesterol: An important component of blood lipids (fats) and a factor determining cardiovascular health. If this is high, it may lead to heart problems.

Clinical Commissioning Groups (CCGs): Groups of clinicians led by GPs who take on the role of purchasing local health services in England.

Clinician: A health professional, who sees and treats patients and is responsible for some or all aspects of their care.

Cognitive behavioural therapy (CBT): A form of psychological therapy, which is usually short-term and addresses thoughts and behaviour.

Cognitive behavioural therapy for psychosis (CBTp): A specialist form of CBT that has been developed to help people experiencing psychotic symptoms, most often hallucinations and delusions. It also focuses on reducing distress, anxiety and depression common in psychosis, developing everyday self-management skills and working towards personal goals.

Community Mental Health Team (CMHT): A group of health professionals who specialise in working with people with mental health problems outside of hospitals.

CQUIN: The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. More information regarding the CQUIN can be found at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

D

Diabetes: A long-term condition caused by having high levels of sugar in the blood. There are two types; type 1 diabetes which can be controlled with insulin injections, and type 2 diabetes which can generally be controlled through diet.

Dyslipidaemia: A condition where a person has an abnormal level of one or more types of lipids. Most commonly there is too high a level of lipids which increases the risk of having a heart attack or a stroke.

E

Ethnicity: The fact or state of belonging to a social group that has a common national or cultural tradition.

F

Fasting plasma glucose: A blood test to see if someone has diabetes.

Family Intervention: A structured intervention involving service users and their families or carers. This intervention aims to support families to deal with problems effectively, improve the mental health of all members and reduce the chance of future relapse.

First episode of psychosis (FEP): First episode psychosis is the term used to describe the first time a person experiences a combination of symptoms known as psychosis. Each person's experience and combination of symptoms will be unique. Core clinical symptoms are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms', (such as apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). A range of common mental health problems (including anxiety and depression) and coexisting substance misuse may also be present.

G

General Practitioner (GP): A doctor who works in practices in the community and who is generally the first point of contact for all physical and mental health problems.

Glucose: A type of sugar. The body uses this for energy.

Glycated haemoglobin: *See* HbA1c.

H

Harmful drinking: A pattern of alcohol consumption causing health problems directly related to alcohol.

HbA1c: Glycated haemoglobin. A form of haemoglobin that is bound to the sugar glucose and can provide an indication of how well diabetes is being controlled.

HoNOS: Health of the Nation Outcomes Scales. Developed to measure various aspects of the level of symptoms, social and other functioning and general health of people with severe mental illness.

High Density Lipoprotein (HDL): One of a group of proteins that transport lipids in the blood.

Healthcare Quality Improvement Partnership (HQIP): An organisation which funds clinical audits and works to increase the impact of these to improve quality in healthcare in England and Wales.

Hub and Spoke model: A healthcare model whereby there is a central hub which offers a full array of services, as well as health professionals working within the community and secondary establishments to increase patient access.

Hyperglycaemia: A situation where a person is found to have high blood glucose (sugar) levels above those normally expected. If persistent it usually suggests the person is suffering from diabetes.

Hypertension: High blood pressure. This is a risk factor for heart disease and stroke.

L

Lipids: Fats, such as cholesterol. They are stored in the body and provide us with energy. Levels too far outside of the normal range increase risk of certain diseases.

M

Mental Health Services Data Set (MHSDS): An approved NHS Information Standard that contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services.

mmHg: Millimeters of mercury.

mmol/l: Millimoles per litre.

Multidisciplinary: Usually refers to a team of health professionals from different professional backgrounds.

N

National Clinical Audit Programme (NCAPOP): A closely linked set of centrally-funded national clinical audit projects that collect data on compliance with evidence-based standards and provide local Trusts with benchmarked reports on the compliance and performance. The programme is funded by NHS England and the Welsh Government.

National guidelines: Nationally agreed documents which recommend the best way of doing something, for example treating a mental health problem.

NHS England: The National Health Service (NHS) England exists to care for people. Their goal is to provide

high quality care for everyone, now and in the future. At a more local level, NHS England works together with Clinical Commissioning Groups (CCGs) who deliver health services locally, and local authorities (Councils) to make shared plans for services that put patients at the centre (http://www.england.nhs.uk/).

NICE (National Institute for Health and Clinical Excellence): An independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health.

NICE guideline: Guidelines on the treatment and care of people with a specific disease or condition in the NHS.

NICE quality standard: Quality standards set out the priority areas for quality improvement and cover areas which have a variation in care. Each standard includes a set of statements to help services improve quality and information on how to measure progress.

O

Obesity: An abnormal accumulation of body fat, usually 20% or more over an individual's ideal body weight. Obesity is associated with increased risk of illness.

Outcomes: What happens as a result of treatment. For example, this could include recovery and improvement.

Outcome indicators: A measure that shows outcomes.

P

Pre-diabetic state: This describes a state in which some but not all diagnostic criteria for diabetes are met. It is where control of blood sugar levels is not normal but not yet definitely sufficiently abnormal to say that diabetes has developed.

Prescription: The supply of medications under the instruction of a health professional.

Primary care: Healthcare services that are provided in the community. This includes services provided by GPs, nurses and other healthcare professionals, dentists, pharmacists and opticians.

Psychological therapies: Covers a range of interventions designed to improve mental wellbeing. They are delivered by psychologists or other health professionals with specialist training and can be one-to-one sessions or in a group.

Psychosis: A term describing people having specific types of symptoms, and where they may lose touch with reality. Symptoms can include difficulty concentrating and confusion, conviction that something that is not true is so (false beliefs or delusions), sensing things that are not there (hallucinations) and changed feelings and behaviour. Psychosis is treatable. It can affect people of any age and may sometimes be caused by known physical illnesses.

R

Reliable: Consistent over time, for example if different people completed a questionnaire, they would get the same answers. An indication of a good measure or tool.

Royal College of Psychiatrists (RCPsych): The professional and educational body for psychiatrists in the United Kingdom.

S

Secondary care: This refers to care provided by specialist teams in Trusts rather than care provided by general practitioners and primary care services. Mental Health Trusts provide secondary care services, most of which involve care provided in the community rather than in hospitals.

Service user: Person who uses mental health services.

Side effects: A consequence of taking a medication that is in addition to its intended effect. Unlike adverse effects, side effects are not always negative.

SNOMED CT: A structured clinical vocabulary for use in an electronic health record. It is mandatory for use in mental health services as the clinical terminology before 1 April 2020.

Substance misuse: The use of illegal drugs to the extent that it affects daily life. Can also refer to the use of legal drugs without a prescription. Substance misuse can lead to dependence on the substance and can affect the person's mental health.

T

Total national sample (TNS): The combined data set of the national sample.

Trusts: National Health Service (NHS) Trusts are public service organisations that provide healthcare services. They include: Primary Care Trusts; Acute Trusts, which manage hospitals; Care Trusts, which cover both health and social care; Foundation Trusts, which have a degree of financial and operational freedom; and Mental Health Trusts, which provide health and social care services for people affected by mental health problems. The term 'Trust' has been used throughout the report to refer to all Trusts and organisations providing NHS funded EIP services in England.

V

Valid: When an instrument or tool measures what it sets out to it is said to be valid.

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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