NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

HQIP
Healthcare Quality Improvement Partnership

National Clinical Audit of Psychosis

National report for the core audit

Executive summary

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This report presents the findings from the core audit of the National Clinical Audit of Psychosis (NCAP). NCAP was previously known as the National Audit of Schizophrenia (NAS) from which two reports were published: NAS1 in December 2012 and NAS2 in November 2014. NCAP is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcome Programme (NCAPOP), which is funded by NHS England and the Welsh Government.

Background

During the last 10 years, various guidelines and initiatives have been developed, aimed at improving the quality of care that people with psychotic disorders receive. The most important of these is the guideline published by the National Institute for Health and Care Excellence (NICE; CG178 *Psychosis and schizophrenia in adults: treatment and management*, 2014). Initiatives to improve the physical health of people with psychotic disorders include the Quality and Outcomes Framework (QOF), which provides financial incentives for primary care physicians, and the national Mental Health Commissioning for Quality and Innovation (CQUIN), which provides financial incentives for Trusts in England. In 2010, the Welsh Government introduced new legislation aimed at improving the quality of care planning, increasing access to independent mental health advocacy and providing more mental health support in primary care settings. In 2012, a programme was established to improve access to psychological therapies for people with severe mental illness (IAPT-SMI), with the aim of making Cognitive Therapy for Psychosis (CBTp) more available.

Audit standards

The audit has focused on four issues relating to the quality of care provided for people with psychotic disorders: management of physical health, prescribing practice, access to psychological therapies and outcomes. Twelve audit standards and two outcome measures were developed to address these issues.

Full details of the NCAP audit standards and outcome measures are provided on page 10 of the full version of this report.

Method

All English Mental Health Trusts and Welsh Health Boards collaborated in this audit (n=62 organisations). A random sample of patients was generated from a list of all those meeting the audit criteria within each organisation. An audit of practice form was completed for each patient. Data were collected regarding the care of 9,449 patients, an 88% return rate on expected submission.

Previous NAS audits only collected data relating to people with a diagnosis of schizophrenia or schizo-affective disorder living in the community. NCAP included people with a wider range of functional psychotic disorders (though specifically excludes affective psychoses and organic psychoses) and includes inpatients as well as community patients.

Main findings

The main results focus on those patients who were living in the community on the 'census date' for the audit and who had a diagnosis of either schizophrenia or schizo-affective disorder (the NCAP community sub-sample; n=7,773). The findings for this sub-sample are directly comparable to the findings from the two previous audits and are summarised in Tables 1 and 2.

In comparison with the findings from NAS1 and NAS2, the NCAP results show some improvements in monitoring of physical health and substantial improvements in the provision of interventions for identified physical health risk factors. However, overall assessment of risk for cardiovascular disease, with a tool such as Q-Risk, requires more attention. There were also improvements in prescribing practice for antipsychotic medications, with a small reduction in polypharmacy and an important reduction in the proportion of patients being prescribed antipsychotics at doses above those recommended in the British National Formulary (BNF). However, provision of written information, or other appropriate forms of information, to patients about their medication remains poor.

Provision of evidence based psychological therapies remains below the expectation of the NICE guideline (NICE CG178) that all patients should be offered these. Only 36% had been offered some form of CBT and only 26% had been offered CBTp. Only 12% of patients in contact with their families had been offered family intervention. Only one in ten patients in the audit were involved in work or education and less than half of those seeking work had been offered appropriate support to help them find a job.

The findings in relation to those patients who were inpatients (n=689) and those who had diagnoses other than schizophrenia or schizo-affective disorder (n=1,034) are summarised in Tables in the main body of the full version of this report (pages 61–66) and compared with performance against standards for the NCAP community sub-sample.

Conclusions

The audit has collected data about the care provided to a large, random sample of patients from all the main provider organisations in England and Wales. The findings show improvements in aspects of physical healthcare for these patients and in prescribing practice. The provision of information about medication to patients remains poor and the availability of psychological therapies remains low. More needs to be done to assist patients into employment.

Recommendations are presented on pages 4 to 6, following Tables 1 and 2 summarising the findings.

Comparison of findings with those from previous audits

Tables 1 and 2 provide a summary of key comparisons (for the NCAP community sub-sample with diagnoses of schizophrenia and schizo-affective disorder) between the findings in NCAP and the findings from the previous audits, NAS2 and NAS1. In these Tables the standards are listed in order by standard number. Full details of the NCAP standards are provided on page 10 of the full version of this report. Similar summary Tables for the sub-sample of inpatients (n=689) can be found on pages 62–63 (Tables 28 and 29) and for the sub-sample of patients with 'other' diagnoses on pages 65–66 (Tables 32 and 33).

Some of the percentages shown for NAS1 and NAS2 may differ slightly from those in the original reports as these have been recalculated to exclude those patients who were attending Early Intervention (EI) services. Patients attending EI services were not included in NCAP as they will be the subject of a further national audit commencing later in 2018.

In NAS1 and NAS2, body mass index (BMI) was used as the sole measure of information about weight. In NCAP, the audit of practice additionally asked about weight gain > 5 kg over a 3-month period. There were some instances where data for BMI were not supplied but where information regarding weight gain was available. This information was then used as evidence that 'monitoring' had occurred and was used to assess whether or not 'intervention' was required. This allowed equivalence with the 2017/2018 national Mental Health CQUIN, for which this audit had to supply the required data.

Table 1: Key comparisons between NCAP, NAS2 and NAS1 for the community patients sub-sample: standards 1 & 2

Standard/indicator	NCAP	NAS2	NAS1
		%	
Standard 1. Physical health monitoring			
Monitoring of all five CVD risk factors	42	34	27
Monitoring of smoking	86	89	87
Monitoring of BMI/weight	65	52	48
Monitoring of glucose control	59	57	50
Monitoring of lipids	57	58	48
Monitoring of blood pressure	66	62	57
Monitoring of alcohol consumption	87	70	69
Monitoring of substance misuse	86	89	84
Standard 2. Physical health intervention			
Intervention for smoking	79	59	57
Intervention for BMI ≥ 25 kg/m^2	78	70	73
Intervention for abnormal glucose control	75	34	26
Intervention for abnormal lipids	52	29	24
Intervention for elevated blood pressure	58	25	26
Intervention for harmful/hazardous use of alcohol	89	73	71
Intervention for substance misuse	83	72	73

Table 2: Key comparisons between NCAP, NAS2 and NAS1 for the community patients sub-sample: standards 3–12

Standard/indicator	NCAP	NAS2	NAS1
		%	
Standards 3 & 4. Provision of information about medication			
Provision of written (or other appropriate format) information about current antipsychotic drug	30	37	43
Record that patient was involved in the prescribing decision	65	55	62
Record of discussion of benefits and adverse effects	79	66	76
Standards 5 & 6. Prescribing			
Frequency of polypharmacy for those on non-clozapine drugs	10	13	11
Frequency of high dose prescribing	7.5	10	10
Rationale documented where high dose is prescribed	66	37	25
Standards 7 & 8. Poor response to medication (investigation and clozapine)			
Medication adherence has been investigated	75	67	86
Alcohol and substance misuse have been investigated	68	58	79
Patients not in remission and not on clozapine without an appropriate reason	53	24	41
Standard 9. Psychological therapies			
Patients offered CBTp	26	n/a	n/a
Patients offered some form of CBT	36	38	n/a
Patients in contact with their family offered family intervention	12	(18[a])	n/a
Standards 10 & 11. Care planning and crisis planning			
Each patient has a current care plan	93	95	n/a
Information in care plan about crisis contact	88	(74[b])	n/a
Standard 12. Assessment of the needs of carers			
Carer's needs assessed (for those with a carer)	55	n/a	n/a
Employment			
Patients involved in work or study related activity outside the home	11	(10[b])	n/a

a. NAS2 data are not fully comparable because they included patients not in contact with their families.
b. Assessed differently in NAS2 and not directly comparable.
n/a, no data available.

Recommendations

This audit has demonstrated improvements in several important aspects of care, including many highlighted as requiring improvement in our previous NAS1 (2012) and NAS2 (2014) reports. It is important that NHS England and Trusts in England, and NHS Wales and Welsh Health Boards, work to maintain and extend these improvements.

Our main recommendations therefore focus on aspects of care where either little change is evident or where there have been improvements in basic practice, but further steps forward are needed.

Where appropriate we quote recommendations from relevant NICE guidelines (using guideline number and paragraph number, e.g. NICE CG178, 1.3.6.5).

Assessment and intervention for risk of cardiovascular disease

This audit has demonstrated clear improvement in the monitoring of patients for key risk factors for the development of cardiovascular disease (CVD) and diabetes (e.g. BMI, blood lipids) and improvements in the delivery of an appropriate intervention for some of these when individual results require this (e.g. treatment for high blood pressure).

However, it is striking that little attention is being paid to making an overall assessment of the specific risk for CVD. The current NICE guideline for assessment of risk for CVD in the general population (NICE CG181, 1.1.8) advises that this should be done using the Q-Risk tool. The same approach should be applied for all people with psychotic disorders, particularly because evidence suggests they have an intrinsically greater risk for CVD and that this may be added to by weight gain and diabetes, often secondary to treatment with antipsychotic medications. Q-Risk is also recommended in the Lester Resource (Shiers et al, 2014) as part of the assessment of any requirement for lipid modification. In this audit only 4% of patients had a record of a Q-Risk2 score (see pages 33–34).

While Q-Risk has some limitations for younger people, and probably underestimates risk for CVD in people with psychosis, it is currently the most readily available and widely used tool for assessing CVD risk in the UK. A new version, Q-Risk3, is likely to become the standard version later in 2018. Q-Risk3 has amendments intended, in part, to make it more applicable to people with psychosis. It is possible that a specific 'CVD risk assessment tool' for people with severe mental illnesses, developed on a UK population, may become available within the next few years, but at present Q-Risk represents the best available practical approach.

RECOMMENDATION 1

Ensure that all people with psychosis:

- have at least an annual assessment of cardiovascular risk (using the current version of Q-Risk)
- receive appropriate interventions informed by the results of this assessment
- have the results of this assessment and the details of interventions offered recorded in their case record.

Psychological therapies and family interventions

This audit found no change in the proportion of patients who have been offered CBT (all types of CBT combined). In NCAP we have separated CBTp (cognitive behavioural therapy for psychosis – a specific form of CBT requiring specified training of the staff delivering it) from other, less specified, forms of CBT that have been available for many years. In NCAP, the sum of those offered CBTp *plus* those offered a less 'specified' form of CBT (36%) is similar to the proportion of patients offered CBT (not specifically defined) in NAS2 (38%). In NCAP, 26% were offered CBTp, the most appropriate form of CBT for people with a psychotic illness. In a national audit of Early

Intervention for Psychosis services (AEIP, 2016), only 41% of patients with a first episode of psychosis or suspected psychosis had been offered CBTp.

The proportions in both audits do not reflect guidance from NICE (NICE CG178, 1.4.4.1) in which it is recommended that all patients with psychosis should be offered CBTp.

Almost identical comments can be made regarding the offer of a family intervention. The proportion of patients offered such in NCAP (12%) is lower than in NAS2 (18%) and much lower than the 31% offered such in the audit of Early Intervention services. One problem here is that for older patients it can be difficult in practice to ascertain from examining clinical records whether such interventions were offered at an earlier stage in a person's illness.

However, for both CBTp and family interventions the audit findings from Trusts and Health Boards indicate that in many cases these therapies were either not available or were available but not offered. Both responses suggest a lack of availability of appropriately trained staff and/or a lack of awareness within some clinical teams that these should be offered.

RECOMMENDATION 2

Ensure that all people with psychosis are offered CBTp and family interventions, by:

- deploying sufficient numbers of trained staff who can deliver these interventions
- making sure that staff and clinical teams are aware of how and when to refer people for these treatments.

Provision of written information to patients

Trusts and Health Boards reported that in only 30% of cases did they know that a patient had been provided with written (or other appropriate) information regarding their antipsychotic medication. Yet 79% reported that the benefits and adverse effects of treatment had been discussed with the patient.

NICE guidance requires that patients are given information about their treatment as well as being involved in a discussion about it (NICE CG178, 1.3.5.1).

RECOMMENDATION 3

Ensure that all people with psychosis:

- are given written or online information about the antipsychotic medication they are prescribed
- are involved in the prescribing decision, including having a documented discussion about benefits and adverse effects of the medication.

Employment and training opportunities

This audit found that only 11% of patients were involved in some form of work or study-related activity outside the home. Of those patients who were unemployed and actively seeking work, only 46% had been offered some form of appropriate programme to help them with this. Of the total population included in the audit, 58% were regarded as being 'long-term sick or disabled and receiving benefits'' and a further 16% were 'not working or seeking work'. These figures suggest a lack of real commitment to address the issue of helping people towards employment or into appropriate training opportunities.

NICE guidance (NICE CG178, 1.5.8.1) requires Trusts and Health Boards to make active steps to support patients towards employment.

RECOMMENDATION 4

Ensure that all people with psychosis who are unable to attend mainstream education, training or work, are offered alternative educational or occupational activities according to their individual needs; and that interventions offered are documented in their care plan.

Annual Summary of Care

In an audit of this nature, the collection of data requires that the relevant information can be found relatively easily in the patients' case records. In most Trusts/Health Boards there is no regular, systematic collation of important information. For example, Trusts are often not able to say whether a patient has, at some point in their history, been considered for CBTp or whether this has been deemed unnecessary or inappropriate. For patients who are not in remission it is often not immediately clear if a trial of clozapine has been considered or perhaps failed in the past.

RECOMMENDATION 5

An Annual Summary of Care should be recorded for each patient in the digital care record. This should:

- include information on medication history, therapies offered and physical health monitoring/ interventions
- be updated annually
- be shared with the patient and their primary care team.

Use of data in conjunction with NHS Digital

NCAP, and previously NAS1 and NAS2, have demonstrated that there are certain key indicators of clinical

performance where there is a very wide range of performance across Trusts/Health Boards. It is also clear that considerable effort is involved in trying to collect and collate the data required to assess these indicators. Yet, much of this information is, or should be, routinely available within Trusts/Health Boards.

NHS systems, such as NHS Digital and NHS Wales Informatics Service (NWIS), informed by the experience of NCAP and similar audits, should develop systems to collect and collate selected information that would routinely allow Trusts, Health Boards and Commissioners to monitor how local services are performing. In England, this information should feed into the Mental Health Services Data Set using SNOMED codes. Collation of such information would be valuable to individual Trusts/Health Boards who could more rapidly identify areas where care was deficient – and then institute local audits to define such issues in more detail.

RECOMMENDATION 6

NHS Digital, NWIS, Commissioners, Trusts and Health Boards should work together to put in place key indicators for which data can easily be collected, perhaps using an Annual Summary of Care (see Recommendation 5, above). This work should be informed by the NCAP results and the experience of the NCAP team.

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For information about the report, please contact the NCAP team: ncap@rcpsych.ac.uk
A full version is available at www.rcpsych.ac.uk/NCAP

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Cover image: Clouds, by Lynda. Image courtesy of The Bethlem Gallery