RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | NCAP NATIONAL CLINICAL AUDIT OF PSYCHOSIS

National Clinical Audit of Psychosis

Early Intervention in Psychosis Audit 2024

Guidance on data collection:
Contextual and Casenote Questionnaires

Contents

About this guidance

This guidance has been provided to assist your Trust/Organisation in collecting data for the Early Intervention in Psychosis (EIP) audit of the National Clinical Audit of Psychosis (NCAP) 2023.

There will be no national or local reports for this audit, all results will be displayed on an online dashboard. The dashboard will update as data is entered. Final datasets will be available on the dashboard once all Trusts have finished entering data.

Timeline

29 January 2024	The NCAP team returns random sample of patients for inclusion in the EIP casenote audit to Trusts/Organisations.
1 February – 31st March 2024	Trusts/Organisations collect data and submit data online (the link to the online data collection platform will be emailed to NCAP audit leads)
31 March 2024	Deadline for Trusts/Organisations to submit data online
5th June 2024	Final datasets available on dashboard

Data collection

Each team is asked to complete:

- One Contextual Questionnaire;
- One Casenote Audit Questionnaire **per service user** identified in your team's random sample for the casenote audit.

An editable version of the casenote and contextual questionnaires have been emailed to the audit leads for your reference only. All required questionnaires must be submitted online by **29th March 2024** via the link provided to the audit contact by the NCAP project team.

Please ensure you review your submissions to check that the data is correct before locking them (see Audit dashboard guidance for further information).

Contextual Questionnaire

All responses should be completed for your individual EIP team and not the Trust/Organisation as a whole. All questions are mandatory.

Service set up

Q1.4-1.5 Type of EI services
This question relates to the type of EI services offered by your individual EIP team and not the Trust/Organisation as a whole.

Type of EIP service:

- **Stand-alone multidisciplinary EIP team**: The service is provided through a stand-alone specialist team which works independently from other generic Community Mental Health Teams (CMHTs). All staff work predominantly for the team and have a shared task to provide EIP services.
- **Hub and spoke model:** The service is provided by dedicated EIP staff ('spokes') which are based within more generic community mental health teams and have access to specialist EIP skills, support and supervision in an EIP 'hub'.
- **EI function integrated into a community mental health team (CMHT):** The service is provided by staff embedded within an existing service, normally a Community Mental Health Team (CMHT). Staff are expected to follow the core principles of EIP care but have less contact with other people for specialist EIP skills, support and supervision.
- **No EI Service:** There is no specialist service.

Q1.6-1.8 Provision of Cognitive Behavioural Therapy (CBT) for At-Risk Mental State (ARMS)
Please ensure that you only answer that CBT for ARMS can be provided within the team or that there is a separate team providing ARMS assessment and intervention if the person delivering the treatment had the relevant skills, experience and competencies.

Provision for Children and Young People

Q2.1 The main model of provision for children and young people
If CYP with psychosis are treated by a separate team in your area, please do liaise with your local team, where appropriate, before completing this section of the questionnaire.

Q2.2 Shared care protocols between the EIP team and the wider CYP mental health service
Shared care protocols should be jointly agreed and implemented between the EIP team, irrespective of age range, and the wider CYP mental health service.

Q2.3 Regular joint or reciprocal training between the EIP team and the wider CYP mental health service
Joint or reciprocal training should be at least annual.

Q2.4 Medication management for CYP
Medication management may involve medical and non-medical prescribers from EIP and/or CYP mental health teams. This question addresses the training and support available to the respective practitioners.

Q2.5 Availability of Cognitive Behavioural Therapy for Psychosis (CBTp) and Family Intervention (FI) for CYP

Please ensure that the person who delivers the following treatments has the relevant skills, experience and competencies defined as:

Cognitive Behavioural Therapy for Psychosis (CBTp):

- Postgraduate diploma level training in generic CBT or equivalent (e.g. IAPT high intensity training or some clinical psychology training programmes), plus additional specialised CBTp training. Those who have completed generic training in CBT and are currently undertaking specialist CBTp training with regular clinical supervision can be included.
- Early cohorts of practitioners involved in developing CBTp may have undertaken a different route to competence. This might have involved:
    - Being a therapist in a CBTp research trial with supervision from an expert in the field;
    - Evidence of attending CBTp conferences (after receiving generic CBT training), with regular supervision from an expert in the field).
- CBTp therapists should also be receiving regular clinical supervision from a supervisor with appropriate CBTp competencies, for a minimum of an hour per month.
- Training in generic psychosocial interventions (PSI), generic CBT alone or short training courses in CBTp alone are not considered sufficient to deliver NICE recommended CBTp.
- CBTp courses should follow curricula derived from the national competence framework.

Family Intervention (FI):

- The competencies required to deliver FI are described in "Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder".
- Practitioners delivering this approach require specific FI training focused on psychosis (based on recommendations in NICE guidelines CG178), lasting five days or more (e.g. Meriden's 5 day "Early Intervention in Psychosis Behavioural Family Therapy Training" or equivalent).
- All staff delivering FI should receive clinical supervision for at least one hour per month if they are actively seeing families, and supervisors must have received training in a FI course and be experienced in providing FI.

Q2.6 Availability of care coordinators specifically for CYP

You can find the definition of a care coordinator on page 21 of the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance.

Casenote Questionnaire

Please complete one casenote questionnaire per service user selected as part of the team's random sample. All questions are mandatory unless otherwise stated.

Demographic Information

Patient ID (NCAP ID)
Please input the anonymised NCAP ID assigned to the patient during sampling e.g. NCAP01. Do not input other information such as initials, electronic record numbers or any other information which could be identifiable.

Q1.2 Age
Only service users aged 65 years and under are eligible to take part in the NCAP EIP Bespoke 2024 audit (at date of sampling, 2nd January 2024).

Q1.3 Gender
For service users who have not specified a gender, or who do not identify themselves as male or female please select the 'other' option.

Q1.4 Ethnicity
For ethnicities not included in the list please select 'any other ethnic background'.

Timely Access

Q25 Date referral received by EIP service or central triage point in the Health Board
This is for the condition being referred to the EIP services, and not previous referrals to mental health services for unrelated issues. If there is a central triage point in your Health Board, please give the date referral received at this point. Only give the date referral received by the EIP service if there is no central triage point in your Health Board. Referrals may come from any source and may be internal (for example from CAMHS, a CMHT, an inpatient ward, prison or forensic mental health services) or external (for example from a GP, self-referral, from carers or referral by a school).

Q1.6 Allocation of an EIP service care coordinator
Please select yes if the patient has been allocated to a care coordinator and specify the date.

Q1.7 Engagement by an EIP service care coordinator
Engagement by the care coordinator should begin immediately upon allocation. However, this might not always be the case. Engagement means that the care coordinator began to form a therapeutic professional relationship with the patients and treatment was started. Please choose 'yes' only if a therapeutic professional relationship has begun to be established and treatment has started. If 'yes', please specify the date treatment was started. Note: This question will only appear if the person has been allocated an EIP care coordinator.

Effective Treatment

Q2.1 Cognitive Behavioural Therapy for Psychosis (CBTp)
Please select 'took up' if the service user received at least one session of any of the treatments listed. If the service user was offered, but refused, any of the treatments, please select 'declined'.

If a service user is receiving a psychological intervention as part of a research trial the team are taking part in, these sessions can be counted as meeting the standard, as long as they are offered alongside traditional therapies. Teams should let the NCAP team know if this is the case.

Please ensure that the person who delivered CBTp had the relevant skills, experience and competencies defined as:

- Postgraduate diploma level training in generic CBT or equivalent (e.g. IAPT high intensity training or some clinical psychology training programmes), plus additional specialised CBTp training. Those who have completed generic training in CBT and are currently undertaking specialist CBTp training with regular clinical supervision can be included.
- Early cohorts of practitioners involved in developing CBTp may have undertaken a different route to competence. This might have involved:
    - Being a therapist in a CBTp research trial with supervision from an expert in the field;
    - Evidence of attending CBTp conferences (after receiving generic CBT training), with regular supervision from an expert in the field).
- CBTp therapists should also be receiving regular clinical supervision from a supervisor with appropriate CBTp competencies, for a minimum of an hour per month.
- Training in generic psychosocial interventions (PSI), generic CBT alone or short training courses in CBTp alone are not considered sufficient to deliver NICE recommended CBTp.
- CBTp courses should follow curricula derived from the national competence framework.

Q2.2.1 Work, education and training
This includes voluntary positions.

Q2.2.2 Supported employment programmes
Note: This question only appears if the auditor answers either 'no option to Q2.2.1.

Please select 'took up' if the service user received at least one session of any of the treatments listed. If the service user was offered, but refused, any of the treatments, please select 'declined'.

- Staff offering education and employment support should have the relevant experience, skills and competencies in delivering specialist education and employment support (e.g. has received specialist training in IPS or similar specialist vocational rehabilitation training) and who has up-to-date welfare benefits knowledge and expertise.
- This may be from a vocational specialist or an occupational therapist based within the EIP team, or the service user may be referred for support from an education and employment specialist/service provided elsewhere in the Trust or by a voluntary or private sector provider.

Q2.3 Family Intervention (FI)
Please select 'took up' if the service user received at least one session of any of the treatments listed. If the service user was offered, but refused, any of the treatments, please select 'declined'.

If a service user is receiving a psychological intervention as part of a research trial the team are taking part in, these sessions can be counted as meeting the standard, as long as they are offered alongside traditional therapies. Teams should let the NCAP team know if this is the case.

Please ensure that the person who delivered FI had the relevant skills, experience and competencies defined as:

- The competencies required to deliver FI are described in "Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder".
- Practitioners delivering this approach require specific FI training focused on psychosis (based on recommendations in NICE guidelines CG178), lasting five days or more (e.g. Meriden's 10 days "Early Intervention in Psychosis Behavioural Family Therapy Training" or equivalent).
- All staff delivering FI should receive clinical supervision for at least one hour per month if they are actively seeing families, and supervisors must have received training in a FI course and be experienced in providing FI.

Q2.4.1 Family members, friend and carer
Where this is not recorded, please select 'no'.

Q2.4.2 Carer-focused education and support programme
Note: This question only appears if the auditor answers either 'yes' option to Q2.4.1.

If the service user has more than one informal carer, please select 'yes' if a programme(s) has been taken up by at least one carer.

A carer-focused education and support programme must include at least one of the following interventions:

- One-to-one advice and information
- Access to carer focused education and support via recovery college courses
- Carer education and support groups
- e-health: evidence-based web- or app-based carer education and support programmes

Please note that carers' assessments do not constitute a carer-focused education or support programme.

Physical health screening and intervention

To ascertain if an individual requires intervention based on their physical health screening, please refer to the Lester Tool. Please note that the intervention questions will only be available to answer if it is indicated that the individual requires intervention as per the Lester tool. This information is ascertained from questions related to screening.

The following questions relate to evidence of screening and interventions carried out between **01/03/2022** and **28/02/2023**, while the service user was on the EIP caseload. If the service user was accepted onto the caseload over a year ago, only screening and interventions that took place between **01/03/2022** and **28/02/2023** accepted. If this is not present, please tick 'not documented'.

Please tick all interventions that apply. Interventions can include attending services which the person has been signposted to.

Q2.5.1 Smoking status
Please note that this does **not** include e-cigarettes.

Q2.5.2 Interventions for smoking cessation
If an intervention was not required because the service user does not smoke, please select 'No intervention needed'.

Q2.5.3 Drinking alcohol

Identification of harmful or hazardous use of alcohol is described in NICE guideline CG115. It may be assessed using structured measures such as the 'AUDIT' or based on enquiring about quantity, frequency and any health or social consequences of alcohol consumption. Where there is a record of drinking that is neither harmful nor hazardous e.g. 'rarely drinks'/ 'drinks in moderation' this should be recorded as 'Alcohol use that is NOT harmful or hazardous'.

Q2.5.4 Interventions for hazardous alcohol use
If an intervention was not required because the service user does not use alcohol in a harmful or hazardous way, please select 'No intervention needed'.

Q2.5.5 Substance misuse
Substance misuse is defined as the excessive or illegal use of drugs.

Q2.5.6 Interventions for substance use
If an intervention was not required because the service user does not use substances, please select 'No intervention needed'.

Q2.5.7 BMI/Weight
Please complete in NN.N format e.g. 26.8 (BMI). Where height cannot be measured, demi span may be used to estimate height in order to allow calculation of BMI:
http://www.bapen.org.uk/pdfs/must/must_explan.pdf (page 14).

Q2.5.7.1 Rapid weight gain and Antipsychotic medication
Rapid weight gain is defined as more than 5% weight gain (average 3-4kg) 4 weeks after starting a new antipsychotic medication as per the Lester Tool.

Q2.5.8 Interventions for weight gain/obesity
If an intervention was not required because the service user did not need an intervention for weight management, please select 'No intervention needed'.

Q2.5.9 Blood pressure
Please complete the systolic and/or diastolic boxes in NNN format e.g. 120 mmHg.

Q2.5.10 Interventions for hypertension
If an intervention was not required because the service user did not need an intervention for hypertension, please select 'No intervention needed'. Please note that there is also an option if an intervention was not required because the service user's repeat blood pressure reading was normal.

Q2.5.11 Glucose
Please complete in N.N format e.g. 6.7 mmol/mol. Please ensure you use the correct units. If these levels are in mg/dl, please use an online converter to calculate into mmol/l or mmol/mol (according to data collection form). One such converter can be found at http://www.diabetes.co.uk/blood-sugar-converter.html

Q2.5.12 Interventions for diabetes/high risk of diabetes
If an intervention was not required because the service user was not at risk of diabetes, please select 'No intervention needed'.

Q2.5.13 Cholesterol
Please complete in N.N format e.g. 7.5 mmol/l. Please ensure you use the correct units. If entering QRISK percentage score, please complete in NN.N format e.g. 14.3%. If entering Total cholesterol: HDL ratio, please complete in NN.N format e.g. 4.5. Please note, Total cholesterol: HDL ratio should

only be provided along with another cholesterol measure (Total cholesterol, non-HDL cholesterol or QRISK score).

Q2.5.14 Interventions for dyslipidaemia
If an intervention was not required because it is not applicable to the service user, please select 'No intervention needed'.

Recording Outcome Measures

Q3.1-3.5 Outcome measures
Only the following standardised and validated outcome measures are accepted to meet the standard for this question:

- HONOS
- HONOSCa
- DIALOG
- QPR
- GBO
- ReQoL-10

There is also the option to record 'other' outcome measures if wished. Please note that any 'other' outcome measures specified will not be included when calculating whether the standard was met for patients aged 18 and over. Information should therefore be recorded in addition to the measures specified above.

Please note that if a **service user is under 18**, and DIALOG and QPR are not suitable, another tool measuring general functioning should be recorded

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Additional Questions

Q4.1 Two adequate but unsuccessful trials of antipsychotic medications
An adequate trial is defined as: If tolerated, each medication is given in a treatment dose for an adequate duration of time and with objective evidence of adherence. A comprehensive review of reasons for a non-response (e.g. intolerant to adverse effects, misdiagnosis, untreated co-morbidities) must be undertaken.

If a service user's illness has not responded to two or more antipsychotic medicines given sequentially, they should be offered clozapine (see below).

Q4.2 Clozapine
Note: This question only appears if the auditor answers 'yes' to Q4.1.

Contact information

For queries about the data collection process please contact a member of the NCAP team:

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