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 Wales
Early Intervention in Psychosis Audit

2020/21

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

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Cover image ‘The Teal Tiger’ by Veenu Gupta

Designed and typeset by Helen Greenwood.

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Foreword

Ten years ago, I was trying to time travel in my hut on the beach in Thailand. I experienced hallucinations, delusions and paranoia as I was not eating, drinking or sleeping properly and I had stopped taking my medication. This meant that I became consumed by my psychosis and thought I was uncovering the mysteries of the universe in a hammock on the beach, watching the moon on the horizon and the formation of waves crashing the shore, that I attributed to the forces of gravity. When I got back to England, Early Intervention in Psychosis (EIP) services brought me back down to reality and supported me in my recovery, to better understand my early warning signs and triggers, and taught me methods to manage and remain well.

Ten years on, I have come a long way and I am now part of the team that conducts NCAP, as a service user advisor. I apply my lived experience to ensure the audit focuses on the needs of the service user, and I am currently realising my dreams doing a PhD in psychology. Recovery is possible and most likely looks different for all service users. EIP services support people to shape this and provide tools to living alongside psychosis or moving on from it.

My experience of EIP services was a good one, and services have come a long way since then. They have evolved over time, and adapted and changed with the needs of the service users and the contexts they are rooted in. The audit is designed to capture EIP provision, which includes a combination of interventions, including medication, cognitive behavioural therapy for psychosis, family intervention, physical health intervention and monitoring, social, housing and employment support.

The results of this and previous audits provide evidence of the good work being done by EIP services. As a service user advisor, I guide and support the team in collecting the audit data and developing recommendations based on the results. EIP services have done a lot to enhance service user involvement in guiding and informing service provision, and should strive to do more. I feel that more could also be done to challenge stigma and ensure that services support people who experience stigma in the future. Moreover, psychosis disproportionately affects people from minority backgrounds and greater effort needs to be made to understand this and its causes. Mental health professionals also need to do more to challenge the discrimination and racism that can trigger psychosis.

Travelling through time, and to our current context, there have been recent challenges along the way. Since the previous round of the national audit, COVID-19 has had a huge impact on the lives of people who provide and use mental health services. People have had to find ways to provide services while maintaining social distancing, and had to find ways to work more flexibly and creatively. This report highlights some of the good practice and innovative work that EIP teams have been doing to support people with psychosis during the pandemic. Services have had to adapt rapidly during this time, while maintaining quality and compassion towards their service users throughout.

I wanted to say thank you to the NCAP team for suggesting I write this foreword and for their dedicated hard work on the audit. Another big thank you to services that supported me in my times of need, and to the many other teams that are helping others with psychosis, too. The work you do makes a difference, so thank you. You have a lasting impact on the many lives you touch, and you stay with us wherever we go. Finally, a big thank you to all the service users and service providers who allow us to learn from their experiences through the data. The experiences and stories of psychosis are never the same but the quality of care and compassion from services can be.

As I have grown through the years, I feel a need to reconnect with the roots of my psychosis. I'm hoping to return to Thailand in the future and create new memories associated with it, like travelling back in time and reimagining it.

Veenu Gupta, Service User Advisor NCAP audit

Key messages in this report

- There is wide variability between EIP services in Wales in terms of timely access, standards met, workforce capacity, staff competencies and resources as well as in the offer, take up and refusal of interventions.
- CYP under 18 with FEP across Wales currently do not have the same access to specialist EIP expertise, care co-ordination and the full range of evidence-based EIP interventions as adults with a first episode of psychosis.
- Screening for all 7 physical health care risks remains low and its importance needs to be understood within EIP services. Where screening for cardiovascular disease or diabetes indicates a health risk for an individual patient, the appropriate interventions are not routinely being offered in response.
- Caseloads across EIP services in Wales are low and do not reflect the expected incidence of first episode psychosis. There is a need to increase the case finding by EIP services to address unmet need and ensure equitable access to EIP service provision across Wales.
- The importance of timely access to EIP services and evidence-based interventions for all people with a first episode psychosis needs to be reinforced by Welsh Government and NHS Wales to ensure this is prioritised by all Health Boards across Wales.

Summary

The audit shows continued improvement on several standards including timely access, take up of supported employment and education, several physical health screening measures and offer of physical health interventions. There is evidence of decline in the offer of clozapine, physical health interventions in response to elevated blood pressure and abnormal blood glucose levels and the take up of carer-focused education and support. It is likely that the COVID-19 pandemic may have had an adverse impact on provision and slowed progress in achieving greater take up of psychological interventions and outcome measurement. The report recommendations address key findings from the data.

1. Introduction

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

The aim of NCAP is to improve the quality of care that NHS mental health Trusts in England, Health Boards in Wales and the Health Service Executive in Ireland provide to people with psychosis. Services are measured against criteria relating to the care and treatment they provide, so that the quality of care can be improved.

The audit is a 5-year programme, commissioned by HQIP on behalf of NHS England, NHS Improvement and the Welsh Government. The first year of the audit (2017/2018) examined care provided to people with psychosis by inpatient and outpatient services; in the second (2018/2019), third (2019/2020) and fourth (2020/2021) years, the audit looked at the care provided by EIP services. In the third year, a service user survey was developed to allow service users to feed back on their experience of EIP services. NCAP worked with people who had experience of EIP services to develop the survey, which asked about the elements of care they felt were important. All reports and their associated documents can be found on the College Centre for Quality Improvement (CCQI) audit reports web page.

For the second time, we are publishing a separate national report for Wales. The first report was published in 2020 due to the earlier developmental stage of EIP services in Wales, and to provide a focus for results from Welsh services and quality improvement work. In 2012, Together for Mental Health (Welsh Government, 2012), a 10-year cross-governmental strategy to improve mental health and wellbeing, identified the development of services for the treatment of people with FEP as a priority. This strategy has been supported by delivery plans. The 2016–2019 delivery plan (Welsh Government, 2016) focused on setting up EIP teams in all Health Boards, and the assessment and provision of National Institute for Health and Care Excellence (NICE)-compliant treatment to 14–25-year-olds with an emerging psychosis. The most recent plan covering 2019–2022 (Welsh Government, 2020) requires the Welsh EIP National Steering Group and Community of Practice[1] to work with the Royal College of Psychiatrists to develop and embed best practice service models in line with standards.

This has been an exceptionally challenging year for healthcare services, with many aspects of their delivery impacted by COVID-19. It is therefore encouraging that at a national level, some data from the 2020/2021 round of the audit does show improvements or maintenance at the same levels as last year's 2019/2020 audit findings. However, other results have been affected, so it is important to look at the data from across teams in Wales to get the fullest picture of service quality, and to consider the impact on staff, and, most importantly, on people using the services and their families.

The standards for the EIP audit are based on the 2016 Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & National Collaborating Centre for Mental Health, 2016), which details a NICE-recommended package of EIP care for treating and managing early psychosis (NICE quality standard 80, 2015; NICE quality standard 102, 2015).

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

2. Methodology

2020

July — 

Health Boards in Wales providing EIP services identify all eligible people on their caseload

Aug

Sept — Health boards submit list of all eligible people to NCAP

NCAP identify a random sample of up to 100 people per team

Oct — **Health Boards collect data on their sample**
Questions about care provided according to the standards (based on NICE guidance on treating and managing psychosis and EIP Access and Waiting Time Standard)

Nov — **Health Boards submit data on their sample**
(Deadline 30th November)

Dec — Data cleaning carried out by NCAP
265 returns from 6 Health Boards

2021

Jan

Feb

Mar — Data analysis and report writing begins

Service user and carer reference group - results provided and discussed

Apr — Preliminary data presented to the Steering Group and recommendations discussed

Report to HQIP and Welsh Government for sign-off

May — Preparation for publication

Summer — National report and lay report published, team-level and Health Board-level reports provided to teams

You can find a PDF of the audit sampling criteria on our website.

3. Findings

Table 1 provides an overview of Health Board performance against access and treatment for people experiencing FEP. This is shown alongside data for Wales from the NCAP EIP Audit 2019/20 and audit data from the England 2020/21 national sample.

Please note, where EIP services in Wales are not stand-alone (see table 2), there are differences regarding classification of service provision that may not meet the criteria for EIP services, therefore some of the data submitted to this audit will not fully meet the audit requirements for EIP services. However, the cases submitted did relate to people identified as having an early intervention need. Improvement Cymru plan to work with EIP teams in relation to the NCAP definitions and developing EIP in a Welsh context.

Table 1: Key comparisons between NCAP EIP Audit 2020/21 and 2019/20

Standard/indicator	NCAP 2020/21 Wales % (n=248)	NCAP 2019/20 Wales % (n=205)	NCAP 2020/21 England % (n=10,033)
Standard 1: Timely access			
Treatment started within 2 weeks of referral[2]	36%	33%	72%
Standards 2 & 3: Take-up of psychological therapies			
Cognitive behavioural therapy for psychosis (CBTp)	52%	51%	46%
Family intervention (FI)	25%	24%	21%
Standard 4: Prescribing			
Offered clozapine[3]	61%	66%	50%
Standard 5: Take-up of supported employment and education programmes			
Supported employment and education programmes[4]	25%	18%	31%
Standard 6: Physical health monitoring[5]			
All 7 screening measures	24%	21%	70%
Smoking	77%	80%	91%
Alcohol use	85%	83%	91%
Substance misuse	89%	91%	91%
Body mass index	49%	38%	84%
Blood pressure	51%	46%	84%
Blood glucose	43%	38%	79%
Lipids	42%	36%	79%

2 Data for this standard in England are from Early Intervention in Psychosis Waiting Times (NHS Digital, 2020).
3 Of those who had not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs.
4 Of those not in work, education, or training at the time of their initial assessment.
5 Taken up or refused.

Table 1 continued:

Standard 7: Physical health interventions[6]			
Smoking	70%	38%	92%
Harmful/hazardous use of alcohol	95%	74%	95%
Substance misuse	81%	52%	93%
Weight/obesity	64%	48%	85%
Elevated blood pressure	7%	17%	70%
Abnormal glucose control	38%	60%	77%
Abnormal lipids	-	-	69%
Standard 8: Take-up of carer-focused education and support programmes			
Carer-focused education and support programmes[7]	23%	44%	53%
Clinical outcome measurement			
2 or more outcome measures were recorded at least twice[8]	7%	5%	55%

6 Of those who were identified as requiring an intervention based on their screening for each measure.
7 Of those with an identified carer. Data for 2019/20 includes take-up and referral to carer-focused education and support programmes.
8 Wales: DIALOG (patient reported outcome measure developed for people with psychosis) and 'Other'; England: Health of the Nation Outcome Scale/Health of the Nation Outcome Scale for Children and Adolescents, DIALOG, Questionnaire about the Process of Recovery (and 'other' for under 18s).

Service level data

Table 2 Contextual questionnaire: Wales (9 teams submitted data) and England (150 teams submitted data)

	Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
Q1. Routinely collected demographic data			
Protected characteristics			
Age	9 (100%)	6 (100%)	150 (100%)
Disability	2 (22%)	4 (67%)	139 (93%)
Gender reassignment	3 (33%)	3 (50%)	89 (59%)
Marriage and civil partnership	3 (33%)	4 (67%)	146 (97%)
Pregnancy and maternity	2 (22%)	4 (67%)	110 (73%)
Race	6 (67%)	5 (83%)	145 (97%)
Religion or belief	7 (78%)	5 (83%)	143 (95%)
Sex	9 (100%)	6 (100%)	147 (98%)
Sexual orientation	2 (22%)	3 (50%)	123 (82%)
None	0 (0%)	-	-
Other demographic data			
Socioeconomic status	4 (44%)	4 (67%)	98 (65%)
Refugees/asylum seekers	4 (44%)	2 (33%)	74 (49%)

Table 2 continued:

		Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
Migrant workers		3 (33%)	2 (33%)	47 (31%)
Homelessness		4 (44%)	2 (33%)	134 (89%)
Q2. Written strategy/strategies to identify and address any mental health inequalities				
Yes		1 (11%)	2 (33%)	96 (64%)
No		8 (89%)	4 (67%)	54 (36%)
Q3. Early intervention (EI) service provided for these age ranges				
18–35 years	Stand-alone multidisciplinary EIP team	4 (44%)	2 (33%)	139 (93%)
	Hub-and-spoke model	0 (0%)	2 (33%)	1 (<1%)
	Integrated community mental health team (CMHT)	4 (44%)	2 (33%)	9 (6%)
	No EI service	1 (11%)	0 (0%)	1 (<1%)
36 years and over	Stand-alone multidisciplinary EIP team	1 (11%)	1 (17%)	121 (81%)
	Hub-and-spoke model	0 (0%)	1 (17%)	3 (2%)
	Integrated CMHT	1 (11%)	0 (0%)	13 (9%)
	No EI service	7 (78%)	4 (67%)	13 (9%)
Q4. Length of treatment packages for different age ranges				
Under 18 years	Number of services	5	5	139
	Mean months (Standard Deviation [SD])	36 (0)	36 (0)	35.59 (3.45)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	45 (3–48)
18–35 years	Number of services	8	6	149
	Mean months (SD)	36 (0)	36 (0)	35.38 (3.44)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	33 (3–36)
36 years and over	Number of services	1	2	137
	Mean months (SD)	36 (0)	36 (0)	33.82 (5.64)
	Range (min.–max.) months	0 (36–36)	0 (36–36)	34 (2–36)

Table 2 continued:

	Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
Q5a. Model of provision for children and young people (CYP)[9]			
Specialist EIP team embedded within CYP mental health services	0 (0%)	3 (50%)	15 (10%)
Specialist CYP EIP team	1 (11%)	1 (17%)	9 (6%)
Adult and young people's EIP service with staff that have expertise in CYP mental health (CYPMH)	1 (11%)	2 (33%)	51 (34%)
Adult EIP service with joint protocols with CYPMH services	3 (33%)	3 (50%)	78 (52%)
No CYP EIP provision	4 (44%)	0 (0%)	5 (3%)
Other	0 (0%)	1 (17%)	16 (11%)
Q5b. Is there a shared protocol between the EIP team and the CYPMH service?			
Yes	3 (33%)	4 (67%)	130 (87%)
No	6 (67%)	2 (33%)	20 (13%)
Q5c. Are joint or reciprocal training events arranged at least annually between the CYPMH and EIP teams?			
Yes	5 (56%)	5 (83%)	52 (35%)
No	4 (44%)	1 (17%)	98 (65%)
Q5d. How is medication managed for CYP?[9]			
CYP team prescribers with specific EIP training and experience prescribe for CYP	0 (0%)	0 (0%)	55 (37%)
CYP team prescribers advise and support EIP team prescribing for CYP	0 (0%)	1 (20%)	40 (27%)
CYP team prescribers do not have specific EIP prescribing training and experience and do not have a protocol or routine access to specialist EIP prescribing advice	5 (56%)	2 (40%)	24 (16%)
EIP team prescribers with specific CYP training and experience prescribe for CYP	0 (0%)	0 (0%)	36 (24%)
EIP team prescribers advise and support CYPMH team prescribing for CYP	2 (22%)	2 (40%)	59 (39%)
EIP team prescribers do not have specific CYP prescribing training and experience and do not have a protocol or routine access to specialist CYP prescribing advice	0 (0%)	0 (0%)	13 (9%)

9 Total percentage may be >100% due to some teams having multiple models.

Table 2 continued:

		Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
Q5e. Provision from appropriately trained practitioners available for CYP, with early onset psychosis[9]				
Provided by CYPMH service	CBTp	0 (0%)	2 (33%)	37 (25%)
	FI	4 (44%)	3 (50%)	52 (35%)
Provided by EIP	CBTp	3 (33%)	3 (50%)	121 (81%)
	FI	3 (33%)	3 (50%)	122 (81%)
Provided by CMHT	CBTp	0 (0%)	0 (0%)	0 (0%)
	FI	0 (0%)	0 (0%)	0 (0%)
Provided by Other	CBTp	0 (0%)	0 (0%)	0 (0%)
	FI	0 (0%)	0 (0%)	0 (0%)
No CYP EIP provision	CBTp	6 (67%)	2 (33%)	3 (2%)
	FI	2 (22%)	1 (17%)	1 (<1%)
Q6a. Whole-time equivalent EIP care coordinators				
Mean (SD)		2.60 (3.13)	3.43 (2.95)	9.90 (5.36)
Range (min.–max.)		7 (0–7)	7 (0–7)	31 (1 – 32)
Q6b. Care coordinators specifically for CYP under 18				
Yes, within EIP team		0 (0%)	1 (17%)	37 (25%)
Yes, within CYPMH		4 (44%)	1 (17%)	17 (11%)
No		5 (56%)	5 (83%)	101 (67%)
Q7. Increase in number of staff posts				
Yes		6 (67%)	4 (67%)	76 (51%)
No		3 (33%)	2 (33%)	74 (49%)
Q8. Cognitive behavioural therapy for at risk mental state (ARMS)				
Elsewhere	Under 18	0 (0%)	0 (0%)	7 (5%)
	18–35	2 (22%)	0 (0%)	13 (9%)
	36 and over	0 (0%)	0 (0%)	14 (9%)
Within the EIP team	Under 18	2 (22%)	2 (33%)	70 (47%)
	18–35	1 (11%)	2 (33%)	68 (45%)
	36 and over	0 (0%)	1 (17%)	32 (21%)
Not at all	Under 18	7 (78%)	4 (67%)	64 (43%)
	18–35	6 (67%)	4 (67%)	61 (41%)
	36 and over	9 (100%)	5 (83%)	102 (68%)
Separate CBT for ARMS team	Under 18	0 (0%)	0 (0%)	9 (6%)
	18–35	0 (0%)	0 (0%)	8 (5%)
	36 and over	0 (0%)	0 (0%)	2 (1%)

Table 2 continued:

			Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
Q9. Total caseload of the EIP team					
Total caseload	Mean (SD)		47.11 (43.47)	61.33 (24.58)	165.97 (103.86)
	Range (min.–max.)		113 (2–115)	72 (35–107)	572 (19–591)
Caseload per whole-time EIP care coordinator	Mean (SD)		14.04 (4.72)	13.85 (5.09)	17.08 (5.83)
	Range (min.–max.)		11.17 (8–19.17)	11.49 (8.85–20.33)	51.75 (2.75–54.50)
Q10. Total caseload by age ranges					
Under 14 years	FEP	Mean (SD)	0.00 (0)	0.00 (0)	0.01 (0.12)
		Range (min.–max.)	0 (0–0)	0 (0–0)	1 (0–1)
	ARMS	Mean (SD)	0.00 (0)	0.00 (0)	0.02 (0.18)
		Range (min.–max.)	0 (0–0)	0 (0–0)	2 (0–2)
	Suspected FEP	Mean (SD)	0.00 (0)	0.00 (0)	0.01 (0.12)
		Range (min.–max.)	0 (0–0)	0 (0–0)	1 (0–1)
14–17 years	FEP	Mean (SD)	1.56 (3.25)	1.83 (2.14)	4.93 (4.82)
		Range (min.–max.)	10 (0–10)	5 (0–5)	23 (0–23)
	ARMS	Mean (SD)	1 (2.65)	1.17 (2.40)	1.22 (2.31)
		Range (min.–max.)	8 (0–8)	6 (0–6)	11 (0–11)
	Suspected FEP	Mean (SD)	0.00 (0)	0.83 (1.17)	1.01 (1.92)
		Range (min.–max.)	0 (0–0)	3 (0–3)	11 (0–11)
18–35 years	FEP	Mean (SD)	38.33 (42.09)	44.33 (20.05)	95.97 (63.18)
		Range (min.–max.)	114 (0–114)	53 (26–79)	315 (0–315)
	ARMS	Mean (SD)	3.44 (8.93)	3.83 (5.60)	5.51 (10.77)
		Range (min.–max.)	27 (0–27)	12 (0–12)	70 (0–70)
	Suspected FEP	Mean (SD)	1.33 (2.65)	6.83 (7.73)	5.10 (9.03)
		Range (min.–max.)	6 (0–6)	17 (0–17)	71 (0–71)

Table 2 continued:

			Welsh services 2020/21 n=9	Welsh services 2019/20 n=6	English services 2020/21 n=150
36 years and over	FEP	Mean (SD)	1.44 (2.96)	2.00 (2.45)	49.10 (43.17)
		Range (min.–max.)	8 (0–8)	6 (0–6)	277 (0–277)
	ARMS	Mean (SD)	0.00 (0)	0.00 (0)	0.75 (2.27)
		Range (min.–max.)	0 (0–0)	0 (0–0)	16 (0–16)
	Suspected FEP	Mean (SD)	0.00 (0)	0.50 (0.84)	2.33 (4.63)
		Range (min.–max.)	0 (0–0)	2 (0–2)	27 (0–27)
Q11. Average length of treatment in months of last 10 FEP service users					
Mean (SD)			17.50 (17.27)	25.15 (12.42)	30.65 (9.45)
Range (min.–max.)			40.30 (0–40.30)	29 (10–39)	53.50 (6.40–59.90)

Demographics

Tables 3 and 4 provide the demographic characteristics for the complete case-note audit sample (n = 248).

Table 3: Number of people in the case-note sample by age and gender (n = 248) shown with the English national sample (n = 10,033)

		Wales 2020/21	England 2020/21
Total sample	n (%)	248 (100%)	10,033 (100%)
	Mean age in years (SD)	24.90 (5.19)	32.68 (11.60)
	Age range in years	29	54.40
	Age min.–max. (years)	16–45	11–65
Male	n (%)	180 (73%)	6,186 (62%)
	Mean age in years (SD)	24.72 (4.68)	31.15 (10.70)
	Age range in years	26	51.27
	Age min.–max. (years)	16–42	14–65
Female	n (%)	68 (27%)	3,833 (38%)
	Mean age in years (SD)	25.38 (6.37)	35.20 (12.53)
	Age range in years	27	54.35
	Age min.–max. (years)	18–45	11–65
Other	n (%)	0 (0%)	14 (<1%)
	Mean age in years (SD)	-	19.44 (3.27)
	Age range in years	-	10.90
	Age min.–max. (years)	-	15–25

Table 4: Number of people in the case-note sample by ethnicity (n = 248) shown with the English national sample (n = 10,033)

Ethnic group	Wales 2020/21 n (%)	England 2020/21 n (%)
White	202 (81%)	6,420 (64%)
Black or Black British	11 (4%)	1,202 (12%)
Asian or Asian British	15 (6%)	1,229 (12%)
Mixed	13 (5%)	411 (4%)
Other ethnic groups	7 (3%)	771 (8%)

4. Discussion

This report presents data collected in the unprecedented context of the COVID-19 pandemic. In these circumstances, it is encouraging to see positive results, with clear improvement shown in some measures and with other measures maintaining the level achieved previously.

We cannot calculate fully the effects of the pandemic, but results summarised in Table 1 and 2 demonstrate an impact in terms of decline in some physical health interventions, take-up of carer-focused education and support, and the offer of clozapine where applicable. It seems likely that the rate of progress in achieving greater take-up of psychological therapies, supported education/ employment, and outcome measures may also have been affected.

Some aspects of physical health monitoring do show improvement from the 2019-2020 audit, but it should be noted that body mass index, blood pressure, glucose and lipid monitoring were carried out for around 50% patients or fewer. There is a slight drop for other aspects of physical health monitoring, notably smoking.

Physical health interventions show some increases, particularly evident for the provision of interventions for smoking, alcohol misuse, substance misuse, and weight/obesity for those patients requiring them. However there appear to be decreases in the provision of interventions for elevated blood pressure and abnormal glucose control.

Services in many areas of Wales are undergoing reorganisation and consolidation, which means that these results must also be considered in the context of an evolving service model and local variations of provision. There is an identified need for service development, including addressing the provision of early intervention services for children and young people.

5. Recommendations

1. Communication

a) The Welsh government should:

- take steps to reinforce expectations of achieving the standards for audit by:
  - communicating clearly to Health Boards the expectations for achievement, including planning, to meet each of the standards.
  - communicating clearly with people using EIP services what their expectations can be in terms of waiting times, physical and health interventions, and outcome measurement.

2. Access and waiting times (AWT)

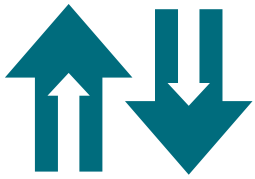
a) The Welsh government should:

- address equity of access throughout Wales, and ensure that Health Boards have a clear plan to achieve the waiting time of two weeks for service users with FEP to begin treatment with an EIP service.

3. Children and young people

a) The Welsh government should:

- work with NHS Wales to ensure children and young people under 18 with FEP across Wales have access to specialist EIP expertise, care coordination and the full range of evidence-based EIP interventions.



4. Variation

The Welsh government should:

- take steps to examine and ascertain causes relating to high variability between services in Wales in terms of:
  - standards met, workforce capacity, staff competences and resources within those EIP services with demonstrated lower performance levels.
  - variation in the offer, take-up and refusal of interventions.

5. Physical healthcare

a. The Welsh government should:

- work with Health Boards and EIP services to ensure that an alert status is created for people with FEP whose screening results demonstrate that further physical healthcare intervention is required as a priority.
- highlight the importance of practitioners routinely asking screening questions in relation to physical healthcare – e.g. about smoking, because smoking alone is the biggest driver of severe health risks such as cardiovascular disease and premature mortality for EIP service users.

b. EIP clinicians should:

- ensure that recommended screening for physical health risks is carried out and its importance understood within the service.
- ensure that where screening for cardiovascular disease or diabetes alerts a health risk (e.g. HBA1C blood glucose levels, hypertension, blood lipid levels) to the patient, the appropriate interventions are offered in response. All interventions in response to the identified risk should be clearly documented in patient health records.

6. Unmet need[10]

a. The National Steering Group (EIP), Health Boards and EIP services should:

- examine the incidence and increase the case finding by EIP services to address unmet need and equity of access to EIP service provision across Wales. Health Boards and services should address this via the National Steering Group and within individual Health Board regions.

10 See table 8 for FEP audit sample and caseload by Health Board as a proportion of estimated incidence of FEP in Wales.

6. Conclusion

The recommendations in this report are aimed at addressing key findings in the data. Some recommendations may be easier to implement locally than others, e.g. monitoring of smoking as a health risk, which requires asking a simple question. The offer, follow-up and recording of appropriate interventions where health risks to patients are identified, such as elevated blood pressure or abnormal glucose, should be routine practice and appropriately recorded.

The recommendations also seek to highlight the role of the Welsh Government in strategic planning for EIP provision across Wales and in ensuring equity of access. The expectation of those who use the services should be considered with high importance – service users should have information about what services will provide and feel assured that they will get the same provision wherever they live.

We are grateful to the Welsh Government for their role in discussing and co-producing recommendations, and for stating the need to continue working towards satisfying the 2020 recommendations and welcoming the 2021 recommendations in offering further support to the implementation of the standards by Health Boards and EIP services across Wales.

7. Compiled by

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Appendix A: Acknowledgements

Development of recommendations

The recommendations for the NCAP EIP 2020/2021 audit were developed by the NCAP team and members of the NCAP steering group. We would like to thank our steering group for their contributions. A list of members of the steering group, together with the organisations they represent, can be found in Appendix B.

Support and input

We would like to thank the staff from participating Trusts, organisations and Health Boards who took part in the collection and submission of data for the EIP 2020/2021 audit. Their continued hard work and dedication to the audit throughout this difficult period, while managing the challenges and demands of COVID-19, is very much acknowledged and appreciated.

We would also like to thank the HQIP team for their guidance throughout the NCAP EIP 2020/2021 audit.

Appendix B: Steering group members

Table 5: Steering group members and organisations (in alphabetical order)

Name	Organisation
Dr Alison Brabban	Early Intervention in Psychosis Network, NHS England and NHS Improvement
Linda Chadburn	Pennine Care NHS Foundation Trust/local audit representative
Prathiba Chitsabesan	NHS England and NHS Improvement
Dr Elizabeth Davies	Welsh Government
Dr Selma Ebrahim	British Psychological Society
Ellie Gordon	Royal College of Nursing
Wendy Harlow	Sussex Partnership Trust/local audit representative
Sam Harper	Healthcare Quality Improvement Partnership
Gabriella Hasham	Rethink Mental Illness
Sarah Holloway	NHS England and NHS Improvement
Steve Jones	NHS England and NHS Improvement
Beth McGeever	NHS England and NHS Improvement
Molly McPaul	Care Quality Commission
Jay Nairn	NHS England and NHS Improvement
Peter Pratt	Prescribing expert, NHS England and NHS Improvement
Caroline Rogers	Healthcare Quality Improvement Partnership
Lucy Schonegevel	Rethink Mental Illness
Dr David Shiers	General Practitioner (retired)/Carer
Dr Shubulade Smith	National Collaborating Centre for Mental Health
Dr Caroline Taylor	Royal College of General Practitioners/ Clinical Commissioning Group representative
Hilary Tovey	NHS England and NHS Improvement
Andrew Turner	Care Quality Commission
Nicola Vick	Care Quality Commission
Dr Jonathan West	Early Intervention in Psychosis Network (London)
Tristan Westgate	Rethink Mental Illness
Dr Latha Weston	Royal College of Psychiatrists, General Adult Faculty

Appendix C: Participating Health Boards

Table 6: Participating Health Boards, provider IDs and EIP teams (alphabetised by trust name)

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

Appendix D: Health board returns

Case-note audit

Table 7: Health Board returns of case-note audit form

Organisation ID	Total eligible cases	Expected sample	Sample submitted	Final sample after data cleaning	Final sample as % of total eligible cases	Final sample as % of expected sample
ORG02	30	30	30	26	87%	87%
ORG03	76	76	75	74	97%	97%
ORG07	24	24	24	19	79%	79%
ORG13	65	65	65	65	100%	100%
ORG19	35	35	31	30	86%	86%
ORG29	40	40	40	34	85%	85%

Table 8: FEP audit sample and caseload by Health Board, and as a proportion of estimated incidence of FEP

Organisation ID	Final cleaned sample	Total number of people with FEP on caseload[11]	Total number of people with FEP on caseload as a proportion of estimated 3-year incidence	Estimated FEP incidence over 3 years[12]
ORG02	26	34	18%	186.6
ORG03	74	111	39%	284.1
ORG07	19	35	12%	295.2
ORG13	65	115	49%	235.2
ORG19	30	41	18%	221.7
ORG29	34	36	22%	165.9

Wales began to develop and implement EIP services following the rollout of the Together for Mental Health Delivery Plan in 2016. Because the rollout is still in an early stage of development, uptake does not yet reflect the incidence of FEP within the population. Caseload numbers can be expected to increase as the services develop in line with the delivery plan.

11 See Table 3. People typically receive support from an EIP team for 3 years.

12 According to the North Wales Clinical Psychology Programme, Bangor University, which provides a prediction of annual FEP incidence. This is multiplied by 3 to estimate expected FEP cases over 3 years.

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