

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

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

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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.'

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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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Contents

| | |
|---|-----------|
| List of tables and figures | 4 |
| Foreword | 6 |
| Infographic: main findings | 7 |
| Executive summary | 8 |
| Background | 8 |
| Method | 8 |
| Response rate | 8 |
| Key findings | 8 |
| Discussion | 10 |
| Conclusions | 10 |
| Recommendations | 11 |
| Context | 13 |
| Methodology | 14 |
| Audit development | 14 |
| Standards and outcome indicators | 14 |
| Development of the audit tools | 14 |
| Identification of the case sample | 15 |
| Audit participation and process | 16 |
| Reading the report | 16 |
| Outliers | 16 |
| Limitations of the methodology and data | 17 |
| Quality assurance | 17 |
| Standard 1: Timely access | 18 |
| Standards 2 and 3: Psychological therapies | 19 |
| Standard 4: Prescribing of clozapine | 21 |
| Standard 5: Supported employment and education programmes | 22 |
| Standard 6: Physical health screening | 24 |
| Standard 7: Physical health interventions | 29 |
| Standard 8: Carer-focused education and support programmes | 35 |
| Outcome indicator | 36 |
| References | 37 |
| Appendix A: Steering Group members | 38 |
| Appendix B: Trust returns of case note audit form | 39 |
| Appendix C: Service-level data | 41 |
| Appendix D: Participating Trusts | 44 |
| Appendix E: Quality assurance visits | 51 |
| Appendix F: Additional analysis | 52 |
| Appendix G: Demographics | 53 |
| Appendix H: Glossary | 54 |

List of tables and figures

| | |
|---|----|
| Table 1: Key comparisons between NCAP spotlight audit 2018/19 and EIP self-assessment 2017/18 | 9 |
| Table 2: NCAP standards and outcome indicator | 15 |
| Table 3: Breakdown of interventions received by those requiring smoking intervention across Trusts | 30 |
| Table 4: Breakdown of interventions received by those requiring harmful or hazardous alcohol use intervention across Trusts | 30 |
| Table 5: Breakdown of interventions received by those requiring substance misuse intervention across Trusts | 32 |
| Table 6: Breakdown of interventions received by those requiring weight loss intervention across Trusts | 32 |
| Table 7: Breakdown of interventions received by those requiring blood pressure intervention across Trusts | 33 |
| Table 8: Breakdown of interventions received by those requiring glucose control intervention across Trusts | 33 |
| Table 9: Breakdown of interventions received by those requiring an intervention for dyslipidaemia across Trusts | 34 |
| Table 10: Steering group members and organisations | 38 |
| Table 11: Expected and actual returns (post data cleaning) from each Trust | 39 |
| Table 12: Contextual questionnaire: England | 41 |
| Table 13: Participating Trusts, provider IDs & EIP teams (alphabetised by Trust name) | 44 |
| Table 14: Participating Trusts & provider IDs (ordered by provider ID) | 48 |
| 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 | 52 |
| Table 16: Number of patients in the NCAP sample by age and gender | 53 |
| Table 17: Number of patients in the NCAP sample by ethnicity | 53 |
| | |
| Figure 1: Timetable of the National Clinical Audit of Psychosis Early Intervention in Psychosis spotlight audit | 14 |
| Figure 2: Proportion of people with FEP who started treatment within two weeks of referral between November 2018 – January 2019 | 18 |
| Figure 3: Proportion of people with FEP who took up CBTp | 19 |
| Figure 4: Proportion of people with FEP and their families who took up Family Interventions | 20 |

| | |
|--|----|
| Figure 5: Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least two other antipsychotic drugs | 21 |
| Figure 6: Proportion of people with FEP who were not in work, who had taken up supported employment and education programmes | 22 |
| Figure 7: Proportion of people with FEP who were screened on all seven physical health measures across Trusts in the past 12 months | 24 |
| Figure 8: Proportion of people with FEP monitored for cigarette smoking across Trusts in the past 12 months | 25 |
| Figure 9: Proportion of people with FEP monitored for alcohol consumption across Trusts in the past 12 months | 25 |
| Figure 10: Proportion of people with FEP monitored for substance misuse across Trusts in the past 12 months | 26 |
| Figure 11: Proportion of people with FEP monitored for BMI across Trusts in the past 12 months | 26 |
| Figure 12: Proportion of people with FEP monitored for blood pressure across Trusts in the past 12 months | 27 |
| Figure 13: Proportion of people with FEP monitored for blood glucose control across Trusts in the past 12 months | 27 |
| Figure 14: Proportion of people with FEP monitored for blood lipids across Trusts in the past 12 months | 28 |
| Figure 15: Composite measure of standards 6 & 7: All seven physical health screenings and relevant interventions offered in the past 12 months | 29 |
| Figure 16: Proportion of people with FEP offered intervention for cigarette smoking across Trusts | 30 |
| Figure 17: Proportion of people with FEP offered intervention for harmful or hazardous use of alcohol use across Trusts | 31 |
| Figure 18: Proportion of people with FEP offered intervention for substance misuse across Trusts | 31 |
| Figure 19: Proportion of people with FEP offered intervention for elevated BMI across Trusts | 32 |
| Figure 20: Proportion of people with FEP offered intervention for elevated blood pressure across Trusts | 33 |
| Figure 21: Proportion of people with FEP offered intervention for abnormal glucose control across Trusts | 34 |
| Figure 22: Proportion of people with FEP whose carers took up or were referred to carer-focused education and support programmes | 35 |
| 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) | 36 |
| Figure 24: Proportion of people with FEP who have taken up supported employment and education programmes based on the entire national sample | 52 |

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.

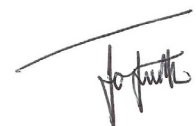
However, there is more to be done. We need to challenge the system to continue to commission high quality EIP services staffed with appropriately trained, skilled staff that are able to deliver against these standards. We know some areas are struggling to provide services for people over the age of 35 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.

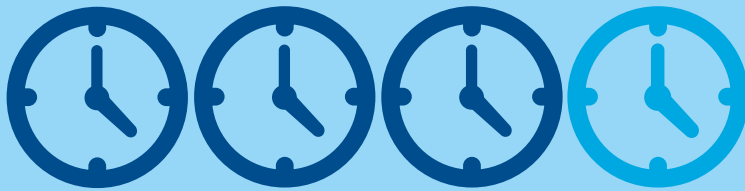


Dr Paul French, NCAP EIP Clinical Advisor



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

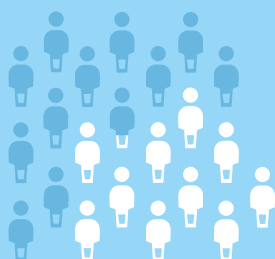


54%

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



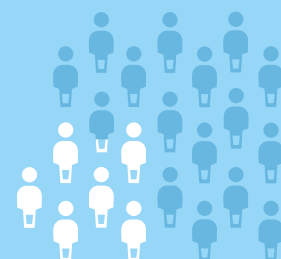
46%

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 monitoring⁶ | | |
| 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 screeningⁱ 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.

^aHoNOS/HoNOSCA, DIALOG, QPR (and 'other' for under 18-year olds).

^bFigure includes patients who were on the caseload for <6 months.

^cOf those not in work, education or training at the time of their initial assessment.

^dIf patient has not responded adequately to or tolerated treatment with at least two antipsychotic drugs.

^eNovember 2017-January 2018.

^fNovember 2018-January 2019.

^gOf those with an identified carer.

^hFigure includes all patients who were on the caseload (i.e. not FEP exclusively) and patients who were on the caseload for <6 months.

ⁱTaken up or refused.

^jTaken up or refused.

^kOf 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 health-care 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.¹

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.

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

Reading the report

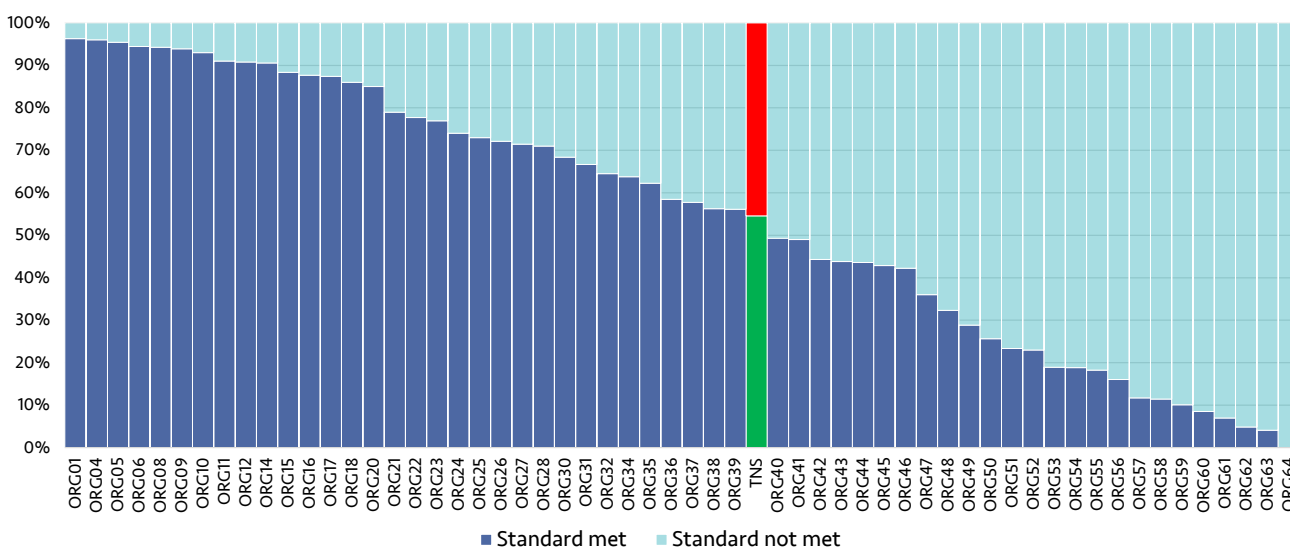
How to read the charts

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

¹These 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.

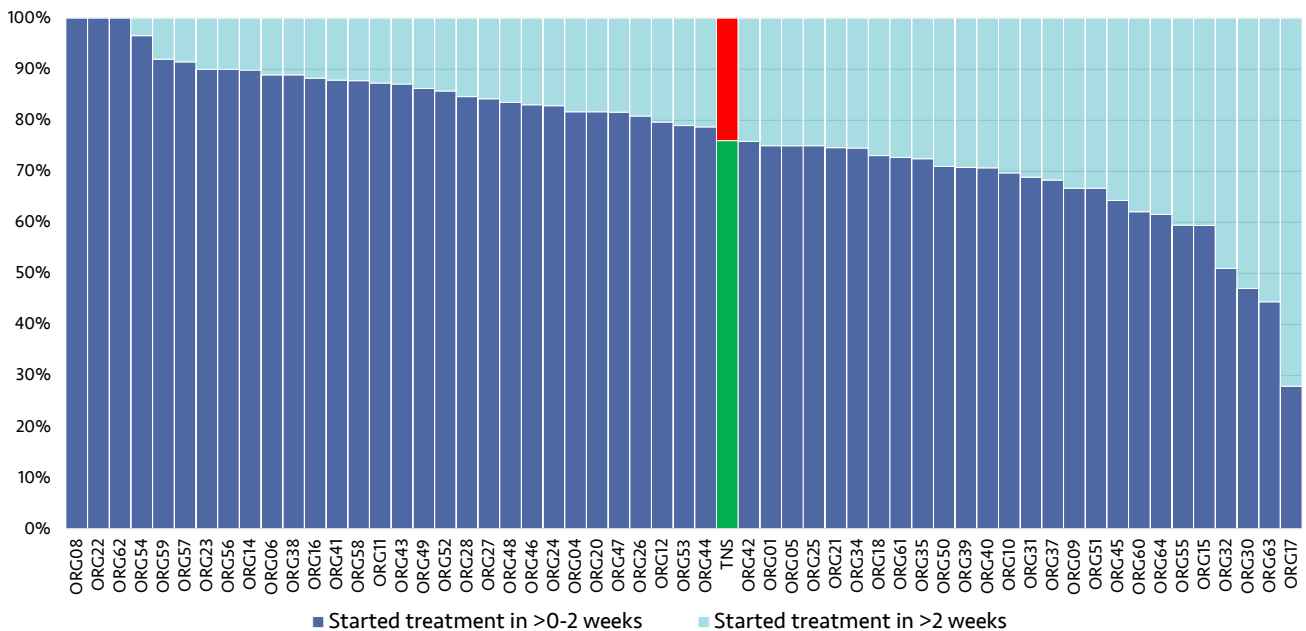


Figure 2: Proportion of people with FEP who started treatment within two weeks of referral between November 2018 – January 2019 (n = 3218)*

*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.

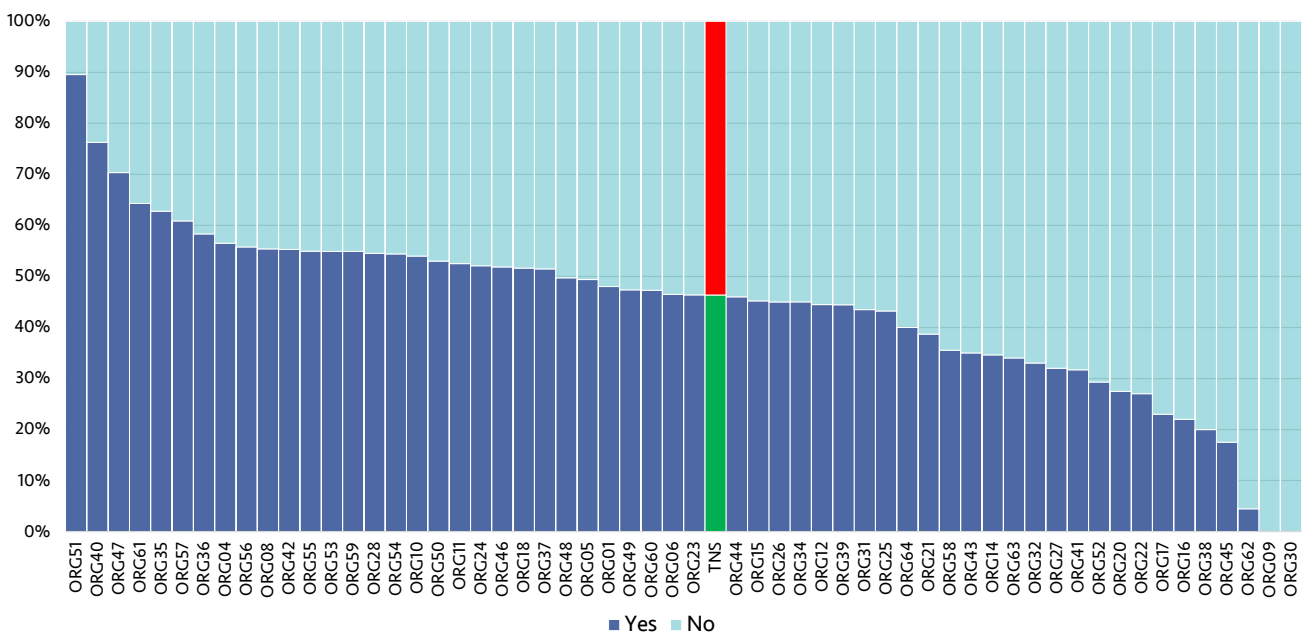


Figure 3: Proportion of people with FEP who took up CBTp (n = 9527)

^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.

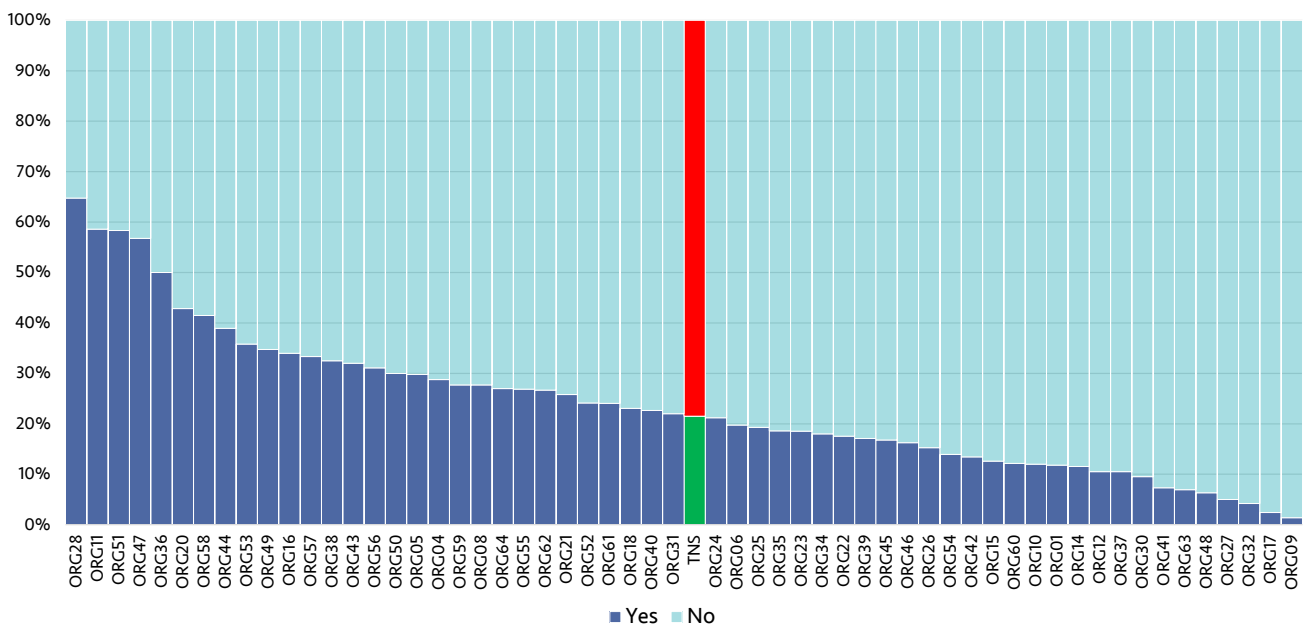


Figure 4: Proportion of people with FEP and their families who took up Family Interventions (n = 9527)

ⁿCompared 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%^o to 54%) in the proportion of patients being offered clozapine after two unsuccessful trials of antipsychotics.

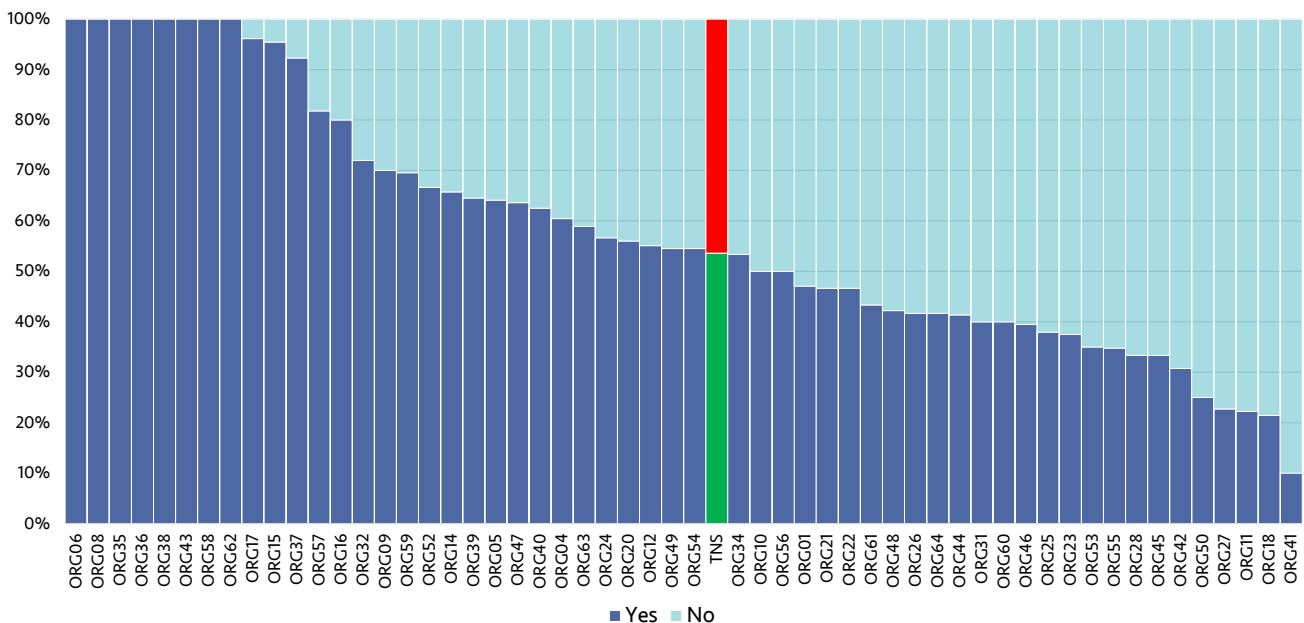


Figure 5: Proportion of people with FEP who were offered clozapine after not responding adequately to or tolerating at least two other antipsychotic drugs (n = 1287)

^oCompared 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

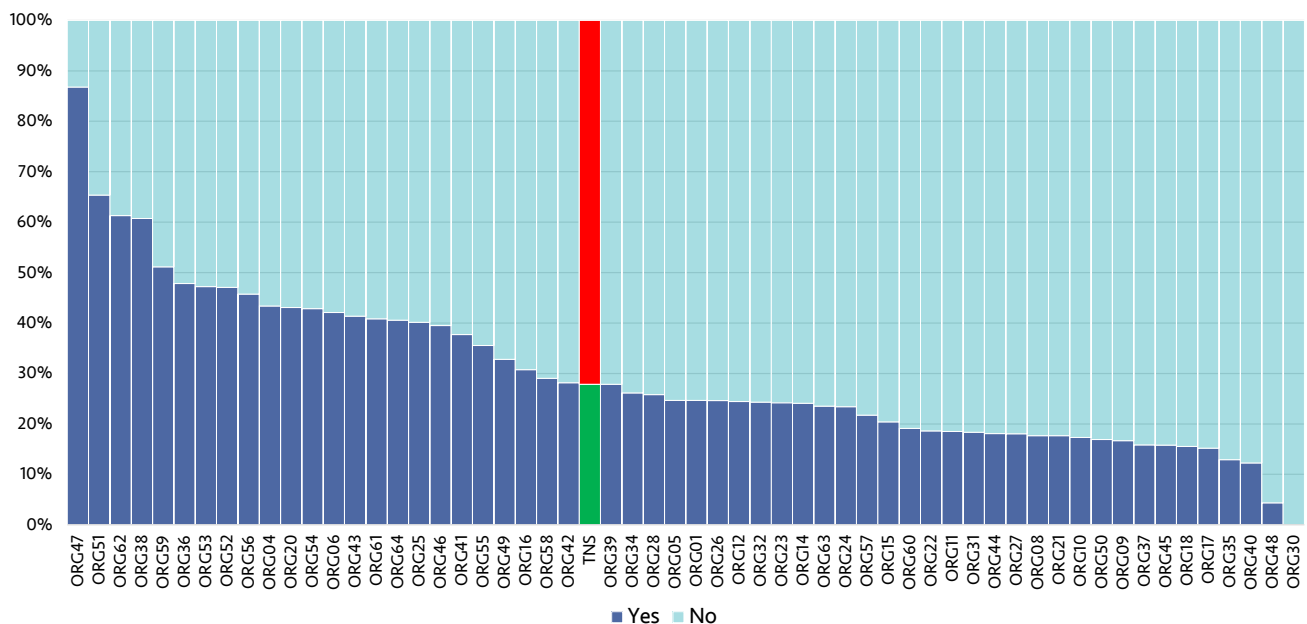


Figure 6: Proportion of people with FEP who were not in work, who had taken up supported employment and education programmes (n = 5782)

^pCompared 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.

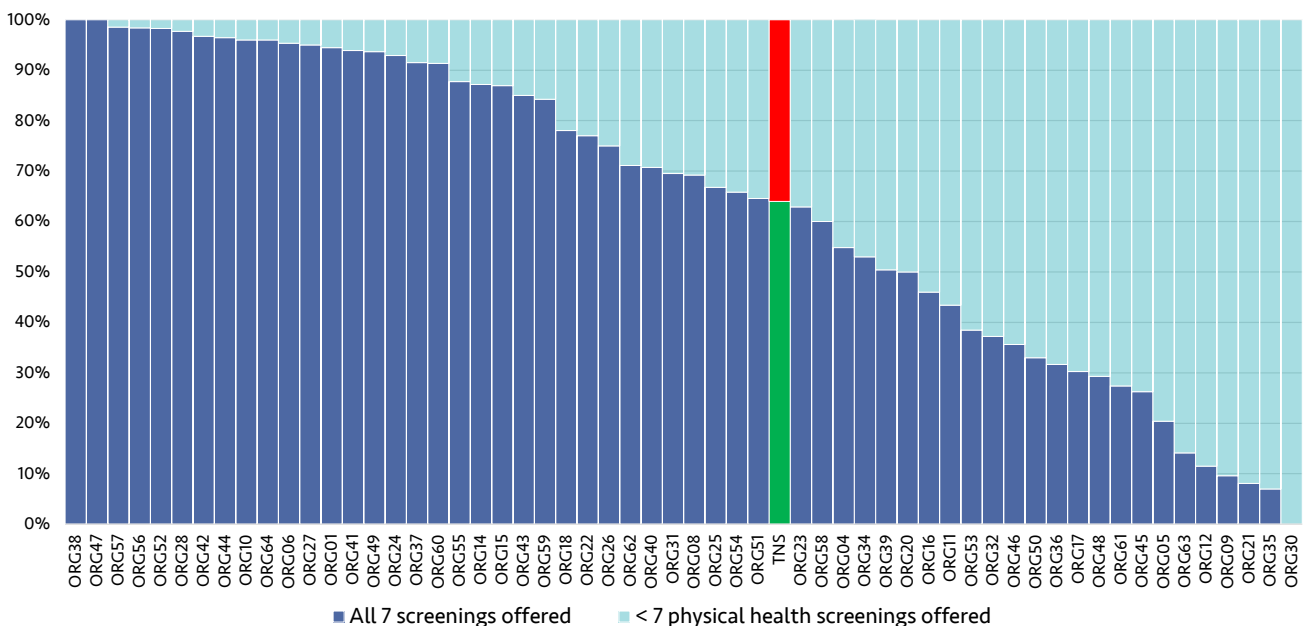


Figure 7: Proportion of people with FEP who were screened* on all seven physical health measures across Trusts in the past 12 months (n = 9527)

* '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.

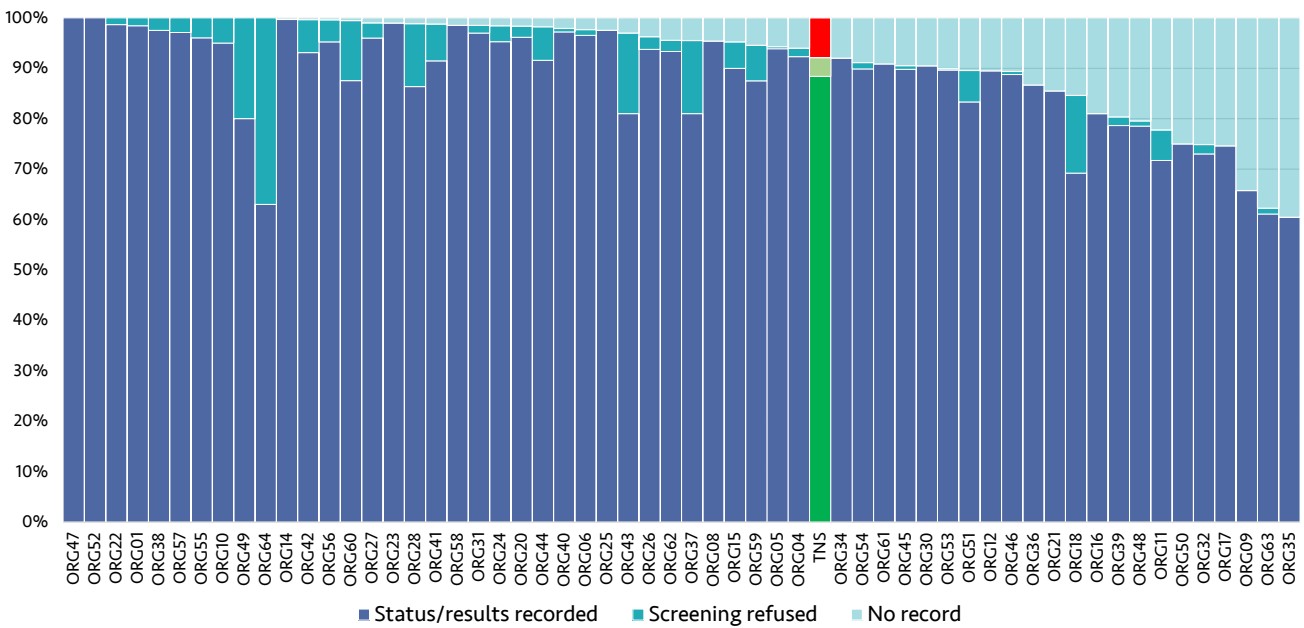


Figure 8: Proportion of people with FEP monitored for cigarette smoking across Trusts in the past 12 months (n = 9527)

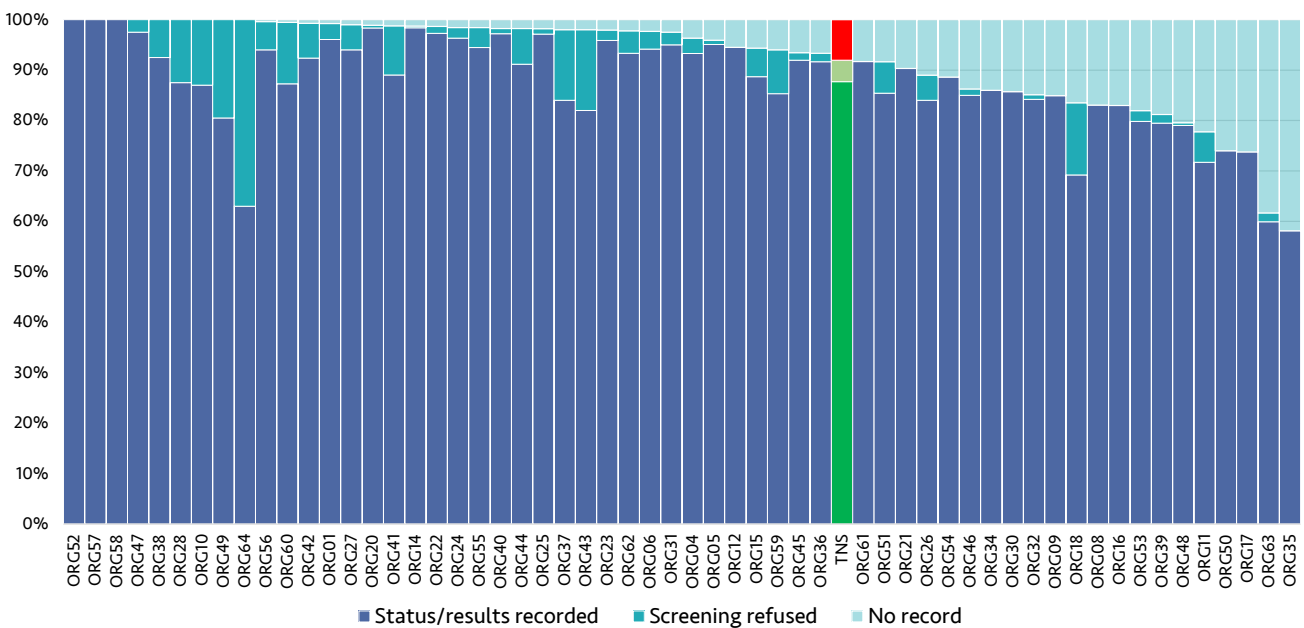


Figure 9: Proportion of people with FEP monitored for alcohol consumption across Trusts in the past 12 months (n = 9527)

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.

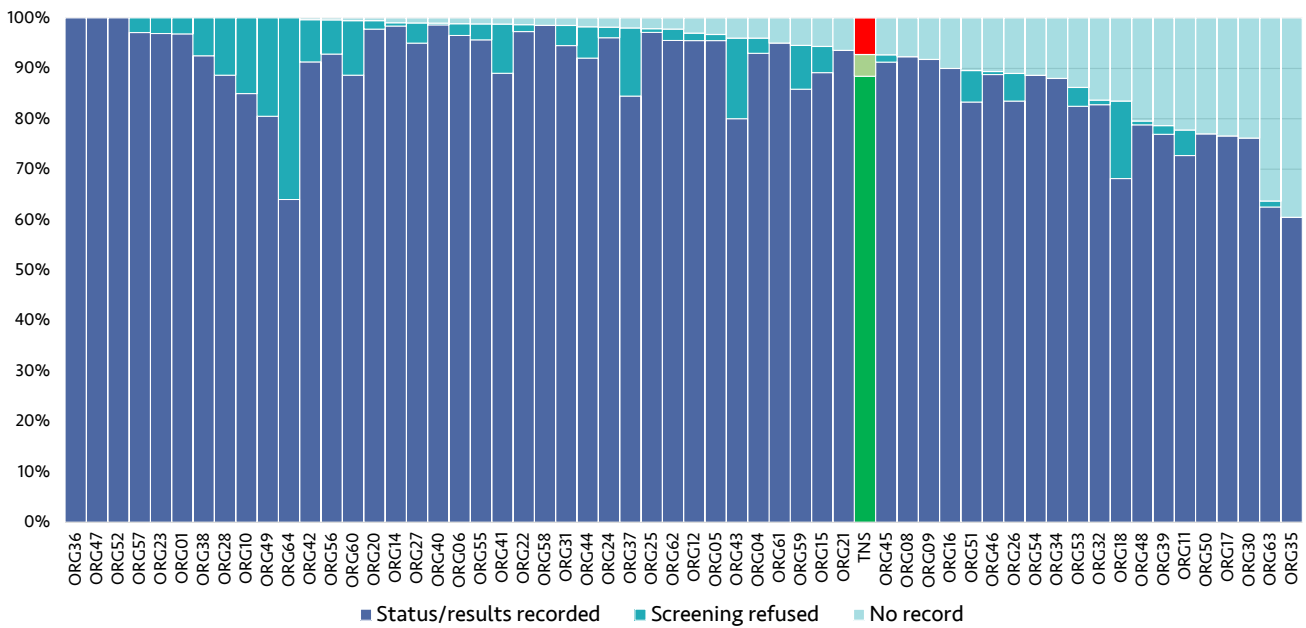


Figure 10: Proportion of people with FEP monitored for substance misuse across Trusts in the past 12 months (n = 9527)

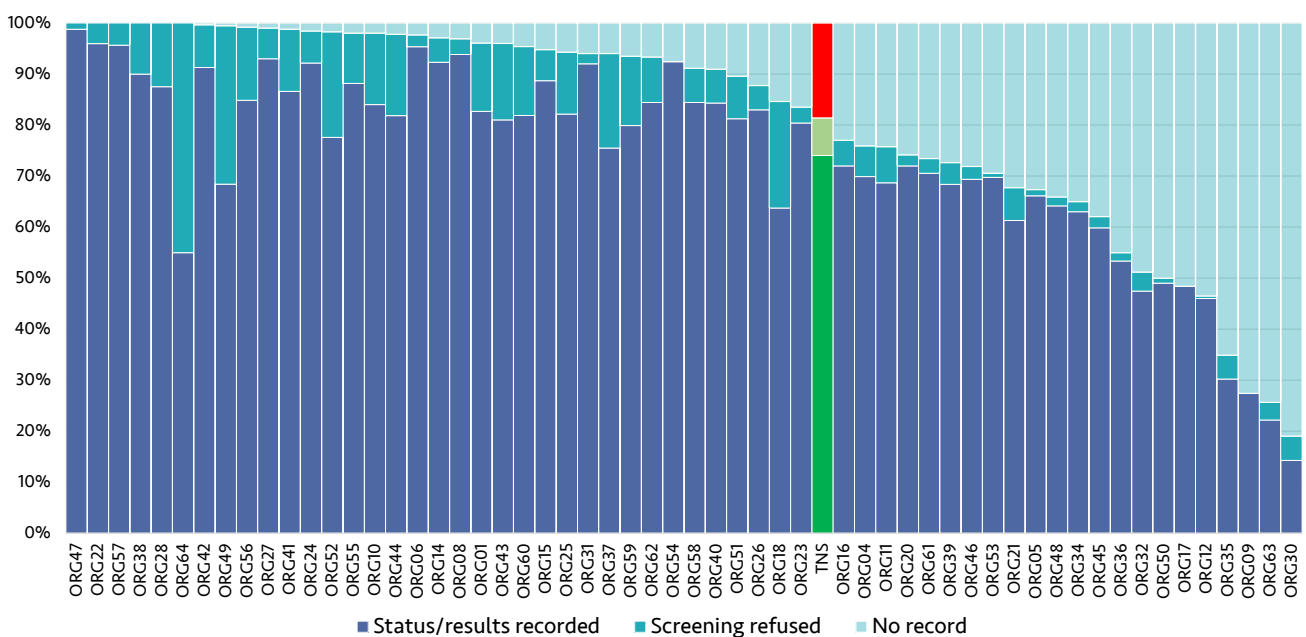


Figure 11: Proportion of people with FEP monitored for BMI across Trusts in the past 12 months (n = 9527)

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.

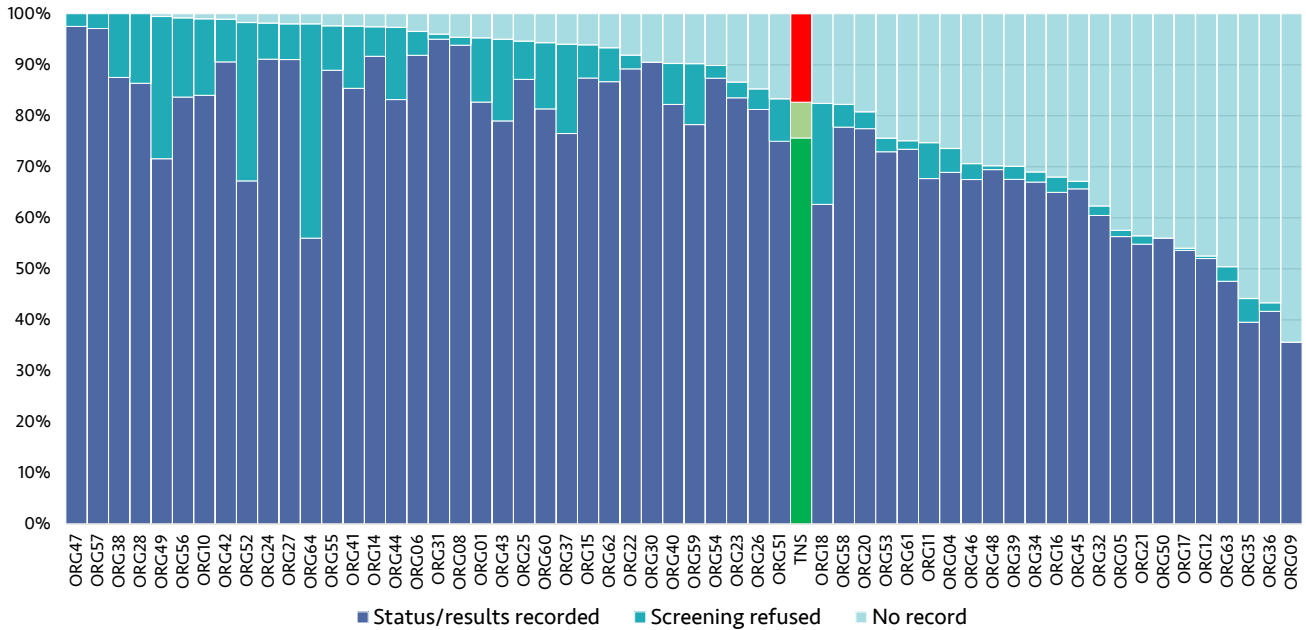


Figure 12: Proportion of people with FEP monitored for blood pressure across Trusts in the past 12 months (n = 9527)

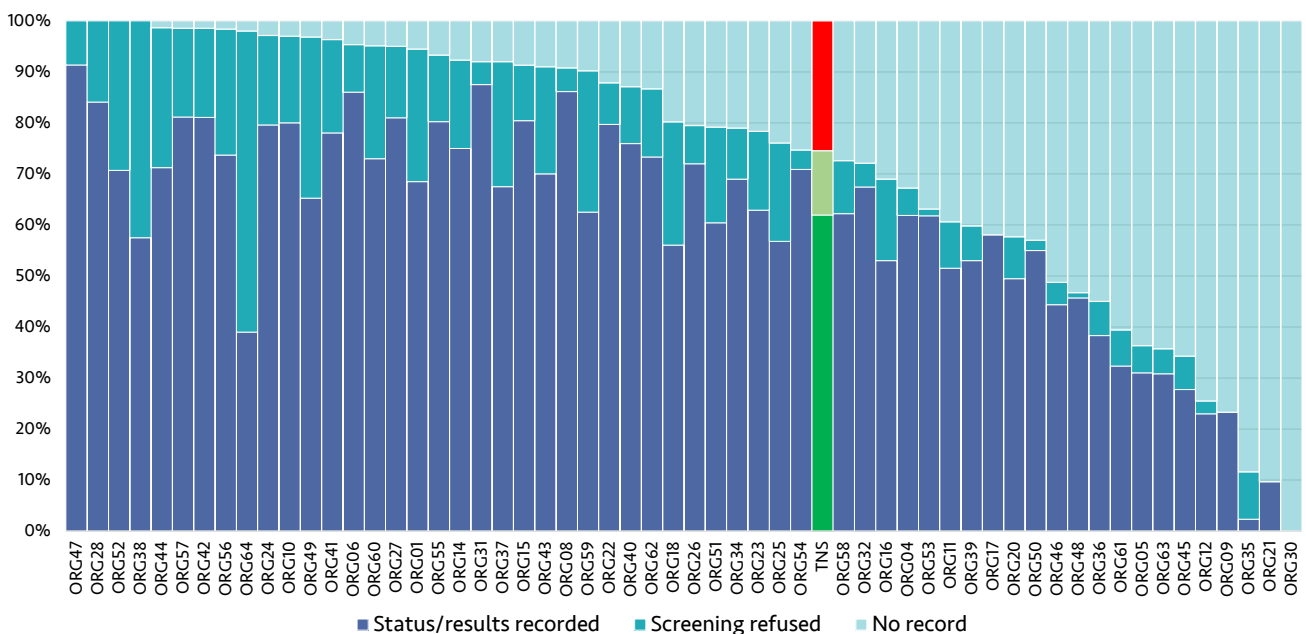


Figure 13: Proportion of people with FEP monitored for blood glucose control across Trusts in the past 12 months (n = 9527)

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.

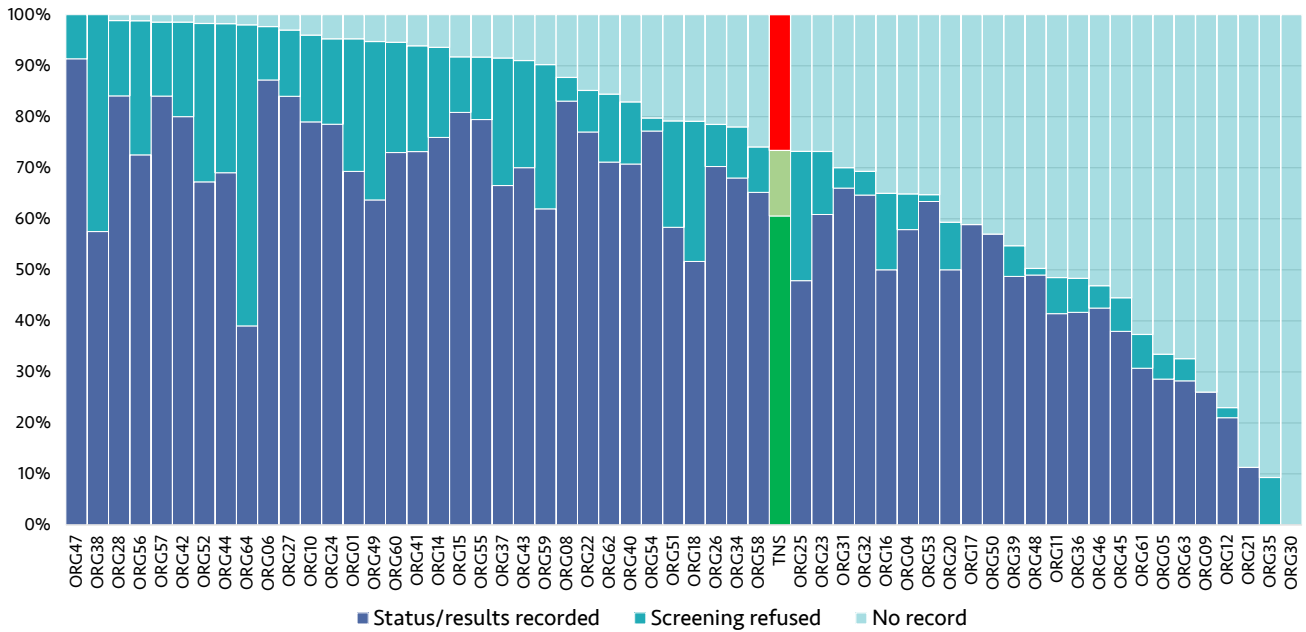


Figure 14: Proportion of people with FEP monitored for blood lipids across Trusts in the past 12 months (n = 9527)

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 $\geq 25\text{kg/m}^2$ (for South Asian and Chinese patients $\geq 23\text{kg/m}^2$).

- **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.

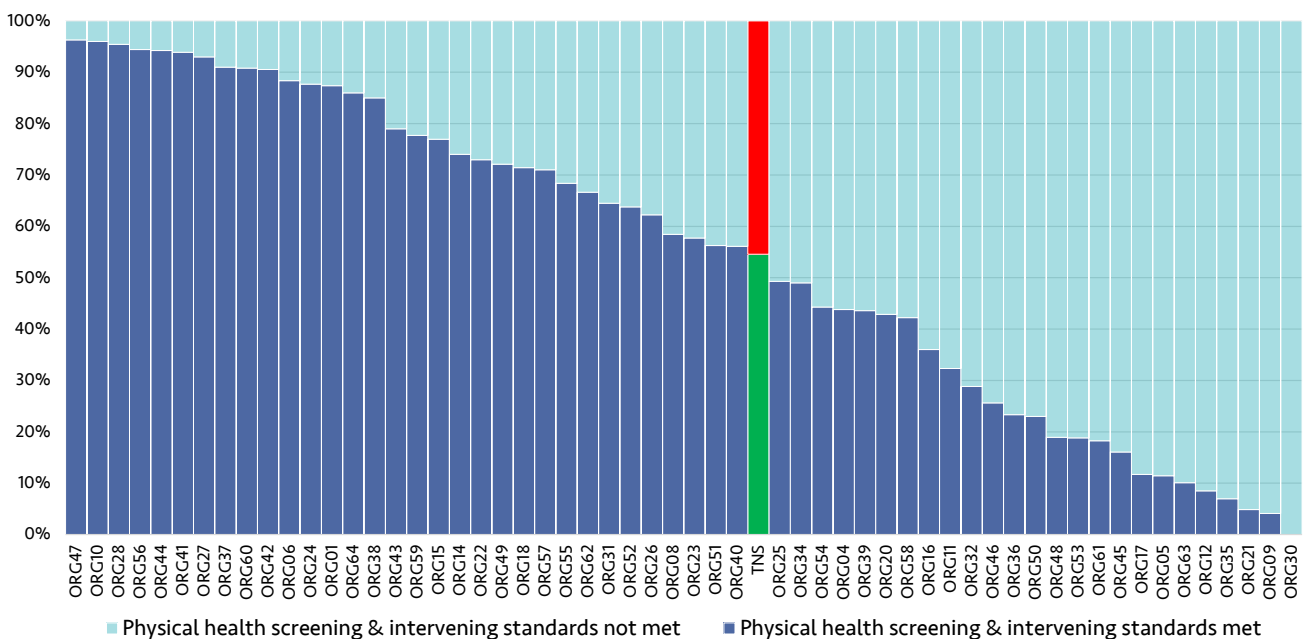


Figure 15: Composite measure of standards 6 & 7: All seven physical health screenings and relevant interventions offered in the past 12 months (n = 9527)

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.

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 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

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.

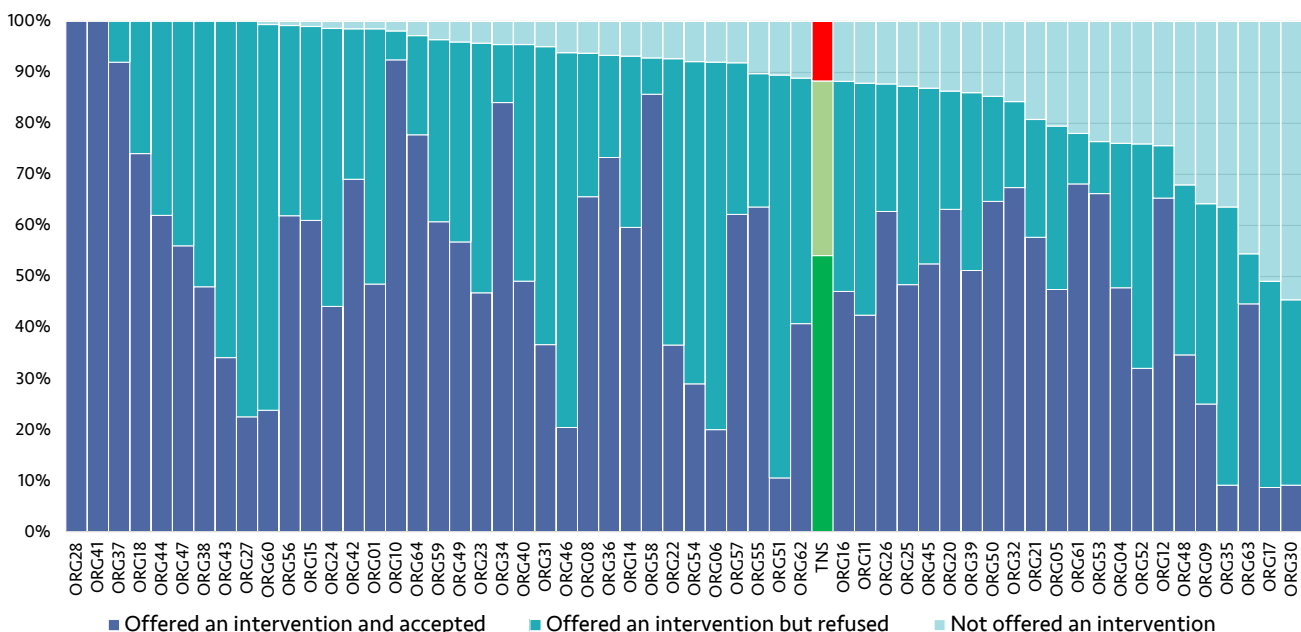


Figure 16: Proportion of people with FEP offered intervention for cigarette smoking across Trusts (n = 4093)

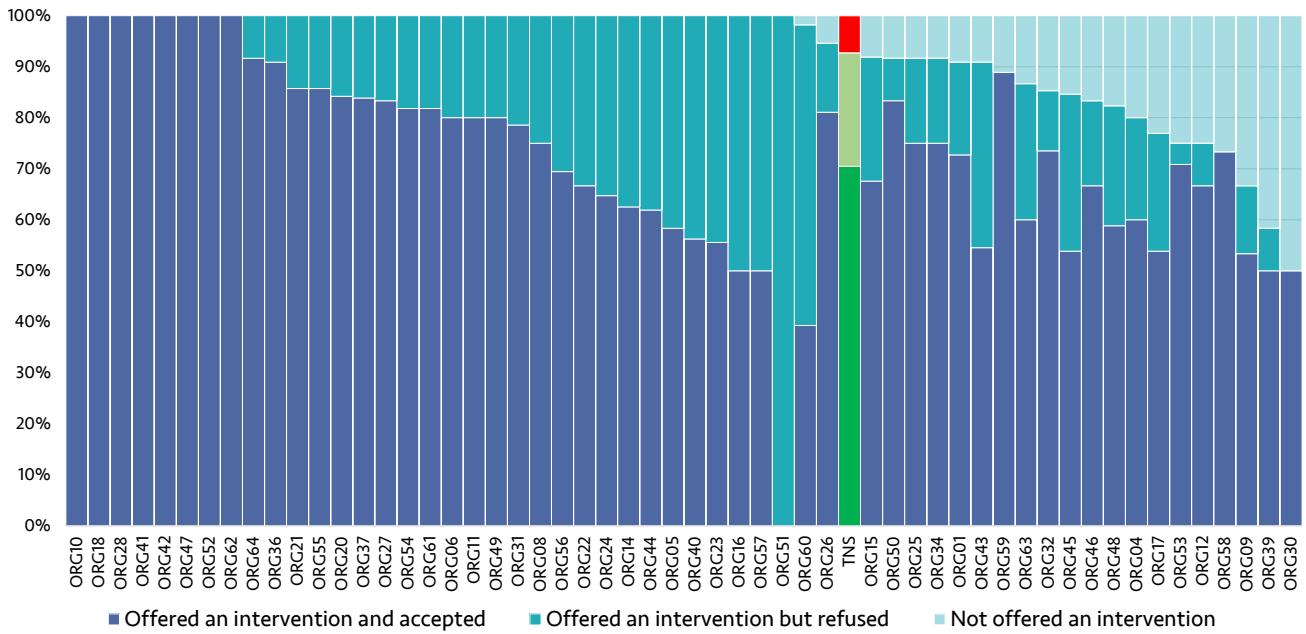


Figure 17: Proportion of people with FEP offered intervention for harmful or hazardous use of alcohol use across Trusts (n = 796)

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.

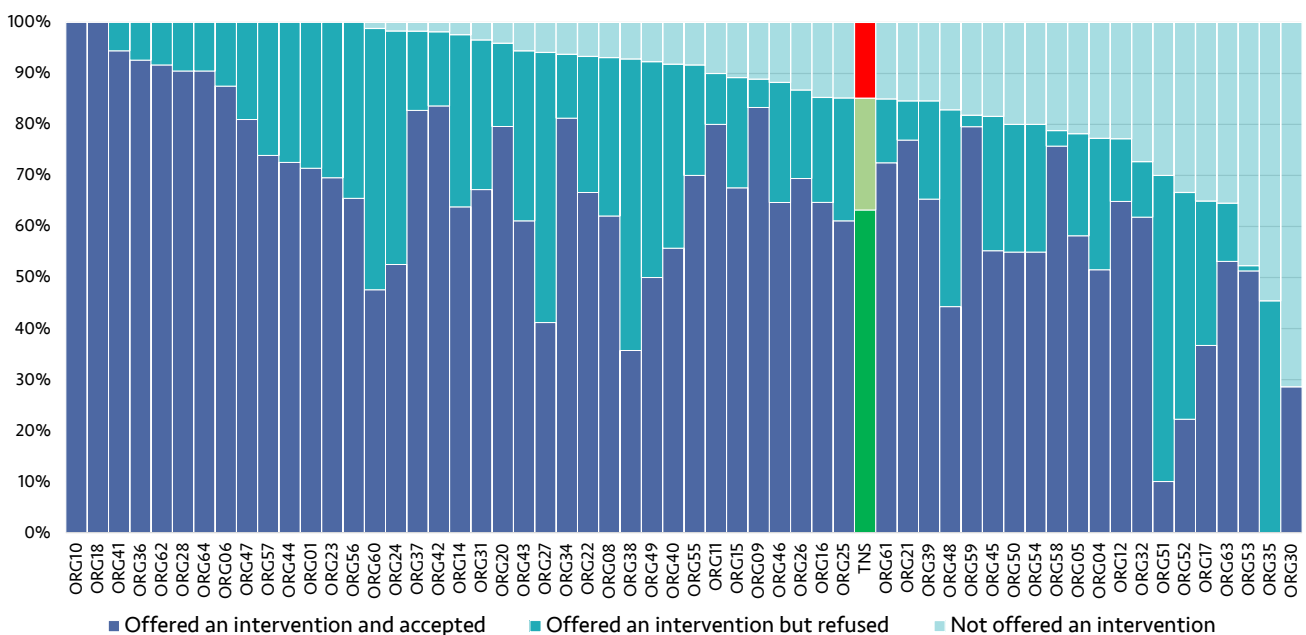


Figure 18: Proportion of people with FEP offered intervention for substance misuse across Trusts (n = 2304)

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

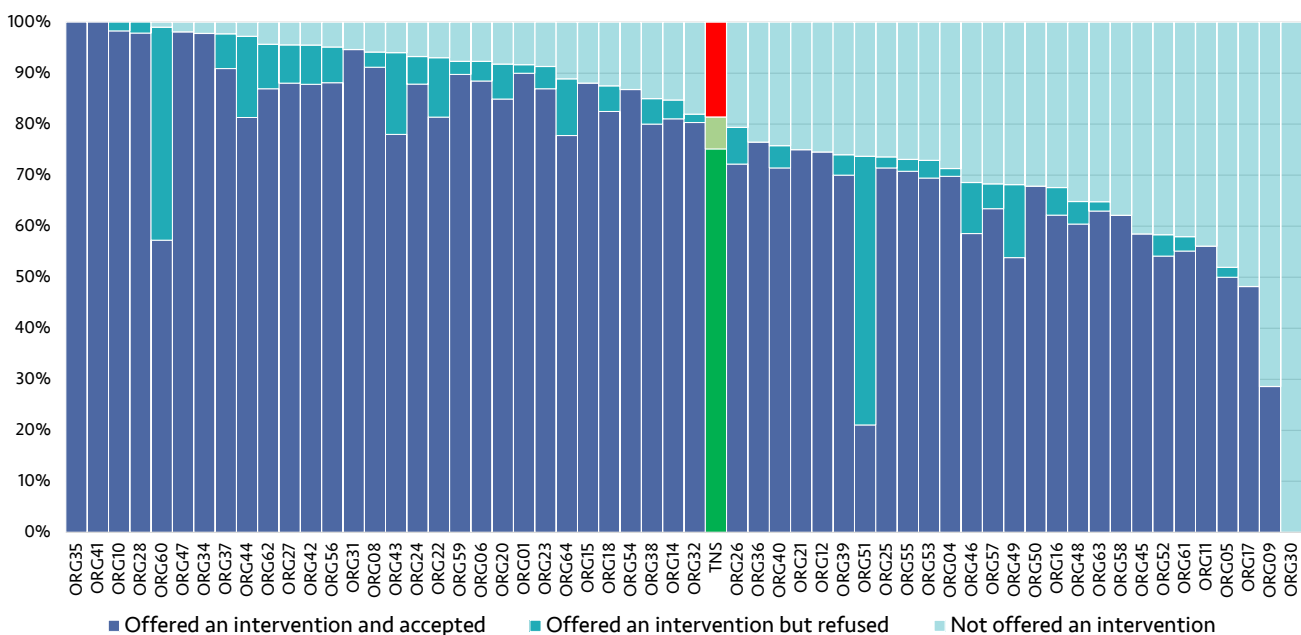


Figure 19: Proportion of people with FEP offered intervention for elevated BMI across Trusts (n = 4394)

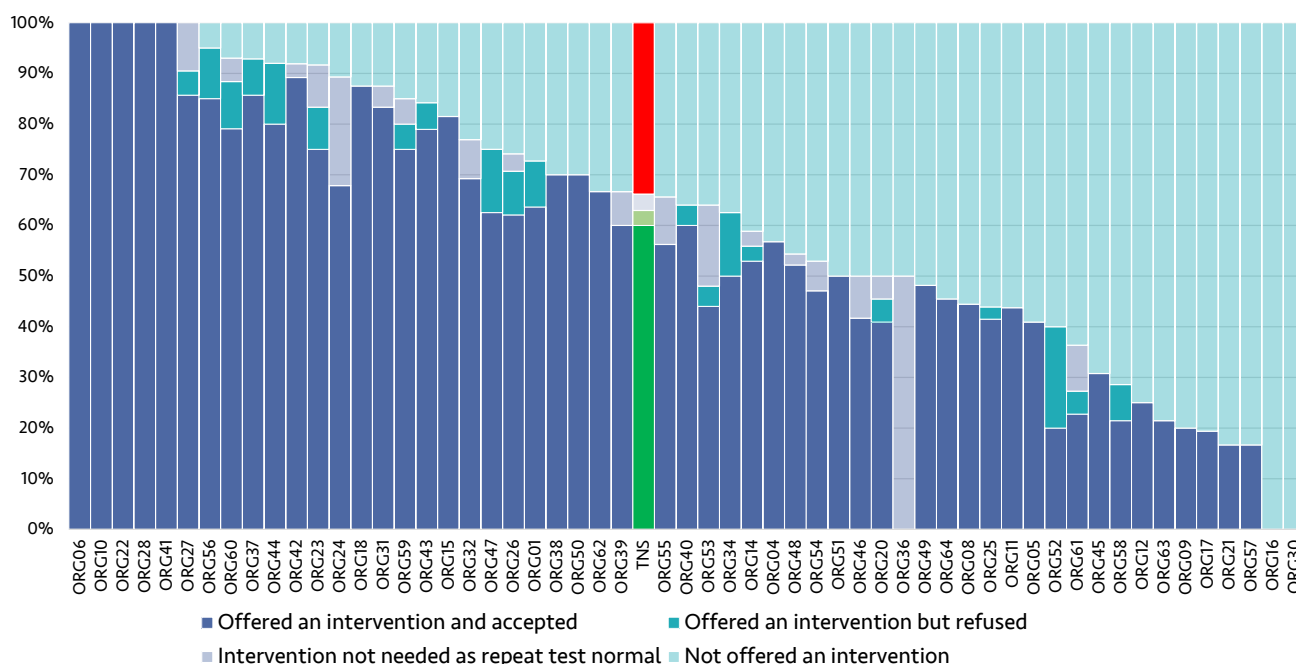


Figure 20: Proportion of people with FEP offered intervention for elevated blood pressure across Trusts (n = 1082)

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.

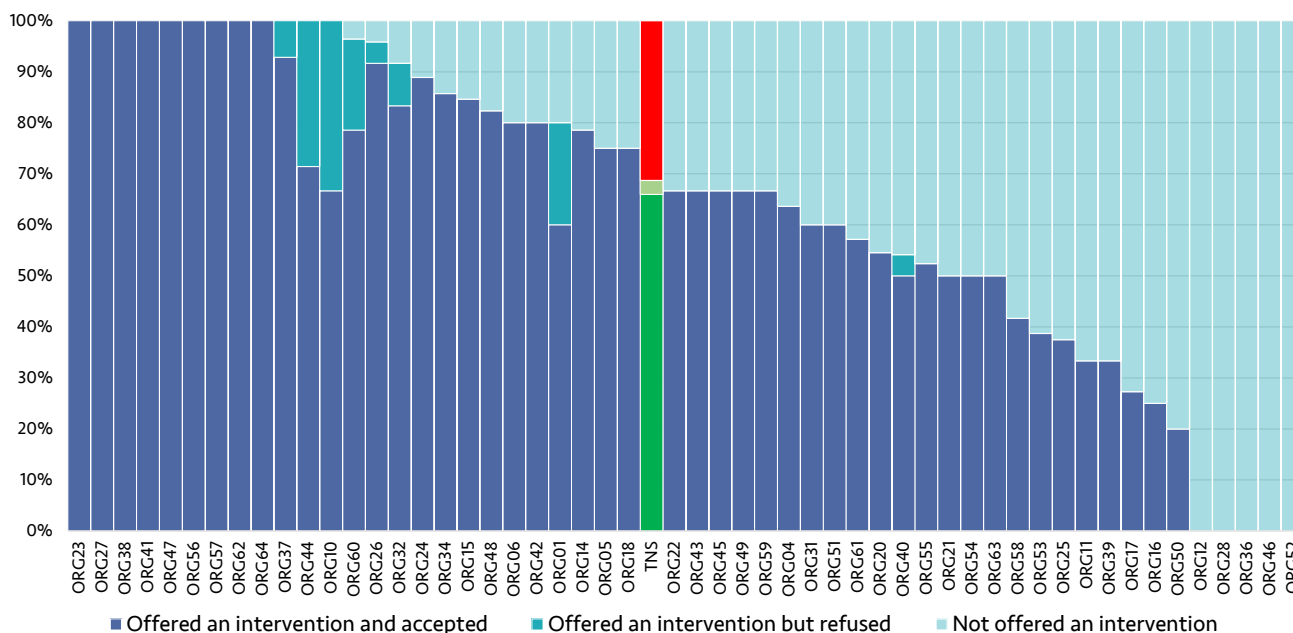


Figure 21: Proportion of people with FEP offered intervention for abnormal glucose control across Trusts (n = 476)

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%^a to 55%) in the proportion of patients whose carers took up or were referred to carer education and support programmes.

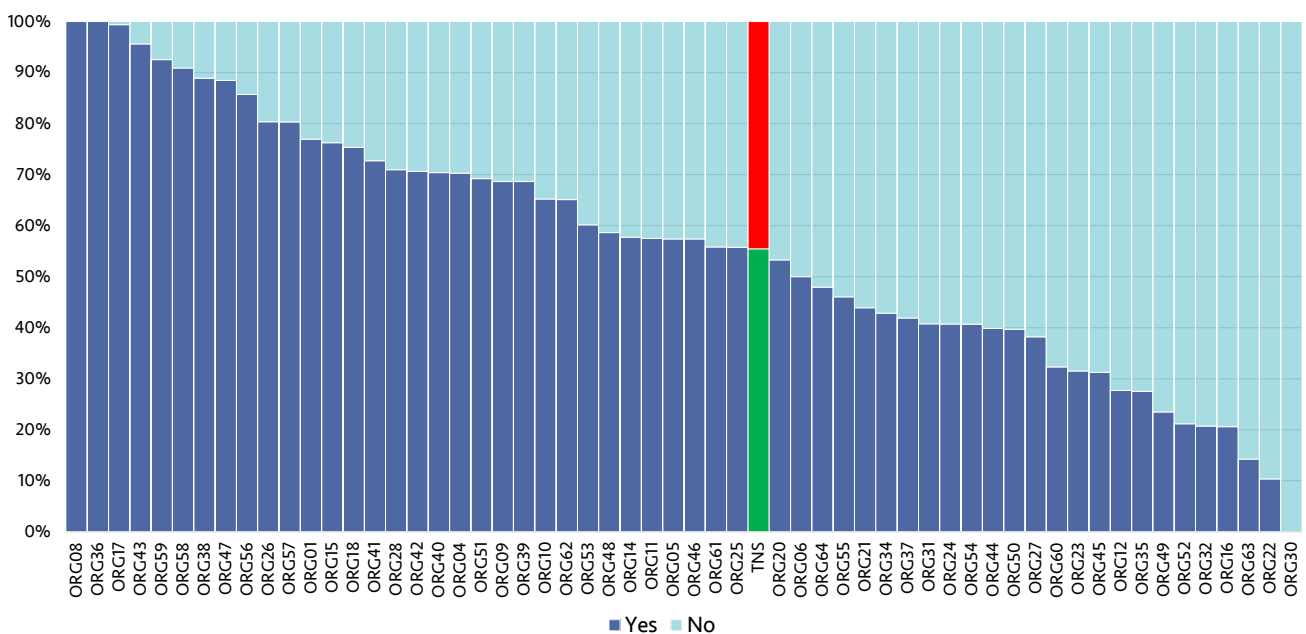


Figure 22: Proportion of people with FEP whose carers took up or were referred to carer-focused education and support programmes (n = 6980)

^aCompared 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, QPR¹) 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%⁵ 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).

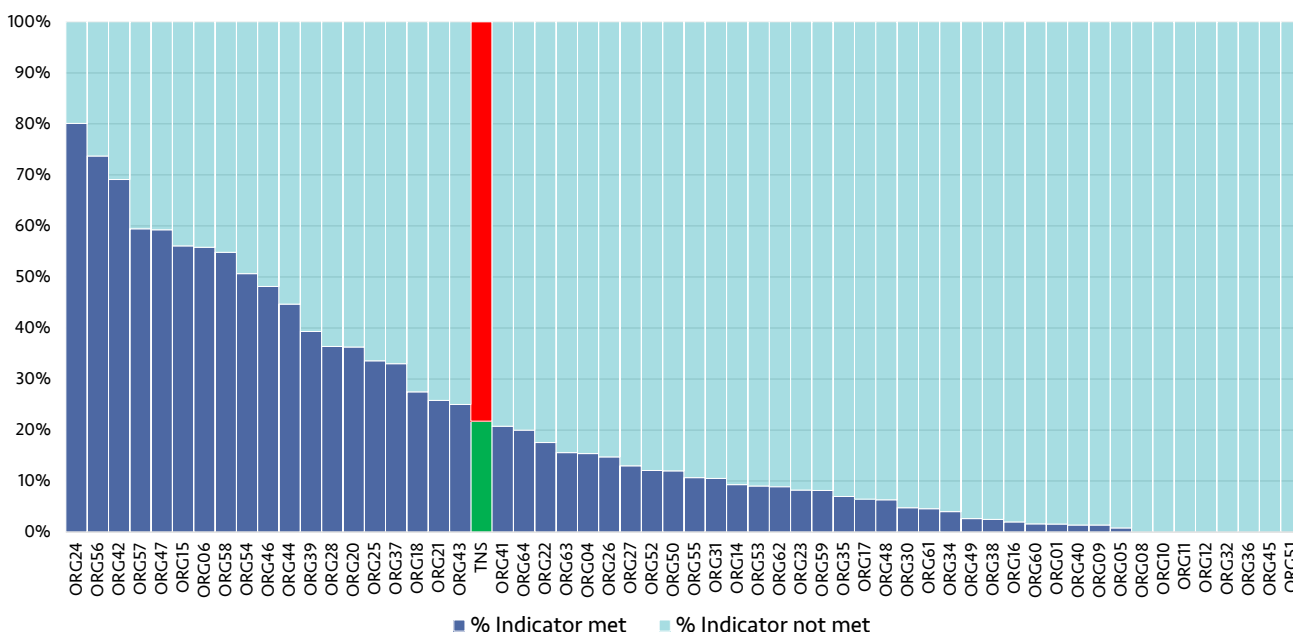


Figure 23: Proportion of people with FEP with clinical outcome measurement data (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) recorded at least twice (at assessment and at one other time point) (n = 9527)

¹HoNOS/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.

⁵Compared 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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Shiers DE, Rafi I, Cooper SJ, Holt RIG (2014) *Positive Cardiometabolic Health Resource: an intervention framework for patients with psychosis and schizophrenia*. 2014 update (with acknowledgement to the late Helen Lester for her contribution to the original 2012 version). London: Royal College of Psychiatrists.

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 multidisciplinary 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 |
| 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 |
| 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 | ORG48 | Tameside Early Intervention Team |
| | | 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 |
| | | Sheffield Early Intervention Service |
| | | 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.

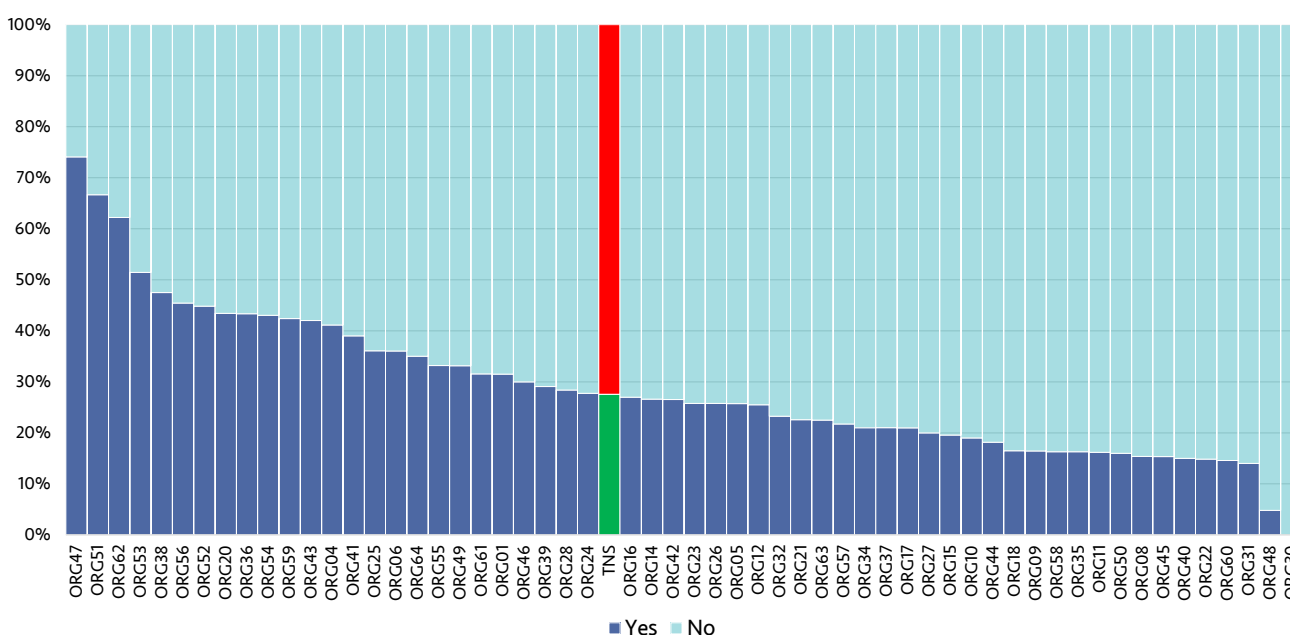


Figure 24: Proportion of people with FEP who have taken up supported employment and education programmes based on the entire national sample (n = 9527)

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



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