Early Intervention in Psychosis Network
Self-assessment tool guidance

September 2016 (updated)
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**Guidance on the self-assessment**

Each team is asked to complete one self-assessment form.

The self-assessment tool must be submitted online by **30 September 2016** via the link provided to the team contact by the EIPN project team. A paper copy of the self-assessment tool is included in Appendix 1 for reference only; if desired, you may record your responses on this copy and when complete, enter your responses online. We recommend you keep a copy for your records.

**Who should complete the self-assessment form?**

Clinicians working in the EIP service and/or the team manager should complete the self-assessment form. To complete this form you should refer to the service specification and the data collected over the data collection period.

**Selecting your sample**

Data for standards on waiting times (waiting time for initial assessment, waiting time for allocation and engagement with an EIP care coordinator and waiting time for specialist ARMS assessment) are collected from a 3 month period. Some of these data can be drawn from your submissions to Unify/Mental Health Services Dataset (MHSDS).

Other standards focus on the total caseload, examining what service users have been offered during their time under the care of the team (e.g. CBTp, Family Interventions etc.).

Some standards focus purely on service delivery and can be answered with knowledge of the team’s ways of working.

**Numerators and denominators**

Numerators and denominators are used to generate percentages for many items, e.g. the percentage of service users with First Episode Psychosis on the caseload that have been offered CBTp. The denominator is the total population for the item (the number of service users with First Episode Psychosis on the caseload) whilst the numerator is a subset of that (the number of service users with First Episode Psychosis on the caseload that have been offered CBTp). The numerator is divided by the denominator to generate a percentage, which will be included in your report and benchmarking.

**Data collection sheet**

Teams have been provided with a data collection sheet to allow them to gather the information requested. Some of the information requested in the self-assessment form and the data collection sheet link directly to identified fields in Unify/MHSDS and these are clearly marked.

Where teams have the ability to draw the information requested from their electronic records, the team must ensure that it complies with the guidance outlined in this document.
Data validation

Many of the items for which a numerical response is required will only accept numbers; if any other characters are entered, the response will be highlighted as invalid.

Where a numerator and denominator are specified, the numerator cannot be larger than the denominator.

The EIPN project team will undertake a process of review and validation of the data submitted on the self-assessment tool. Teams will be selected at random, or by relevant experts, and may be asked to provide some or all of the following to the EIPN project team as part of the process of data validation and review:

- A copy of their raw data used to calculate the figures submitted on the self-assessment tool;
- A random sample of anonymised case notes.

Scoring

A scoring system will be utilised, giving an individual score for some items and an overall score for the EIP team, which will be made available to the public. Teams will receive a report detailing their scores against each item, including benchmarking information. These ratings are as follows:

- Outstanding
- Good
- Requires improvement
- Requires substantial improvement
Self-Assessment Tool

All questions in the self-assessment tool are mandatory.
All responses should be completed for your individual early intervention in psychosis team and not the Trust as a whole.

Q1. Service type

Q1. Type of EIP service

| Stand-alone multidisciplinary EIP team: | The service is provided through a stand-alone specialist team which works independently from other generic Community Mental Health Teams (CMHTs). All staff work predominantly for the team and have a shared task to provide EIP services. |
| Hub and spoke model | The service is provided by dedicated EIP staff (‘spokes’) which are based within more generic community mental health teams and have access to specialist EIP skills, support and supervision in an EIP ‘hub’. |
| EI function integrated into a community mental health team (CMHT) | The service is provided by staff embedded within an existing service, normally a Community Mental Health Team (CMHT). Staff are expected to follow the core principles of EIP care but have less contact with other people for specialist EIP skills, support and supervision. |
| Other | |

Other model – please specify

What is the rationale for the use of a hub and spoke model?
This question is only asked if a team answers ‘hub and spoke model’ to the question above. It may include differences in geography, commissioning decisions or funding.

Has the use of this model been carefully considered to mitigate any risks and ensure the same level of care is delivered as with a stand-alone service?
This question is only asked if a team answers ‘hub and spoke model’ to the question above. Please detail the risks considered and the action taken to address these, as well as steps taken to ensure the level of care is equal to a stand-alone service.
Q2. Does the service review access data at least annually, comparing data with local population statistics and taking action to address any inequalities of access where identified?

Guidance: These data are used to understand who is accessing the service, identify underrepresented groups, promote the service to these groups and improve the accessibility of the service.

Teams answering yes to this question are expected to be able to demonstrate evidence that they are:

- Comparing expected local psychosis incidence per year, using the National Mental Health Intelligence Network’s fingertips tool or PsyMaptic, with referrals to their service AND;
- Considering the demographic profile of their referrals and caseload compared with their local population demographics AND;
- Have taken action to address inequalities of access.

Examples may include developing links with local organisations which provide support to underrepresented groups to improve awareness of the service, or review barriers to access that may deter prospective service users and their families.

Q3. What is the total caseload of the service?

This should be completed for your individual team, and not the Trust as a whole. If the service is part of a larger team (integrated into a CMHT, for example), please only count EIP cases.

Q4. How many people on the total caseload are under 18?

The figure should include all service users on the EIP caseload up to (but not including) age 18. If children and young people are cared for by a separate service, do not include them in this figure.

Q5. How many people on the total caseload are 18 or over?

The figure should include all service users on the EIP caseload aged 18 or over.

Q6. How many people on the total caseload have confirmed First Episode Psychosis (FEP)?

The figure should include all service users on the EIP caseload diagnosed with First Episode Psychosis.

Q7. How many people on the total caseload have an At-Risk Mental State for Psychosis (ARMS)?

The figure should include all service users on the EIP caseload assessed as having At-Risk Mental State (ARMS) for psychosis.
Q8. Engagement

**Denominator:** What is the total caseload of the service? (As Q3).

**Q8. Numerator:** How many service users that were engaged with the service disengaged/were lost to follow-up between 5 July 2015 and 4 July 2016?

This figure should include all service users who:

- Were allocated a care coordinator AND;
- Engaged with the care coordinator BUT;
- Were subsequently lost to follow-up or disengaged from the service before completion of their treatment, between 5 July 2015 and 4 July 2016. i.e., people who the team is not able to locate or get in touch with, or people who refuse care from the team and discontinue their involvement altogether.

**Exclusions**

- This does not include service users that have been discharged, or transferred to another service or area.

Q9. Full-time care coordinators have a caseload of no more than 15 (reduced pro-rata for part-time staff)

**What is the total caseload of the service? (As Q3).**

**Q9. How many whole time equivalent EIP care coordinators work for the service?**

This should be completed for your individual team, and not the Trust as a whole. This should include the total number of whole time equivalent staff in the service that are care coordinators for EIP.

For example, if a service has three full-time nurses, two full-time social workers and one half-time occupational therapist who act as care coordinators for EIP, their response would be 5.5.

**Exclusions**

- If the EIP service is integrated into another team, do not count staff members that do not care coordinate EIP cases.

Q10-11. Children and Young Peoples’ Mental Health (CYPMHS) provision

**Q10. Please select the option that best describes the model of CYPMHS provision in your service:**

Specialist EIP team embedded within CYPMHS
Adult EIP service with staff that have expertise in CYPMHS
Adult EIP service with joint protocols with CYPMHS
No CYPMHS provision
Other - please specify below

Please specify how early intervention in psychosis support for children and young people is provided within your team.

Q11. Are there staff members with dedicated sessional time in the team from the following professions with competence in working with children and young people? (Tick all that apply)
Psychiatrist; Psychologist; Nurse; Family therapist; Other

In order to select any of these professions, there must be:

- A member of that profession with dedicated sessional time for the EIP team AND;
- They must have relevant experience and/or qualifications in working with children and young people.

Q12. Drug and alcohol services

Q12. Can staff in your service signpost/refer service users to a specialist drug and alcohol service?

Note: These services may be provided by the NHS, voluntary or private sectors

Services answering yes to this question should:

- Be able to signpost or refer service users on to a drug and alcohol service, OR;
- Include specialist drug and alcohol staff within the EIP Team.

Q13-19. Availability of interventions

Q13-15. Cognitive Behavioural Therapy for Psychosis (CBTp)

Q13. How many hours of CBTp are delivered per week in the service?

This should include the total number of hours that staff in the EIP service spend delivering CBTp in an average week. For example, if one member of staff spends 3 hours delivering CBTp and another spends 4 hours in one week, the total would be 7 hours of CBTp.

Exclusions

- Do not record the whole-time-equivalent of staff trained to deliver CBTp; only time spent delivering CBTp itself.
- If full-time CBTp therapists are employed by the team, please only count time spent delivering CBTp one-to-one with service users (not, for example, admin)
Q14. How many whole-time equivalent staff members are trained, or are currently receiving training, to deliver CBTp?

Training is defined as:

- Postgraduate diploma level or equivalent generic CBT training (in the form of a CBT training programme or in the course of training as a clinical psychologist), plus additional specialised CBTp training.
- An HEE-approved training course.
- Early cohorts of practitioners involved in developing CBTp may have undertaken a different route to qualification. This might have involved:
  - Being a therapist in a CBTp trial with supervision from experts in the field;
  - Attending numerous CBTp conferences (post generic CBT training) with supervision from experts in the field.
- Training in generic Psychosocial Interventions (PSI), generic CBT alone or brief training courses in CBTp are not considered sufficient to deliver NICE recommended CBTp.
- The competences required to deliver CBTp are described in the “Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder”. CBTp courses should follow curricula derived from this national competence framework.

For example, if the service has 3 full-time nurses and one half-time psychologist trained to deliver CBTp, the response would be 3.5.

Q15. Do staff members delivering CBTp receive clinical supervision for at least 1.5 hours per month, delivered by an appropriately trained and experienced supervisor?

Services answering yes to this question are expected to be able to evidence that:

- All staff delivering CBTp receive clinical supervision for at least 1.5 hours per month;
- Supervisors should have received training in a recognised CBTp course and be experienced in providing CBTp.

Q16. Supported Employment

Q16. Please indicate the type(s) of supported employment programmes available to people that use your service.

Note: These services may be provided by the NHS, voluntary or private sector.

All the programmes listed are provided in a formalised programme approach, and do not include general support provided at appointments by EIP staff.

There are three options:

- **Provided by the EIP team** – staff in the EIP team deliver supported employment programmes during sessional time in the EIP team OR the team has a contractual agreement with another service to provide supported employment programmes.
• **Available locally (external to the EIP team)** – delivered by other local providers such as other NHS teams, the voluntary sector or private sector and available to service users in the catchment area that the EIP team covers.

• **Not available**

**Individual Placement and Support (IPS)**

IPS is an evidence-based Supported Employment Programme for people with severe mental illness. Service users are placed in paid, competitive employment immediately, receiving training and support on the job. For more information on how IPS should operate, please see [Centre for Mental Health](#) guidance.

**Supported Employment Programme**

Any approach which aims to place people in competitive employment immediately. A period of preparation may be included but this should last less than one month and not involve a work placement in a sheltered setting, transitional employment or training.

**Work Placement Schemes**

This may include placement in a protected, sheltered setting (e.g. social firms), work experience programmes, volunteering, or transitional employment (e.g. paid, temporary jobs organised by the scheme) which aim to develop people’s skills and confidence.

**Back to work support**

This may include programmes which provide practical support to people returning to work such as developing and agreeing reasonable adjustments or a phased return to work plan with people and their employer; support to people and their employer during fluctuations in their mental health; practical support and encouragement when people experience difficulties, and regular contact to help people find solutions to situations which may affect work performance.

**Employment preparation programmes**

An approach where people undergo a period of preparation before being encouraged to enter competitive employment. Preparation may include sheltered work placement and pre-vocational skills training.

**Other**

**Other – please specify**

**Q17-19. Family Interventions (FI)**

**Q16. How many hours of Family Interventions are delivered per week in the service?**
This should include the total number of hours that staff in the EIP service spend delivering FI in an average week. For example, if one member of staff spends 1 hour delivering FI and another spends 2 hours in one week, the total would be 3 hours of FI.

**Exclusions**
- Do not record the whole-time-equivalent of staff trained to deliver Family Interventions; only time spent delivering Family Interventions itself.

**Q17. How many whole-time equivalent staff members are trained or are currently receiving training, to deliver Family Interventions?**

Staff must have completed, or are currently attending, a training course in providing Family Interventions which is recognised by Health Education England (HEE). Staff who have completed a recognised training course have been assessed as having the competencies required to deliver FI. For example, if a service has one half-time family therapist and one half-time psychologist that deliver FI, the response would be 1.

**Q18. Do staff members delivering Family Interventions receive clinical supervision for at least 1.5 hours per month, delivered by an appropriately trained and experienced supervisor?**

Services answering yes to this question are expected to be able to evidence that:
- All staff delivering family interventions receive clinical supervision for at least 1.5 hours per month AND;
- Supervisors have received training in a recognised Family Interventions course and be experienced in providing Family Interventions.

**Q20-22. Service users referred with suspected first episode psychosis receive an initial assessment within 2 weeks of receipt of referral**

**Q20. Denominator: How many people with suspected first episode of psychosis were referred to your service during the last 3 months?**

These data are submitted to Unify. Please enter the data you submitted for the most recent 3 months, where the data meets the definitions outlined in the EIPN Self-assessment tool guidance.

This should include all those referred with a (suspected) first episode of psychosis and not include any previous referrals to mental health services for unrelated issues.
- Data submitted to Unify/Mental Health Services Minimum Dataset may be used to populate this question. Data must be from the most recent 3 months available
- If Unify data are used, they must be specific to your EIP service and not the Trust
• This includes referrals not initially flagged as FEP, but the person is assessed or triaged as such
• This does not include those who, following consultation or triage by the EIP service clearly do not have psychosis.

Referrals may come from any source, and may be internal (e.g. Children and Young Peoples’ Mental Health Services, community mental health team, an inpatient unit, forensic mental health services, prison), or external (e.g. GP, school, self-referral, carer referral).

Q21. Numerator: Of those, how many received an assessment within 2 weeks of referral?

Clock start

• The single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’ OR;
• The single point of access or triage service receives a referral not flagged as ‘suspected first episode psychosis’, but the person is assessed or triaged as such (clock starts on date referral was originally received) OR;
• The EIP service accepts a direct referral flagged as ‘suspected first episode psychosis’

Clock stop

• The person receives an initial face-to-face assessment from a competent and qualified professional in the EIP Team OR;
• The team is still unable to assess someone after proactive attempts to engage, the referrer and carer(s) are consulted and if necessary the person discharged.
• Non-attendance or cancellations will not stop or pause the clock.

Exclusions

• The single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’, but following consultation with the EIP service it is triaged as clearly not psychosis OR;
• The single point of access or triage service receives a referral of a person experiencing psychotic symptoms with a confirmed organic cause, for example, brain diseases such as Huntington’s and Parkinson’s disease, HIV or syphilis, dementia, or brain tumours or cysts.

Q22. Additional: Of those, how many were triaged (if the EIP team triages referrals) or assessed and consequently found not to be suitable for EIP?
This figure should include all service users referred with suspected first episode psychosis, who referrals are subsequently rejected by the EIP team, or who are signposted or referred on to alternative services instead of EIP.

Please answer the following questions using data on those service users who are currently receiving treatment for first episode psychosis only

Q23-24. Service users with first episode psychosis are allocated to, and engaged with, an early intervention in psychosis (EIP) care coordinator within 2 weeks of receipt of referral

These data are submitted to Unify. Please enter the data you submitted for the most recent 3 months, where the data meets the definitions outlined in the EIPN Self-assessment tool guidance.

Q23. Denominator: How many people with first episode psychosis were allocated and engaged with an EIP care coordinator in the last 3 months?

- Data submitted to Unify/Mental Health Services Minimum Dataset may be used to populate this question. Data must be from the most recent 3 months available
- If Unify data are used, they must be specific to your EIP service and not the Trust

This figure should include the total number of service users with first episode psychosis allocated to an EIP care coordinator in the most recently available 3-month period. The EIP care coordinator must:

- Actively attempt to engage with the service user AND;
- Offer any of the following treatments:
  - Care from the EIP Team
  - Pharmacological interventions
  - Psychological interventions
  - Psychosocial interventions
  - An initial treatment plan

Q24. Numerator: Of those, how many were allocated and engaged with an EIP care coordinator within 2 weeks of referral?

Clock start

- The single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’ OR;
The single point of access or triage service receives a referral not flagged as 'suspected first episode psychosis', but the person is assessed or triaged as such (clock starts on date referral was originally received) OR;

The EIP service accepts a direct referral flagged as 'suspected first episode psychosis'.

Clock stop

The person is deemed to be experiencing first episode psychosis and is allocated and engaged with an EIP care coordinator (as above) OR;

It is recorded that the person is not experiencing first episode psychosis, nor an at-risk mental state for psychosis, and an onward referral or discharge is made.

Exclusions

People found not to be experiencing first episode psychosis but may have an at-risk mental state for psychosis (see Question 36-7).

Q25-26. Service users with first episode psychosis are offered Cognitive Behavioural Therapy for psychosis (CBTp)

Denominator: How many people on the total caseload have confirmed First Episode Psychosis? (As Q6)

Q25. Numerator: How many service users with FEP currently on the caseload have been offered CBTp?

This figure should include the total number of service users with FEP whose case notes show evidence that they have been offered CBTp with a suitably qualified therapist, regardless of whether the service user took up the offer.

Exclusions

Do not include people without confirmed FEP.

Q26. Additional numerator: Of those, how many took up CBTp?

This figure should include all service users whose notes demonstrate that they have:

- accepted the offer of CBTp AND
- attended at least one session.

Q27-29. Service users with first episode psychosis are offered supported employment programmes

Guidance: These may include programmes such as Individual Placement and Support (IPS), employment placements, back to work support, and employment preparation programmes.
Q27. Denominator: How many people with First Episode Psychosis who were not in work, education or training at the point of assessment are there on the caseload?

This figure should include service users on the caseload who:

- Have confirmed first episode psychosis AND;
- Were not in work, education or training at the point of assessment.

**Exclusions**

- Those receiving employment and support allowance (incapacity benefit);
- Those currently working.
- Those currently in education.

Q28. Numerator: Of those, how many have been offered a supported employment or education programme?

This figure should include all service users whose case notes demonstrate that they have been offered a formal supported employment or education programme, regardless of whether the offer has been taken up. Formal supported employment programmes are outlined on page 8.

Q29. Additional numerator: Of those, how many took up a supported employment or education programme?

This figure should include all service users whose notes demonstrate that they have:

- accepted the offer of a supported employment or education programme AND
- attended at least one session.

Q30-32. Service users with first episode psychosis and their families are offered Family Interventions

Q30. Denominator: How many people with FEP who are in contact with their family are there on the caseload?

This figure should include service users who:

- Have confirmed first episode psychosis AND;
- Have at least 10 hours’ contact with their parents, siblings or partner per week.

Q31. Numerator: Of those, how many have been offered Family Interventions?

This figure should include all service users whose case notes demonstrate that they have been offered a Family Intervention with a suitably qualified therapist, regardless of whether the offer was taken up.

Q32. Additional numerator: Of those, how many peoples’ families took up Family Interventions?

This figure should include all service users’ families that have:

- accepted the offer of family intervention AND
• attended at least one session.

Please count service users rather than family members (i.e. if multiple family members of one service user receive the intervention, this counts as one).

**Q33-34. Service users with first episode psychosis are offered antipsychotic medication**

**Denominator: How many people on the total caseload have confirmed First Episode Psychosis?**

(As Q6).

**Q33. Numerator: How many service users with FEP currently on the caseload have been offered antipsychotic medication?**

This figure should include service users whose case notes show evidence that:

- They have confirmed FEP AND;
- they have been offered antipsychotic medication by a health professional, regardless of whether they took up the offer AND;
- A joint discussion has taken place between the service user and clinician about antipsychotic medication.

If a service user was offered antipsychotic medication by another healthcare team whilst under the care of the EIP team (for example, inpatient, crisis team, CMHT, etc.) please include them in this count.

**Q34. Additional: How many service users with FEP currently on the caseload took up antipsychotic medication?**

This figure should include service users whose case notes demonstrate that they accepted a prescription of antipsychotic medication.

**Q35. If a service user’s illness does not respond to an adequate trial of two different antipsychotic medicines given sequentially, the service user is offered clozapine**

**Q35a. Denominator: How many people with FEP on the caseload have had two adequate but unsuccessful trials of antipsychotic medications?**

This figure should include service users:

- With confirmed first episode psychosis AND;
- Who have had 2 unsuccessful trials according to the following criteria:
  - The treatment dose was adequate AND;
  - The treatment duration was adequate AND;
  - A comprehensive review of other reasons for a non-response has been undertaken (for example misdiagnosis or untreated comorbidites) AND;
  - Two different medications were trialled sequentially;
BUT the person’s response to the medication is inadequate as assessed using appropriate outcome measures.

**Q35b. Numerator: Of those, how many have been offered clozapine?**

This figure should include all service users with FEP on the caseload who have been offered clozapine, regardless of whether this was taken up.

**Please answer the following questions using data on those service users who are currently receiving treatment for an At-Risk Mental State for psychosis only.**

**Q36-37. Service users referred with, but found not to have, First Episode Psychosis are offered a specialist ARMS assessment within 2 weeks of receipt of the original referral**

**Q36. Denominator: How many people were referred to your service with suspected first episode psychosis, but found to have an At-Risk Mental State (ARMS) for psychosis between 1 April and 30 June?**

This figure should include all those referred to the service with a (suspected) first episode of psychosis, who were assessed and found not to have FEP, but an at-risk mental state for psychosis is suspected.

**Q37. Numerator: Of those, how many commenced a specialist ARMS assessment within 2 weeks of referral?**

This figure should include all those referred to the service with a (suspected) first episode of psychosis, who were assessed as not having FEP, but had commenced or received a specialist ARMS assessment within two weeks of receipt of the original referral.

**Specialist ARMS assessment:** This should be carried out by a trained EIP specialist using a recognised assessment tool such as the Comprehensive Assessment of At-Risk Mental States (CAARMS), the Structured Interview for Prodromal Syndromes (SIPS) or the Scale of Prodromal Symptoms (SOPS). The clinician conducting the assessment should be either a Consultant Psychiatrist or Mental Health Professional who has received additional training on assessing at risk mental states.

**Clock start**

- The single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’ but the person is assessed as having an at-risk mental state OR;
- The EIP service accepts a direct referral flagged as ‘suspected first episode psychosis’ but the person is assessed as having an at-risk mental state.

**Clock stop**
• The person receives an initial face-to-face specialist ARMS assessment from a competent and qualified professional in the EIP Team OR;
• The team is still unable to assess someone after proactive attempts to engage, the referrer and carer(s) are consulted and if necessary the person discharged.
• Non-attendance or cancellations will not stop or pause the clock.

Exclusions

• The single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’, but following consultation with the EIP service it is triaged as clearly not psychosis OR;
• The single point of access or triage service receives a referral of a person experiencing psychotic symptoms with a confirmed organic cause, for example, brain diseases such as Huntington’s and Parkinson’s disease, HIV or syphilis, dementia, or brain tumours or cysts.

Q38-39. Service users with an at-risk mental state for psychosis (ARMS) are offered Cognitive Behavioural Therapy for their at-risk mental state

Denominator: How many people on the total caseload have an At-Risk Mental State for Psychosis (ARMS)?

(As Q7).

Q38. Numerator: How many service users with ARMS currently on the caseload have been offered CBT for their at-risk mental state?

This figure should include all service users with ARMS whose case notes show evidence that they have been offered CBT for their at-risk mental state with a suitably qualified therapist, regardless of whether the service user took up the offer.

Q39. Additional numerator: Of those, how many took up CBT for their at-risk mental state?

This figure should include all service users with ARMS who have accepted the offer of CBT for their at-risk mental state.

Please answer the following questions using data from all service users

Q40 All service users are supported to develop a personal recovery plan using a structured tool

Guidance: The plan focusses on the person’s strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and should reference the management of transitions.

Denominator: What is the total caseload of the service?

(As Q3).
Q40. Numerator: How many service users currently on the caseload have been supported to develop a personal recovery plan using a structured tool (as above)?

This figure should include all service users whose case notes show that they have an up-to-date personal recovery plan. The recovery plan should include reference to:

- The person’s strengths
- The person’s self-awareness
- Sustainable resources
- Support systems
- Distress tolerance skills
- Management of transitions

**Exclusions**

- A personal recovery plan is a formal, structured tool. Do not include service users with a care plan only.

Q41. Service users are supported to develop a structured safety and staying well (crisis and relapse prevention) plan in collaboration with their family, friend or carer (where appropriate), which is shared with primary care and other organisations involved in their care, with their consent.

**Denominator: What is the total caseload of the service?**

(As Q3).

Q41. Numerator: How many service users currently on the caseload have been supported to develop a structured safety and staying well (crisis and relapse prevention) plan in collaboration with their family, friend or carer (where appropriate)? The plan should be shared with primary care and other organisations involved in their care, with their consent.

This figure should include all service users whose case notes include:

- An up-to-date crisis and relapse prevention plan AND;
- Evidence that this has been shared with their GP, other organisations involved in their care (if applicable), and their family, friend or carer (with consent).

**Exclusions**

- A structured safety and staying well (crisis and relapse prevention) plan is a formal, structured tool. Do not include service users with a care plan only.
Q42-43. Service users with FEP have a physical health review at the start of treatment (baseline), at 3 months and then annually (or 6 monthly for young people) unless a physical abnormality arises.

Guidance: This includes:
- A personal/family history (at baseline and annual review);
- Lifestyle review (at every review);
- Weight (at every review) and height (baseline and every 6 months for young people);
- Waist circumference (at baseline and annual review for adults; at baseline and every 6 months for young people);
- Blood pressure (at every review);
- Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review);
- Lipid profile (at every review).

These data align with the Physical Health of People with Serious Mental Illness (PSMI) CQUIN. Please note that personal/family history and waist circumference are not included in CQUIN requirements but should be included here.

The Lester UK Adaptation of the positive cardiometabolic health resource can be used to help monitor service users’ physical health.

Denominator: What is the total caseload of the service?
(As Q3).

Q42. Numerator: How many service users with FEP currently on the caseload had a physical health assessment, including all the elements listed above, between 5 July 2015 and 4 July 2016?

This figure should include all service users:

- With confirmed FEP
- Whose case notes demonstrate that they received a comprehensive physical health assessment between 5 July 2015 and 4 July 2016 AND;
- Whose assessment includes:
  - A personal/family history;
  - Lifestyle review;
  - Weight and height;
  - Waist circumference;
  - Blood pressure;
  - Fasting plasma glucose/HbA1c (glycated haemoglobin);
  - Lipid profile.

Q43. Do all service users with FEP have a physical health assessment at the following intervals:
3 months after starting treatment?
Annually after starting treatment (or 6 monthly for under 18s)?
Teams answering yes to these questions are expected to be able to demonstrate evidence that:

- There are documented processes which outline the frequency of physical health assessments and the guidance includes reference to each of the above elements AND;
- There is a process in place for monitoring the frequency of physical health assessments AND;
- Their case notes demonstrate that service users have physical health assessments at the recommended intervals.

**Q44-49. Service users are offered physical health interventions, including advice and/or signposting to healthy eating, physical activity and smoking cessation services**

**Weight management**

**Q44. Denominator: How many service users currently on the caseload have been identified as needing a physical health intervention for weight management?**

This figure should include all service users whose case notes demonstrate that they require help to manage their weight or other cardiovascular risk factors.

**Q45. Numerator: Of those, how many have been offered physical health interventions, including advice and/or signposting to combined healthy eating and physical activity services?**

This figure should include all service users whose case notes demonstrate that they have been offered:

- advice to manage their weight (e.g. guidance about diet, increasing their physical activity) AND/OR;
- have been provided with information on where and how they can access additional support from specialist healthy eating and physical activity services (see table below).

**Q46. Additional: Of those, how many took up physical health interventions, including advice and/or signposting to combined healthy eating and physical activity services?**

This figure should include all service users whose case notes demonstrate that they accepted advice and/or accessed healthy eating and physical activity services (see table below).

<table>
<thead>
<tr>
<th>Healthy eating</th>
<th>May include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Advice, discussion and encouragement;</td>
</tr>
<tr>
<td></td>
<td>• Structured diet education and healthy eating programmes;</td>
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<tr>
<td></td>
<td>• Referral to a lifestyle weight management scheme.</td>
</tr>
</tbody>
</table>
Physical activity

May include:
- Advice, discussion and encouragement;
- Support to access the local gym, walking group, or similar;
- Structured exercise education, training and psychological support programmes;
- Referral to a lifestyle weight management scheme (if appropriate)

Smoking

Q47. Denominator: How many service users currently on the caseload have been identified as needing a physical health intervention for smoking?

This figure should include all service users whose case notes demonstrate that they require help to stop smoking.

Q48. Numerator: Of those, how many have been offered physical health interventions, including advice and/or signposting to smoking cessation services?

This figure should include all service users whose case notes demonstrate that they have been offered:
- advice to help stop smoking AND/OR;
- have been provided with information on where and how they can access additional support from specialist smoking cessation services (see table below).

Q49. Additional: Of those, how many took up physical health interventions, including advice and/or signposting to smoking cessation services?

This figure should include all service users whose case notes demonstrate that they accepted advice and/or accessed smoking cessation services (see table below).

Smoking cessation

May include:
- Advice, discussion and encouragement;
- Self-help material (e.g. manual or structured programme to support a person’s attempt to quit without the help of a health professional);
- Pharmacotherapy (e.g. nicotine replacement therapy, varenicline);
- Access to behavioural counselling, or;
- Referral to a smoking cessation service or specialist

Q50-52. Carers are offered carer-focussed education and support programmes
Q50. Denominator: How many service users currently on the caseload have an identified carer?
This figure should include all service users whose case notes identify that they have a carer.

Q51. Numerator: Of those, how many service users’ carers have been offered carer-focused education and support programmes?
*Note: If a service user has more than one carer, please count this as one.*
Please count service users rather than carers (i.e. if a service user has two people that act as carers, this counts as one).

This figure should include all service users whose case notes demonstrate that the people they are in close contact with have been offered support and information on psychosis (which emphasises recovery). This may include:
- One-to-one advice and information;
- Access to recovery college courses aimed at those who care for people with psychosis;
- Carer support groups.

Q52. Additional: Of those, how many service users’ carers have been offered carer-focused education and support programmes?
*Note: If a service user has more than one carer, please count this as one.*
This figure should include all service users whose carer(s) accepted the offer of carer-focused education and support programmes.

Q53-55. Clinical outcome measurement data is collected at assessment, after 6 months, 12 months and then annually until discharge

Denominator: What is the total caseload of the service?
(As Q3).

Q53. Numerator: How many service users currently on the caseload have two or more clinical outcome measures (from HONOS/HONOSCa, DIALOG or QPR) recorded at least twice (at assessment and one other time point)?
This figure should include all service users on the caseload whose notes demonstrate that:
- At least two of the following outcome measures have been recorded in their notes:
  - HONOS or HONOSCa;
  - DIALOG;
  - QPR, AND;
• These outcome measures have been collected at assessment and repeated at a later date for monitoring and comparison purposes.

Exclusions
• If a service user is under 18, and DIALOG and QPR are not suitable, another tool measuring general functioning should be recorded.

Q54. Are outcome measures recorded on an electronic care record system?

Services answering yes to this question are expected to be able to demonstrate that:
• The service uses an electronic care record system AND;
• Outcome measures are recorded on this system.

Q55. Are outcome measures used to inform supervision and service user reviews?

Services answering yes to this question are expected to be able to demonstrate that:
• Outcome measures are a standing agenda item for clinical supervision sessions AND;
• Outcome measures are a standing agenda item for service user review sessions.

Q56. The service offers an optimum treatment package of 3 years, with consideration of service user need

Q56. Please state the length in treatment in months, to the nearest month, of the last 10 service users diagnosed with First Episode Psychosis discharged from the service.

Please include service users who:
• Have confirmed First Episode Psychosis AND;
• Were accepted for treatment by the EIP team AND;
• Completed treatment from the EIP Team.

Please calculate the length of treatment in months, for example if a service user was treated for 3 years the response would be 36 (months).

Exclusions
• Only include service users who were discharged from EIP altogether. Do not include those that have been transferred to another EIP team.
• Do not include people that disengaged from the service.
Appendix 1 – Self-assessment tool (reference only)

Early Intervention in Psychosis Network
Self-Assessment Tool

Please complete one self-assessment form per Early Intervention in Psychosis team.

All data must be collected and submitted by 30 September 2016.

Please refer to the 'Guidance on the self-assessment tool' document for information on how to complete this tool, including definitions and guidance for each item.

This self-assessment tool should be completed using data from all service users currently on the caseload, unless a specific sampling frame is stated.

Many of the questions are phrased as a numerator and denominator, which will be used to calculate a percentage for each item. Some questions have an additional numerator which qualifies or adds detail to the item.

An additional data collection sheet is provided to help your team collect the relevant data if required.

If you have 'cookies' enabled on your computer, it is possible to save this survey and come back to it at a later date.

If you require further assistance, please contact the EIPN project team on eipn@rcpsych.ac.uk or 0203 701 2649, or visit our website at www.rcpsych.ac.uk/eipn.

All questions in this tool are mandatory.

All responses should be completed for your individual early intervention in psychosis team and not for the Trust as a whole.
# ABOUT YOUR SERVICE

The following questions relate to your individual early intervention in psychosis team and should be completed to reflect your current service provision.

**Trust/organisation name**

**Service name**
Please indicate the location of your service if this is not in your service name, for example *Early Intervention Team, Northampton* or *Early Intervention Service, Cheshire West*

**Email address** of person completing this form (in case of data enquiries)

**Confirm email address**

## Service Type

**Type of EIP service:**
- [ ] Stand-alone multidisciplinary EIP team
- [ ] Hub and spoke model
- [ ] EI function integrated into a community mental health team (CMHT)
- [ ] Other - please specify below

**Other model - please specify**

**What is the rationale for use of a hub and spoke model?**

**Has the use of this model been carefully considered to mitigate any risks and ensure the same level of care is delivered as with a stand-alone service?**

*Please detail the risks considered and the action taken to address these.*
Access

Does the service review access data at least annually, comparing data with local population statistics and taking action to address any inequalities of access where identified?

Guidance: These data are used to understand who is accessing the service, identify under-represented groups, promote the service to these groups and improve the accessibility of the service.

Q2

- Yes
- No

What is the total caseload of the service?

Q3

How many people on the total caseload are under 18?

Q4

How many people on the total caseload are 18 or over?

Q5

How many people on the total caseload have confirmed First Episode Psychosis (FEP)?

Q6

How many people on the total caseload have an At-Risk Mental State for Psychosis (ARMS)?

Q7
Engagement

Denominator: What is the total caseload of the service?
You entered {Q3}

Numerator: How many service users that were engaged with the service disengaged/were lost to follow-up between 5 July 2015 and 4 July 2016?

Full-time care coordinators have a caseload of no more than 15 (reduced pro-rata for part-time staff)

What is the total caseload of the service?
You entered {Q3}

How many whole time equivalent EIP care coordinators work for the service?
Child & Adolescent Mental Health Service (CAMHS) Provision

Please select the option that best describes the model of CAMHS provision in your service:

- Specialist EIP team embedded within CAMHS
- Adult EIP service with staff that have expertise in CAMHS
- Adult EIP service with joint protocols with CAMHS
- No CAMHS provision
- Other - please specify below

Other model - please specify

Are there staff members with dedicated sessional time in the team from the following professions with competence in working with children and young people? (tick all that apply)

- Psychiatrist
- Psychologist
- Nurse
- Family therapist
- Other

Drug and alcohol services

Can staff in your service signpost/refer service users to a specialist drug and alcohol service?

Note: These services may be provided by the NHS, voluntary or private sectors

- Yes
- No
Availability of Interventions

A. Cognitive Behavioural Therapy for Psychosis (CBTp)

Q13 How many hours of CBTp are delivered per week in the service?

Q14 How many whole-time equivalent staff members are trained, or are currently receiving training, to deliver CBTp?

Q15 Do staff members delivering CBTp receive clinical supervision for at least 1.5 hours per month, delivered by an appropriately trained and experienced supervisor?

   ○ Yes   ○ No

B. Supported Employment

Please indicate the type(s) of supported employment programmes available to people that use your service:

Note: These services may be provided by the NHS, voluntary or private sectors

Q16 Provided by EIP Team Available locally (external to EIP team) Not available

   Individual Placement and Support (IPS)
   Supported Employment Programme
   Work Placement Schemes
   Back to work support
   Employment preparation programmes
   Other
   Other - please specify

C. Family Interventions

Q17 How many hours of Family Interventions are delivered per week in the service?

Q18 How many whole-time equivalent staff members are trained, or are currently receiving training, to deliver Family Interventions?

Q19 Do staff members delivering Family Interventions receive clinical supervision for at least 1.5 hours per month, delivered by an appropriately trained and experienced supervisor?

   ○ Yes   ○ No
Service users referred with suspected first episode psychosis receive an initial assessment within 2 weeks of receipt of referral

Q20 Denominator: How many people with suspected first episode of psychosis were referred to your service between 1 April and 30 June 2016?

Q21 Numerator: Of those, how many received an assessment within 2 weeks of referral?

Q22 Additional: Of those, how many were triaged (if the EIP team triages referrals) or assessed and consequently found not to be suitable for EIP?

Service users with first episode psychosis are allocated to, and engaged with, an Early Intervention in Psychosis (EIP) care coordinator within 2 weeks of receipt of referral

These data are submitted to Unify. Please enter the data you submitted for the last quarter, between 1 April and 30 June 2016.

Q23 Denominator: How many people with first episode psychosis were allocated and engaged with an EIP care coordinator between 1 April and 30 June 2016?

Q24 Numerator: Of those, how many were allocated and engaged with an EIP care coordinator within 2 weeks of referral?
Service users with first episode psychosis are offered Cognitive Behavioural Therapy for Psychosis (CBTp)

Denominator: How many people on the total caseload have confirmed First Episode Psychosis?
You entered: **Q6**

Numerator: How many service users with FEP currently on the caseload have been offered CBTp?

**Q25**

Numerator: Of those, how many took up CBTp?

**Q26**

Service users with first episode psychosis are offered supported employment programmes

*Guidance: These may include programmes such as Individual Placement Support (IPS), employment placements, back to work support, employment preparation programmes, and educational support programmes.*

**Q27**

How many people with First Episode Psychosis who were not in work, education or training at the point of assessment are there on the caseload?

Numerator: Of those, how many have been offered a supported employment or education programme?

**Q28**

Additional: Of those, how many took up a supported employment or education programme?

**Q29**

Service users with first episode psychosis and their families are offered Family Interventions

Denominator: How many people with FEP who are in contact with their family are there on the caseload?

**Q30**

Numerator: Of those, how many have been offered Family Interventions?

**Q31**

Additional: Of those, how many peoples' families took up Family Interventions?

**Q32**
Service users with first episode psychosis are offered antipsychotic medication

Denominator: How many people on the total caseload have confirmed First Episode Psychosis?
You entered: \{Q6\}

Numerator: How many service users with FEP currently on the caseload have been offered antipsychotic medication?

Additional: How many service users with FEP currently on the caseload took up antipsychotic medication?

If a service user's illness does not respond to an adequate trial of 2 different antipsychotic medicines given sequentially, the service user is offered clozapine

Denominator: How many people with FEP on the caseload have had two adequate but unsuccessful trials of antipsychotic medications?

Guidance: Each medicine should be given in a treatment dose for an adequate duration of time and with objective evidence of adherence. A comprehensive review of reasons for a non-response (e.g. misdiagnosis, untreated comorbidities) is undertaken

Numerator: Of those, how many have been offered clozapine?
Please answer the following questions using data on those service users who are currently receiving treatment for an at risk mental state (ARMS) for psychosis only.

**Service users referred with, but found not to have first episode psychosis, are offered a specialist ARMS assessment within 2 weeks of receipt of the original referral**

Q36 Denominator: How many people were referred to your service with suspected first episode psychosis, but found to have an At Risk Mental State (ARMS) between 1 April and 30 June 2016?

Numerator: Of those, how many commenced a specialist ARMS assessment within 2 weeks of referral?

Q37

**Service users with an at-risk mental state for psychosis (ARMS) are offered Cognitive Behavioural Therapy (CBT) for their at risk mental state.**

How many people on the total caseload have an At-Risk Mental State for Psychosis (ARMS)?
You entered: \{Q7\}

Numerator: How many service users with ARMS currently on the caseload have been offered CBT for their at-risk mental state?

Q38

Additional: Of those, how many took up CBT for their at-risk mental state?

Q39
Please answer the following questions using data from all service users

**Service users are supported to develop a personal recovery plan using a structured tool**
*Guidance: The plan focuses on the persons’ strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and should reference the management of transitions.*

**Denominator:** What is the total caseload of the service?
You entered \{Q3\}

**Numerator:** How many service users currently on the caseload have been supported to develop a personal recovery plan using a structured tool (as above)?

**Q40**

**Service users are supported to develop a structured safety and staying well (crisis and relapse prevention) plan in collaboration with their family, friend or carer (where appropriate), which is shared with primary care and other organisations involved in their care, with their consent**

**Denominator:** What is the total caseload of the service?
You entered \{Q3\}

**Numerator:** How many service users currently on the caseload have been supported to develop a structured safety and staying well (crisis and relapse prevention) plan in collaboration with their family, friend or carer (where appropriate)? The plan should be shared with primary care and other organisations involved in their care, with their consent.

**Q41**
Service users have a physical health review at the start of treatment (baseline), at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises. This includes:
- A personal/family history (at baseline and annual review);
- Lifestyle review (at every review);
- Weight (at every review) and height (baseline and every 6 months for young people);
- Waist circumference (at baseline and annual review for adults; at baseline and 6 monthly for young people);
- Blood pressure (at every review);
- Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review);
- Lipid profile (at every review)

Please note these requirements align with the CQUIN for Physical Health of People with Serious Mental Illness (PSMI)

Denominator: What is the total caseload of the service?
You entered {Q3}

Numerator: How many service users currently on the caseload had a physical health assessment including all the elements listed above, between 5 July 2015 and 4 July 2016?

Q42

Do all service users have a physical health assessment at the following intervals as a minimum:

Q43

3 months after starting treatment? [ ] Yes [ ] No

Annually after starting treatment (or 6 monthly for under 18s)? [ ] Yes [ ] No

Service users are offered physical health interventions, including advice and/or signposting to healthy eating, physical activity and smoking cessation services

Weight management

Q44

How many service users currently on the caseload have been identified as needing a physical health intervention for weight management?

Numerator: Of those, how many have been offered physical health interventions, including advice and/or signposting to combined healthy eating and physical activity services?

Q45
Numerator: Of those, how many took up physical health interventions, including advice and/or signposting to combined healthy eating and physical activity services?

**Smoking**

Q47 How many service users currently on the caseload have been identified as needing a physical health intervention for smoking?

Numerator: Of those, how many have been offered advice and/or signposting to smoking cessation services?

Q49 Numerator: Of those, how many took up advice and/or signposting to smoking cessation services?
Carers are offered carer-focussed education and support programmes

Denominator: How many service users currently on the caseload of the service have an identified carer?
Q50

Numerator: Of those, how many service users’ carers have been offered carer-focussed education and support programmes?
Q51 Note: if a service user has more than one carer, please count this as one

Additional: Of those, how many service users’ carers took up carer-focussed education and support programmes?
Q52 Note: if a service user has more than one carer, please count this as one

Clinical outcome measurement data is collected at assessment, after 6 months, 12 months and then annually until discharge

Denominator: What is the total caseload of the service?
You entered {Q3}

Numerator: How many service users currently on the caseload have two or more clinical outcome measures (from HONOS/HONOSCa, DIALOG or QPR) recorded at least twice (assessment and one other time point)?
Q53

Are outcome measures recorded on an electronic care record system?
Q54 □ Yes
□ No

Are outcome measures used to inform supervision and service user reviews?
Q55 □ Yes
□ No

The service offers an optimum treatment package of 3 years, with consideration of service user need

Q56 Please state the length of treatment in months, to the nearest month, of the last 10 service users diagnosed with First Episode Psychosis discharged from the service:

Service user 1 (months)
Service user 2 (months)
Service user 3 (months)
Service user 4 (months)
<table>
<thead>
<tr>
<th>Service user</th>
<th>(months)</th>
</tr>
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<tbody>
<tr>
<td>5</td>
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Thank you for completing this survey. Please press 'Submit' to send your data to the EIP Network team.