

Early Intervention in Psychosis:

Recording and reporting on
NICE-recommended interventions
using SNOMED CT codes



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Introduction

Background

In February 2016, the independent Mental Health Taskforce published the [Five Year Forward View for Mental Health](#) which set out the current state of mental health service provision in England and made recommendations in all service areas. NHS England accepted all the recommendations in the report for which it held responsibility, and it was agreed with the Government that to support this transformation, mental health services will benefit from additional investment of £1bn by 2020/21. In July 2016, NHS England published an [Implementation Plan](#) detailing how it will deliver the recommendations made by the Taskforce working with its partner arms-length bodies.

The early intervention in psychosis access and waiting time standard

The access and waiting time standard for Early Intervention in Psychosis (EIP) requires that, from 1st April 2016 at least 50% of people experiencing a first episode of psychosis will commence treatment with a NICE-approved care package¹ with a specialist early intervention in psychosis (EIP) service within a maximum of two weeks from referral to start of treatment. The standard will be extended to reach at least 60% of people experiencing first episode psychosis, by 2020/21.

The standard is ‘two-pronged’ and both conditions must be met for the standard to be deemed to have been achieved:

- 1. A maximum wait of two weeks from referral to start of treatment; and**
- 2. Treatment delivered in accordance with NICE guidelines and Quality Standards for psychosis and schizophrenia – either in children and young people (CG155 and QS102) or in adults (CG178 and QS80).**

The standard is targeted at people aged 14-65.²

The approach to measurement of performance against the standard has been designed to ensure that both elements can be assessed and outcomes (clinician and service user reported) routinely collected and reviewed.

This document builds on the variety of codes which were offered in [Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance](#).

The following NICE guidance may be useful:

- (QS80) NICE Quality Standard – Psychosis and schizophrenia in adults (2015).
- (CG178) NICE Guideline – Psychosis and schizophrenia in adults: prevention and management (2014).
- (QS102) NICE Quality Standard – Bipolar disorder, psychosis and schizophrenia in children and young people (2015).
- (CG155) NICE Guideline – Psychosis and schizophrenia in children and young people: recognition and management (2013).
- (QS95) NICE Quality Standard – Bipolar disorder in adults (2015).
- (CG185) NICE Guideline – Bipolar disorder: assessment and management (2014).
- (CG120) NICE Guideline – Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011).
- (CG136) NICE Guideline – Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011).

¹ Throughout the rest of this document the term ‘NICE-recommended’ package of care/intervention has been used at the request of NICE.

² EIP services may also be clinically appropriate for people outside the 14-65 age group. Professionals should use their clinical judgement when considering whether people outside the 14-65 age group should be referred to/accepted by EIP services with commissioners and providers ensuring that people are not inappropriately restricted from accessing care.

Purpose of this document

The purpose of this document is to provide guidance for services providing care to those with a first episode of psychosis, and NHS Digital in relation to recording, reporting and interpreting data on interventions and outcomes, and to support services to submit this data to NHS Digital as part of the national Mental Health Services Data Set (MHSDS) in line with contractual requirements.

This guidance offers suggestions for:

- How services could record interventions and outcomes locally in line with NICE guidelines, as appropriate.
- How services could flow such interventions and outcomes data through the MHSDS for national reporting.

This document will look at how clinicians record what interventions they have delivered to service users and provide suggested direction on agreed definitions of the intervention terms, as laid out in the [Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance](#). The aim is to support providers to report key interventions and outcomes in a consistent way, using interventions and outcome data mapped to relevant SNOMED CT codes which will then flow to NHS Digital as part of the MHSDS. This document will also recommend how these submitted interventions and outcomes data will be used in the future by NHS Digital to report on NICE concordance.

This guidance is intended to complement work which has already been done locally to map SNOMED CT codes to clinical pathways, rather than duplicating or impeding innovative work already undertaken by services.

The expectation is that EIP teams should be flowing data during 2018/19, with this data being shared and reviewed locally. It is intended that data collected will be assessed iteratively over a period of time in order to fully understand which codes are most appropriate. Once data is of sufficient quality and completeness, it will be used to decide on quality benchmarks to assess NICE concordance from 2019/20.

How was this document developed?

This guidance was developed by NHS England, with direction provided by an oversight group of experts, as well as an additional period of external engagement (see Appendix A).

This document covers **NICE Quality Standard recommended interventions**, as outlined in the [EIP Access and Waiting Time Standard: Guidance, NICE Quality Standard 80 – Psychosis and schizophrenia in adults \(2015\)](#) and [NICE Quality Standard 102 – Bipolar disorder, psychosis and schizophrenia in children and young people \(2015\)](#).

- Cognitive behavioural therapy for psychosis (CBTp)
- Family interventions (FI)
- Treatment with clozapine
- Physical health assessments and healthy lifestyle promotion
- Physical health interventions
- Education and employment support
- Carer-focused education and support

The two-week referral to treatment aspect of the standard is not covered in this guidance.

What is SNOMED CT?

SNOMED CT (SNOMED Clinical Terms)³ is a structured clinical vocabulary for use in an electronic health record.

SNOMED CT is the [information standard](#) for clinical terminology and the required terminology to support direct management of care, across all care settings in England⁴, as set out in the National Information Board (NIB) publication [Personalised Health and Care 2020: A Framework for Action](#).

³ SNOMED® and SNOMED CT® are registered trademarks of SNOMED International (www.snomed.org).

⁴ NHS Digital SNOMED CT browser can be viewed at: <https://termbrowser.nhs.uk>

Interventions and outcomes data will be collected through the MHSDS, which will be used by NHS Digital to report on the care being delivered. The MHSDS utilises SNOMED CT to allow services to demonstrate the full range of activity provided. This data will be used by NHS Digital to report on NICE recommended treatment. The MHSDS was accepted as an [Information Standard](#) by the Standardisation Committee for Care Information (SCCI) and an Information Standards Notice (ISN) was released in July 2015. Submission of MHSDS data is mandatory for NHS funded care, including independent sector providers.

The headline data requirements recommended in this guidance are the minimum requirements for the EIP standard. The data will not replace more detailed records of interventions and outcomes at a local level. It will illustrate variation at a national level, and provide a platform for more detailed local discussions.

During the period of time service users are in the EIP service, professionals should consider the suitability of offering the whole package of NICE recommended interventions, where appropriate. Specific interventions received can be recorded by the EIP team, as per the guidelines which follow.

Note that SNOMED CT codes may be subject to change under international agreement⁵, therefore iterative versions of this guidance may be published in the future.

There are placeholders indicated throughout this document for additional SNOMED CT codes which will be available for services to use from October 2018, when updated guidance will be available.

Service user choice

As an integral part of good clinical practice, it is important that throughout the period of engagement with an EIP service, service users are given the opportunity for meaningful choice around the range of appropriate interventions available. This ensures a partnership approach between health-care professional and service user, and encourages the service user to have an active involvement in their own care.

⁵ Any changes to SNOMED CT codes centrally will automatically update on supplier systems. The latest agreed version of these codes are available to view as part of the EIP guidance subset: <https://dd4c.digital.nhs.uk/dd4c/publishedmetadatas/intid/707>

Clinically indicated interventions

The interventions in this guidance are not intended as a comprehensive list of all those that should be offered in an EIP service. It is recognised that in clinical practice many other interventions will be appropriate and these should still continue. This document looks only at the specific elements of NICE-recommended care as outlined in NICE Quality Standard 80; the minimum that should be routinely offered and reported on.

The 7 interventions recommended in NICE QS80 for people experiencing first episode psychosis make up the mandatory intervention fields which should be reported on by EIP teams; NHS Digital will make available national data on this activity. If other interventions are being carried out, these should also be recorded by EIP teams to inform clinical practice. All interventions recorded should be flowed by providers within the MHSDS submission but may not necessarily be reported by NHS Digital on a regular basis.

This document is based on current published NICE guidance (NICE QS80 – February 2015).

Outcome measures

Delivering the Five Year Forward View for Mental Health: Developing quality and outcomes measures, published by NHS England and NHS Improvement, recommends the routine use of Health of the Nation Outcome Scales (HoNOS), DIALOG and Process of Recovery Questionnaire (QPR) to measure service user outcomes in EIP services. Other outcome data may be collected locally. Outcome data should be recorded as part of the service user's electronic care record and submitted as part of routine MHSDS returns.

The above outcomes tools are all well-established within the scope of the MHSDS and outcome score reporting should now be routine for services using these tools. Existing guidance can be found in the User Guidance and Technical Output Specification, both of which are available on the MHSDS webpage: <http://content.digital.nhs.uk/mhsds/spec>.

In particular, the "MH Assessment Scales" tab of the Technical Output Specification contains the SNOMED CT mapping for each rating.

Recording an intervention offer

As a minimum, EIP services should record when an intervention is delivered. However, it is expected that the uptake of interventions will be lower than the offer of interventions given that packages of care must be tailored to the needs of the individual. Therefore it is important for the offer of NICE-concordant interventions to be recorded in instances where this is not delivered. This should not be viewed as a requirement to impose interventions on service users in order to record them, and it is not expected that records will show all service users are offered all interventions as this may not be appropriate for every individual.

From April 2018, the MHSDS will have enhanced functionality allowing services to additionally indicate whether an intervention has been offered, declined or accepted. This is through the new Coded Procedure and Procedure Status (SNOMED CT) data item, included within MHSDS v3.0, which allows an intervention to be 'qualified' with such additional context. Further guidance can be found in the 'MHS202 Care Activity' section of the [MHSDS v3.0 User Guidance](#).

Example:

To flow a procedure and qualifier, three pieces of information are required:

- The procedure code (for example: 718026005 Cognitive behaviour therapy for psychosis)
- The qualifier code (for example: 410527000 Offered)
- A code that links the procedure and the qualifier (in this case: 408730004 Procedure context)

Upon analysis, the three codes are linked for submission as follows:

- 718026005:408730004=410527000 (Cognitive behaviour therapy for psychosis: Procedure context = Offered)

Qualifier codes:

Qualifier	SNOMED CT Concept ID
Offered	410527000
Refused	443390004

Therefore, to record the offer and/or decline of an intervention, the relevant SNOMED CT intervention code should be flowed, alongside the suitable 'qualifier' e.g. offered, declined. Recording an intervention without a qualifier indicates that the intervention has been delivered.

The recording of an intervention being delivered, or an onward referral, will be referenced throughout the document where applicable.

If systems do not currently allow for the recording of 'qualifier' codes, then services should endeavour to record the intervention delivery, until a point where qualifiers can be added.

Recording an intervention referral

When the EIP service cannot treat a service user directly, there may be a requirement to refer onwards to another service. Through SNOMED CT, it is possible to make distinction between referrals to onward treatment and the provision of interventions directly from the EIP (or equivalent) team. Throughout this guidance, reference will be made to the relevant intervention concepts and their 'referred for' equivalents.

The codes suggested throughout the remainder of this document are examples of some of the codes which may be appropriate for onward referral; however local areas should be encouraged to record any additional codes that may be appropriate for the care of the service user.

Reporting by NHS Digital

Analysis of all interventions may include mean, median, range etc. All reports will include aggregated data.

Reporting 'At Risk Mental State' (ARMS)

The referral to treatment strand of the EIP access and waiting time standard also applies to people at high risk of psychosis (an 'at risk mental state'). It is important that services code for a clinical finding of an 'at risk mental state' (ARMS). The interventions recommended by NICE are for people experiencing first episode psychosis only. It is not expected that those identified with an 'at risk mental state' will require all of these interventions. A SNOMED CT code for 'at risk mental state' will be available for services to use from October 2018.

Clozapine

This document acknowledges that recording of clozapine in the way outlined would not fully be able to record the context of the NICE Quality Standard, due to restrictions in the capability of NHS Digital to capture information on the relevant denominator (the number of adults that have not responded adequately to treatment with at least two antipsychotic drugs, at least one of which should be a nonclozapine secondgeneration antipsychotic) and numerator (number of those in the denominator who receive clozapine) at present.

However, recording if a service user is offered clozapine will allow proxy information on absolute numbers of offers of clozapine to be reviewed at a local level. Future iterations of this guidance will look to provide detail on how to more accurately measure this NICE Quality Standard.

Recording and reporting on NICE-recommended interventions

Cognitive behavioural therapy for psychosis (CBTp)

Cognitive behavioural therapy for psychosis (CBTp) should be considered to have been provided when delivered by a member of staff who has appropriate training and competencies in CBTp (see below). The competencies required to deliver CBTp are described in the "[Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder](#)".

Someone who is trained in CBTp will be able to judge the appropriate level (e.g. format, duration) of CBTp to be provided and the focus of therapy, based on the individual needs of the person. It is recognised that the focus of a CBTp session may not always be on psychotic symptoms but should be related to the service user's needs and goals. CBTp should be offered and/or re-offered as appropriate, or in line with the service user's care plan.

Every time a session of CBTp is delivered, this should be recorded on the service user's electronic health record.

Appropriate training is defined as:

- Postgraduate diploma level training in generic CBT or equivalent (e.g. IAPT high intensity training or some clinical psychology training programmes), plus additional specialised CBTp training.
- Early cohorts of practitioners involved in developing CBTp may have undertaken a different route to competence. This might have involved:
 - Being a therapist in a CBTp research trial with supervision from an expert in the field;
 - Evidence of attending CBTp conferences (after receiving generic CBT training), with regular supervision from an expert in the field.

CBTp therapists should also be receiving regular clinical supervision from a supervisor with appropriate [CBTp competencies](#), for a minimum of an hour per month, based on expert consensus.

Training in generic psychosocial interventions (PSI), generic CBT alone or short training courses in CBTp alone are not considered sufficient to deliver NICE recommended CBTp. CBTp courses should follow curricula derived from the national competence framework.

Table 1 outlines how this CBTp intervention data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

Family interventions (FI)

Family interventions (FI) must be delivered by a member of staff who has had formal training in FI, and has the competencies of a FI practitioner. The competencies required to deliver FI are described in "[Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder](#)". Practitioners delivering this approach require specific FI training focused on psychosis (based on recommendations in NICE guidelines CG178), lasting five days or more. All staff delivering FI should receive clinical supervision for at least one hour per month if they are actively seeing families, and supervisors must have received training in a FI course and be experienced in providing FI. Someone who is trained in FI will be able to judge the appropriate level (e.g. format, duration) to be provided, based on the needs of the family. FI should ideally include the service user, but in some cases this may not be possible or appropriate.

Every time a session of FI is delivered, this should be recorded on the service user's electronic health record⁶.

Table 1 outlines how this FI data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

⁶ The MHSDS does not currently allow for accurate reporting of this intervention unless the service user is present. Accurate recording of this data is an expectation at a national level in order to monitor the early intervention in psychosis access and waiting time standard, therefore the MHSDS will be modified from April 2019 in order to accommodate this.

Clozapine

NICE Quality Standard 80 recommends that people who have not responded adequately to treatment with at least two antipsychotic drugs should be offered clozapine. The sequential use of adequate doses of at least two different antipsychotics should each be used for 6-8 weeks (or according to clinical judgment). At least one of the antipsychotics prescribed should be a non-clozapine second-generation antipsychotic. If the service user has not responded, the drug is not considered effective or has not been tolerated, and provided there are no contraindications, then clozapine should be offered. The clinical judgement of the prescribing clinician should be used when considering dosages and whether the service user is responding adequately to current antipsychotic medication (CG155, QS80).

It is important that 'offered' is within the context of a shared decision making process, and potential risks and benefits must always be explained to the service user. Language use and means of

communication should be appropriate, and service users must be given the opportunity to discuss the offer in a meaningful way, and have questions answered. Ways of addressing service user, carer and family concerns should be identified.

The offer or decline of clozapine should be recorded on the electronic health record using the below code and relevant qualifier.

The service user may decline the offer of clozapine, or it may be decided that this is not appropriate; however the discussion around the drug and the offer being made should still be recorded.

The service user may accept the offer of clozapine, and therefore if the clinician prescribes the drug, **clozapine therapy should be recorded on the electronic health record, using the code below.**

Table 1 outlines how clozapine prescribing data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

Table 1.

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Cognitive Behavioural Therapy for Psychosis (CBTp)	<p>718026005 Cognitive behavioural therapy for psychosis</p> <p>Placeholder Referral for cognitive behavioural therapy for psychosis</p>	<ul style="list-style-type: none"> Was the service user offered CBTp? Did the service user receive CBTp? How many sessions of CBTp did the service user receive, per year, and on discharge, while under the care of the EIP service?* At discharge, what was the duration from the first session of CBTp to the last session of CBTp, while under the care of the EIP service?
Family Interventions (FI)	<p>985451000000105 Family intervention for psychosis</p> <p>859411000000105 Referral for family therapy</p>	<ul style="list-style-type: none"> Was the service user and their family offered FI? Did the service user and their family receive FI while under the care of the EIP service? How many FI sessions did the service user and their family receive per year, and on discharge, while under the care of the EIP service? At discharge, what was the average duration from the first session of FI to the last session of FI, while under the care of the EIP service?
Clozapine	<p>723948002 Clozapine therapy</p>	<ul style="list-style-type: none"> Was the service user offered clozapine therapy?

* There is currently no set minimum number of expected sessions for therapy.

Physical health assessments and healthy lifestyle promotion

In line with the [2017-19 Physical Health \(PH\) in Serious Mental Illness \(SMI\) CQUIN](#), a comprehensive physical health assessment includes a completed assessment for each of the following cardiometabolic parameters, as well as observable values with the given unit of measurement⁷. Results of assessments should be entered on the service user's electronic health record.

- Smoking status;
- Lifestyle (including exercise, diet, alcohol and drug use);
- Body Mass Index;
- Blood pressure;
- Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate);
- Blood lipids;

Assessments should be carried out by a member of staff who has had appropriate training and has the necessary competencies to complete a comprehensive physical health assessment, as outlined in the Public Health England '[NHS Health Check – Best Practice Guide](#)' (February 2017).

Every time a cardiometabolic parameter is assessed, this should be recorded on the service user's electronic health record, along with the results.

⁷ It should be noted that children and adolescents may be in a period of growth which may require a different way of assessing excessive weight gain.

Recording of the physical health assessment should be done within the EIP team, or if the person is referred for assessment to another clinician outside of the EIP team, by the assessing clinician as appropriate. If the service user has recently undergone a comprehensive physical health assessment in a different setting, e.g. has entered via an inpatient ward, it may not be necessary to repeat these assessments.

An assessment for each of the six parameters should be completed with each service user seen by the EIP team. Each parameter should be recorded as a minimum at baseline⁸ (prior to starting anti-psychotic medication), after one treatment year, and at least annually thereafter⁹. A follow-up assessment should be made within 6 weeks before or after the first anniversary of acceptance onto the EIP caseload. For those patients where a physical health issue or risk has emerged, appropriate action should be taken. Appropriate action may include referral for further investigation, diagnosis, and/or treatment by an appropriate clinician. Physical health should be regularly assessed as clinically indicated. However, note that there is currently variation between recommendations in NICE guidelines which state baseline recordings should be established within 12 weeks, whereas the national CQUIN states within 6 weeks.

Table 2 outlines how physical health assessment data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

⁸ Please refer to NICE CG178 (Rec 1.3.6.1) and NICE CG155 (Rec 1.3.16).

⁹ NICE guidelines recommend that baseline recordings should be established within no more than 12 weeks from admission, reflecting the acceptable delay in obtaining these findings. The national CQUIN states that a baseline position of the service user should be established within 6 weeks, before commencement of antipsychotic intervention. Baseline assessment should normally be made prior to an individual commencing antipsychotic treatment, recognising the potential for rapid weight increase and metabolic disturbance.

Table 2.

Cardiometabolic Parameter Assessment	SNOMED CT Concept ID	Reported by NHS Digital
Smoking status	196771000000101 Smoking assessment	
Lifestyle (including exercise, diet, alcohol and drug use)	443781008 Assessment of lifestyle	
Body Mass Index	698094009 Measurement of body mass index	
Blood pressure	171222001 Hypertension screening	
Glucose regulation*	43396009 Haemoglobin A1c measurement	<ul style="list-style-type: none"> Was a comprehensive*** physical health assessment carried out within 12 weeks from acceptance onto the EIP caseload? Was a comprehensive physical health assessment carried out, one year after the first assessment (+/- 6 weeks)? For any service users in the care of the EIP team for longer than a year, was an annual comprehensive physical health assessment carried out in the previous 12 months?
	271062006 Fasting blood glucose measurement	
	271061004 Random blood glucose measurement	
Blood lipids**	121868005 Total cholesterol measurement	
	17888004 High density lipoprotein measurement	
	166842003 Total cholesterol: HDL ratio measurement	
	1085971000000102 Assessment using QRISK cardiovascular disease 10 year risk calculator	

* It is recommended that services take consideration of all three measurements and record at least one.

** Services may also want to consider recording Triglycerides (TG) and non-HDL cholesterol for completeness.

*** 'Comprehensive' should indicate that all physical health assessment parameters have been considered by the clinician and the service user.

Physical health interventions

As per the PH SMI CQUIN, for all patients in the “red zone” of the [Lester Tool](#), the EIP service should work with the service user and primary care as appropriate, to ensure interventions and monitoring are provided and recorded.

It may be the case that EIP teams will not deliver interventions themselves and will instead refer the service user on to a more appropriate service **for investigation, diagnosis and consideration of treatment** (e.g. for diabetes or cardiovascular disease increased risk). In these instances, making the referral would be regarded as the intervention, however this would only be in cases where the intervention is delivered by another provider and therefore cannot be recorded and submitted as part of EIP service national data.

Every time a service user receives a physical health intervention from the EIP service **OR** is referred on (normally to primary care) for investigation, diagnosis and consideration of treatment, **OR** no further action is required, this should be recorded on the service user’s electronic health record, using the codes as per the table below.

Table 3 outlines how the physical health interventions and monitoring data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

Table 3.

Cardiometabolic Parameter	Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Smoking status	Help with smoking cessation	225323000 Smoking cessation education	<ul style="list-style-type: none"> What percentage of service users assessed by the EIP service were identified as in the ‘red zone’ on the Lester tool and requiring an intervention? What percentage of these service users were offered/received an intervention to address their increased risk (either within the EIP team, or referred to another service)?
		Placeholder Provision of smoking cessation therapy	
		871661000000106 Referral to smoking cessation service	
Lifestyle (including exercise, diet, alcohol and drug use)	Advice about diet and exercise, aimed at helping the person to maintain a healthy weight	715282001 Combined healthy eating and physical education programme	
		1094331000000103 Referral for combined healthy eating and physical education programme	
		281078001 Education about alcohol consumption	
		425014005 Substance use education	
		Placeholder Referral to alcohol service	
Placeholder Referral to substance use service			

Table 3: continued

Cardiometabolic Parameter	Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Body Mass Index	Treatment for people with an elevated BMI and rapid weight gain.	699826006 Lifestyle education regarding risk of diabetes	<ul style="list-style-type: none"> • What percentage of service users assessed by the EIP service were identified as in the 'red zone' on the Lester tool and requiring an intervention? • What percentage of these service users were offered/received an intervention to address their increased risk (either within the EIP team, or referred to another service)?
		Placeholder Referral for lifestyle education	
		Placeholder Weight management programme	
Placeholder Referral for weight management, and lifestyle education			
Blood pressure	Treatment for hypertension	Placeholder Referral to General Practice	
		Placeholder Referral for antihypertensive therapy	
Glucose regulation*	Treatment for diabetes	308116003 Antihypertensive therapy	
	Treatment for high risk of diabetes	Placeholder Referral for diabetic care	
		385804009 Diabetic care	
Blood lipids**	Treatment for dyslipidaemia / or if high (>10%) risk of CVD based on Q-RISK assessment	Placeholder Referral to General Practice	
		Placeholder Diet modification	
		Placeholder Metformin therapy	
		Placeholder Lipid modification therapy	
		Placeholder Referral for lipid modification therapy	

*It is recommended that services take consideration of all three measurements and record at least one.

**Services may also want to consider recording Triglycerides (TG) and non-HDL cholesterol for completeness.

Education and employment support

Adults with psychosis who wish to find or return to work should be helped to access supported employment programmes, including [Individual Placement and Support \(IPS\)](#)¹⁰.

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

¹⁰ The 'IPS' SNOMED concept ID should only be used for IPS services meeting international [IPS fidelity criteria](#). If another non-IPS type of employment support is offered, the Employment Support SNOMED concept ID should be used, once available.

Each time a session of education and employment support is delivered, **OR** when the service user is referred on for Education and Employment Support, this should be recorded on the service user's electronic health record.

Table 4 outlines how education and employment support interventions data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

Table 4.

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Education Support	183339004 Education rehabilitation	<ul style="list-style-type: none"> Did the service user receive any type of education and/or employment support? How many sessions of education and/or employment support was the service user given per year and in total, by the EIP service? What was the average duration of any type of education and/or employment support (from first to last session) given to each service user per year and in total, by the EIP service? How many referrals for education and/or employment support were made per year by the EIP service? How many EIP service users received Individual Placement and Support (IPS) per year?
	415271004 Referral to education service	
Vocational Support	70082004 Vocational rehabilitation	
	18781004 Patient referral for vocational rehabilitation	
Employment support	335891000000102 Supported employment	
	Placeholder Employment support Placeholder Referral to an employment support service	
IPS	1082621000000104 Individual Placement and Support	
	1082611000000105 Referral to an Individual Placement and Support service	

Carer focused education and support

Carer education, advice and support should be routinely available as needed from the EIP service, and appropriate referral pathways for specific carer/family member support programmes should be in place (QS80).

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

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

Every time a session of carer focused education and support is delivered **OR** a referral is made to a relevant service providing carer-focused education and support (e.g. via a recovery college course or carer education and support group or e-health carer education and support programme), this should be recorded on the service user's electronic health record¹¹.

Table 5 outlines how carer focused education and support interventions data can be recorded at service level and will then be used by NHS Digital to report on NICE concordance.

¹¹ The MHSDS does not currently allow for accurate reporting of this intervention unless the service user is present. Accurate recording of this data is an expectation at a national level in order to monitor the early intervention in psychosis access and waiting time standard, therefore the MHSDS will be modified from April 2019 in order to accommodate this.

Table 5.

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Carer focused education and support	<p>726052009 Carer focused education and support programme</p> <p>Placeholder Referral for carer focused education and support programme</p>	<ul style="list-style-type: none"> • Did the carer receive carer focused education and support? • At what time point after acceptance to the EIP service was the carer given carer focused education and support? • How many sessions of education and support were carers given per year and in total, by the EIP service? • What was the average duration of carer focused education and support for each carer? • How many referrals for carer focused education and support were made per year by the EIP service to another service?

Useful references:

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- Five Year Forward View for Mental Health (2016) (<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>)
- Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance (2016) (<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf>)
- Reporting against access and waiting time standards FAQs: Early Intervention in Psychosis (2016) (<https://www.england.nhs.uk/wp-content/uploads/2017/03/waiting-time-faqs-updated-march-17.pdf>)
- Guidance for reporting against access and waiting time standards: Children and Young People with an Eating Disorder Early Intervention in Psychosis (2016) (<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf>)
- (QS80) NICE Quality Standard – Psychosis and schizophrenia in adults (2015) (<https://www.nice.org.uk/guidance/qs80>)
- (QS102) NICE Quality Standard – Bipolar disorder, psychosis and schizophrenia in children and young people (2015) (<https://www.nice.org.uk/guidance/qs102>)
- (CG178) NICE Guideline – Psychosis and schizophrenia in adults: prevention and management (2014) (<https://www.nice.org.uk/guidance/cg178>)
- (CG155) NICE Guideline – Psychosis and schizophrenia in children and young people: recognition and management (2013) (<https://www.nice.org.uk/guidance/cg155>)
- (QS95) NICE Quality Standard – Bipolar disorder in adults (2015). (<https://www.nice.org.uk/guidance/qs95>)
- (CG185) NICE Guideline – Bipolar disorder: assessment and management (2014) (<https://www.nice.org.uk/guidance/cg185>)
- (CG120) NICE Guideline – Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011) (<https://www.nice.org.uk/guidance/cg120>)
- (CG136) NICE Guideline – Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011) (<https://www.nice.org.uk/guidance/cg136>)
- CCQI – Report of the Early Intervention in Psychosis Audit (<http://www.rcpsych.ac.uk/pdf/EIP%20Audit%20National%20Report.pdf>)
- CCQI – EIP Self-Assessment Tool Guidance (September 2016) (<http://www.rcpsych.ac.uk/pdf/EIP%20Self%20Assessment%20Guidance%20270916.pdf>)
- NICE Guidance -Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (<https://www.nice.org.uk/guidance/cg115>)

- NHS England and NICE - Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance (<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf>)
- Personalised health and care 2020: A framework for Action (2014) (<https://www.gov.uk/government/publications/personalised-health-and-care-2020>)
- Delivering the Five Year Forward View for Mental Health: Developing quality and outcomes measures (2016) (<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/mh-quality-outcome.pdf>)
- Mental Health Services Data Set (MHSDS) v2.0 User Guidance (2017) (<http://content.digital.nhs.uk/mhsds/spec>)
- Mental Health Services Data Set (MHSDS) v3.0 User Guidance (2018) (<http://content.digital.nhs.uk/mhsds/spec>)
- Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder (https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychological_Interventions_with_People_with_Psychosis_and_Bipolar_Disorder)
- SNOMED CT information standard (2016) (<http://content.digital.nhs.uk/isce/publication/scci0034>)
- Outcome measures for routine use in EIP services (<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/earlyinterventionpsychosis/resources.aspx>)

Appendix A

Members of Project Oversight Group:

- Sarah Amani, Senior Programme Manager, South of England Early Intervention in Psychosis Programme;
- Alison Brabban, Expert Advisor to the Adult Mental Health Programme, NHS England (*chair*);
- Guy Dodgson, Regional Clinical Lead in EIP for Cumbria and the North East;
- Paul French, Associate Director, Greater Manchester West NHS Mental Health Trust;
- Philippa Garety, Professor of Clinical Psychology, King's College London;
- Nick Gitsham, Improvement Manager – Mental Health, NHS Improvement;
- Aaron Leathley, Business and Operational Delivery Management Officer, NHS Digital;
- Lauren Melleney, Project Manager, Adult Mental Health Programme, NHS England;
- Jay Nairn, Programme Manager, Adult Mental Health Programme, NHS England;
- Margaret Oates, Mental Health Information Programme Manager, NHS England;
- David Shiers, Former GP in North Staffordshire, and Honorary Reader in Early Psychosis, University of Manchester;
- Jo Simpson, Analytical Section Head, NHS Digital;
- Gareth Staton, Senior Analytical Lead, NHS England;
- Jo Smith, Professor in EIP and Psychosis, University of Worcester;
- Michael Watson, Improvement Manager – Mental Health, NHS Improvement;
- Elaine Wooler, Advanced Terminology Specialist, NHS Digital.

External engagement:

There was an additional period of external engagement where a group of external stakeholders were given the opportunity to review and provide feedback on the draft document.

These included:

- Regional EIP leads;
- NHS England Adult Mental Health delivery group;
- Selected EIP providers;
- Selected EIP commissioners;
- Performance leads.

