also captured. Referrals of children and young people will include some who were subsequently identified following assessment for a neurodevelopmental disorder or for trauma.

- Arrive at a local referral estimate. Combine the two factors above with any specific local factors that may impact on the referral rate.
- Understand the demographic profile. Beneath an overall incidence rate for an area, incidence rates vary across age, gender and ethnicity. PsyMaptic provides a breakdown of this for each local authority area, giving estimates split into two age groups (16–35 and 36–64 years), and then broken down again by gender and across different ethnicities. This will show commissioners the impact of any particular demographic considerations in their area on the incidence rate, which should be taken into account when designing services.

Step 2: Develop an outline service model

Commissioners and providers should work together, using the staffing models, service examples and pathways provided in this tool to:

- Apply the understanding of local need to identify the staffing complement and competencies required. The workforce planning tool can be used to help with this. See section 3.6.
- Consider any reasons why the use of a 'stand-alone' team would not be the appropriate model, such as geography. If using a 'hub and spoke' model, consider how the service will overcome the inherent risks of this approach and deliver the same benefits as the evidence-based 'stand-alone' model. See section 3.7.
- Consider the age-appropriateness of the service offered. This should be informed by the age profile of the CCG area and the impact it has on incidence, and arrangements for those under 18.
- Outline the service model, including consideration of the number of teams, management, clinical leadership, and any specific characteristics the team will need in order to address demographic considerations identified in step 1.
- Identify and understand current referral pathways, including external and internal referral sources (for example, self-referrals, GPs, inpatient wards, assessment teams, crisis resolution and home treatment teams, drug and alcohol services, schools, colleges and universities, and the police), partners in service delivery or identification of referrals (for example, voluntary and community organisations and social services) and discharge pathways (for example, into CMHTs, primary care).

Step 3: Obtain baseline current service provision and identify gaps

Once an outline service model has been developed, a plan should be produced that sets out how to progress from current service provision to the new model. Commissioners should work with their providers to:

- Compare staffing numbers, skill mix and competencies in the new model with current provision. As well as current staffing of EIP services, this should take into account the resources currently being used for those aged over 35 (if not currently supported by an EIP service). Consideration also needs to be given to the qualifications, competencies and supervision arrangements of those providing CBT for psychosis and family intervention, prescribing, employment support and physical health interventions.
- Identify gaps in provision. This should enable development of recruitment and training plans.

This work should be informed by the findings of the EIP national clinical audit (see section 4.3.3) and the outcome of the local self-assessment exercise against the framework published by CCQI (see section 4.3.4).

Step 4: Baseline current performance against the new standard

Commissioners should work with their local provider to obtain a baseline of performance against the access and waiting time standard. There are sources of information available to support this, including existing performance reports, NHS Benchmarking data, NICE guidelines and quality standards and the National Audit of Schizophrenia. Commissioners should work with their local provider and stakeholders to:

- Assess current performance against the two-week RTT waiting time standard, using the performance measurement criteria described in section 4.2.
- Assess current provision of CBT for psychosis and family intervention by looking at the percentage of caseload who have received one or both of these interventions.
- Assess the number of people who have received a physical health check and have been offered combined healthy eating and physical activity programmes. Information from the National Audit for Schizophrenia and The Lester UK Adaption of the Positive Cardiometabolic Health Resource will assist in understanding current performance.
- Assess current medication practice against the Psychosis and Schizophrenia in Children and Young People NICE guideline; Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People NICE quality standard; Psychosis and Schizophrenia in Adults NICE guideline; Psychosis and Schizophrenia in Adults NICE quality standard and other relevant NICE guidelines.
- Assess level of provision of employment and educational support. This should incorporate both the number of service users who receive support and the type of support that is provided.
- Assess level of provision of carer-focused education and support programmes. This should incorporate both the number of carers who receive support and the type of support that is provided.

Step 5: Agree service redesign, recruitment and training plans

Once assessment of workforce requirements has been made, the implications for service reconfiguration, recruitment and workforce development will need to be considered jointly with providers. This should include assurance that providers have a plan to collect and routinely use outcome measures as specified in section 4.4. A task and finish design and implementation group will need to be established to ensure the necessary changes are made. Commissioners should:

- Agree service redesign plans with providers. This may involve major or minor redesign, but should include arrangements to ensure:
  - *the EIP service can routinely provide NICE-recommended interventions to people with or at high risk of developing first episode psychosis*
  - *interventions are provided by suitably qualified staff who are properly supervised*
  - *clinician and service-user reported outcomes are routinely collected and used effectively to improve care.*
- Agree recruitment plans with providers, including how they will address any specific demographic issues. For example, in culturally and ethnically diverse areas, providers should actively try to ensure that the workforce reflects this same diversity.
- Agree training plans with providers, engaging local education and training boards as necessary, and ensuring that:
  - *there are sufficient numbers of people trained in CBT for psychosis*
  - *staff delivering family intervention are suitably trained*
  - *staff delivering educational and employment support are suitably trained*
  - *all staff have a good knowledge of the importance of physical health interventions for people with psychosis, and how they will deliver these.*

Step 6: Design local referral to treatment pathways and accompanying protocols and guidance

Having identified referral pathways in step 2, local services and commissioners will need to develop protocols and guidance consistent with their current referral practices, for example single point of access or referral directly to EIP services, and electronic care record systems.

They should:

- Compile a list of external and internal referral sources, consulting with stakeholders to ensure the list is comprehensive.
- Ensure that protocols and guidance are in place for the pathway. These should make it clear who should be referred and when in order to ensure that the access and waiting time standard can be met. There should also be protocols to ensure children and young people's mental health services and adult services work together as described in section 3.7.4.
- Provide education and training programme for referrers to ensure that people with suspected first episode psychosis or an at risk mental state are picked up in primary care, or in other non-specialist settings, including education, youth justice and third sector counselling, and promptly referred.
- Consider a public awareness campaign working with local authorities and other partners to raise the overall levels of awareness in the population about psychosis, in order to increase the likelihood of signs or symptoms of psychosis being recognised and reducing the stigma associated with it.

Step 7: Ensure the necessary changes have been made to provider electronic care records and information systems to enable monitoring of performance against the standard

HSCIC has notified providers regarding the changes required for submission of the new MHSDS, which will support monitoring of the EIP access and waiting time standard (see section 4.2.3). Commissioners should assure themselves that their local provider has made the necessary updates to their electronic care record system to ensure clinicians are able to enter the data required to monitor performance against the new standard as per the Information Standards Notice.

The electronic care record system should enable collection and submission of data in three key areas:

- Referral to treatment waiting time performance – see section 4.2.3
- Performance against the requirement that the treatment accessed is in line with NICE recommendations – see section 4.3.2
- Routine measurement of outcomes as specified in section 4.4.

Step 8: Agree data quality improvement and performance monitoring plans

Commissioners should:

- Agree a data quality improvement plan with their provider to ensure full reporting against the standards (as per step 7 above), including timescales and milestones.
- Agree a schedule for performance reporting – this may be worked into existing performance reporting and management arrangements.

Step 9: Agree benefits realisation plan

This should identify key benefits and set out how they will be delivered, measured and reported, in the context of a multi-year development trajectory. Key benefits of providing an EIP service should include:

- reduced waiting times for people accessing services through meeting the two-week maximum RTT waiting time standard
- improved care for individuals, families and carers through routine access to the full range of NICE-recommended interventions delivered by suitably qualified and supervised staff
- improved mental health, physical health and social outcomes for service users
- improved experience of services for people in need of mental health care and their families

- potential for reduced costs, through reduced use of crisis and acute services, including use of the Mental Health Act 1983
- improved awareness and satisfaction among referrers.

Engagement in regional preparedness programmes

Commissioners and providers should already be aware that four regional EIP preparedness programmes have been established with broad stakeholder input. The work of these programmes has included:

- raising awareness of the requirements of the new standard
- bringing together local experts and establishing quality improvement networks, ensuring effective linkage with strategic clinical networks
- analysing levels of demand in constituent CCGs and any inequities in access relative to the levels and patterns of psychosis incidence in the population
- analysing baseline performance and capacity and undertaking a gap analysis
- supporting work to optimise local referral to treatment pathways
- supporting preparation for the new data collection requirements
- supporting local workforce development programmes.

Contact details for regional leads can be found in the Helpful Resources pack.

Appendix 1 – ERG membership

Matthew Patrick (Chair)
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Tim Kendall (Facilitator)
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Appendix 2 – Essential components of a NICE-approved care package

This appendix provides a summary of NICE-recommended interventions from the Psychosis and Schizophrenia in Children and Young People NICE guideline, the Psychosis and Schizophrenia in Adults NICE guideline and the Psychosis and Schizophrenia in Adults NICE quality standard.

Table 1: NICE-recommended interventions for children and young people with psychosis

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	To address psychiatric, medical, physical health and wellbeing, psychological and psychosocial, developmental, social, occupational, and economic domains, and to routinely monitor coexisting conditions, for all children and young people with first episode psychosis.	Specialist EIP service, whether situated in a children and young people's mental health service or an adult EIP service with input from consultants from children and young people's mental health services.	Comprehensive coproduced biopsychosocial formulation inclusive of trauma and adversity.
CBT for psychosis	To be offered in conjunction with family intervention and antipsychotic medication. Advice that they are more effective in combination should be provided. If the child or young person has a psychological intervention without antipsychotics, a time limit of one month for reviewing treatment options should be agreed. Deliver on a one-to-one basis over at least 16 planned sessions.	Clinical psychologists or CBT therapists who have undertaken specific training in CBT for psychosis, on a course meeting competency standards for NICE-recommended therapy.[52]	Reduced hospitalisation, improved symptoms of psychosis and depression.

Intervention	Delivery of the interventions	Provider	Outcome
Family intervention	To be offered in conjunction with CBT for psychosis and antipsychotic medication. Advice that they are more effective in combination should be provided. If the child or young person has a psychological intervention without antipsychotics, a time limit of one month for reviewing treatment options should be agreed.	A therapist or care coordinator, who is trained in family intervention.	Reduced hospitalisation and relapse, and improved social functioning.
Antipsychotic medication	To be offered in conjunction with CBT for psychosis and family intervention. Advice that they are more effective in combination should be provided. A baseline investigation and regular and systematic monitoring of symptoms and side effects should be conducted.	Psychiatrist.	Reduced symptom severity and associated distress, improved rates of recovery, decreased relapse rates.
Monitoring of physical health	To be monitored at least once a year. Children and young people who smoke or who have high blood pressure, raised lipid levels or increased waist measurement should be identified and cardiovascular disease and diabetes monitored for.	Mental healthcare provider maintains responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until the child or young person's condition has stabilised; thereafter, the responsibility for this monitoring may be transferred to primary care (the GP or practice nurse) under shared care arrangements.	To reduce the trajectory towards weight gain, minimise adverse change in glucose and lipid metabolism, improved quality of life and improved rate of smoking cessation.

Table 2: NICE-recommended interventions for children and young people with an at risk mental state

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	To be carried out if a child or young person experiences: • transient or attenuated psychotic symptoms OR • other experiences or behaviours suggestive of possible psychosis. If no clear diagnosis can be made, monitor for changes in symptoms and functioning for up to three years.	Children and young people's mental health services or an EIP service; assessments in children and young people's mental health services should include a consultant psychiatrist; assessments in EIP services should be multidisciplinary.	To identify whether or not a child or young person may be at risk of developing psychosis.
Individual CBT with or without family intervention	To be offered along with interventions recommended in NICE guidelines for coexisting mental health problems (see row below). CBT: Deliver on a one-to-one basis over at least 16 planned sessions. For the number of sessions of family intervention see Table 1.	Clinical psychologists or CBT therapists, who have undertaken training, on a course meeting competency standards for NICE-recommended therapy.[52] A therapist or care coordinator, who is trained in family intervention.	To prevent transition to psychosis.
Interventions for coexisting mental health problems	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	Primary care, children and young people's mental health services, substance misuse services.	To treat coexisting mental health problems
Antipsychotic medication	NOT to be offered to children and young people for psychotic symptoms or mental state changes not sufficient for a diagnosis of psychosis or schizophrenia OR with the aim of decreasing the risk or preventing psychosis.	–	–

Table 3: NICE-recommended interventions for adults with psychosis

Intervention	Delivery of the interventions	Provider	Outcome
Comprehensive multidisciplinary assessment	To address psychiatric, medical, physical health and wellbeing, psychological and psychosocial, developmental, social, occupational, and economic domains, and to routinely monitor coexisting conditions, for all people with first episode psychosis.	Psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia.	Comprehensive coproduced biopsychosocial formulation inclusive of trauma and adversity.
Antipsychotic medication	To be offered in combination with family intervention and individual CBT for psychosis for first episode psychosis and subsequent episodes. The choice of drug should be made by the service user and healthcare professional together, after provision of information and discussion about the likely benefits and possible side effects of each drug. Adults with schizophrenia whose symptoms have not responded adequately to treatment with at least two antipsychotic drugs used sequentially should be offered clozapine. Antipsychotic medication should not be offered to people considered to be at increased risk of developing psychosis or with the aim of decreasing the risk of or preventing psychosis.	Psychiatrist.	Reduced symptom severity, and associated distress, improved rates of recovery.

Intervention	Delivery of the interventions	Provider	Outcome
CBT for psychosis	To be offered in combination with family intervention and antipsychotic medication for first episode psychosis and subsequent episodes. CBT for psychosis should be delivered on a one-to-one basis over at least 16 planned sessions.	Clinical psychologists or CBT therapists who have undertaken specific training in CBT for psychosis, on a course meeting competency standards for NICE-recommended therapy.[52]	Reduced distress and severity of symptoms, improved social functioning and reduced hospital rates.
Family intervention	To be offered in combination with individual CBT for psychosis and antipsychotic medication for first episode psychosis and subsequent episodes. Family intervention should be delivered for between three months and one year over at least 10 planned sessions; the person with psychosis should be included if practical; and the family's preference for single- or multi-family group intervention and the relationship between the main carer and the person with psychosis should be taken into account.	A therapist or care coordinator who is trained in family intervention.	Reduced hospitalisation and relapse, increased medication adherence and improvement in social functioning.
Supported employment programmes and vocational rehabilitation	To be offered to people with psychosis who wish to return to work. Other occupational or educational activities, including pre-vocational training, can be considered for people who are unable to work or are unsuccessful in finding employment.	Trained vocational workers or employment specialists, who are aware of the specific needs of people with psychosis.	Higher rates of competitive employment, longer duration of employment and number of hours worked.

Intervention	Delivery of the interventions	Provider	Outcome
Carer-focused education and support programmes	To be offered as early as possible to all carers. These programmes, which may be part of a family intervention, should be available as needed and provide a message about recovery.	Any EIP team member.	Reduced carer burden, reduced long-term distress and improved experience of caregiving.
Physical health interventions and monitoring	A combined healthy eating and physical activity programme should be offered to people with psychosis, especially those taking antipsychotics. Weight and cardiovascular and metabolic indicators of morbidity should be monitored. If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, interventions in line with relevant NICE guidance should be offered. Help to stop smoking should be offered.	Mental healthcare provider maintains responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised; thereafter, the responsibility for this monitoring may be transferred to primary care (the GP or practice nurse) under shared care arrangements.	To reduce the trajectory towards weight gain, minimise adverse change in glucose and lipid metabolism, improved quality of life and improved rate of smoking cessation.

Table 4: NICE-recommended interventions for adults with an at risk mental state

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	To be carried out if a person is distressed, has a decline in social functioning and has: • transient or attenuated psychotic symptoms OR • other experiences or behaviours suggestive of possible psychosis OR • a first degree relative with psychosis or schizophrenia.	A consultant psychiatrist or mental health practitioner in an EIP service or specialist mental health service with training in identifying at risk mental states.	To identify whether or not a person may be at risk of developing psychosis.
Individual CBT with or without family intervention	To be offered along with interventions recommended in NICE guidelines for coexisting mental health problems (see row below). CBT: Deliver on a one-to-one basis over at least 16 planned sessions. For the number of sessions of family intervention see Table 3.	Clinical psychologists or CBT therapists, who have undertaken training on a course meeting competency standards for NICE-recommended therapy.[52] A therapist or care coordinator who is trained in family intervention.	To prevent transition to psychosis.
Interventions for coexisting mental health problems	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	Primary care, secondary care mental health services, substance misuse services.	To treat coexisting mental health problems.
Antipsychotic medication	NOT to be offered for people considered to be at increased risk of developing psychosis OR with the aim of decreasing the risk or preventing psychosis.	–	–

Appendix 3 – SNOMED-CT codes

Providers should ensure that the following list of NICE-recommended interventions can be entered by EIP clinicians on to the electronic care record and submitted as SNOMED-CT codes[u] as part of Mental Health Services Dataset (MHSDS) submissions.

NICE recommended intervention		SNOMED-CT concept description	SNOMED-CT concept ID
1	Cognitive behavioural therapy for psychosis	Cognitive behavioural therapy for psychosis	984091000000108
2	Family intervention	Family intervention for psychosis	985451000000105
3	Antipsychotic medication	Medication monitoring	395170001
4	Physical health interventions and monitoring	Assessment of physical health	705139001
		Weighing patient	39857003
		Diabetic care	385804009
		Weight management programme	990121000000104
		Cardiovascular therapy	309513005
		Combined healthy eating and physical education programme	967251000000101
		Referral to smoking cessation service	871661000000106
5	Supported employment programmes and vocational rehabilitation	Educational rehabilitation	183339004
		Vocational rehabilitation	70082004
6	Carer-focused education and support programmes	Carer-focused education and support programme	985651000000108
7	Care planning	Mental health care and treatment planning	861361000000109
		Provision of information about psychosis	985681000000102
8	Substance misuse	Substance misuse assessment	777041000000105
		Substance use therapy	385989002

To access the latest version of the SNOMED-CT codes, click here.

[u] *SNOMED-CT (Systematized Nomenclature of Medicine Clinical Terms) consists of comprehensive scientifically validated content. SNOMED-CT is available in more than 50 countries and is managed and maintained internationally by the International Health Terminology Standards Development Organisation and in the UK by the UK Terminology Centre.*

SNOMED-CT supports recording of clinical information in a way that allows data management and analysis to support patient care, while enabling data extraction and data exchange. SNOMED-CT is specified as the single terminology to be used across the health system in Personalised Health and Care 2020: A Framework for Action.

Appendix 4 – Outcome measures for routine use in EIP services

This appendix provides the outcome measures recommended for routine use in EIP services. Sources of further information are listed below each questionnaire.

DIALOG: user-reported outcome measure

DIALOG	Totally dissatisfied	Very dissatisfied	Fairly dissatisfied	In the middle	Fairly satisfied	Very satisfied	Totally satisfied	Additional help wanted Y/N
How satisfied are you with your mental health?								
How satisfied are you with your physical health?								
How satisfied are you with your job situation?								
How satisfied are you with your accommodation?								
How satisfied are you with your leisure activities?								
How satisfied are you with your friendships?								
How satisfied are you with your partner/family?								
How satisfied are you with your personal safety?								
How satisfied are you with your medication?								
How satisfied are you with the practical help you receive?								
How satisfied are you with consultations with mental health professionals?								

Name …….. Date ……..

DIALOG has been developed by s.priebe@qmul.ac.uk – it is free to use and no permissions are needed

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[50] Priebe S, McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinez-Leal R, et al. Structured patient–clinician communication and 1-year outcome in community mental healthcare. Cluster randomised controlled trial. The British Journal of Psychiatry. 2007;191:420–26.

[51] Law H, Neil ST, Dunn G, Morrison AP. Psychometric properties of the Questionnaire about the Process of Recovery (QPR). Schizophrenia Research. 2014;156:184–89.

[52] Roth AD, Pilling S. A Competence Framework for Psychological Interventions with People With Psychosis and Bipolar Disorder. London: University College London; 2013.