Guidance for reporting against access and waiting time standards:

Children and Young People with an Eating Disorder

Early Intervention in Psychosis

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**04754**
Document Purpose	Guidance
Document Name	Guidance and FAQs for reporting against access and waiting time standards: Children and Young and People with an Eating Disorder
Author	NHS England, Mental Health
Publication Date	February 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs , NHS England Regional Directors, NHS England Directors of Commissioning Operations, Communications Leads, Directors of Children's Services, NHS Trust CEs
Additional Circulation List	CSU Managing Directors, Medical Directors, Directors of Nursing
Description	This document provides detail on access and waiting times indicators for Children and Young People with an Eating Disorder and Early Intervention Psychosis Services. It explains the indicator constructions and confirms the data required to allow measurement from the Mental Health Services Data Set (MHSDS)
Cross Reference	Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16 Guidance for reporting against AWT for CYP with ED and EIP FAQs
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Mental Health Team Skipton House 80 London Road SE1 6LH

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Guidance for reporting against access and waiting time standards: Children and Young People with an Eating Disorder Early Intervention in Psychosis

Version number: 1

First published:

Prepared by: NHS England[1]

Classification: OFFICIAL

[1] The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Introduction

NHS England has outlined a clear commitment to driving a more equal response across mental and physical health. A key element of this is ensuring that people have timely access to evidence-based and effective treatment, a vision outlined in *Achieving Better Access for Mental Health Services by 2020*[2]. In addition the Children and Young People's Mental Health and Wellbeing Taskforce report, *Future in Mind*[3], proposed a wide range of measures to transform the design and delivery of services for children and young people with mental health needs.

Initial areas in which access and waiting time standards have been developed are for children and young people (CYP) with eating disorders (ED) and people experiencing a first episode of psychosis who need early intervention in psychosis (EIP). These are supported by recurrent investment from NHS England budgets.

2 Purpose of this document

This document aims to explain how the indicators for the referral to treatment waiting time elements of the two standards are constructed and confirms the data that will need to be submitted as part of the new Mental Health Services Data Set (MHSDS) to measure progress and inform future development. For the EIP standard, the standard construction and definitions also apply to the aggregated, interim data collection on referral to treatment waiting times via the Unify system, which will be collected from January 2016.

An Information Standards Notice (ISN) has already been issued for the MHSDS (SCCI10011), and all adult and child and adolescent mental health services are mandated to submit monthly data as part of this. Full guidance on data requirements and how to submit can be found at http://www.hscic.gov.uk/mhsds

The MHSDS will enable collection, measurement and reporting of the standard referral to treatment waiting times. It will also include a mechanism by which NICE-approved interventions can be captured and routine outcomes monitored. Clinicians, service managers and information leads will need to work together to ensure the data required to measure the standards is complete and of good quality.

Frequently asked questions are published separately and should be read in conjunction with this technical guidance. Experience from other implementations has shown that this can be an iterative process. The intention is to review this guidance annually to reflect this.

[2] https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020
[3] https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

3 Summary of the standards

3.1 Children and young people with an eating disorder

Children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case.

NICE–approved treatments to treat eating disorders alongside the most common types of co-existing mental health problems (for example, depression and anxiety disorders) in collaboration with family or carer are:

- Family therapy
- Cognitive behavioural therapy
- Guided self-help
- Interpersonal psychotherapy
- Focal psychodynamic therapy

The standard includes all children and young people up to the age of 19 years in whatever setting (community or inpatients) the young person is receiving care.

3.2 Early Intervention in Psychosis

From 1 April 2016, more than 50% of people with **first episode** of psychosis (FEP) are treated with a NICE-approved package of care within two weeks of referral.

The current expectation is that, within a maximum of two weeks of referral, more than 50% of people with suspected FEP:

- Have been assessed by the EIP service

And, where appropriate:

- Have been accepted onto the EIP service caseload.
- Have been allocated an EIP care coordinator who has actively engaged with the person to develop a plan of care and commence treatment in line with NICE recommendations.

The focus of service design for early intervention in psychosis is likely to be for people in the14-65 age group, given the evidence of when first episode psychosis is most likely to occur [4]. However, the EIP approach might also be helpful for people outside this age range. Professionals should use their clinical judgement when considering whether people outside this range should be referred to EIP services and whether they would benefit from these interventions. Commissioners and providers will need to ensure that people are not inappropriately restricted from accessing care. The only exemptions from these arrangements will be referrals of people who are experiencing psychotic symptoms with a confirmed organic cause, for example brain

[4] It should be noted that the evidence underpinning the NICE quality standard and adult guideline is from populations aged under 60 (nevertheless these interventions may be appropriate for older populations).

diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia, or brain tumours or cysts.

4 Measuring and monitoring access and waiting time standards – general principles

The intention of mental health access and waiting time standards is to provide timely access to evidence-based care for those in need.

There are some common principles across standards. These include:

- Any clock stops without treatment are made in the best clinical interest of the person and are not influenced by the impact of other factors (such as the impact of incomplete pathways on waiting time performance).
- Choice of the time of treatment by the person is important (taking account of clinical advice where undue delay may present a risk to them). This is why ED and EIP standards 'do not attends' (DNAs) and cancellations will not stop the clock.
- Measurements and monitoring of the standards should always keep the experience of the person at the centre. The aim of the standards is to improve experience and outcomes for people and to inform and guide treatment.
- Local areas are accountable for the information that they report and submit. As well as the key definitions associated with measuring the overall standards, localities may wish to consider if other measures are appropriate locally to ensure that people are getting timely access to evidence-based care.
- It is vital that localities are considering the people who are still waiting for access to evidence based treatment when monitoring performance as well as those who have already accessed support within the waiting time thresholds.
- In addition to tracking compliance against standards waiting times for incomplete referral pathways will be monitored both nationally and locally.

5 Measuring and monitoring access and waiting time (AWT) standards

Appendix A summarises the specific waiting time pathways.

5.1 Clock Starts

The waiting time clock for the EIP and CYP ED standards **starts** when:

i) A referral request is received for an assessment for a child or young person with a suspected ED or person with suspected first episode psychosis (FEP), or is recognised as such upon receipt.

ii) The primary reason for referral should be CYP with suspected ED or suspected FEP. The clock start date is defined as the date referral received – this must be recorded accurately so the referral can be tracked.

iii) Where pathways start with an interface service, such as clinical triage, assessment centre, single point of access, the clock start date is the date the interface service receives the referral – not the date the referral is passed onto the relevant clinical team.

iv) Where a service accepts direct referrals (no interface service), the clock will start from the date the referral is received by that service.

v) Where a primary reason for referral is not recorded as suspected FEP or ED, but this is identified during triage/single point of access, the clock start date is the date of initial referral. If this is not suspected during triage but at a subsequent assessment then the date the clock starts is when suspicion is first raised.

vi) If a person is already in contact with mental health services (including acute hospital liaison) the clock starts when suspicion of FEP or ED is first raised (not backdated to their initial contact with the mental health service). Protocols should be in place so that staff can make timely referrals to the relevant specialist service for assessment and treatment.

Referral sources

Referrals may come from any source and the clock will start regardless of the agency making the request. Referrals may therefore be internal to provider organisations (e.g. a children and young people's mental health service, a CMHT, inpatient ward or forensic mental health service) or external (e.g. a GP, carer, school or self-referral). The clock also starts regardless of any comorbidities, such as learning disabilities, substance misuse, personality disorder or autism

It is therefore important that staff within provider organisations are trained and aware so they can make timely referrals to the relevant specialist service for assessment and treatment. Referrals could be in person, telephone, email, letter, or online.

Vetting referrals

Timely, clinically-led vetting of referrals will ensure referrals are appropriate and can assist in identifying if an alternative pathway may be more suitable. Vetting of urgent referrals should be prioritised and ideally be completed on the day of referral or the morning of the following day. Vetting can be carried out by an appropriately trained team of staff which should help minimise delays. Staff should follow clear protocols and be subject to continuous monitoring and audit. The vetting process **should not** delay clock start.

Recording clock start in the MHSDS

Clock start is recorded in the MHS101 Table and all the required fields should be completed in line with the data standard. The following will identify referrals to be assessed for the Mental Health AWT standards and the date of the clock start:

For EIP:

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS101 – Service or Team Referral	Primary reason for referral	01: (Suspected) First Episode Psychosis	Identifies EIP referrals
MHS101 Service or Team Referral'	Referral request received date	Date received	Clock start date

Table 1

For CYP with an ED:

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS101 – Service or Team Referral	Primary reason for referral	12: Eating Disorder	Identifies suspected ED referrals
MHS001 – MPI	Person birth date	Under 19 years	Identifies age
MHS101 – Service or Team Referral	Clinical response priority type	1:Emergency[5] 2:Urgent/serious	Identifies urgent case
MHS101 – Service or Team Referral	Clinical response priority type	3: Routine	Identifies routine case
MHS101 - Service or Team Referral	Referral request received date	Date received	Clock start date

Table 2

Coexisting conditions

Only referrals where Primary reason for referral is 01:(Suspected) First Episode Psychosis and 12: Eating Disorder will be included in AWT reporting. These people could have a co-existing problem and this might be recorded in Table MHS103 as Other Reason for Referral.

5.2 Clock Stops and included in AWT measurement (waiting time ends)

5.2.1 Clock stops and counted for EIP waiting time indicator

i) The referral is confirmed as having FEP or suspected FEP following appropriate assessment[6] or;

ii) The referral is confirmed as requiring 'at risk' mental state (ARMS) specialist assessment

And;

iii) NICE-approved package of care starts, this is when the person:

- has had an initial assessment, **AND**
- has been accepted on to the caseload of an EIP service, **AND**
- has been allocated to and engaged with an EIP care coordinator.

The care coordinator's role is to engage, arrange assessments and treatment, develop the care plan and make arrangements for timely multidisciplinary team reviews. The care coordinator must be able to demonstrate they are actively engaging with the person and attempting to form a therapeutic professional relationship. The expectation is that face-to-face contact is made as soon as possible after the coordinator is assigned.

[5] For the purpose of CYP ED AWT measurement CYP with a response priority type of 'Emergency' and 'Urgent' will be treated as urgent and should be treated within week.
[6] Good practice highlights the importance of face to face contact when completing an assessment.

Where FEP is not confirmed but ARMS is suspected then an ARMS assessment should commence, by an appropriately trained and qualified clinician, on allocation to, and engagement with, a care coordinator.

Recording in MHSDS

The clock stop requires that the dates in the table below are recorded and the start of treatment (waiting time ends with treatment) will be the latest of these two dates:

MHSDS Table	MHSDS Data Item Name
MHS201 Care Contact	Care contact date
MHS006 Mental Health Care Coordinator	Start date

Table 3

Both these dates must be equal to or greater than the Clock Start Date.

All the required data items in tables MHS201 and MHS006 must be recorded in line with the data standard. The *following* data items and national codes will be used to show that the patient has been assessed by the EIP service and, where appropriate, been accepted onto the EIP service caseload and been allocated an EIP care coordinator who has actively engaged with the person to develop a plan of care and commence treatment in line with NICE recommendations

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS201 Care Contact	Care Professional Team Local Identifier		Will be used to identify Early Intervention Team for Psychosis, linking to Care Professional Team Identifier in Table MHS102 Service or Team Type Referred To
MHS201 Care Contact	Consultation Medium Used	01:Face to face communication 02:Telephone 03:Telemedicine web camera 04:Talk type for a person unable to speak	Will identify active engagement:
MHS201 Care Contact	Attended or did not attend code	5:Attended on time or, if late, before the relevant professional was ready to see the patient 6:Arrived late, after the relevant professional	Will identify active engagement:

		was ready to see the patient, but was seen	
MHS006 Mental Health Care Coordinator	Care Professional Service or Team Type Association (Mental Health)	A14: Early Intervention Team for Psychosis	Identifies that patient has been allocated an EIP Care Coordinator
MHS102 Service or Team Type Referred To	Care Professional Team Local Identifier		Will be used to link to Care Professional Team Identifier in Table MHS201 Care Contact
MHS102 Service or Team Type Referred To	Service or Team Type Referred to	A14: Early Intervention Team for Psychosis	Identifies that patient has been accepted on to EIP service caseload and (via link to MHS201 Care Contact) has been assessed by EIP service.

Table 4

Although the clinical pathway may be different, clock stops for people who, following the FEP assessment, are identified as having an at-risk mental state (ARMS) will initially be measured in the same way as FEP.

Currently it is not possible, via the MHSDS, to use SNOMED-CT codes as part of the measurement of the referral to treatment waiting time element of the EIP standard. However, services are encouraged to use the following codes as soon as local IT systems allow to indicate allocation of a care coordinator and commencement of ARMS assessment. This should be included in MHSDS submissions using Table MHS202 Care Activity, (linked to MHS201 Care contact) as specified below. Further work is intended during 2016/17 to develop recording around ARMS assessments and activity.

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS202 Care Activity	Procedure Scheme in use	06	Indicates Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)
MHS202 Care Activity	Coded Procedure	802551000000107	SNOMED code for Mental health risk indicator assessment

Table 5

5.2.2 Clock stops and counted for CYP with an Eating Disorder

i) The referral is confirmed as having an ED or suspected ED **AND**;

ii) The first definitive treatment starts i.e. on the day the first session of NICE-approved treatment for the eating disorder is delivered.

iii) Regardless of setting; treatment could be delivered by community eating disorder service (CED-CYP), generic CAMHS, general psychiatric in-patient unit.

Recording in MHSDS

The NICE-approved treatments for CYP with an ED that will stop the clock are:

- Family Therapy
- Cognitive behaviour therapy
- Guided self-help
- Interpersonal psychotherapy
- Focal psychodynamic therapy

The following data items and national codes **must** be recorded and will be used to show that the CYP has been accepted on the ED pathway and has started treatment. For CYP with an ED the MHSDS will capture treatment provided using SNOMED CT codes.

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS201 Care Contact	Care contact date	Date of appointment	Identifies first treatment appointment
MHS202 Care Activity	Procedure Scheme in use	06	Indicates Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)
The following coded procedures will stop the AWT clock for CYP with an ED			
MHS202 Care Activity	Coded Procedure	51484002	SNOMED code for Family therapy (regime/therapy)
		304891004	SNOMED code for Cognitive - behaviour therapy (regime/therapy)
		444175001	SNOMED code for Guided self-help cognitive behavioural therapy (regime/therapy)
		443730003	SNOMED code for Interpersonal psychotherapy (regime/therapy)
		984421000000104	SNOMED code for Focal psychodynamic therapy (regime/therapy)

Table 6

5.3 Clock Stops for non-treatment (waiting time ends):

Waiting times clock stops for non-treatment when it is communicated to the patient and GP and/or other referrer without undue delay that:

i) A clinical decision has been reached not to treat as ED or FEP/ possible 'at risk' mental state is not evident following assessment[7]. In this case the person should be discharged back to primary care with advice about next steps, for

[7] For the EIP standard "assessment" refers to the assessment for FEP. If this does not identify FEP but highlights a person may have an at-risk mental state (ARMS), an ARMS assessment should then be commenced by an appropriately trained and qualified clinician.

example, treatment of depression, anxiety or any other common mental health problem.

ii) If there is suspicion of a different condition then they should be referred to an appropriate service. If the receiving service has an access and waiting time standard the clock will continue and the initial clock start date and person identifier must be forwarded with the onward referral.

iii) The person declines assessment /treatment having been offered it and the decision is made to discharge back to referrer/GP.

It is important that everyone who is referred to the service is seen and assessed in accordance with the standard. Clock stop for non-treatment should be excluded from the main indicator but until the clock stops for these pathways, they will be included in incomplete pathway reports and should be monitored locally.

Recording in MHSDS

The clock stop date for non-treatment **must** be recorded in MHS102. There may also be a Service Discharge Date recorded in MHS101.

MHSDS Table	MHSDS Data Item Name
MHS101 Service or Team Referral	Service Discharge Date
MHS102 Service or Team Type Referred To	Referral Closure Date

Table 7

Referral Closure Reason **must** be recorded and will be used to show that a clinical decision has been reached not to treat and the AWT clock will stop as:

- FEP, possible ‘at risk’ mental state or ED is not evident following assessment.
- There is suspicion of a different condition.
- The person declines assessment/treatment.

Alternatively, in a small number of cases a Referral Rejection Reason may be recorded where an administrative error has been identified. Local processes must be put in place to ensure that mistakes are communicated and rectified immediately.

Contextual reports will be developed to understand why referrals do not go on to treatment.

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS102 Service or Team Type Referred To	Referral Closure Reason	04: No further treatment appropriate 08:Referred to other specialty/Service (at the same or other Health Care Provider)	Shows that no further treatment by EIP team appropriate or there is suspicion of a different condition.

MHS102 Service or Team Type Referred To	Referral Closure Reason	06:Patient died 07:Patient requested discharge 09:Refused to be seen	Person declines assessment / treatment.
MHS102 Service or Team Type Referred To	Referral Rejection Reason	02: Inappropriate referral request (Referral request is inappropriate for the services offered by the Health Care Provider)	Administrative error

Table 8

5.4 Delays, cancellations and DNAs

Non-attendance or cancellations will not stop or pause the clock for the referral to treatment waiting time.

It is vital for services to work proactively to engage with the person (and also their families or carers) as it is often those who do not engage with services immediately who are most in need of support.

However if the referral persistently DNAs and the provider can demonstrate that every effort has been made to engage (by recording DNAs in their local system for inclusion in MHSDS) then the referral could be discharged to the care of their GP provided that:

- The provider can demonstrate that the appointment was clearly communicated to the patient
- Discharging the patient is not contrary to their best clinical interests
- Discharging the patient is carried out according to local publicly available/published policies on DNAs and wider access protocols.
- Local policies are clearly defined and specifically protect the clinical interest of vulnerable patients including children and young people are agreed with clinicians.

In such cases, details should be provided to enable rapid reassessment by the appropriate service if necessary.

In order to deliver the mental health access and waiting times standards, providers will need to establish processes that offer people sufficient choice and be able to book an acceptable appointment within the time frame set out in the standard.

5.5 Indicator Constructions

5.5.1 Early Intervention in Psychosis

The proportion of people experiencing first episode psychosis or ‘at risk mental state’ that wait 2 weeks or less to start NICE recommended package of care.

Numerator: The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.

Denominator: The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period.

5.5.2 Children and Young people (up 19 years) with an eating disorder

Indicator 1:

The proportion of CYP with ED (urgent cases) that wait 1week or less from referral to start of NICE-approved treatment.

Numerator: The number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral in the reporting period.

Denominator: The number of CYP with a suspected ED (urgent cases) that start treatment in the reporting period.
Indicator 2:

The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment.

Numerator: The number of CYP referred (routine cases) with suspected ED that started treatment within 4 week of referral in the reporting period.

Denominator: The number of CYP referred (routine cases) with suspected ED that start treatment in the reporting period.

The designation of an urgent or routine referral is a clinical decision based on the information received (see Commissioning Guidance[8]) and recorded in the 'clinical response priority type' on local IT systems.

5.6 Reporting

Reporting for the referral to treatment waiting time element of the EIP standard will initially be at https://www.england.nhs.uk/statistics/ from the Unify data collection. The HSCIC will monitor data quality and completeness of MHSDS returns and take a phased approach to reporting publishing reports as data quality is assured starting from March 2016 for EIP and later in the year for ED.

5.7 Delays in the pathway

It is important to understand delays across the whole care pathway and understand whether this is due to service capacity or patient choice delays. Local partnerships will need to develop and report a number of supporting measures that will put referral to treatment in context with patterns of care and related outcomes.

[8] Access and Waiting Time Standard and Commissioning Guide for Children and Young People with an Eating Disorder

5.8 Contextual measures

It is important to look at access and waits in context of wider patterns of treatment and outcomes and guard against unintended consequences.

Monitoring incomplete pathways will help local partnerships understand capacity and demand. NHS England will publish incomplete pathways alongside the EIP standard and CYP ED baseline reports at: https://www.england.nhs.uk/statistics/

Local partnerships should also capture additional information to drive best practice and avoid perverse incentives, such as:

- Proportion of all referrals assessed where a decision is made not to treat.
- Proportion of CYP taken on by a specialist eating disorders team but made to wait before NICE-approved treatment starts.
- Where a care coordinator is assigned to someone with FEP without real engagement.
- Time between being allocated a care coordinator and starting a NICE-recommended intervention for FEP i.e. family intervention.
- Time between first and second treatment appointments.

6 Outcomes and patient experience data requirements

Section 5 describes rules for measuring waiting times. From this point service provision is monitored through collection and submission of a variety of data connected to treatment, clinical outcomes and service user and carer experiences.

Three outcome measures tools are recommended for routine use in EIP services and initially should be collected during assessment, at 6 and 12 months, and then annually, or on discharge whenever this occurs. Ultimately, it is expected that these or other suitable measures are collected routinely (at every clinical session if possible).

i) Health of the Nation Outcome Scales (HoNOS) and Health of the Nation Outcome Scales for Children & Adolescents (HoNOSCA) for under19s (clinician-rated).
ii) DIALOG (service user-rated, Priebe et al., 2007).
iii) Process of Recovery Questionnaire (QPR) (developed in collaboration with service users, Law et al., 2014).

CYP services have a developed suite of recommended tools to guide treatment, measure progress and inform supervision. Appendix C provides an example of the minimum set of measures that should be used for CYP with an ED, however, other measures should be added as relevant to the child or young person's presentation.

Many of the recommended outcome tools used across mental health are subject to copyright conditions and licensing. The HSCIC will develop and maintain a National Clinical Content Repository (NCCR) and where necessary work towards securing permissions for the use of MHSDS tools within Service Provider IT systems. This work is underway and updates on progress will be posted regularly at: http://systems.hscic.gov.uk/clinrecords/nccr .

All outcome tools scores will also be required to flow to HSCIC as SNOMED CT codes.

7 Recording outcome tools and NICE-approved interventions SNOMED-CT

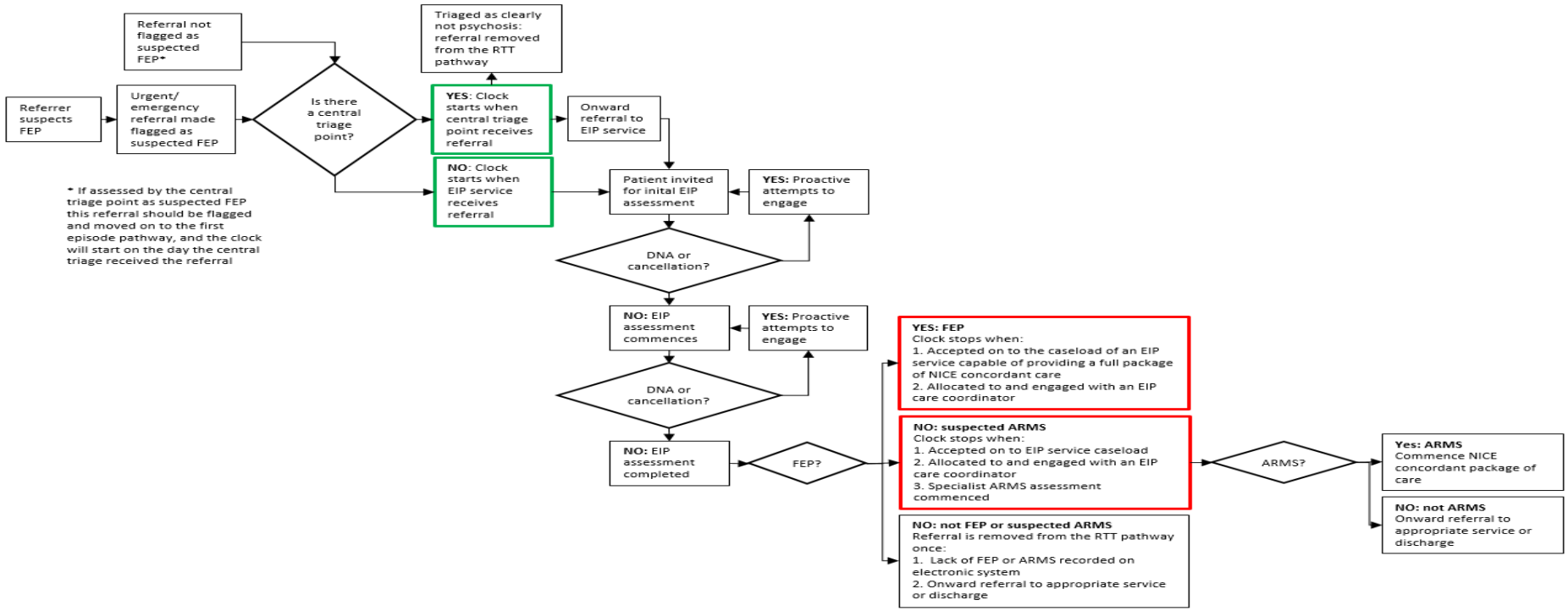
Interventions and outcome tools should be recorded in the MHSDS using SNOMED - CT (Systematized Nomenclature of Medicine Clinical Terms) codes.

Appendix D provides a list of some of the most commonly used codes to describe psychological and physiological interventions and procedures for EIP services and CYP with an ED. This is not an exhaustive list and it is essential that clinicians use the most appropriate codes to describe the care delivered even if it not listed.

Appendix A: Referral pathways

Children and young people with an Eating Disorder: The ED guidance pathway flow diagrams are split up according to stage along the pathway and do not provide a complete picture. For the referral path details refer to pages 27, 33, 37 and 40 of the [Access and Waiting Time Standard and Commissioning Guide for Children and Young People with an Eating Disorder]

Early Intervention in Psychosis



Appendix B: Outcome measure tools recommended for use with CYP with an eating disorder

When to collect	Child/young person	Parent /carer	Clinician rated
At assessment *(a) what is the problem?* *(b) what do you want to change?/what goals do you want to set?*	**General functioning**	**General functioning**	**General functioning**
	HoNOSCA-YP SDQ	HoNOSCA-Parent SDQ	HoNOSCA CGAS
	Mental health symptom tracker	**N/A**	**N/A**
	EDE-Q Other symptom measures as relevant (for example, RCADS)		
	Physical health symptom tracker	**N/A**	**N/A**
	Percentage median BMI		
	Family functioning	**Family functioning**	**Psychosocial complexity**
	Score 15 – family functioning measure	Score 15 – family functioning measure BPSES	Current view tool
During partnership/therapy *(c) How are we getting on together?* *(d) How are things going?* *(e) Symptom and goal tracker session by session*	**Alliance**	**Alliance**	**N/A**
	SFQ	SFQ	
	Goals	**Goals**	**N/A**
	GBOs ORS (13+) ORS (6-12)	GBOs	
	Mental health symptom tracker	**N/A**	**N/A**
	EDE-Q Other symptom measures as relevant (for example, RCADS)		
	Physical health symptom tracker	**N/A**	**N/A**
	Percentage median BMI		
At review and last session *(f) Have we done as much as we can review T1 scores with last scores* *(g) It is a shared decision to close or refer on* *(h) How has this experience been*	**General functioning**	**General functioning**	**General functioning**
	HoNOSCA-YP SDQ	HoNOSCA SDQ	HoNOSCA CGAS
	Mental Health symptom tracker	**N/A**	**N/A**

generally	EDE-Q Other symptom measures as relevant (for example, RCADS)		
	Physical Health symptom tracker	**N/A**	**N/A**
	Percentage median BMI		
	Family functioning	**Family functioning**	**N/A**
	Score 15- family functioning measure	Score 15 – family functioning measure BPSES	
	Goals	**Goals**	**N/A**
	GBOs ORS (13+) ORS (6-12)	GBOs	
	Experience of care	**Experience of care**	**N/A**
	CHI ESQ-YP	CHI ESQ-Parent	

Key: BPSES = Brief Parental Self-Efficacy Scale; BMI = body mass index; CGAS = Children's Global Assessment Scale; CHI-ESQ = Commission for Health Improvement Experience of Service Questionnaire; EDE-Q =Eating Disorder Examination Questionnaire; GBOs = Goals Based Outcomes; HoNOSCA = Health of the Nation Outcome Scales; MHSDS = Mental Health Services Data Set; ORS = Outcomes Rating Scale; RCADS = Revised Child Anxiety and Depression Scale; SDQ = Strengths and Difficulties Questionnaire; YP = young person

Table 9

Appendix C: SNOMED CT Codes

The two tables below provide a list of commonly used NICE-recommended psychological and physiological interventions and procedures for i) people with FEP and ii) CYP with an ED. These procedure/intervention codes will be used at various points in the care pathway and not all will stop the AWT clock (refer to the main body of this report for details). Trusts should ensure that these SNOMED CT codes can be recorded on local IT systems.

For EIP services

Domain	SNOMED-CT concept description	SNOMED-CT concept ID
Psychological		
1	Cognitive behavioural therapy for psychosis	984091000000108
2	Family intervention for psychosis	985451000000105
3	Educational rehabilitation	183339004
4	Vocational rehabilitation	70082004
Physical		
5	Medication monitoring	395170001
6	Weighing patient	39857003
7	Assessment of physical health	705139001
8	Diabetic care	385804009
9	Weight management programme	990121000000104
10	Cardiovascular therapy	309513005
11	Substance misuse assessment	777041000000105
12	Substance use therapy	385989002
Smoking status		
13	Referral to smoking cessation service	871661000000106
Education		
14	Combined healthy eating and physical education programme	967251000000101
15	Carer-focused education and support programme	985651000000108
16	Provision of information about psychosis	985681000000102

Table 10

For CYP with an eating disorder

The eating disorder waiting times standard for CYP is from referral to delivery of NICE-approved treatment. NICE Eating Disorder NICE guideline was published in 2004. This will be updated in 2017. For this reason when developing commissioning guidance NHS England considered both current (2004) guideline and possible future changes outline in the NICE surveillance review, see Commissioning guidance for CYP with eating disorder for full details.

The table below provides a list of recommended psychological and physiological interventions and procedures for CYP with eating disorder. Corresponding

observations and findings have also been included in this table alongside each procedure/intervention.

Domain	SNOMED-CT concept description	SNOMED-CT concept ID
Psychological		
1	Family therapy (regime/therapy)	51484002
2	Cognitive - behaviour therapy (regime/therapy)	304891004
3	Guided self-help cognitive behavioural therapy (regime/therapy)	444175001
4	Interpersonal psychotherapy (regime/therapy)	443730003
5	Focal psychodynamic therapy (regime/therapy)	984421000000104
6	Informing patient (procedure)	310866003
Physical		
7	Weighing patient (procedure)	39857003
	Body weight (observable entity)	27113001
	Weight loss (amount) (observable entity)	363806002
8	Measuring height of patient (procedure)	14456009
	Body height measure (observable entity)	50373000
	Growth velocity centile (observable entity)	248340003
9	Measurement of body mass index (procedure)	698094009
	Body mass index (observable entity)	60621009
	Body mass index centile (observable entity)	446974000
	Child body mass index centile (observable entity)	896691000000102
	Percentage median body mass index for age and sex (observable entity)	990291000000106
10	Pulse taking (procedure)	65653002
	Pulse rate (observable entity)	78564009
11	Blood pressure taking (procedure),	46973005
	Blood pressure (observable entity)	75367002
	Systolic blood pressure (observable entity)	271649006
	Diastolic blood pressure (observable entity)	271650006
	Postural drop in blood pressure (finding)	271648003
12	Temperature taking (procedure)	56342008
	Body temperature (observable entity)	386725007
13	Neurovascular assessment of lower limb (procedure)	424653005
14	Neurovascular assessment of upper limb (procedure)	424342008
15	Standard electrocardiogram (procedure)	164847006
16	Sit up, squat, stand test (procedure)	990281000000109
17	Skin assessment (procedure)	225397006
	Purpuric rash (disorder)	284078000
Smoking status		
18	Smoking assessment (procedure)	196771000000101
	Tobacco use and exposure (observable entity)	229819007
	Tobacco smoking consumption (observable entity)	266918002
	Smoker (finding)	77176002

	Ex-smoker (finding)	8517006
	Current non-smoker but past smoking history unknown (finding)	405746006
	Never smoked tobacco (finding)	266919005
Lifestyle		
19	Assessment of lifestyle (procedure)	443781008
20	Exercise status screening (procedure)	171253004
21	Dietary intake assessment (procedure)	225388007
22	Substance misuse assessment (procedure)	777041000000105
23	Alcohol consumption screening (procedure)	171208001
Laboratory measurements		
24	Haemoglobin A1c measurement (procedure)	43396009
25	Fasting blood glucose measurement (procedure)	271062006
26	Glucose measurement, urine (procedure)	30994003
27	Complete blood count (procedure)	26604007
28	Urea and electrolytes (procedure)	252167001
29	Phosphate measurement (procedure)	104866001
30	Albumin measurement (procedure)	26758005
31	Creatinine measurement (procedure)	70901006
32	Protein kinase measurement (procedure)	104903006
33	Fasting blood lipids (procedure)	270927009

Table 11