Service for the treatment and management of schizophrenia in adults

Commissioning guide
Implementing NICE guidance

March 2009
Service for the treatment and management of schizophrenia in adults

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health and social care professionals in England to commission an effective service for the treatment and management of schizophrenia in adults (18 years and over) with an established diagnosis of schizophrenia with onset before age 60. The schizophrenia guideline does not address the specific treatment of young people under the age of 18, except those who are receiving treatment and support from early intervention services.

Commissioning a comprehensive range of interventions, including services that promote recovery for people with schizophrenia, needs effective joint commissioning between primary care trusts (PCTs) and local authorities to ensure integrated partnership working across the NHS, social care, housing sector, not-for-profit and private sector organisations.

This commissioning guide should be read together with the following NICE guidance:

- NICE clinical guideline CG82. Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.

The clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide. Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

The guide:

- makes the case for commissioning a schizophrenia service
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide can be downloaded or accessed from the navigation menu on the right hand side of the screen. Download the openly available commissioning and benchmarking tool, there is no need to register.

1 This includes schizoaffective disorder, schizophreniform disorder and delusional disorder.
We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- **Topic-specific Advisory Group: schizophrenia service**

March 2009
Commissioning a service for the treatment and management of schizophrenia in adults

Schizophrenia is a major psychiatric disorder, or cluster of disorders, and is characterised by psychotic symptoms that alter a person’s perception, thoughts and behaviour. The nature of the condition varies from person to person but the main symptoms are psychotic experiences, for example hearing voices and other hallucinations or having fixed beliefs that are false but which the person believes in completely (delusions). Typically there is a prodromal period characterised by deterioration in personal functioning including memory and concentration problems, unusual behaviour and ideas, disturbed communication and affect, and social withdrawal.

Recently, there has been a new emphasis in services on early detection and intervention, and a focus on long-term recovery and promoting people’s choices about the management of their condition. There is evidence that most people will recover, although some have persisting difficulties or remain vulnerable to future episodes. Carers, relatives and friends of people with schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments.

The difficulties experienced by people with schizophrenia are not solely the result of recurrent episodes or continuing symptoms. Unpleasant side effects of treatment, social adversity and isolation, poverty and homelessness also play a part. These difficulties are not made any easier by the continuing prejudice, stigma and social exclusion associated with the diagnosis, which can lead to reduced opportunities to get back to work or study, and problems forming new relationships.

Social functioning and reduced isolation can be improved through social interventions that strive to promote recovery such as access to work, education and recreation. Social support and services looking at independent accommodation/housing, fighting stigma, improving access to meaningful activities, and promoting health in the wider communities, are all important considerations for health and social care commissioners when planning services.

Over a lifetime, about 1% of the population will develop schizophrenia. The prevalence of schizophrenia and related disorders is estimated to be 5 per 1000; estimates vary widely and are known to be affected by several factors including social deprivation and ethnicity. Mortality among people with schizophrenia is approximately 50% above that of the general population, partly as a result of an increased incidence of suicide (about 10% die by suicide) and violent death, and partly as a result of an increased risk of a wide range of physical health problems, including those induced by cigarette smoking, obesity and diabetes.

The estimated total societal cost of schizophrenia in England is £6.7 billion (in 2004/05 prices). Of this, around £2 billion (about 30% of the total cost)
comprises direct costs of treatment and care, while the rest £4.7 billion (70% of the total cost) constitutes indirect costs to society[6].

**Benefits**

The potential benefits of robustly commissioning an effective comprehensive schizophrenia service across all phases of the condition include:

- **reducing self-harm and deaths from suicide**
- **improving clinical and social outcomes** through early detection, intervention, treatment and structured day-time activity
- **improving support** for carers and families
- **promoting recovery** and increasing independence and self-management
- **reducing the frequency of relapse** and subsequent hospital admissions
- **increasing earlier discharge** from inpatient wards
- **improving general physical healthcare**, for example increasing the number of people with schizophrenia who undergo a cardiovascular disease risk assessment as described in *Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease (NICE clinical guideline 67)*
- **improving access to** high quality evidenced based care across all phases of the condition
- **reducing inequalities** and improving access to primary and secondary care services, particularly for people from deprived areas and different ethnic groups
- **increasing patient choice** about the management of their condition and improving partnership working, service user experience, engagement and retention with treatment
- **better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians and social care professionals to undertake local service redesign to meet local requirements in novel ways.

**Key clinical issues**

Key clinical issues in providing an effective schizophrenia service are:

- **improving access to and engagement with a range of services** for all people affected by schizophrenia
• **providing effective and efficient clinical care** in line with [NICE clinical guideline CG82 on schizophrenia](#), and ensuring appropriate treatment of comorbid disorders

• **ensuring the service is integrated** with other services that address health and social care needs

• **providing a quality assured service**.

**National drivers**

National priorities and initiatives relevant to commissioning a schizophrenia service include:

• **World class commissioning**.

• [The NHS in England: the operating framework for 2009/10](#). See the vital signs national requirement targets: ‘proportion of adults in contact with secondary mental health services in employment’ and ‘proportion of adults (18 and over) supported directly through social care to live independently at home’ and national priority for local delivery target: ‘suicide and injury of undetermined intent mortality rate’.

• [National service framework for mental health: modern standards and service models](#).

• [New Horizons in mental health](#).

• [High quality care for all: NHS next stage review](#) identifies the need for locally led, patient-centred and clinically driven change.

• **Transforming social care**.

• [The NHS Plan: a plan for investment, a plan for reform](#).

• [Choosing health: supporting the physical health needs of people with severe mental illness](#).

• [Delivering race equality in mental health care: an action plan for reform inside and outside services](#).

• [Mental health policy implementation guide: community development workers for black and minority ethnic communities](#).

• The [Care closer to home](#) initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.

• **Commissioning framework for health and well-being**.

• Considering the impact of [patient choice](#).

• The [Expert patients programme](#).

• The [Personalisation programme for health and social care](#).

• [A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services](#).
Implementation of NICE clinical and public health guidelines. These are currently core standards, and performance against these standards will be assessed by the Care Quality Commission in line with assessment processes. See also the Care Quality Commission 2009–10 periodic review indicators for mental health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

References


Specifying a schizophrenia service

Service components

The key components of a schizophrenia service are:

- early intervention and early treatment
- treatment of the acute episode
- promoting recovery
- developing a high-quality schizophrenia services across all phases of the condition

Early intervention and early treatment

Commissioners should ensure that people with first presentation of psychotic symptoms in primary care can be urgently referred to a local community-based secondary mental health service (for example, crisis resolution and home treatment, early intervention service, community mental health team).

Referral to early intervention services may be from primary or secondary care and should be available to all people with a first episode or presentation of psychosis irrespective of the person’s age or the duration of untreated psychosis. Early intervention services should aim to provide the full range of relevant pharmacological, psychological, social, occupational and educational interventions for people with psychosis, consistent with NICE clinical guideline CG82 on schizophrenia.

Treatment of the acute episode

Commissioners may wish to consider commissioning community mental health teams alongside other community-based teams as a way of providing services for people with schizophrenia during an acute episode. NICE clinical guideline CG82 on schizophrenia recommends:

- Crisis resolution and home treatment teams should be used to support people with schizophrenia during an acute episode in the community. They should also be considered for people with schizophrenia who may benefit from early discharge from hospital following a period of inpatient care.
- Acute day hospitals should be considered alongside crisis resolution and home treatment teams as an alternative to acute admission to inpatient care and to help early discharge from inpatient care.

NICE clinical guideline CG82 on schizophrenia recommends that cognitive behavioural therapy (CBT) should be offered to all people with schizophrenia, and family intervention should be offered to all families of people with schizophrenia. Cognitive behavioural therapy and family intervention should be offered either in the acute phase or later, including in
inpatient settings, and delivered in line with the recommendations for the principles for providing and delivering psychological interventions within NICE clinical guideline CG82 on schizophrenia.

Commissioners should ensure that healthcare teams working with people with schizophrenia identify a lead healthcare professional within the team whose responsibility it is to monitor and review:

- access to and engagement with psychological interventions
- decisions to offer psychological interventions and equality of access across different ethnic groups.

Commissioners should also ensure that healthcare professionals providing psychological interventions:

- have an appropriate level of competence in delivering the intervention to people with schizophrenia in line with the recommendations in NICE clinical guideline CG82 on schizophrenia
- have regular supervision during psychological therapy by a competent therapist and supervisor.

Commissioners may also wish to make resources available for arts therapies. Arts therapies may be offered to all people with schizophrenia, particularly for the alleviation of negative symptoms. This can be started either in the acute phase or later, including in inpatient settings.

<table>
<thead>
<tr>
<th>Commissioners may wish to note that NICE does not recommend:</th>
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<tbody>
<tr>
<td>- Routinely offering counselling and supportive psychotherapy (as specific interventions) to people with schizophrenia. However, service user preferences should be taken into account, especially if other more efficacious psychological treatments, such as CBT, family intervention and art therapies, are not available locally.</td>
</tr>
<tr>
<td>- Offering adherence therapy (as a specific intervention) to people with schizophrenia.</td>
</tr>
<tr>
<td>- Routinely offering social skills training (as a specific intervention) to people with schizophrenia.</td>
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**Promoting recovery**

Commissioners should ensure that people with schizophrenia continue to have access to the recommended treatments and interventions in the recovery phase including access to CBT, family interventions, arts therapies and pharmacological interventions in accordance with NICE clinical guideline CG82 on schizophrenia.
People with schizophrenia are at increased risk of developing cardiovascular disease and/or diabetes; therefore commissioners should make sure that mental health services work closely with primary care to ensure that the physical health needs of people with schizophrenia are monitored at least once a year and that their care is managed in accordance with the appropriate NICE guidance.

Commissioners should work in partnership with other health and social care professionals including those representing black and minority ethnic groups, to enable people with mental health problems, including schizophrenia, to access local employment and educational opportunities. Employment and educational opportunities should be sensitive to the person’s needs and skill level and is likely to involve working with agencies such as Jobcentre Plus, disability employment advisers and non-statutory providers.

Commissioners may wish to consider partnership working to ensure that supported employment programmes are provided for those people with schizophrenia who wish to return to work or gain employment. However, such programmes should not be the only work-related activity offered when individuals are unable to work or are unsuccessful in their attempts to find employment.

**Developing a high-quality schizophrenia service across all phases of the condition**

When commissioning schizophrenia services, commissioners should ensure that services offer a comprehensive range of interventions and that all people with schizophrenia receive a comprehensive, multidisciplinary assessment including a psychiatric, psychological and physical health assessment in accordance with NICE clinical guideline CG82 on schizophrenia.

Commissioners should also consider the needs of people from black and minority ethnic groups with schizophrenia when planning services as they are more likely than people from other groups to be disadvantaged or to have impaired access to and/or engagement with mental health services.

Commissioners should be aware of the new recommendations for pharmacological interventions. NICE clinical guideline CG82 on schizophrenia recommends that people with newly diagnosed schizophrenia are offered oral antipsychotic medication and that they are provided with information and the opportunity to discuss the benefits and side-effect profile of each drug. This is a change from the recommendation in NICE guidance on the use of newer (atypical) antipsychotic drugs for the treatment of NICE technology appraisal guidance 43 on schizophrenia. This is to aid adherence to medication by encouraging agreement with the service user. It is anticipated that better adherence will lead to better outcomes and savings overall. However, this may change the mix of drugs currently being prescribed and may have a cost impact locally.

**Service models**
Commissioners may wish to consider delivering a schizophrenia service in a number of different ways, and mixed models of provision may be appropriate across a local health economy. The NICE shared learning database offers examples of how organisations have implemented NICE guidance and developed services for people with schizophrenia locally.

Assertive outreach teams should be provided for people with serious mental disorders. This includes teams for people with schizophrenia, who make high use of inpatient services and who have a history of poor engagement with services, which can lead to frequent relapse and/or social breakdown.

**Service specification**

Local stakeholders, including service users and carers, should be involved in determining what is needed from a schizophrenia service in order to meet local needs. The service should be client-centred and integrated with other elements of care for people with schizophrenia.

The service specification needs to consider:

- the required competencies of, and training for, staff responsible for providing the service
- the expected number of people affected by schizophrenia (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally
- care and referral pathways, including potential sources of referral to enable service users to access, as soon as possible, assessment and treatment throughout all phases of care
- information and audit requirements, including IT support and infrastructure
- planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks
- **service monitoring criteria**.

Useful sources of information may include:

- The standard NHS contracts for acute hospital, mental health, community and ambulance services.
- The Map of medicine provides an information resource that visually organises the care pathway. Map of medicine – schizophrenia and chronic schizophrenia.
• Costing tool and slide set for NICE clinical guideline CG82 on schizophrenia

• Guide to resources for NICE clinical guideline CG82 on schizophrenia
Determining local service levels for a service for the treatment and management of schizophrenia in adults

**Benchmarks for a standard population**

Available data suggest that the indicative benchmark rate for the treatment and management of schizophrenia in adults is 0.5%, or 500 per 100,000 population, aged 18 years and older per year.

For the purpose of this commissioning guide the adult population has been defined as people aged 18 years and older. Approximately 80% of the population in England is aged 18 years and older.

For a **notional primary care trust** population of 250,000 (of whom around 200,000 are aged 18 years and older), the average number of people needing a schizophrenia service would be around 1000 per year (0.5% of the population aged 18 years and older).

For an **average practice** with a list size of 10,000 (of whom around 8000 are aged 18 years and older), the average number of people needing a schizophrenia service would be around 40 per year (0.5% of the population aged 18 years and older).

These figures vary depending on the local prevalence of schizophrenia, which is known to be affected by several factors including social deprivation and ethnicity[1].

Examine the **assumptions used in estimating these figures**.

This service is likely to fall under the **programme budgeting** category 205C (mental health disorders – psychotic disorders).

Use the service for the treatment and management of schizophrenia in adults **commissioning and benchmarking tool** to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

**Further information**

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the Commissioning framework for health and well-being outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health Delivering quality and value – focus on benchmarking.
- Communities and neighbourhoods indices of deprivation.
• NICE Health equity audit – learning from practice briefing.

• The Disease management information toolkit (DMIT) is a good-practice tool for decision-makers, commissioners and deliverers of care for people with long-term conditions, which presents data on conditions that contribute to high numbers of emergency bed days. It models the effects of possible interventions that may be commissioned at a local level and helps users to consider the likely impact of commissioning options.

• PARR (Patients at risk of rehospitalisation) is a risk prediction system for use by primary care trusts to identify patients at high risk of hospital re-admission.

• PRIMIS+ provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.

References
Assumptions used in estimating a population benchmark

The assumptions used in estimating a population benchmark for the treatment and management of schizophrenia in adults aged 18 years and older of 0.5%, or 500 per 100,000 population per year, and the assumptions used in estimating the expected number of acute episodes of schizophrenia of 165 per 100,000 population, aged 18 years and older, per year are based on the following sources of information:

- epidemiological data on the prevalence of schizophrenia
- hospital episode statistics data to establish the number of admissions for people with a diagnosis of schizophrenia
- current practice to establish the number of people with schizophrenia in contact with GP services
- published research on schizophrenia
- expert clinical opinion of the topic-specific advisory group, based on experience in clinical practice and literature review.

For the purpose of this commissioning guide the adult population has been defined as people aged 18 years and older. Approximately 80% of the population in England is aged 18 years and older.

Epidemiological data

Prevalence estimates for schizophrenia in published literature vary widely and are known to be affected by a number of factors including social deprivation and ethnicity.[1]

The survey on psychiatric morbidity conducted by the Office for National Statistics in 2000[2] found that the prevalence for probable psychotic disorder was 5 per 1000 (0.5%) adults aged 16 to 74, equivalent to around 197,000 people aged 18 years and older. A small percentage of these people will have psychotic conditions other than schizophrenia, and the figures will not include people who did not take part in this household survey, for example those living in temporary accommodation.

The survey on psychiatric morbidity conducted by the Information Centre in 2009[3] concluded that there was no change in the prevalence of probable psychosis between the 2000 and 2007 surveys, the figure remaining at around 0.5% of people aged 16–74 years.

Over a lifetime, about 1% of the population will develop schizophrenia. The lifetime prevalence of schizophrenia has also been estimated to range from between 0.4% and 1.4%[4].
Hospital episode statistics data

The ‘Hospital episode statistics’ (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

Data were extracted to determine the number of people who were admitted to secondary care either as a planned or an emergency admission with a primary diagnosis of schizophrenia and related disorders in 2008/09. The international classification of diseases (ICD) (10th revision) codes used to extract the data were: F20, F21, F22, F23, F24, F25, F28 and F29.

Analysis suggests that around 26,100 people were admitted with a primary diagnosis of schizophrenia and related disorders.

Current practice

IMS Disease Analyser is a database that holds data from a sample of GP practice systems. Data were extracted from the database to assess the prevalence of diagnosed schizophrenia. Based on this data, the prevalence of schizophrenia among people aged 15 to 84 years is around 0.42%. This is slightly below previous estimates and may be accounted for by coding issues in general practice.

Published research

To inform the report Helping people through mental health crisis: The role of crisis resolution and home treatment services (CRHT), the National Audit Office produced a model to assess the economic impact of integrating CRHT and inpatient services. The model assumes that for people with a psychosis, depression or anxiety disorder experiencing a crisis, overall, the percentage who are not admitted is 60%, with 40% being admitted.

Expert clinical opinion

NICE clinical guideline CG82 on schizophrenia recommends that cognitive behavioural therapy (CBT) should be offered to all people with schizophrenia. This can be started either in the acute phase or later, including in inpatient settings. The consensus opinion of the topic-specific advisory group is that 70% of those people offered CBT will take up the offer.

NICE clinical guideline CG82 on schizophrenia also recommends that family intervention should be offered to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started in either the acute phase, or later, including in inpatient settings. The consensus opinion of the topic-specific advisory group is that:

- around 50% of people with schizophrenia live with or have close contact with their families
• of the 50% offered family intervention, around half would take up the offer
• in total, around 25% of people with schizophrenia will take up family intervention.

Conclusions

Based on the epidemiological data and other information outlined above, it is concluded that a population benchmark for the treatment and management of schizophrenia in adults aged 18 years and older is 0.5%, or 500 per 100,000 population per year and that there are around 165 acute episodes of schizophrenia per 100,000 population aged 18 years and older, each year. These figures are based on the following assumptions:

• the population prevalence of schizophrenia in adults is around 0.5%. This is equivalent to around 500 per 100,000 people aged 18 years and older or 197,000 people in England
• the number of admissions to secondary care for schizophrenia and related disorders in 2008/09 was 26,100
• admissions to secondary care account for around 40% of acute episodes experienced by people
• adjusting for the 60% of acute episodes not admitted to secondary care gives an annual figure of around 65,300 acute episodes
• there are around 39,400,000 people aged 18 years and older in England
• there are therefore around 165 acute episodes per 100,000 people aged 18 years and older.

Therefore the population benchmark for the treatment and management of schizophrenia in adults is estimated to be 0.5% per year, with around 165 acute episodes per 100,000 population aged 18 years and older expected.

Use the service for the treatment and management of schizophrenia in adults commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References


The commissioning and benchmarking tool

**Download the schizophrenia service commissioning and benchmarking tool.**

Use the schizophrenia service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

**Identify indicative local service requirements**

The indicative benchmark based on the national average for the treatment and management of schizophrenia in adults aged 18 years and older is **0.5%**, or **500 per 100,000 population, aged 18 years and older per year**.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population has lower or higher levels of social deprivation or an ethnic composition different from the national average, you may need to provide services for relatively fewer or more people.

**Review current commissioned activity**

You may already commission a schizophrenia service for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.
Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the schizophrenia service may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for people with schizophrenia and their carers. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account service user’s views and carer’s views and those of other stakeholders when making commissioning decisions.

A schizophrenia service needs to:

- be effective and efficient
- be responsive to the needs of people with schizophrenia and their carers
- provide treatment and care based on best practice, as defined in NICE clinical guideline CG82 on schizophrenia
- deliver the required capacity
- be integrated with other elements of health and social care for people with schizophrenia
- define agreed criteria for referral, local protocols and care pathways for people with schizophrenia at different phases of the condition. The care programme approach should be used to help ensure effective collaboration with other care providers during transfer between services and should include details of how to access services in times of crisis.
- be client-centred and provide equitable access, ensuring that people are treated with dignity and respect, are fully informed about their care and treatment and are able to make decisions about their care including advance decisions and advance statements in partnership with health and social care professionals.
- consider and respond to recommendations arising from any audit, serious untoward or patient safety incidents
- demonstrate how it meets requirements under equalities legislation
- demonstrate value for money.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.
• **Service and performance targets**, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that service users and carers do not experience unnecessary delays), complaints procedures.

• **Clinical governance arrangements**, including incident reporting.

• **Clinical quality criteria**: appropriateness of referral, consenting procedures in line with the code of practice that accompanies the [Mental Capacity Act](https://www.legislation.gov.uk/ukpga/2005/9) clinical protocols.

• **Audit arrangements**: frequency of reporting, reporting route and format, and dissemination mechanisms; arrangements should include developing and using practice case registers in primary care to monitor the physical and mental health of people with schizophrenia, and organisations should ensure that services providing psychological interventions routinely and systematically monitor a range of outcomes across relevant areas (see [NICE clinical guideline CG82 on schizophrenia audit support for primary care](https://www.nice.org.uk/guidance/cg82), [audit support for organisational criteria](https://www.nice.org.uk/guidance/cg82), [audit support for clinical criteria](https://www.nice.org.uk/guidance/cg82) and [audit support for pharmacological interventions](https://www.nice.org.uk/guidance/cg82) for further information).

• **Health, safety and security**: of staff and service users, full risk assessment, infection prevention, waste management, confidentiality procedures, legislative requirements.

• **Accreditation requirements**: for some or all elements of the service, the premises and/or staff. Arts therapies should be provided by Health Professions Council (HPC) registered arts therapist, with previous experience of working with people with schizophrenia.

• **Patient and service user experience**: using the [national patient survey](https://www.nice.org.uk/guidance/cg82); taking into account perspectives and perception of service provision to help shape services; engagement to inform commissioning decisions; complaints.

• **Patient outcomes**: see [Health of the Nation Outcome Scales](https://www.nice.org.uk/guidance/cg82) (HoNOS), include clinical, patient reported and social outcomes

• **Staff competencies**: trusts should provide access to training that equips healthcare professionals with the competencies required to deliver the psychological therapy interventions recommended in [NICE clinical guideline CG82 on schizophrenia](https://www.nice.org.uk/guidance/cg82)

• **Information requirements**, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).
• The process for reviewing the service with stakeholders, including decisions on changes necessary to improve or to decommission the service.

• Achieving targets associated with equalities legislation.

Further information

General information on quality and corporate assurance can be obtained from the following sources:

• The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

• NHS Alliance online resources. NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

• The DH commissioning framework provides guidance on the commissioning process in the context of the NHS reform agenda.

• NHS Institute for Innovation and Improvement support for commissioners, includes Commissioning for Health Improvement products to accelerate the achievement of world class commissioning; The Productive Leader programme to enable leadership teams to reduce waste and variation in personal work processes, and Better care, better value indicators to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

• 10 Steps to your SES: a guide to developing a single equality scheme. This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

Specific information on quality and corporate assurance for a schizophrenia service can be obtained from the following sources:

• Better metrics is a pragmatic project that provides clinically relevant measures of performance to support the development
of measurable local targets and indicators for local quality improvement projects. See adult mental health metric 9.06–9.17

- **Quality and outcomes framework (QOF)** is a voluntary quality incentive scheme that rewards general practices for implementing systematic improvements in the quality of patient care.

- **National mental health development unit** provides national support for implementing mental health policy

- **Delivering race equality dashboard** is a tool designed to support the measurement of key priorities within race equality and mental health

- **Skills for health** works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the mental health competence framework.
Topic-specific Advisory Group: Schizophrenia service

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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