NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Psychosis and schizophrenia in adults

Date of Quality Standards Advisory Committee post-consultation meeting:
04 November 2014

2 Introduction

The draft quality standard for psychosis and schizophrenia in adults was made available on the NICE website for a 4-week public consultation period between 08 September and 06 October 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 21 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- There was general support for the quality standard and the areas raised reflect key areas for quality improvement.
- Concerns were raised about the perceived promotion of anti-psychotic drugs within the introduction to the quality standard.
- The need for training, particularly within cognitive behavioural therapy and family interventions, was raised.

- The role of carers was highlighted and the value of service being provided outside mental health services.
- Continuity of care and integrated commissioning was promoted.

Consultation comments on data collection

- With appropriate systems in place it should be possible to collect data.
- May be useful to have some measures that are non-symptom based.
- Would be useful to audit GP practices as a source of data collection.
- Some of this data can be collected within the National Audit of Schizophrenia and this should be referenced.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults with a first episode of psychosis are referred to early intervention in psychosis services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Stakeholders felt that there should be an indication of timing added to this statement, possibly adding "… and are assessed without delay". This could improve outcomes such as duration of untreated psychosis.
- Stakeholders highlighted that further detail could be provided in the commissioning section of the audience descriptors to ensure that integrated commissioning takes place.
- A stakeholder highlighted the importance of evidence-based treatments and that this should be re-iterated in the audience descriptors and definitions.
- A stakeholder stated that it needed to be clear who was responsible for ensuring this happens; the referrer or the early intervention in psychosis services (EIPS). If it is for EIPS it is important to note that current provision from these services is up to 35 years of age.

- A stakeholder highlighted that EIPS will assess some individuals who may appear to have psychosis but who are not diagnosed with such, this should be reflected in the statement.

5.2 Draft statement 2

Adults with an acute episode of psychosis or schizophrenia that exceeds the capability of community based services are offered care by crisis resolution and home treatment teams.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- A stakeholder highlighted the importance of this statement and that responses to mental health crises should be the same as physical health crises, integrated care planning could improve this.
- A stakeholder felt that this statement should also emphasise the importance of accessing psychological therapies for those who are involved with crisis resolution and home treatment teams.
- Stakeholder felt that it would be useful to have some detail on the care pathway of service users within this statement; this could potentially be within the commissioning section of the audience descriptors.
- A stakeholder highlighted that national mental health surveys collect some data on crisis care and this should be referenced.
- A stakeholder stated that some of the terms used within the statement are not consistent.

5.3 Draft statement 3

Adults with psychosis or schizophrenia are assessed for coexisting psychiatric conditions.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders highlighted that co-existing psychiatric conditions are inextricably linked with psychosis and schizophrenia and these links should be made clear.
- A stakeholder felt that not enough attention is given to trauma as this goes beyond identifying a condition.
- Stakeholders highlighted that in order to see improvement in this area there needs to be some detail about referral for treatment.
- A stakeholder stated that this needs to be part of an assessment alongside physical health and substance misuse at an initial assessment.

5.4 Draft statement 4

Adults with psychosis or schizophrenia are offered cognitive behavioural therapy (CBT).

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- A stakeholder highlighted that further outcome measures could be identified such as co-morbid psychiatric conditions, quality of life, social functioning or mental health confidence.
- Stakeholders felt that this statement should not focus solely on CBT and should ensure that service users have a choice of psychological therapies.
- Stakeholders stated that CBT is also recommended for emerging/developing psychosis and this should be addressed.
- A stakeholder highlighted that CBT may be offered but declined which may affect measurement.
- A stakeholder felt this statement should not stand in isolation as investment in all psychological therapies is required.

5.5 Draft statement 5

Family members of adults with psychosis or schizophrenia are offered family interventions.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders generally supported this statement and the support and inclusion it provides for family members and carers.
- Quality of life may be a useful outcome measure (service user and family member) as well as how many sessions are offered and awareness of interventions.
- A stakeholder felt that family therapy should be referenced.
- A stakeholder highlighted that family interventions may be offered but declined which may affect measurement.
- A stakeholder was not clear on the distinction between this statement and statement 10 (carer-focused education and support).
- A stakeholder felt that the process measure denominators need to be more explicit.

5.6 Draft statement 6

Adults with schizophrenia that has not responded adequately to at least 2 anti-psychotics drugs are offered clozapine.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- A stakeholder felt that this statement needed to focus on the monitoring of antipsychotics, and that a clinician would still need to continue monitoring after prescribing clozapine.
- A stakeholder highlighted that adherence to antipsychotics is an issue and that this needs to be addressed before prescribing clozapine.
- A stakeholder felt that the term "treatment resistant schizophrenia" could be considered negative and suggested using "clients with ongoing distressing psychotic experiences".
- A stakeholder highlighted that information around licensing is not correct and may need to be amended within the statement rationale.

- A stakeholder stated that outcome measures could also include symptom control, patient satisfaction and hospital admission rates.

5.7 Draft statement 7

Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 7:

- A stakeholder felt that this statement should highlight the competencies of healthcare professionals to raise the topic of employment as this can be a significant barrier.
- A stakeholder highlighted that supported employment programme should be made available as soon as a service user wishes rather than when a healthcare professional believes so.
- A stakeholder felt that the commissioning aspect of the audience descriptors should specify that this service is commissioned as part of fully integrated mental health service.
- A stakeholder stated that a single point of access is needed for this service.

5.8 Draft statement 8

Adults with psychosis or schizophrenia have their physical health routinely monitored.

Consultation comments

Stakeholders made the following comments in relation to draft statement 8:

- A stakeholder highlighted that additional measures of physical health could be included such as prolactin levels and electrocardiogram (ECG) monitoring.
- Stakeholders felt that this may miss service users who remain in only primary care or secondary care.
- A stakeholder stated that there needs to be greater emphasis on access to primary care services within this statement.

- A stakeholder felt that nutritional status should be explicitly stated in the statement, rather than just be in the definitions of physical health.
- Stakeholders felt that the statement needed recommend intervention and not only monitoring.
- Stakeholders stated that the data sources (such as QOF and CQUIN) may not be relevant and could lead to gaps for service users.
- Stakeholders felt that there should be more emphasis on healthcare professionals being aware of referral pathways as well as commissioners to provide these.
- Stakeholders highlighted that using a toolkit as a reference would be useful, particularly the Lester tool kit.
- Stakeholders felt that the impact of antipsychotics on physical health should be more explicitly stated.
- A stakeholder highlighted that some of the measurements were problematic such as the intrusive nature of weekly weight measurement, as well as whether waist circumference or BMI should be used.

5.9 Draft statement 9

Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

Consultation comments

Stakeholders made the following comments in relation to draft statement 9:

- Stakeholders highlighted that using a toolkit as a reference would be useful, particularly the Lester tool kit.
- Stakeholders felt that the impact of antipsychotics on physical health should be more explicitly stated.
- A stakeholder stated that interventions must be evidence based and include advice on alcohol consumption.
- A stakeholder highlighted that this needs to happen in primary as well as secondary care.
- A stakeholder highlighted that some service users may not want help to stop smoking.

5.10 Draft statement 10

Carers of adults with psychosis or schizophrenia are offered a carer-focused education and support programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 10:

- Stakeholder generally supported this statement and the support and inclusion it provides for family members and carers.
- A stakeholder was not clear on the distinction between this statement and statement 5 (family interventions).
- A stakeholder felt this should be more specific about what carer-focused education and support entails.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Recovery focused care and rehabilitation services
- Antipsychotics – Service users who decline medication e.g. “Adults with psychosis or schizophrenia who decline medication are offered support and a full range of psychological, social and occupational interventions”
- Antipsychotics – reduction or discontinuation for long-term treatment
- Antipsychotics – appropriate dosage
- Checking/confirming diagnosis
- Information provision
- Information sharing between providers
- Co-ordinated care planning

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
001	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	General	The statement made that drugs remain the primary treatment for psychosis implies that this is an acceptable and legitimate situation. The statement then made indicating that up to 40% of service users find this unacceptable should support a position that psychological interventions should be equitably available. Is would be helpful if such a position was made clear in this document.
002	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	General	It may not be within the remit of NICE but defining the standards of training required for psychological therapies in psychosis, especially CBT, but also for Family Therapy, would be extremely helpful for commissioners of training.
003	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	General	Each statement here is worded as “adults WITH psychosis or schizophrenia”. This implies the client has some form of specific illness. This is not clearly the case and certainly not agreed upon amongst researchers, clinicians and service users. It would be more helpful to use terminology something like “adults with experience of psychosis”
004	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	General	Within both hospital and community settings, antipsychotic drugs remain the primary treatment for psychosis and schizophrenia. There is well-established evidence for their efficacy in both the treatment of acute psychotic episodes and relapse prevention over time.” This is contested as untrue. A short read of recent available materials suggests quite clearly otherwise. Here are some examples; Leiberman, J. 2005 Effectiveness of anti-psychotic drugs in patients with Schizophrenia, new England journal of medicine, 1209 – 33 Davies, L. 2007, Cost effectiveness of first v second generation antipsychotic drugs, British Journal of Psychiatry, 191, 14-22 Tyrer, P. 2009, the spurious advance of antipsychotic drug therapy, Lancet, 373, 4-5. The increase in the number of, length of and frequency of relapse is now known to be higher since the introduction of

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement No	Comments[1]
			neuroleptics than those who are not prescribed them. There has been several studies and meta-analyses showing that antipsychotic meds make things worse for a majority of people. These studies have taken place over years. Also if the epidemiology is considered there has been an explosion of psychosis and hospitalised people since 1954 when these drugs were first introduced.
005	Carers Trust	General	Carers Trust welcomes the opportunity to comment on this new draft quality standard.
006	Carers Trust	General	There are a number of things to note to ensure the value of the service: It is important to ensure the standards of the Triangle of Care are implemented in services or there will not be a consistent signposting/referral process for all carers. The quality of the service must be ensured. It may be important to recognise the value of a service being provided outside of the mental health service ensuring that carers are linked into other support services and their needs identified.
007	College of Mental Health Pharmacy (CMHP)	General	No additional comments, seems fine.
008	IRIS	General	Yes we welcome the inclusion of employment and physical health as key elements of the treatment of psychosis. We welcome the inclusion of referral to a specialist Early Intervention in Psychosis multidisciplinary teams for young adults with first episode psychosis and hope this will reduce the risk of such services being disbanded or assimilated into CMHTs as part of so called ‘Transformation’ plans P2: we wondered if there needed to be reference to the tolerability/side effects of antipsychotic medication. With regard to the statement ‘There is well-established evidence for their efficacy’ we are bound to comment on the high reliance on drug company research for much of the evidence for the efficacy of neuroleptics. This is probably a comment on the Guideline rather than the QS, but we think NICE should be slightly more cautious in their endorsement of anti-psychotic medication. P6: We welcome the inclusion of suicide rates as an indicator of premature mortality
009	ISPS UK	General	A further Quality Statement is needed for clients who refuse medication – perhaps: ‘Adults with psychosis or schizophrenia who decline medication are offered support and a full range of psychological, social and occupational interventions’. It is known that a substantial proportion of clients do not consistently take medication over a period – the treatment for these clients is an important consideration.
010	Janssen Cilag UK	General	Continuity of care and thus integrated commissioning is crucial across all the Quality Standards as this will support patients with respect to most domains of the Social Care Outcomes Framework.
011	Lundbeck / Otsuka	General	Lundbeck UK and Otsuka Pharmaceuticals (the Alliance) welcome the publication of this quality standard for psychosis and schizophrenia in adults. Ensuring that people with these conditions are able to receive the highest

ID	Stakeholder	Statement No	Comments[1]
			possible quality of care is key to making recovery a realistic expectation. This consultation response focuses on the areas that we believe have not been given sufficient regard or have been overlooked because of the drive to keep the quality standard succinct. Although we recognise the value and importance of brevity, in its current form we believe this quality standard overlooks some key areas of care that need to be improved. Nonetheless, the Alliance strongly supports many of the quality statements currently proposed – and not discussed in detail in this consultation response - and would be concerned if any were removed or substantially amended. In particular, we support the focus on access to services, including early intervention in psychosis services and cognitive behavioural therapy (CBT), as well as the focus on holistic support for people affected by these conditions.
012	NHS Choices – Digital Assessment Service	General	Welcome the QS and have no comments on its content as part of the consultation.
013	NHS England	General	No substantive comments to add
014	Royal College of Psychiatrists	General	The quality standards as such do not cover all of the key areas. It does not adequately cover substance misuse, psychosocial rehabilitation or physical health. Data could be collected on each of the current quality standards.
015	Royal College of Nursing	General	No substantive comments to add
016	SANE	General	· This response has been submitted on behalf of the Mental Illness and Employment Task and Finish Group (T&F Group), which was set up in 2013, and has looked to explore in detail how best existing health policy levers can be used to drive improvements in employment outcomes for people with severe mental illness, as well as how it can work to support the uptake and implementation of these levers at a local level. The Mental Illness and Employment T&F Group is chaired by the Rt Hon Paul Burstow, former Minister for Care Services, and Marjorie Wallace, Chief Executive of SANE. This Mental Illness and Employment T&F Group welcome this draft NICE Quality Standard on psychosis and schizophrenia in adults and the response to this consultation has been informed by a workshop held by the Mental Illness and Employment Task and Finish Group in May 2014, which was attended by the following: Dr Jed Boardman, Royal College of Psychiatrists Margaret Edwards, SANE Dr Charlotte Harrison, Royal College of Psychiatrists Dr Alison Brabban, National Clinical Advisor for SMI (IAPT)

ID	Stakeholder	Statement No	Comments[1]
			Miles Rinaldi, South West London & St George's Mental Health NHS Trust Becky Aldridge, Dorset Mental Health Forum Ruth Allen, South-West London and St Georges (ADASS) Lynne Miller, Central and North West London NHS Foundation Trust Professor Jo Smith, Worcestershire Health and Care NHS Trust Paula Reid, Rethink Mental Illness
017	Tees Esk and Wear Valley NHS Trust	General	The whole document is clearer and therefore more likely to be read and understood.
018	Tees Esk and Wear Valley NHS Trust	General	The term psychosis used throughout is a refreshingly accurate description of service user experience and establishes it as the term of choice.
019	Tees Esk and Wear Valley NHS Trust	General	The document establishes Recovery as the term of choice.
020	Tees Esk and Wear Valley NHS Trust	General	The review team are reassuringly credible and are a team that includes our very own Recovery Lead Dr Alison Brabban.
021	Tees Esk and Wear Valley NHS Trust	General	CHIME factors are given the correct and central position.
022	Tees Esk and Wear Valley NHS Trust	General	The document is essentially a menu and audit tool for service users, carers and professionals to measure their local services against.
023	Tees Esk and Wear Valley NHS Trust	General	The term Declined is a respectful addition to the care lexicon and is to be celebrated.
024	Tees Esk and Wear Valley NHS Trust	General	Carer centrality to successful care provision is recognised.
025	Tees Esk and Wear Valley NHS Trust	General	Peer support workers are introduced and permission given for progressive organisations to be innovative in their employ.
026	Tees Esk and Wear Valley NHS Trust	General	The document places a much needed change of emphasis on engagement of service users rather than risk management or perceived risk management as a general principle.
027	Tees Esk and Wear Valley NHS Trust	General	There is an acknowledgement that a return to primary care is an outcome to be celebrated.
028	Tees Esk and Wear Valley NHS Trust	General	Permission is given for innovative medication management/coming off/choices to be explored.
029	Tees Esk and Wear Valley NHS Trust	General	Overall feedback from the Ripon Community Mental Health Team is that this document was difficult to read and understand.(comment submitted as part of the Tees Esk & Wear Valley NHS Trust comment proforma)
030	Birmingham & Solihull	Question 1	Yes, the statement does reflect the key areas for quality improvement

ID	Stakeholder	Statement No	Comments[1]
	Mental Health NHS Foundation Trust (Meriden Family programme)		
031	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Question 1	Yes, the statement does reflect the key areas for quality improvement
032	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Question 1	Certainly the standard does identify the key areas for quality improvement but there are a number of additions which are detailed above which would assist clarity in certain areas, especially access to psychological therapies and language used to describe difficulties related to psychosis
033	College of Mental Health Pharmacy (CMHP)	Question 1	Yes
034	College of Mental Health Pharmacy (CMHP)	Question 1	Yes
035	College of Mental Health Pharmacy (CMHP)	Question 1	Yes
036	Worcestershire Health and Care NHS Trust	Question 1	• Yes • Welcome the focus on supporting recovery and quality of life within the consultation's 'introduction section' and that employment and physical health are included as key elements of this. • Welcome inclusion of employment and vocational and premature mortality rates within the 6 outcome improvement areas. • Welcome ambition to relate Quality Standards to overarching outcome measures within existing frameworks, and note the importance of ensuring outcomes/incentives are aligned within the new commissioning environment including Public Health and NHS Outcome Framework indicators. • Welcome and fully support the inclusion of referral to a specialist Early Intervention in Psychosis Service for young adults with first episode psychosis, CBT, family/carer interventions, employment and physical health monitoring and intervention as key Quality Statement areas.

ID	Stakeholder	Statement No	Comments[1]
037	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Question 2	Yes, with appropriate new systems it should be possible to collect data for the proposed quality measures
038	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Question 2	Yes, with appropriate new systems it should be possible to collect data for the proposed quality measures
039	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Question 2	With the correct systems in place it would be possible to collect data related to quality outcomes, but it would be additionally helpful to include measures that are non symptom based, thereby capturing more specifically the targets of psychological and psychosocial interventions in line with recovery ideology
040	Care Right Now (CIC)	Question 2	1. Cross check people who have been, or are, under the care of secondary care psychiatric services with the GP Practice SMI (serious mental illness) register? 2. Audit GP practice for copies of relapse prevention plans (is there a READ code for this?)
041	College of Mental Health Pharmacy (CMHP)	Question 2	Yes
042	College of Mental Health Pharmacy (CMHP)	Question 2	Yes
043	College of Mental Health Pharmacy (CMHP)	Question 2	Yes
044	IRIS	Question 2	Yes, this is achievable.
045	Lancashire Care NHS Foundation Trust	Question 2	Local data collection seems to be the default, but some of this would be available if services participate in the National audit of schizophrenia.
046	Royal College of Psychiatrists	Question 2	Yes by and large.
047	SANE	Question 2	The Mental Illness and Employment Task and Finish Group suggests that the collection of data as outlined in Quality Statement 7's 'Quality Measure' is achievable.
048	Worcestershire Health and Care NHS Trust	Question 2	• Yes, this is achievable.

ID	Stakeholder	Statement No	Comments[1]
049	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Question 3	More could be done to support improvement and overcome barriers to the implementation of family interventions including: • improving access to family interventions through GP's • ensuring that CCG's are more influential in encouraging providers to make family interventions available • promoting the need for more training and improving implementation, including measurement of outcomes • asking CQC to monitor performance in terms of the numbers of NICE compliant family interventions delivered
050	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Question 3	The comments above detail some ideas as to what is required to support improvement but to reiterate the key points: what is required, is a health and social care system that offers service users genuine choice in how to understand their problems and to utilise the treatments that are can be effective. In order to achieve this we need to have an equitable mental health professional resource working consistently within a true psychosocial model, that is available for clients from entry to the service through to recovery and discharge.
051	College of Mental Health Pharmacy (CMHP)	Question 3	Barriers possibly overcome through pharmacy led training/education and medication review service
052	College of Mental Health Pharmacy (CMHP)	Question 3	CQUIN probably the best way to support improvement and overcome barriers
053	College of Mental Health Pharmacy (CMHP)	Question 3	Training and education, smoking cessation clinics, access to dietician. Pharmacist available to advise on smoking cessation agents and medication.
054	IRIS	Question 3	A key part of driving implementation is ensuring that specialist EI services are provided and maintained for young adults with psychosis and that employment support, family intervention, CBT and physical health interventions are included as core interventions and fully integrated into routine clinical practice - this is not included within the current draft Standard. The supporting guidance within the Quality Standard should also make clear that Health and social care practitioners should ensure that best evidence based practice informs their interactions and interventions with adults with psychosis and schizophrenia and their families. Attitudes, lack of knowledge and competence of healthcare professionals have been identified as some of the biggest barriers affecting implementation, so it is important to provide leadership that sensitively support staff in challenging their attitudes to care and improving their knowledge and skills in this area. Ensure these quality standards inform commissioning specifications and local CQUIN indicators to ensure these interventions are integrated and provided as part of a routine clinical practice of clinical teams to help drive implementation of the Quality Statement and improve outcomes for adults with psychosis and their families.
055	SANE	Question 3	For each quality statement what do you think could be done to support improvement and help overcome barriers?

ID	Stakeholder	Statement No	Comments[1]
			NICE Quality Standards are designed to drive up standards of care in a given clinical area, and a key barrier to achieving this ambition can be through a possible lack of implementation of the relevant guidance at a local level. A key part of achieving implementation therefore is helping to ensure that the offer of supported employment programmes becomes part of routine clinical practice, and it is important that this is reflected in the guidance. Healthcare professionals It is also important that that the guidance within Quality Statement 7 highlights the need for health and social care practitioners to help create a recovery orientated environment for people who do wish to return to work, as evidenced within associated national ImROC research. This is particularly pertinent as a lack of encouragement by healthcare professionals has been identified as one of the biggest barriers to people with serious mental illness gaining employment. A report from SANE in 2013 for instance, contained findings of a survey of the experiences of people with schizophrenia in regards to employment. The findings showed that over half of respondents did not feel encouraged by health professionals in finding employment, with individual responses including: “ It seems to me that permanent unemployment is seen by many in the caring professions as the natural state for people with a diagnosis of schizophrenia and I would strongly challenge that view. ”4 “ Mental health services seem orientated to people out of work and on benefits (who at least seem to assume this). They should equally help and support people who are in work or who want to work. They should acknowledge people’s life goals. (I wanted to work, and would have liked to have got married). ”4 Whilst each situation will be different, every health professional should feel able to encourage people with schizophrenia to consider how they might move towards a situation where they can be involved in employment or related activities. Practices that are helpful for healthcare professionals to consider are: Creating an atmosphere where anyone who chooses to work can work. Asking people if they want to work as part of routine clinical practice. Within community teams promoting employment consistently and regularly as a positive, achievable outcome.

ID	Stakeholder	Statement No	Comments[1]
			Encouraging people to talk about their fears and concerns about work and providing the assistance needed to address these concerns. Building confidence by giving attention to each individual's strengths, goals and motivations.
056	Worcestershire Health and Care NHS Trust	Question 3	• Acknowledge that Quality Standards are expected to improve the current quality of care. This guidance should therefore set out how best the Quality Statements can be implemented, and make a clear how although lack of resources and staff time are often identified as key barriers to implementation, these are not insurmountable and are no excuse for not delivering the best evidence based intervention and support to adults with psychosis and their families. • A key part of driving implementation is ensuring that specialist EI services are provided and maintained for young adults with psychosis and that employment support, family intervention, CBT and physical health interventions are included as core interventions and fully integrated into routine clinical practice - this is not included within the current draft Standard. • The supporting guidance within the Quality Standard should also make clear that Health and social care practitioners should ensure that best evidence based practice informs their interactions and interventions with adults with psychosis and schizophrenia and their families. Attitudes, lack of knowledge and competence of healthcare professionals have been identified as some of the biggest barriers affecting implementation, so it is important to sensitively support staff in challenging their attitudes to care and improving their knowledge and skills in this area. • Ensure these quality standards inform commissioning specifications and local CQUIN indicators to ensure these interventions are integrated and provided as part of a routine clinical practice of clinical teams to help drive implementation of the Quality Statement and improve outcomes for adults with psychosis and their families.
057	Critical Psychiatry Network	Quality statement 1	There should be a standard such as "A person with a diagnosis of psychosis should be given a chance to recover by exploring the content of their complaints like hearing voices and paranoia."
058	Critical Psychiatry Network	Quality statement 1	There should be standard about long-term treatment with antipsychotics to consider dose reduction or discontinuation. People should not drift back to primary care on long term antipsychotics without routine reviews to consider dose reduction or discontinuation.
059	Critical Psychiatry Network	Quality statement 1	There should be standard for adults with psychosis who do not wish to take medication to be offered an appropriate service
060	Critical Psychiatry Network	Quality statement 1	What about standard for checking the diagnosis?
061	Critical Psychiatry Network	Quality statement 1	There should be a standard on providing information on alternatives to medication-based therapies.

ID	Stakeholder	Statement No	Comments[1]
062	IRIS	Quality statement 1	Is there an opportunity to include a waiting-time/delay (or DUP) target here?
063	ISPS UK	Quality statement 1	We would favour strengthening this further to read 'Adults with a first episode of psychosis are referred to early intervention in psychosis services and assessed without delay'. Although this is in the spirit of the draft (the added phrase occurs at the foot of p.10 within the definition of early intervention) we believe that explicit mention within the Quality Statement itself would be valuable in ensuring the attention of, for example, commissioners on an element of response that is of crucial importance for clients and their families, but which has not been consistently achieved.
064	Janssen Cilag UK	Quality statement 1	We support the quality statement insofar as it required commission groups, etc, use local referral pathways and integrated commissioning. This should go further than suggesting that the service providers are aware and that services are available. Integrated commissioning requires patients actually receive the care. The NHS Future Forum report called for greater interoperability between local services as a key means to improve integration. Improving handovers and transitions in care is a major part of this. The NHS Institute works with providers in general practice, acute, mental health and community trusts to help them improve the reliability of handovers and transitions (http://www.institute.nhs.uk/commissioning/commissioning/integration.html#sthash.MS0Toucv.dpuf)
065	Lancashire Care NHS Foundation Trust	Quality statement 1	It isn't clear if this is for Early Intervention Services (EIS) to be responsible for, or if it is for all mental health teams. If it is for EIS then it needs to include a maximum age cutoff (ie "up to 34 years of age" or "under 35 years of age"); unless the guidance is intended to change national EI service model and associated commissioning arrangements. The outcome might need more work. There's evidence about the effectiveness of early intervention other than reduced admission rates.
066	RCGP	Quality statement 1	There is a wealth of evidence that focuses on transitions in mental health services and the negative effects poor transition planning can have on a person's mental health. As well as consideration of referral into EIS, care should be taken to ensure that there is an integrated pathway in place which includes discharge from the service into other settings including Primary Care, CMHT and pathways between the justice system and EIS (Young adults (18-24) in transition, mental health and criminal justice. Bradley Commission briefing 2;) https://www.rcpsych.ac.uk/.../JCP-MH%20CAMHS%20transitions%20(March%202012
067	Rethink Mental Illness	Quality statement 1	The rationale for this quality statement talks about early intervention in psychosis (EIP) services delivering evidence-based treatment. The 2014 Lost Generation report from Rethink Mental Illness showed that many EIP services were concerned about the 'hollowing out' of EIP services in a time of budget cuts. 52% services felt that the quality of EIP services had been adversely affected, including reductions in the range of interventions offered and in specialist staff numbers. It is therefore important that this quality statement reiterates the importance of evidence-based treatments within EIP services in the sections for health professionals and commissioners, and also in the definition of EIP services itself.

ID	Stakeholder	Statement No	Comments[1]
			We would also like to see some indication of timely or prompt referrals in this quality statement. This would reflect a key area for quality improvement in reducing duration of untreated psychosis for people experiencing a first episode of psychosis, therefore improving long-term outcomes.
068	Royal College of Psychiatrists	Quality statement 1	Early Intervention services assess, and should assess, a significant number of individuals whose behaviour/symptoms raise a suspicion of psychosis but who turn out not to have such. The Statement does not seem to take this into account. It potentially enlarges the denominator (and numerator). However, we accept this could be difficult to measure. This approach should not be restricted to people in first episodes. There is even more of a need for this approach when people experience a prolonged or relapsing/remitting course.
069	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Quality statement 2	There is no mention of access to psychological therapies for clients who are involved with crisis resolution and home treatment teams. These services should also be resourced with appropriately qualified and trained psychological therapists. More generally it would be useful to have a statement about ensuring clients have access to psychological therapies across their care pathway, from entry into the service in acute environments, or elsewhere, through to their recovery and discharge.
070	Care Right Now (CIC)	Quality statement 2	It would be helpful to include more on the service user’s pathway and continuity of care. Service users can fall in to a gap between primary and secondary care if links are not maintained, and the right information is not shared. For example when the Community Mental Health team discharges the service user to the GP
071	Care Right Now (CIC)	Quality statement 2	Suggested additional wording (shaded) on page 13:
072	Care Right Now (CIC)	Quality statement 2	(such as clinical commissioning groups) work with providers to ensure that they continue to commission crisis resolution and home treatment teams and ensure care pathways are in place to refer to crisis resolution and home treatment teams when necessary. Care pathways should include a relapse prevention plan, produced as part of a shared decision making process with the service user, cares and relatives as appropriate. These plans may enable direct access to specialist teams (e.g. Community Mental Health Teams or Home Treatment Teams) if previously agreed signs of relapse are evident. The emphasis being on detection of early warning indicators and prevention of deteriorating health and associated risks.
073	Lancashire Care NHS Foundation Trust	Quality statement 2	National mental health surveys collects some data on crisis care.
074	RCGP	Quality statement 2	Responses to mental health crises should be on a par with responses to physical health crises. This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, every day of the year. Integrated care planning approach for a crisis with clear and accessible care plans available and communicated to all

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			stakeholders.
075	Rethink Mental Illness	Quality statement 2	Some of the definitions in this quality statement are inconsistent and could be confusing for people trying to apply it. In the rationale, the term 'home-based care services' is used, although this quality statement also promotes the use of crisis houses, which are not home-based. Similarly, the definitions section talks about community teams/community-based services as separate to crisis resolution and home treatment teams and crisis houses, although these are delivered in the community. The language used here could therefore be more consistent. The role of crisis resolution and home treatment teams in supporting people after they are discharged from hospital is also referenced in the definition of these teams, but does not appear to be covered in other parts of the quality statement.
076	Rethink Mental Illness	Quality statement 2	If community alternatives to admission are to be included in this quality statement, then there should be a note to commissioners to ensure that these services are available locally for people to access in a timely way.
077	Royal College of Psychiatrists	Quality statement 2	Enhanced interventions from home treatment teams should be available to supplement the EI or Community Team input if needed. This should be available if early signs of relapse are identified and access to such additional input should not require the individual to deteriorate to a certain required level of severity before that input is made available. This needs early identification and seamless referral processes. There may need to be further capacity building for this to be possible. They need to be present during ward rounds to shorten stays.With the range of services that provide crisis intervention, Assertive Outreach Teams might be explicitly stated as providing a crisis function to some service users. Adults with an acute episode of psychosis or schizophrenia that exceeds the capability of community based services are offered care by crisis resolution and home treatment teams
078	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Quality statement 3	The assessment of co-existing psychiatric conditions in psychosis suggests that they are distinct disorders. More often such disorders are inextricably linked with the experience of psychosis, for example in trauma, anxiety and depression. It would be helpful to make these links clear. In addition the statement says nothing about access to treatment where individual psychological therapy would be clearly indicated
079	College of Mental Health Pharmacy (CMHP)	Quality statement 3	No outcomes have been stated
080	IRIS	Quality statement 3	Including substance misuse as a coexisting condition on P15 would be helpful (it is referred to later).
081	ISPS UK	Quality statement 3	In its draft form we think that this is insufficient to ensure that adequate and serious attention is given to the assessment of the client's history of trauma. This needs to go beyond merely identifying a psychiatric condition (such as PTSD), and – particularly because the occasion of assessment is likely to be a singular opportunity for facilitating clients' disclosure of vital information about trauma - we would favour an additional Quality Statement specifically focusing on eliciting information about clients' histories of trauma and adversity ('Adults with psychosis are explicitly

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			and sensitively asked about their experiences of trauma and adversity').
082	Janssen Cilag UK	Quality statement 3	Needs to go beyond just making sure they are assessed. How they are subsequently treated/supported and have continual relevant care is crucial and this too links into the integrated commissioning.
083	RCGP	Quality statement 3	In addition, there needs to be assurances that there is adequate capacity within the CMHT to then offer appropriate psychological therapies within a reasonable timeframe. Consideration should be given to a limited waiting time on par with physical health services- 18 weeks.
084	Rethink Mental Illness	Quality statement 3	While we support the inclusion of a quality statement about identifying coexisting psychiatric conditions, identification in itself will not lead to improved outcomes unless services are then in place to support people. Within mental health services, coexisting mental health problems are often not well managed. Local referral criteria and commissioning arrangements mean that people may not be able to access multiple mental health services at the same time for different mental health conditions. For this quality statement to really drive improvement, it needs to include access to services that can adequately support people. It is also unclear whether coexisting drug and alcohol use is included under this quality statement. It is included under 'what this statement means for adults with psychosis or schizophrenia' but is not mentioned anywhere else in this quality statement. This is again a crucial area where people fall between gaps in services, as mental health services will often not work with people until substance use has been addressed and drug and alcohol services will often not work with someone until their mental health is being treated. If it is included, this should be made clear in the rationale and sections for service providers, practitioners and commissioners.
085	Royal College of Psychiatrists	Quality statement 3	Adults with psychosis or schizophrenia are assessed for coexisting psychiatric conditions.This needs to be part of current assessment documentation alongside physical health and substance misuse. This should occur at initial assessment and be reviewed as required.
086	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Quality statement 4	Connected with the comment above it would be good to see outcomes identified for co-morbid psychiatric conditions as well as psychotic symptoms. Also other targets for psychological therapies might be appropriate to identify e.g. quality of life, social functioning or mental health confidence
087	Critical Psychiatry Network	Quality statement 4	Adults with psychosis should be allowed to seek alternative psychotherapies, not just CBT. Expand statement to "Adults with psychosis or schizophrenia are offered suitable evidence-based psychological and psychosocial interventions". Then statement would include Systemic Family Therapy approaches, as well as Open Dialogue, and the 'therapeutic environment' approaches like Soteria, clubhouse, TCs, greencare.
088	IRIS	Quality statement 4	CBT as an effective treatment for emerging psychosis is recognized in the latest guidelines but not apparent in this QS.
089	ISPS UK	Quality statement 4	In our view the singular emphasis on CBT is unhelpful, and a statement such as 'Adults with psychosis or schizophrenia are offered evidence-based therapy, taking their own wishes into account' would be preferable, and in

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			keeping with Guideline recommendation 1.4.4.6 about taking service users' preferences into account). There is, for example, considerable evidence concerning the Open Dialogue approach, evidence from Denmark about the value of Supportive Dynamic Therapy, as well as the evidence about arts-based therapies. For those clients who have a marked preference for counselling and supportive therapy we would think the prospects of progress would be better using these approaches, given the extent to which in comparative studies 'counselling' rivals CBT in effectiveness even for those who have not expressed such a preference.
090	Rethink Mental Illness	Quality statement 4	The NICE guideline that this quality statement derives from also mentions offering CBT to people at risk of developing psychosis. This is not covered in this quality statement and could help improve outcomes for people at risk.
091	Rethink Mental Illness	Quality statement 4	It would be good to see inclusion here of a discussion of treatment options with the person with psychosis or schizophrenia, including giving them accessible written information about these options. It is important that people's preferences are taken into account in all treatment decisions, not just around prescribing medication.
092	Royal College of Psychiatrists	Quality statement 4	Adults with psychosis or schizophrenia are offered cognitive behavioural therapy (CBT). However, this cannot stand in isolation. There is a complete lack of investment in psychological therapy and this requires increased investment and consideration for new technologies such as tablet PC and computerised CBT interventions to make it more widely available.
093	Lancashire Care NHS Foundation Trust	Quality statements 4 & 5	CBT may be offered but could be declined, the numerator and denominator might need more work to pick that up. Same with FI, it might be offered but declined, or the person may not have family.
094	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Quality statement 5	Relapse prevention is the key to family therapy outcome but other outcomes may be just as valid from a service user perspective, and hence equally valid as an outcome measure e.g. quality of life
095	Carers Trust	Quality statement 5	We welcome Quality Standard 5 and the emphasis on the value of improving the lives of carers. There are a number of points to note: Family interventions currently are provided in a very small number of mental health providers and as such a more general indicator looking at the inclusion and involvement of carers would be more beneficial. For example the Triangle of Care clearly sets out how carers should be included and the benefits for this. Where family intervention services are commissioned the outcome should also be a measure of the carer's improved well-being as well as the relapse rates of service users. Where family interventions are available it would be valuable to measure how many are offered, the awareness of service users and carers to this services.
096	College of Mental Health	Quality	A separate outcome for family and carers is required also

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	Pharmacy (CMHP)	statement 5	
097	Critical Psychiatry Network	Quality statement 5	It is important to stress the significance of Family Therapy in relation to psychosis and schizophrenia. Family interventions do not quite capture the skill needed to engage family members in the treatment. NICE has also accepted that there is evidence for the use of Family therapy.
098	Royal College of Psychiatrists	Quality statement 5	The statement that Family Interventions should form part of a broad based approach is important and welcome in terms of guiding successful implementation of these standards. Family members of adults with psychosis or schizophrenia are offered family interventions. This is an area which is massively under resourced and yet is vital to recovery. There are often complex family dynamics that lead to relapse. Time limited interventions by family therapists would help. Outcome measures may need to be thought of as reduction in symptoms not necessarily just relapse. The denominator proposed for Family Intervention is the number with psychosis or schizophrenia. Surely this should be the number who have contact with families and are in geographical proximity? (Similar to the qualification in QS 7.)
099	Tees Esk and Wear Valley NHS Trust	Quality statement 5	Clear research direction is given. My only negative comment concerns the guidance on Family Intervention which could be more robust and compel organisations to provide dedicated Family Intervention teams for maximum effectiveness. I feel an opportunity has been lost here.
100	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Quality statements 5 & 10	The Meriden Family Programme wishes to support statements 5 and 10 in the draft Psychosis and Schizophrenia in Adults quality standard. These are very welcome and much needed recommendations which fully support the important concept of carers and families being included and supported
101	Lancashire Care NHS Foundation Trust	Quality statements 5 & 10	We were not clear if statements 5 and 10 are talking about different provisions – family interventions include carer focused education and support, so some clarification around whether statement 10 means something slightly different would be helpful.
102	British Association for Behavioural & Cognitive Psychotherapies / NHS Lothian	Quality statement 6	The language could be more helpful in this statement. The term “treatment resistant schizophrenia” is clearly very negative from a service user perspective. Using language which encourages a greater degree of optimism e.g. “clients with ongoing distressing psychotic experiences” would be more appropriate here.
103	Janssen Cilag UK	Quality statement 6	This quality standard does not reference whether or not adherence is an issue. NICE guidelines 178: You cannot define someone as a non-responder unless it has been established that medication has been taken.

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104	Lancashire Care NHS Foundation Trust	Quality statement 6	P.8 (etc.) Needs clarifying / making consistent with other statements. Is it only for adults with schizophrenia, and not adults with psychosis or schizophrenia. A couple of typos on statement 6 need correcting - "has not" should read "have not", and "anti-psychotics drugs" should be "anti-psychotic drugs".
105	Lundbeck / Otsuka	Quality statement 6	We are concerned that quality statement 6 – while touching on the issue – does not go far enough in terms of highlighting the importance of ongoing monitoring and management of people's medication and treatment. This should include a full range of interventions based on the latest robust clinical evidence. We would welcome this quality standard focusing on ensuring that the right person receives the right medicine. Among the main considerations is that clinicians need to balance tolerability, efficacy and patient choice when deciding on a medication that is right for the person. In doing this all medicines reviews should be striving to improve the individuals' long-term health outcomes, as well as the immediate effects of the medication. We believe it is unhelpful that this quality statement gives the impression that a clinician's job will be done once they have offered clozapine to patients who have not responded adequately to at least two anti-psychotics. In reality this is an ongoing process which must consider a person's holistic needs – including other comorbidities – to optimise treatment and focus on recovery in the long term.
106	Royal College of Psychiatrists	Quality statement 6	Adults with schizophrenia that has not responded adequately to at least 2 anti-psychotics drugs are offered Cozapine. This is easily achievable and is part of most current practice. Outcome measure needs to be measured by symptom control not just relapse. The rationale reads "…It is only licensed for use in adults whose schizophrenia has not responded to at least 2 antipsychotics including 1 second-generation drug". This statement is incorrect. Clozapine is licensed for "…patients unresponsive to, or intolerant of, conventional antipsychotic drugs". The issue of whether it should be used after trials of two previous antipsychotic medications is one that comes from various clinical guidelines including the NICE Guideline. A further issue here is whether the denominator should include some reference to whether or not there is some contra-indication to Clozapine. This is appropriate but the outcome measure should include measures of patient satisfaction, and measures of hospital admissions. The development of concentrated expertise through specialist Clozapine clinics embedded within community based teams can aid recruitment of suitable patients and effective, efficient implementation of associated quality standards
107	Rethink Mental Illness	Quality	We know from our work on employment that the attitudes of health professionals can be a significant barrier to people

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		statement 7	accessing employment support. Many practitioners may be worried about broaching the subject of employment for fear of making people anxious or feel under pressure to return to work. This can mean that these conversations happen at quite a late stage in someone's recovery when they could, and should, happen much earlier and be included in all recovery planning. With this in mind, we feel some comment here about health professionals having the appropriate awareness and competencies to raise the topic of employment early with people would be appropriate.
108	Royal College of Psychiatrists	Quality statement 7	This is welcome. This is currently given a low priority in some organisations. It is important that other options are also available as described and embedding this intervention within EIS teams and Community Teams will aid implementation (co-location). Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes. - Supported employment programmes need a single access point and comprehensive databases of supported employment available locally. There needs to be further development with larger partners such as supermarket chains etc
109	SANE	Quality statement 7	The Mental Illness and Employment T&F Group welcomes this draft Quality Standard on psychosis and schizophrenia and feels that it does accurately reflect the key areas for quality improvement. The Mental Illness and Employment T&F Group supports the focus within this draft Quality Standard on the need to support recovery and promote people's choices about condition management, and welcomes in particular the inclusion of an employment-orientated Quality Statement. The Mental Illness and Employment T&F Group also welcomes the inclusion of employment and vocational rates as one of the 6 outcome improvement areas listed within this draft Quality Standard and highlights the importance of ensuring that these ambitions are aligned with the overarching outcome measures included within existing NHS frameworks. In respect of employment, the ambitions included within the draft Quality Standard should be aligned to the following indicators to ensure effective and joined-up commissioning: Public Health Outcome Framework indicator 1.8 NHS Outcome Framework indicator 2.1, 2.5 Whilst the Mental Illness and Employment T&F Group welcomes the inclusion of Quality Standard 7, we feel that it is important to outline in the guidance how the offer of supported employment programmes for an individual is made

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			available 'as soon as they wish'. The research evidence demonstrates that enabling people to access employment support when the person wants rather than when healthcare professionals consider the person to be 'job-ready', increases their chances of gaining employment. This is one of the evidence-based principles of supported employment (IPS). A recent study demonstrates this point and suggests that often clinicians may discourage their clients from participating in employment support programmes because they fear that work will precipitate a relapse, but conversely, when provided with support, they are better able to gain employment. Furthermore, making an early functional recovery – that is getting back to school or work – is more predictive of long-term outcomes than making an early symptomatic recovery. The evidence therefore suggests that IPS should be available to young people with a first episode of psychosis, and in a way that is fully integrated with their mental health treatment.
110	SANE	Quality statement 7	Quality Statement 7 should make reference to the need for commissioners to commission evidence-based employment support services as part of a routine clinical practice as a key means of overcoming the implementation barrier. In addition, commissioners should look to ensure the delivery of integrated employment interventions, as supported employment programmes, such as Individual Placement and Support (IPS), are most successful when provided as a fully integrated element of mental health treatment.
111	College of Mental Health Pharmacy (CMHP)	Quality statement 8	· Prolactin levels should also be monitored, especially in 1st episode psychosis as hyperprolactinaemia has been linked to osteoporosis and breast cancer. Also ECG monitoring required for antipsychotics. All monitoring should also be carried out at baseline. This statement indicates that patients with 1st episode psychosis and patients with psychosis and schizophrenia transferred from secondary to primary care will have their physical health monitored, but what about patients with psychosis and schizophrenia who remain in primary care? They should have regular physical health monitoring too.
112	Critical Psychiatry Network	Quality statement 8	Most of the literature shows that doctors and the NHS are incapable of meeting standards for screening of physical health in most cases (Yeomans et al, Systematic computerised cardiovascular health screening for people with severe mental illness Psychiatric Bulletin, published online ahead of print. http://pb.rcpsych.org/content/early/2014/07/14/pb.bp.113.045955.abstract). Not only is there evidence of poorer long term recovery with antipsychotics, there is considerable evidence of physical disorder (and increased risk of future physical disease) for people treated this way. Antipsychotic medication is likely to be one of the causes.

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113	Food for the Brain Foundation	Quality statement 8	Adults with psychosis or schizophrenia have their physical health 'and nutritional status' routinely monitored. We favour an addition to this statement, as shown in italics, in light of the growing evidence for a role of nutritional intervention for the adjunctive treatment of schizophrenia, as reviewed in the following paper in the Nutrition Journal - http://www.nutritionj.com/content/13/1/91
114	Janssen Cilag UK	Quality statement 8	Focus is purely around monitoring and testing. The Quality standard needs to drive the NHS Domain 1 and PH04 domains focus of reducing under 75 mortality especially through physical health monitoring and importantly intervention. The Quality statement only focuses on the monitoring and not the intervention required when physical health intervention is needed therefore there is no driver of improvement. NB Great to see the transfer of patients to primary care in this as a measure aligned to physical health monitoring.
115	RCGP	Quality statement 8	Physical health care monitoring should be done using a structured tool such as the Lester cardiometabolic toolkit. In addition there should be interventions offered where appropriate after screening has taken place. This is also supported by the Lester toolkit. To facilitate this, the NAS resource also suggests a structured integrated pathway to support individuals accessing physical health care. The need for information sharing between healthcare providers must be emphasised. http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#IPHPathway
116	Rethink Mental Illness	Quality statement 8	We are concerned about the data sources cited in this section of this quality statement. Firstly, the CQUIN indicator on improving physical healthcare is currently focused on inpatient settings only and it is uncertain what will happen to this indicator in future years. This is therefore not very practicable as a long-term data source. Secondly, the use of NICE QOF menu will not adequately capture data on all the physical health parameters. In 2014/15, some of the physical health checks for people affected by mental illness were retired - these were BMI, cholesterol and blood glucose or HbA1c. In current plans for data capture under this quality statement, these measures will therefore not be captured for people with schizophrenia or psychosis in the community. These quality measures also do not cover the baseline measure for these physical health parameters at the initiation of treatment, which means that changes once treatment has been initiated cannot be captured.
117	Rethink Mental Illness	Quality statement 8	Rethink Mental Illness is pleased to see the inclusion of two quality statements on physical health (8 and 9). However, in order to echo the new 2014/15 CQUIN indicator, we feel this quality statement should also focus on follow up action, not just monitoring results, in order to really drive quality improvement. The 2012 National Audit of Schizophrenia showed that, even where physical health problems are identified, few people are offered interventions

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			to address this. For example just 25% of people with high blood pressure were offered support. This approach is also promoted in the Lester adaptation (2014 update), which forms the basis of the 2014/15 CQUIN indicator. We would therefore recommend that this section also includes a point about health professionals being aware of, and utilising, referral pathways for any necessary follow up physical health care.
118	Rethink Mental Illness	Quality statement 8	This quality statement mentions the importance of shared care arrangements where responsibility for physical health monitoring transfers from secondary to primary care. This was a welcome clarification in CG178 (recommendation 1.3.6.5). Commissioners and service providers have a responsibility for ensuring these arrangements are in place and that information systems and local processes facilitate the transfer of this responsibility. This should be highlighted under this quality statement.
119	Royal College of Psychiatrists	Quality statement 8	Adults with psychosis or schizophrenia have their physical health routinely monitored. This needs to be defined further and whether it is the role of primary or secondary care. Quality of life measure could be an outcome measure. This section does not make reference to smoking or to the use of alcohol and drugs which are important factors contributing to the observed excess mortality and morbidity. I think it is important that explicit reference is made to this in this section even though there is a separate QS relating to some of these issues (QS9). This section should include all patients and not just first episode patients. I presume this is an unintentional typographical error. The later process descriptions appear to imply that most patients with schizophrenia will transfer back to Primary Care. It may be that this is not the intention but if it is, I would question both the desirability of this and the actual practice of this in current services. Most Primary Care services are not equipped to manage the complexities of managing people with recurrent-relapsing psychosis or psychosis with significant residual symptoms as services currently stand. Whilst some good prognosis individuals seen by early intervention services may be suitable for discharge to Primary Care, many will not achieve good long term outcomes through this approach. Ideally people should be enabled to access appropriate primary care services with a good flow of information between primary care and secondary care and vice versa. Staff training around these issues is likely to be a key component to successful implementation as is breaking down the sense of it being somebody else's job. Simple interventions may improve this aspect of care such as making appropriate equipment available to staff (are there scales in every clinic room? Blood pressure monitors? Do staff (nursing and medical) have access to on-line blood results? Do they have basic training in what the tests are for and what abnormalities mean?
120	Royal College of Psychiatrists	Quality statement 8	The order of the physical health risk factors seems rather strange given those which are most important in this patient group. Perhaps physical inactivity, obesity, glucose control, blood pressure, lipids would be a better prioritisation (smoking would be first but appears elsewhere)

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121	Royal College of Psychiatrists	Quality statement 8	The way this is written we think it is unclear whether each factor is to be measured separately, whether all have to be measured or whether achievement of any one might count.
122	Royal College of Psychiatrists	Quality statement 8	There will be a significant proportion of individuals who may find weekly monitoring of weight too intrusive. While weekly monitoring would be ideal there is not data to suggest whether this results in better outcome (in terms of actually preventing obesity) than say 2 weekly. Clearly the EUFEST data suggest this needs to be reasonably frequent in the early stages of treatment. We ask that you consider the balance of issues here against how far your process needs to aim for the ideal. A further issue here is whether this Statement should be expanded to include frequent monitoring of weight if medication is changed (e.g. aripiprazole to clozapine would have new implications for potential weight gain).
123	Royal College of Psychiatrists	Quality statement 8	While the NICE Guideline (CG178) has advised monitoring of waist circumference this appears to run counter to NICE CG43 (Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children) in which BMI is regarded as the preferable measure with limitations on where waist circumference is valid.(para 1.2.2.2 and 1.2.2.3). CG43 would appear to regard waist circumference as a further measure if one wishes to refine the level of risk posed by a particular level of BMI. Clearly in 'b' you have delineated a Statement for BMI. Experience in the National Audit of Schizophrenia is that <10% of patients have a recorded waist circumference and that its measurement may often be at odds with the recorded BMI when it is recorded. While from an academic standpoint waist circumference may be a better measure of abdominal adiposity, there does not seem to be a strong rationale to use it in this population in whom at present we are struggling to have the more straightforward measure of BMI recorded. We would urge a degree of simplicity here and stick to BMI alone.
124	Royal College of Psychiatrists	Quality statement 8	Physical health should be monitored by primary care. Whilst there is a responsibility for both primary and secondary services there appears to be a shift toward physical health monitoring part of the remit of mental health teams
125	Royal College of Psychiatrists	Quality statement 8	By not making mention of access to primary care services, and therefore placing responsibility for physical healthcare on secondary mental health services, who do not have primary care expertise, means that parity of esteem is not respected. This need should be reflected in commissioning guidance.
126	Lundbeck / Otsuka	Quality statements 8 & 9	The Alliance welcomes the focus on improving and protecting the physical health of people with schizophrenia in quality statements 8 and 9. Evidence has shown that people with psychosis or schizophrenia have significantly worse physical health outcomes than the general population. The Schizophrenia Commission report found, for example, that people with the condition are three times more likely to die from cancer than the general population. Prevalence of type 2 diabetes is also two to three times higher for people with schizophrenia. In addition, people with severe mental illness are twice as likely to die from heart disease as the general population.

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			The National Audit of Schizophrenia also raised major concerns regarding the poor physical health of people with schizophrenia, highlighting that many people are not getting the assessments they need to detect and treat physical health problems. Similarly, a recent survey conducted by Lundbeck, Otsuka and SANE found that around half (51 per cent, n=49) of respondents stated that they were dissatisfied with the support they, or the person they cared for/their family member, received from their doctor in monitoring their physical health. As this is an area where rapid progress is needed, we would recommend more specific reference to the tools that might be used to assess and monitor the physical health needs of people with schizophrenia. In particular, the Lester tool which can help facilitate assessment and treatment of physical health needs in people with schizophrenia and is designed to support collaborative practice across professional disciplines and service settings. As such, referencing it in the quality statement would be helpful to signpost it to a wide range of stakeholders. Furthermore, it is important to note that medicines choice will have an influence on the physical health and wellbeing of patients. In this context the NICE Clinical Guideline (CG178) recommends that the choice of antipsychotic medication should be made by the service user, healthcare professional and the carer (if the service user agrees), and the choice should take into account inter alia metabolic factors. NICE should consider, when communicating these quality statements, how to highlight this important consideration to professional audiences.
127	RCGP	Quality statement 9	Programmes, advice and interventions offered must be evidence based and appropriate for this group of people. In addition, it would be beneficial if the 70% of people in primary care with schizophrenia or psychosis who are not under secondary care are also able to access interventions. Advice and interventions should include alcohol.
128	Royal College of Psychiatrists	Quality statement 9	This is important. Teams need to access and harness mainstream community resources as part of this process. Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking. This requires regular investment in short term manualised programmes over 6 weeks that are simple.
129	Royal College of Psychiatrists	Quality statement 9	In the 2nd National Audit of Schizophrenia, 27% of service users who smoke said they did not want help to stop. Does the denominator require some qualification? In fact there is some inconsistency in the Statement as under ‘structure’ you talk about the arrangements to offer help to individuals to stop smoking but then decide to count those who have received help.
130	Birmingham & Solihull Mental Health NHS Foundation Trust (Meriden Family programme)	Quality statement 10	More could be done to support improvement and overcome barriers in respect of carer focused education and support programmes including: • ensuring that each mental health provider of secondary services has such a programme available to carers of people who use its services on an on-going basis. • ensuring that local authorities work with service providers in meeting this standard

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			• linking such courses to needs identified through statutory carer assessment processes
131	Carers Trust	Quality statement 10	Carers Trust welcomes the inclusion of education and support for carers as a measurable quality standard, as many carers feel ill-informed about mental health conditions, treatment and how to support individuals with a serious mental health condition.
132	Royal College of Psychiatrists	Quality statement 10	This is also an important component of effective services. Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes. This statement should be more specific to encompass medication, symptoms, management and prognosis
133	Critical Psychiatry Network	Additional areas	The list reads quite negatively. Should there not be statements relating to recovery focused care with emphasis on individual choice with regard to treatment options and recovery outcomes (not simply 'remission')?
134	Lundbeck / Otsuka	Additional areas	The Alliance is particularly concerned by the lack of a quality statement on access to high quality written information to support shared decision-making and adherence to treatments. We were surprised that such a quality statement has not been included, given its importance and usefulness in improving the care of people with schizophrenia, and the evidence that many people with schizophrenia do not have access to meaningful information. The provision of high quality information underpins the principle of patient choice, which is at the heart of the NHS Constitution[i]. Timely, accurate and understandable information on treatment and care options is key to enabling people with psychosis or schizophrenia to feel in control, and empowering them to make an informed decision about their treatment[ii]. Although the provision of verbal advice from a healthcare professional is vital, it can be easily forgotten after a face-to-face appointment. It is therefore important that people are also provided with high quality written information or signposted to other sources of information, as soon as possible in the care pathway. Ensuring that everything is done to support people with psychosis or schizophrenia to adhere to their treatment is particularly important. There is evidence from psychiatry and a number of other areas of medicine that shared decision-making can improve adherence with treatment[iii],[iv]. Indeed, non-adherence to treatment is the most common cause of relapse for people with schizophrenia, as reported in the National Audit of Schizophrenia[v]. However, recent findings have shown that more efforts need to be made to ensure that people with schizophrenia, as well as family members and those who care for people with schizophrenia, are provided with high quality, accessible information on treatment and care options, and are able to get actively involved in shared decision-making. The 2012 National Audit of Schizophrenia found that only 62 per cent of service users surveyed received information in a form they could properly understand[vi]. It also found that while clinical staff reported that they had involved service users in the choice of medication in 62 per cent of cases, only 41 per cent of service users felt their views were taken into account[vii].

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			These findings were echoed by a survey recently conducted by Lundbeck, Otsuka and SANE, which found that over half of people with schizophrenia who responded to the survey (58 per cent, n=30) received no information at diagnosis[viii]. Also, 37 per cent (n=19) said they were dissatisfied or very dissatisfied with the level of information they received[ix]. In addition, the large majority of respondents felt completely uninvolved, or only partly involved (86 per cent, n=41) in their choice of treatment[x]. We therefore suggest that providing ongoing high quality accessible information is a current area of weakness in the care and support of people affected by psychosis and/or schizophrenia, and call for the inclusion of a quality statement on information and shared decision making. We would, therefore, suggest: Adults with psychosis or schizophrenia are provided with high quality understandable verbal and written information throughout the course of their treatment, enabling them to make fully informed choices
135	Lundbeck / Otsuka	Additional areas	The Alliance is also concerned that the quality standard does not highlight the importance of the care planning process for people with schizophrenia and psychosis. There is significant evidence that many people with these conditions are not being provided with an accessible care plan and that they feel that their plan is not relevant to them. The Schizophrenia Commission highlighted significant concerns about the quality of care planning for people with schizophrenia[xi]. It recommended that all care plans should give people an element of choice as to where they are treated, and by whom, and include goals which have been agreed by the person[xii]. It is crucial that effective care planning is undertaken in collaboration with healthcare professionals, service users and carers and produced following a holistic assessment. As such, it is important that care plans reflect the full spectrum of needs and remain understandable and user-friendly for healthcare professionals, people with psychosis and/or schizophrenia and their carers. They should set out the psychological, pharmacological and physical treatment being received, as well as how someone's social needs, e.g. housing and education, are being met. The Government's principle of 'no decision about me, without me' should be a key priority for mental health services. In practice, this can be achieved by ensuring that people with psychosis and/or schizophrenia and, where appropriate, their carers, are: informed about the full range of treatment options involved in care planning

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			supported to exercise informed choice Also essential to achieving this ambition is ensuring that throughout a person's treatment, recovery goals are promoted and clinicians focus on improving the long-term outcomes of people affected these conditions[xiii],[xiv]. Care plans are an important and practicable step to achieving this. Furthermore there is scope to measure the impact of this quality statement using the Quality and Outcomes Framework (QOF) indicator MH002[xv], which measures the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented, in the preceding 12 months, agreed between individuals, their family and/or carers.
136	RCGP	Additional areas	There needs to be a greater focus on integrated care pathways and care planning. 2. There needs to be a greater focus on not just screening but also intervening for physical health care. 3. There needs to be a greater focus on information sharing between all the stakeholders involved- particularly primary and secondary care. 4. There needs to be a mention of the attitude and approach services should use- a personalised recovery focused approach.
137	Royal College of Psychiatrists	Additional areas	There is no mention of interventions for people with enduring psychosis and who have not adequately responded to treatment. Evidence is as below. Intervention for people whose illness has not responded adequately to treatment There is no mention of Rehabilitation services, inpatient, and in areas which have, Community Rehabilitation teams. These services have expertise in treating patients whose illness has not responded adequately to treatment. Approximately 10 of patients presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services due to the severity of their functional impairment and symptoms. Craig, T., Garety, P., Power, P., et al (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. BMJ, 329, 1067–1071. These patients require a large proportion of mental health services Around one half of the total mental health and social care budget is spent on services for people with longer term mental health problems. Half of this (one quarter overall) is spent on rehabilitation services and specialist mental health supported accommodation. This also includes psychosocial interventions (not just CBT), to enable people who require such interventions to live as independently as possible. Mental Health Strategies (2010) The 2009/10 National Survey of Investment in Mental Health Services. London Department of Health

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			There is evidence for the efficacy of Rehabilitation services : 1. Around two-thirds of people supported by rehabilitation services progress to successful community living within five years, and around 10% achieve independent living within this period. Killaspy, H.and Zis, P. (2012) Predictors of outcomes of mental health rehabilitation services: a 5-year retrospective cohort study in inner London, UK. Social Psychiatry and Psychiatric Epidemiology. 2. People receiving support from rehabilitation services are eight times more likely to achieve/sustain community living, compared to those supported by generic community mental health services. Lavelle, E., Ijaz, A., Killaspy, H.et al (2011) Mental Health Rehabilitation and Recovery Services in Ireland: a multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these services. Final Report for the Mental Health Commission of Ireland, 2011
138	Royal College of Psychiatrists	Additional areas	The quality standard document does lay out an appropriate, broad and welcome set of quality standards. However, a quality standard incorporating the principles outlined in the section on co-ordinated care ("A person-centered, integrated approach to providing services is fundamental to delivering high- quality care to adults with psychosis and schizophrenia")would be helpful to ensure that it is not only people in first episodes who receive a comprehensive co-ordinated approach. E.g. all adults with psychosis or schizophrenia should be offered contact with a named individual or individuals to co-ordinate the person centred integrated approach that is essential to delivering high quality care A statement such as this may seem obvious but with the exception of the EI recommendation, the standards otherwise sit as a series of welcome but potentially disconnected interventions. The concept of continuity and follow through is essential to good psychosis care and is of course well encapsulated in the EI model and well described in the preceding paragraphs of the document. Most people with psychosis and schizophrenia are managed in services that manage much greater patient numbers than are seen by EI teams. Without a QS equivalent to the EI QS, for the majority of patients there is a danger that the other QS items will be seen in isolation. The great majority of people with psychosis are not receiving their input through such services - almost by definition this group, seen after the first three years of psychosis or excluded from EI services for other reasons, will have a greater complexity than those in a first episode service. Specific interventions for the bulk of patients (such as CBT, Family Interventions, physical health improvement interventions and employment Interventions etc) need to take place within a framework of trust and collaboration underpinned by a general therapeutic relationship with named individuals that will endure longer than the time frame of each of the specific interventions described. A QS that recognises this would underpin the

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			framework that is essential to implementation of good services across the course of the disorder.
139	Royal College of Psychiatrists	Additional areas	Three important issues for consideration in the list of Quality Statements are: (a) Prescribing Standards; (b) Intervention for Physical Health Problems (other than lifestyle interventions); and (c) evidence of an annual review of key aspects of the person's care. (a) It might be appropriate to include the proportion of service users being prescribed antipsychotic medication(s) at doses above 100% of BNF recommended upper limits where no appropriate rationale has been recorded in the casenotes. Both the first and second rounds of the National Audit of Schizophrenia have found wide variation between Trusts in this regard. While there is no absolutely appropriate proportion who may appropriately be prescribed higher doses the variation suggests inappropriate practice in some Trusts. (b) It is clear from both rounds of the National Audit of Schizophrenia that intervention when evidence of a physical illness is found is frequently poor. While it is less easy to gather evidence about this, and while some individuals may refuse intervention, nevertheless a standard for such might be beneficial. (c) It is clear that information systems in mental health are poor (within Trusts, between Trusts and Primary care, at National level). The 2nd National Audit of Schizophrenia encountered difficulties within many Trusts when even simple information was requested. Such problems are likely to impact upon the ability of clinicians to manage their patients and to communicate appropriately with primary care colleagues. One consideration might be a Quality Statement seeking evidence of an annual review of the care of each service user where information such as: current medication and significant changes (with reasons) was recorded; is the person in remission; were there situations appropriate to a psychological intervention/was such offered/was such accepted by the service user; has Clozapine been a consideration and was it offered or not; has physical health been monitored; what were the results; was intervention required/delivered;

Stakeholders who submitted comments at consultation

- British Association for Behavioural & Cognitive Psychotherapies, NHS Lothian
- Care Right Now
- Carers Trust
- College of Mental Health Pharmacy
- Critical Psychiatry Network

- Food for Brain Foundation
- IRIS Early Intervention Network
- International Society for Psychological and Social Approaches to Psychosis UK (ISPS UK)
- Janssen Cilag UK
- Lancashire Care NHS Foundation Trust
- Lunbeck and Otsuka (joint response)
- The Meriden Family Programme, Birmingham and Solihull Mental Health NHS Trust
- NHS Choices – Digital Assessment Service
- NHS England
- Rethink Mental Illness
- Royal College of GPs
- Royal College of Nursing
- Royal College of Psychiatrists
- SANE
- Tees Esk and Wear Valley NHS Trust
- Worcestershire Health and Care NHS Trust