Report of the National Audit of Schizophrenia (NAS) 2012

Executive Summary

Commissioned by

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This is an executive summary from the national report; the full version of the report is available at www.rcpsych.ac.uk/quality/NAS-reports.

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Executive summary

Background

This report presents the findings of the first National Audit of Schizophrenia (NAS), one of only three audits in the National Programme on Mental Health (http://www.hqip.org.uk/national-clinical-audit-and-patient-outcomes-programme). Approximately 220,000 people in England and Wales have a diagnosis of schizophrenia. It is an illness which commonly severely restricts an individual's life, varies considerably in outcome between individuals and is associated with premature mortality. In 2007 it accounted for approximately 30% of the total expenditure on adult mental health and social care services.

A national guideline exists for the treatment and management of those suffering from schizophrenia: the 'NICE Guideline on Core Interventions in the Treatment and Management of Schizophrenia in Adults' (NICE CG82, 2009).The aim of this audit was to examine how far this guideline is being implemented and to stimulate improvements in the care and treatment of adults in the community with a diagnosis of schizophrenia.

The following quotation from one of the members of the independent Schizophrenia Commission in their report 'The Abandoned Illness' (Schizophrenia Commission, 2012) perhaps provides the strongest reason for initiating a process of national audit and quality improvement:

> *"More is known in how to care and treat schizophrenia but it is not always applied. I want better from the mental health system for everyone."*
>
> Yvonne Stewart-Williams

Aims

The key aims of the audit were to measure:

- Service users' experience of care and treatment and outcomes.
- Carers' satisfaction with the support and information they have received.
- Practice in the prescribing of antipsychotic medications.

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- The use of psychological therapies.
- The quality of physical health monitoring and interventions offered.

Standards and outcome indicators

The standards set for this audit are based on the NICE Guideline (2009). Thus, the audit particularly focuses on the satisfaction of service users and carers with the services offered to them, prescribing practice, psychological interventions offered and the quality of monitoring of physical health for these service users.

Method

Of the 64 NHS Mental Health Trusts and Health Boards in England and Wales identified by the NAS team as eligible to participate at the time of data collection, 60 (94%) submitted data. Each Trust/Health Board was asked to submit data on a representative sample of 100 adults under their care with diagnoses of either schizophrenia or schizoaffective disorder and who had been under the care of specialist mental health teams in the community for at least twelve months. A more detailed description of the methods and the development of the audit tools can be found in the methodology section (page 31) of the national report (www.rcpsych.ac.uk/quality/NAS-reports).

It was clearly challenging for Trusts/Health Boards to establish a reasonably comprehensive list of those people under their care with a diagnosis of schizophrenia. However, Trust/Health Boards clinicians and audit departments worked hard to collect the relevant information from their own organisations and often also from primary care. This means that the audit of practice forms were completed in a comprehensive manner. Trusts/Health Boards also distributed the relevant service user survey forms to service users who, in turn, distributed the relevant surveys to the individual they considered to be their closest carer.

Key national findings

Many aspects of the treatment and care provided were positive. The survey of the views of service users indicated a good level of satisfaction with services, but

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it was clear that there are differences between the information that Trust/Health Board staff think they have given to service users and the service users' perception of the understandability of that information. Although response rates from carers were rather low in number, their views generally mirrored those of service users.

Prescribing practice was very good in many Trusts/Health Boards. However, for some aspects of prescribing, for example polypharmacy, there continues to be a significant degree of variation between Trusts/Health Boards, beyond that which might be related to differences in the geographical distribution of people with a diagnosis of schizophrenia, such as between urban and rural populations. Clozapine is being widely used for those whose illness is most resistant to treatment. However, evidence emerged that a significant number of service users with treatment resistant illness remain for whom a trial of clozapine has not yet been considered. The availability of psychological therapies for those with schizophrenia is very variable.

The most serious deficits to emerge were in the monitoring and management of physical health problems. Those with schizophrenia have increased risks of premature death from coronary heart disease. Monitoring of cardiometabolic risk factors for this, particularly weight gain, is extremely poor. It is clear that a major initiative is required to address this issue. Improved protocols between primary and secondary care with regard to *'who does what and when'* are urgently needed, as well as an agreed set of parameters for the basic physical health measures to be assessed.

The following numbered points outline specific key findings by each major aspect of the audit:

1. Service user and carer views

The audit showed that service users were generally satisfied with the experience and outcomes of their care. The average rating of satisfaction across Trusts/Health Boards was 76%, using a variety of measures in the service user survey. Overall 49% of carers reported being very satisfied with the support and information they received.

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2. Involvement in choice of medication

Many service users felt they were not provided with information about their medication in an adequately understandable form. Only 62% reported that the information was in a form they could properly understand. Further, they did not always feel sufficiently involved in the final decision about which medication they should take. While clinical staff reported that they thought they had involved service users in the choice of medication in 62% of cases, only 41% of service users felt their views were taken into account.

3. Prescribing

Appropriate treatment guidelines are being followed for the majority of service users. An appropriate percentage of the most severely ill patients are receiving clozapine. However, 20% of the total population surveyed in the audit had not demonstrated an adequate response to treatment received, and would be regarded as treatment resistant. For some of these service users there were appropriate reasons for not being offered a trial of clozapine. However, 43% of the treatment resistant group had not been offered clozapine and had no documented reason for this.

The use of more than one antipsychotic drug at a time for treatment is not recommended, except in exceptional situations. While practice in this respect is good in many Trusts/Health Boards, overall 16% of service users were receiving more than one antipsychotic drug at a time. There were some Trusts/Health Boards where this was occurring in up to 30% of service users. This issue will need to be addressed. Some service users (5%) were also being prescribed medication in higher doses than is recommended in the British National Formulary (BNF), without clear documentation of the reasons.

4. Psychological treatments

There was wide variation in the availability of psychological treatments between different Trusts/Health Boards. Across England and Wales 34% of service users who were not in remission had not been offered any form of psychological therapy.

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5. Physical health

People with schizophrenia have increased risks for development of physical health problems, particularly heart disease and diabetes. However, only 29% of this population received a fully comprehensive assessment of important cardiometabolic risk factors. In particular, only 56% of service users were reported to have been weighed during the previous 12 months.

For those service users with evidence of physical health problems, for example high blood pressure and high cholesterol levels, there is frequently no evidence that they have had further appropriate investigation or treatment for these problems. At even a simple level, for those with elevated BMI there was only evidence of advice being given about diet and exercise in 76% of cases.

This report makes a series of recommendations to help address the problems identified. A summary of these is below. **The full set of NAS recommendations are listed individually for key individuals and organisations and can be found on page 115 in the national report(downloadable from www.rcpsych.ac.uk/quality/NAS-reports)**

Everyone should read this list to view the recommendations that apply specifically to their area of responsibility.

Summary of Recommendations

Experiences of people using services and experiences of carers

- Mental Health Trusts and Health Boards should involve local people who use services and carers in developing a local action plan for improving care and support offered.
- For the next audit the minimum requirements for experiences and outcomes should be raised so that services continue improving.

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Shared decision making

- Health professionals should review the written information they provide to people affected by schizophrenia, and their carers, about medication and check that it is clear and easy to understand.
- Professionals who prescribe medication should have the appropriate skills to involve service users in decisions about medication. This should include the ability to talk about the benefits and risks associated with treatment.

Prescribing standards

- Psychiatrists must recognise that antipsychotic polypharmacy is only rarely appropriate and if used requires clear documentation of the reasons.
- Psychiatrists should be aware of the upper dose limits for prescribing antipsychotic medication. If they prescribe above this level they should have a clear and documented reason for doing so.
- Trusts/Health Boards should make sure that health professionals understand the guidelines for the prescribing of antipsychotic medications and guidelines for prescribing outside the usual licensed indications.
- Trained clinical pharmacists should be available to offer advice on prescribing to other professionals.

Psychological therapies

- Providers and commissioners of mental health services must ensure that there is good access to psychological therapies for people with schizophrenia, particularly cognitive behavioural therapy, family therapy and other evidence-based treatments.
- Trusts/Health Boards should identify and address the barriers they face in offering and delivering these therapies.

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Management of physical health issues

- All health professionals working with people affected by schizophrenia should have training on common physical health problems experienced by this group. This includes how to assess physical health and identify any problems, and knowledge of interventions for treating these problems.
- Mental health services should have access to the correct equipment to monitor a person's physical health. If treatment is needed for physical health problems, staff in mental health services should help to ensure that people receive this.
- Mental health services and primary care services need to work together to agree who will monitor and treat physical health problems among people with schizophrenia.

Conclusions

The results of this audit highlight good practice but they also point to a need for greater improvement. The audit results provide a benchmark against which services can compare themselves. In April 2012 each participating Trust/Health Board received a report describing their own individual data in the context of the national findings. This was for the purpose of benchmarking and to provide an opportunity to begin a process of improvement. The full list of recommendations is provided on page 115 of the national report (www.rcpsych.ac.uk/quality/NAS-reports). We hope that this will help clinical staff, managers and commissioners to plan and instigate improvements in the care of people with a diagnosis of schizophrenia. There are also important messages for the relevant professional bodies in relation to education. In particular, it is clear that the government and commissioners need to set a clear framework for the monitoring of physical health in service users with a diagnosis of schizophrenia.

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