NICE National Institute for Health and Care Excellence

NICE quality standard

Service user experience in adult mental health services

Quality standard
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www.nice.org.uk/guidance/qs14

Contents

This standard is based on CG136.

This standard should be read in conjunction with QS8, QS11, QS84, QS86, QS15, QS23, QS24, QS34, QS39, QS50, QS51, QS53, QS54, QS61, QS88, QS101, QS102, QS95, QS80, QS115 and QS184.

Quality statements

Statement 1 People using mental health services are treated with empathy, dignity and respect. **[2011, updated 2019]**

Statement 2 People using mental health services are supported in shared decision making. **[2011, updated 2019]**

Statement 3 People using mental health services are asked about their experiences and their feedback is used to improve services. **[2011]**

Statement 4 People using mental health services understand the roles of the members of their multidisciplinary team and know how to contact them about their ongoing healthcare needs. **[2011]**

Statement 5 People can access mental health services, including crisis support, when they need them. **[2011, updated 2019]**

Statement 6 People using mental health services jointly agree a care plan with health and social care professionals, including a crisis plan if they may be at risk of crisis. **[2011, updated 2019]**

Statement 7 People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to them and regularly see other members of the multidisciplinary mental healthcare team. **[2011]**

Statement 8 People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm. **[2011]**

In 2019 this quality standard was updated. Some statements were merged (2011, updated

2019) or had wording amended. For more information, see update information.

The 2011 quality standard for service user experience in adult mental health services is available as a pdf.

Quality statement 1: Empathy, dignity and respect

Quality statement

People using mental health services are treated with empathy, dignity and respect. **[2011, updated 2019]**

Rationale

To have a good experience of NHS services, people must be treated with empathy, dignity and respect. This is also fundamental for developing good relationships between people providing services and those having care and treatment. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 made it a statutory requirement that all people who use services are treated with dignity and respect, and the NHS Constitution for England states that patients have the right to be treated with respect and dignity. There can be stigma around mental health problems, which can act as a barrier to people seeking help and accessing mental health services. Therefore, a sensitive, respectful approach is important to encourage people to get the help they need.

Quality measures

Structure

a) Evidence of local arrangements to ensure that mental health and social care professionals treat people using mental health services with empathy, dignity and respect.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that a strategy is developed with other local organisations to combat stigma in the community and the NHS associated with mental health problems.

Data source: Local data collection.

Process

Proportion of people who felt they were treated with respect and dignity by NHS mental health services in the past 12 months.

Numerator – the number in the denominator who felt that they were treated with respect and dignity by NHS mental health services in the past 12 months.

Denominator – the number of people receiving care from NHS mental health services in the past 12 months.

Data source: Local data collection. Questions on treating people with dignity and respect are contained within the Care Quality Commission (CQC) Community mental health survey. This survey is repeated annually and results are available for NHS trusts providing community mental health services.

Outcome

a) Evidence from experience surveys and feedback that people using mental health services feel they are treated with empathy, dignity and respect.

Data source: Local data collection. Questions on treating people with dignity and respect are contained within the CQC Community mental health survey.

b) Evidence from experience surveys and feedback that people using mental health services feel less stigmatised in the community and NHS.

Data source: Local data collection from local surveys.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) ensure systems are in place to give guidance to all staff on how to treat people using mental health services with empathy, dignity and respect; and collect feedback from people using mental health services on their experience of care.

Health and social care staff (such as psychiatrists, mental health nurses, social workers, receptionists and domestic services staff) ensure they treat people using mental health services with empathy, dignity and respect.

Commissioners ensure the mental health services they commission can provide evidence that people feel they are treated with empathy, dignity and respect.

People using mental health services feel they are treated with understanding, dignity and respect.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendations 1.1.1, 1.1.7 and 1.1.9

Quality statement 2: Decision making

Quality statement

People using mental health services are supported in shared decision making. **[2011, updated 2019]**

Rationale

People using mental health services should have overall responsibility for managing their health. This needs to be recognised when providing services, and in the ways healthcare professionals interact with them. Health and social care professionals and service providers need to recognise that many people want to be active in their own care, although not everyone wants an active role. People should be able to work with services to actively manage their health, rather than passively receive care. Supporting people to be at the centre of decisions about their own treatment and care, including people detained under the Mental Health Act, results in better quality decisions that are more appropriate to the person. Feeling supported to make decisions also helps foster an atmosphere of hope and optimism.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people being assessed by mental health services are given information and have their care explained so they understand the assessment process, their diagnosis and treatment options.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people using mental health services, including people formally detained under the Mental Health Act, are supported in shared decision making.

Data source: Local data collection.

Outcome

a) Evidence from experience surveys and feedback that people being assessed by mental health services understand the assessment process, their diagnosis and treatment options.

Data source: Local data collection.

b) Evidence from experience surveys and feedback that people using mental health services, including people formally detained under the Mental Health Act, feel supported in shared decision making.

Data source: Local data collection. Questions on involvement in making decisions are contained within the Care Quality Commission (CQC) Community mental health survey.

c) Evidence from experience surveys and feedback that people using mental health services feel optimistic that their care will be effective.

Data source: Local data collection. Questions on feelings of optimism are contained within the CQC Community mental health survey.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) ensure that systems are in place to provide information for people using mental health services and support shared decision making.

Health and social care professionals (such as psychiatrists, mental health nurses and social workers) give people using mental health services information and support to enable shared decision making.

Commissioners ensure that the mental health services they commission support shared decision making.

People using mental health services are given information and support to help them understand the choices available and make decisions about their care and treatment. Being at the centre of decisions about their own care can help people feel optimistic about the future.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendations 1.1.1, 1.1.2, 1.3.3 and 1.6.3

Definitions

Shared decision making

Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example through advance care planning.

It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.

This joint process empowers people to make decisions about the care that is right for them at that time (with the option of choosing to have no treatment or not changing what they are currently doing always included). [NICE's guideline on shared decision making, terms used in this guideline]

Equality and diversity considerations

People using mental health services should have access to an advocate for shared decision making in accordance with the relevant legislation set out in recommendation 1.1.1 of NICE's guideline on advocacy services for adults with health and social care needs. Advocacy should be offered to people who are not covered by the legal entitlement but who would otherwise not be able to express their views or sufficiently influence decisions that are likely to have a substantial impact on their wellbeing or the wellbeing of someone

they have caring or parental responsibility for.

Quality statement 3: Involvement to improve services

Quality statement

People using mental health services are asked about their experiences and their feedback is used to improve services. **[2011]**

Rationale

People who have used services have a unique insight into what works well through their direct experience. People's experience of services affects whether they continue to use the services, how they use them and whether they will use them again. Capturing this feedback in the review and planning of services is essential. People can become experts through experience and should be involved in the planning, commissioning, delivery and monitoring and review of mental health services to guide improvements.

Quality measures

Structure

a) Evidence of local arrangements to collect and use the views of people who use mental health services to monitor and improve performance.

Data source: Local data collection.

b) Evidence of local arrangements to involve people who use mental health services in monitoring services; for example, using exit interviews undertaken by people who have used services.

Data source: Local data collection.

c) Evidence of local arrangements to provide the executive board with reports on acute and non-acute mental health pathways, with a breakdown of people's experience of care

according to gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and disability.

Data source: Local data collection.

Outcome

Evidence from surveys and feedback that people using mental health services feel that their views are being used to improve services.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) ensure that systems are in place to collect the views of people using services and use them in monitoring and improving services.

Health and social care professionals (such as psychiatrists, mental health nurses and social workers) give people using mental health services opportunities to give feedback on their experience.

Commissioners ensure that the mental health services they commission use the views of the people using those services to monitor and improve them.

People using mental health services are asked about their experience of care, and their feedback is used to monitor and improve the service. They are also given the chance to be directly involved in reviewing and improving services.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendations 1.1.20 to 1.1.22

Quality statement 4: Contacts for ongoing care

Quality statement

People using mental health services understand the roles of the members of their multidisciplinary team and know how to contact them about their ongoing healthcare needs. **[2011]**

Rationale

Mental health services are provided by different types of professionals in a range of settings, which can be confusing. Understanding the role of all those directly involved in a person's care and how to contact them can build trust and confidence, reduce concerns and help develop relationships. Maintaining a consistent team can provide familiarity and help improve relationships. This supports a person to more effectively manage their health and the effect it has on their life.

Quality measures

Structure

a) Evidence of local arrangements to ensure continuity of support for people using mental health services.

Data source: Local data collection.

b) Evidence of local arrangements to ensure people using mental health services are given information on the roles of the people involved in their care and how to contact them.

Data source: Local data collection.

Outcome

Evidence from experience surveys and feedback that people using mental health services understand the roles of the multidisciplinary team members and know how to contact them.

Data source: Local data collection. Questions on knowing who the main person in charge of organising a person's care is and how to contact them are contained within the Care Quality Commission Community mental health survey.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) have systems in place to ensure that people using mental health services understand the roles of the multidisciplinary team members and how to contact them.

Health and social care professionals (such as psychiatrists, mental health nurses and social workers) ensure that people using mental health services understand their role in the person's care team, what they can help with, and how and when they should be contacted.

Commissioners ensure that the mental health services they commission help people using mental health services understand the roles of the multidisciplinary team members and how to contact them.

People using mental health services understand the roles of the different people involved in their care and know how to contact them.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendation 1.4.7

Quality statement 5: Access to services

Quality statement

People can access mental health services, including crisis support, when they need them. **[2011, updated 2019]**

Rationale

People should be able to access mental health services when they need them. Delays in care and support can have a negative impact on their health and wellbeing. Timely access to mental health services is essential for effective treatment of mental health conditions and can help avert a crisis. For people in crisis, access to support should be available 24 hours a day, 7 days a week. Crisis support includes a comprehensive assessment and crisis plan to identify the right care and treatment.

Quality measures

Structure

a) Evidence of local arrangements to ensure agreed referral methods are in place between primary, community and secondary care services.

Data source: Local data collection.

b) Evidence of local arrangements to ensure people have access to a local 24-hour helpline staffed by mental health and social care professionals.

Data source: Local data collection.

c) Evidence of local arrangements to ensure crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.

Data source: Local data collection.

d) Evidence of local arrangements to ensure that people accessing crisis support have a comprehensive assessment, including a crisis plan.

Data source: Local data collection.

Process

a) Proportion of people with a non-acute referral to mental health services who had a face-to-face appointment that took place within 3 weeks of referral (or within 2 weeks of any change of date).

Numerator – the number of people in the denominator who had a face-to-face appointment that took place within 3 weeks of referral (or within 2 weeks of any change of date).

Denominator – the number of people with a non-acute referral to mental health services.

Data source: Local data collection.

b) Proportion of people being assessed by mental health services who were seen within 20 minutes of the agreed appointment time.

Numerator – the number of people in the denominator who were seen within 20 minutes of the agreed appointment time.

Denominator – the number of people with an agreed appointment time for a mental health assessment.

Data source: Local data collection.

c) Proportion of people in crisis referred to specialist mental health services who were seen within 4 hours.

Numerator – the number of people in the denominator who were seen within 4 hours.

Denominator – the number of people in crisis referred to specialist mental health services.

Data source: Local data collection.

d) Proportion of people admitted to a 'place of safety' who were assessed under the Mental Health Act within 4 hours.

Numerator – the number of people in the denominator who were assessed under the Mental Health Act within 4 hours.

Denominator – the number of people admitted to a 'place of safety'.

Data source: Local data collection.

e) Proportion of people accessing crisis support who have a comprehensive assessment.

Numerator – the number of people in the denominator who have a comprehensive assessment.

Denominator – the number of people accessing crisis support.

Data source: Local data collection.

Outcome

a) Evidence from experience surveys and feedback that people can access a local helpline 24 hours a day.

Data source: Local data collection. Questions on knowing who to contact out of hours in the event of a crisis are contained within the Care Quality Commission (CQC) Community mental health survey.

b) Evidence from experience surveys and feedback that people accessing crisis support were asked about their relationships, their social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) ensure that systems are in place to provide access to mental health services when people need them.

Health and social care professionals (such as psychiatrists, mental health nurses and social workers) ensure that people can access mental health services when they need them.

Commissioners ensure that they commission services that provide access to mental health services when people need them.

People can get support from mental health services when they need them. This might involve calling a telephone helpline, seeing their doctor or nurse, or having an urgent referral if they are having a crisis.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendations 1.2.1, 1.2.3, 1.3.6, 1.5.3, 1.5.5 to 1.5.7 and 1.8.8

Definitions

Comprehensive assessment

This includes details of the person's:

- relationships with others
- social and living circumstances
- level of functioning
- symptoms
- behaviour

- diagnosis
- current treatment.

[NICE's guideline on service user experience in adult mental health, recommendation 1.5.3]

Quality statement 6: Joint care planning

Quality statement

People using mental health services jointly agree a care plan with health and social care professionals, including a crisis plan if they may be at risk of crisis. **[2011, updated 2019]**

Rationale

By jointly agreeing a care plan, people using mental health services can identify how support can help them to live an independent life, and achieve their goals and preferred outcomes. The care plan sets out the care and treatment they need, and a copy is given to the person. A suitable date to review the care plan should be agreed to take account of changes. For people who may be at risk of crisis, a crisis plan should be developed, agreed with their care coordinator and incorporated into their care plan. This helps people plan ahead by identifying possible early warning signs, coping strategies and how to access support to prevent crises. It also includes details of the person's needs and preferences if they need to be admitted to hospital.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people using mental health services jointly develop a care plan with mental health and social care professionals.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people using mental health services are given a copy of their care plan.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that people using mental health services have

an agreed date to review their care plan.

Data source: Local data collection.

d) Evidence of local arrangements to ensure that people using mental health services who may be at risk of crisis jointly develop a crisis plan with mental health and social care professionals.

Data source: Local data collection.

Process

a) Proportion of people using mental health services who have a jointly agreed care plan with mental health and social care professionals.

Numerator – the number of people in the denominator who have a jointly agreed care plan with mental health and social care professionals.

Denominator – the number of people using mental health services.

Data source: Local data collection.

b) Proportion of people using mental health services given a copy of their care plan.

Numerator – the number of people in the denominator given a copy of their care plan.

Denominator – the number of people using mental health services with a care plan.

Data source: Local data collection.

c) Proportion of people using mental health services with an agreed date to review their care plan.

Numerator – the number of people in the denominator with an agreed date to review their care plan.

Denominator – the number of people using mental health services with a care plan.

Data source: Local data collection.

d) Proportion of people using mental health services who may be at risk of crisis who have a crisis plan.

Numerator – the number of people in the denominator who have a crisis plan.

Denominator – the number of people using mental health services who may be at risk of crisis.

Data source: Local data collection.

Outcome

a) Evidence from experience surveys and feedback that people using mental health services jointly developed a care plan with mental health and social care professionals.

Data source: Local data collection.

b) Evidence from experience surveys and feedback that people using mental health services were given a copy of their care plan.

Data source: Local data collection.

c) Evidence from experience surveys and feedback that people using mental health services have an agreed date to review their care plan.

Data source: Local data collection.

d) Evidence from experience surveys and feedback that people using mental health services who may be at risk of crisis jointly develop a crisis plan with mental health and social care professionals.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as mental health trusts and community services) ensure that care plans are jointly developed with people using mental health services and reviewed regularly. They also ensure that crisis planning is included if needed.

Health and social care professionals (such as psychiatrists, mental health nurses and social workers) work with people using mental health services to jointly develop care plans, ensure that people are given copies of their care plan and agree review dates. They also discuss with the person if a crisis plan would be of benefit.

Commissioners ensure that they commission services that jointly develop care plans with people using mental health services, share copies and agree review dates.

People using mental health services work with mental health and social care professionals to jointly develop and agree a care plan. They keep a copy of their care plan and agree a date to review it. People who may be at risk of crisis also have a crisis plan in their care plan.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendations 1.1.11, 1.1.12, 1.4.2 and 1.4.5

Definitions

Care plan

This should include the needs of the person using the service, activities promoting social inclusion, such as education, employment and volunteering, and other specified occupations, such as leisure activities and caring for dependants. [NICE's guideline on service user experience in adult mental health, recommendation 1.4.2]

Crisis plan

This should contain:

- possible early warning signs of a crisis and coping strategies
- support available to help prevent hospitalisation
- where the person would like to be admitted in the event of hospitalisation
- the practical needs of the service user if they are admitted to hospital (for example, childcare or the care of other dependants, including pets)
- details of advance statements and advance decisions
- whether and the degree to which families or carers are involved
- information about 24-hour access to services
- named contacts.

[NICE's guideline on service user experience in adult mental health, recommendation 1.4.5]

Equality and diversity considerations

People using mental health services should have access to an advocate for jointly agreeing a care plan, in accordance with the relevant legislation set out in recommendation 1.1.1 of NICE's guideline on advocacy services for adults with health and social care needs. Advocacy should be offered to people who are not covered by the legal entitlement but who would otherwise not be able to express their views or sufficiently influence decisions that are likely to have a substantial impact on their wellbeing or the wellbeing of someone they have caring or parental responsibility for.

Quality statement 7: Inpatient contact with staff

Quality statement

People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to them and regularly see other members of the multidisciplinary mental healthcare team. **[2011]**

Rationale

Staying in hospital for mental health care can be a difficult and worrying experience for some people. Having regular one-to-one contact with known healthcare professionals helps to build trust and confidence, reduce concerns and develop relationships. This supports a person to manage their health and the impact it has on them more effectively. Regularly seeing other members of the multidisciplinary team gives the person the opportunity to discuss any concerns and be actively involved in the coordination and management of their care.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people staying in hospital can see a known mental healthcare professional on a one-to-one basis every day for at least 1 hour.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people staying in hospital can see their consultant on a one-to-one basis at least once a week for at least 20 minutes.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that people staying in hospital are given an

opportunity to meet a specialist mental health pharmacist.

Data source: Local data collection.

Process

a) Proportion of people staying in hospital for mental health care who saw a mental healthcare professional known to the person using services on a one-to-one basis every day for at least 1 hour.

Numerator – the number of people in the denominator who saw a mental healthcare professional known to the person using services on a one-to-one basis every day for at least 1 hour.

Denominator – the number of people admitted as inpatients to mental health services.

Data source: Local data collection.

b) Proportion of people staying in hospital for mental health care who saw their consultant on a one-to-one basis at least once a week for at least 20 minutes.

Numerator – the number of people in the denominator who saw their consultant on a one-to-one basis at least once a week for at least 20 minutes.

Denominator – the number of people admitted as inpatients to mental health services.

Data source: Local data collection.

c) Proportion of people staying in hospital for mental health care who saw a specialist mental health pharmacist.

Numerator – the number of people in the denominator who saw a specialist mental health pharmacist.

Denominator – the number of people admitted as inpatients to mental health services.

Data source: Local data collection.

Outcome

a) Evidence from experience surveys and feedback that people staying in hospital for mental health care see a mental healthcare professional known to the person using services on a one-to-one basis every day for at least 1 hour.

Data source: Local data collection.

b) Evidence from experience surveys and feedback that people staying in hospital for mental health care see their consultant on a one-to-one basis at least once a week for at least 20 minutes.

Data source: Local data collection.

c) Evidence from experience surveys and feedback that people staying in hospital for mental health care know they can meet a specialist mental health pharmacist.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as mental health trusts) ensure that systems are in place for people staying in hospital for mental health care to have daily one-to-one contact with known mental healthcare professionals and regularly see other members of the multidisciplinary mental healthcare team.

Health and social care professionals (such as psychiatrists, mental health nurses and pharmacists) ensure that people staying in hospital for mental health care have daily one-to-one contact with known mental healthcare professionals and regularly see other members of the multidisciplinary mental healthcare team.

Commissioners ensure they commission services that provide people staying in hospital for mental health care with daily one-to-one contact with known mental healthcare professionals and the opportunity to see other members of the multidisciplinary mental healthcare team.

People staying in hospital for mental health care see a mental healthcare professional who they know every day, and regularly see other members of their multidisciplinary mental healthcare team.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendation 1.6.6

Quality statement 8: Inpatient meaningful activities

Quality statement

People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm. **[2011]**

Rationale

Staying in hospital for mental health care can be a difficult and worrying experience for some people. Giving people the opportunity to do meaningful activities can help provide a structure to their day and reduce stress, frustration and boredom. It can also help to increase their social interactions, relieve anxiety and improve wellbeing. Being engaged in meaningful activities can help to foster an atmosphere of hope and optimism, which can enhance recovery. Activities can help maximise therapeutic benefits and prevent a ward from being seen as a place of containment.

Quality measures

Structure

Evidence of local arrangements to ensure that people staying in hospital have access to meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.

Data source: Local data collection.

Outcome

Evidence from experience surveys and feedback that people staying in hospital felt they could access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as mental health trusts) ensure that systems are in place for people staying in hospital for mental health care to access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.

Health and social care professionals (such as psychiatrists and mental health nurses) ensure that people staying in hospital for mental health care have access to meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.

Commissioners ensure that they commission services providing people in hospital for mental health care with meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.

People staying in hospital for mental health care can join in with a range of activities, including creative and leisure activities and exercise, 7 days a week, both during the day and in the evening.

Source guidance

Service user experience in adult mental health services. NICE guideline CG136 (2011), recommendation 1.6.9

Definitions

Meaningful and culturally appropriate activities

Meaningful and culturally appropriate activities should include creative and leisure activities, exercise, self-care and community access activities (where appropriate). Activities should be facilitated by appropriately trained health or social care professionals. [NICE's guideline on service user experience in adult mental health, recommendation 1.6.9]

Update information

July 2019: This quality standard was updated to ensure that it remains current. Statements from the 2011 version have been retained or merged with statements covering similar topics.

Statements that remain unchanged, or that have had minor wording changes for house style and clarity, are marked **[2011]**. Statements that have been merged are marked **[2011, updated 2019]**. The following list explains how the 2011 statements have been updated:

- Statements 1, 3, 7 and 11 have been merged to form statement 2
- Statements 2 and 15 have been merged to form statement 1
- Statement 4 has been retained as statement 4
- Statement 5 has been retained as statement 3
- Statements 6 and 10 have been merged to form statement 5
- Statements 8 and 9 have been merged to form statement 6
- Statement 12 has been retained as statement 7
- Statement 13 has been retained as statement 8
- Statement 14 has been removed as it is covered by the 2017 quality standard on violent and aggressive behaviours in people with mental health problems.

The 2011 quality standard for service user experience in adult mental health services is available as a pdf.

Minor changes since publication

May 2023: The equality and diversity sections of statements 2 and 6 were updated to align with NICE's guideline on advocacy services for adults with health and social care needs.

August 2021: The definition of shared decision making in statement 2 was updated to align with NICE's guideline on shared decision making.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and

equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Anxiety UK
- British Association for Counselling and Psychotherapy