

Patient experience in adult NHS services

Quality standard

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This standard is based on CG138 and NG197.

This standard should be read in conjunction with QS2, QS5, QS6, QS8, QS9, QS10, QS11, QS12, QS13, QS14, QS55, QS65, QS72, QS78, QS84, QS86, QS90, QS16, QS17, QS18, QS19, QS20, QS21, QS22, QS24, QS25, QS26, QS27, QS28, QS29, QS32, QS33, QS34, QS35, QS36, QS37, QS38, QS39, QS40, QS41, QS42, QS43, QS45, QS46, QS47, QS49, QS50, QS51, QS52, QS53, QS54, QS56, QS58, QS61, QS62, QS63, QS66, QS67, QS68, QS69, QS70, QS71, QS73, QS74, QS75, QS76, QS77, QS79, QS81, QS87, QS91, QS92, QS93, QS96, QS97, QS105, QS106, QS104, QS103, QS95, QS80, QS109, QS110, QS114, QS113, QS116, QS120, QS121, QS124, QS130, QS134, QS135, QS144, QS3, QS170, QS177, QS180, QS48, QS184 and QS198.

Quality statements

Statement 1 People using adult NHS services are treated with empathy, dignity and respect. **[2012]**

Statement 2 People using adult NHS services understand the roles of healthcare professionals involved in their care and know how to contact them about their ongoing healthcare needs. **[2012, updated 2019]**

Statement 3 People using adult NHS services experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. **[2012]**

Statement 4 People using adult NHS services experience care and treatment that is tailored to their needs and preferences. **[2012, updated 2019]**

Statement 5 People using adult NHS services have their preferences for sharing information with their family members and carers established, respected and reviewed throughout their care. **[2012]**

Statement 6 People using adult NHS services are supported in shared decision making. **[2012, updated 2019]**

In 2019 this quality standard was updated. Some statements were merged or had wording

amended (2012, amended 2019). For more information, see [update information](#).

The [2012 quality standard for patient experience in adult NHS services](#) is available as a pdf.

Quality statement 1: Empathy, dignity and respect

Quality statement

People using adult NHS services are treated with empathy, dignity and respect. [2012]

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.

Quality measures

Structure

Evidence of local arrangements to provide guidance to staff on how to treat people with empathy, dignity and respect.

Data source: Local data collection from service specifications.

Process

a) Proportion of people who feel they are treated with respect and dignity while staying in hospital.

Numerator – the number in the denominator who feel they are treated with respect and dignity.

Denominator – the number of people who stayed overnight in hospital.

Data source: The Care Quality Commission (CQC) Adult inpatient survey. This survey is repeated annually, and results are available for NHS trusts.

b) Proportion of people who feel they were treated with care and concern by a healthcare professional at their last GP appointment.

Numerator – the number in the denominator who feel the healthcare professional was good or very good at treating them with care and concern.

Denominator – the number of people reporting on their most recent appointment with their current GP practice.

Data source: The NHS England GP patient survey. Results are available for individual GP practices.

c) Proportion of people who feel they were treated with respect and dignity by their dentist at their last visit.

Numerator – the number in the denominator who feel they were treated with respect and dignity by their dentist at their last visit.

Denominator – the number of people reporting on their last visit to see their dentist.

Data source: Local data collection, for example based on local surveys.

Outcome

Evidence from patient experience surveys and feedback that people using NHS services feel they have been treated with empathy, dignity and respect.

Data source: Local data collection from local surveys.

What the quality statement means for different audiences

Service providers (such as primary care, secondary care and tertiary services) ensure that systems are in place to give guidance to all staff in treating people using NHS services with empathy, dignity and respect.

Health and social care professionals (such as GPs, doctors, dentists, nurses and non-clinical staff such as receptionists and porters) treat people using NHS services with empathy, dignity and respect.

Commissioners (such as clinical commissioning groups and NHS England) commission services with specifications that require staff to treat patients with empathy, dignity and respect.

People using NHS services are treated with understanding, dignity and respect.

Source guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.2.1

Quality statement 2: Contacts for ongoing care

Quality statement

People using adult NHS services understand the roles of healthcare professionals involved in their care and know how to contact them about their ongoing healthcare needs. [2012, updated 2019]

Rationale

NHS 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. All 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 that patients are aware of all healthcare professionals involved in their care. This should include the roles and responsibilities of the members of the healthcare team and how to contact them about ongoing healthcare needs.

Data source: Local data collection.

b) Evidence of local arrangements to ensure continuity of care and that, whenever possible, people see the same healthcare professional or team throughout a single episode of care.

Data source: Local data collection.

Process

a) Proportion of people staying in hospital who knew which nurse was in charge of looking after them.

Numerator – the number in the denominator who felt they knew which nurse was in charge of looking after them.

Denominator – the number of people staying overnight in hospital.

Data source: The Care Quality Commission (CQC) Adult inpatient survey. This survey is repeated annually, and results are available for NHS trusts.

b) Proportion of people staying in hospital who were told who to contact if they were worried about their condition or treatment after they left hospital.

Numerator – the number in the denominator who were told who to contact if they were worried about their condition or treatment after they left hospital.

Denominator – the number of people staying overnight in hospital.

Data source: The CQC Adult inpatient survey. This survey is repeated annually, and results are available for NHS trusts.

c) Proportion of people attending an emergency department who were told who to contact if they were concerned about their condition or treatment after they left.

Numerator – the number in the denominator who were told who to contact if they were worried about their condition or treatment after they left the department.

Denominator – the number of people attending a type 1 or type 3 emergency department.

Data source: The CQC Emergency department survey. This survey is repeated annually, and results are available for NHS trusts.

Outcome

a) Evidence from patient experience surveys and feedback that patients were aware of all

healthcare professionals involved in their care, and the roles and responsibilities of the members of the healthcare team.

Data source: Local data collection, for example from surveys.

b) Evidence from patient experience surveys and feedback that patients saw the same healthcare professional or team throughout a single episode of care.

Data source: Local data collection, for example from surveys.

c) Evidence from patient experience surveys and feedback that patients know who to contact, how to contact them and when to make contact about their ongoing healthcare needs.

Data source: Local data collection, for example from surveys.

What the quality statement means for different audiences

Service providers (such as GP practices, hospitals, community services and local authorities) ensure that systems are in place to deliver care by the same healthcare professional or team (whenever possible). Service providers also ensure that people using their services understand the roles of healthcare professionals involved in their care and know how to contact them about their ongoing healthcare needs.

Health and social care professionals (such as GPs, doctors, dentists, nurses and social workers) explain to the people they provide care to about their role, how it relates to the roles of others, and how and when to contact them about their ongoing healthcare needs.

Commissioners (such as clinical commissioning groups and NHS England) commission services with specifications that require healthcare professionals to explain to the people they provide care to about their roles and how to contact them about their ongoing healthcare needs.

People using NHS services understand the roles of the different people involved in their care and are given clear advice about how and when to contact them about their healthcare needs. If possible, they see the same professionals throughout their care.

Source guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendations 1.4.1 and 1.4.4 to 1.4.6

Quality statement 3: Information exchange

Quality statement

People using adult NHS services experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. [2012]

Rationale

For many people care is not about a single visit to a single service. Even for a common condition someone may start with their GP, go to a hospital for tests and then be referred to a service in the community such as physiotherapy. Health and care services may provide high-quality care individually, but may fail people moving between services if they are not working well together with other services. Information needs to be exchanged effectively between services so that care can be coordinated across specialties and between providers.

Quality measures

Structure

Evidence of local arrangements to support coordinated care through clear and accurate information exchange between relevant health and social care professionals.

Data source: Local data collection.

Process

a) Proportion of people staying in hospital who thought that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them.

Numerator – the number in the denominator who thought that the specialist they saw in hospital been given all the necessary information about their condition or illness from the person who referred them.

Denominator – the number of people staying overnight in hospital as a planned admission.

Data source: The Care Quality Commission (CQC) Adult inpatient survey. This survey is repeated annually, and results are available for NHS trusts.

b) Proportion of all cancer patients who thought that their GP was given enough information about their condition and the treatment they had at hospital.

Numerator – the number in the denominator who thought that their GP was given enough information about their condition and the treatment they had at the hospital.

Denominator – the number of people with a confirmed primary diagnosis of cancer admitted to hospital as an inpatient or day case for cancer-related treatment.

Data source:Quality Health National Cancer Patient Experience Survey.

Outcome

Evidence from patient experience surveys and feedback that people feel that information about their care was shared clearly and accurately between relevant health and social care professionals.

Data source: Local data collection, for example, local surveys.

What the quality statement means for different audiences

Service providers (such as GPs, hospitals, community services and local authorities) ensure that systems are in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals.

Health and social care professionals (such as GPs, doctors, nurses and social workers) check if people they are seeing are being cared for by other teams or services. They

exchange clear and accurate information for people they are treating across disciplines, services and settings to coordinate a person's care.

Commissioners (such as clinical commissioning groups and NHS England) ensure they commission services that support coordinated care through clear and accurate information exchange between relevant health and social care professionals.

People using NHS services can expect information about their care to be exchanged in a clear and accurate way between relevant health and social care professionals, so that their care is well coordinated with the least possible delay or disruption.

Source guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendations 1.4.2 and 1.4.3

Quality statement 4: Individualised care

Quality statement

People using adult NHS services experience care and treatment that is tailored to their needs and preferences. [2012, updated 2019]

Rationale

The [NHS Constitution for England](#) says that services must reflect, be coordinated around and tailored to, the needs and preferences of patients. Recognising people as individuals improves the safety, efficiency and effectiveness of healthcare. Understanding which aspects of individuality and service responsiveness are important and valued by patients ensures that the human nature of healthcare is not lost. This involves giving people opportunities to discuss their needs and preferences. Engaging people in their own care helps them to actively manage their health and wellbeing.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people have opportunities to discuss their health beliefs, concerns and preferences.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people's needs and preferences are assessed, addressed and regularly reviewed.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that care and treatment is tailored to people's needs and personal preferences.

Data source: Local data collection.

Process

a) Proportion of people given the opportunity to discuss their health beliefs, concerns and preferences.

Numerator – the number of people in the denominator who were given the opportunity to discuss their health beliefs, concerns and preferences.

Denominator – the number of people accessing NHS services.

Data source: Local data collection, for example patient records. The [Care Quality Commission \(CQC\) Adult inpatient survey](#) presents information on people staying in hospital who found someone on the hospital staff to talk to about their worries and fears.

b) Proportion of people with care tailored to their needs and preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Numerator – the number of people in the denominator whose care was tailored to their needs and preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Denominator – the number of people accessing NHS services.

Data source: Local data collection, for example patient records and surveys. The [CQC Adult inpatient survey](#) presents information on people staying in hospital. This includes whether people thought they were given the right amount of information about their condition or treatment and had enough emotional support from hospital staff, and if staff did everything to help them control their pain. It also surveys if people thought they had enough to drink and were given enough help to eat meals, to wash and to clean. The [NHS GP patient survey](#) presents information on the proportion of people who felt that their needs were met at their last GP appointment.

c) Proportion of people accessing NHS services who have their needs and preferences assessed, addressed and regularly reviewed.

Numerator – the number of people in the denominator who have their physical and psychological needs regularly assessed, addressed and regularly reviewed.

Denominator – the number of people accessing NHS services.

Data source: Local data collection, for example patient records and surveys. The [CQC Adult inpatient survey](#) presents information on people staying in hospital. This includes whether people thought they were given the right amount of information about their condition or treatment and had enough emotional support from hospital staff, and if staff did everything to help them control their pain. It also surveys if people thought they had enough to drink and were given enough help to eat meals, to wash and to clean. The [NHS GP patient survey](#) presents information on the proportion of people who felt that their needs were met at their last GP appointment.

Outcome

a) Evidence from patient experience surveys and feedback that people feel their care has been informed by their health beliefs, concerns and preferences.

Data source: Local data collection, for example local surveys.

b) Evidence from patient experience surveys and feedback that care was tailored to people's needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Data source: Local data collection, for example local surveys and records of feedback from people using services.

c) Evidence from patient experience surveys and feedback that patients feel their physical and psychological needs were assessed, addressed and regularly reviewed.

Data source: Local data collection, for example local surveys and records of feedback from people using services.

What the quality statement means for different audiences

Service providers (such as GPs, hospitals, community services and local authorities) ensure that systems are in place to provide opportunities to establish people's health beliefs, concerns and preferences and use them to offer individualised care. Service providers tailor care and treatment to people's needs and personal preferences, taking into account their ability to access services and their coexisting conditions. They also have systems in place to regularly assess, address and review people's physical and psychological needs.

Health and social care professionals (such as GPs, doctors, nurses and social workers) discuss with people their health beliefs, concerns and preferences. They tailor care and treatment to a person's needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions. They also assess, address and regularly review a person's physical and psychological needs.

Commissioners (such as clinical commissioning groups and NHS England) commission services in which people's individual health beliefs, concerns and preferences are established and care is tailored to people's needs and personal preferences. These should take into account people's ability to access services and their coexisting conditions and should assess, address and regularly review people's physical and psychological needs.

People using NHS services have opportunities to discuss their health beliefs, concerns and preferences with the people providing their care. Their care and treatment take these into account along with their needs, personal circumstances, how easy it is for them to use the services and any other health problems they have. People are regularly checked and asked whether they need any extra support, for example with eating and drinking, pain relief, continence problems or anxieties.

Source guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendations 1.2.4 to 1.2.9, 1.3.1 to 1.3.3 and 1.1.4

Definitions of terms used in this quality statement

Needs and preferences

These relate to an individual and include:

- health beliefs
- concerns
- preferences
- personal circumstances including ability to access services
- physical needs including nutrition, hydration, pain relief, personal hygiene and anxiety
- psychological needs including anxiety and depression
- coexisting conditions.

[NICE's guideline on patient experience in adult NHS services]

Equality and diversity considerations

People using adult NHS services should have access to an advocate when discussing their health beliefs, concerns and preferences, 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 5: Preferences for sharing information

Quality statement

People using adult NHS services have their preferences for sharing information with their family members and carers established, respected and reviewed throughout their care. [2012]

Rationale

People vary in whether they want partners, family members, friends and carers to be involved in their healthcare, and how much involvement they want them to have. Partners, family members, friends and carers might need information to help them to care for the person. Service providers need to know and understand these preferences and be aware that they may change over time.

Quality measures

Structure

Evidence of local arrangements to ensure that people's preferences for sharing information with family members and carers are established, respected and reviewed throughout their care.

Data source: Local data collection.

Process

Proportion of people using adult NHS services whose preferences for sharing information with family members and carers are established, respected and reviewed throughout their care.

Numerator – the number in the denominator whose preferences for sharing information with family members and carers are recorded and reviewed throughout their care.

Denominator – the number of people using adult NHS services.

Data source: Local data collection using audits of patient records.

Outcome

Evidence from patient experience surveys and feedback that people's preferences for sharing information with family members and carers were established, respected and reviewed throughout their care.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GPs, hospitals, community services and local authorities) ensure that systems are in place to establish, respect and review people's preferences for sharing information with family members and carers.

Health and social care professionals (such as GPs, doctors, nurses, social workers) establish and respect people's preferences for sharing information with family members and carers. They document preferences and check if they have any new or changed preferences throughout their care.

Commissioners (such as clinical commissioning groups and NHS England) commission services in which people's preferences for sharing information with family members and carers are established, respected and reviewed.

People using NHS services are asked if they want their family members and carers to be given information about their care. Their preferences are respected and reviewed throughout their care.

Source guidance

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.3.10

Quality statement 6: Decision making

Quality statement

People using adult NHS services are supported in shared decision making. [2012, updated 2019]

Rationale

People 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 services 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 from services. Both healthcare professionals and patients have a role and responsibility for contributing to the decision-making process. Healthcare professionals contribute information about diagnosis, cause of disease, prognosis, treatment options and outcomes. Whereas, patients contribute the experience of their illness, how they manage their illness, social circumstances, attitudes to risk, values and preferences.

Quality measures

Structure

a) Evidence of a system that supports the use of shared decision making such as appointment systems that allow decisions to be discussed, and patient record systems that can document shared decisions and patient preferences.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that healthcare professionals support people to understand their treatment options, including the benefits, risks and potential consequences of relevant treatments.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that people are actively involved and supported in shared decision making.

Data source: Local data collection.

d) Evidence of local arrangements to ensure that people are made aware of their right to choose, accept or decline treatment and that these decisions are respected and supported.

Data source: Local data collection.

e) Evidence of local arrangements to ensure that people are made aware that they can ask for a second opinion.

Data source: Local data collection.

Process

a) Proportion of people who reported that a member of staff answered their questions before their operation or procedure in a way they could understand.

Numerator – the number in the denominator who reported that, before their operation or procedure, a member of staff answered their questions about it in a way they could understand 'completely'.

Denominator – the number of people having an operation or procedure as an inpatient in hospital.

Data source: Care Quality Commission (CQC) Adult inpatient survey.

b) Proportion of people staying in hospital who reported that they were involved as much as they wanted to be in decisions about their care and treatment in hospital.

Numerator – the number in the denominator who reported that they were 'definitely' involved as much as they wanted to be in decisions about their care and treatment.

Denominator – the number of people staying as an inpatient in hospital.

Data source:CQC Adult inpatient survey.

c) Proportion of people who reported that they were involved as much as they wanted to be in decisions about their discharge from hospital.

Numerator – the number in the denominator who reported that they felt they were involved as much as they wanted to be in decisions about their discharge from hospital.

Denominator – the number of people staying as an inpatient in hospital.

Data source:CQC Adult inpatient survey.

d) Proportion of people who were involved in decisions about their care and treatment as much as they wanted to be at their last GP appointment.

Numerator – the number in the denominator who were involved in decisions about their care and treatment as much as they wanted to be.

Denominator – the number of people reporting on their last GP appointment.

Data source:NHS England GP patient survey.

Outcome

a) Evidence from patient experience surveys and feedback that people feel able to make decisions that reflect what is important to them.

Data source: Local data collection from surveys.

b) Evidence from patient experience surveys and feedback that people know about their right to choose, accept or decline treatment and feel that their decisions were respected and supported.

Data source: Local data collection from surveys.

c) Evidence from patient experience surveys and feedback that people know that they can

ask for a second opinion.

Data source: Local data collection from surveys.

What the quality statement means for different audiences

Service providers (such as GPs, hospitals, community services and local authorities) ensure that systems are in place to train and assess staff competency in relevant communication skills. They have systems to support people to understand relevant treatment options, actively involve them in shared decision making and support them to make fully informed choices about investigations, treatment and care. Providers make patients aware of their right to choose or decline treatment, or ask for a second opinion, and make sure that their staff respect these decisions.

Health and social care professionals (such as GPs, doctors, nurses and social workers) have training in relevant communication skills. They support people to understand treatment options and actively involve them in shared decision making to make fully informed choices about investigations, treatment and care. Professionals make people aware of their right to choose or decline treatment, or ask for a second opinion, and respect these decisions.

Commissioners (such as clinical commissioning groups and NHS England) commission services that have arrangements for competency-based training and assessment of relevant communication skills. They use service specifications to ensure that people are supported to understand relevant treatment options, are actively involved in shared decision making and supported to make fully informed choices about investigations, treatment and care. They commission services that make people aware of their right to choose or decline treatment, or ask for a second opinion, and these decisions are respected.

People using NHS services are cared for by staff who can talk to them in a clear and understandable way. They are helped by healthcare professionals to understand their treatment options and are actively involved in shared decision making to make fully informed choices about investigations, treatment and care. People have their choices respected when deciding to choose or decline treatment, or ask for a second opinion.

Source guidance

- [Shared decision making. NICE guideline NG197 \(2021\)](#), recommendations 1.2.1, 1.2.7 to 1.2.13, 1.4.1, 1.4.2 and 1.4.5 to 1.4.11
- [Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 \(2012, updated 2021\)](#), recommendations 1.1.2, 1.3.7, 1.3.8, 1.5.4 and 1.5.10

Definitions of terms used in this quality statement

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 adult NHS services should have access to an advocate when discussing their health beliefs, concerns and preferences, 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.

Update information

July 2019: This quality standard was updated to ensure that it remains current. Statements from the 2012 version have been retained with amendments 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 **[2012]**. Statements that have been merged are marked **[2012, updated 2019]**. The following list explains how the 2012 statements have been updated:

- Statement 1 has been retained as statement 1
- Statements 2, 5, 6, 7 and 8 have been merged to form statement 6
- Statements 3, 11 and 14 have been merged to form statement 2
- Statements 4, 9 and 10 have been merged to form statement 4
- Statement 12 has been retained as statement 3
- Statement 13 has been retained as statement 5

The [2012 quality standard for patient experience in adult NHS services](#) is available as a pdf.

Minor changes since publication

May 2023: The equality and diversity sections for statements 4 and 6 were updated to align with [NICE's guideline on advocacy services for adults with health and social care needs](#).

June 2021: Changes have been made to align statement 6 in this quality standard with the [NICE guideline on shared decision making](#). The source guidance and definition of shared decision making have been updated.

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.

Resource impact

NICE quality standards should be achievable by local services. The potential resource

impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact summary report for the NICE guideline on shared decision making](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development 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.

- [Royal College of Physicians \(RCP\)](#)
- [College of General Dentistry](#)
- [British Association for Counselling and Psychotherapy](#)