National Institute for Health and Clinical Excellence

Service user experience in adult mental health
Guidance and Quality Standard Consultation Comments and Responses Table
21 June – 19 July 2011

No.	Stakeholder	Order No	Document	Section No	Page No	Comments	Developer's Response
519	Action on Hearing Loss	15.01	QS	General	General	We recognise that this is a quality standard designed for all service users in adult mental health, and not any specific group. However, some groups, such as people with hearing loss, face particular challenges in that they are both more likely to face mental health issues and there are barriers to their treatment. Therefore, it is essential that the standards emphasise the importance of good communication.	Thank you for your comment, recommendation 1.1.3 states that healthcare professionals should: *take into account communication needs, including those of people with learning disabilities, sight or hearing problems or language difficulties*
575	Action on Hearing Loss	15.02	QS	Scope	2	We strongly welcome the recognition that good communication between health and social care professionals is essential and that treatment and care should be accessible to people with sensory disabilities. However, the guidance should also refer to the importance of providing information in the service-user's preferred format, for instance, British Sign Language (BSL) clips, where they cannot read standard English. Similarly we welcome the recommendation that service users should have access to an interpreter if needed. However, some interpreters are not available at short notice. Therefore, attention should be drawn to the need to ask the service user about their communication needs at the first point of contact with the health service and that these are recorded, so that everyone involved in treatment and care is aware of this. Similarly, we believe that the quality standard should indicate the need to plan in advance, where possible, so that appropriate communication support is available at appointments. We welcome the fact that communication is included in the scope; however, we believe that there should also be mention of this in the quality standard itself as this will be the focus of attention for many service users and services. While we recognise that this quality standard is	Thank you for your comment. The quality standard contains reference to ensuring accessibility for people with additional needs. We have also now included this reference against a number of specific quality statements.

						designed for all service users in adult mental health, and not any specific group, effective communication is central to the effective delivery of mental health services to all service users and is important at all stages. Similarly we recognise that the 'patient experience in generic terms' quality standard also applies to the provision of adult mental health services and that this addresses some of the above issues. However, there are certain points at which it is particularly important to meet the service user's communications needs, and we have indicated this at the relevant section.	
635	Action on Hearing Loss	15.03	QS	3	8	Draft quality statement 3: autonomy and active involvement. While the NHS mental health inpatient survey asks the respondent whether they are deaf or have a severe hearing loss, the NHS community mental health survey does not. However, issues around communication may mean that people with hearing loss have different experiences to other groups in areas such as involvement. It would be useful to separate out the results for people with hearing loss and, therefore, if this survey continues to be used as an indicator we believe that a question around hearing loss should be included.	Thank you for your comment. Local organisations are free to focus on specific sub groups and their attainment against the quality standard.
718	Action on Hearing Loss	15.04	QS	7	13	Draft quality statement 7: Assessment. We would also add that staff should take steps to establish factors, such as sensory loss, that affect service users' ability to take in explanations and information about the assessment process. They should then go on to provide explanations and information in a way that is accessible to the service user. This could encompass a range of methods, for instance, some service users may benefit from communication support, such as a speech-to-text reporter[1]. For others, this may mean ensuring that a working induction loop is available so that the service user can benefit from their hearing aid.	Thank you. The quality standard has been amended to ensure that 'people using mental health services understand the assessment process'. This will hopefully ensure that people are supported to understand the process, regardless of their needs.
764	Action on Hearing Loss	15.05	QS	9	15	Draft quality statement 9: Care planning. Services should also offer care plans in alternative formats, for instance, using British Sign Language clips, to people who find it difficult to understand written English.	Thank you for your comment. The quality standard indicates that information should be provided in appropriate formats.
826	Action on Hearing Loss	15.06	QS	12	21	Draft quality statement 12: Admission to hospital We recommend adding communication needs and preferences to those that are taken into account.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should

[1] A speech-to-text reported produces a real-time written version of the discussion.

							be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
965	Action on Hearing Loss	15.07	QS	20	30	Draft quality statement 20: Explaining control and restraint and compulsory treatment Again, it is essential that any explanation is accessible to the service-user and we believe that the draft quality statement should state this explicitly.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
41	Alzheimer's Society	24.01	Full	General	General	Alzheimer's Society would like to see the specialist needs of people with early onset (pre-65) acknowledged in the guidance. Many people with early onset dementia are referred to community mental health teams or to other services in adult mental health. This can be a difficult experience for them as services are unused to dealing with dementia and the person may fall between old age services and adult mental health services.	Thank you for your comment, the guidance is applicable for all people using adult mental health services and therefore we are unable to comment on specific conditions.
719	Alzheimer's Society	24.02	QS	7	13	Alzheimer's Society would like to see reference to accuracy of diagnosis as well as explanations and information of the assessment process and diagnosis. Many people under the age of 65 with dementia are wrongly diagnosed with depression in the first instance, due to poor awareness of early onset dementia. Broader understanding of a full range of conditions which affect mental health in GPs and others making diagnoses would improve the experience of care for people with early onset dementia and others.	Thank you for your comment. The focus of this quality statement is the provision of information.
307	Association for Family Therapy and Systemic Practice	29.01	NICE		5	AFT welcomes the guidelines that listen to the needs and wishes of service users, including: 'if the service user agrees, families and carers should have the opportunity to be involved in decisions about the treatment and care. Families and carers should also be given the information and support they need'.	Thank you for your comments.
1	Association for Family Therapy and Systemic Practice	29.02	All	General	General	It would be good if this guideline could lead to a review of the criteria that NICE uses for evidence in the guidelines. In FULL there are many references to difficulties in accessing psychotherapies and the value of psychotherapies by service users. The fact that most psychotherapy research does not meet NICE criteria omits the way that psychotherapies respect service users and are effective in helping them to recover and find ways to deal with many of the issues connected with their diagnoses. The term	Thank you for your comment, the National Collaborating Centre for Mental Health is unable to amend the *NICE Process Manual*. NICE are currently reviewing the *NICE Process Manual* and this will subject to a consultation exercise later in the year.

						'psychotherapy' is absent from NICE and Quality Standards, which is could mean that there is even less access to psychotherapies.	
327	Association for Family Therapy and Systemic Practice	29.03	NICE	1.1.1	8	It would be helpful to give more details for ' work in partnership with service users and families or carers'	Thank you for your comment. Further details are given in the section on involving families and carers (now recommendations 1.1.14 to 1.1.18).
368	Association for Family Therapy and Systemic Practice	29.04	NICE	1.1.12.	11	It would be helpful to include therapy as one of the options to be considered.	Thank you for your suggestion. We think you are referring to recommendation 1.1.13 [now 1.1.15] (there are no options in 1.1.12 [now 1.1.14]), which does include 'treatment plans'.
376	Association for Family Therapy and Systemic Practice	29.05	NICE	1.11.14	11	Family therapy and family interventions should be included in these options, depending on what is available locally.	Thank you, we believe the second bullet point deals with this.
382	Association for Family Therapy and Systemic Practice	29.06	NICE	1.1.16	12	These options focus on the need for the parent to have space on their own – but it should also be important to have access to therapies that help the parent strengthen attachment to an infant / child, and feel more confident about parenting	Thank you for commenting. The stem of the recommendation states that service users should 'receive support to access the full range of mental health and social care services', which covers your point. For further information regarding these issues see the NICE guidance 'Antenatal and postnatal mental health.'
514	Association for Family Therapy and Systemic Practice	29.07	NICE	4	27	Recommendations focus on individuals rather than the involvement of families, so suggest that a recommendation on the ways to involve families. The value of a having a wide systemic approach to service users helps professionals who undertake training to work with families, as happens in some Trusts, such as South London and Maudsley and Somerset. Evidence of the value for training in Somerset can be found in: Brooker, C. & Brabban, A. (2004) Measured Success: a scoping review of evaluated psychosocial interventions training for work with people with serious mental health problems. National Institute for Mental Health in England/Trent WDC Given the pressures on staff in the current environment, it is likely to lead to less support from managers for family work as well as other recommendations within these documents.	Thank you for your comment, we are unable to amend the guidance in this way as this is focusing on the family/carer experience rather than the service users'.
936	Association for Family Therapy and Systemic Practice	29.08	QS	18	28	None of the hospital statements refer to families and carers – but it is important for various reasons – families may be able to offer support, but if the family involves young children, it is important to consider them in the decisions for discharge. If families have access to ward staff it can help provide service users with support, as well as acknowledging the impact of admission and the implications for the family, including	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

						parenting roles. An acute inpatient ward in Lewisham offers all families up to 4 sessions with the ward manager.	
979	Association for Family Therapy and Systemic Practice	29.09	QS	21	32	It would be helpful to include the option of systemic family therapy, as this approach works well when it is part of a service, as well as other ways for families and carers to be involved.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
567	Association for Family Therapy and Systemic Practice	29.10	QS & NICE	General	General	Family therapy offers a relatively brief psycho-therapeutic intervention for many diagnoses and for the issues that service users often have to deal with, some of which are recommended by NICE. Having a general term rather than specific recommendations is more useful to ensure access to services.	Thank you for commenting. It would not be appropriate for this guidance to make recommendations about treatment, beyond those interventions specifically designed to improve the experience of care.
657	Association for Family Therapy and Systemic Practice	29.11	QS	4	9	Systemic Family Therapy could have a useful role for service users who need access to different services, e.g. moving from CAMHS to adult services; or needing Social services as well as Adult Mental Health Services.	Thank you for your comment, however we are unable to recommend specific therapies, other than those designed to improve the experience of care and included in our review (please see Chapter 12 of the full guidance).
42	Association of Directors of Adult Social Services	42.01	Full	General	General	Having reviewed the draft NICE guidelines and quality standards on the service user experience in mental health, the **Association of Directors of Adult Social Services** has a number of concerns about the approach which has been taken. The concerns arise from a strong sense in the main document – and this is backed up by the development of the quality standards – that the significant interaction between a clinical mental health problem and its social context has not been fully understood. This interaction can be both a cause and an effect of a mental health condition, and the interaction is central to the achievement of positive outcomes which make a real difference to the experience of people who use mental health services. The interaction between clinical and social factors in mental health has long been recognised in research, and more importantly has been central to the way mental health services have been designed and delivered across the country. Although there are many different models of delivery, the key theme has been to establish services which are operationally and philosophically integrated, so that people who use services experience a consistent, seamless approach	Thank you for your comment. Whilst NICE will (subject to legislation) be taking on a responsibility for developing quality statements for social care, the current statements are being published for the NHS. The prime perspective is of the NHS and therefore the key interactions between the NHS and social care are considered but not explored in detail. <u>Recovery approaches to mental health:</u> The GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model. Quality statement 9 (now QS8) includes details of activities to promote social inclusion. <u>Social inclusion:</u> Quality statement 9 (now QS8) includes details of activities to promote social inclusion. <u>Personalisation or self-directed support:</u>

						to assessment and care management. In terms of the overall approach, we consider that this interaction needs to be embedded throughout the guidelines and quality standards. Instead, the guidelines in particular are very clinically-led and focus on treatment and medical approaches. This is very obvious in Chapter 5, which relates to community mental health services, and which is the ideal opportunity to link clinical and social care issues, but which becomes (in our view) sidetracked into issues of medication and side-effects which could be more appropriately placed elsewhere in the main document. Although social care and issues of social inclusion are mentioned, these appear to be secondary to a focus on treatment and medical staff. In consequence, we would like the first two chapters to be rewritten to reflect the importance of working with the whole person, which has to include the overall context of their life. There are significant gaps which need to be addressed in the main document, which we will now outline in brief: <u>Recovery approaches to mental health:</u> although the main document refers to the need for staff to give people hope, there is very little reflection of the models of recovery from mental ill-health which are being adopted in all mental health services. The guidelines need to reflect what makes a difference to people who use services, and encourage mental health services to develop and promote positive outcomes for people which support their continued integration into society. Approaches such as the Recovery Star – which is a user-led development in itself – should be incorporated into both the main document and the quality standards. We believe that Quality Standard 1 should be redrafted, with a requirement that health and social care staff should actively promote recovery and social inclusion in all cases. There is a range of data sources and indicators within social care which could be incorporated into this. <u>Social inclusion:</u> we acknowledge that there has been some attempt to include this in the main document, but this seems limited in its approach and at times outdated. There is reference at one point, for example, to day centres (Section 7.2.6), but many localities are	Quality statement 3 reflects shared decision-making and self-management primarily from the perspective of the health care setting. Quality statement 8 (consultation version) has been removed. <u>Dignity:</u> We agree that dignity is very important and feel that all the quality statements support the dignity of service users. The recommendations in the NICE guidance make direct reference to the importance of treating service users with dignity see 1.1.6 (now 1.1.7), 1.8.2, and QS2. <u>Other issues:</u> The chapter looks at the evidence, such as it is, from the literature supplemented by the views of the GDG, which included a majority of service users and carer. The aim of this guidance is to improve the experience of care and this chapter focuses on doing so during detention under the Mental Health Act. As you are probably aware, the MHA is used when people are unwilling to receive treatment and care without compulsion. The recommendations in this chapter directly address the process for detention. Most of this will occur before hospitalisation. In terms of avoiding the use of the MHA this is probably outside of the scope of this guidance, and as many people who are sectioned avoid services in the period running up to the use of the act there is little that this guidance can say about improving the experience of care amongst those who are avoiding care. <u>Risk assessment and risk management:</u> We agree that risk assessment and management is an important for services and are aware of systems that are in place for this. Because of the timeframe for this work, the areas prioritised by the GDG are those that the group felt would have the most impact on services and which would lead to the greatest improvement in service user experience. <u>Crisis planning:</u> The experience of, and support for, families and carers is outside of the scope of this guidance and quality standard. However, recommendation 1.5.8 of the

						moving away from an approach which separates people from their communities to something which is much more inclusive and which engages people directly with their communities, networks and with mainstream services. This is a key point – social inclusion is about the person's whole life, and it is impossible to improve the service user experience without actively considering this at all stages. There is some useful comment in the main document about some aspects of social inclusion but it does not reflect the extent to which social inclusion in all its aspects can improve a person's wellbeing and have a dramatic influence on their mental health. We were concerned that the quality standards had little to say about social inclusion and would like further consideration of this. <u>Personalisation or self-directed support:</u> the scope for a person to take control over their life decisions is now enshrined in social care practice. The main document makes some reference to this but primarily in terms of obtaining direct payments as part of a service package. Self directed support is much more than this: at its best, individuals are fully engaged in developing and implementing their own care and support plans, and a range of outcomes fall out of this. This is a substantial culture change for both staff and people who use services, and the principles and processes apply not just for social care but also for all aspects of health services. The main document needs to reflect this and to consider the extent to which self directed support can apply to all situations that a service user may be in; for example, detained patients can still have some elements of actual control over their care and support whilst others aspects of their lives are subject to control by staff. Again, the quality standards fail to fully address this. In Standard 3, we would argue that this lends itself well to consideration of self directed support but that this should be made more explicit. We would also suggest that it is made clear that there should be integrated systems across health and social care providers which support delivery of self directed support. We would argue that Standard 8 becomes redundant if	guidance regarding avoiding admission to hospital during a crisis has been amended to include exploring the support mechanisms available to the service user, including families and carers. <u>Hospital admission:</u> Whilst the GDG agree that the maintenance of relationships in the inpatient setting is important, they had to develop 15 Quality Statements. The 15 statements prioritise the areas that the GDG felt would have the most impact on services and which lead to the greatest improvement in service user experience.

						Standard 3 properly includes self directed support, as person-centered care is at the heart of self directed support. Dignity: the dignity agenda is very high profile within social care and the main document makes considerable reference to the extent to which this is important to people who use services. However this needs to be incorporated more fully throughout the main document in an explicit way – for example we would suggest that there needs to be specific consideration of how people who are detained in hospital are treated with dignity from the start. The quality standards need to reflect the dignity agenda too. We would particularly suggest that this is included in Statement 12, and would recommend that provider services are encouraged to appoint Dignity Champions who would take a lead role in this. Other issues: We were concerned that there was little consideration in Chapter 11 of the main document of the process leading to detention in hospital. This phase of a person's life can be crucial to their whole experience of and feeling about mental health interventions and it is important that this is addressed. We would recommend that there is again explicit reference to the dignity agenda and in particular how the negative experience of being detained can be modified by a respectful, supportive, dignified and empathetic approach. One area that is missing from any of the main document, at least in detail, is the matter of risk assessment and risk management. This can be a key source of concern to some people who use mental health services and it needs to be made clear that the same principles of openness, shared planning and dignity should apply to this area as to all other assessments. Crisis planning: this is identified in Standard 10 – this must include reference to crisis support for families and carers, and also to the social care services and supports which might reduce the impact of a crisis. Hospital admission: Standard 12 – this should also include a requirement on mental health services to ensure that active steps are taken to encourage people to maintain their social and community relationships	

						whilst they are an inpatient.	
2	AstraZeneca UK Ltd	48.00	All	General	General	AstraZeneca would like to thank NICE for the opportunity to comment on the development of the guidance for improving the experience of care for people using adult mental health services and the quality standards which set out definitions of high quality care.	Thank you for your comments.
3	AstraZeneca UK Ltd	48.01	All	General	General	AstraZeneca support the principles of choice, autonomy and continuity of care for patients with mental illness as outlined in the guidance document and the draft quality standards. The draft statements offer a clear description of what service users should expect from high quality care. AstraZeneca do note a lack of information around what service users can expect in terms of relapse prevention and advice on treatment adherence and make the following suggestions.	Thank you for your comments.
581	AstraZeneca UK Ltd	48.02	QS	QS 1	3/5	A comment specifically on the first draft quality statement which refers to people using mental health services & their families and carers. This may be confusing given that in the initial statement around the scope (page 1) it is explicitly stated that this quality standard does not cover experiences of families or carers. Clarification may be required.	Thank you for commenting. While the quality statements are not designed to specifically improve the experience of carers and families, they are included where it was thought that this would improve the experience of the service user.
369	AstraZeneca UK Ltd	48.03	NICE	1.1.12	11-13	Based on feedback from NHS stakeholders AstraZeneca would suggest the inclusion of a statement that families and carers should be made to feel that they are not being disloyal if they inform healthcare professionals about compliance / adherence issues	Thank you for your comment; we are unable to amend the guidance in this way as this is focusing on the family/carer experience rather than the service users'.
636	AstraZeneca UK Ltd	48.04	QS	QS 3 &7	8 &13	In order to improve patient outcomes especially around relapse prevention, we would recommend the provision of information to the service user on the importance of treatment adherence. Promote a non judgemental atmosphere to openly discuss issues around non adherence to all aspects of the care plan	Thank you for your comment, this guidance is concerned with improving the experience of care for service users and therefore adherence is outside the scope. For further guidance on this topic, please see NICE guidance *'Medicines Adherence, CG76'.*
332	AstraZeneca UK Ltd	48.05	NICE	1.1.2	8	Healthcare professionals should be urged to discuss the importance of adherence with patients and how non adherence can lead to increased risk of relapse.	Thank you for your comment, this guidance is concerned with improving the experience of care for service users and therefore adherence is outside the scope. For further guidance on this topic, please see NICE guidance *'Medicines Adherence, CG76'.*
792	AstraZeneca UK Ltd	48.06	QS	QS10	17	AstraZeneca agree that identifying early warning signs is important and would suggest the explicit inclusion of identifying possible causes of relapse and planning	Thank you for this suggestion. The GDG expect this would be part of a crisis plan, and made a recommendation to cover this (please see

						how these situations may be avoided.	recommendation 1.4.5 in the NICE guidance).
720	AstraZeneca UK Ltd	48.07	QS	QS7	13	AstraZeneca would suggest the inclusion of a statement on reducing the time to diagnosis. Data suggests that some Bipolar patients for example may wait up to 8.9 years from first seeking help to a correct diagnosis. (J Cl i n P s.vch iat y 2000: 6) : 804-808)	Thank you for your comment. The quality standard applies to all service users of specialist mental health services. We have not split by diagnosis or focused on issues particular to specific diagnoses.
588	Birmingham and Solihull Mental Health Foundation Trust	20.01	QS	1	5	A very subjective and non-specific standard, very difficult to demonstrate and evidence. Also perceptions of these qualities will change, especially if someone is receiving treatment or interventions under MHA/against their will. There may be evidence of this approach by the provider on their public/service user bit of web-site, otherwise it will be difficult to ascertain evidence other than in very specific qualitative surveys/interviews. Organisations could be construed as meeting through proxy measure (e.g. respect and dignity) which is a very different standard.	Thank you for your comment. If local organisations feel they have existing mechanisms to help measure compliance against a quality statement they are able to do so. The GDG believe that this quality statement applies regardless of whether or not the MHA is being applied.
614	Birmingham and Solihull Mental Health Foundation Trust	20.02	QS	2	6	Good standard, important in a place like Birmingham and possible to measure by looking at evidence on training in staff records in house (part of the stat/man training already), but also training provided by other organisations (e.g. Pattigift).	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
637	Birmingham and Solihull Mental Health Foundation Trust	20.03	QS	3	8	A measurable standard from national survey information, CQUINs and local surveys, e.g. Real time Feedback. Could also audit ICRs, look for evidence of Advance Statements, use of tools like 'recovery start' etc which are written by service users and not clinicians.	Thank you for your comment. If local organisations feel they have existing mechanisms to help measure compliance against a quality statement they are free to do so.
658	Birmingham and Solihull Mental Health Foundation Trust	20.04	QS	4	9	Might be ideal for most - but some patients don't want this approach and may actively prefer a mix, or it may benefit them to see different staff and approaches. A significant challenge for service users who move between care pathways in a 'functionalised' care system like those in B'ham & Solihull. Continuity is provided by the care coordinator. We have now realigned to ensure that different teams cover different steps along the pathway to ensure they are experts in their steps. This of course means that there will not be continuity of care.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
682	Birmingham and Solihull Mental	20.05	QS	5	10	A good standard to drive up quality and ensure that all the surveying and feedback is used to improve	Thank you for your comments.

	Health Foundation Trust					services rather than just being reported. Range of opportunities for teams and services to respond to feedback and share action plans. The NICE suggested measure of quality may work if the sample size is representative enough to show improvement. National and local patient surveys, R-T feedback, other user consultation can gather evidence for benchmarks and improvement.	
698	Birmingham and Solihull Mental Health Foundation Trust	20.06	QS	6	11	Something to be aspired to. Teams would be unable to meet these currently. Commissioning and pressure within teams means that these are ideals to try and attain but cannot be achieved in the near future.	Thank you for your comment. The measures have been amended in light of consultation comments. It is hoped by the GDG that they remain aspirational yet achievable,
721	Birmingham and Solihull Mental Health Foundation Trust	20.07	QS	7	13	Evidence of information being given e.g. welcome leaflets, explanations of mental health services, info about 'diagnosis or what to expect should be made available. Emotional support for sensitive issues is very subjective and very difficult to measure (same problems as with standard 1)	Thank you for your comment. It is hoped that services might ask service users whether they received emotional support.
738	Birmingham and Solihull Mental Health Foundation Trust	20.08	QS	8	14	Not sure if this is reasonable as a standard – 'person centred' and 'customer care' is more than training, it is more about organisational culture. They are also 2 different things. Lots of people will not need training as they behave in this way naturally. Also this should be on the agenda of professional training rather than just the trusts. Could ensure customer care surveys are done (we do Mystery shopping, R-T feedback etc) and address any shortfalls and evidence that?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
765	Birmingham and Solihull Mental Health Foundation Trust	20.09	QS	9	15	A good recovery focussed standard the trust should aspire to. Current national surveys are used to ascertain if people have been offered or have a written copy of their care plan, and ask about wider issues. The content of that care plan could be looked at additionally, as suggested in other standards.	Thank you for your comments.
793	Birmingham and Solihull Mental Health Foundation Trust	20.10	QS	10	17	A good standard however very hard to define this population group.	Thank you for your comment. The GDG recognise the challenges in measuring this statement however, felt it of significant importance to include in the final quality standard.
811	Birmingham and Solihull Mental Health Foundation Trust	20.11	QS	11	19	Could be evidenced in surveys and interviews, but also be the quality of assessment documentation.	Thank you for your comment. The structure measure can be used to evidence this.
827	Birmingham and Solihull Mental	20.12	QS	12	21	These are 2 standards. One is about common courtesy, the other is about meeting of psychological	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15

	Health Foundation Trust					and emotional needs. Could be confusing. The latter is potentially highly subjective from the service users' perspective at the point of admission.	statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
845	Birmingham and Solihull Mental Health Foundation Trust	20.13	QS	13	22	All our assessments will happen by our Home Treatment services prior to admission and not on admission.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
860	Birmingham and Solihull Mental Health Foundation Trust	20.14	QS	14	23	Difficult to evidence apart from patient surveys	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
875	Birmingham and Solihull Mental Health Foundation Trust	20.15	QS	15	24	This is much the same as standard 3. Should we differentiate between service user groups? I don't think that helps, should apply to everyone, irrespective of whether MH Act or not.	Thank you for your comment. The GDG chose to highlight this particular group for statement 15 (now QS11). It was felt use of shared decision making was particularly poor in inpatient settings for those subject to the Mental Health Act.
895	Birmingham and Solihull Mental Health Foundation Trust	20.16	QS	16	25	The first part is difficult to meet as named healthcare workers don't work 7 days.	Thank you for your comment. The statement has been amended to "known" professional.
918	Birmingham and Solihull Mental Health Foundation Trust	20.17	QS	17	27	An essential standard for all sorts of reasons. Could evidence ward activity programmes	Thank you for your comment, we agree this is very important for service users.
937	Birmingham and Solihull Mental Health Foundation Trust	20.18	QS	18	28	A better standard may be that people are actively involved in their discharge planning, and that the mental health services also involved relevant friends and family too, and they made aware of services and support available to them prior to discharge. This is another patient survey and CQUIN question. Having standards around the agreed discharge date may not be realistic in today's climate.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
949	Birmingham and Solihull Mental Health Foundation Trust	20.19	QS	19	29	agreed	Thank you for your comments.
966	Birmingham and Solihull Mental Health Foundation Trust	20.20	QS	20	30	Good standard but would be difficult to collect routine data on without carrying out adhoc clinical audits.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have

							the most impact on services and lead to the greatest improvement in service user experience.
980	Birmingham and Solihull Mental Health Foundation Trust	20.21	QS	21	32	Good standard and critical. It's the start of social inclusion! Should be documented in notes, also could be ascertained through surveys	Thank you for your comments.
996	Birmingham and Solihull Mental Health Foundation Trust	20.22	QS	22	33	Very difficult to measure	Thank you for your comment. Existing indicators are included to highlight where organisations can use existing mechanisms. Further work may be required in alternative settings to mechanisms.
520	Birmingham and Solihull Mental Health Foundation Trust	20.23	QS	general	general	A lot of these standards will pose problems with current constraints and funding restrictions. The idea of some standards to work towards and for patients to expect is a good one, however these are brand new ideas and are unlike other quality standards which are established best practice which services have been trying to implement for some time. In addition User Involvement is always creative and influenced by service users' own agendas. This could lead to user involvement projects merely cross-checking standards and diverted into basics which we should be able to sort, without some of these criteria.	Thank you for your comment and general support. NICE Quality Standards are aspirational but achievable and give an indication of what high quality care should consist of. It is expected that those services which cannot meet the standards will put in place plans to improve their services to achieve them over time.
223b	Bright Response/Star Wards		Full	9.1	100-101	Page 100, line 35 – page (appropriately) 101, line 25 presents a breathtakingly one-sided perspective and an energetic disregard for most of the most important contemporary evidence about inpatient care.	Thank you for your views. As you know, the guidance has been undertaken by a majority of service users/carer, as has much of the writing and analysis. It is not intended to appear one sided.
1006	Bright Response/Star Wards		All	General	General	The transparent hostility to inpatient care is perhaps a reflection of the apparent non-involvement of the national inpatient care experts. We would expect any serious research into inpatient care to include: • Prof Len Bowers, ex-City University, now at Institute of Psychiatry. The pre-eminent academic in mental health inpatient care. (Prof Alan Simpson at City has also been involved in crucial work such as the City 128 study.) • Malcolm Rae and/or Paul Rooney (previously joint acute care leads for NIMHE/NMHDU) • Outstanding practitioners such as Geoff Brennan, Helen Bennett, Ellie Walsh, Alan Howard, Alan Metherall, Andy Johnston, Sarah Wilson, Angus Forsyth, Joanne McDonnell • Mark Beavon or Paul Lelliott from RCPysch's outstanding AIMS scheme • Ian Hulatt (RCN mental health adviser) • John Hanna (C&I and BPS)	Thank you for commenting. We do not believe that the guidance is hostile to inpatient care, which is an essential component of the care pathway. However, mindful of the findings of research in this field we have tried to highlight some the experiences of service users who have received inpatient treatment and make recommendations for improving service user experience. Thank you also for suggesting these people. However, it is outside the remit of this work, and the rules for research recommendation development, to identify potential researchers.

						• Centre for Mental Health (SCMH produced ground-breaking work in their Acute Solutions project) Representative from Star Wards (the only national structure for inpatient mental health care and with a strong evidence-base in creating swift and lasting improvements on wards)	
1007	Bright Response/Star Wards		All	General	General	We have considerable difficulty with your consistent problem-orientation, not just because solution focused practice is where it's at in inpatient care, but also because we can't understand how identifying a set of problems can possibly be described as an outcome. (Unless in the sense of an at best futile but probably aggravating outcome.) The astonishing negativity about inpatient care is in sharp contrast to Star Wards' appreciative inquiry approach.	Thank you for commenting. We do not believe our approach was entirely problem-focused. While it is true we used qualitative and survey evidence to identify key themes relating to a poor experience of care, we also spent considerable time in Guidance Development Group (GDG) meetings discussing the key requirements for the provision of high quality service user experience. The latter was solution-focused and based on GDG expert opinion. We stand by this approach given the relatively short development time allowed for this work. With regard to how we could describe a set of problems as an outcome, we refer you to section 3.5 where we describe the review protocol. In Table 1 we define the outcome as what is really important for the service user. If the objective of the review was to identify the key problems associated with care, then it seems to appropriate to describe key problems as the outcome for the purpose of the review. With regard to inpatient care, the survey data clearly show that in some areas of the country service users rate their experience of care much better than in other areas. However, to improve the experience for all people, the GDG felt strongly that they should focus on the issues where there was evidence of poor experience.
1008	Bright Response/Star Wards		All	General	General	It is unclear why some guidance statements became quality standards and others (most) didn't. Similarly, the differentiation between guidance, recommendations and quality standards was not obvious.	Thank you for your comment. The GDG discussed what they considered to be key recommendations for implementation taking into account findings from the key problems review and their own experience. Through a process of informal consensus they decided which of these key recommendations should be developed into quality statements. More information about recommendations and Quality Statements can be found in Chapter 1 of the full

							guidance (and on the NICE website).
1009	Bright Response/Star Wards		All	General	General	What works isn't simplistic slagging off of hospitals (decades of failed campaigns, ignored report recommendations, government edicts etc), but empathetic, respectful, collaborative and practical involvement with frontline staff, like Sainsbury Centre for Mental Health's *Acute Solutions* project, AIMS, Productive Ward etc. This produces a positive circle of ward improvements. Star Wards helps staff feel appreciated and reassured about their skills, usually resulting in a rise in morale, energy, motivation, engagement and creativity. This is accompanied by a parallel positive process for patients, who are given the time, support and confidence to regain their daily living skills and their self-esteem. The Royal College of Psychiatrists' recent *Do the Right Thing* report on inpatient care produced standards *"distilled from agreed existing standards for in-patient care, including those adopted by the Care Quality Commission, the Acute Care Declaration, Star Wards, NHS Mental Health Minimum Dataset and the latest data from the Royal College of Psychiatrists' Quality Improvement Network. Those are standards that working psychiatrists believe to be vital to the effective operation of wards and delivery of high-quality care, and those that most directly affect outcomes."*	Thank you for your comment. The GDG would agree that 'empathetic, respectful, collaborative and practical involvement with frontline staff' is important for improving the experience of care. Many of the recommendations in Chapters 9 to 11 were designed to do exactly that. We also believe that these recommendations cover many of the standards developed by the Royal College of Psychiatrists.
1010	Bright Response/Star Wards		All	General	General	We use the strongest possible evidence base about inpatient care and about effective social marketing practices to achieving large-scale, sustainable changes in staff practice. What works isn't simplistic slagging off of hospitals (decades of failed campaigns, ignored report recommendations, government edicts etc), but empathetic, respectful, collaborative and practical involvement with frontline staff, like Sainsbury Centre for Mental Health's Acute Solutions project, AIMS, Productive Ward etc. This produces a positive circle of ward improvements. Star Wards helps staff feel appreciated and reassured about their skills, usually resulting in a rise in morale, energy, motivation, engagement and creativity. This is accompanied by a parallel positive process for patients, who are given the time, support and confidence to regain their daily living skills and their self-esteem.	Thank you for your comment. The GDG would agree that 'empathetic, respectful, collaborative and practical involvement with frontline staff' is important for improving the experience of care. Many of the recommendations in Chapters 9 to 11 were designed to do exactly that.

1011	Bright Response/Star Wards		All	General	General	The draft recommendations/standards are all sound, but it is unclear why these rather than others are included. The following is based on inpatient research, service users' experiences and feedback from our 600 member wards. Our top 20 1. Staff being friendly, kind, empathetic and good communicators. 2. No ward rounds. 3. Single consultants (max 2 per ward). 4. Graduated self-medicating 5. Pets 6. Music 7. Nintendo Wii 8. Outdoor exercise equipment 9. Silence, meditation, contemplation are recognised and facilitated 10. Multi-sensory resources to soothe, vent etc 11. Patients can use Skype to keep in touch with friends and family 12. Visits arranged for the visitorless 13. Peer supporters recruited and on ward each day 14. Making best use of night staff's time and skills and them feeling truly connected and appreciated 15. All staff (including non-clinical staff eg receptionists) are encouraged to share their leisure interests with individuals and groups 16. Staff are trained in enabling 'supervised self-harm' rather than the counter-productive zero tolerance of self-harming by inpatients 17. Door control by fobs, swipe card or equivalent 18. Smokers can have a fag whenever they want unless there are exceptional reasons why this isn't possible. 19. Shopping options, especially for detained patients 20. Not just CBT but at least one other choice of therapy. Mentalisation Based Treatment shouldn't be considered only for patients with Borderline Personality Disorder Thematic priorities	Thank you very much for your affirmative comment. The recommendation and statements have been selected by consensus of the GDG. Thank you for your list of top 20 points and thematic priorities.

						1. Recreation and conversation a. Gardening including indoor and ecotherapy b. Pets c. Nintendo Wii d. Music e. Recreation resources include good library of self-help books and CDs, DVDs (films, nature documentaries etc) novels, biographies, illustrated books on popular topics, daily newspapers and nice magazines **2. Physical health & activity** a. Outdoor exercise equipment, b. Regular opportunities for exercise including dance **3. Visitors** a. Visits arranged for the visitorless b. Peer supporters recruited and on ward each day c. Patients can use Skype to keep in touch with friends and family d. Patients' pets are recognised as being essential in their caring circles e. Volunteer(s) f. Prayer, faith & cultural meetings **3. Care and care planning** a. Video intro to ward b. Admissions and departures c. No seclusion rooms unless it's a secure unit (LSU etc) d. No ward rounds. e. Patients given opportunity to learn about the brain and its relation to mental illness f. 'Protected engagement time' **4. Talking, creative and complementary therapies** a. Not just CBT but at least one other choice of therapy b. Staff trained in mentalisation based treatment c. OTs & creative therapists d. Multi-sensory resources to soothe, vent etc e. Silence, meditation, contemplation are recognised and facilitated	

						5. Ward community a. Ward community group b. Mealtimes made special **6. Patient autonomy** a. Door control by fobs, swipe card or more advanced security technology b. Supervised self-harm as pioneered by South Staffs c. Weekly and daily programmes attractively produced and accessibly displayed d. Graduated self-medication system e. Smokers can have a fag whenever they want unless there are exceptional reasons why this isn't possible. f. Shopping options especially for detained patients **7. Staff** a. Making best use of night staff's time and skills and them feeling truly connected and appreciated b. Culture of trusting staff c. Staff are well supported, inc 1:1s, reflecting practice groups, supportive debriefing after traumatic occurrences d. No agency staff e. Single consultants. **8. Environment** a. Importance of décor in patients (and staff) feeling valued and respected and the reciprocal behaviour.	
109	British Association of Art Therapists	27. 01	Full	2.4	16	Line 42: Since all NICE guidelines explicitly aim to promote person-centred care we would like to highlight art therapy in the service user experience in adult mental health: In research by Burns (2006) who looked at the patterns of practice of Art therapists working with older people who have dementia in the UK, the therapist's he interviewed said there is a "need of this client group to feel connected" to the world around them. The study also goes on to explore and illustrate that the person does not necessarily feel disconnected because of the disease, even though it is a factor the disconnection per se arises as a result of psychological	Thank you for your comments. As described above, the GDG could not make recommendations regarding specific therapies as this was outside the scope of the guidance.

						and emotional support available to the person. This warrants more person to person care (Marshall, 2001), however in routine care settings it is not always possible (Waller, 2002). One of the key objectives of art therapy on the other hand is to make the person feel more connected not just to a sense of self but also to the individual's surroundings. Burns, J. (2006), A perspective: Art Therapy and Dementia in Scotland. In: Spring, D. (ed.) Art in Treatment: A Transatlantic Dialogue. Charles C Thomas Publishers: Springfield Marshall, M. (2001), Care settings and the environment. In: Cantley, C (ed) A Handbook of dementia care. Open University Press: Buckingham Diane Waller [Ed]. (2002), Arts Therapies and Progressive Illness - Nameless Dread. Brunner - Routledge 2002.	
43	British Association of Art Therapists	27.02	Full	General	General	British association of Art Therapists have carried out a questionnaire on art therapies which focused on access, types of and outcomes for service users with mental health issues. These questionnaires were devised in consultation with all the four arts therapies (Art, Dance/Movement, Drama and Music Therapies) and disseminated through the official websites of all the Arts Therapies Professional Bodies. They were logged onto a monkey survey hosted for the purpose of analysis by the British association of Art Therapists. Through the survey we would like to highlight some key areas of service user experience that are being considered in the consultation document in particular- Barriers to accessing art therapies: that AT proves to be very beneficial from the responses that we have received but the fact remains that it is inaccessible and therefore negates a service users experience of mental health services, some responses from the questionnaires highlighted that SU's had been trying to get AT but couldn't for months and when they finally did get access the group was shut down due to lack of funding (thereby creating an inequality of experience). Lack of information provided, lack of choice, availability, inequalities to access and the methods of referral. We are pleased to see that this guideline is being put together but we do hope that the above issues will be considered and that there will be certain level of accountability generated. (Please find details of our report here:	Thank you for your comments. The GDG made general recommendations for improving access to care, but could not make recommendations regarding specific therapies as this was outside the scope of the guidance.

						http://www.baat.org/Report_on_Art_therapies_questionnaire.pdf)	
521	British Association of Art Therapists	27.03	QS	General	General	The British Association of Art Therapists are pleased to endorse these quality standards, they fully reflect key domains as related to service user experience across all clinical pathways. Our Organisation would be more than happy to act as a publication partner in support of these quality standards.	Thank you for your comments.
44	British Association of Social Workers	8.01	Full	General	General	General Comments: All in all it is a positive document but needs to be condensed to the key recommendations against which MH services can then audit themselves and develop an action plan. There is no mention of social work - although there is mention of social care workers, particularly in relation to community involvement There are no social workers on the advisory board for the consultation. Social workers have a long history of service user engagement and user empowerment and I think it is a real oversight that no one is involved in this important piece of work There is no mention of the barriers that affect service users as a result of the implementation of Payment by Results - with its assessment and resource allocation based on medical diagnosis This creates significant problems in relation to services not being outcome focused and not fitting with community care assessments and social services systems. The title of the document suggests that it relates to all service users of MH Services but most of the document is about inpatient experiences. This could be an opportunity to present a document that promotes holistic services and which acknowledges that the service user's pathway involves care and treatment in the community as well as hospital. Mental Health services are provided in through partnerships between the NHS, Local Authorities and independent or voluntary organisations. Mental Health teams should use an inclusive framework such as the Care Programme Approach to ensure co-ordination of assessment and service provision including all input from professionals. Many service users have several concurrent "care plans" such as Nursing Plans, Treatment Plan, Risk Plans, Discharge Plan, Crisis Plan, Advance	Thank you for your comments. The NICE version of the guidance and the quality standard are the condensed version against which services can audit themselves. The NICE implementation team will provide tools which can be use to assist this process. Advice about social work came from Sarah Carr, Senior Research Analyst, Social Care Institute for Excellence. It is not appropriate for this guidance to make comments about the nation-wide development of PbR. The guidance covered adult mental health services, and in the full guidance, approximately half of the chapters covered issues to do with community care. In addition, about half of the quality statements are about community care. Regarding the CPA, the DH advised that guidance about CPA was changed several years ago to make it clear that the CPA is not appropriate for everyone in contact with specialist MH services. Regarding care plans, there are recommendations which cover your suggestion, however, the GDG prioritised the following as a quality statement: "People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.." As described above, we had a member from SCIE on the development group. Given that half of the GDG were service user representatives, we could not have every health professional represented, but we do

						Statement and Activity Plans. A useful Quality Standard might be to define a care plan and how this is different to the other plans made about service users. A care plan should provide a summary of needs and how these will be addressed – including the service user responsibilities. It should also state when and how it will be reviewed. The lack of representation from mental health social work causes particular concern, especially due to the integrated nature of mh services The lack of representation from AMHP Leads is also concerning and leads to some worrying comments re the process of admission and detention.	believe a good balance was reached.
580	British Association of Social Workers	8.02	NICE	QS1, 3, 5-8, 10, 12, 14, 17, 19-22	6-7	Agree	Thank you for your comments.
611	British Association of Social Workers	8.03	NICE	QS2	6	Cultural Awareness Training should be sourced from expert organisations with relevant knowledge	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
652	British Association of Social Workers	8.04	NICE	QS4	6	Agree about the transitional issues The community based multi disciplinary team should maintain contact with service users throughout their time away from home e.g. either as inpatients or prisoners. Teams generally work to geographical boundaries and where service users have chaotic lives because of the impact of their health and social needs this can result in them moving between areas. An important feature of this standard could be that there should be co-operation between teams to maximise the consistency in support for service users.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
754	British Association of Social Workers	8.05	NICE	QS9	6	Yes, people should have a copy of their care plan but should also be involved in the development and writing of the plan in line with a Recovery Approach. The care plan should also include input from all professionals involved including medics, therapists,	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a*

						nurses, Social Workers and other services.	*care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
807	British Association of Social Workers	8.06	NICE	QS11	6	Yes, plus the service user's own view of the situation	Thank you for this suggestion. The GDG have included this in more general recommendations, such as 1.4.6 (NICE guidance document).
839	British Association of Social Workers	8.07	NICE	QS13	6	I'm not sure what this means. All people admitted to hospital will have experienced some assessment before admission. There will have been different levels of assessment depending upon the admission route.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
870	British Association of Social Workers	8.08	NICE	QS15	7	Should this say "service users formally detained under the 1983 Mental Health Act (amended in 1995 and 2007)"?	Thank you for your comment. The statement has been amended,
888	British Association of Social Workers	8.09	NICE	QS16	7	I think this is impossible to deliver as no member of staff works seven days a week. I agree with the promotion of protected 1:1 time with key workers and consultants. I agree that the old practice of huge, intimidating ward rounds should be challenged but it is important that service users are included in discussions about them particularly where decisions are being made about liberty etc. It is also important that advocacy services such as IMHAs can contribute to discussions.	Thank you for your comment. The statement has been amended to "known" professional.
934	British Association of Social Workers	8.10	NICE	QS18	7	People should be involved in discharge planning with their health and social care team.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
45	British Association of Social Workers	8.11	Full	General	General	We do not think that they tackle the issue of confidentiality sufficiently when service users don't give consent for relatives to receive information. I think that the duty of care / risk must be included in the guidance, plus advice for professionals on how to minimise the exclusion of relatives.	Thank you for your comment, recommendation 1.1.15 (now 1.1.17) does address what to do if the service user does not want their family/carers to be involved. We are unable to make recommendations further to this about the involvement of families and carers as it is outside the scope of this guidance.
173	British Association of Social Workers	8.12	Full	6.3 7.5.21 7.5.2.5 7.5.2.6 7.5.2	63 & 89	Service users‟ wishes about the involvement of their family and carers in the assessment process is respected There is regard to the possibility of safeguarding issues and the need to see the service user alone Family/carers are offered an assessment of their needs as a carer Family carers play a vital role in the assessment, treatment, recovery and on going care of people with	Thank you for your comment, the guidance does make recommendations about working with families and carers, if the service user agrees. However, it is not possible to recommend any actions further to this if the service user does not give their consent for this to happen.

				.7 7.5.2 .8		mental health problems. The issue of confidentiality is something that carers often raise and discussions with teams of mental health professionals has demonstrated to BASW that the issues are complex and that solutions need to be found to the issue of confidentiality. Safeguarding concerns should not be dismissed in any way and should clearly “trump” issues of patient confidentiality. Professional social workers and others describe how they work with the issues of confidentiality in constructive ways so as not to exclude carers. This could be as advised in the NICE guidelines by encouraging service users to allow relatives to receive information about mental health problems in general. The advice to refer carers to carers support organisations etc. is essential There needs to be more acknowledgement of the need to share information with relatives, not least when considering compulsory admission, and in arranging discharge where there may be risk issues which require wider discussion with family and carers.	
228	British Association of Social Workers	8.13	Full	9.2.7	109	- The guidance that service users should be supported to maintain their social networks when in hospital is obviously important but in my area a 'local' bed is considered to be any bed within the Trust area (which is the whole of Lancashire). This has massive implications for family being able to visit and for the patient to be able to continue with their social support where appropriate. The suggestion that service users should have a choice about where they are admitted seems to raise expectations which in many cases would be impossible to meet. Again in my area a number of local psychiatric units are being merged leaving some towns/cities with no local unit to which they could be admitted.	Thank you for your comment, 9.2.7 refers to continuity of care and smooth transitions not choice and we are, as a consequence unfortunately unable to respond to your comment.
262	British Association of Social Workers	8.14	Full	11.3	139	Of particular concern is the guidance that the involvement of police should be avoided wherever possible when arranging admission and does not acknowledge the role of the AMHP in coordinating the process (there is no reference to the code of practice in any of the discussions re use of the MHA which could lead to confusion between the statutory code and NICE guidance).	Thank you for your comment, this is not supposed to be ‘generic good practice guidance’ but rather recommendations about what services should do to improve their experience of care for service users.
46	British Psychological Society	30.01	Full	General	General	We know that mental ill health can have a significant negative effect on people’s quality of life.	Thank you for your comment. We are not clear if you are suggesting a change to the guidance or simply

						Family carers and others are also affected in terms of stress, emotional affect and other negative effects on quality of life. Quality of life has both subjective (obtained through personal appraisal) and objective (rating scales, direct observation and questionnaires) components. Measurable aspects of quality of life and mental well-being include: • emotional well being, physical adjustment and happiness; • feeling of being safe and secure from harassment, abuse and bullying; • interpersonal relationships/ friendship/social contacts; • material well-being; • personal development and physical well-being; • staying healthy; • self determination; • social Inclusion; • rights and respect at individual and community level; • personal choice, control and empowerment. Such an emphasis fits well with the new mental health strategy – '*No Health Without Mental Health'* – and, of course with the wider Cabinet Office and Office for National Statistics' consultation on measuring national well-being. It therefore follows that proper emphasis on the full range of service user and carer well-being outcomes is potentially of great value.	proving general information.
47	British Psychological Society	30.02	Full	General	General	The draft guideline reflects the view that service users and their experience of mental health services are at the centre of service planning and service delivery issues but, within the powerful professional world of psychiatry and mental health services, the service user's voice may become a minority/hidden voice. Minority views are characterised by possessing traits held in low esteem by the dominant view and by being seen and heard as subordinate segments of complex state societies. Some professionals working in the mental health field believe they know best in terms of the service that will be provided, the choices that are made for service users. They may also display their power in such ways as entering service users' rooms without permission	Thank you for your comment, we agree that empowering service users and ensuring they have an active role in their care is extremely important, and hope this guidance will aid this process. In the NICE guidance we specifically make recommendations that autonomy and self-management should be encouraged (see recommendation 1.1.2) and that service users should be involved in shaping services and training staff (see recommendations 1.1.17-20 [now 1.1.19-1.1.22])

						and instructing service users in what to wear and what to eat. The Society recommends a re-negotiation of the balance of power with service users. Again, because well-being encompasses more than narrow symptom specific domains, it is important that the voices of service users and carers are actively heard: they may be disempowered, they may also be addressing issues not of the immediate interest of the professional with whom they are interacting, but which are of major objective importance (these may, of course, include issues of risk). Professionals must ensure genuine openness to service users' and carers' views.	
48	British Psychological Society	30.03	Full	General	General	The Society also recommends that equality principles for all users of mental health services (including black and minority ethnic users, older people, working class people, etc) should be promoted. In addition, measures need to be taken to ensure that the treatment of carers and users is based in respect and dignity, with assumptions and stereotyped views being kept to a minimum.	Thank you for your comment, the GDG agree that stigma and stereotyping can be extremely damaging for people with mental health conditions and the guidance makes recommendations to avoid stigma and promote social inclusion, see recommendations 1.1.5-1.1.8 (now 1.1.6-1.1.9). Recommendation 1.1.6 (now 1.1.7) has also been amended to include further minority groups.
49	British Psychological Society	30.04	Full	General	General	We further recommend that measures are needed to empower service users with knowledge of community care legislation and user's rights when receiving mental health care, including their rights to: appropriate information regarding assessment and treatment processes; be seen in the community or at home; and to be treated by trained staff with appropriate awareness, understanding and knowledge of the needs of the various diverse local population. This empowerment should be active – professionals are (or should be) aware of their powers and resources. , provision of information is important but service users and carers need active support in helping them use the information provided, and support in interpreting the implication of such information to ensure that they can use it.	Thank you, we think that empowering service users with knowledge is addressed in the guidance, e.g. the provision of information is dealt with in recommendations 1.3.3 and 1.6.2, culturally specific services are addressed in recommendations 1.2.4 and 1.4.9.
50	British Psychological Society	30.05	Full	General	General	Evidence from the Social Exclusion unit (2004) suggests very low numbers of people with significant mental health difficulties are working. We recommend mention of the role that NHS mental health workers play in ensuring a service user maintains (or finds) employment. Some members have observed poor practice in this area.	Thank you for your comment, we agree that finding employment can be very important, and have recommended that care plans are developed jointly with the service user to take account of this, see recommendation 1.4.2.

						This issue links with the wider well-being agenda (work is a fundamental issue of well-being), to the multi-dimensional nature of mental health problems, and to the multi-professional responses needed. It is not only therapeutically important to explore the full range of psychosocial interventions available (for instance the effective interventions to support return to work), but also to understand the wider national economic benefits of unemployment related to mental health issues. Social Exclusion Unit (2004) http://www.communities.gov.uk/publications/corporate/mentalhealth Accessed 11 July 2012	
51	British Psychological Society	30.06	Full	General	General	Members of the Division of Clinical Psychology's Service User and Carer Liaison Committee found some aspects of the document frustrating to read. Many of the recommendations are at the level of desirable behaviour of professionals, however the reasons why their current behaviour is not desirable has not been addressed. There is often a prevailing attitude towards service users that they are irrational, that their mind is broken in some way and they are abnormal. If attitudes changed, such that a person presenting with mental health problems was considered as rational as anyone else then all the other aspects of the personalisation agenda would fall into place. The following quote is from a service user: *"I told lies and acted in unusual ways whilst in inpatient care but for "rational" reasons either because I did not trust the person, as an attempt to communicate or from a kind of "well if they think I'm mad let's see how mad I can be" - not my proudest moments! When I reflect, as far as I can possibly tell, I was always reachable but very few approached me with respect as a human being and I found the prevailing patronising attitude profoundly insulting."* The Society is very concerned that any service user feels they have been put in this position. We believe that by addressing the underlying attitudes, rather than prescribing a change of behaviour, professionals would act in the same empathic, respectful and caring way	Thank you for your comments, the GDG agree that stigma, within and without the health service can have a very negative effect on service users and impact on their recovery. The guidance does make recommendations to address these issues (see recommendations 1.1.5-1.1.8 [now 1.1.7-1.1.9]). However, guidance is unable to make recommendations to regulatory bodies.

						they do in their other relationships. Without this the practical value of the recommendations is undermined. Action on this point might involve exploring with regulatory bodies how attitudinal factors are reflected in standards of proficiency, and how they are policed.	
52	British Psychological Society	30.07	Full	General	General	We believe that giving hope to service users as part of their "treatment" would make a significant difference to their experience. The following quote is from a service user: *"It is possible to make significant recovery from even the most severe mental illness. It is possible to enjoy life again and live without the possibility of relapse being a fear. It is possible to live without shame."*	Thank you for your comment, the GDG felt that all care should be delivered within an atmosphere of hope and optimism, and therefore included this in the first recommendation (1.1.1)
53	British Psychological Society	30.08	Full	General	General	Building a trusting relationship with professionals is essential. It is not enough to be objectively assessed and given medication.	Thank you, the GDG agree and hope recommendation 1.1.1 will encourage healthcare professionals to do so.
54	British Psychological Society	30.09	Full	General	General	We are concerned that there is no reference in the document to service users from the LGBT community, and the particular needs of this group especially Transgender. There is also no mention of the homeless, asylum seekers or refugees. We recommend that the document is widened to include *all* minority communities and moves away from race and culture.	Thank you for your comment, the GDG agrees that service users other diverse groups should be referred to in the document and the recommendation 1.1.6 (now 1.1.7) has been amended to read: *When working with people using mental health services:* • *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from different genders, cultural, ethnic, religious or other diverse backgrounds.*
55	British Psychological Society	30.10	Full	General	General	There is no mention of the need for the availability of independent advocacy services until section 5.5.1.2. We recommend including the word 'independent' wherever advocacy is mentioned.	Thank you for your comment, the recommendations have been updated to include reference to Independent Mental Health Advocates.
100	British Psychological Society	30.11	Full	2.1	14	We recommend that this section includes recommendations on how service users are treated. For example, work in NHS Forth Valley has found that patients want to: • be confident their needs are met; • share in decision making; engaged and involved;	Thank you for your comment, this section of the guidance is an introduction and therefore not the appropriate place for recommendations. These are included in chapters 4-12 and follow a review of the evidence.

						• be kept safe from harm; • be treated with dignity and respect; • be allowed to take responsibility for their care; • receive the highest standards of care; to have their family and carers supported; • be supported and cared for at the end of their life.	
101	British Psychological Society	30.12	Full	2.1	14	We recommend that in the third paragraph, a lack of knowledge of the resources available (by GPs and service users/carers), is added as an additional barrier.	Thank you for your comment, the text has been amended to reflect your suggestion.
127	British Psychological Society	30.13	Full	5.1	39	We recommend that this section is expanded to include recognition of: • asylum seekers; • illegal immigrants (who may not seek help for fear of being deported); • those without English as a First Language; • those in the criminal justice system; • victims of domestic violence (who may be less likely to come forward because of repercussions at home); • Lesbian, gay, bisexual and transgender (LGBT)?	Thank you for your suggestion. Chapter 5 is about improving the experience of accessing community care. We believe that the recommendations do address the aim of the chapter, and in particular there is recommendation that health and social care professionals make sure services are equally accessible to, and supportive of, all people using mental health services.
135	British Psychological Society	30.14	Full	5.2.1		It is incumbent on mental health services to avoid offering only homogenised services and to ensure to that the needs of individual service users are addressed (for example, by the provision of women-only wards, the use of trained interpreters in assessment work, the influence of religion and spirituality in the interpretation and understanding of mental health, the use of the voluntary sector in the community, etc.). Steps are needed to reduce the risk of things being ***done to***, rather than ***with***, service users. Quality of care provided within the service, the way services are planned and delivered, the way monitoring of the service takes place without any real input from service users is a harsh reality for a lot of service users' experience of the mental health service system. Over-emphasis on control of behaviour/symptoms via medication and difficulties in accessing psychological therapies imply that once a person is labelled as having a mental health problem the person is at risk of social exclusion, disadvantage and discrimination within the mental health care system.	Thank you for your comments; we agree all these factors can lead to a poor experience of care and services. We hope this guidance will help to improve both services, and the experience of them.

139	British Psychological Society	30.15	Full	5.2.5	46	We feel that this section would benefit from evidence on “revolving door patients”, where some are passed from service to service with no one service taking full responsibility. We believe there is a failure to understand the needs of some groups by some professionals.	Thank you for your suggestion. Being passed from service to service was highlighted by some service users, but we classified this as a theme relating to ‘fast access to reliable health advice’. We agree this theme is more to do with effective treatment and will amend the text.
142	British Psychological Society	30.16	Full	5.2.7	50	As well as a lack of information acting as a barrier, information not being provided in readily-understood formats creates barriers to accessing services There is an additional need to be specific about who the information is for; GPs require information so they can refer on; service users need information so they may choose; and carers require information so they can support and be supported.	Thank you for your comment. In this section we were summarising what key theme(s) had been extracted from the qualitative and survey evidence. Therefore, we can’t add themes.
143	British Psychological Society	30.17	Full	5.2.7	50	Under the heading ‘Fast Access to reliable health advice’, we suggest that a Single Referral Pathway should be considered. Referral can then work up and down within the same pathway, from less to more intensive intervention, depending upon need at a given time. This would avoid the service user having to repeat their story to a variety of professionals and health care providers – (see Clackmannanshire Integrated MH Services) Clackmannshire Integrated Mental Health Services. http://www.clacksweb.org.uk/social/mentalhealthdayservices/ Accessed 11 July 2012	Thank you, but again in this section we were summarising themes that came from the qualitative and survey evidence, not trying to suggest the way that services should be structured, as to do this would have been outside of the guideline scope.
144	British Psychological Society	30.18	Full	5.2.7	50	We suggest the inclusion of evidence to support the lack of out-of-hours provision mentioned in this section.	Thank you for your comment. As described above, in this section we were summarising what key theme(s) had been extracted from the qualitative and survey evidence. Therefore, we can’t add themes.
97	British Psychological Society	30.19	Full	General	50-51	Anecdotal evidence cites a number of service users who have expressed concern about difficulty in understanding staff –whose first language is not English. They have been unable to understand or discuss their medication concerns in a comfortable way because of this. A practical issue that follows might be to review the standards of proficiency in spoken English required by regulatory bodies. Such a review could include examining whether this anecdotal evidence can be substantiated.	Thank you for your comment, however NICE guidance makes recommendations to healthcare professionals regarding clinical practice, and are unable make recommendations to regulatory/educational bodies.
147	British Psychological Society	30.20	Full	5.3 Table 12	51	We recommend including provision for Braille, large print, British Sign Language, audio, etc.	Thank you for your comment. Recommendation 1.1.3 now reads:

							When working with people using mental health services and their family or carers: *- ensure that you are easily identifiable (for example, by wearing appropriate identification) and approachable* *- address service users using the name and title they prefer* *- clearly explain any clinical language and check that the service user understands what is being said* *- take into account communication needs, including those of people with learning disabilities, sight or hearing problems or language difficulties and provide independent interpreters (that is, someone - who does not have a relationship with the service user) or communication aids (such as using pictures, symbols, large print, Braille, different languages or sign language) if required.*
145	British Psychological Society	30.21	Full	5.3 Table 12	50	We believe that information should be written in conjunction with service user groups to avoid ambiguity.	Thank you for your comment, the text has been amended to reflect your suggestion.
148	British Psychological Society	30.22	Full	5.3 Table 12	51	Under the heading 'Attention to physical and environmental needs', the Society has concerns about confidentiality if community settings are utilised.	Thank you for your comment. These qualitative statements were generated by the GDG, but the one you mention was not taken forward and developed into a recommendation.
149	British Psychological Society	30.23	Full	5.3 Table 12	51	Under the heading 'Involvement of, and support for, family and carers', we feel there should be a definition of 'not normally' within 'Family and carers should not normally be used ….' Our view is that family and carers should be used only in exceptional circumstances and for the most rudimentary things.	Thank you, but these statements were turned into recommendations (where appropriate), which are designed to clearly specify what should be done. We're not convinced this is necessary.
153	British Psychological Society	30.24	Full	5.4	52	This section would benefit from information on what services exist – including social prescribing. This would be of particular help to GPs.	Thank you for this suggestion, but section 5.4 attempts to describe the rationale for the recommendations, so it would not be appropriate to provide information about what services exist.
154	British Psychological Society	30.25	Full	5.4	52	Line 24. We would emphasise that when requirements such as 'trained interpreters' are an aspiration and not a right, there will always be problems ensuring person-centred care.	Thank you for your comment.
159	British Psychological Society	30.26	Full	5.5.1.2	54	We recommend investigating secure methods of providing information about appointments that is not always by letter, but in whatever format preferred by the service user.	Thank you, everyone understands what an appointment letter whereas few people will easily understand your suggestion. Therefore, the GDG have decided to retain term appointment 'letter'.
167	British Psychological Society	30.27	Full	5.5.2.1	55	We recommend that the police and schools are included here, and that service user and carer groups	Thank you for your comment, however we are unable to make recommendations for police and schools as

						are involved in developing the strategy.	NICE guidance only covers health and social care.
169	British Psychological Society	30.28	Full	6.1	57	It is important that confidentiality is emphasised in this section, and it is made clear that service user will not be discussed with anyone else without their consent. We are concerned that there is no mention of service user's right to a Named person, or of the use of Advance Statements.	Thank you for your comment. The GDG agree that confidentiality is important, therefore in the NICE version of the guidance there is a separate section on 'Consent, capacity and treatment decisions' (see section 1.1). Also, see recommendation 1.1.2 (now 1.1.4), 1.1.13 (now 1.1.14) and 1.3.2.
170	British Psychological Society	30.29	Full	6.2	57	We have concerns over the rights of the individual to confidentiality in this section.	Thank you, but as described above this is covered in the NICE guidance (section 1.1).
177	British Psychological Society	30.30	Full	6.5.1.3	66	Information should be available in a variety of formats, including Braille and audio.	Thank you for your comment, recommendation 1.1.2 (now 1.1.4) – which applies to all aspects of care and in all settings – recommends that all information be given in '*an appropriate language or format'.*
183	British Psychological Society	30.31	Full	6.5.1.8	66	We suggest that 'and carers' be added after 'service users'.	Thank you for your comment, this issue is addressed in recommendation 1.1.14. (now 1.1.16).
197	British Psychological Society	30.32	Full	7.3 Table 14	85	Information, verbal and written, may be better received if offered repeatedly and/or in varying degrees of complexity.	Thank you for your comment, the text has been amended to reflect your suggestion.
198	British Psychological Society	30.33	Full	7.3 Table 14	85	Under the heading 'Emotional support, empathy and respect', we recommend that the second bullet point is expanded to provide examples of choice.	Thank you, the examples are too numerous to detail individually.
200	British Psychological Society	30.34	Full	7.4	87	Line 27. We suggest changing '…supporting people from minority groups to get access to…' to 'supporting people from harder to engage groups to get access to'	Thank you for your suggestion, we felt it important to keep the reference to minority groups, but have added '*groups that are harder to engage*' to the text.
203	British Psychological Society	30.35	Full	7.5.1.10	89	We recommend including LGBT and disability groups here.	Thank you, the recommendation has been amended to include 'other minority groups'.
522	British Psychological Society	30.36	QS	General		We believe that 'timely' needs to be added to the existing strands of 'quality' care. Care may be exceptional, but is of little use if it is not there when it is needed.	Thank you for your comments. Discussions on timely access to services featured in the development of the quality statements and are a component of the clinical effectiveness and patient experience strands of quality. There is a specific quality statement related to the timely access to services.
523	British Psychological Society	30.37	QS	General	General	Some service users may be unaware of the meanings of 'numerator' and 'denominator'.	Thank you for your comment, this document is produced for health and social care professionals. A document for service users and carers called 'Understanding NICE guidance' will also be published with the guidance.
524	British Psychological Society	30.38	QS	General	general	We believe that the descriptions of what the quality statement means for each audience could be strengthened throughout the document.	Thank you for your comment. The quality standard will be re-examined to ensure audience descriptors are as useful as possible.
584	British Psychological Society	30.39	QS	1	3	This statement comes across as a little dictatorial. It might be better changed to "people using mental	Thank you for your comment. The applicable quality statement has been amended to make it less

						health services and their families or carers are supported to feel optimistic about their future, optimistic about their recovery, and that their experience will lead them to feel positive about their care".	dictatorial.
612	British Psychological Society	30.40	QS	2	3	We recommend that the cultural awareness training programme statement is revised to include the needs of LGBT and disability groups.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
993	British Psychological Society	30.41	QS	22	4	We recommend amending this statement to read '…working with local *and national* organisations to combat…'	Thank you for this suggestion, but the GDG felt the focus of this statement is the local community and therefore has highlighted working with local organisations.
589	British Psychological Society	30.42	QS	QS 1	5	The draft quality statement states that *'…. and their families or carers are supported ….'.* Feedback from carers and family therefore needs to be obtained to measure the level of supported.	Thank you for commenting. The guidance includes families and carers only in so far as their involvement improves the experience of care for the service user. Therefore, the views and experience of families and carers is not measured.
615	British Psychological Society	30.43	QS	QS 2	6	We recommend including LGBT and disability groups here.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
699	British Psychological Society	30.44	QS	QS 6	11	The Society recommends the addition of evidence that service users found appointment times to be acceptable.	Thank you for your comment. The quality statement contains five outcome measures requiring evidence of the experience of service users.
739	British Psychological Society	30.45	QS	QS 8	14	In general, the term 'Customer care' comes across as rather impersonal in the context of health care and particularly mental health care.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as
794	British Psychological Society	30.46	QS	QS 10	17	We recommend that this standard takes account of 'Advance Statements' in mental Health Act (Scotland) 2003. Mental Health Act (Scotland 2003 http://www.legislation.gov.uk/asp/2003/13/contents Accessed 11 July 2012.	Thank you for your comment. The guidance is not applicable in Scotland, and therefore would not be appropriate to include this.
861	British Psychological Society	30.47	QS	QS 14	23	We suggest defining 'as soon as possible'.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should

							be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
876	British Psychological Society	30.48	QS	QS 15	24	In the draft quality statement, we suggest the insertion of 'all' before 'healthcare professionals' to avoid the possibility of satellite working.	Thank you for your comments, we have expanded this to include health and social care professionals.
896	British Psychological Society	30.49	QS	QS 16	25	We suggest including the concept of 'protected time' to avoid meetings taking place in hall-ways.	Thank you for your comment. The concept of protected time may be one method which local organisations use to ensure achievement of the statement. The quality standard does not specify the method by which this statement must be achieved.
919	British Psychological Society	30.50	QS	QS 17	27	We recommend: • inserting 'appropriate' before meaningful activities; • a definition of 'meaningful'; • making such activities 'optional'; • specifying the duration of activities.	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
938	British Psychological Society	30.51	QS	QS 18	28	If service users are involved in their care plans, and discharge is planned for from the point of admission, then this time scale may not be needed as discharge should be planned with their key worker.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
997	British Psychological Society	30.52	QS	QS 22	33	We recommend that 'the police' be added to the end of the Draft quality statement.	Thank you for your comment, the statement does not prescribe the exact organisations that should be worked with.
277	Care Quality Commission	59.00	NICE	general	general	Suggest the reference to the related generic patient experience guidance document and the nature of the relationship between the two is made explicit early on in the document. Ideally, this would be to state that the generic patient experience guidance applies equally to people in contact with mental health services and that this guidance offers additional standards to be met within this particular setting.	Thank you for your comment. It is intended that the guidance and quality standards are used in the specific areas that they have been developed for. However, the principles from the patient experience in generic terms guidance may be of interest to those working in the mental health setting.
308	Care Quality Commission	59.01	NICE	general	5	Suggest rephrasing the first sentence – to improving the experience of people who use adult NHS funded services	Thank you for your comment, this guidance is about mental health services, not generic health services.
309	Care Quality Commission	59.02	NICE	general	5	The introduction on person centred care should also reference the participation principle and the Mental Health Act (MHA) Code of Practice for people who are detained under the MHA	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
609	Care Quality Commission	59.03	NICE	QS2	6	We suggest making this statement more generic so that cultural awareness training is sourced from expert	Thank you for your comment. This quality statement has been removed from the final quality standard. The

						organisations with relevant knowledge	GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
632	Care Quality Commission	59.04	NICE	QS3	6	We suggest adding 'care' as follows: … are actively involved in **care and** treatment decisions ….	Thank you for your comment. The statement has been revised to make it succinct.
649	Care Quality Commission	59.05	NICE	QS4 and 1.4.7	6 & 17	As currently phrased, this quality statement does not necessarily reflect the realities of the way that some services are organised, particularly where teams work to geographical boundaries, service settings or work for different organisations (some local authorities have withdrawn social work staff from integrated community mental health teams). However, it is key that people receive both continuity within a service and that there is effective cooperation between teams or organisations to maximise the consistency of support for services users – for example, community teams sustaining contact with someone if they are admitted to hospital.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
760	Care Quality Commission	59.06	NICE	QS 9 and 10 1.4.2 and 1.4.5	6 & 16 -17	There are slightly different expectations in national policy in relation to care planning and crisis planning depending on whether people are on the Care Programme Approach or not: • Service users on CPA should have a comprehensive formal written care plan detailing their care and treatment. In the case of those who are not on CPA, there is no formal requirement to have a written care plan or indeed review. However for those not on CPA, policy guidelines recommend that there be some form of recorded agreement with the service user about how their treatment will be carried out and by whom. • All service users on CPA should have explicit crisis and contingency plans set out in their care plan which explains what they should do in a crisis. Although there is not the same policy requirement for service users not on CPA, they should be aware of who to contact in the event of a crisis. Should quality statements 9 and 10 be amended to be consistent with the expectations of national policy?	Thank you for your comments. The GDG believe that all people using mental health services should be able to jointly develop a care plan to improve the experience of care.
755	Care Quality Commission	59.07	NICE	QS9	6	In addition to having a copy of their care plan, people should also be involved in the development and writing of the plan in line with a recovery approach.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read:

						The care plan should also include input from all professionals involved in their care including doctors, therapists, nurses, social workers and other services and reflect the service user's own view of the situation.	*People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
842	Care Quality Commission	59.08	NICE	QS13	6	We are unclear what this means. All people admitted to hospital will have experienced some assessment before admission. There will have been different levels of assessment depending upon the admission route.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
871	Care Quality Commission	59.09	NICE	QS15	7	Should this say "service users ***formally detained*** under the 1983 Mental Health Act (amended in 1995 and 2007)"?	Thank you for your comment. The statement has been amended,
886	Care Quality Commission	59.10	NICE	QS16	7	Although we support the promotion of protected 1:1 time with named health professionals/key workers, this part of the standard would be impossible to deliver as no member of staff works seven days a week.	Thank you for your comment. The statement has been amended to "known" professional.
338	Care Quality Commission	59.11	NICE	1.1.3.	8	At times the guidance is confusing about who is being addressed – e.g. ensure you are easily identifiable.	Thank you for your comment, the NICE guidance is a document specifically for healthcare professionals.
346	Care Quality Commission	59.12	NICE	1.1.5	9	It would be helpful to spell out what is meant by the 'limits of confidentiality'	Thank you for your comment, the final bullet point of recommendation 1.1.5 (now 1.1.6) has been amended to read: • *be clear with service users about limits of confidentiality, that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others*
354	Care Quality Commission	59.13	NICE	1.1.7	10	Second bullet point – suggest amendment to wording to read: … if possible, and **care,** treatment **and support** options. Also should the diversity issues have their own section (as this is slightly different to avoiding stigma and promoting social inclusion) which focuses more on cultural competence?	Thank you for your comment, the recommendation has been amended in line with your suggestion.
363	Care Quality Commission	59.14	NICE	1.1.9	10	Non-mental health professionals should also be competent in understanding/applying the principles of the Mental Capacity Act.	Thank you for your comment, this guidance is applicable to anyone working in adult mental health services, whether they are mental health professionals or not.
425	Care Quality Commission	59.15	NICE	1.4.6	17	Many service users have several concurrent "care plans" such as Nursing Plans, Treatment Plan, Risk Plans, Discharge Plan, Crisis Plan, Advance Statement and Activity Plans. A useful Quality Standard might be to define a care plan and how this is different to the other plans made about service users.	Thank you very much, the guidance is specifically directed at improving service user experience rather than integrating the different aspects of care planning, which does make sense but isn't directly relevant here.

						A care plan should provide a summary of needs and how these will be addressed – including the service user responsibilities. It should also state when and how it will be reviewed.	
446	Care Quality Commission	59.16	NICE	1.5.9	20	We are unclear what is meant by 'the reliability of access to and the person's cooperation with treatment' – we would not want to see a situation where services were being encouraged to admit people to hospital because the range of community alternatives was insufficient.	Thank you for your comment, we have removed 'the reliability of access to and' from the recommendation to address your concerns.
448	Care Quality Commission	59.17	NICE	1.5.10	20	We are unclear what is meant by 'when it is safe …. to do so'.	Thank you for your comment. During a crisis, questions of safety are paramount, both in terms of the safety of the individual and others. It is important to prioritise helping the service user in the first instance and to address the needs of families and carers after you are satisfied that the situation/crisis is safe and you are able to give proper attention to the needs of carers and families.
462	Care Quality Commission	59.18	NICE	1.6.7.	21	'… at regular multidisciplinary meeting led by the consultant and team manager' …. This is at odds with the national guidance published in 2007 on New Ways of Working (NWW) see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079106.pdf for further information). In NWW, leadership should depend on who is the most able and competent rather than a prescribed professional. We also have concerns that this standard may perpetuate the lack of involvement of services users in MDT meetings to discuss/ plan their care and treatment. It is important that service users are included in discussions about them, particularly where decisions are being made about liberty etc. It is also important that advocacy services such as IMHAs can contribute to discussions.	Thank you for your comment**, a**ll wards should have a clinical and managerial lead who work cooperatively and collaboratively. Traditionally the clinical lead is called the consultant and the managerial lead the team manager. We have not specified that the consultant is a psychiatrist as it could be consultant nurse.
482	Care Quality Commission	59.19	NICE	1.6.13	22	Although we would be highly supportive of access to peer support/advocacy, we would also want to encourage access to professional advocacy and legal advocacy (i.e. IMHAs and IMCAs) too.	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and have amended the recommendation to read: *Ensure that all service users in hospital have access to advocates who can regularly feed back to ward professionals any problems experienced by current service users on that ward. Advocates may be formal IMHAs, or former inpatients who have been trained to be advocates for other non-mental health act service*

							users.
485	Care Quality Commission	59.20	NICE	1.7.1	22/23	We suggest a more active statement about involving/negotiating discharge planning with people who use services – rather than people being informed/careful discussion etc.	Thank you for your comment, the recommendation has been amended to ensure discussion with the service user regarding discharge.
493	Care Quality Commission	59.21	NICE	1.7.7.	23	Suggest strengthening this to read 'encourage' rather than 'consider encouraging'	Thank you for your comment. This recommendation has been amended and no longer uses the word encourage.
499	Care Quality Commission	59.22	NICE	1.8.1	24	Suggest rewording to: 'carry out an assessment for possible detention under the Mental Health Act … in a calm and considered way; respond to their needs, treat them with dignity and respect and whenever possible respect their wishes'.	Thank you, we have amended the recommendation in line with your suggestion.
501	Care Quality Commission	59.23	NICE	1.8.3	24	Surely ascertaining if a bed is available would be part of the assessment process?	Thank you for your comment, the guidance is focused on improving the experience of care. We do understand the limited availability of beds will impact on the experience of care but this guidance is not able to make specific recommendations about the availability of beds (increasing this or providing alternatives).
505	Care Quality Commission	59.24	NICE	1.8.6	24/25	It is important that this is amended to reflect that we have a second stage complaints function in relation to people detained under the Mental Health Act (MHA)/be more specific about the focus. We can help if people's complaint is about how somebody used their powers or carried out their duties under the MHA in respect of someone detained in hospital or on a community treatment or guardianship order. However, we would encourage people to contact the service they are using in the first instance and to contact us (CQC) if they are not satisfied with their response, or want further information on how we can help with their complaint.	Thank you for your comment, we have amended the recommendation to address your point: *Tell the service user that if they are dissatisfied with their care and wish to make a complaint while under the Mental Health Act (1983; amended 1995 and 2007) they should, in the first instance direct their complaints to the service within which they have been detained. If they are dissatisfied with the response of the service, inform them they can complain to the Care Quality Commission and how to do this.*
506	Care Quality Commission	59.25	NICE	1.8.7	25	This standard comes too late in the guidance and should be moved to the beginning of section 1.8	Thank you for your comment, we agree and have moved this recommendation to be the first in this section.
278	Care Quality Commission	59.27	NICE	general	general	Although the guideline is very comprehensive, we would perhaps expect to see reference to/a bit more emphasis on: • Involvement in how the service is run • Ensuring an effective transition from hospital to community (including follow up) Also, quality statements/standards in the generic document that would be relevant to mental health settings. For example, there should be an equivalent to the generic guidance quality statement 16 (Patients	Thank you for your suggestions. The NICE version of the guidance has a section on engaging service users in improving care with four recommendations (see section 1.1), and a section on discharge and transfer of care with seven recommendations (see section 1.7). Regarding information provision, please see QS7. Further advice is given in recommendation 1.1.2 (now 1.1.4).

						are provided with evidence-based information [about treatment options] that is understandable, personalised and clearly communicated) in the mental health guideline.	
509	Care Quality Commission	59.56	NICE	1.8.10	25	We would suggest a gentler introduction to this issue.	Thanks you, many of the service users on our GDG have had direct experience of this. It was their wish that this should be made prominent, and the professional members on the GDG agreed.
4	Central & North West London NHS Foundation Trust	23.01	All	General	General	Pulling together the SUE guideline in such a short time is certainly a challenge so the team should be commended for producing this piece of work.	Thank you for your comments.
5	Central & North West London NHS Foundation Trust	23.02	All	General	General	In the scope it says that you will be reviewing qualitative and quantitative studies relating to SUE. However, it seems that the recommendations have been formed primarily using previous NICE reviews (which focus on specific problems) and GDG opinion. Please can you explain why updated searches for qualitative and quantitative studies have not been included?	Thank you for your comment. You are right that we did utilise reviews done for existing NICE guidelines for our review of the key problems associated with the experience of care. We believe this is justified given that eight existing guidelines reviewed qualitative evidence, which in total amounted to 133 qualitative studies or reviews of qualitative studies. This was supplemented by recent qualitative analyses, including one conducted for the SUE guidance, and recent surveys conducted for the Care Quality Commission. For the review of interventions to improve the experience of care, for efficiency we utilised existing reviews, and conducted a search for recent trial evidence in April 2011. Please see Appendix 5 in the full version of the guidance for the review protocols which set out the approach taken.
318	Central & North West London NHS Foundation Trust	23.03	NICE	Draft quality statements	6-7	Statement 21 regarding families and carers might be better placed up with the initial statements which focus on support during care.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience. However, families and carers are included in QS 1 and 2.
319	Central & North West London NHS Foundation Trust	23.04	NICE	Draft quality statements	6	This statement says 'People using mental health services are supported by staff from a single, multidisciplinary team', however we feel that although a single MDT might be appropriate for those with severe and enduring mental health problems, for those with common mental health problems this might not be necessary, practical or cost effective.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
108	Central & North West	23.	Full	2.2.2	15	Lines 31-35: This sentence sounds like a	Thank you for pointing this out, it has been amended in

	London NHS Foundation Trust	05				recommendation and we agree it is an important point. However this point is not reflected in the NICE guideline recommendations.	the text.
113	Central & North West London NHS Foundation Trust	23.06	Full	3.4	20	You have used a matrix for the SUE guideline based on the Picker categories. Please can you explain why you decided this would be a good way of categorising the data and how exactly the matrix was used?	Thank you for your comment. The Picker framework (also used by the Institute of Medicine) was presented to the GDG at the first meeting, and it was agreed that this framework was appropriate. As described in section 3.4 the matrix was primarily used to classify evidence during the data abstraction and synthesis process. We believe the matrix was helpful in ensuring consistency across key points on the pathway of care. We have added a sentence explaining the rationale for choosing the Picker framework. Further information about how the matrix was used can be found in section 3.6.3.
115	Central & North West London NHS Foundation Trust	23.07	Full	3.5	20	Line 28: Here is says 4 main questions but below the table includes 5 questions.	Thank you for pointing this typo out, it has been amended in the text.
226	Central & North West London NHS Foundation Trust	23.08	Full	9.2.3 - 9.3.6	104 107 108	In these sections you have summarised results from the national inpatient survey in the form of percentages. Although these provide some insight into the processes that occur in inpatient settings, it is important to note that these results do not necessarily reflect patient experience in terms of satisfaction with care. For example, even though only 30% of respondents were told about meal times, that does not tell us how many patients wanted to know about meal times and how this would have impacted on their experience of care.	Thank you for your comments. The GDG acknowledge that the survey results are limited, hence the reason for reviewing qualitative evidence about the experience of care.
207	Central & North West London NHS Foundation Trust	23.09	Full	7.5.3.1	91	The research recommendation here is extremely broad; could it be made more specific?	Thank you for your comment, there are now 2 research recommendations that are more specific.
279	Central & North West London NHS Foundation Trust	23.10	NICE	general		The guidance provides a very comprehensive and laudable set of good practices which will undoubtedly lead to better experiences of mental health care for many people. The key to success is getting ALL clinicians to sign up to these and practice them.	Thank you for your comments, we agree implementation is an important issue and the GDG will work closely with NICE to help implement this guidance.
373	Central & North West London NHS Foundation Trust	23.11	NICE	1.1.13	11	I think it is important that mental health staff should identify the support needs of carers and family and the extent to which they are primary providers of support for service users	Thank you for your suggestion. Recommendation 1.1.14 (now 1.1.16) deals with this issue.
513	Central & North West	23.	NIC	3	27	In terms of implementation of the guidance this needs	Thank you for your comment, the NICE implementation

	London NHS Foundation Trust	12	E			to include a more easily digestible version of the guidance and standards. I suggest this could be broken down into a 10-12 step guide identifying the key behaviours which will make the most impact on the service user's experience of services and care. This would help because many practitioners would not take the time to read through the whole document and we need to make it as easy as possible to get the maximum impact	team will devise a number of tools to aid implementation, including a pathway to easily see the recommendations via the internet. We will pass your suggestion to the implementation team. Also, a version for service users and carers called 'Understanding NICE guidance' will be published with the guidance.
56	College of Mental Health Pharmacy	6.01	Full	General	General	We welcome this new guideline from NICE and offer our support in ensuring service users have safe and appropriate medication which they have chosen.	Thank you for your comments.
57	College of Mental Health Pharmacy	6.01	Full	General	General	We are disappointed there was no specialist mental health pharmacist on the GDG.	Thank you for your comment, vacancies for GDG positions are posted on the NICE website. They may also appear on the website of the NCC and/or the Royal College or professional body that hosts the NCC, and in other appropriate places identified by the NCC. Furthermore, NICE informs registered stakeholder organisations about the advertisement. Finally, the consultation period provides further opportunity for relevant experts to review the evidence and provide feedback on the guidance.
271	College of Mental Health Pharmacy	6.02	Full / NICE	General	General	Can we ensure that medication and its management are highlighted in all care pathways. We have developed pharmaceutical care models for care delivery which are found at: http://www.rpharms.com/public-health-issues/mental-health.asp	Thank you for your comment, this guidance is about experience of care, and not about pharmacy. Nevertheless we did think it was important for pharmacy to be available for people in inpatient settings and so have added it to recommendation 1.6.6, so as to improve the experience of care with regards to the medication advice.
106	College of Mental Health Pharmacy	6.03	Full	2.2.1	15	[line 5] This should be the English and Welsh Mental Health Act	Thank you for pointing this out, it has been amended in the text.
178	College of Mental Health Pharmacy	6.04	Full	6.5.1.3	65	[line 6] "outline different treatment options" One concern from our group is the lack of reliable, unbiased, patient centred information on medication. We recommend the web resource www.choiceandmedication.org.uk to all health professionals, patients and carers who are seeking sensible, readable advice on medication. The resource also has comparative tables where patients can easily view differences in the medication choices. This is invaluable to help engage patients in the choice of their medication.	Thank you for this suggestion. We don't think it would be appropriate to recommend one particular web resource without reviewing everything that is currently available, and this is somewhat outside the scope of this work. For further guidance on this topic, please see NICE guidance *'Medicines Adherence, CG76'.*
190	College of Mental Health Pharmacy	6.05	Full	7.2.2	73	See previous comment	Thank you for this suggestion. We don't think it would be appropriate to recommend one particular web resource without reviewing everything that is currently

							available, and this is somewhat outside the scope of this work.
192	College of Mental Health Pharmacy	6.06	Full	7.2.5	78	“side effects often outweighed the positive aspects of medication” Are there case reports from those who have had a positive experience with medication we can include to give a balanced view.	Thank you for your comment. In this section were trying to find the main themes relating to poor experience of care. We were not examining generally whether people taking medication (or any other treatment) have a positive or negative experience.
232	College of Mental Health Pharmacy	6.07	Full	9.3	111	“Access to pharmacy staff” Suggest we change this to regular access to mental health specialist pharmacy staff who can advise on side effects and medication choices.	Thank you for your comment, this has been amended and added to recommendation 1.6.6.
237	College of Mental Health Pharmacy	6.08	Full	9.5.1.6	114	Suggest we add: “Offer service users in hospital” - an opportunity to meet with a specialist mental health pharmacist to discuss medication choices and the risks and benefits associated.	Thank you for your suggestion, this has been added to the recommendation.
452	College of Mental Health Pharmacy	6.09	NICE	1.6.1	21	Suggest we add: “Offer service users in hospital” - an opportunity to meet with a specialist mental health pharmacist to discuss medication choices and the risks and benefits associated.	Thank you for your suggestion, this has been added to recommendation 1.6.6.
525	College of Occupational Therapists	3.01	QS	General	General	The College of Occupational Therapists (COT) welcomes all of the quality statements as demonstrating clear concepts, definitions and descriptions. COT is focusing its comments on the quality standards that relate to our area of expertise in promoting the importance occupational functioning, meaningful activity and the links with social inclusion.	Thank you for your comments.
766	College of Occupational Therapists	3.02	QS	9	15	COT welcomes the emphasis on the importance of including details of activities to promote social inclusion and the clear link with occupational performance. The QS could be enhanced by specifying that the care plan should include the support to be provided to enable the service user to reach and maintain their chosen level of occupational functioning in the specified occupations.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
418	College of Occupational Therapists	3.03	NICE	1.4.2	16	This is a clear statement that could be clarified to include the support offered. See comment on QS9.	Thank you for your comment, recommendation has been amended to better reflect your comments: *Develop care plans jointly with the service user, and:* • *include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants* • *provide support to help the service user realise the*

							plan • *give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it.*
795	College of Occupational Therapists	3.04	QS	10	17	COT comment is that the practical examples of the needs of service users in crisis planning should include planning to safeguard existing employment, volunteering, housing and other social inclusion activities.	Thank you for your comment, the needs of a service user will vary for each individual and the examples given are indicative only – they are not an exhaustive list.
443	College of Occupational Therapists	3.05	NICE	1.5.8	19	COT comment is this is clear in the NICE guidance but is not explicit in QS 10 – See above comment on QS10.	Thank you for your comment, the practical needs of a service user will vary for each individual and therefore the GDG feel it is more inclusive to leave it as 'practical needs' rather than specify what these may be.
920	College of Occupational Therapists	3.06	QS	17	27	COT considers this QS to be very clear and an essential guideline. Access to meaningful activities while on a mental health ward is of great importance to service users. The quality standard should include a reference to activities being facilitated by an appropriately trained professional. See NICE Guidance 1.6.9.	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
468	College of Occupational Therapists	3.07	NICE	1.6.9	22	COT welcomes the guidance that access to occupations and activities while in hospital should be everyday, throughout the day and facilitated by appropriately trained professionals. Occupational Therapists are specifically qualified and trained in the therapeutic use of activity to enhance occupational engagement and functioning, and recognition of this within 1.6.9 would ensure quality.	Thank you for this suggestion. The GDG believe that specifying 'appropriately trained health or social care professionals' would ensure quality.
518	College of Occupational Therapists	3.08	NICE	4.4	30	COT agrees research in this area will be beneficial to service users and services.	Thank you for your support.
981	College of Occupational Therapists	3.09	QS	21	32	Links with family and carers can be important to service users in maintaining social inclusion. This QS is clear that service users should be asked if and how they would like them to be involved in their care. COT's comment is this QS should include regularly revisiting any decision to exclude family and carers as the service users condition changes, supporting re-involvement when the service user wishes it.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
5	Critical Psychiatry Network	54.00	All	General	General	Personally I think this is a very important document. I have only read through it quickly and quite superficially. I can share some of David's concerns about its recommendations still coming across as service-led but I can also share Mike's view that it will "help to support continuing efforts in this direction". We	Thank you for your comments.

						have to remember, as I am sure Mike knows only too well, the formal policy context in which this guidance will have been produced. In particular I imagine these were concordance with agreed DH commitments to improving "patient experience" and a commitment to basing recommendations upon accepted "evidence". This cannot have been a licence or even encouragement to wax lyrical about the importance of the relational aspects of what mental health services do, but to a large extent you seem to have achieved it!	
6	Critical Psychiatry Network	54.01	All	General	General	In particular; * An emphasis on qualitative evidence which immediately draws attention to the interpersonal dimension, and therefore relationship rather than just "patient experience". * The added value of drawing in relevant evidence from other mental health guidelines. This illustrates the ubiquity of the importance of relational factors across diagnostic domains. * Repeated reference to the positive value of good relationship in the several service contexts the guideline considers.	Thank you for your comment, we agree that relationships are very important in influencing the experience of care and have made recommendations about the relationship between service user and professional (see recommendations 1.1.1 and 1.1.2). Also, the guidance makes recommendations for professionals to take into account the service users' relationships with families and carers (which includes significant others), see recommendations 1.1.12-16 (now 1.1.14-18)
7	Critical Psychiatry Network	54.02	All	General	General	Obviously many might feel that the guideline doesn't go far enough to satisfy more ideological perspectives, but if the evidence it draws on were to be fully acknowledged and acted upon, mainstream NHS mental health service provision would have to move in what I understand to be a direction CPN would endorse.	Thank you for your comments.
8	Critical Psychiatry Network	54.03	All	General	General	What we will discover in due course is whether or not such guidelines are capable of influencing practice in the face of other forces such as, in this case, as David remarks, the parallel and not always compatible expectation upon us to contribute to social order. Two sets of depression guidelines have so far had little or no effect upon the steadily rising rate of antidepressant prescribing!	Thank you, the GDG are very keen for this guidance to impact on services and a number of implementation tools will be developed to aid this.
9	Critical Psychiatry Network	54.04	All	General	General	From my brief reading of the shorter NICE document on patient experience there was only one member of the guideline committee that was a declared service user and acting in that capacity. My reading of the document is that it reflects a service view of what a service user would want. There are some very positive statements and standards, but there is still a sense that the service comes first.	Thank you, half the members of the GDG for this guidance were service users and their views and experiences were pivotal in the development of the guidance and quality statements.

						Having said that, the draft quality statements would be helpful to services determined to develop recovery focused practice and person centred practice.	
10	Critical Psychiatry Network	54.05	All	General	General	The emphasis on shared decision making does not really put the person using the service in the driving seat; involved, yes; but steering, no.	Thank you, recommendation 1.1.2 outlines that healthcare professionals should foster the service users' autonomy and self-management.
11	Critical Psychiatry Network	54.06	All	General	General	More could be done to encourage people who use services to set their own goals that the services then try to engage with. The third quality statement mentions self management.	Thank you, recommendation 1.1.2 outlines that healthcare professionals should foster the service users' autonomy and self-management.
12	Critical Psychiatry Network	54.07	All	General	General	In the 7th draft quality statement, there is an assumption that diagnosis is needed, so a service user can be informed of it. There is no mention of other types of formulation, or a service user focused formulation. This standard is therefore less person centred than it could be. It also suggests a strong medical model has steered the guideline development.	Thank you for your comments, the inclusion of diagnosis was at the behest of service users in the GDG who were keen that this should be discussed and have adequate information and explanation for this. We do not think a strong medical model has steered the GDG, more than 50% of the panel were not professionals and only 2 psychiatrists were involved.
13	Critical Psychiatry Network	54.08	All	General	General	There is little mention of what services should stop doing in order to improve service user experience. As a result this guidance may be seen as yet another thing to do. For people using services there is a potential for their experience to become another list of boxes to be ticked off by services, rather than a driver for service improvement. For example, there was little said about risk assessment or personal safety planning. Risk assessment takes up an large amount of time. In my experience, NHS mental health services are obsessed with risk assessment and can find it difficult to share risk and responsibilities with service users and their families.	Thank you for your comment, guidelines are usually focused on people's professional behaviour and activity and how this can be changed to improve the lot of those who use their service. However, where possible we have emphasised that services should not pass service users from one team to another, for example 1.2.4. With regard to risk assessment, the forthcoming 'Long term management of self-harm' guideline does highlight the problems you have identified with risk assessments in the NHS. This will be published in November 2011.
14	Critical Psychiatry Network	54.09	All	General	General	The comment about having a single team and reducing handovers is welcome, though many mental health services are now structured around functional models that increase handovers and discontinuity.	Thank you for your comments.
15	Critical Psychiatry Network	54.10	All	General	General	I think it is important to have guidance on collecting service user experience. In my own Trust we are collecting this formally in an anonymised way given a concern that service users giving negative feedback could worry about negative repercussions from staff. I can see the value in this approach but it concerns me if we don't explore the notion further. We should be aiming to convey to service users that we value their feedback, negative or not. If service users believe they will suffer if they give us negative feedback directly ,	Thank you for your comment. This is comprehensively dealt with in recommendations 1.1.17-1.1.21 (now 1.1.18 and 1.1.22) and we have added a new recommendation (1.3.9) about making complaints.

						that means our engagement is limited and might be improved.	
360	Department for Work and Pensions	12.01	NICE	1.1.8	10	Trust boards should also engage with local employer organisations, Work Programme providers and Jobcentre Plus.	Thank you for your comments, we have included work programme providers but feel adding jobcentre plus would be over prescriptive.
488	Department for Work and Pensions	12.02	NICE	1.7.3 & 1.7.4	23	Prior to discharge and where applicable, mental health teams should also inform the employer / college with the service user's agreement. Work and / or study situations should be assessed before discharge – having meaningful contact with the employer / college will help mental health teams to do this.	Thank you for your comment, the service user members of the guidance development group felt very strongly that it should be up to SUs whether they tell their employer/college about their mental health problems.
767	Department for Work and Pensions	12.03	QS	9	15	How will the quality and appropriateness of care plans be evaluated? The current measure sounds more like a measure of quantity than quality – simply handing a plan to the service user doesn't address issues of efficacy of that plan. Although these quality measures may have to be high-level process measures, they could still be included – perhaps in 1.4.2 of the main guidance?	Thank you for your comment. It is hoped that the outcome measure would give information on the quality of the plans.
16	Department of Health (PPEE)	44.00	All	General	General	This is strong on discharge planning, range of needs being assessed, families being informed, notice being given etc. Which is just as important for the generic standard and therefore not clear why this has been omitted.	Thank you for your comment. The patient and service user experience guidance and quality standards have been developed following the same overarching NICE process. The content of the guidance and quality standard is based on the priorities that the Guidance Development Groups felt would have the greatest improvement for patient and service user experience and the most impact on services according to the evidence available and GDG consensus.
17	Department of Health (PPEE)	44.01	All	General	Generall	The Mental Health QS uses the 8 Picker Institute themes as a framework, however the generic standard does not. There are concerns over potential confusion to the NHS cover these two very different approaches.	Thank you for your comment. The patient and service user experience guidance and quality standards have been developed following the same overarching NICE process. The content of the guidance and quality standard is based on the priorities that the Guidance Development Groups felt would have the greatest improvement for patient and service user experience and the most impact on services according to the evidence available and GDG consensus.
722	Department of Health (PPEE)	44.02	QS	Statement 7	13	The different stages of treatment may benefit from a reference to the appropriate quality statement - this could improve uptake by clinicians.	Thank you for your comment. This comment will be shared with the implementation directorate.
18	Department of Health (HG)	44.03	All	General	General	Overall we think there is much in both these drafts which is to be welcomed. However, possibly because of the new methodology used to develop them, there are, we think, some significant problems. Firstly, they	Thank you for your comments. The remit from the DH was "To produce a Quality Standard and guidance on patient experience in adult mental health" Therefore, there was no option to produce a scope covering

						are both only for working age adults (which in itself is disappointing) but there seems to be a uniform model of service throughout based on people with relatively long-term care needs provided through the Care Programme Approach (the CPA), the guidance for which we changed several years ago to make it clear that the CPA is not appropriate for everyone in contact with specialist MH services. Although this isn't overtly stated, it's implicit in the guidance and standards.	children and young people. The guidelines were not specifically developed for people with long-term mental health needs – aside from those which relate to inpatient and compulsory treatment for whom many would be treated under CPA.
19	Department of Health (HG)	44.05	All	General	General	We are sorry that this is such a long response but we really think both the guideline and the standard are of crucial importance and hence we think it's imperative to get them right. For whatever reason(s), in their existing form they fall short of the mark - but with some appropriate changes, we think they could be immensely helpful.	Thank you for your comments.
58	Department of Health (GREFD)	44.06	Full	General	General	The document utilises the Picker Institute Europe eight dimensions of patient centred care. Although the focus on 'Attention to physical and environmental needs' is welcome, it is deficient in addressing '*Hospital surroundings and environment kept in focus,'* as advocated by the Picker Institute in their eight dimensions of patient centred care. We recommend that there are two areas where this could be improved: a) We do not believe the 'attention to physical and environmental needs' is considered in sufficient detail and should be broadened in scope. b) Where it is considered, the points raised are not taken forward into the recommendations and subsequently the Quality Standard.	Thank you for your comments, and for bringing this to our attention. As subsequently agreed, specific recommendations about the physical environment are outside the scope of what was possible in the time frame. However, we agree that the introduction should cover this issue and it should be made clear that we are not providing guidance about interventions that change the physical environment.
651	Department of Health (HG)	44.07	NICE	QS4	6	It says services should be provided through a single multidisciplinary team (MDT). Well a range of specialist services and teams may be required and this seems to be directly opposed to collaborative or shared care. There is an issue about making sure care is properly integrated and joined up, but specifying this does not provide the right solution.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
759	Department of Health (HG)	44.08	NICE	QS9	6	It says "People using mental health services are given a written copy of a care plan that includes details of activities to promote social inclusion such as education, employment, volunteering and other specified occupations such as leisure activities and	Thank you for your comments. The GDG believe that all people using mental health services should be able to jointly develop a care plan to improve the experience of care.

						caring for dependants." Having such a comprehensive care plan is appropriate for most people, especially if they're on the CPA, but not for everyone. So it should be followed by the words "where appropriate" or "if on the CPA".	
806	Department of Health (HG)	44.09	NICE	QS11	6	It says "People in crisis have an assessment undertaken by a competent professional that includes their relationships, their social and living circumstances and level of functioning, their symptoms, behaviour, diagnosis and current treatment." Well ideally, yes, but it simply isn't always possible in the middle of a crisis to get such comprehensive information. So it should say, in my view, something like "comprehensive assessment should be undertaken wherever possible. If not, full aspects of the assessment should be undertaken as soon as possible after the crisis has been dealt with".	Thank you for your comment. The GDG is highlighting that all people accessing crisis services should have a comprehensive assessment.
837	Department of Health (HG)	44.10	NICE	QS13	6	It is not specified what "formally assessed" means.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
887	Department of Health (HG)	44.11	NICE	QS16	7	It says "People in hospital for mental health treatment and care see, on a one-to-one basis, their named healthcare professional every day for at least 1 hour and their consultant at least once a week for at least 20 minutes." I think the aim is appropriate but as stated, it doesn't make sense. It is simply not possible to see the same person every day for 7 days a week and it should specify what it really means (named key worker, co-worker etc). And for consultant it should say "consultant psychiatrist or Responsible Clinician (RC)" because under the changes to the Mental Health Act (MHA) in 2007, a person detained under the MHA can have an RC who isn't necessarily a doctor.	Thank you for your comment. The statement has been amended to “known” professional.
961	Department of Health (HG)	44.12	NICE	QS20	7	It says that people should have the reasons for any episode of restraint explained "immediately" afterwards. Well again, this may simply not be possible, especially if emergency sedation is used, so it should say, in my view, "as soon as possible afterwards".	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
361	Department of Health (HG)	44.13	NICE	1.1.8	10	Why are Trust Boards singled out? Given the increasing plurality of provision, surely it should refer to	Thank you for your comment, this has been amended in the guidance to ‘*health and social care provider*’.

						all provider organisations?	
98	Department of Health (GREFD)	44.14	Full	1.1.5	11	PCTs, some already in clusters, will not exist post 2013.	Thank you for pointing this out, this has been amended in the document.
386	Department of Health (HG)	44.15	NICE	1.1.16	12	I'm not sure but is the intention to specify that childcare and supported family accommodation should be provided by all MH service providers for all services? If so, though it might be a good aim, it doesn't seem realistic and if not, how would providers go about ensuring access?	Thank you for your comment, on reflection the GDG agree this may not be feasible and have removed this from the recommendation.
394	Department of Health (HG)	44.16	NICE	1.1.19	13	Again, the reference is to Trusts rather than all providers.	Thank you for your comment, this has been amended in the guidance to *'health and social care provider'.*
102	Department of Health (GREFD)	44.17	Full	2.1/2.2/2.3	14-15	[Introduction]There is no reference to the physical environment. We suggest this is an omission as reasons why user experience is important, should include, the environment for care as required in the NHS Constitution. In addressing "Quality of care and environment", the NHS Constitution has a related pledge that "The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice"	Thank you for your comment, please see our response to your previous comment about the environment.
414	Department of Health (HG)	44.18	NICE	1.3.8	16	I think it should specify what a "formal community care assessment" is.	Thank you for your comment, we have changed the recommendation to read: *Inform service users of their right to a formal community care assessment (delivered through local authority social services[1]), and how to access this.* *[1]http://www.nhs.uk/carersdirect/guide/assessments/pages/communitycareassessments.aspx*
426	Department of Health (HG)	44.19	NICE	1.4.7	17	Again, there is reference to a single MDT. And while service users should not be passed from on team to another with any frequency, sometimes it is essential for specific reasons. No single team can guarantee to do everything. Also, the reference is to Trusts again.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore this has been amended to read: *Health and social care providers should ensure that service users:* • *can routinely receive care and treatment from a single multidisciplinary community team* • *are not passed from one team to another unnecessarily* • *do not undergo multiple assessments.* Thank you for highlighting this, all reference to trusts will be amended to 'health and social care providers'.

439	Department of Health (HG)	44.20	NICE	1.5.6	19	It states “Trusts should ensure that service users have access to 24-hour helplines, staffed by trained health and social care professionals, and that all GPs in the area know the telephone number." The reference is, again, to Trusts and there are many, very good helpline services run by the voluntary sector (ref the Mental Health Helplines Partnership). There should certainly be crisis lines run by services but they are different from most helplines and maybe this should be clarified.	Thank you for highlighting this, all reference to trusts will be amended to ‘health and social care providers’. The GDG felt the recommendation is clear.
440	Department of Health (HG)	44.21	NICE	1.5.7	19	There should, of course, be crisis resolution and home treatment services but there are some crises which are and should be assessed by others, for example MH Liaison Teams working into acute hospitals (some of which operate 24 hours a day).	Thank you for your comment, although we agree that crises can be dealt with by other teams, this recommendation simply supports DH policy and prior nice guidelines, that crisis teams should be available at all times; it does not preclude other teams being involved and to say this would probably complicate matters and possibly give the impression that crisis teams could be replaced by other teams.
119	Department of Health (GREFD)	44.22	Full	3.6.2	21-22	The systematic review of literature appears to have excluded clinical settings / environment.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
472	Department of Health (HG)	44.23	NICE	1.6.10	22	Access to the internet is a key issue in secure services and this needs to be reflected in such a broad statement.	Thank you for commenting, but as set out in the scope, this guidance covers community and inpatient settings, not secure services.
475	Department of Health (HG)	44.24	NICE	1.6.11	22	I'm not clear why being trained "as a group" needs to be specified, especially as some MH professionals work into different teams.	Thank you for your comment, there are 2 reasons by group based training would be preferable to individual. Firstly, where a group of staff are working collaboratively and as part of an integrated team, training as a group would be essential to ensure person-centred care is delivered in the same way by the whole team. Secondly group based training is likely to be less expensive than individual training. We have changed the 'group' to 'team' to highlight this is the indivisible unit for the delivery of mental health care in a hospital setting.
479	Department of Health (HG)	44.25	NICE	1.6.13	22	I think it should specify any differences between the advocacy described here, and formal advocacy under the MHA.	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and have amended the recommendation to read: *Ensure that all service users in hospital have access to advocates who can regularly feed back to ward professionals any problems experienced by current service users on that ward. Advocates may be formal IMHAs, or former inpatients who have been trained to*

							be advocates for other non-mental health act service users.
150	Department of Health (GREFD)	44.26	Full	5.3/5.5	51 54	Attention to physical and environmental needs is identified as a key requirement in 5.3 but excluded from the recommendations at 5.5.	Thank you for your comment, please see our response to your previous comment about the environment.
171	Department of Health (GREFD)	44.27	Full	6	57 -66	6.1 'a safe and suitable location' is identified as a key requirement; 6.2 no evidence is identified for environmental needs 6.3 attention to physical needs is identified as a key requirement 6.5.1.7 & 6.5.2.1 refer to waiting rooms and settings for discussions More generally environmental needs should be carried forward in recommendations.	Thank you for your comment, please see our response to your previous comment about the environment.
195	Department of Health (GREFD)	44.28	Full	7	80	7.2.7 survey results suggest that physical and environmental needs are poorly catered for. 7.4 surveys identify poor waiting facilities often lacking privacy Recommend that the above should be considered for inclusion in the recommendations.	Thank you for your comment, please see our response to your previous comment about the environment.
208	Department of Health (GREFD)	44.29	Full	8	92 -97	8.2 no evidence is identified addressing physical and environment needs 8.3 identifies physical and environment needs as a key requirement 8.4 no significant recommendations are made relating to the above, other than the location should take account of user preference.	Thank you for your comment, please see our response to your previous comment about the environment.
225	Department of Health (GREFD)	44.30	Full	9	101 -117	9.1 reference to 'untherapeutic and unsafe' care and wards 9.2 attention to physical and environmental needs is identified as a key problem 9.2.5 many service users were shocked by the physical environment on the wards 9.2.6 inpatient environment not appropriate for young children 9.3 identifies physical and environment needs as a key requirement Recommend that the above should be considered for inclusion in the recommendations.	Thank you for your comment, please see our response to your previous comment about the environment.
251	Department of Health (GREFD)	44.31	Full	10	119	10.2 attention to physical and environmental needs is not identified as a key problem but could be a consideration in decisions about transfer to alternative accommodation.	Thank you for your comment, please see our response to your previous comment about the environment.
260	Department of Health	44.	Full	11	132	11.2 attention to physical and environmental needs is	Thank you for your comment, please see our response

	(GREFD)	32			-143	identified as a key problem 11.2.3 loss of privacy & dignity is also an environmental issue 11.2.5 & 2.5.7 evidence suggest that people find 'hospital frightening' , 'disorientating and distressing' Recommend that the above should be considered for inclusion in the recommendations.	to your previous comment about the environment.
267	Department of Health (GREFD)	44.33	Full	12.4	173	Note GDG agreed that further research should be conducted in mental health settings. Recommend that GDG examine further the evidence available, and identify any gaps, on the role of the physical setting in Mental Health care	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
270	Department of Health (GREFD)	44.34	Full	13	175	Recommend include reference to DH Health Building Note suite of documents for Mental Health on Space for Health.	Thank you for your comment, please see our response to your previous comment about the environment.
38	Department of Health (GREFD)	44.35	Appendices 14	General	General	The 'full' mental health document contained the following recommendation on page 173 paragraph 12.4 that has not been taken forward into the areas of priority research identified in appendix 14. *'The GDG discussed the lack of research conducted in mental health settings, and 14 agreed that further research should be a priority in this area.'* We support the view in the 'full' document that research into mental health settings should be a priority.	Thank you for your comments. Two of the research recommendations have been prioritised and are amongst the 5 key research recommendations.
526	Department of Health (GREFD)	44.36	QS	General	General	The Quality Standard and the Quality Statements do not adequately address the contribution that the physical environments for care makes to patient experience. This is a major omission. To fill this gap, we recommend a separate quality statement be developed, along with a full review of how the care environment can be integrated into the remaining statements.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
570	Department of Health (GREFD)	44.37	QS	General	1	The mental health guidance identifies "attention to physical and environmental needs" as a domain in the provision in patient centred care. This is welcome, but has not been developed into the draft quality standard needed to improve the experience for users of adult mental health services.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
571	Department of Health (GREFD)	44.38	QS	Scope & Evidence	1	The scope includes the physical environment and the reference to Pickers "attention to physical and environmental needs" is welcomed. However, this is not represented in the quality statements and we	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

				Sources		recommend that this should be reconsidered.	
572	Department of Health (GREFD)	44.39	QS	Evidence Sources	1	The evidence sources do not fully include the well established body of evidence demonstrating the importance of good environment on positive mental health outcomes (see Appendix 1 page 34 comments)	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
573	Department of Health (GREFD)	44.40	QS	Overview of Statement	1	Although the attention to physical and environmental needs is recognised as a key requirement for the provision for high quality service user experience this is not reflected in either the recommendations or the quality statements.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
574	Department of Health (GREFD)	44.41	QS	Quality Measures	1	The document does not refer to quality measures relating to the environment although they do exist, e.g. survey information on privacy and dignity and gender separation	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
576	Department of Health (GREFD)	44.42	QS	Diversity, Equality & Language	2	This section is not just about good communications it is also about providing the right physical environment – this is not adequately addressed in the resulting quality statements. The needs of disabled and vulnerable people across the sector are also materially affected by the environment eg access, accessible WCs, induction loops etc, and the ability to cope with normal daily living activities as acknowledged by the Picker Institute. We note there is no equality impact assessment included in the document.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
577	Department of Health (GREFD)	44.43	QS	Consulta ti-on & Feedback	2	We note the intention of the guidance development group to “further refine” the statements and measures. However, we believe a much more fundamental review is required due to the omission of the physical and environmental needs in the quality statements.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
578	Department of Health (GREFD)	44.44	QS	Explanatory note on relevant existing	2	We note indicators are needed and would remind you that there are indicators for the physical environmental, such as National Patient Safety Agency PEAT (Patient Environment Action Team) and patient surveys	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

				indicators			
566	Department of Health (GREFD)	44.45	QS	General	3-4	Physical and environmental needs is not considered in any of the 22 quality statements. It should be. In addition, we consider it is essential that a stand alone statement covering all aspects of physical and environmental needs is required.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
613	Department of Health (HG)	44.46	QS	QS2	3	It says "People using mental health services are supported by mental health and social care professionals who have received cultural awareness training from a programme that has input from local voluntary organisations who work with the black and minority ethnic communities." The aim is right but I'm not at all clear why it should have to be provided only by the local voluntary sector.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
655	Department of Health (HG)	44.47	QS	QS4	3	There is the same issue of specifying a single MDT as outlined above.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
735	Department of Health (HG)	44.48	QS	QS8	3	It says "People working in mental health services are trained in person-centred care and/or customer care by service users." The training should certainly involve service users but does it have to be provided wholly by them as implied here?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
761	Department of Health (HG)	44.49	QS	QS9	3	It says "People using mental health services are given a written copy of a care plan that includes details of activities to promote social inclusion such as education, employment, volunteering and other specified occupations, such as leisure activities and caring for dependants." This is absolutely appropriate for people on the CPA - but not necessarily if they're not. So it should, in my view, specify that it's for people on the CPA.	Thank you for your comments. The GDG believe that all people using mental health services should be able to jointly develop a care plan to improve the experience of care.
840	Department of Health (HG)	44.50	QS	QS13	4	As with the draft guideline, I think it should specify what "formally assessed" means.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
893	Department of Health	44.51	QS	QS16	4	As with the draft guideline, it needs to specify what this means as it isn't possible to see the same person 7	Thank you for your comment. The statement has been amended to "known" professional.

	(HG)					days a week.	
963	Department of Health (HG)	44.52	QS	QS20	4	As with the draft guideline, "immediately" should be changed to "as soon as possible".	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
616	Department of Health (HG)	44.53	QS	2	6	Point c): It states "Proportion of staff supporting people using mental health services who are trained in cultural awareness by a programme with input from local voluntary organisations who work with the black and minority ethnic community." Obviously there's the issue about the local voluntary sector mentioned before, but how often should such training take place to meet this standard?	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
659	Department of Health (HG)	44.54	QS	QS 4	9	As previously mentioned, this indicator potentially disrupts collaborative and shared care. The aim, I think, is to ensure consistency and integrated care but this is not, in my view, the way to achieve it.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
700	Department of Health (HG)	44.55	QS	QS6	11	I don't see how this data could be collected routinely without adding very significantly to the existing bureaucratic burden. Perhaps it could be collected as individual, periodic audits.	Thank you for your comment. Quality statements do not prescribe the time period or frequency of monitoring. That is a decision for local services.
740	Department of Health (HG)	44.56	QS	QS 8	14	As stated above, I think the training obviously needs to involve service users centrally, but not necessarily exclusively and I think this should be made clear.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as
768	Department of Health (HG)	44.57	QS	QS 9	15	As a standard, it should be made clear that this should apply to people who are on the CPA.	Thank you for your comments. The GDG believe that all people using mental health services should receive a care plan.
796	Department of Health (HG)	44.58	QS	QS 10	17	The denominator proposed here is the number of people using mental health services at risk of hospitalisation. I really don't know how that could be recorded accurately and reliably.	Thank you for your comment. The GDG recognise the challenges in measuring this statement however, felt it of significant importance to include in the final quality standard.
812	Department of Health (HG)	44.59	QS	QS 11	19	As stated in relation to the guideline, comprehensive assessment as described isn't always possible (or appropriate) in the middle of a crisis. However, where is is possible, it should be done, and if not, as soon as possible afterwards. So the standard could be around the number of people "who have experienced" rather than "who are in" crisis.	Thank you for your comment. The measure has been amended.
897	Department of Health (HG)	44.60	QS	QS 16	25-26	Again, the issue of seeing the same person every day.	Thank you for your comment. The statement has been amended to "known" professional.

1003	Department of Health (GREFD)	44.61	QS	Appendix 1 Policy Context	34	We welcome the evidence sources include reference the NHS Constitution and the 2009 Health Care Bill because of their reference to physical and environmental needs. We suggest another evidence source such as the Mental Health strategy would be helpful.	Thank you for your comment. We have added this.
1004	Department of Health (GREFD)	44.62	QS	Appendix 1 Key Development Sources	34	We note that there are two development sources and would suggest with reference to physical environmental matters reference could be made to Laying the foundations for better acute mental health (Care services improvement partnership/Department of Health, 2008), and the forthcoming revision to the Department's Health Building Note for acute mental health facilities.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
1005	Department of Health (GREFD)	44.63	QS	Appendix 1 National Data Sources	35	Consideration could be given to other data sources such as PEAT.	Thank you for your comment. Physical environment is outside the scope of this guidance and quality standard
733	Dudley PCT	33.01	NICE	QS8	6	Quality statement 8 – *"People working in mental health services are trained in person-centred care and/or customer care by service users"* One of our lead GP's feels that from experience it can be difficult to engage and sustain service users who have an interest and capability for doing this, we would welcome further clarification on this.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
889	Dudley PCT	33.02	NICE	QS16	7	Quality statement 16 – *"People in hospital for mental health treatment and care see, on a one-to-one basis, their named healthcare professional every day for at least 1 hour and their consultant at least once a week for at least 20 mins"* The PCT would welcome clarification on whether to fulfil this standard the same named healthcare professional would be expected to work 7 days a week in order to fulfil the criteria	Thank you for your comment. The statement has been amended to "known" professional.
932	Dudley PCT	33.03	NICE	QS18	7	Quality statement 18 – *"people in hospital for mental health treatment and care are involved in their discharge planning and have at least 2 days notice of their discharge date"* what if the patient isn't in that long? – clarification needed	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest

							improvement in service user experience.
20	Gender Identity Research & Education Society	63.00	All	General	General	Not sure, but it is extremely difficult to assess results when the original triggers of mental illness or apparent mental illness are not discussed in the outcomes, or if they are in the original studies, they are not reflected in the document we are asked to review. Of course, our area is highly specific, and is also associated with a high degree of mental stress in children and young people, secondary to the experience of gender variance in childhood, which may or may not result in transsexualism in the adolescent or adult. Depression, low self-esteem, self harm, attempted and actual suicides are all features of the young lives of trans people. Trans people may be 'diagnosed' with depression, bi-polar disorder, and a variety of other mental disorders, which significantly diminish or even disappear when their gender dysphoria is acknowledged, respected and, ultimately, treated.	Thank you for your comment. The GDG discussed during development meetings that there are many specific issues relevant to groups of people in society, although it would not be possible to make specific recommendations to address all these issues. However, recommendations were made to avoid stigma and promote social inclusion. Given your comment, the recommendation 1.1.6 (now 1.1.7) has been amended to include wider, more diverse groups.
21	Gender Identity Research & Education Society	63.01	All	General	General	That's the problem. I don't know if there are areas excluded. They are not mentioned in the document, but may have been considered in the original studies. I can't tell whether consideration was given to the effect of CBT (which can lead to repression of gender variance, i.e., 'reparative therapy'. CBT will not be effective unless the child's gender identity is recognised, and is respected); or group therapy (which would be intimidating for any LGBT young person unless the group was LGBT); family therapy (useless unless it is helping an unwilling family to accept the reality of their child's gender identity); relaxation (only helpful if it is in the context of respecting an identity which might not even be disclosed by a young person), CAMHS may or may not be useful input as many are still ignorant of gender variance in children, so they increase stress for the young person, by enhancing the opposition to the social expression of the innate gender identity in the family and at school; SSRIs given to gender variant youngsters may be completely inappropriate as they may be aimed at the symptoms rather than the cause of the depression. The latter also lower libido. Could that be depressing to an adolescent?	Thank you for your comment. The remit from the Department of Health was "To produce a Quality Standard and guidance on patient experience in adult mental health", therefore we have not covered children and young people. In addition, we did not review the effect of therapy, but rather interventions designed to improve the experience of care.
22	Gender Identity Research &	63.02	All	General	General	Gender reassignment is a protected characteristic under the Equality Act 2010. This is relevant, not only	Thank you for your comment. As explained above, this guidance and quality standard is for adults. However,

	Education Society					in protecting trans adults, but also adolescents and children from discrimination, both direct and indirect, in their access to treatment, the kind of treatment that they are offered, and the way in which it is delivered. Without express inclusion in studies, by default, matters that affect gender variant youngsters may not be taken into account. This may have a disproportionately negative effect on these young people because they simply become invisible in studies such as those that address mental health treatments. An example of the potentially negative impact caused by lack of stakeholder inclusion in the development of treatment protocols, is the failure of the only treatment centre for adolescents – the Tavistock and Portman Gender Identity Development Service – to provide hormone blockers (Gonadotrophin Releasing Hormone analogue) to suspend puberty. This has led to a great deal of self harm and serious suicide attempts over the last few years. Several have had to go to the United States for treatment. Recently, the UK clinicians agreed to follow international best-practice and provide hormone blockers under a research protocol, but the first Ethics committee refused permission, and the second has not yet decided. The information provided to these committees did not include any direct evidence from stakeholders. It appears that no equality impact assessment was done to ensure that both the committee procedures and the Tavistock research protocol adhered to equality law. The clinicians who represent the Tavistock were warned, before the second Ethics committee meeting, that stakeholders should be involved, and invited to give evidence if they wished, and that failure to involve them may breach equality law. As a footnote, the same considerations apply to some extent to matters of sexual orientation in young people. We know that many LGBT youngsters have low self-esteem, suffer depression, bullying at school etc. and as a result indulge in risky and damaging behaviours. We have no way of telling, from the document about which NICE seeks comments, whether anything will emerge from this exercise that would be beneficial to young trans people.	we agree that the issues you raise for young people are important. We suggest you submit this as a topic to NICE for future guidance.

695	Hafal	16.01	NICE	QS6	6	Draft Quality Statement 6 is very loosely worded (not time specific).	Thank you for your comment. The time specifics appear in the measures.
756	Hafal	16.02	NICE	QS9	6	Draft Quality Statement 9 - for users of secondary MH services in Wales this will be a legal requirement under The Mental Health (Wales) Measure 2010 from June 2012. This Care Plan should be reviewed every 12 months at the very least.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
789	Hafal	16.03	NICE	QS10	6	Draft Quality Statement 10 – Crisis plan should be distributed to GP, carer, significant others, etc	Thank you for your comment. The GDG have focussed the statement on the initial offer.
890	Hafal	16.04	NICE	QS16	7	Draft Quality Statement 16 – highly commendable. This would make a vast improvement to the experience of most service users whose main point of contact for a one-to-one is the cleaner.	Thank you for your comment
975	Hafal	16.05	NICE	QS21	7	Draft Quality Statement 21 (as with DQS 10) should be covered where possible during periods of stability in the client's mental health and family and/or carers involved where possible.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
365	Hafal	16.06	NICE	1.1.10	10	Advance statements should also be distributed to carer, significant others, etc and regularly updated	Thank you for your comment. The GDG created specific recommendations for involving families and carers (please see 1.1.14 to 1.1.18.)
367	Hafal	16.07	NICE	1.1.12	10	These should be covered where possible during periods of stability in the client's mental health and family and/or carers involved where possible.	Thank you for your comment, this recommendation has been amended to highlight that discussions about family/carer involvement should be ongoing.
387	Hafal	16.08	NICE	1.1.17	12	For example see Hafal's Expert Patient Trainer Project (http://www.hafal.org/hafal/EPT.php)	Thank you.
389	Hafal	16.09	NICE	1.1.18	12	For example see Hafal's Expert Patient Trainer Project (http://www.hafal.org/hafal/EPT.php)	Thank you.
397	Hafal	16.10	NICE	1.2	13	People should not have access to secondary services removed by reason of them missing appointments without further investigation into circumstances and consultation with them.	Thank you for your comment, you raise an important point. However, it would be very difficult to operationalise your suggested recommendation without risking large numbers of DNAs. In any event, it is probably unethical for secondary care services to deny access due to missed appointments.
419	Hafal	16.11	NICE	1.4.2	16	Agree review date of plan with service user depending on agreed outcomes, etc. Care plans should be reviewed every 12 months minimum.	Thank you for your comment, the recommendation has been amended to include *"and agree a suitable time to review the plan."*
430	Hafal	16.12	NICE	1.4.8	18	(within the prescribed time guidance).	Thank you for your comment, we have added 'timely' to the recommendation to reflect your suggestion.

638	Hafal	16.13	QS	3	8	Despite there being much anecdotal evidence to suggest that self-management courses reduce the need for in-patient care and reliance on home treatment teams or crisis resolution teams there seems to be very few opportunities for service users to access courses and information on self-management. I undertook the Bipolar Self-Management Course almost 10 years ago and despite having been sectioned on a variety of occasions have not needed hospitalisation since. I also work full-time whilst managing my illness. Courses have been offered by third sector organisations such as The Bipolar Organisation and The Mental Health Foundation but there seems to be no over-arching UK-wide strategy. This seems extremely short-sighted as such a strategy would realise greater long-term savings to the NHS and society in general than any initial investment and would result in huge benefits to service users.	Thank you for your comment. QS3 has been changed to read '*People using mental health services are actively involved in shared decision-making and supported in self-management'.*
661	Hafal	16.14	QS	4	9	Any transition from one professional to another should include a scheduled 'hand-over' meeting which involves the service user being introduced to the newer professional allowing for a reasonable overlapping period for the service user to become acquainted with that member of staff before the transition is completed.	Thank you for this suggestion. The GDG agree that this would be good practice, but at this point in time, the priority was to ensure support from a single team with whom they have a continuous relationship.
701	Hafal	16.15	QS	6	11	Process a) should use a term such as "service user request for change of appointment date" rather than "cancellation".	Thank you for your comment. This has been amended
702	Hafal	16.16	QS	6	11	A service should not be withdrawn by reason of a service user's failure to keep any appointment(s) without first investigating the reasons with the service user.	Thank you for your comment
769	Hafal	16.17	QS	9	15	Included in the Care Plan should be a time for review. A review must take place at least once in a 12 month period.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
813	Hafal	16.18	QS	11	19	All relevant services and healthcare professionals have access to service user Crisis Plans (see QS 10).	Thank you for your comment
939	Hafal	16.19	QS	18	28	On discharge there must be evidence that the service user has suitable accommodation in place.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should

							be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
982	Hafal	16.20	QS	21	32	Where possible discussions regarding involvement of families and/or carers should take place during periods of relative stability for the service user and any agreements made recorded in advance statements as during periods of illness perceptions of family and/or carers can often shift negatively. Also, where possible, such discussions should also include the family and/or carers.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
587	Inner North West London PCTs	62.00	QS	QS 1	3	Suggest changing" empathetic and non-judgemental" to "knowledgeable, empathetic and non-judgemental" – (our feedback suggests that some staff, notably on wards, do not always show an adequate understanding of mental health)	Thank you for your comment. We've revised QS1 and 2 taking into account comments about measurability from several stakeholders.
633	Inner North West London PCTs	62.01	QS	QS 3	3	The quality standard refers to 'person-centred care', 'shared decision making' and 'self management' but make no reference to recovery, a term (and model) more commonly used by mental health trusts. Suggest that using a shared terminology will enhance acceptance and adherence to the quality standard by mental health trusts	Thank you for your comment, the GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.
654	Inner North West London PCTs	62.02	QS	QS 4	3	Suggest adding "and regular contact"	Thank you for your comment. The GDG felt this is included in the term "continuous".
680	Inner North West London PCTs	62.03	QS	QS 5	3	Suggest changing "monitor the performance of services" to "monitor and improve the performance of services"	Thank you for your comment. This has been amended
734	Inner North West London PCTs	62.04	QS	QS 8	3	Add "training in mental health awareness and addressing stigma"	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
762	Inner North West London PCTs	62.05	QS	QS 9	3	Suggest replacing "written copy of care plan" with "written copy of care plan developed in partnership"	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
790	Inner North West London PCTs	62.06	QS	QS 10	3	Add "have easy access to an efficient, local out of hours crisis service"	Thank you for your comment. Access to out of hours services is measured by statement 6.
82	Inner North West	62.	QS	QS	3	Suggest changing "psychosocial and emotional needs	Thank you for your comment. The GDG had to reduce

2	London PCTs	07		12		to “psychosocial, cultural/language and emotional needs”	the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
841	Inner North West London PCTs	62.08	QS	QS 13	4	Suggest adding “ offered a ward orientation and ward guide”	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
874	Inner North West London PCTs	62.09	QS	QS 15	4	Suggest adding “and offered an advocacy service”	Thank you for this suggestion. The GDG felt that the priority was to improve shared-decision making, therefore the suggested amendment was not made.
914	Inner North West London PCTs	62.10	QS	QS 17	4	Suggest adding “and a range of healthy food choices meeting cultural and personal preferences”	Thank you for your comment. The focus of this statement is activities, not food.
531	Inner North West London PCTs	62.11	QS	General	General	Suggest adding an additional QS around people using mental health services developing guidance for meetings such as Ward Rounds and CPA Review meetings	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the quality standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience.
532	Inner North West London PCTs	62.12	QS	General	General	Suggest adding an additional QS around physical healthcare of mental health service users and primary/secondary care liaison	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
533	Inner North West London PCTs	62.13	QS	General	General	Suggest adding an additional QS around psychological therapies in impatient units and in community	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience. Therefore, this suggestion has not been adopted.
534	Inner North West London PCTs	62.14	QS	General	General	Suggest adding an additional QS around mitigating medication side effects through support and information	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience. Therefore, this suggestion has not been adopted.
535	Inner North West London PCTs	62.15	QS	General	General	Suggest adding an additional QS around safety and security on inpatient units	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience. Therefore, this suggestion has not been adopted.

273	ISPS UK	38.02	NICE & QS	General	General	It would be helpful for there to be an overview of these recommendations, and which services are covered (eg secure accommodation)	Thank you for your comments, the NICE guidance is an overview of all the evidence reviewed in the full guidance and distilled into recommendations. The guidance covers community and inpatient services, but not secure/forensic settings.
582	ISPS UK	38.03	QS	1 7 14 15 19 22	5 13 23 24 29	Whilst this is an important recommendation, it is too non-specific to feel helpful or useable. One of the problems will be that professionals who feel that they are empathic, non-judgemental, supporting optimism, etc, may not be experienced as such by service users.	Thank you for your comment. Quality statements are designed to be measurable, therefore service providers can check whether the statement is being met, and if not, can then address the reasons for this.
618	ISPS UK	38.04	QS	2	6	Whilst some voluntary agencies will provide the best training locally, there is no guarantee that they are always better than other services, and it is important for collaboration between such services.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
640	ISPS UK	38.05	QS	3	8	The first part of the recommendation is too non-specific (see Statement 1), and way it is written implies that professionals have decisions in the 'engagement in self-management'?	Thank you for your comment. The statement has been revised to "supported in self management".
663	ISPS UK	38.06	QS	4	9	It is not clear what this means – does it mean that the same team should look after people in hospital and outside, for example? Whilst this may be a good recommendation, it would require a major re-organisation of current services.	Thank you for your comment. The quality statement has been amended to emphasise that this is community services.
684	ISPS UK	38.07	QS	5	10	Good idea, but it is a real struggle to do this – typically a response is 10-20%.	Thank you for your comments. The process measure on proportion of people receiving an exit interview has been removed.
743	ISPS UK	38.08	QS	8	14	It is good to have service users involved in training, and the term 'customer care' is likely to have a different influence on the role and value of the training.	Thank you for your comments.
770	ISPS UK	38.09	QS	9	15	This may not be appropriate for all service users,	Thank you for your comments. The GDG believe that all people using mental health services should receive a care plan.
814	ISPS UK	38.10	QS	11	19	This seems to be based on part of a standard comprehensive assessment, and should also be applicable for those who are not in crisis.	Thank you for your comment. Based on evidence reviewed during development, the GDG felt that the quality statement should focus on assessment in crisis.
828	ISPS UK	38.11	QS	12	21	The first part of the recommendation sounds fine, but it would be helpful to have more specific comments for 'their psychological and emotional needs and preferences taken into account'	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest

							improvement in service user experience.
847	ISPS UK	38.12	QS	13	22	Term 'formally assessed' not clear, and needs to be more specific.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
899	ISPS UK	38.13	QS	16	25	This will require changes in staffing levels.	Thank you for your comment, the GDG feel this is achievable, although on reflection did agree that it may not be possible to see the same person every day and have therefore amended this to 'a healthcare professional known to them'.
941	ISPS UK	38.14	QS	18	28	Whilst 2 days notice is useful for planned discharge, some service users would like to leave as soon as possible.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
968	ISPS UK	38.15	QS	20	30	It would be helpful for service users to have opportunity to add their own account of other aspects of their problems to the care record, too, not just this.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
984	ISPS UK	38.16	QS	21	32	Families need to be offered support sometimes in their own right, even though the service users does not want them involved in their own care.	Thank you for commenting. Please see recommendation 1.1.15 in the NICE guidance (now 1.1.17), which covers this scenario. It was not prioritised by the GDG as a quality statement.
664	King's College London	5.01	QS	4	9	' … supported by staff from a single, multidisciplinary team … ' This will vary depending on the local model of care. Not all service users will need continuing care from one team. Suggest omit.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
922	King's College London	5.01	QS	17	27	This has huge resource implications at a time when resources are being cut.	Thank you for your comment. The GDG felt this is a priority area that is aspirational in nature.
704	King's College London	5.02	QS	6	11	Structure b) – this assumes that staff are replaceable or never go on more than 2 week holidays. 4 weeks more realistic for non acute appointments. Structure c) '…. are seen within 10 minutes…' – 10 minutes cannot always be avoided. 20 minutes more realistic.	Thank you for your comment. The measures have been amended in light of consultation comments. It is hoped by the GDG that they remain aspirational yet achievable.
744	King's College London	5.03	QS	8	14	' customer care' rather dated – omit.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have

							the most impact on services and lead to the greatest improvement in service user experience.
798	King's College London	5.04	QS	10	17	'Draft quality measure – Outcome' – cannot assume all such plans will be met or that resource will be available to meet a crisis which by definition cannot always be planned.	Thank you for your comment. The outcome measured has been amended to examine whether service users were offered a crisis plan.
848	King's College London	5.05	QS	13	22	'People admitted to hospital …. formally assessed within 2 hours of arrival' –has to be some leeway on this at night.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
900	King's College London	5.06	QS	16	25	This has enormous resource implications and assumes junior staff time is not important. Would imply trebling consultant time on inpatient units, and the number of other staff. Suggest aiming for a more realistic standard that has some hope of being met: such as 30 minutes a week one-to-one time by a consultant or one of their therapy staff, once a fortnight.	Thank you for your comment. This statement was prioritised by the guidance development group. It was felt that contact with staff was of vital importance for people admitted to wards. It is acknowledged that for some organisations this will be aspirational however the group felt it would be achievable.
605	Lancashire Care NHS Foundation Trust	7.01	QS	1	6	We felt it was not possible to be optimistic all the time. Instead people should be supported and have confidence in their healthcare partners / partnership. Empowerment was felt to be more sustainable than optimism	Thank you for your comment, the GDG felt very strongly that health and social care professionals should support service users to feel optimistic about their care. The statement has been amended however to"optimistic that their care will be effective" to give greater clarity and a focus on the outcome of that support.
619	Lancashire Care NHS Foundation Trust	7.02	QS	2	6	The sentence is too wordy. You've got too many points in one sentence, better to break them down. It was felt to be good practice, but not a priority for a QS	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
634	Lancashire Care NHS Foundation Trust	7.03	QS	3	6	We absolutely agreed with this. Please keep.	Thank you for your comments.
656	Lancashire Care NHS Foundation Trust	7.04	QS	4	6	This is ideal, but unhappily not consistent with initiatives such as "new ways of working" or the stepped care model. Our services users commented they absolutely wanted this one kept in, but perhaps reword to "who they know and with who they have a positive and continuous relationship with"	Thank you for your comment. The quality statement has been amended to "single, multi-disciplinary community team". It is not intended that this limit use of the stepped care model.
68	Lancashire Care	7.0	QS	5	6	We absolutely agreed with this. Please keep.	Thank you for your comments.

1	NHS Foundation Trust	5					
697	Lancashire Care NHS Foundation Trust	7.06	QS	6	6	We felt effective to be a better word than efficient, and this would be a tricky one to monitor unless defined clearly.	Thank you for your comment. This has been amended.
714	Lancashire Care NHS Foundation Trust	7.07	QS	7	6	We felt it you got point 8 right, point 7 would be automatic, so exclude.	Thank you for your comment.
736	Lancashire Care NHS Foundation Trust	7.08	QS	8	6	We absolutely agreed with this. Please keep.	Thank you for your comments.
763	Lancashire Care NHS Foundation Trust	7.09	QS	9	6	This should be standard practice, and monitored via other workstreams so possibly a duplicate and to be excluded from the QS. Service users commented the care plan should be written in conjunction with them. They felt the word "occupations" excluded some people and could be changed to "health and wellbeing".	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should remain as a priority and be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
791	Lancashire Care NHS Foundation Trust	7.10	QS	10	6	This should be standard practice, and monitored via other workstreams. Also, our care plans have a crisis plan on the bottom, so a duplicate with point 9 and to be excluded from the QS. An advance statement might be a better thing?	Thank you for your comment. The GDG prioritised this statement for inclusion in the final standard.
809	Lancashire Care NHS Foundation Trust	7.11	QS	11	6	This should be standard practice, and monitored via other workstreams so possibly a duplicate and to be excluded from the QS. OR amalgamate points 9,10,11.	Thank you for your comment. This quality statement has been prioritised by the GDG for inclusion in the final quality standard because of its impact on service user experience.
823	Lancashire Care NHS Foundation Trust	7.12	QS	12	6	If you get point 8 right, that should be automatic. If you have to include it, please could you include an example of preference to be "e.g. choice of drink". We've heard stories in the past of dehydration because people (who hate tea) were given it automatically.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
843	Lancashire Care NHS Foundation Trust	7.13	QS	13	7	Inpatient wards now are for people who are very unwell, often in crisis, a formal assessment within 2 hours is unrealistic. Perhaps change to informal assessment within 2 hours, then formal "as soon as the person is able"	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
858	Lancashire Care NHS Foundation Trust	7.14	QS	14	7	If you get point 8 right, that should be automatic.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have

							the most impact on services and lead to the greatest improvement in service user experience.
873	Lancashire Care NHS Foundation Trust	7.15	QS	15	7	Shared decision making should take place regardless of setting	Thank you for your comment. QS 3 refers to shared decision making in all settingsl.
892	Lancashire Care NHS Foundation Trust	7.16	QS	16	7	We agree that contact should be for at least that time, but not concentrated into one timeslot i.e. spread out. If a named Nurse has 6 pts on her caseload you'll never reach that target on one shift. Service users felt strongly that this should be kept in the QS	Thank you for comment. The statement does not state that the one hour must be a continuous hour.
916	Lancashire Care NHS Foundation Trust	7.17	QS	17	7	Yep. Increased investment in occupational therapy / but also being creative ie by supporting volunteers / asking local colleges to input into inpt wards would help to achieve this..	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
935	Lancashire Care NHS Foundation Trust	7.18	QS	18	7	We agree, but unfortunately there's so much pressure on inpt beds, some people aren't in for as many as 2 days. Our service users felt strongly that this should be kept in the QS	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
948	Lancashire Care NHS Foundation Trust	7.19	QS	19	7	Absolutely. Perhaps combine with point 20?	Thank you for your comment
964	Lancashire Care NHS Foundation Trust	7.20	QS	20	7	Could you provide a template for this as an implementation tool? It's difficult for clients to start from a blank piece of paper. Our care records are electronic, and I think most Trusts are the same. But the paper could be scanned.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
978	Lancashire Care NHS Foundation Trust	7.21	QS	21	7	If you get point 8 right, that should be automatic. If you have to include, perhaps put it closer to the top?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
995	Lancashire Care NHS Foundation Trust	7.22	QS	22	7	This should be in the guideline, but not so much a priority for the QS.	Thank you for your comment
536	Lancashire Care NHS Foundation Trust	7.23	QS	General	General	Experience surveys: Our service users felt there was an over reliance on these, also when being discharged from a ward, people often just want to leave ASAP and not think about their experience until after a period of reflection. A persons carer could be approached (with	Thank you for your comment. If local organisations feel they have existing mechanisms to help measure achievement against a quality statement they are able to do so.

						permission) instead for some things ie did he or she come home with all their clothes? Were you given enough notice of discharge? Were you able to feedback on how leave went?	
281	Lancashire Care NHS Foundation Trust	7.24	NICE	General	General	Our service users were happy with this, they felt it reflected what was important with little jargon and easy to read. Once it's final we'll tailor our feedback mechanisms to reflect the guidance.	Thank you for your comments.
274	Lancashire Care NHS Foundation Trust	7.25	NICE & QS	General	General	As an area of good practice, we have "video booths", where service users are helped to make a video of their experience, then this is played back to staff. It's powerful stuff, and we'd be happy to discuss in greater depth.	Thank you for your comment, this does indeed sound like an interesting way of collecting evidence about service user experience. It would be useful if this was evaluated formally, so future updates to this guidance could evaluate whether service user experience is improved. Please let us know if or when the evaluation is done.
61	Leicestershire Partnership NHS Trust	35.01	Full	general	general	Our comments are as follows; that although service users and carers have been fully engaged in the development of this work, there is little evidence to show that they are representative in terms of geography, age, ethnicity etc. This could potentially impact on the views received as for example we know that people from BME groups sometimes face quite different barriers to accessing services. We also know that the experience of service users from various Trusts can differ.	Thank you for your comments, GDG members are there to represent the views of service users/professionals but not to be *representative* of a particular group/geographical area. The guidance is written to be applicable to all mental health services.
155	Leicestershire Partnership NHS Trust	35.02	Full	5.4	52	With regards to lines 39 – 41. There is some concern that this reads that the responsibility of tackling stigma lies predominantly with the NHS provider organisation. Keeping in mind that fact that PCTs are being abolished and the role of health promotion, prevention and communication will lie with the local authorities, perhaps the Trust should maintain a role but the responsibility should lie with the LAs. The concern is that this role could divert the Trust from what is its core function – to provide good quality health care.	Thank you for your comment, the full guidance has been amended to reflect your suggestion, as well as recommendation 1.1.8. (now 1.1.9).
156	Leicestershire Partnership NHS Trust	35.03	Full	5.4	53	With regards to line 6 – 7. Has there been an evaluation on the potential impact on services of achieving this target with NHS Trusts? Is this a realistic target, affordable target etc.	Thank you for your comment. We are not aware of any evaluation on the potential impact. It was the GDG's expert opinion that longer than 3 weeks would lead to a poor experience of care.
537	Liverpool PCT	55.00	QS	General	General	We agree with underpinning principles, particularly issues about BME groups. Recovery and co-production are implicit in sections but not as explicit as we'd expected. There isn't much in here about a	Thank you for your comment. Recommendation 1.3.3 has been amended to increase the emphasis on treatment options and informed decision making.

						`think family` approach, there isn't much to say people will be given information about treatment options including medication so they can make an informed decision. Half of the standards are about in-patient care – agreed this should be where those with most need are…but the majority of individuals in mental health services are in the community. There is an absence of focus for people who have a learning disability, there is no specific mention of how adult mental health services inpatient services meet the needs of people with a learning disability and a mental health problem.	The quality statements were prioritised following consultation and there are now 4 statements (less than a third) relating solely to inpatient care. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
568	Liverpool PCT	55.01	QS & NICE	General	General	The documents circulated are not `user friendly` for service users to read and digest. The NICE brand has started to move into patient/user environments. The other flip side is that they are normally focused on Medicine and treatment. Why are [NICE] now doing guidelines that CIPPH (pre 2008) who supported PPI Forums in every trusts and LINKS (post 2008) have done similar works and guidelines? Is this a repeat of what has already been said. Also FT Trusts have their own service user guidance and governor's guidance. They are their own entities. On this subject what is happening with the new Health watch dogs and will they have further service user guidelines?? The equality duties do not seem fully covered. Are all the equality strands/issues i.e. LGBT issues and learning disability? Basic Human rights I have not seen a big enough emphasis on the role of the Community Development Workers to contribute to effective engagement of BME communities. By working with services and local organisations we could have offered, Engagement , consultation, Awareness workshop and Training on • Identifying Mental Health needs in BME communities • Engaging with Mental Health Services • Cultural Competency in Mental Health. The role of faith and culture in Mental Health needs to be looked at.	Thank you for your comment, this guidance will be published with an accompanying booklet called 'Understanding NICE guidance' which is devised for services users, carers, the public etc. The DH sent NICE the remit for this guidance. Please contact the DH directly about the overlap with other work and new health regulators. Recommendations 1.1.5-1.1.7 (now 1.1.6-8) do address the need for healthcare professionals to consider the cultural difference of people accessing mental health services.
23	Liverpool PCT	55.02	All	General	General	The guideline doesn't seem to identify how trusts are going to analyse PALS, Compliments and complaints with service user experience themes in it.	Thank you for your comments. We have made it clear that services should utilise feedback from service users. It is a local responsibility to decide how to

						Many private industry and more NHS/service providers have a 'you say we did' board/website so issues are transparent and broader so people are not singled out. How is the service user experience reported back and who is accountable to these standards at Trust board, ward and individual staff level. Will people want to be truthful during one to one feedback or named questionnaires when people are vulnerable especially if under language, cultural differences and clinical pressures? There has to be a timed face to face or questionnaire at pre, during and post patient care if possible to get a broader and maybe accurate picture. Can the volunteer and advocacy services (or named lead) help to give a sense of neutrality when engaging with service users for their feedback. Many Trusts/service providers have open days and engagement/awareness sessions. This is vital to break down stigma, barriers and show real people/issues Customer service training is vital to all staff obviously that should include cultural competency training as we need to be world class. In any other people industry that is mandatory or they will lose 'business'.	analyse data. We already include recommendations on person-centred training. Please see recommendations 1.1.17-1.1.20 (now 1.1.19-1.1.22) for recommendations relating to service user feedback and exit interviews including those conducted by service users themselves.
310	Liverpool PCT	55.03	NICE	Person Centred Care	5	No reference to importance of Recovery approaches as a way of framing service improvement.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
388	Liverpool PCT	55.05	NICE	1.1.17	12	Service users should be involved in every stage of service improvement in a culture of collaboration (cf SCIE Guidance on service user participation in mh services	Thank you for your comment, although it would be desirable to have service users involved in service improvement projects, we have restricted our recommendations to ways in which service users can be involved to specifically improve service user experience. To go beyond this is outside the scope of this document.
390	Liverpool PCT	55.06	NICE	1.1.18	12	Independent service user organisations can provide independent perspective and are not compromised by being NHS employees.	Thank you for commenting, but we are not sure what you are suggesting. The recommendation is about employing service users to train NHS staff that come into contact with people who use mental health services.
399	Liverpool PCT	55.07	NICE	1.2.2	14	Letter should also include contact details for other sources of support – e.g. community groups, domestic violence, rape crisis etc.	Thank you for your comment, however the GDG felt this may be too overwhelming for service users, particularly if accessing services for the first time.
400	Liverpool PCT	55.08	NICE	1.2.3	14	Specialist and primary care services should work collaboratively to support service users with complex	Thank you for your comment; we feel this recommendation sufficiently covers the need for

						needs across service boundaries.	services to work together under all circumstances.
402	Liverpool PCT	55.09	NICE	1.2.4	14	Culturally specific services for minoritised groups (BME, Disabled People, LGBT) should be available – one size does not fit all.	Thank you for your comment, the recommendation has been amended to include a wider range of minority groups.
445	Liverpool PCT	55.10	NICE	1.5.9	20	Personality Disorder should not be a diagnosis of exclusion in these circumstances.	Thank you for commenting. The GDG agrees and the intention of the recommendation is to stop any diagnosis being used as a reason for exclusion.
453	Liverpool PCT	55.11	NICE	1.6.2	20	Information about other support groups and organisations should be made available. Specialist teams should work jointly with community groups and voluntary sector organisations.	Thank you for your comment, the provision of information regarding support groups has been added to recommendation 1.1.2 (now 1.1.4).
463	Liverpool PCT	55.12	NICE	1.6.7	21	Service user should be aware of right of representation and availability of advocacy support to input to MDT meetings.	Thank you for your comment the recommendation has been amended to read: *Ensure that the overall coordination and management of care takes place at a regular multidisciplinary meeting led by the consultant and team manager with full access to the service user's paper and/or electronic record. Service users and their advocates should be encouraged to participate in discussions about their care and treatment, especially those relating to the use of the Mental Health Act (1983; amended 1995 and 2007). However, these meetings should not be used to see service users or carers as an alternative to their daily meeting with their named healthcare professional or their weekly one-to-one meeting with their consultant.*
480	Liverpool PCT	55.13	NICE	1.6.13	22	Detail lacking on how this might be independently structured and sustainably resourced.	Thank you for your comment. The NICE implementation team will provide further help with regard to issues of implementation.
502	Liverpool PCT	55.14	NICE	1.8.4	24	Patients subject to the Mental Health Act should be given immediate access to Independent Mental Health Act Advocacy.	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and references to IMHAs have been added to recommendations 1.6.13 & 1.8.5.
350	Liverpool PCT	55.15	NICE	1.1.6	9	No reference is made to particular needs of women service users and the need for gender appropriate support.	Thank you for your comment, the recommendation has been amended to read: *When working with people using mental health services:* • *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from*

							different genders, cultural, ethnic, religious or other diverse backgrounds.
351	Liverpool PCT	55.16	NICE	1.1.6	9	No reference is made to the particular needs of people from LGBT and the barriers they face in accessing care.	Thank you for your comment, recommendation 1.1.6 (now 1.1.7) has been amended to include the issue of wider diverse groups: *When working with people using mental health services:* • *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from different genders, cultural, ethnic, religious or other diverse backgrounds.*
311	Liverpool PCT	55.17	NICE	Person Centred Care	5	No reference to importance of Recovery approaches as a way of framing service improvement.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
24	Liverpool PCT	55.18	All	General	General	Some clinicians may be resistant to cultural competency training, however this is at the heart of a lot of the poor experience of mental health services, especially but not uniquely among BME groups, but also in older people, disabled & learning disabled people and people who are gay. This should also be facer to face and challenging Effective clinicians are well aware of their cultural blind spots and these are bets made conscious by challenging forms of training. I T based packages are not good for this sort of issue. This guideline could be improved with good approaches to post exit experience as these best capture patient experience after the persons has left and recovered.	Thank you for your comment, the GDG feel these issues have been addressed by the recommendations – BME/cultural issues in recommendations 1.1.5-1.1.8 (now 1.1.6-9), and post exit experience in recommendations 1.1.17-20 (now 1.1.19-1.1.22).
569	Liverpool PCT	55.19	QS & NICE	6	11	[Also NICE p16: 1.3.6] Although as a commissioning organisation these standards (how much contact patients should have with clinicians and how long they should wait for treatment) are welcomed, many providers may struggle with this. Ensuring that patients waiting for an assessment for no longer than 10 minutes may be especially problematic.	Thank you for your comment. The GDG do believe these statements are achievable for all services. However, taking consideration of stakeholder feedback the GDG have amended this target to 20 minutes.
58	Lundbeck	36.	QS	Gen	3	Lundbeck fully support the requirement that 'services	Thank you for your support.

3		01		eral		should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway'. The importance of an integrated approach was highlighted in the recent 'listening exercise' for the NHS reforms and will help ensure secondary prevention services for public health priorities such as screening and brief interventions for alcohol misuse are commissioned and funded in primary care settings.	
538	Lundbeck	36.02	QS	General	General	We believe the right to choose and choice of treatment needs to be strengthened in the adult mental health QS and at least equivalent to statement 8 in the patient experience in generic terms QS – 'Patients' rights to choose, accept or decline treatment are respected and supported'. Choice is currently included in the adult mental health QS in statement 3 - 'People using mental health services are actively involved in treatment decisions and shared decision-making, and engaged in self-management' and supported by statement 7 - 'People using mental health services are given explanations and information about the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues'. Service user choice would also be enhanced by including recommendation 21 from the generic terms NICE guideline 'Give the patient information about relevant and available treatment options, even if these are not provided locally' as an additional quality statement or incorporated into statement 7 of the adult mental health QS.	Thank you for your comment. The GDG also felt it important that the quality standard emphasises choice. Quality statement 7 states that service users are given information about their "diagnosis and treatment options". Quality statement 3 focuses on shared decision making. Service user choice is a necessary component of these statements in order to demonstrate achievement.
724	Lundbeck	36.03	QS	7	13	Lundbeck support this quality statement – 'People using mental health services are given explanations and information about the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues'. We believe it would benefit from being supported by inclusion of statement 16 from the patient experience in generic terms QS - 'Patients are provided with **evidence-based information** that is understandable, personalised and clearly communicated'.	Thank you for your comment.
539	Mencap	13.01	QS	General	General	Mencap welcome the focus on mental health services the Quality Standard brings, whether these are delivered for inpatients or in the community. People with a learning disability continue to	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.

						experience worse health outcomes than the general population and are at disproportionate risk of mental ill health and premature death. Mencap feels that that this guidance should make some mention of the unique mental health needs of people with a learning disability, as the impact of mental health services for this group can have disproportionately larger ramifications than the general population. Mencap would also like to draw your attention to the AIMS standards for inpatient assessment and treatment units for people with learning disabilities produced by the Royal College of Psychiatrists.	
540	Mencap	13.02	QS	General	General	In 2007, Mencap's Death by Indifference report told the stories of six people with a learning disability who died prematurely after inadequate care within the NHS. While none of these deaths occurred while in the care of mental health services, one person was admitted to an assessment and treatment unit in the mistaken belief that the change in his behaviour was due to mental health issues when it was in fact due to sever physical pain. Since publishing the report we are also supporting the complaint regarding the death of another person who died having been admitted to e mental health unit and where her change in behaviour had again wrongly been attributed to her mental health rather than a symptom of extreme physical pain. A key factor was that reasonable adjustments were not made and as a result people with a learning disability died avoidably. Making reasonable adjustments is a legal requirement under the Equality Act and this applies equally to mental health services, irrespective of whether someone is detained or being treated in the Community.	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
62	Mencap	13.03	Full	General	General (and continued below)	This guidance identifies that when people are detained under the Mental Health Act they feel vulnerable and that control over their own lives has been removed. This is hard to bear for anyone detained, but for people with a learning disability, whose ability to gain perspective on a current/past event may be limited, dealing with the psychological impact of admission to an inpatient psychiatric unit can be catastrophic. When admission is the right course (namely is in the	Thank you for your comment, this guidance is applicable to secondary mental health care services. It does not focus on particular subgroups.

						patient's best interests) the key is to ensure that reasonable adjustments are made.	
541	Mencap	13.04	QS	General	General	Mencap notes that there is no specific section in this document on people who may be treatment avoidant, as well as also having a learning disability. Over the past few years, Mencap have been aware of a number of excellent case-studies where patients with a learning disability (who have been needle or hospital phobic) after hospitals treating have made expert reasonable adjustments. These included an anaesthetist coming out to a person's own home to administer the anaesthetic, rather than forcing an admission to hospital. While again these cases are not specifically about mental health, they are indicative that where care and consideration is shown, better health outcomes can be achieved. This care and planning is just applicable to mental health services, irrespective of the setting.	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
542	Mencap	13.05	QS	General	General	One of the key reasonable adjustments for ensuring better health outcomes for people with a learning disability is the provision of Independent Mental Capacity or Independent Mental Health Advocates (IMCA/IMHA). Both have a crucial role to play in advocating for those whose capacity is in question or who are detained. Their expertise can help reassure people with a learning disability and conversely ensure that services are making reasonable adjustments in the way in which they deliver care.	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
590	Mencap	13.06	QS	1	General	Mencap very much welcome point 1 of the Quality Standard. People with a learning disability still face significant stigma, including from within the NHS, and being optimistic about the life chances of people with a learning disability is a vital facet to mention, particularly as it reinforces the dignity of all people.	Thank you for your comments.
782	Mencap	13.07	QS	9/10	General	People with a learning disability are likely to have difficulties in communication and therefore it is vital that when delivering mental health services, special care is taken to ensure that communication is clear, free of complex words, and is based on a respect for the human rights of the individual. One key intervention that has been shown to help improve outcomes is the use of Health Passports. These documents are carried by people with a learning disability or their families and document the	Thank you for your comment, the quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.

						likes/dislikes and some basic information about the person. This can be very helpful in establishing a baseline for healthcare professionals to work from, either when treated in the community or when a person is admitted.The use of a health passport would fit in very well with the Quality Standard's call for a written care plan and written crisis care plan, based on the needs of the individual.	
953	Mencap	13.08	QS	19	General	In addition, any action taken must avoid discrimination and prejudice. This is particularly important, when communicating treatment is going to happen against the consent of the individual. Clear guidance exists on the use of restraint and people with a learning disability; see the Challenging Behaviour Foundation. A person's inability to communicate (just as an example), should not be used as an excuse to avoid following such guidance, otherwise the safety of people with a learning disability who are detained will be prejudiced. The recent abuse highlighted at Winterbourne View (at an Assessment and treatment centre) displayed many facets of bad practice both in communication and restraint. It also went against the accepted body of best practice, both in terms of restraint and personalised services (including Professor Jim Mansell's Raising our Sights report).	Thank you for your comment. The quality standard references how service must have regard for the Equality Act 2010.
954	Mencap	13.09	QS	19	General	Mencap remains concerned about the over use of anti-psychotic drugs – particularly when combined with inappropriate restraint techniques that pose a real danger to the lives of those people with a learning disability detained. Mencap would like to draw the Quality Standard team's attention to the guidelines we published in partnership with the University of Birmingham in this regard.	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
543	Mencap	13.10	QS	General	General	Mencap would ask for a section to be included about underlying medical conditions, the medication being used to treat this and the need to avoid diagnostic overshadowing, particularly when a patient is admitted to an inpatient facility, Even in the community, when new drug combination treatment regimes are being trialled, it is also vital that healthcare professionals are alive to the existing drug regimes that people with a learning disability are on.	Thank you for your comment. We acknowledge that this is an important issue and should be part of good clinical practice. However, the GDG had to reduce the Quality Standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience. Therefore, this suggestion has not been adopted.
54	Mencap	13.	QS	Gen	Gen	For many people with a learning disability,	Thank you for your comment. The quality standard is

4		11		eral	eral	discrimination can begin with poorly adjusted, primary healthcare provision. In June 2010, Mencap conducted a survey of healthcare professionals that showed that nearly 4/10 doctors did not know how to reasonably adjust the care they offered to this group. With the critical role played by GPs in optimising the mental wellbeing of people with a learning disability, more work is needed to show that all healthcare professionals, in whatever setting, have a role to play in driving up outcomes in mental health.	for all service users of NHS mental health services. It does not focus on particular subgroups
592	Mental Health Foundation	41.01	QS	1	5	"people are supported to feel optimistic" -This is unclear and not measurable, also the content does not match the heading. Existing indicators seem based only on NHS MH in-patient survey, which has some flaws regarding response rates e.g. from BME groups (who tend to report the worst care), or from groups whose first language is not English. Additional work should be done to reach these groups.	Thank you for your comment. The statement has been revised to "optimistic that their care will be effective" to give greater clarity Existing indicators are included to highlight where organisations can use existing mechanisms. Further work may be required in alternative settings to identify mechanisms.
620	Mental Health Foundation	41.02	QS	2	6	"professional who have received cultural awareness training" – This is not specific enough, does not indicate how much training etc.. Regarding indicators, it mentions diversity and equality – needs to be clarified, and ensure that culture is not confused with religion.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
641	Mental Health Foundation	41.03	QS	3	8	"people using services are actively involved" – This is not specific enough, not defined well or measurable. Also does not mention choice.	Thank you for your comment. The GDG felt that services could ask service users if they felt actively involved.
665	Mental Health Foundation	41.04	QS	4	9	Continuity of care – not clear if this refers to only in-patient or only out-patient care, or if it refers to continuity of care across both settings. Also does not mention choice.	Thank you for your comment. The quality statement has been amended to emphasise that this is community services.
685	Mental Health Foundation	41.05	QS	5	10	Not clear how service users will help monitor the performance of services. Not clear what proportion of people are given an exit interview, what happens with the data, and how the information collected is taken on board by the services.	Thank you for your comment. The process measure on proportion of people receiving an exit interview has been removed.
705	Mental Health Foundation	41.06	QS	6	11-12	The role of police in relation to the Mental Health Act should be mentioned.	Thank you for this suggestion. However, the role of the Police is outside the scope of this Quality Standard.
725	Mental Health Foundation	41.07	QS	7	13	Informed consent and choice, treatment alternatives (e.g. IAPT, exercise), disagreement regarding treatment, risks associated with treatment (side effects) are all missing.	Thank you for your comment. These are important areas in the care and support of service users. However the GDG did not prioritise these areas for inclusion in the final 15 statements.
745	Mental Health Foundation	41.08	QS	8	14	It is not stated how much training by service users will be received, how will that be assessed, etc.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15

							statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
779	Mental Health Foundation	41.09	QS	9	16	Care plans need to be accessible, use appropriate language, and be timely.	Thank you for your comment. The quality standard indicates that information should be provided in appropriate formats.
820	Mental Health Foundation	41.10	QS	11	20	The mention of the role of advocates is missing	Thank you for your comment. The GDG felt the priority was to focus on the role of the professional when making a quality statement about assessment in crisis.
829	Mental Health Foundation	41.11	QS	12	21	It is not clear what “needs and preferences will be taken into account” really mean. No indication how this might be assessed.	Thank you for your comment. The structure measure intends to examine the structures in place to ensure these needs are taken into account when admitted to hospital. The experience measure examines the issue from the service users’ viewpoint.
849	Mental Health Foundation	41.12	QS	13	22	Need to define assessment indicators.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
863	Mental Health Foundation	41.13	QS	14	23	“as soon as possible” – there should be a specific timeline	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
878	Mental Health Foundation	41.14	QS	15	24	It is not clear what these decisions are about, who is present, what choice people have. Also, it is assessed only by one question in the NHS MH in-patient survey, which is not sufficient.	Thank you for your comment. Where existing mechanisms do not exist it will be necessary for local organisations to develop new mechanisms.
923	Mental Health Foundation	41.15	QS	17	27	“meaningful activities” – this needs more detail, activities with a purpose.	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
942	Mental Health Foundation	41.16	QS	18	28	Not clear what “involved” means here, who decides whether someone is involved	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
951	Mental Health Foundation	41.17	QS	19	29	This aspect needs an independent verification, e.g. an independent review every time it happens	Thank you, the GDG had some sympathy with your view, but were not convinced that this would necessarily improve the experience of care. In addition the GDG focused on this statement as the most likely aspect of the guidance to improve experience of care.

969	Mental Health Foundation	41.18	QS	20	30	What happens with these experiences, is the information catalogued, acted upon, e.g. who does it happen to etc.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
998	Mental Health Foundation	41.19	QS	22	33	This point seems to relate to discrimination by staff, and should reflect that in the title. Also needs a measure, not just an attitude survey.	Thank you, for reasons of space we have not extended the title. Thank you, stigma is very difficult to measure and we're not aware of any specific measure that could be used in the community and NHS.
304	Mental Health Foundation	41.20	NICE	Intro	3	The Mental Health Act Commission reports on the use of Mental Health Act for patients detained under the Act (now part of CQC) highlighted poor service users experience. E.g. CQC 2009/10 annual report raises concerns about patient involvement in the care planning process; some people on CTOs are not involved in drawing up their care plans. This is an example of f=real life not fitting with the draft QS 3, 15 and 18 and the principle of people making informed decisions about their care and treatment.	Thank you for commenting. We think this illustrates why the Quality Standard will be important for improving the experience of care.
312	Mental Health Foundation	41.21	NICE	Person-centred care	5	People under Supervised Community Treatment (SCT) with a Community Treatment Order (CTO) can have capacity to make decisions about their care, but this is over-ridden by the Act's powers. This group of people should be covered in the first paragraph.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
320	Mental Health Foundation	41.22	NICE	Draft Quality Statements	6-7	Missing one aspect of care, which is the trust that is necessary between the service user and the professional. Trust should be drafted into this (empathetic and non-judgemental is not the same).	Thank you for your comment. This statement has now been separated into two: "*People using mental health services, and their families or carers, feel optimistic that care will be effective.*" and "*People using mental health services, and their families or carers, feel treated with empathy, dignity and respect."* As, the GDG felt it would be very difficult to measure trust.
331	Mental Health Foundation	41.23	NICE	1.1.1	8	Mentions hope and optimism, but does not refer to recovery; should be included.	Thank you for your comment, the GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.
431	Mental Health Foundation	41.24	NICE	1.4.8	18	Access to interventions – not clear, perhaps a timeframe could be added.	Thank you for your comment, we have added 'timely' to the recommendation to reflect your suggestion.
477	Mental Health Foundation	41.25	NICE	1.6.12	22	Routinely visited – needs a timescale (every day/week?)	Thank you for your comment, in this context routinely means in the ordinary course of events. It would be

							impossible to specify how often or within what timescale as this will depend on the individual, their particular condition and its severity and the length of admission. With regard to the latter, about half of admissions last less than 1 month, and about half of those about less than 2 weeks. Moreover, some admissions can last for well over a year. I hope it's clear that routinely simply would mean that this should happen in most cases.
282	Meriden Family Programme	14.01	NICE	General	General	This guideline is very welcome and the Meriden Family Programme is pleased to support recommendations that will enhance the experience of service users in services where people's experiences have not always been positive.	Thank you for your comments.
283	Meriden Family Programme	14.02	NICE	General	General	Service users draw from their experiences in mental health systems based on individual models of care, and are constrained by the experiences they have in services. This comes through in the guidance e.g. lack of psychological/talking therapies which are not even mentioned presumably because most service users have not had access to these both when in hospital or when being treated in the community. Receiving effective psychological 'talking' or non-talking therapies would be one of the most significant things that would enhance service user experience. We had added in more emphasis on the involvement of those who are significant in the lives of others. It can be hard to get representation from all service user groups – majority get support from others in their lives, and some will have had difficult experiences in their families. The main point is that we need to begin to encourage more dialogue.	Thank you for your comment. The GDG agree that access to effective psychological therapy is important and make several recommendations specifically about this. Please see 1.4.8, 1.4.9, 1.6.8.
313	Meriden Family Programme	14.03	NICE	Person Centred Care	5	After the word 'practitioners' at the end of the third sentence we feel it would be good to insert 'and with those who care about them and are important in their lives. We want to encourage Triangles of Care – 3 way collaborative relationships between service users, their social network and service providers.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
314	Meriden Family Programme	14.04	NICE	Person Centred Care	5	In the second paragraph, amend the first line to read 'In this guidance, the term families and carers includes relatives, friends….'	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.

315	Meriden Family Programme	14.05	NICE	Person Centred Care	5	In the second paragraph, amend the last sentence so that it reads as follows: 'Families and carers and friends should also be given the information and support they need to enable them to support their relative/friend.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
678	Meriden Family Programme	14.06	NICE	QS 5	6	We suggest point 5 could read 'People using mental health services can be assured that the views of service users and of those family and friends who provide immediate support and care for them are used to help monitor the performance of services.	Thank you for your comment. The focus of the quality standard is service users.
857	Meriden Family Programme	14.07	NICE	QS 14	7	Point 14, we suggest continuing the sentence as follows '…and a member of the mental health team is in contact with their relative or nominated support person. Arrangements are made for the care of anyone who is dependent on the service user e.g. children, elderly parents, family members with disabilities etc'	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
891	Meriden Family Programme	14.08	NICE	QS 16	7	In point 16, what is meant by 'their consultant'? Does it refer to a psychiatrist? Should specify if that is what is meant. I'm wondering if the fact that it doesn't specify is a reflection of the lack of experiences in services of service users being given time by any other types of consultants e.g. consultant nurses or psychologists.	Thank you for your comment. Traditionally the clinical lead is called the consultant - we have not specified that the consultant is a psychiatrist as it could be consultant nurse.
913	Meriden Family Programme	14.09	NICE	QS 17	7	Point 17 – we are really surprised that there is no mention of treatment e.g. psychological treatment and arts therapies. What comes across is a sense that most service users have not been offered these, therefore are not even aware how these would help them.	Thank you for your comment. There is a recommendation about access to psychological treatment (please see 1.6.8 in the NICE guidance document). However, the GDG felt that the priority for improving the experience of care was to improve access to activities that were meaningful to the service user, not to specifically recommend treatment options. .
931	Meriden Family Programme	14.10	NICE	QS 18	7	Point 18 – We suggest adding the following '…Where they are being discharged and will return to live with a relative or friend, or where relatives or friends provide them with support, these relevant people should be involved in the discharge planning.'	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
962	Meriden Family Programme	14.11	NICE	QS 20	7	Point 20 – We suggest adding '…Where possible, people are given choices about taking oral medication.' Should there be mention of the use of advance directives here or even a separate standard on Advance Directives which can be a very positive way of service users and services working together and	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

						can greatly enhance service user experience.	
974	Meriden Family Programme	14.12	NICE	QS 21	7	Point 21 – As it stands this standard appears narrow and does not do justice to the complexity of people's lives. Many service users have people who are significant in their lives and who provide them with support and whom they in turn support in reciprocal relationships. Three way collaborative relationships are encouraged between services, service users and those who are important in the lives of the service user to ensure that the best possible care is provided. This dialogue should continue over time taking account of changing needs and situations.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
325	Meriden Family Programme	14.13	NICE	QS	7	We are surprised that there is no standard around physical health care. It is important to have a standard around physical health and that this idea is incorporated at various points in the guidance including those relating to links between primary and secondary care. Because of the increasing evidence of physical health risks and reduced life expectancy for people with mental health problems, especially those on psychotropic medication, attention should be paid to their physical health needs, and routine physical health checks, including dental care, should be provided. Specialist programmes should be provided for those experiencing problems such as weight gain and obesity, and smoking management programmes.	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
371	Meriden Family Programme	14.14	NICE	1.1.12	11	We suggest a new sentence following on from this point to read 'Discussions should take place over time and repeatedly to acknowledge changes in circumstances, and should not be seen as a one-off event. As these situations can be quite complex, staff should receive training in the skills needed to work with families and carers. They should also receive training in managing issues relating to information sharing and confidentiality.	Thank you for your helpful comment, the recommendation has been amended in line with your suggestion.
372	Meriden Family Programme	14.15	NICE	1.1.13	11	Insert a new bullet point after the second bullet: 'Offer family interventions where these have proven effectiveness or are recommended in NICE Guidance.	Thank you for your suggestion. Recommendation 1.1.14 (now 1.1.16) deals with this issue.
385	Meriden Family Programme	14.16	NICE	1.1.16	12	We suggest inserting new bullet point at the end of this point: 'Appropriate facilities on in-patient units where their children can visit them when in hospital.	Thank you for your comment, your suggestion has been added to the recommendation.
412	Meriden Family	14.	NIC	1.3.3	16	We suggest amending the penultimate bullet point so	Thank you for your comment, the recommendation has

	Programme	17	E			that it read as follows: 'Outline different treatment options including talking treatments and give information about these to promote discussion and shared understanding. Information should include information on side effects of treatments so that service users should make informed choices.	been amended to cover the points you raised.
444	Meriden Family Programme	14. 18	NIC E	1.5.8	19	We suggest inserting an extra bullet point at the end as follows: 'Explore with them what support systems they have including family and friends that might enable them to avoid admission.	Thank you for your suggestion, this has been added to the recommendation.
454	Meriden Family Programme	14. 19	NIC E	1.6.2	20	We suggest amending the second bullet point as follows: Treatments, activities, treatment options and services available.'	Thank you for your comment, giving information about treatment includes treatment options.
460	Meriden Family Programme	14. 20	NIC E	1.6.6	21	In the last bullet point what kind of consultant is being referred to? Is this a psychiatrist? If so, it should specify this.	Thank you for your comment, this will usually be a consultant psychiatrist, however there are some inpatient units run by consultant nurses so it would be better not to specify a discipline.
464	Meriden Family Programme	14. 21	NIC E	1.6.7	21	Same comment as in point 20 above	Thank you for your comment, this will usually be a consultant psychiatrist, however there are some inpatient units run by consultant nurses so it would be better not to specify a discipline.
465	Meriden Family Programme	14. 22	NIC E	1.6.8	21	We suggest amending the first sentence to read as follows: '…recommended in NICE guidance provided by trained and competent health….'	Thank you for your comment, the GDG did not feel this insertion was necessary as to be competent health and social care professionals should be trained.
489	Meriden Family Programme	14. 23	NIC E	1.7.3	23	We suggest amending this point to read as follows: 'Before discharge or transfer of care, ensure that discussions take place with any involved family or carers.' We suggest changing this point to discussions to convey the concept of a dialogue regarding care rather than suggesting that family or carers are simply 'informed' that this is happening rather than involving them in the process and checking what information they need etc.	Thank you for your comment, this recommendation has been amended to reflect your comments.
500	Meriden Family Programme	14. 24	NIC E	1.8.2	24	Should something be included about asking them if they would like a supportive person with them – a friend or a family member?	Thank you, we have amended the recommendation in line with your suggestion.
516	Meriden Family Programme	14. 25	NIC E	Why is this impo	28	We suggest amending the last bullet point to read: CMHTs and wards where training is delivered by a professional trainer, service user(s) and family members.	Thank you for your comments. The GDG disagree. The research suggested compares training delivered by professionals, by professionals and service users versus no training at all. Further research examining

				rtant		It would be an idea to add family members here to give an overview of the total care system.	the impact of including family members could be added; however, the GDG were keen to make this manageable for this piece of guidance and opted not to include a fourth group.
517	Meriden Family Programme	14.26	NICE	4.3	29	Should the shared decision-making also include family members/partners/those significant in the person's life?	Thank you for your comment, this is specifically to improve the experience of care for service users and therefore we do not feel this would be appropriate.
985	Meriden Family Programme	14.27	QS	21	32	Please see point 12 relating to Draft Quality Standard No 21. In many circumstances, the service user experience can be greatly enhanced by the involvement of those who are close to them and who care about them. In the context of services where staff frequently lack confidence and training in how to handle complex situations involving service users and family members, we are concerned that the wording of this standard will lead to one-off simplistic questions that do not take account of how people's views can vary over time e.g. asking service user – 'Do you want your family involved? No – that's fine then' and there is no further discussion or consideration of how the family's perspective could be valuable to the person's care.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
303	Mersey Care NHS Trust	2.01	NICE	Title and Introduction	1 & 3	Our comments are as follows… 1. Please clarify what you mean by "adult mental health services" This would, until a short time ago, have meant people under 65 years of age. We are now developing age appropriate services which may include people both below and above 65 years. Suggest the guidance should relate to all service users whatever their age or diagnosis. 2. Whilst we appreciate the guidance is intended to apply to a wide range of service provision, some of it cannot be applied in a high secure setting because of Security Directions. It would be useful for the guidance to make some reference to forensic mental health settings.	Thank you for your comments. The scope of the guidance covers community and inpatient mental health settings, so it will depend on how your Trust is structured. Prisons and forensic settings are outside the scope.
606	Mersey Care NHS Trust	2.02	NICE	Draft quality statements 2	6	Our comments are as follows No 2 …Cultural awareness training needs to be of a high standard. The contribution of local voluntary organisations to cultural awareness training needs to be valued, recognised and remunerated.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

631	Mersey Care NHS Trust	2.03	NICE	Draft quality statements3	6	Our comments are as follows… Quality statement No 3 needs to recognise this should happen where possible and with reference to Mental Capacity Act, Mental Health Act and Code of Practice.	Thank you for your comment. QS11 highlights that people subject to the Mental Capacity Act and Mental Health Act can still be involved in shared decision making.
650	Mersey Care NHS Trust	2.04	NICE	Draft quality statements 4 & 1.4	6 & 17 (1.4.7)	Our comments are as follows… Quality statement No 4 should recognise that the needs of individuals change or may be very specific so it may not be possible or appropriate for service users to be supported by staff from a single multidisciplinary team as not every team will have a full complement of staff with absolutely all the required skills. Point 1.4.7. needs to make clear reference to the reality that the National Service Framework for Mental Health created a multiplicity of teams (eg CMHT, AOT, CRHT). If NICE is suggesting a change to this current pattern of provision it perhaps needs to be explicit about this and recognise the potential upheaval/time this will take. Meantime, important to say that people should have a continuous relationship with a Care Co-ordinator. Point 1.4.7 would not appear to acknowledge that some specialist mental health services are provided on a regional and not a local basis and this will mean handover from one team to another.	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
679	Mersey Care NHS Trust	2.05	NICE	Draft Quality statements 5 and 1.1	6 & 13 (1.1.19)	Our comments are as follows… Quality statement 5 is agreed but 1.1.19 needs to change to say "Trust managers should involve/employ service users to monitor…" We offer payment to service users to do this but, because of their financial circumstances not everyone can be employed/accept payment and service users should not be excluded from being involved in performance monitoring because of their financial circumstances.	Thank you for your comment, this recommendation goes on to say 'for example, by paying them' and therefore we do not feel anyone would be excluded from being involved.
696	Mersey Care NHS Trust	2.06	NICE	Draft quality statements 6 and 1.2, 1.3, 1.5	6 & 13 16 & 19	Our comments are as follows…. Quality statement 6 is agreed but... 1.2.1. With a current target of 6 weeks instead of proposed 2 weeks, there is concern that speed of response does not compromise quality of assessment 1.3.6. A wait of ten minutes after agreed appointment time is desirable but may be impractical if previous client needs more time to talk/a clinic emergency – important to set out how any additional waiting time is approached/addressed	Thank you for your comment. The measures have been amended in light of consultation comments. It is hoped by the GDG that they remain aspirational yet achievable,

						1.5.5. Can you clarify if there is evidence for 4 hours? Or is it linked to A and E waiting time Targets/standards expected elsewhere? 1.5.6 May be useful to clarify relationship of 24 hour helplines to NHS Direct	
732	Mersey Care NHS Trust	2.07	NICE	Draft quality statements 8 and 1.1	6, 12 & 22	Our comments are as follows…. Quality statement 8 is agreed with but .. 1.1.18 needs to change to say involving as well as employing service users (see point 5 above)	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
366	Mersey Care NHS Trust	2.08	NICE	1.1.10	10 & 11	Our comments are as follows…. 1.1.10 Guidance needs to be clear that whilst NHS organisations have a role to play in enabling and supporting service user to make an Advanced Statement it is their decision whether to do so or not and whether or not to provide NHS organisations with a copy. The guidance is right to focus on our obligation to ensure we have system in place to record the existence of an AS.	Thank you for your comment, the recommendation has been amended in line with your suggestions.
457	Mersey Care NHS Trust	2.09	NICE	1.6.4	21	Our comments are as follows.. 1.6.4.It may take time to undertake assessment so suggest "Undertake formal assessment and admission processes within 2 hours of arrival.." be changed to "Commence formal assessment and admission processes within 2 hours of arrival…" Guidance needs to be clear that assessment can be commenced by any competent healthcare professional.	Thank you for your helpful suggestion, we have amended the recommendation to say this.
458	Mersey Care NHS Trust	2.10	NICE	1.6.5	21	Our comments are as follows … 1.6.5. Appreciate the spirit but query as to whether "first 12 hours " is practical/desirable if say patient admitted at 8pm in evening.	Thank you for your comment, the GDG believe this is achievable.
459	Mersey Care NHS Trust	2.11	NICE	1.6.6	21	Our comments are as follows… 1.6.6. Appreciate the spirit of staff spending time with patients but the wording seemsvery prescriptive and would not seem to be led by needs of patients which may require a more flexible approach. If the "named healthcare professional" is, as it implies, a single person it is not deliverable as it takes no account of staff holidays etc. Consideration also needs to be given to service users in longer term care (eg average length of stay in high secure services is @ 7 years)	Thank you for your comment, the recommendation starts with 'offer the service user' and therefore we do not feel any change is necessary.

						who may need different levels of input at different times by different professionals. As currently written the guidance could be both unrealistic in a high secure environment as well as potentially overwhelming for some patients. eg when patient is in seclusion.	
473	Mersey Care NHS Trust	2.12	NICE	1.6.10	22	Our comments are as follows … 1.6.10 The guidance as written is not suitable for patients in high secure hospitals where security directions preclude access to the internet.	Thank you for commenting, but as set out in the scope, this guidance covers community and inpatient settings, not secure services.
933	Mersey Care NHS Trust	2.13	NICE	QS18 & 1.7	7 & 23	Our comments are as follows... Quality statement 18 could be strengthened by discharge planning being started on admission to hospital.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
593	Mersey Internal Audit Agency	18.01	QS	1	5	Outcome measure - might need to separate this into 2 measures as there are 2 different issues being addressed. 1. Support for service users and 2. attitude of staff i.e. empathetic & non-judgemental	Thank you for your comment. This quality statement has been split into statements (now QS1 and 2) which should make measurement clearer.
666	Mersey Internal Audit Agency	18.02	QS	4	9	Is this achievable 100% of the time?	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
686	Mersey Internal Audit Agency	18.03	QS	5	10	Quality statement – revise to read 'People using mental health services can be assured that (delete 'the views of') service users are used to help monitor the performance of services' Measure b) – not sure how this fits in to this QS	Thank you for your comment. The process measure on proportion of people receiving an exit interview has been removed.
712	Mersey Internal Audit Agency	18.04	QS	6	12	Outcome measures - accurate information on access times should be gathered from official records rather than patient feedback	Thank you for your comment. The expert group felt it important to supplement hard data with the experience of service users to add qualitative data to quantitative figures.
799	Mersey Internal Audit Agency	18.05	QS	10	17	Would be useful to know effect of having crisis plan on experience in hospital	Thank you for your comment
850	Mersey Internal Audit Agency	18.06	QS	13	22	Outcome measure – again relying on service user feedback might not be reliable. Will they know that they were 'formally assessed' within 2 hours of arrival? Audit of patient records would be more reliable.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this standard should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
864	Mersey Internal Audit Agency	18.07	QS	14	23	Quality statement – 'as soon as possible'. Very subjective and not measureable	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have

							the most impact on services and lead to the greatest improvement in service user experience.
901	Mersey Internal Audit Agency	18.08	QS	16	25	Outcome measure - accurate information on contact times should be gathered from official records rather than patient feedback	Thank you for your comment. As this is a quality standard on service user experience it is hoped that services would utilise service user feedback alongside more official records.
924	Mersey Internal Audit Agency	18.09	QS	17	27	Quality statement – 'meaningful' is rather subjective term. What about stimulating or appropriate? Or can it just be 'access to activities …….'	Thank you for your comment. The term 'meaningful' is to emphasise that the activities should be meaningful to the service user, that they should not be generic activities for every service user irrespective of their preferences.
952	Mersey Internal Audit Agency	18.10	QS	19	29	This statement is measuring 2 different things. Quality statement – states that staff should be trained and competent etc. Outcome measure – asking service users if restraint was used as last resort with minimum force. Should be second measure about staff training and competence	Thank you. The measures have been amended to examine the proportion of staff receiving training as well as service user opinion on the use of control and restraint.
986	Mersey Internal Audit Agency	18.11	QS	21	32	Quality statement – could this be expanded to include 'and documented in care plan'?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
999	Mersey Internal Audit Agency	18.12	QS	22	33	Outcome measure – not sure that this can be measured effectively just by asking service users how they feel about services combating stigma.	Thank you for your comment. The outcome measure has been altered to assess service user experience of stigma.
321	Mime Project	56.00	NICE	QS1-20	6-7	Our comments are as follows: MIME welcomes the quality statements which relate to issues raised in the consultations we have undertaken with service users and carers which are accessible via our website www.mimeproject.org.uk	Thank you for your comments.
333	Mime Project	56.01	NICE	1.1.2	8	In relation to maintaining continuity of individual therapeutic relationships – our consultations have shown that this is highly valued by service users but is one of the most frequent complaints – that there is no continuity. Including 'wherever possible' would be perceived as service users as an obvious get out clause for service providers – strict monitoring would be necessary to secure and maintain service user confidence	Thank you for your comment, we agree that every effort should be made to ensure continuity in relationships, however this may not always be feasible for example when staff are on holiday, or leave the service.
339	Mime Project	56.02	NICE	1.1.3	9	BME service users who were involved in our Big Conversation highlighted the importance of independent translators but also the need for all letters and information leaflets to be available in their own	Thank you for your comment, recommendation 1.1.2 (now 1.1.4) – which applies to all aspects of care and in all settings – recommends that all information be given in '*an appropriate language or format'.*

						language as well	
359	Mime Project	56.03	NICE	1.1.8	10	Should include service user groups and academic institutions in stakeholders mentioned	Thank you for your comments, we have included service user groups but feel adding academic institutions would be over prescriptive.
393	Mime Project	56.04	NICE	1.1.17-19	12-13	Involving service users in training is to be welcomed and in gathering of evidence of service user experience	Thank you for your comments.
395	Mime Project	56.05	NICE	1.1.20	13	Given the above there should be a commitment to including evidence gathered by service users in the reports	Thank you for your comment, we have amended the recommendation to include this.
401	Mime Project	56.06	NICE	1.2.3	14	Our consultations show that many service users report a lack of interest/expertise in primary care around mental health – should there be something about expectations around training for primary care practioners both from trusts and service user organisations	Thank you for your comment, the scope of this guidance only focuses on secondary mental health services.
408	Mime Project	56.07	NICE	1.3.3	15	'enough time' is a bit woolly and hard to quantify. While we accept it is difficult to set guidelines perhaps a minimum might be helpful	Thank you for your comment, as you suggest it is very difficult to specify as this will be different for each service user. This is a matter for clinical judgement.
421	Mime Project	56.08	NICE	1.4.5	17	The crisis plan is a good idea but might be improved if it included a declaration of what support is available and when to a service user at risk of hospitalisation in order to prevent their admission.	Thank you for your comment, the recommendation has been amended to read: *For people who may be at risk of crisis, a crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan. The crisis plan should include:* • *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 (childcare or the care of other dependants, including pets). [QS]* • *details of advance statements and advance decisions (see 1.1.11)* • *whether and the degree to which families or carers are involved* • *information about 24-hour access to services* • *named contacts.*
427	Mime Project	56.09	NICE	1.4.7	17	The commitment to a single team is good but service users really want to see the same person each time	Thank you for your comment, this may be very difficult to operationalise and the GDG felt the MDT would be

						where possible	more achievable. However, there is a recommendation that those receiving inpatient care should have the opportunity to see a healthcare professional known to them each day, and their consultant each week. (see recommendation 1.6.1)
441	Mime Project	56.10	NICE	1.5.7	19	CRHT teams have been operating for some time and trusts say they are accessible 24 hrs a day 7 days a week but there is widespread dissatisfaction with the service they provide – how will this guideline improve that?	Thank you for commenting. The GDG's intention was to make recommendations across the key points on the care pathway to improve the experience of care, rather than make specific recommendations for every possible team configuration and treatment option.
467	Mime Project	56.11	NICE	1.6.9	22	The commitment to moving beyond the usual 9-5 is to be welcomed but should there be a minimum number of hours offered each day	Thank you for your comment, the GDG did not agree that this would be feasible.
474	Mime Project	56.12	NICE	1.6.11	22	Service users would wish to be included in this training	Thank you for your comment, we have made recommendations about service users being involved in training in 1.1.17 and 1.1.18. (now 1.1.19 and 20)
510	Mime Project	56.13	NICE	1.8.10	25	Service users who have experienced control and restraint should be included in training for professionals	Thank you for your comment, recommendations 1.1.17 and 1.1.18 (now 1.1.19 and 20) ensure service users are included in all aspects of training.
357	Mime Project	56.14	NICE	1.1.7	10	When explaining the causes – there are a variety of explanations for mental health conditions depending on the model of different practioners – should not be an exclusively medical model explanation	Thank you, we have amended this to the 'possible causes'.
370	Mime Project	56.15	NICE	1.1.12	11-12	Practioners should be trained in awareness of the complicated family dynamics between service users and carers and be able to recognise potential conflicts of interest	Thank you for your comment, the recommendation has been amended in line with your suggestion.
379	Mime Project	56.16	NICE	1.1.15	12	If the service user doesn't want carer involved why are you putting pressure on them to change their minds	Thank you for commenting. The GDG considered this carefully, and agreed that at some points service users may not want their families/carers involved, but then later change their mind. We would not want healthcare professionals to put pressure on service users, merely to revisit this decision.
63	MIND	47.00	Full	General	General	Mind welcomes this draft guideline and the opportunity it represents to improve the experience of mental health services. Overall we strongly support its recommendations and associated quality statements.	Thank you for your comments.
64	MIND	47.01	Full	General	General	A few individuals with direct personal experience of mental health problems and of caring sent in comments via Mind and specific points have been included at various points in the response. Key issues they raised included the substantial gap between the guidance and much of current practice, the need to say more about how to provide services, and the importance of confidentiality in helping to overcome	Thank you for yours, and your members comments, we agree that in some services there is a gap between the guidance recommendations and current practice, and hope that the guidance will help to address these shortcomings and improve the experience of care.

						stigma. One of these commentators was also complimentary about the issues included, ease of understanding and length.	
326	MIND	47.02	NICE	1.1	8	Mind is frequently contacted by people who have had difficulty making complaints about services, or feel their complaints have not been taken seriously. A good experience of care must include confidence that staff and provider organisations are accountable and that complaints will be addressed fairly and without adverse repercussions for the individual concerned. We suggest a recommendation on this.	Thank you for your comment, in light of your other stakeholders comments we have added a recommendation regarding making complaints: *Inform service users on how to make complaints, and how to do this safely without fear of retribution.*
785	MIND	47.03	NICE	QS 10	6	[Also, NICE p17: 1.4.5 & Full p88: 7.5.1.5] Mind very much supports the use of crisis plans – they are not only desirable in providing a way for people's preferences to be known and respected in crisis, but joint crisis plans have also been shown to reduce compulsion (Chris Flood et al *Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial* . BMJ 10.1136/bmj.38929.653704.55). We agree that they are particularly useful for people who have previously been admitted to hospital, but we suggest that their use and usefulness should not be defined solely by the person's risk of hospitalisation. While particularly necessary for people who may be admitted to hospital, the value of planning ahead is to mobilise resources and facilitate decisions that can best support the person through the crisis in the way that they want, whether or not that involves hospital and whether or not the person would meet current criteria for admission. The statement could be rephrased to "how and where the person would like to be cared for" to encompass support at home, hospital admission and a range of other possibilities.	Thank you for your comment. The GDG have amended the statement to all service users being offered a crisis plan.
786	MIND	47.04	NICE	QS 10	6	[Also, NICE p17: 1.4.5 & Full p88: 7.5.1.5] We also welcome the reference to **joint** crisis plans. It should be noted that a key component of joint crisis plans in the trials of this approach is the involvement of an independent facilitator (Chris Flood et al, see previous comment). This enables negotiation of a genuinely co-produced plan.	Thank you for your comment.

						We recommend that the guideline makes this point.	
787	MIND	47.05	NICE	QS 10	6	[Also, NICE p17: 1.4.5 & Full p88: 7.5.1.5] We think there should be reference to treatment preferences as well as refusals, in order to support shared decision-making.	Thank you, but the QS already includes 'preferences for admission and treatment'.
423	MIND	47.06	NICE	1.4.5	17	This section should reflect the full draft quality statement and include reference to treatment refusals (and preferences).	Thank you for your comment, this has been added to the recommendation with a link to recommendation 1.1.11 which further discusses advanced directives.
788	MIND	47.07	NICE	QS 10	6	[Also, NICE p17: 1.4.5 & Full p88: 7.5.1.5] It may be helpful to include a reference to the smaller things that can make a very significant difference to people, such as what people want to have with them if they are admitted to hospital, how they like to be addressed, and anything else they would like people to know about them.	Thank you for your comment. The GDG have focussed the statement on the contents identified in the recommendation.
334	MIND	47.08	NICE	1.1.2 1.1.6 1.8	8 9 24	Mind strongly supports the inclusion of advocacy in this guideline as it is an essential way of supporting service users to be informed and exercise their rights, and is itself an entitlement for those detained under the Mental Health Act. It is not only the provision of mental health services that needs to be culturally relevant and respectful but also mental health advocacy. In particular, Independent Mental Health Advocacy has a vital role to play in race equality as people from black and minority ethnic (BME) communities are disproportionately affected by the Mental Health Act. However a report written by Mind staff for the Mental Health Alliance shows serious limitations in the commissioning of IMHA services tailored to the needs of BME communities - http://www.mentalhealthalliance.org.uk/resources/Independent_Mental_Health_Advocacy_report.pdf The guideline should be amended to state the need for advocacy and IMHA services tailored to the needs of BME communities, and for mental health staff to enable all eligible service users to access IMHA services.	Thank you for your comment, recommendation 1.8.5 has been amended in line with your suggestion.
348	MIND	47.09	NICE	1.1.5 1.3.2	9 15	One person sent in comments to Mind about the importance of confidentiality. This person has been deterred from seeking help because of stigma and her	Thank you for your comment, the final bullet point of recommendation 1.1.5 (now 1.1.4) has been amended to read:

						knowledge of the extent of information-sharing within health and social care and the breaches of confidentiality that have occurred. This person recommends proactive mechanisms to prevent unnecessary access to records, and informing the service user about how information is stored, accessed and shared. She cites positively a trial at South London and Maudsley Trust (not her local trust) which enables service users to access their records directly, make notes and see who has accessed their data. Mind believes that service users should be provided with greater awareness of and control over the information held about them.	*"be clear with service users about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others)"*
349	MIND	47.10	NICE	1.1.5 1.3.2	9 15	A second point made by an individual who sent comments to Mind was that, with electronic data systems in particular, there are no safeguards against sensitive information being shared – histories of violence and abuse, therapy notes and details of the traumatic events that may be recalled when in crisis. She called for paper records to be used on some occasions to protect confidentiality. Confidentiality is a vital component both of respect and access, as people will not access care if they do not feel safe to do so. We should like NICE to address these issues in the guideline.	Thank you for your comment, the final bullet point of recommendation 1.1.5 (now 1.1.6) has been amended to read: *be clear with service users about limits of confidentiality, that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others.*
364	MIND	47.11	NICE	1.1.10	10	Mind strongly supports the use of advance statements. A person who sent comments in to Mind on this draft guideline said that she had drawn up an advance statement after a difficult experience and found it supportive to know that her wishes and needs were taken into account when in crisis. However she was shocked at how very few service users she met knew about advance statements. Given that NICE has been advocating advance statements throughout its development of mental health guidelines, we suggest NICE could work proactively on this as an implementation priority.	Thank you for your comments. The GDG agreed that this was a priority for implementation and so drafted a Quality Statement (QS9) regarding crisis plans, which should contain advanced statements.
450	MIND	47.12	NICE	1.6	22	Some inpatient environments are physically substandard, neither supporting recovery nor a sense of service users (or staff) being valued. We suggest	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

						including a standard about cleanliness, comfort and access to attractive outdoor space.	
496	MIND	47.13	NICE	1.8	24	We suggest making reference to the Mental Health Act Codes of Practice as these provide more detail about provider organisations' and staff duties to people who are detained and in particular the principles that should guide practice.	Thank you for your comment, this is a professional issue. The GDG felt that anyone who is in the position to detain someone under the MHA would know about the code of practice.
103	MIND	47.14	Full	2.2	14-15	**Influence of the Mental Health Act (1)** We welcome the recognition up-front of the experience of people who are detained under the Mental Health Act. It is essential that guidance on mental health service quality includes the perspectives of those who are or could be subject to the Act. We note that there is no equivalent to this section in the NICE version of the guideline. It may be helpful to incorporate a sentence or two into the section on Person-centred care to acknowledge the profound impact of detention and compulsion and what it means for the relationships between service users and services, including for those people on community treatment orders.	Thank you, we agree this is important issue, which is reflected by the fact that there are 14 recommendations in the NICE version of the guidance that refer to the MHA, including section 1.8 on assessment and treatment under the MHA.
104	MIND	47.15	Full	2.2	15	Line 5 – the Mental Health Act applies in Wales as well as England	Thank you for pointing this out, it has been amended in the text.
105	MIND	47.16	Full	2.2	14-15	**Influence of the Mental Health Act (2)** In addition to the points already made in the draft, we should like to see more explicit acknowledgement of the wider impact the Mental Health Act can have – for example people may be reluctant to seek help or to speak frankly with mental health professionals about how they feel for fear of being sectioned.	Thank you for your comment, the section 2.2.1 has been amended to reflect your suggestion
118	MIND	47.17	Full	3.6 and Appendix 5	21-25 and 201-205	We welcome the inclusion of all the sources used for the review of qualitative evidence of service users' experiences. However there is some doubt as to how comprehensive the review is. Much service user research is generic rather than diagnosis or condition based and therefore would presumably not be picked up in the work on existing mental health guidelines. While generic in terms of condition, such research may bring out specific issues in relation to different groups or aspects of treatment. They will often look at the wider context of people's lives, as well as service use. GDG members may be familiar with the wider literature, but it would be good to know it was directly considered. A few examples are:	Thank you, but given the short amount of time allocated to developing this guidance we believe that utilising work done for existing NICE guidelines or reviews of interventions was the only approach we could take (for example, in the key problems review we included 133 qualitative studies or reviews of qualitative studies, four qualitative analyses, including one done specifically for the guidance, and three surveys). It would be difficult to justify adding the general reports you cite without conducting a more comprehensive search for this type of evidence. However, we acknowledge that given more time it may be useful to do this.

						Men and mental health: get it off your chest (Mind, 2009) Poll and focus groups. Not all about experience of mental health service use but particularly relevant to access and identification of problems. http://www.mind.org.uk/assets/0000/0186/men_and_mental_health_report.pdf *Psychiatric drugs: key issues and service user perspectives* (Palgrave Macmillan, 2009). Reports Mind's research into service users' experiences of taking and coming off medication and other service user research on these issues. Service user/survivor research. Kalathil, J (2011), *Recovery and resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress*. (Mental Health Foundation). Not primarily about *service* experience but has vital lessons for the quality of services and how they are provided. Service user/survivor research. http://www.mentalhealth.org.uk/content/assets/PDF/publications/recovery_and_resilience.pdf *Double stigma: the needs and experiences of lesbian, gay and bisexual people living with mental health issues in Wales.* A report for Stonewall Cymru and mental health organsation partners Mind Cymru, Hafal and Journeys (2009) http://www.stonewall.org.uk/cymru/english/what_we_do/research_and_policy/lgb_mental_health_research_project/default.asp Mind's Care in Crisis inquiry has been collecting evidence since autumn 2010 about acute and crisis mental health services. This includes a great deal of personal testimony from people with direct personal experience. The independent inquiry panel's vision and recommendations will be published by Mind in November 2011 and form the basis for a campaign for better responses to people in mental health crisis.	
133	MIND	47.18	Full	5.2	41	**Re lack of evidence about attention to physical and environmental needs** *One town for my body, another for my mind: services for people with physical impairments and mental health support needs* by Jenny Morris (JRF, 2004) was a research project carried in partnership between JRF and Mind. It sets out a range of problems for people with physical impairments and mental health support needs both in terms of accessing and using mental	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

						health services and physical disability services. http://www.jrf.org.uk/sites/files/jrf/1859351948.pdf	
134	MIND	47. 19	Full	5.2	41	**Re lack of evidence about involvement of and support for family and carers** The value of the support of friends and family, and the difficulties created by services being at a distance from home, were recurrent themes in Mind's Care in Crisis call for evidence about acute and crisis care (2010-11 unpublished). In addition to testimony from carers themselves, Mind hears from people with mental health problems concerned about the lack of support for their partner, other family members or other people close to them, or the consequences for those closest to them of shortcomings in care. The following quotes are from this call for evidence. This is from someone describing a serious incident in their own mental health: "I needed someone to physically be with me and my partner, to deal with the immediate issues. …. My husband needed to get me help and called our out of hours GP who told him i was attention seeking and refused to come out, the crisis team told him they would speak to me but not visit, even though they had visited previously. They ultimately left my poor husband with me in a chaotic situation without any way to help or diffuse the situation…. … I would like family and friends of patients to get support and information, not be expected to KNOW how to best care and support the patient." "When I am in crisis I rely completely on my support worker and partner to organise 'something'. Unfortunately my support worker has recently gone part-time, resulting in my partner taking a lot of the 'jobs' on himself - such as trying to get hold of my psychiatrist to get an earlier appointment, contacting the GP to get some extra short-term meds." One person who sent in comments on the draft NICE guideline wrote in very strong terms about the lack of practical support for her as her husband's carer, lack of support for their relationship, and the way that psychiatric services treat carers as "the enemy". She contrasted this with the way that physical health services recognise the value of utilising family members' input. She also regretted the exclusion of carers from the scope of the guideline.	Thank you for your comments. Recommendations are made specifically for supporting families in several chapters. In particular: *If the person using mental health services wants their family or carers to be involved, give the family or carers verbal and written information about:* • *the mental health problem(s) experienced by the service user and its treatment, including relevant 'Understanding NICE guidance' booklets* • *statutory and voluntary local support groups and services specifically for families and carers, and about how to access these* • *their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.*

138	MIND	47.20	Full	5.2.4	44	**Re Barriers: service (waiting list)** – the second quote on this page reflects a common comment about thresholds for accessing in-patient mental health services (psychosis and/or high risk of suicide), which though relating to the capacity of services is not necessarily to do with waiting lists as such. It begs questions as to the timeliness and adequacy of community-based care and support as well as the function and capacity of in-patient units.	Thank you for your comment, we agree that timeliness for accessing services is of central importance to service users and have included specific recommendations for this in the NICE guidance, see section 1.2.
164	MIND	47.21	Full	5.5.1.4	55	[Also NICE p14: 1.2.4] **Re BME groups' access to services** – we strongly support this recommendation but suggest changing 'same access' to 'equal access' (or something more specific such as 'equal ease of access and speed of response') to reflect the fact that the 'same' access may not be equal and that ensuring equality could entail differences in access arrangements to meet BME groups' needs.	Thank you for your comment, the recommendation has been amended in line with your suggestion.
165	MIND	47.22	Full	5.5.1.4	55	[Also NICE p14: 1.2.4] Vulnerable migrants have a very high risk of mental health problems, because in addition to the issues facing everyone they may also be suffering the consequences of poverty, war, torture and trauma in their country of origin, as well as the prolonged disruption caused to their lives by the UK asylum process. The obstacles to accessing mental health services include confusion regarding entitlement to care. Therefore it would be helpful to specify vulnerable migrants among the wider constituency of BME groups.	Thank you for your comment, the recommendation has been amended to include other diverse groups.
172	MIND	47.23	Full		57	**Re lack of evidence on continuity of care and smooth transitions** In a survey carried out by Mind to contribute to the Future Forum on NHS reforms, Mind found that 45 per cent had been assessed three times or more to gain access to services, with nearly one in 10 assessed eight times or more. (The survey was carried out between 21 April and 13 May 2011 in response to the listening exercise on the Health & Social Care Bill. It received 1442 responses and 94 per cent of those responding had experience of mental distress.) Numerous people responding to Mind's Care in Crisis call for evidence recounted experiences of multiple assessments to access services even in crisis.	Thank you for your comment. The GDG agreed that continuity of care is important and choose to make a recommendation in Chapter 7 (please see 7.5.1.7) as they felt it applied more generally to community care.

174	MIND	47.24	Full		63	'Involvement in decisions and respect for preferences' – the statement does not really reflect this heading	Thank you for your comment. We have added the word 'preferences' into the statement.
176	MIND	47.25	Full	6.5.1.2	65	[Also NICE p15: 1.3.2] 'the assessment will cover all aspects of their experiences and life' – while we agree with comprehensive assessment, and respecting and understanding all facets of a person's life, this needs to be acceptable to the service user and is only realistic in a context of trust and accountability	Thank you for your comment, we agree that all assessment, and care in general, should be given in this context and recommend in 1.1.1 that all healthcare professionals should develop a supportive, empathic and non-judgemental relationship with all service users.
185	MIND	47.26	Full	6.5.3	67	Re research as to whether people want to know their diagnosis - are there different issues here? One question might be what kinds of knowledge people want in relation to their mental health experiences, and another might be what people want to know about the clinical diagnoses and related information that their mental health professionals are working with.	Thank you for your comment, the guidance group have emphasised only one aspect of this in the research recommendation (knowledge about the diagnosis and related information).
186	MIND	47.27	Full	7.1	68	Thank you for referencing Mind. Please could you change case from 'MIND' to 'Mind'.	Thank you for pointing this typo out, it has been amended in the text.
191	MIND	47.28	Full	7.2.5	77	We welcome the attention to self harm and no-harm contracts. Mind's Care in Crisis inquiry has heard from people who value different ways of approaching harm and risk in relation to self harm.	Thank you for your comment.
193	MIND	47.29	Full	7.2.5	78	Re sexual dysfunction it should be noted that there are reports of post-SSRI sexual dysfunction (ie it is not resolved by stopping treatment). This has very profound implications for quality of life.	Thank you for your comment. In this section were trying to find the main themes relating to poor experience of care. We were not examining whether there are specific side-effects of medication.
263	MIND	47.30	Full	11.5.1.10	143	[Also, NICE p25: 1.8.10] **Control and restraint** It is very important that any use of restraint is a last resort, carried out by those trained and competent to do so. However Mind would prefer to see an emphasis on more humane alternatives to restraint being used. This is a critical safety issue – to prevent death and injury – and also an issue of respect and dignity. This report by the service user group Maat Probe highlights differents forms of abuse experienced by black mental health service users and the impact of restraint. http://www.maat.face-2-face.org.uk/ Approaches we are aware of are: Respect Solutions - http://www.navigocare.co.uk/index.php?id=respect-training-solutions This approach is advocated by Maat	Thank you for your comment, we agree that this should be used only as a last resort and have amended to recommendation to make this clearer: *Control and restraint, and compulsory treatment including rapid tranquillisation, should be used as a last resort, only after all other attempts at negotiation and persuasion have been tried; and only by healthcare professionals trained and competent to do this. Document the reasons for such actions.*

						Probe. Studio III - http://studio3.org/about/	
264	MIND	47.31	Full	11.5.1.10	143	[Also, NICE p25: 1.8.10] Police practice generally may be outside the scope of this guidance, but police intervention on NHS premises and in returning patients who are detained and have left hospital without leave, should be of concern to the NHS. There have been at least two deaths associated with restraint in these circumstances in the last year. Therefore our view is that NHS guidance on the safe management of violence/aggression should apply to the police as well.	Thank you for your comment. You are right that Police practice is outside the scope, but we agree that this guidance will be useful for Police intervention on NHS premises.
65	NETSCC-HTA Referee 1	10.01	Full	General	General	The work fulfills the intentions of the nice guidelines	Thank you for your comments.
66	NETSCC-HTA Referee 1	10.02	Full	General	General	The methods used to present the data are appropriate for the study being undertaken. However, a lot of the work is based on the comments of service users who have had negative experiences and does not present comments from those who have had positive experiences. My concern about the validity of the work is that there is no indication that the comments included in the study are from service users in general or just a small sub-group who have had bad experiences.	Thank you for your comments.
67	NETSCC-HTA Referee 1	10.03	Full	General	General	This is primarily a qualitative review. A few summary statistics (percentages) and effect sizes from systematic reviews are quoted in the text, these are correct and appropriate for the review undertaken	Thank you for your comments.
68	NETSCC-HTA Referee 1	10.04	Full	General	General	The recommendations included in this manuscript are based on the evidence and are appropriate for the level of evidence.	Thank you for your comments.
69	NETSCC-HTA Referee 1	10.05	Full	General	General	A lot of the evidence is based on service user comments reported in other studies. This may lead to bias as only those who have had a bad experience are included. This limitation should be included in the report	Thank you for your comment. However, the purpose of the first review question was to capture the key problems associated with the experience of care (please see the review protocol in Appendix 5), therefore capturing bad experiences was not a limitation, but the objective. Note, we supplemented this evidence with themes to do with suggestions for how to improve services and data from surveys. We used GDG expert opinion to determine what the key requirements were for a good experience of care. We believe that this was an appropriate approach to take given the limited development time.

70	NETSCC-HTA Referee 1	10.06	Full	General	General	The report is very readable and it is easy to understand how conclusions have been reached	Thank you for your comments.
71	NETSCC-HTA Referee 1	10.07	Full	General	General	The research recommendations are clear and justified	Thank you for your comments.
72	NETSCC-HTA Referee 1	10.08	Full	General	General	My criticism with this type of report is that no comparison is given with those who have had positive experience. It may be that the comments included were not typical of the service user but were from individuals that were difficult to treat	Thank you for your comment. As described above, we used GDG expert opinion to determine what the key requirements are for a good experience.
73	NETSCC-HTA Referee 2	11.01	Full	General	General	**1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** No	Thank you for your comments.
74	NETSCC-HTA Referee 2	11.02	Full	General	General	Please note I have used this section to present the bulk of my comments, some of which also apply or are relevant to sections of the review below. I have made overall points below, rather than repeat specific comments made in this section.	Thank you for your comments.
110	NETSCC-HTA Referee 2	11.03	Full	3 & 3.3.1	19	Lines 17-19 imply that service users in the GDG were not treated in the same way as non service users, since service user concerns were routinely discussed as part of the standing agenda (ie given special treatment). This may well be appropriate, but a rationale to explain this would be useful.	Thank you for your comment. Chapter 3 is a taken from a template used by NCCMH for every guideline. This standing agenda item, as with every guideline group, is to ensure service user and carer members are fully engaged with the process.
111	NETSCC-HTA Referee 2	11.04	Full	3.3.3	19	Lines 34-35 Did the service users/carers contribute generally to creating the recommendations, as well as from their own perspectives? Why not categorise the roles of all members, not just service users and carers?	Thank you for your comment. Chapter 3 is a taken from a template used by NCCMH for every guideline, and therefore do not feel it necessary to amend this.
112	NETSCC-HTA Referee 2	11.05	Full	3.3.4	19	More detail about the special advisors (how and what they contributed) is needed, either in the main report or in appendix 3.	Thank you for your comment. Chapter 3 is a taken from a template used by NCCMH for every guideline, for more information about special advisors please see section 3 of the NICE Guidelines Manual.
114	NETSCC-HTA Referee 2	11.06	Full	3.4	20	Lines 5-8 More detail about how the GDG developed the matrix and the rationale for using the Picker Institute matrix are needed, to help the reader can assess the validity of the approach.	Thank you for your comment. We have added a sentence explaining the rationale for choosing the Picker framework.
116	NETSCC-HTA Referee 2	11.07	Full	3.5	20	Lines 19-24 Why were the PICO guidelines used, what is the rationale, what are the benefits and challenges. How relevant and valid are these for this guideline.	Thank you for your comment. The PICO framework was used because this is what is advised in the NICE guidelines manual for interventions. We realise that the key problems review was not about interventions, but the PICO framework still seemed appropriate. We would be interested in hearing if there is a more valid approach to structuring the review question.

117	NETSCC-HTA Referee 2	11.08	Full	3.5	20	Both reviews used a focused search strategy, which appears appropriate to the aims and the constraints in terms of time and resources. It would be useful if more detail could be given about the rationale behind various limitations on the search (eg range of studies searched for, sources etc). Particularly for the first review about problems experienced by service users, could important single studies have been missed by the search methods used? Could more evidence that was pertinent to the objectives of the review have been identified by searching the single study literature rather than focusing on existing guidleines and reviews?	Thank you, but given the short amount of time allocated to developing this guidance we believe that utilising work done for existing NICE guidelines or reviews of interventions was the only approach we could take (for example, in the key problems review we included 133 qualitative studies or reviews of qualitative studies, four qualitative analyses, including one done specifically for the guidance, and three surveys). We agree that it's possible that more recent single studies could have been published, but given the purpose of the key problems review (to identify only the key problems – not every problem), then we think it unlikely that this approach would have produced any major bias. We agree that we could make the rationale for the approach more explicit, so we have added a sentence to section 4.2.
120	NETSCC-HTA Referee 2	11.09	Full	3.6	24	Lines 16-20 The methodology checklists referred to in Appendix 9 are screening questions. Does this mean that any reviews failing one or more of the screening questions were excluded and if so, what are the implications of this. Some more general points are that it would be useful to give a blank version of the methodology checklist and data extraction forms at the beginning of each appendix or in the main report. It would also be useful if the data reported in the appendices (and the main report in places) could be summarized in tables, rather than giving the 'raw' unstructured data. This could facilitate comparison across studies for each key theme (eg Appendices 12 and 13). The replications of excel spreadsheets in Appendix 11 needs to be re-visited, since on a practical level they are very difficult to read.	Thank you for your comments. The methodology checklist was from the NICE guidelines manual. It was not used to exclude studies, but rather to assess the risk of bias (reported in tables 22 to 31). Blank versions of the methodology checklists can be found in the NICE guidelines manual. We will add a blank version of the data extraction checklist to Appendix 8. We did summarise key themes for the GDG, but have not added this as an Appendix. We will do this for the published version. We agree that Appendix 11 is difficult to read as they were designed to be projected on large screen for GDG meetings (in colour). We will re-consider how to make these available.
121	NETSCC-HTA Referee 2	11.10	Full	4	27	The title of this section could be changed. My first interpretation was that the section dealt with the problems faced in conducting the reviews, not the problems experienced by service users.	Thank you, the title has been amended to read: *"Review protocol and sources of evidence for the review of key problems associated with the experience of care"*
122	NETSCC-HTA Referee 2	11.11	Full	4	27	In this and subsequent sections it would be useful to have a flow diagram of the number of titles identified, screened, included, numbers of titles excluded for	Thank you for this suggestion, but we are not convinced that a flow diagram would add much to what is described in the text. Because we utilised existing

						different reasons.	guidelines and 3 surveys, we did not have excluded studies in the same way a traditional review would have.
124	NETSCC-HTA Referee 2	11. 12	Full	4.3	28	Lines 9-11 Either in this section or in chapter 3, it would be useful to have more detail about how the surveys used were identified, presumably not by the search strategy used to identify the reviews.	Thank you, we agree this could be clearer, and have added extra text to section 4.2.
125	NETSCC-HTA Referee 2	11. 13	Full	4.3	36	What methods were used for the qualitative analysis reported in Table 10? There is a note of limitations, but this is in fact a rationale for not including numbers in the analysis, rather than a limitation of the analysis. Qualitative researchers disagree over whether numbers and percentages should or should not be included. Some of the limitations recorded in this table appear to be results rather than or as well as limitations. For example, if participants do not know the type of staff they have seen, this may be a problem they have encountered in using the service, rather than a limitation of the anlaysis.	Thank you, the method should have been described. This has been added. The section about limitations is also a place to note anything important about the analysis. The first bullet point is an important point rather than a limitation. The limitation about participants not being aware of who was treating them could be about the care they received, but also was a limitation of the method because the guidance is about secondary care, but it was not always possible to know if the evidence came from service user's experience of primary or secondary care.
126	NETSCC-HTA Referee 2	11. 14	Full		38	What methods were used to analyse the data from the surveys (Table 11)?	Thank you, again this was an oversight as the method section should have been filled in.
129	NETSCC-HTA Referee 2	11. 15	Full	5 -11	39 -144	A general point about sections 5-11 is that it is sometimes hard to identify detail in the appendices that would facilitate understanding of the summaries in the main report. Better signposting of where information in the appendix can be found would be helpful (eg table numbers/page numbers	Thank you for this suggestion. We think that signposting to a summary of key themes (as you suggested in comment 120) may be the most appropriate and helpful approach.
130	NETSCC-HTA Referee 2	11. 16	Full	5	39	Lines 15-18 The report could also consider explicitly the difference between clinical effectiveness and value of an outcome or set of effectiveness outcomes to the service user. An intervention may be judged to be clinically effective, but the outcomes have little value to the service user, particularly if compared to the costs of participation and side effects. Thus treatment avoidance is an objective reaction, rather than lack of insight.	Thank you, we acknowledge that it is important to consider the difference between clinical effectiveness and value to the service user, although it could be argued that this should be done by guidelines examining the effectiveness of treatment. We think your final point is covered in lines 17-18.
136	NETSCC-HTA Referee 2	11. 17	Full	5.2.3	42	Is it possible to give more detail here. For example are professionals viewed as a barrier across all services/service levels, or are there issues that are specific to say primary or secondary care. It would be	Thank you for your comment. For the review of key problems we aimed to tease out only the high level themes across disorders. The approach was used because we had a very limited time to develop the guidance given we had to cover all adult secondary

						useful if more detail could be teased out here, since it is important to formulate recommendations. The narrative in this section identifies the theme, but doesn't really explore the problems. For example, in what ways were the people accessing alcohol services treated poorly/silenced, what were they denied access to? It's hard to consider the implications if the problems are not clearly defined. If the literature reviewed does not give this level of detail, it is important to state this.	care. We think that given the aim of the review, a more detailed analysis is not needed.
141	NETSCC-HTA Referee 2	11.18	Full		49	Lines 25-26 How did social networks facilitate/impinge on access to care?	Thank you, we've amended the sentence to read: *Many participants described how their social networks facilitated (by providing support) or impinged (by normalising drug use) on accessing care or treatment (PSM guideline [NCCMH, in press]).*
146	NETSCC-HTA Referee 2	11.19	Full		50	Table 12, first statement: it would be useful if this was expanded: is this just preferences for time/date of appointment, or does it also include preferences for location/who with etc.	Thank you for your comment, the text has been amended to reflect your suggestion.
151	NETSCC-HTA Referee 2	11.20	Full		51	Table 12, third statement: respectful way – what does this mean. Some definition of terms like these would be useful, since perceptions of respect vary between ages and cultures.	Thank you, but these statements were turned into recommendations (where appropriate), which are designed to clearly specify what should be done. We're not convinced this is necessary.
152	NETSCC-HTA Referee 2	11.21	Full		51	Table 12, What is a containing intervention?	Thank you, but again these statements were turned into recommendations (where appropriate), which are designed to clearly specify what should be done. We're not convinced this is necessary.
175	NETSCC-HTA Referee 2	11.22	Full	6	63	Table 13, what is meant by assessment are person and culturally centred; service user is treated with respect and empathy.	Thank you, but these statements were turned into recommendations (where appropriate), which are designed to clearly specify what should be done. We're not convinced that defining every term in the table is necessary.
187	NETSCC-HTA Referee 2	11.23	Full	7	68 -91	An additional theme to explore in this section, identified in the introduction to the theme is whether people are aware of and enabled to use the personal budgets. If there is no data about this, then it would also be useful to state this.	Thank you for your comment, personal budgets are clearly discussed (see page 68 under Background) and recommended in 7.5.1.4.
194	NETSCC-HTA Referee 2	11.24	Full		78	Lines 30-35 the quote here is about the benefits of treatment being less than costs of side effects and does not match the preceding comment.	Thank you, but the quote is about one person's experience of suicidal/self-harm thoughts while taking medication. It is suppose to illustrate Lines 25-30.
199	NETSCC-HTA Referee 2	11.25	Full	Table 14	85	Table 14 and more generally, it is important to make sure that the statements in the tables are sufficiently	Thank you for your comment, the statements in these tables are not recommendations. All the

						detailed so that the reader could follow both the spirit and letter of the recommendation. For example a standard letter and form sent in advance could result in impersonal communications, which contradicts the preceding evidence and recommendation 7.5.1.1. Another example, is the care plan to include meaningful activities, is this meaningful to the service user or the health care provider? How should a refusal of treatment be dealt with? It would be good to have a follow on statement that deals with this.	recommendations appear in 7.5. With regard to meaningful activities, it would have to be meaningful to the service user rather than the service provider. As the guidance is concerned with the experience of care it is outside the scope to delineate how treatment refusal should be dealt with.
210	NETSCC-HTA Referee 2	11. 26	Full	8	94	Does the data from the reviews in personality disorder actually address the issues of diagnosis in crisis situations. The quotes presented suggest that it does not. It also replicates the data presented in earlier sections. It may be better to state that there is no direct relevant evidence to address this issue.	Thank you, we agree that the issues for people with personality disorder are not necessarily about diagnosis in crisis. We will amend the text.
212	NETSCC-HTA Referee 2	11. 27	Full	8	95	Should the recommendation also include the need for health care professionals to make sure the service user is aware that advocacy services are available, rather than simply waiting for the service user to request one.	Thank you for your comment, recommendation 1.1.2 states that healthcare professionals should offer access to advocates.
234	NETSCC-HTA Referee 2	11. 28	Full		112	Lines 28-43 These points appear to relate to community care, some clear signposting to make it clear whether they are also relevant to inpatient care would be useful. It would also be useful if the community care section included a signpost to this information.	Thank you for your comment. The reference to community care was a typo, it should have read 'hospital care'. We have corrected this error.
250	NETSCC-HTA Referee 2	11. 29	Full	10	118 -130	Overall, I found it hard to disentangle discharge from community care from discharge from inpatient care. Perhaps the information could be presented in separate sub-sections/tables: one for points that are relevant to both settings, one for additional points that are only relevant to community care and one for additional points that are only relevant to inpatient care.	Thank you for your suggestions, in the time available this would not be possible.
255	NETSCC-HTA Referee 2	11. 30	Full		125	The statement about service users being informed of discharge at least 48 hours before discharge/transfer. Does this statement refer to both transfer and discharge. If so, perhaps it would be useful to separate out time to transfer and time to discharge. For example, 48 hours could be too long in situations	Thank you for your comment, the GDG believe that 2 days was the minimum period of time for service users to be able to make arrangements and adjust to a change either in the community or from inpatient to community services. The GDG also thought this was realistic.

						where the service user is transferred from community care to inpatient care in crisis, and too short in discharge situations. Can the arrangement required for discharge realistically be made in 48 hours?	
254	NETSCC-HTA Referee 2	11.31	Full		124 -127	Are there any differences in the content/details provided in Tables 17 and 18. If not, then why duplicate them.	Thank you, table 17 relates to community care, table 18 to hospital care.
266	NETSCC-HTA Referee 2	11.32	Full	12	149	The font size is too small and not readable.	Thank you for your comment, the font size is the same for all tables in the document, and for all tables in all our guidelines.
268	NETSCC-HTA Referee 2	11.33	Full		174	The evidence and discussion also suggest an additional recommendation for practice and research: training/coaching service users in how to get the best from shared decision making processes.	Thank you for your comment. We agree that there is a place for an additional research recommendation on the effect of training/coaching service users to either be more assertive in the 'consultation process' to enhance shared decision making. Recommendation 12.5.1.2. has been amended to include this.
265	NETSCC-HTA Referee 2	11.34	Full	12	145 -174	A general point for this section is whether the reviews/studies evaluated actually measure outcomes that are relevant to the intervention studied or to the objectives of this review. Improving service user experience is a complex process. Can this really be evaluated in any meaningful sense by measures of user satisfaction, particularly those used in the studies. Some comment on this would be useful.	Thank you for this suggestion. We agree that improving service user experience is a complex process. The GDG did discuss the difficulty of interpreting the included studies, and this could be expanded on in the evidence to recommendations section.
75	NETSCC-HTA Referee 2	11.35	Full	General	General	No health economics or statistics included in the guideline, which at the level of evidence available seems appropriate	Thank you for your comments.
76	NETSCC-HTA Referee 2	11.36	Full	General	General	The recommendations appear to clearly follow from the evidence and discussions presented.	Thank you for your comments.
77	NETSCC-HTA Referee 2	11.37	Full	General	General	Key limitations of the evidence reviewed appear to be presented and discussed appropriately.	Thank you for your comments.
78	NETSCC-HTA Referee 2	11.38	Full	General	General	The material is well presented and the style is easy to read and accessible. The recommendations follow from the evidence presented and/or is clearly justified in the text (for example where no evidence is available and the views/experience of the GDG were used to derive recommendations).	Thank you for your comments.
79	NETSCC-HTA Referee 2	11.39	Full	General	General	Overall, there appears to be a lot of duplication of material and I've noted some examples below. It would be useful if all the guideline report and appendices	Thank you for your comment. We will remove unnecessary duplication.

						were read through to identify duplication and assess whether it is appropriate and/or necessary.	
123	NETSCC-HTA Referee 2	11.40	Full	4 -11	27 -144	Within each of these sections there is a lot of duplication between 3 subsections: the table of key requirements, evidence to recommendations and the more detailed practice recommendations. The information in the table appears to summarise the latter 2 sub-sections, and appears to be redundant. There are some cases where the need to be concise may lead to statements that are open to misinterpretation. I have detailed examples of these in earlier comments.	Thank you for your comments. The duplication you mention is appropriate in our opinion. The table of key requirements presents the statements for high quality experience based on GDG expert opinion. The recommendations were drafted by taking into account these key requirements in light of the evidence problems review. The evidence to recommendations section is required by NICE to provide a narrative description of how the GDG moved from the evidence to the recommendations.
80	NETSCC-HTA Referee 2	11.41	Full	3 12 & Appendices	General	There is some duplication of the review protocols between the main text and the appendices, with a summary given in section 3, a detailed account of the protocol for interventions given in section 12 and the summary repeated in the appendices.	Thank you for your comment. We agree there is duplication. We will amend the chapters so as to summarise the review protocols, with full protocols in the appendix.
81	NETSCC-HTA Referee 2	11.42	Full	General	General	There are quite a few typos/spelling/grammatical/punctuation errors which in some places make the meaning ambiguous. In places it appears that odd words remain after re-ordering the text. A thorough proof reading of the report and appendices is needed to identify and correct these.	Thank you, the guidance will be thoroughly proof read by the NCCMH and NICE editors before publication.
82	NETSCC-HTA Referee 2	11.43	Full	General	General	The research recommendations are clear and justified by the preceding evidence/discussion.	Thank you for your comments.
83	NHS County Durham & Darlington	32.01	Full	General	General	Overall it is useful guidance and has potential for informing CQUIN Targets	Thank you for your comments.
84	NHS County Durham & Darlington	32.02	Full	General	General	There are significant training implications in a number of the recommendations- not least those that apply to “all health and social care staff” some indication of expected priority groups and priority training areas from the several mentioned in the guidance would be helpful.	Thank you, we agree training will be important. The GDG formed the quality statements based on the priority recommendations, therefore, the quality standard should be used to identify priority training areas.
85	NHS County Durham & Darlington	32.03	Full	General	General	Some excellent work has been done locally on forensic service user engagement by Carlie Blyth – often guidance contains local examples and this may be worth submitting if Carlie has not already done so.	Thank you, but forensic service user engagement is outside the scope. Further guidance is needed to cover this issue.
157	NHS County Durham & Darlington	32.04	Full	5.4	53	There are some statements on referral to appointment times within one section suggesting this is 2 weeks (p53) and another suggestion about contact about the appointment within 2 weeks (p63). The latter is	Thank you for your comment, the GDG believe this is achievable. It was the GDG’s expert opinion that longer than 3 weeks would lead to a poor experience of care.

						reasonable but 2 weeks referral to appointment is not currently realistic- we are currently looking to achieve 90% at 6 weeks which would make Durham one of the best performers nationally.	
231	NHS County Durham & Darlington	32.05	Full	9.3	110	The ability to be admitted to hospital of choice – would say that some parameters need to be put around this e.g. within commissioned services or within NHS costs. There are a number of independent providers who do not have block contracts who in theory this could apply to and could lead to significant cost pressures whilst mental health is still contracted under block arrangements.	Thank you for your comments, this was listed as an aspirational target by the GDG and was not taken forward as a recommendation, and therefore services would not be expected to deliver this.
239	NHS County Durham & Darlington	32.06	Full	9.5.1.6	114	The recommendation to have as an inpatient 20 mins a week with a consultant and 1 hour a day with lead professional appears a sound recommendation I would like to understand the feasibility of this from providers.	Thank you for your comment. We believe that these targets should be easily achievable for inpatient units that have effect quality improvement programmes already ongoing. Daily one-to-one sessions are already a part of many DH flagship initiatives, regular meetings with the consultant at 20 minutes per week does not seem onerous, given that most inpatient wards now have a full time consultants serving between 18-24 service users.
86	NHS County Durham & Darlington	32.07	Full	General	General	I am pleased to see the inclusion of social issue sin care planning as a priority	Thank you for your comments.
87	NHS County Durham & Darlington	32.08	Full	General	General	The guidance list of recommendations for referral letters and first appointments is a helpful checklist	Thank you for your comments.
25	NHS Direct	26.01	All	General	General	NHS Direct welcome the guidance and have no comments on the content during the consultation.	Thank you for your comments.
26	Northumberland, Tyne & Wear NHS Foundation Trust	68.00	All	General	General	Overall the Guidelines are welcomed and obviously help support our putting the patient at the heart of all we do. I have some concerns about how we will demonstrate our compliance. From my reading there will be implications for the Trust on the following Quality Indicators:	Thank you for your comments.
667	Northumberland, Tyne & Wear NHS Foundation Trust	68.01	QS	4	9	“people using mental health services are supported by staff from a single MDT” with reference to SMR and scaffolding will need to be taken into consideration in the wording of any document	Thank you for your comment, as policy often changes the GDG have tried to keep references to specific policy to a minimum.
746	Northumberland, Tyne & Wear NHS Foundation Trust	68.02	QS	8	14	there will be a requirement to source training in person centred and or customer services by service users **– *cost implication***	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
771	Northumberland, Tyne & Wear NHS	68.03	QS	9	15	it is not always clinically appropriate for patients to have written copies of care plans – there are issues	Thank you for your comments. The GDG believe that all people using mental health services should receive

	Foundation Trust					around writing a care plan so that is followed by trained staff and something that is written to be understood and meaningful to patients. There may be duplication of effort and time costs.	a care plan.
851	Northumberland, Tyne & Wear NHS Foundation Trust	68.04	QS	13	22	clarification about 'formal assessment' would be important. If that is nursing assessment that should be easily met. If it is medical assessment then the current out of hour on call system would struggle to meet this because of the multiple sites covered. It may also skew a doctors order of work away from what is clinically indicated ie having to prioritise a stable admission over a high risk presentation elsewhere. ***Clinical judgement and safety implications***	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
902	Northumberland, Tyne & Wear NHS Foundation Trust	68.05	QS	16	25	1:1 with named health professional every day – likely to be a nurse is highly unlikely to be achieved. Again 20 mins with a doctor may lead to limits on patient numbers per consultant ***– workforce implications***	Thank you for your comment. The statement has been amended to "known" professional.
955	Northumberland, Tyne & Wear NHS Foundation Trust	68.06	QS	19	29	Control and restraint and rapid tranquilisation as a last resort. Again it is important how this is interpreted. Staff in their management of violence and aggression are trained to de-escalate and to act to keep all safe. This may mean pro-actively using control and restraint before and to avoid an incident. - ***Clinical judgement and safety implications***	Thank you, the GDG considered a number of suggestions, and reworded this to read: *People in hospital for mental health care are confident that the use of control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely, and only as a last resort with minimum force.*
970	Northumberland, Tyne & Wear NHS Foundation Trust	68.07	QS	20	30	"people using mental health services who are subject to control and retraint or compulsory treatment inclusding rapid tranquilisation have the reasons explained to them immediately afterwards and at discharge, and are given the opportunity to document their experience in their care record – already in our policy EXCEPT not necessarily immediately afterwards – likely to re-inflame the situation. Moreover staff should be talking to the patient and explaining what is happening when or before it happens.- ***Clinical judgement and safety implications***	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
88	Northumberland, Tyne & Wear NHS Foundation Trust	68.08	Full	General	General	Looking through Chapters 9, 10 and 11 there is not a great deal that is contentious. It does feel like all the negative comments from research have been summarised though – ie there are relatively few examples given of "this was the good experience I had that helped me during my stay in hospital". One thing that was interesting which may have some impact – (although not much in LD) – is the recommendation to	Thank you for your comment. However, the objective of the review covered in chapters 4 to 11 was to identify the key problems in current service user experience of NHS mental health services. Therefore, we extracted primarily themes regarding poor experience. Please see Chapter 4 for further information about the review protocol.

						give at least 48 hours notice prior to discharge taking place.	
213	Northumberland, Tyne & Wear NHS Foundation Trust	68.09	Full	8.3	95	Generally all recommendations are uncontentious but a few minor points / Recommendations Service users can expect a health and social care professional to attend to them, respecting their views and exploring other options where possible apart from hospital admission. The inequality of power in the relationship is respected, giving the service user access to an advocate where requested Is 'recognised' a better word than 'respected'? Service users can expect all staff to work together well; those best known to him/her to have a "buddy" who will cover for the healthcare professional when they are absent. Realistically I think this may be difficult to achieve in practice with large teams and a phrase such as keeping to minimum changes of staff and ensuring that information is passed across between staff.	Thank you for your comment, the guidance has been amended to reflect your first point. In regards to your second point, the GDG agree it won't be easy (and therefore this point has not been reflected in the final recommendations), however it is something that many service users would like.
131	Nottinghamshire Healthcare NHS Trust	17.01	Full	5.1	39	Line 16: The term "insight" is a controversial one as there are many different ways of seeing mental health problems and it is a contested area. Often insight refers to not agreeing with a medical diagnosis. It would be more appropriate to talk about "a divergent view of their difficulties and what may help from mental health services".	Thank you for your suggestion, the text has been amended.
132	Nottinghamshire Healthcare NHS Trust	17.02	Full	5	39 -55	Overall some very useful points and standards. My own view is that we can also offer service users different explanations of their difficulties. We take someone's diagnosis as a given but whether diagnosis is the right way to categorise MH difficulties is highly contested. The use of diagnosis as the report highlights can feel stigmatising and my belief is that we should be more open to different explanations of mental health difficulties. Diagnosis could be offered as one way of seeing a person's difficulties but acknowledged that that this is a perspective rather than a truth. Also in this section, having timescales for seeing MH professional is how it should be but I wonder about how doable this is with services shrinking at the moment. A number of the recommendations could however be achieved without increase in resources needed.	Thank you for your comment. The inclusion of diagnosis was at the behest of service users in the GDG who were keen that this should be discussed and have adequate information and explanation for this. We disagree. We do not think a strong medical model has steered the GDG, more than 50% of the panel were representing service user and carer interests and only 2 psychiatrists were involved.
168	Nottinghamshire Healthcare NHS	17.03	Full	6	56 -67	A general point regarding decision making. My sense is that the whole influence of power in decision making	Thank you for this suggestion, but we believe this is covered this in Chapter 11 on detention under the

	Trust					is not always considered or talked about enough. Whilst noted in the introduction, MH services have a care agenda but also a social control agenda through mental health legislation. In terms of the recommendations in the section, I would like to see something more explicit about maximising the influence that service users have in those situations where legislation removes a large chunk of influence.	MHA.
188	Nottinghamshire Healthcare NHS Trust	17.04	Full	7	68-91	Given the importance people put on being offered psychological interventions it was a shame that this was not stressed in the key requirements section.	Thank you for your comment, access to appropriate psychological interventions is recommended in 1.4.8 of the NICE guidance.
241	Nottinghamshire Healthcare NHS Trust	17.05	Full	9.5.1.9	114	I wonder if this could go further and actually recommend that each ward has a employed activities co-ordinator.	Thank you for your comment. The GDG agreed that it was more important to ensure that activities are provided than what type or how many staff from a particular background are employed to deliver these activities.
224	Nottinghamshire Healthcare NHS Trust	17.06	Full	9	100-117	Would it be possible for the report to go further. My understanding is that where user-led crisis houses are used the experience is improved. I wonder about recommending that trusts invest in at least one crisis house rather than always using NHS wards.	Thank you for your comment, however our reviews found no evidence to support this as a recommendation.
89	Nottinghamshire Healthcare NHS Trust	17.07	Full	General	General	Overall there are many positive suggestions and I believe this to be a very positive and informative document. I think that the challenge will be to enhance service user experience in a shrinking mental health service which naturally becomes even more focused on risk.	Thank you for your comments.
90	OCD Action	31.01	Full	7.3 9.3 10.3	General	Since the 1st April 2009, patients have had a right to choose the organisation that provides their treatment when they are referred for their first outpatient appointment with a consultant-led team. See “The Handbook to the NHS Constitution” which is explained on the following website: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Yourrightstochoice.aspx The legal right applies at present to referrals for elective care services only (that is, ones which are pre-arranged). The Department of Health now appears to discriminate against people who are disabled by their mental disorder, and needing elective care, as ***mental health services are specifically excluded from the legal right for choice of referral.*** As part of the process of producing guidelines on service user experience NICE must seek to remove	Thank you for your comment, however NICE guidance makes recommendations to healthcare professionals regarding clinical practice, and are unable to change policy issued by the Department of Health.

						this inequality. A significant number of referrals for mental health services are elective. This is especially relevant for those users who have not made progress locally and are seeking specialist service.	
284	POhWER	49.00	NICE	General	General	As the largest advocacy-only charity in England we welcome the references to advocacy in this document. However as a significant provider of Independent Mental Health Advocacy and the largest provider of Independent Mental Capacity Advocacy we are concerned that neither of these statutory services is specifically mentioned in the guidance. We acknowledge that for service users who are not eligible to access the statutory services professional advocacy is not always available. We support the use of peer advocacy but would urge NICE to include written guidance about ensuring that any advocacy services which service users are referred to are of an appropriate standard (for example, advocates should have the National Qualification in Independent Advocacy and the organisation should hold the Quality Performance Mark) and are well managed.	Thank you for your comment, we agree with your point that training for advocates had been omitted from the document and we have therefore amended recommendation to 1.1.2 to reflect this. However, we are unable to specify the type of training or qualification as this is a professional/accreditation issue that is beyond the scope of this guidance.
337	POhWER	49.01	NICE	1.1.2	8	Bullet point four – 'offer access to an advocate' There should be reference here to the responsible person's duty to provide verbal and written information to qualifying patients about the statutory right to an Independent Mental Health Advocates (IMHAs).	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and have amended recommendation 1.6.13 to read: *Ensure that all service users in hospital have access to advocates who can regularly feed back to professionals any problems experienced by current service users on that ward. Advocates may be formal IMHAs, or former inpatients who have been trained to be advocates for other non-mental health act service users.*
341	POhWER	49.02	NICE	1.1.3	8	Bullet point 2 - 'address service users using the name and title they prefer' It would be helpful if, having established the service users' preference this could be recorded for the use of others. Clients often say that it is discouraging to have to re-introduce themselves over and over.	Thank you for your comment, some service users may wish to be addressed differently by different healthcare professionals depending on how well they know them, and therefore the GDG feel the current wording is sufficient.
362	POhWER	49.03	NICE	1.1.9	10	This section refers to the Mental Capacity Act (2005). However there is no reference to the statutory role of Independent Mental Capacity Advocates (IMCAs) in decisions about treatment for service users who have been assessed as lacking capacity. Service users who	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and have amended recommendation 1.6.13 to read: *Ensure that all service users in hospital have access to*

						have capacity should be referred to an IMHA (if qualifying) or a community advocate.	*advocates who can regularly feed back to ward professionals any problems experienced by current service users on that ward. Advocates may be formal IMHAs, or former inpatients who have been trained to be advocates for other non-mental health act service users.*
377	POhWER	49.04	NICE	1.1.14	11	An additional bullet point could be added: • Their rights if they are the nearest relative	Thank you for your comment, we are unable to make recommendations further to those made about the involvement of families and carers as it is outside the scope of this guidance.
398	POhWER	49.05	NICE	1.2.2	13	Bullet point 6 – suggested rewording: 'Explain that ….. it is preferable to see the person alone for some of the assessment **and why**'.	Thank you for your comment, it would be difficult to operationalise 'why' in this context and the GDG feel would be introducing unnecessary and distracting detail to this recommendation.
405	POhWER	49.06	NICE	1.2.5	15	Access to suitable advocacy support is often a very effective reasonable adjustment. Organisations like ours are able to offer support to people with a variety of different communications needs.	Thank you for your comment, the whole of section 1.2 captures many of the principles in the Equality Act 2010: this recommendation is primarily to remind health and social care professionals they should take into account requirements of that act.
409	POhWER	49.07	NICE	1.3.3	15	Bullet point 4 – suggested rewording: 'Explain and give **accessible** written material…..'	Thank you for your comment, this has been amended to reflect your suggestion.
413	POhWER	49.08	NICE	1.3.4	16	Suggest including giving the service user the option to access an advocate	Thank you for your comment. Access to an advocate is covered in recommendation 1.1.2.
415	POhWER	49.09	NICE	1.4	16	Remind user of availability of advocacy support for the care planning process	Thank you for your comment. Access to an advocate is covered in recommendation 1.1.2.
437	POhWER	49.10	NICE	1.5.1	18	Suggest adding finding out if the service user has an advance directive. It may also be worth establishing if the person has an advocate who can support them, and in areas where crisis advocacy is available, make reference to this.	Thank you for your comment, the recommendation has been amended to read: *Immediately before assessing a service user who has been referred in crisis, find out if they have had experience of acute or non-acute mental health services, and consult their crisis plan or advance directive if they have one. Find out if they have an advocate and contact them if they wish. Ask if the service has a preference for a male or female health or social care professional to do the assessment and comply with their preference wherever possible.*
455	POhWER	49.11	NICE	1.6.2	20	Bullet point 5: Suggest adding access to advocacy, including IMHA if appropriate	Thank you for your comment, however advocacy is discussed in other recommendations and therefore is not necessary here.
470	POhWER	49.12	NICE	1.6.9	22	Suggest including self-help groups	Thank you for your comment, we feel this is included in 'self-care'.
471	POhWER	49.	NIC	1.6.1	22	Suggest adding access to a telephone	Thank you for your comment, this has been added.

		13	E	0			
481	POhWER	49.14	NICE	1.6.13	22	This section should make reference to the duty to inform qualifying patients of their statutory right to access a qualified IMHA. We welcome the promotion of peer advocacy. This is a service we provide as part of our advocacy portfolio in support of the recovery model. However, our experience suggests that such schemes need careful management to ensure independence, knowledge and reliability otherwise they fall into disrepute causing damage to peer advocates and to clients. We suggest that these services are most effective where they are properly commissioned and professionally delivered. See note 18 below.	Thank you for your helpful comment, we agree that this was omitted from the first draft of the guidance and have amended the recommendation to read: *Ensure that all service users in hospital have access to advocates who can regularly feed back to ward professionals any problems experienced by current service users on that ward. Advocates may be formal IMHAs, or former inpatients who have been trained to be advocates for other non-mental health act service users.*
484	POhWER	49.15	NICE	1.6.14	22	We find that food is frequently commented upon – especially by people who are inpatients for a length of time. We suggest adding that patients should be involved in menu planning.	Thank you for your comment, this may not be possible in all settings but in the last sentence of the recommendation we have stated that this should be considered by services.
487	POhWER	49.16	NICE	1.7.2	23	A significant number of clients who have called to discuss problems arising after discharge tell us that they have been unable to obtain much help as professionals do not have access to their notes. It can sometimes take a great deal of effort to make a call and an unhelpful response does a lot of damage. In setting standards therefore, it is important to emphasise that those responding to patient concerns must be able to offer adequate responses or let the patient know how and when they will be contacted by someone who can address their concerns	Thank you for your comment, this issues is covered in greater detail in chapter 10 of the full guidance.
494	POhWER	49.17	NICE	1.7.7	23	This section needs to be rewritten. PALS stands for Patient **Advice** and Liaison Service, not Advocacy. Advocacy is available by statute to most mental health inpatients and is commissioned from trained, specialist providers, usually by PCTs. It is quite separate from PALS. We suggest that the paragraph be amended to say: "Commissioners should be encouraged to specify and commission a peer advocacy service through a statutory advocacy provider.' 'If a peer advocacy service has been commissioned, when preparing a service user for discharge, consider encouraging patients to contact the relevant advocacy service to find out about peer advocacy opportunities'.	Thank you for your comment, recommendations for commissioners are included in the quality statements.
503	POhWER	49.	NIC	1.8.4	24	Suggest adding an additional bullet point concerning	Thank you for your comment, this would not be

		18	E			the Mental Capacity Act and providing information for the nearest relative about Independent Mental Capacity Advocates.	applicable here as under the MHA the relevant advocates would be IMHAs, which we have added to recommendations 1.6.13 and 1.8.5.
545	POhWER	49.19	QS	General	General	Access to advocacy is a statutory right for qualifying patients and is commissioned by PCTs (IMHA) and Local Authorities (IMCA) from specialist providers with trained staff. There is guidance about commissioning IMHA services available at: http://www.dh.gov.uk/en/Healthcare/Mentalhealth/InformationontheMentalHealthAct/DH_091895 and guidance about commissioning IMCA available at: www.scie.org.uk/publications/guides/guide31/index.asp In many areas commissioners go further and extend advocacy to a wider group of patients and some commission peer advocacy as part of the service. Whilst we are pleased to the many references to advocacy throughout the document we are concerned about the apparent lack of knowledge about the nature of the statutory services, about the professional training that is required and the standards that apply. We are also concerned about the rather casual reference to peer/inpatient advocacy and the erroneous link with PALS. Considerable work has been done to develop peer advocacy in a way that protects patients' interests and supports peer advocates to develop a new skill, yet this is not referred to. It is worrying that a document about the service user experience should lack such fundamental knowledge about a statutory service that so many service users campaigned for, contributed to and see as fundamental to a more effective relationship between service users and professionals To address this, we would like to see a separate standard concerning advocacy which would support the requirements of the Mental Health Act and Mental Capacity Act.	Thank you for your comment. We acknowledge that this is an important issue and is addressed in recommendation 1.8.5. However, the GDG had to reduce the Quality Standard to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience. Therefore, this suggestion has not been adopted.
579	POhWER	49.20	QS		2	We agree that a great deal more needs to be done to ensure that people from BME groups get fairer access to services. We think that this also applies to all equality groups and would like this standard to recognise the reasonable adjustments that all equality groups are entitled to.	Thank you for your comments. Access to services for specific groups is not highlighted as a specific quality statement however the guidance has been amended to draw attention to this issue (Rec 1.1.6 – 1.1.8)

800	POhWER	49.21	QS	10	17	Quality Standard 10 implies that service users are able to refuse treatment and that this can be included in their crisis plan. For those subject to a compulsion order who can be treated for up to three months without their consent refusal of medication is not an option.	Thank you for your comment. Preferences for refusals of treatment can be included in a crisis plan.
973	Princess Royal Trust for Carers	22.01	NICE	QS 21	7	The guidance states that service users will be asked if information can be shared with carers. However, this should be expanded to ask service users to identify carers. This would enable carers to receive support and information if the service user declined consent.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
383	Princess Royal Trust for Carers	22.02	NICE	1.1.16	12	The guidance does take into consideration service users needs as parents or care givers. It would be beneficial to expand this section to include identifying whether children are acting as young carers. These young carers then can be provided with support and information in their own right.	Thank you for your comment, we agree this is an important issue, however it is outside the scope of this guidance. In most mental health NICE guidelines we do raise this issue.
286	Princess Royal Trust for Carers	22.03	NICE	General	General	It is readily identified that service users and service providers have a better experience if carers are included in all aspects of care and support. The embedding of carer inclusion in all aspects of service delivery as clearly identified in “The Triangle of Care, Carers Included: A guide to best practice in acute mental health care”. I would recommend this as a reference document. It is also included in the new mental health strategy. As such, I feel that the needs and input of carers is sadly sidelined; when in reality carers are essential to the ongoing improvement in service users mental, emotional and physical well-being.	Thank you, but the GDG recognised the importance of carers and created a specific section in the NICE guidance on involving families and carers, which has five recommendations, four of which are very detailed.
287	RCGP	51.00	NICE	General	General	The ethos of patient centred care is to be encouraged. The difficulty is whether bust mental health services could meet all the standards.	Thank you for commenting. The GDG acknowledge in the full guidance that some recommendations are aspirational, but believe that these are very important if the experience of care is to be improved.
594	Rethink Mental Illness	61.00	QS	1	5	Rethink agree that mental health practitioners need to be non judgemental and display true empathy, so that a therapeutic relationship can be established. For this to happen more authentically, more people with direct experience of mental illness should be employed as peer support workers. People with their own experience of mental illness (peers) can directly contribute to the recovery of others.	Thank you for your comment, the GDG discussed the ‘recovery model’ at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.

						We would like to see more explicit reference to the possibility of recovery and pathways to recovery outcomes, particularly around staff competence. "Useful work has been done on the training needs of staff (knowledge and skills) in the capabilities for inclusive practice (National Social Inclusion Programme, 2007) This builds on the Ten Essential shared Capabilities Framework (NIME, 2004) which contains many recovery ideas." (Geoff Shepherd et al (2008) *Making recovery a reality*) Rethink would also like to see more emphasis placed on pathways to individual recovery outcomes which also recognise the variety of individual experiences of mental illness and the range of conditions in the treatment and care of people using mental health services. **Personal recovery** is an idea that has emerged from the expertise of people with lived experienced of mental illness, and means something different to clinical recovery, though clearly the two can be interlinked. The most widely used definition of personal recovery is from Anthony 1992: "…a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Mike Slade (2009) *'100 ways to recovery'* Rethink publication)	
622	Rethink Mental Illness	61.01	QS	2	6	Rethink recommends that Equality and Diversity should extend to other equalities strands, including Lesbian, Gay, Bisexual and Trans (LGBT) People accessing services are protected from discrimination on the grounds of sexual orientation, and on the grounds of their sex (which specifically	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the

						includes people at any stage of undergoing gender reassignment). Research draws attention to institutional homophobia within mental health services. LGBT people can still be faced with homophobic attitudes from mental health services. 1/3 of gay men, 1/4 of bisexual men and over 40% of lesbians have experienced negative or mixed reactions from mental health professionals when they disclosed their sexual orientation. Some health professionals may wrongly attribute mental ill health to sexual orientation, as opposed to the pressures faced by LGBT people due to prejudice and discrimination. 20% of lesbians and gay men and 1/3 of bisexual men stated that a mental health professional had made a direct causal link between their sexual orientation and their mental health problem. Consideration should also be given to people vulnerable to dual discrimination e.g. who are gay and black. (Department of Health (2007) *Briefing 9: Mental Health issues within lesbian, gay and bisexual communities*) There can be particular issues for trans people when accessing services, especially those which are gender segregated. 21% of trans people have reported that their GP did not want to support them, and 6% of people were refused help from their GP – even on non-gender reassignment issues. Discrimination against transgender people is called 'transphobia'. By law, services must recognise the new gender identity of a person who has completed gender transformation and has been issued with a 'Gender Recognition Certificate'. However, trans people who may not have completed gender reassignment surgery will not have a certificate but are still entitled to be safe and treated with dignity. We note that the practical guide for the NHS on trans issues from Department of Health does not address best practice in such circumstances. The National Institute for Mental Health England recommended that 'an awareness of the mental health needs of LGB people should become a standard part of training for health and social work professionals. Rethink agrees with this recommendation, though we wish to see inclusion also of the needs of transgender	greatest improvement in service user experience.

						people. See Rethink's policy statement 71: *Meeting the needs of LGBT people with a severe mental illness:* http://www.rethink.org/how_we_can_help/campaigning_for_change/rethink_policy_documents/groups_who_are_at_ri.html Mental health is also one of three key areas highlighted for urgent attention in the national review of age discrimination. The review states that ''Every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age appropriate services, drawing from insights from reports such as Equality in Later Life and other sources of good practice" (Department of Health (2009) *Achieving age equality in health & social care*)	
642	Rethink Mental Illness	61.02	QS	3	8	**QS 3&9** could be one standard. We welcome self management, shared decision making around care and treatment. We also agree that it is important to promote social inclusion and potential pathways to recovery through activities that the service user has chosen. "Supporting the user- developed work–books Wellness Recovery Action Planning (WRAP) is the most widely used approach internationally. Staff can support learning about recovery , from websites, recovery narratives and meeting people in recovery" (Mike Slade (2009) *'100 ways to recovery'* Rethink publication*)* The report '*Transforming Social Care: sustaining person - centred support* (May 2011) from the Standards We Expect Consortium, draws attention to the **values** definition that person centred support looks like for people using services rather than techniques or procedures: Some of these are: • Putting the person at the centre, rather than fitting them into services • Treating service users as individuals • Ensuring choice and control for service users • Setting goals with them for support • Emphasising the importance of the	Thank you for your comment. The GDG decided to keep QS3 and QS9 (now QS8) as separate statements.

						relationship between service user and practitioners • Listening to service users and acting on what they say • Providing up to date, accessible information about appropriate services • Flexibility and; • A positive approach, which highlights what service users might be able to do, not what they cannot do	
668	Rethink Mental Illness	61.03	QS	4	9	We welcome this standard to ensure service users receive consistency and stability in their care.	Thank you for your comments, we agree this is extremely important.
687	Rethink Mental Illness	61.04	QS	5	10	Rethink Mental Illness welcomes the standard that ensures that the views of people who use services are used to help monitor the performance of services. However, we also recommend that the standard refer specifically to feedback being used to inform assessment of local need and commissioning decisions. "Commissioning holds a crucial key to the future success of the NHS. This is where the levers of reform will increasingly be located. Vesting in commissioners the power to use money to buy services on behalf of patients, with the money following the patient, is intended to drive up quality standards and improve efficiency in health services. It will only succeed in this goal if it is based on a thorough understanding of patients' experiences and the needs and preferences of local people. Those services that do not provide high quality outcomes, are not responsive to patients' needs, or provide a poor patient experience, will have to improve or see 'customers' go elsewhere". (Picker Institute (2007) *Patient and public involvement in PCT commissioning)*	Thank you for your comment. Whilst and important area in the commissioning of services, this has not been prioritised in the development of the quality standard.
711	Rethink Mental Illness	61.05	QS	6	12	Rethink Mental Illness recommends that timely and efficient access to mental health services takes place across all care pathways, not only in secondary care and crisis resolution services. There are pressing issues with regards to access to **inpatient care** and **psychological therapies**, both of which seem to be particularly vulnerable when commissioners are looking for immediate financial savings. Inpatient bed occupancy is likely to be a good indicator	Thank you for your comment, the scope of this guidance covers secondary mental health services, and we are unable to make recommendations outside of this setting. The GDG recognised the importance of access to NICE recommended treatment, and believe that this statement along with the associated recommendations, will improve the experience of care.

						of availability of inpatient care. Inadequate provision of inpatient care is associated with higher rates of detention under the Mental Health Act – which can be taken as an indicator of higher rates of unsupported crisis. The annual reduction in provision of mental illness beds was associated with the rate of involuntary admissions over the short to medium term. (Keown et al (2011) *Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study BMJ* 2011;343:d3736 doi: 10.1136/bmj.d3736) "Bed occupancy rates are a main driver of in-patient care standards. A bed occupancy rate of 85% is seen as optimal.1 This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person's illness to worsen and may be detrimental to their long-term health". (Royal College of Psychiatrists (2011) *Do the right thing: how to judge a good ward: Ten standards for adult in-patient mental healthcare).* Similarly, the standard must reflect access to psychological therapies for those who would benefit. Access to NICE recommended psychological therapies for severe mental illness has not improved in recent years, despite the expectation that the Improving Access to Psychological Therapies programme would 'free up' space in specialist psychological therapy services. The key point is that local commissioners and providers need to realise the benefits of talking therapies for people with common mental health problems alongside severe mental illness. This will be addressed by: involving Rethink, as part of the 'We Need To Talk' coalition, the NHS Confederation Mental Health Network and other key stakeholders in: • Leading the development of PROMs for people with severe mental illness who receive talking therapies; and • Working collaboratively across the professions	

						that work in this area, including with the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists, the Institute of Psychiatry and other professional bodies, to develop appropriate care pathways that are designed to ensure that the benefits of IAPT are available to people with severe mental illness; and • Working with clinical leaders, including GPs and mental health specialists, to understand existing capacity and how it is deployed; and develop competency frameworks and appropriate additional training for the doctors and therapists who treat people with severe mental illness, incorporating appropriate additional material in future IAPT training courses to ensure better management of and outcomes for these patients. Department of Health (2011) *Talking therapies: A four-year plan of action*	
726	Rethink Mental Illness	61.06	QS	7	13	Rethink is pleased that people using mental health services receive information and explanations about the assessment process, their diagnosis and treatment options.	Thank you for your comment
747	Rethink Mental Illness	61.07	QS	8	14	Rethink Mental Illness welcomes this standard ensuring that people working in mental health services are trained in person-centred care and that training is delivered by service users. Training that is provided by people with lived experience of mental illness can be more authentic and the interaction between mental health professionals and service users reduces stigma and removes barriers.	Thank you for your comments.
772	Rethink Mental Illness	61.08	QS	9	15	This standard could be incorporated into QS3	Thank you for your comment. The GDG decided to keep QS3 and QS9 (now QS8) as separate statements
801	Rethink Mental Illness	61.09	QS	10	17	Rethink Mental Illness is pleased that crisis planning is part of the care planning process, we believe that instead of 'risk of hospitalisation the QS could read 'risk of relapse'. QS10 &11 could be one QS	Thank you for your comment. The GDG felt that the term at risk of hospitalisation would apply more than just those people at risk of relapse. .
815	Rethink Mental Illness	61.10	QS	11	19	This QS could be incorporated into QS9	Thank you for your comment
830	Rethink Mental Illness	61.11	QS	12	21	Although we welcome the commitment to improving experience in inpatient care, we feel that the extent of focus within these Quality Standards may come at the expense of care in the community. QS 12-20 are	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have

						related to inpatient care. We believe that inpatient QS could be reduced into fewer standards whilst still collating data on the specific indicators referred to.	the most impact on services and lead to the greatest improvement in service user experience.
925	Rethink Mental Illness	61.12	QS	17	27	We are pleased that the QS takes into account the patient's right to access different forms of activities as chosen by the person, at time that they wish. There is, however, no mention of access to outside space, fresh air and green space and its associated therapeutic benefits. Kellert & Wilson (1993); Maller et al (2002) and Quite, Clark and Ackrill (2006) talk about the broader mental health and psychological benefits from green spaces.	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
943	Rethink Mental Illness	61.13	QS	18	28	Rethink Mental Illness recommends that this QS relating to discharge planning should extend to carers (where appropriate). Many people are likely to be supported by, and perhaps go to stay with, carers (if they do not in fact live them, which often tends to be the case). Preferences about discharge plan sharing with carers should be included in crisis plans i.e. information about practicalities, treatment etc.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
987	Rethink Mental Illness	61.14	QS	21	32	We recommend focusing this standard on competence of health professionals to involve carers and families appropriately. We believe this QS could go directly after QS7 to order the Quality Standards according to relevance. Rethink's research-based briefing on carers and confidentiality states "The nature of the information shared can also vary according to the circumstances. **General information.** This includes information already in the public domain on mental health problems, and information about treatments or local services. **Personal information.** For example, specific information about the type of medication the service user is on, the diagnosis and what care is planned. **Sensitive personal information.** This would include information of a highly personal nature, such as HIV	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

						status, details of previous sexual or emotional abuse, and the service user's views about family members Information that may be general in one context, however, could be classified as "sensitive personal information" in another. For example, giving a carer a leaflet about schizophrenia when they know that this is the service user's diagnosis would count as general information; but if the carer did not know the diagnosis, such an act could be a serious breach of confidentiality. Information-sharing is something professionals have to get right first time. As one service user told the researchers, "Possibly the most important thing about sharing is, once you have, you can't change things, you only get one chance, so it has to be right." The report emphasises that professionals, faced with weighing up the kinds of issues outlined above during the short period of a consultation, need more training to help them make these difficult decisions. Training must involve carers, as well as service users, if professionals are to understand their views." (Rethink (2006) *Sharing mental health information with carers: pointers to good practice for service providers* www.sdo.nihr.ac.uk/files/adhoc/54-briefing-paper.pdf)	
91	Rethink Mental Illness	61.15	Full	General	General	We recommend that the following areas are included into the Quality Standards: **1. Holistic approach to health within mental health services, specifically monitoring and coordination of physical health problems.** People with severe mental illness do not get the physical healthcare that the rest of the population takes for granted. People with severe mental illness die on average 20 years earlier than the general population, largely owing to physical health. There are a number of reasons why people with severe mental illness may have poor physical health including: • **The side effects of medication** – fewer than half of service-users are being offered information about the side effects of medication, even where those side-effects present significant health risks. • **Diagnostic overshadowing** – where staff	Thank you for your comments: 1. This guidance is about the experience of care, not about specific care interventions. Also, physical healthcare is outside the scope of this guidance. Therefore, we are unable to make recommendations specific to improving physical health.

						wrongly attribute physical symptoms to medication or to a person's mental illness. • **Inadequate screening** - having a mental illness can make it harder to access physical healthcare. We found that only one in three surveyed service users had been offered a physical health check. (Rethink (2010) *Fair Treatment Now* campaign report) Despite NICE guidelines stating that the physical health needs of people with severe mental illness need to be monitored and addressed, in many areas this is not happening effectively. Mental health services must play a role in supporting the physical health needs of people with mental illness. This is essential in a person-centred, holistic approach. An indication of good practice could be the carrying out of physical health checks in mental health services – which simply flag up any potential issues and inform an action plan for addressing these. Rethink Mental Illness has developed a tool for mental health service professionals carry out a physical health check: www.rethink.org/how_we_can_help/research/service_evaluation_and_outcomes/physical_health_check/physical_health_chec.html **2. Ensuring that people with dual diagnosis or complex needs are supported appropriately with treatment and support they feel is useful.** Rethink members continue to flag up major problems in accessing specialist help for dual diagnosis relating to mental illness or personality disorder experienced alongside drug or alcohol misuse. This is despite the recognition given to dual diagnosis by the Care Programme Approach review in 2008 which prioritised co-ordination of care for service users with complex needs. Standards should be extended to include specific indicators for service users with dual diagnosis, who often report very poor experience of mental health services.	2. This piece of guidance focuses on ways to improve the experience of care for all people who use adult mental health services. For specific recommendations for people with a dual diagnosis, please see the recently published NICE guideline – *CG120 Psychosis and Substance Misuse* (NICE, 2011)

						The most commonly used substances by those with serious mental illness are alcohol, cannabis and stimulants. Very few are actually physically dependent, but their use of substances often exacerbates problems with their mental state, finances, legal issues and poor engagement with services. Their needs are high and treatment outcomes are poor. Rather than seeing people with dual diagnosis as having two main problems, it may be more useful to acknowledge that they have complex needs including physical health, social issues such as housing, relationship and family problems, risk of suicide, victimisation and violence. They face social exclusion and often have difficulty accessing appropriate services due to their complex presentations. One of the main problems is the lack of skills and knowledge in the workforce to address their complex needs in an integrated and effective way. (Liz Hughes (2006) *Closing the Gap: a capability framework for working effectively with people with combined mental health problems and substance use problems (Dual Diagnosis)* CSIP/ DH Dual Diagnosis Framework document). **3. Safety** Rethink Mental Illness believes that patients should feel safe as a human right when in acute care. In Rethink's report '*Behind Closed Doors'* service users described how "all too often the experience of acute inpatient care is felt to be neither safe nor therapeutic …Systems must be in place to deal with conflicts, violent incidents, racial /sexual harassment and other forms of unacceptable behaviour. Wards need Codes of Conduct negotiated with service users." (Rethink (2008) *Behind Closed Doors-Acute Mental Health Care in the UK*) The Mental Health Act Commission found that from 2007-2009, 30% of acute mental health wards were over-occupied, and 27% were running at full occupancy. (Mental Health Act Commission (2009) *Coercion and consent monitoring: the Mental Health Act 2007-9: Thirteenth Biennial Report 2007-9*)	3. Thank you for your helpful suggestion, we agree that the general safety of service users on the ward should be included in this document and have amended recommendation 1.6.1 to read: *When a service user enters hospital, greet them using the name and title they prefer, in an atmosphere of hope and optimism, with a clear focus on their emotional and psychological needs, and their preferences. Ensure that the service user feels safe and address any concerns about their safety.*

						Over-occupied wards are not the safe havens that they should be for in-patients. In 2009, the Care Quality Commission found that, of people who had recently been discharged from inpatient mental health care, 16% of inpatients never felt safe, with 39% reporting that they felt safe only some of the time. (Care Quality Commission (2009) *Mental health acute inpatient users survey*) The most recent *Count Me In* census of mental health patient gives us clues as to why. In 2009, 67% of respondents were not in a single-sex ward – similar proportions as in 2007 and 2008, while 1 in 5 men and a quarter of women did not have access to toilet or bathing facilities designated for single-sex use. (Care Quality Commission (2010) *Count Me In* census) **4. SU Experience in Primary Care** We recognise that this guideline and Quality Standard relates to secondary mental health services. However, primary care is increasingly becoming responsible for providing ongoing support for people with severe and enduring mental illness, which often fluctuate and demand movement between primary and secondary care. The guideline should therefore include reference to the experience of mental health service users in primary care as part of the care pathway. A GP is often the first person that a person with a mental health problem speaks to. This experience needs to be a positive one so that early intervention and prevention work can take place, reducing the risk of leaving things when people reach a crisis. I in 4 GP consultations are for mental health problems (Department of Health, 2000). Rethink's report '*What's Reasonable? A toolkit produced in collaboration with Royal College of General Practitioners'* describes how GP practices can make reasonable adjustments for people with mental illness. Some of these are: • People may need longer appointments to explain their symptoms. The Disability Rights Commission	4. Thank you for your comment, as you highlight primary care is not within the remit of this guidance and we are therefore unable to make recommendations relating to primary care.

						categorised this as a reasonable adjustment in 2006. • Practice staff particularly reception staff are crucial to people's experience in primary care. Mental Health Awareness training to practice staff is classed as a 'reasonable adjustment' under the DDA, as it covers staff behaviour. • One way to make waiting areas more comfortable is to display posters and leaflets on mental health, this can make people feel welcome rather than shunned, and enable better understanding in other registered patients. • Sometimes people with mental illness can be forgetful due to their symptoms. Adjustments should be made to take account of this. For example, writing out appointment cards or sending out a reminder. • It may be necessary to develop a flagging system for patient records to show whether adjustments are required. This shouldn't contain any information about a service users mental health history - it should just state access requirements or similar, as when flagging a physical disability. (Rethink (2008) *GP Toolkit: What's Reasonable? mental illness and disability law in your GP practice*)	
92	Rethink Mental Illness	61.16	Full	General	General	Given the nature of this consultation, Rethink feels that it was unfortunate that individuals were not able to respond individually to the guidelines but were instead required to go through registered stakeholders. Although we understand there were time pressures around this consultation, we believe that time should have been factored in from the outset for dealing with individual responses. We know from our own members that there was great disappointment about this and wanted to note it as part of our feedback.	Thank you for your comment, we are sorry that some of your members felt excluded from commenting, however this is the NICE process which we are unable to change. We will feedback your comments to NICE.
99	Richmond Fellowship	4.01	Full	1.2.2	12	Is there a reason to exclude service user experience of primary mental health services – the experience of gateway services provided by GPs is an essential part of SU experience of health care as evidenced by your own analysis on page 39 and in a case study on p41	Thank you for your comment, primary care is outside the scope of this guidance which focuses on secondary mental health services. However, the GDG acknowledged that primary care is involved in access to secondary care, therefore included qualitative evidence related to this issue.
107	Richmond Fellowship	4.02	Full	2.2.2 & 3	14 & 15	This section seems somewhat narrow by focusing purely on the MH act – I'd have thought that issues of	Thank you for your comment, the text has been amended to reflect your suggestion.

						stigma and the interaction of MH on eg issues of self esteem and capacity to be assertive would also qualify MH SUs for particular consideration. In addition this section reads as if SU experience is only important because of detention under the act.	
607	Richmond Fellowship	4.03	NICE	QS 2	6	I'm not sure where the evidence is that training in cultural competency is better delivered *by local* voluntary organisations or indeed better provided by the voluntary sector – as a national social care provider we provide cultural competency training nationally in-house – given that cultural competency includes community engagement it is post training that we would expect services to engage locally	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
424	Richmond Fellowship	4.04	NICE	1.4.5	17	In a modern MH service it seems strange to define the need for a crisis plan in relation to risk of hospitalisation – given that increasingly crisis services are provided external to hospitals	Thank you for your comment, we are not suggesting that those who are not at risk of hospitalisation should not have a crisis plan, but are making recommendations about crisis plans of those who are (where the need is greater).
428	Richmond Fellowship	4.05	NICE	1.4.7	17	Again in a modern health system with a market economy of provision it isn't clear why this duty falls to trusts. It isn't clear what ability trusts have to impact the commissioned system of care	Thank you for highlighting this, all reference to trusts will be amended to 'health and social care providers'.
466	Richmond Fellowship	4.06	NICE	1.6.8	21	As above – what impact does the existence of private & 3rd sector provision of hospital services have on this requirement? And in the quality standard the Trust area seems to be shorthand for a geographical/community area – but surely the advent of patient choice means that local geography and location of treatment are not necessarily co-terminus?	Thank you for your comment, none whatsoever. It is an unfortunate myth that non-NHS providers can provide care with employees who are not competent. All health and social care providers should be competent. Secondly, it is not acceptable for private and third sector hospital service providers to work in isolation from other community based services that frequently provide the bulk of care for service users. Private and 3rd sector will have to integrate with NHS to provide continuity of care.
275	ROLE network CIC	52.00	NICE & QS	General	General	These documents don't mention the word 'recovery' once. Elements of recovery include 'control' and 'choice'. These could be included alongside 'hope and optimism' within the guidelines.	Thank you for your comment, the GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.
546	ROLE network CIC	52.01	QS	General	General	The document focuses on secondary care – this is not clear from the title and introduction, which implies it covers 'adult mental health care'. Does it include primary mental health care? The document also emphasises treatment within an inpatient setting. There is little emphasis on quality of	Thank you; we will discuss with NICE how to clarify that primary care is not covered in this guidance. The quality statements were prioritised following consultation and there are now 4 statements (less than a third) relating to inpatient care.

						community care.	
547	ROLE network CIC	52.02	QS	General	General	You suggest on page 1 that the document does not cover families and carers. But where is their experience covered? Mental health problems, and the care and support offered to people experiencing them, have an impact on the whole family.	Thank you for your comment; we agree that mental health issues can have a huge impact. However, it is outside the remit of this document to make recommendations on how to improve the experience of families and carers. Suggestions for guidance can be made to the NICE topic selection panel through the NICE website: www.nice.org
595	ROLE network CIC	52.03	QS	1	5	Statement mentions '..and their families or carers', but nothing else on that page refers to them. Are you interested in the views or experience of families or carers? Confusing after the statement on page 1.	Thank you for commenting. The guidance includes families and carers only in so far as their involvement improves the experience of care for the service user. Therefore, the views and experience of families and carers is not measured.
623	ROLE network CIC	52.04	QS	2	6	The training should be delivered by or have input from people within BAME communities who have used mental health services, not just organisations who work with those communities.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
669	ROLE network CIC	52.05	QS	4	9	Doesn't describe the nature of the relationship – it needs to be a positive relationship. It also needs to consider the right of the person using services to change teams if that relationship isn't positive – the current wording would imply that was a failure, so services may not encourage or allow it.	Thank you for your comment. The intention of the statement is to reduce unnecessary transfers of service users to different teams. It was felt by the GDG that it is important to service users to develop and maintain relationships with professionals. It is not advocating removing the right of the service user to change teams if they so request.
688	ROLE network CIC	52.06	QS	5	10	Draft measure gives an example of using exit interviews, and the process describes discharge from hospital. Monitoring needs to be throughout the time within services, not just at specific exit points. Commissioners should ensure they commission people who use services to monitor performance. People who use services will be assured that their views are used if the monitoring is done by peers.	Thank you for your comment. The process measure on proportion of people receiving an exit interview has been removed. The example of exit interviews by service users included in the structure measure is an example only.
706	ROLE network CIC	52.07	QS	6	11	Is all about timing of access. There is nothing about venues – and having local, easily accessible venues for mental health care. This is very important for people who live in rural areas and may affect timing.	Thank you for your comment. The physical environment has not been part of the scope of the QS.
707	ROLE network CIC	52.08	QS	6	11	Helpline staffed by 'trained health and social care professionals' – can this include peers? Volunteers?	Thank you for your comment. The GDG felt strongly that helplines should be staffed by mental health and social care professionals.
708	ROLE network CIC	52.09	QS	6	11-12	'People in crisis' – needs a definition of crisis. 'referred to MH secondary care services are seen within 4 hours' – referred by who? (self referral?) What	Thank you for your comment. The GDG felt that the related recommendations provide sufficient information for this quality statement to be interpreted

						happens about paper screening to check eligibility? Does that count as being seen? What happens if they don't meet the criteria for acceptance by that service? If a service receives many inappropriate referrals, will they still need to see them all within 4 hours? What happens about access via A&E? or other acute hospital trusts?	by health and social care staff.
748	ROLE network CIC	52.10	QS	8	14	Trained by service users – add 'and carers'. Training needs to be inclusive of all that they come into contact with – and should include young carers. It should ideally include people from equalities groups such as BAME groups.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
773	ROLE network CIC	52.11	QS	9	15	Care planning There is nothing here that says the person using services should be involved in writing the care plan. This is essential to ensure that the person receives care that is appropriate for them.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
774	ROLE network CIC	52.12	QS	9	15	The care plan written to your outcome could be a standardised list of social inclusion opportunities with no personalized element at all. These may be totally inappropriate for the person. There is no guarantee of quality.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
775	ROLE network CIC	52.13	QS	9	15	'Care for dependants' is far more than an indicator for social inclusion. Plans to support someone in their parenting or caring responsibilities should have far more consideration than being slipped into a section on social inclusion alongside 'leisure activities'.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
802	ROLE network CIC	52.14	QS	10	17	How will you define 'people using mental health services at risk of hospitalisation'.	Thank you for your comment. The GDG recognise the challenges in measuring this statement however, felt it of significant importance to include in the final quality standard.
803	ROLE network CIC	52.15	QS	10	17	Pleased to see an emphasis on using crisis plans, but would like to see more emphasis on 'early warning signs' and the actions to take to avoid hospital admission.	Thank you for this suggestion. The GDG made a recommendation to cover this issue (please see recommendation 1.4.5 in the NICE guidance).

816	ROLE network CIC	52.16	QS	11	19	As statement 6 – what is the definition of a crisis? How do you count 'the number of people in a crisis'?	Thank you for your comment. The statement has been altered to "people accessing crisis support".
831	ROLE network CIC	52.17	QS	12	21	Consist of 3 separate Targets – how do you compare services which only meet 1 out of 3? - addressed personally - have their preferences taken into account - have their immediate psychological needs taken into account Why are these only for people admitted to hospital? Why aren't they for all people using mental health services?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
832	ROLE network CIC	52.18	QS	12-19	21-29	Are all about people admitted to hospital for treatment. Why aren't they for all people admitted to any services?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
833	ROLE network CIC	52.19	QS	12-19	21-29	How are these statements linked in with AIMS or star wards?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
834	ROLE network CIC	52.20	QS	12-19	21-29	How are these statements linked in with triangle of care to ensure that carers support is included throughout an inpatient admission?	Thank you for your comment, we are unable to comment other programmes of work in the guidance as this would be a matter for implementation.
835	ROLE network CIC	52.21	QS	12-19	21-29	Where are equivalent specialist statements for people who use community services?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
852	ROLE network CIC	52.22	QS	13	22	We're confused by the terms 'admitted' and 'arrival'. Arrival where? Is this just from admission?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
853	ROLE network CIC	52.23	QS	13	22	Also how does this fit with the assessments that people have before they are admitted? Is this duplication?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
86	ROLE network CIC	52.	QS	14	23	It may be confusing to be introduced to the team as	Thank you for your comment. The GDG had to reduce

5		24				soon as possible – what will this take into consideration? For people who are admitted in distress, it may be preferable to be introduced to one key worker who will remain a constant for the first few days. People do not always want to meet every person and it can be confusing and intimidating. It varies for each person and there should be choice. The information should be available, but it should not be forced on people.	the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
879	ROLE network CIC	52.25	QS	15	24	Should include reference to use of advocates and IMHA.	Thank you for this suggestion. The GDG felt that the priority was to improve shared-decision making, therefore the suggested amendment was not made.
903	ROLE network CIC	52.26	QS	16	25	How does this fit in with shift patterns? How can anyone see their named professional every day? This will need to include deputies to cover annual leave and rotas. Can it also include, for example, time spent with peer support workers? What do you mean by 'one hour'? It isn't clear in this statement whether this is in total over the day or a continuous slot of one hour. Five minutes an hour over an 8 hour shift, would meet your target of one hour, but wouldn't necessarily be helpful. Time spent with someone doesn't measure the quality of the intervention.	Thank you for your comment. The statement has been amended to "known" professional.
926	ROLE network CIC	52.27	QS	17	27	'Meaningful activities' is very broad. Can this be as defined by the individual person in hospital? Or can there be a menu of suggested activities that a ward should provide as a minimum? Can it include outside activities as well as indoor?	Thank you for your comment. This is a matter for local services, taking into account other recommendations for improving the experience of care.
944	ROLE network CIC	52.28	QS	18	28	There is no mention of the quality of discharge planning. There needs to be some overlap into the community to ensure that people are supported in the community for a period after discharge. This is not included in this document.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
956	ROLE network CIC	52.29	QS	19 & 20	29 & 30	Control and restraint may be used disproportionately on people from BAME communities. This needs recognition within the standards. Where will it be measured?	Thank you for your comment. The quality standard is for all service users of NHS mental health services. It does not focus on particular subgroups.
957	ROLE network CIC	52.30	QS	19	29	Needs to be clearer that staff are trained to use C&R only as a last resort and with minimum force.	Thank you for your comments, the GDG felt that this is adequately covered by recommendations 1.8.10-1.8.12 in the NICE guidance and quality statement 19 (now QS14).
97	ROLE network CIC	52.	QS	20	30	Needs to include something about the need to	Thank you for your comment. The GDG had to reduce

1		31				understand the explanations – it is no use to explain the reasons if the person cannot understand it, for reasons of language, learning disability or sensory disability, or because of the effects of medication.	the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
988	ROLE network CIC	52.32	QS	21	32	This reads like an afterthought. When are people to be asked about involvement of family and/or carers? For people admitted to hospital, why aren't there timescales, as there are for other statements? How often should people be asked, given that at times of distress, people may have different views about whether they want family involved. How does this fit in with 'triangle of care'?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
1000	ROLE network CIC	52.33	QS	22	33	Should link into national work on stigma (time to change). People need to see the same message several times for it to have the most impact. Local work should link into and reinforce national messages for best value for money.	Thank you for your comments, we agree that services should work with other local initiatives, however we are unable to state this as it is a matter for implementation.
548	ROLE network CIC	52.34	QS	General	General	Specialist services There should be outcomes related to referral to specific specialist provision such as: Personality disorder services Veterans services	Thank you for your comment, the guidance is applicable for all people using adult mental health services and therefore we are unable to comment on specific conditions. The specialist needs of people with any condition are explored in the applicable guidelines.
288	ROLE network CIC	52.35	NICE	General	General	There are many very good statements included within the guidance. These are not reflected in the Quality Statements. We hope that the quality statements will be reviewed frequently to ensure that all the good practice in the guidance is implemented.	Thank you for your comment. The Quality Statements reflect what the GDG thought were the priority for improving the experience of care. NICE reviews all guidance every few years (please see the website for further information).
384	ROLE network CIC	52.36	NICE	1.1.16	12	This would make a huge difference for people with parenting responsibilities. Can this be included within the quality statements so that it is measured and organisations are encouraged to implement it.	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Statements to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience.
434	ROLE network CIC	52.37	NICE	1.4.10	18	Understanding of the word 'culture' should extend beyond issues related specifically to race, so that mental health and social care professionals have an understanding of the culture of all individuals who use their services.	Thank you for your comment, the recommendation has been amended to refer to 'other minority groups'.
507	ROLE network CIC	52.38	NICE	1.8.7	25	Alternatives to detention – where will use of alternatives be monitored? National data on their use including qualitative data would be useful to develop alternatives.	Thank you for your comment, it is beyond the scope of this guidance to advise on how this should be monitored nationally.
289	Rotherham Doncaster and South	60.00	NICE	General	General	As a provider of services there is a need for greater clarity as to what are "Adult Mental Health Services".	Thank you for your comment. The scope of the guidance covers community and inpatient mental

	Humber NHS Foundation Trust					Does this include Older People's Mental Health Services, Substance Misuse Services and Learning Disability Services?	health settings, so it will depend on how your Trust is structured.
322	Rotherham Doncaster and South Humber NHS Foundation Trust	60.01	NICE	Draft Quality Statements	6	Quality Statement 4: People using mental health services are supported by staff from a single, multidisciplinary team, who they know and with whom they have a continuous relationship. The term continuous could be seen as a suggestion that service users will never be discharged from a team, or from mental health services.	Thank you for your comment, we feel that it is clear that a continuous relationship should be maintained whilst the service user is being treated by the mental health service and do not feel this will lead to services never discharging service users.
323	Rotherham Doncaster and South Humber NHS Foundation Trust	60.02	NICE	Draft Quality Statements	6	Quality Statement 13: People admitted to hospital for mental health treatment and care are formally assessed within 2 hours of arrival. Admissions should be formally assessed by the Crisis Team prior to admission to acute care, and another assessment within 2 hours of admission may be repetitive. The guidance on page 21 helps: Undertake formal assessment and admission processes within 2 hours of arrival. Engagement and admission processes describes the process better. A formal assessment should only be applied where there has not been a prior formal assessment.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
885	Rotherham Doncaster and South Humber NHS Foundation Trust	60.03	NICE	Draft Quality Statements 16	7	Quality statement 16: People in hospital for mental health treatment and care see, on a one-to-one basis, their named healthcare professional every day for at least 1 hour and their consultant at least once a week for at least 20 minutes. A single "named healthcare professional" would not have the capacity to deliver a daily 1:1 meeting due to working shifts, days off etc. This might be better as: "a healthcare professional, who is part of your named care team".	Thank you for your comment. The statement has been amended to "known" professional.
290	Rotherham Doncaster and South Humber NHS Foundation Trust	60.04	NICE	General	General	As a Trust we are using the RETHINK Physical Healthcare Checklist and it is disappointing that there is no reference to the need to support access to high quality physical healthcare screening and treatment, as well as consideration of lifestyle changes that will support good physical health. There is an evidence base to suggest that the physical healthcare needs of mental health service users are often unmet.	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
27	Royal College of	37.	All	Gene	Gene	The Royal College of Nursing welcomes proposals by	Thank you for your comments.

	Nursing	01		ral	ral	NICE to make explicit the standards that adult service users can expect when receiving adult NHS services. The guidelines and quality standard for improving experience of care for people using adult NHS services is timely and comprehensive. The RCN actively promotes and actively supports patient-centred care. The RCN in partnership with Department of Health (England), the Nursing and Midwifery Council and other patient and service user organisations, recently developed the Principles of Nursing Practice (www.rcn.org.uk/nursingprinciples). These consist of eight principles describing what the public can expect from nursing practice in any setting. These principles, particularly Principle D, encourages nurses and nursing staff to provide and promote care that puts people at the centre, involves patients, services users, their families and carers in decisions and help them make informed choices about their treatment and care. The guidelines and standard align to the nursing principles.	
160	Royal College of Nursing	37.02	Full	5.5.1.2	54	To add in 'ask if prefer to be seen in another environment and healthcare professional to contact and arrange e.g. home, GP surgery, other community venues accessible'	Thank you for your comment, it would be very difficult to operationalise your suggested amendment to the recommendation and will very clearly depend on resources. Home treatment is appropriate for home treatment teams but probably not an option for a non-acute referral.
162	Royal College of Nursing	37.03	Full	5.5.1.3	54	Add • Agreed pathways and process for referral etc	Thank you for your comment, we believe this is already covered in recommendations 1.2.1 and 1.2.4.
163	Royal College of Nursing	37.04	Full	5.5.1.3	54/55	Add • Services have equal access for all irrespective of gender, age etc	Thank you for your comment, recommendation 1.2.4 has been amended to include other diverse groups.
179	Royal College of Nursing	37.05	Full	6.5.1.4	66	Not just patient but also with consent involvement of carer. All discussions with the patients should be conducted in a way that allows the patient to express their personal needs…	Thank you for your comment, however the GDG feel the points you raise are covered in recommendations 1.1.13 (now 1.1.15) and 1.1.2.
189	Royal College of Nursing	37.06	Full	7.1	69	CPA has local guidelines that are not only about 'between hospital and community but also as 'standard care' identifying the professional responsible for ensuring all needs are met. – Local guidance re: CPA	Thank you for your comment, the text has been amended to reflect your suggestion.
201	Royal College of Nursing	37.07	Full	7.5.1.5	88	Crisis *and contingency* plans should include… • Information about 24 hour access to services • Early warning signs and action points	Thank you for your comment, the recommendation has been amended in line with your first three suggested bullet points to read:

						• Named contacts • Option to use PRN as required	*For people who may be at risk of crisis, a crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan. The crisis plan should include:* • *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 (childcare or the care of other dependants, including pets). [QS]* • *details of advance statements and advance decisions (see 1.1.11)* • *whether and the degree to which families or carers are involved* • *information about 24-hour access to services* • *named contacts.* However, the GDG did not feel it appropriate to add PRN as it would allow the potential for some dangerous practices and this should only be agreed on an individual basis.
648	Royal College of Nursing	37.08	NICE	QS4	6	Draft quality statements – No.4 People using Mental Health services etc It should read *'where possible*', because needs change e.g. CMHT involvement but have a crisis and therefore another part of the service responds at this present time! In the future that hopefully will change?	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the recommendation.
429	Royal College of Nursing	37.09	NICE	1.4.7	17	This does not take into consideration the changing needs of someone who may require a specialist second opinion of care package delivered by another service. Patient needs to know what the mechanism is for seeking second opinion. Care pathway - an option for specialised clinical opinion should also be made available.	Thank you for your comment, the purpose of this recommendation is to ensure that an unnecessary transfer of care between specialist teams should be minimised. 1.3.4 makes recommendations regarding a second opinion.
272	Royal College of Nursing	37.10	Full and NICE	General	General	Question: Why do both the Full and NICE have service user then it changes to person? Feedback:	Thank you for your comment. In most instances we have used 'people using mental health services' to be clear about the population in question; to avoid repetition within a sentence or paragraph we have

						The person-centred dialogue group have stated that they are not service users but people?	used person or service user depending on the context.
715	Royal College of Nursing	37.11	QS	7	3	Draft statement No. 7 re: diagnosis and treatment options. This should include care needs and interventions to cover all other healthcare professionals	Thank you for your comment, this statement is focussed on giving information. It does recommend that service users are given information about their treatment options, or interventions. QS9 (now QS8) is about ensuring people's needs are met.
717	Royal College of Nursing	37.12	QS	7	3	Statement 7 – re: assessment process, their diagnosis and treatment options – as per above	Thank you for your comment
624	Royal College of Nursing	37.13	QS	2	6	Draft statement No. 2 Description: add:- People using mental health services are supported by a team of staff, who they know etc…	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
670	Royal College of Nursing	37.14	QS	4	9	Draft Statement No. 4 Description of what the quality statement means for each audience – support this statement - people using mental health services are supported by a team of staff, who they know etc…	Thank you for your comment.
727	Royal College of Nursing	37.15	QS	7	13	Descriptions are clear, measurable but not easy to collect the data as yet due to the present financial constraints in improving the clinical systems to meet both the people who need the care and the clinicians who provide the care.	Thank you for your comment. If there are difficulties in measuring statements then organisations are free to utilise existing mechanisms.
728	Royal College of Nursing	37.16	QS	7	13	The quality of service today would range from 60 – 95%. Otherwise easy to read and follow. More needs to be identified re: pathways and package of care/interventions and not just about diagnosis and treatment.	Thank you for your comment. The GDG felt these areas were important points at which the service user should receive information and explanations and so focussed the statement.
549	Royal College of Nursing	37.17	QS	General	General	It could be changed to better promote Mental health promotion and prevention, clarity re: equality of opportunity relating to age. Equality of opportunity is affected by the interpretation of what is 'Adult' (age specific 18-64 or inclusive 18- 65+)	Thank you for your suggestion. MH promotion and prevention is starting to go beyond our remit, but there are some recommendations that could be said to address these issues (for example 1.1.9). Regarding age, children and young people were excluded because of the very different issues and service configuration. There is no upper age limit.
93	Royal College of Psychiatrists	1.01	Full & NICE	General	general	The General Adult Faculty welcomes this guidance as a clear and positive statement of what service users should expect from their contact with mental health services.	Thank you for your comments.

355	Royal College of Psychiatrists	1.02	NICE	1.1.7 1.1.8 1.4.9 1.4.10	9-10 18	1.1.7 and 1.1.8 are clear and welcome as a statement committing services towards social inclusion as are paragraphs 1.4.9 and 1.4.10.	Thank you for your comments.
776	Royal College of Psychiatrists	1.03	QS	QS9	15-16	However, the quality statement relating to this is too specific in requiring a particular type of approach to this from provider organisations.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
550	Royal College of Psychiatrists	1.04	QS	general	general	It is essential with the quality statements that they are worded in ways that do not lead to tick box approaches to implementation. There is a danger in being so prescriptive as to generate an industry for forms which then loses sight of the wider goal implicit in the nature of this guidance, of improving patient experience of care.	Thank you for your comment, we agree that a tick box approach is unhelpful and hope these statements will aid services in improving the experience of care for all service users.
904	Royal College of Psychiatrists	1.05	QS	QS16 QS17	25-27	However, the specified minimums for activity and contact are an important statement that should drive quality improvement. As such, in this case, the specific Quality Statements (16 and 17 in relation to patient –staff contact and available activities) are helpful and important as a clear minimum base standard.	Thank you for your comments.
28	Royal College of Psychiatrists	1.06	All	General	general	The aspiration that service users are not 'passed from one team to another' is supported. In view of the functionalised nature of current service configurations it is however is an ideal that is likely to be difficult to achieve without radical reorganisation. Most services have now institutionalised discontinuities by having separate in-patient and community services or acute and on-going care services. The College General Adult Faculty does not have a consensus on the ideal configuration for services. We would make the observation that many of the radical changes of recent years were made without adequate note being taken of the views of experienced psychiatrists. The Faculty strongly supports efforts being made to find ways of ensuring that service users are able to regain a sense of their care being owned jointly with them by a team and individuals capable of providing the necessary sense of continuity. The concept of a	Thank you for your comments, on reflection the GDG agree that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore this has been amended to read: *Health and social care providers should ensure that service users:* • *can routinely receive care and treatment from a single multidisciplinary community team* • *are not passed from one team to another unnecessarily* • *do not undergo multiple assessments.*

						service being willing to accept 'ownership' is important in this respect.	
596	Royal College of Psychiatrists	1.07	QS	1	5	Need to include measure from carers, especially for people without capacity (not just dementia), and in section on what it means to users	Thank you for commenting. The guidance includes families and carers only in so far as their involvement improves the experience of care for the service user. Therefore, the views and experience of families and carers is not measured. The GDG will consider what this means for people without capacity.
643	Royal College of Psychiatrists	1.08	QS	3	8	This again need to take into consideration people who lack capacity, the need to involve them to the best of their capacity, and the need to involve carers for feedback where necessary – national surveys have been notorious for ignoring this issue.	Thank you for your comments. The equality considerations section of this quality statement now references people with reduced capacity.
671	Royal College of Psychiatrists	1.09	QS	4	9	How does a team stay continuous?	Thank you for your comment. The "continuous" aspect relates to the continuous relationship. As the source recommendation states it is the intention that the service user is not transferred to different teams unnecessarily.
689	Royal College of Psychiatrists	1.10	QS	5	10	Similar comments – if you want service users to monitor services then people with impaired capacity need to be represented	Thank you for your comment. The GDG felt the priority was to get services using the views of service users generally. Getting the views of people with impaired capacity could be important local implementation issue.
709	Royal College of Psychiatrists	1.11	QS	6	11	G These teams were introduced in the mental health NSF and are not widely available to older adults. With the equality act this is a great opportunity to ensure equality of access to similar services, though they need to be age appropriate and non-discriminatory	Thanks for your comment. The guidance is for service user experience in adult mental health in community and in patient settings; although much will be applicable to other groups and settings, it does not specifically address other groups and settings, such as the elderly in older adult services.
804	Royal College of Psychiatrists	1.12	QS	10	17	Is this denominator measurable? Also for this and other standards addressing advance decisions / planning, need reference to capacity and evidence of advance decisions / power of attorney.	Thank you for your comment. The GDG recognise the challenges in measuring this statement however, felt it of significant importance to include in the final quality standard.
817	Royal College of Psychiatrists	1.13	QS	11	19	How will you measure the denominator without the numerator? - how to define crisis unless you have a crisis service? Also both health and social care professionals are involved in crisis management. Older adult mental health services are less integrated so social care professionals will have no direct link with CMHTs	Thank you for your comment. The statement has been altered to "people accessing crisis support".
866	Royal College of Psychiatrists	1.14	QS	14	23	The social care team in a hospital will not be around out of hours, and the timing of getting to meet the social care "team" may be difficult to identify for the service user.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest

							improvement in service user experience.
880	Royal College of Psychiatrists	1.15	QS	15	24	I would have thought the relevant act would be the mental capacity act, for decision making? Need to reference this.	Thank you. We disagree. In adult mental health services (at which this guidance is aimed) the MHA is the main legislation considered in inpatient settings.
905	Royal College of Psychiatrists	1.16	QS	16	25	This I think is challenging. At the least, the named healthcare professional needs a deputy to cover shifts / days off? Also 20 mins per consultant face to face may be unnecessary for someone with dementia and gradually resolving problems.	Thank you for your comment. The statement has been amended to “known” professional.
945	Royal College of Psychiatrists	1.17	QS	18	28	This again (care planning involvement / decision making) requires consideration of people without capacity and carer / advocate involvement.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
958	Royal College of Psychiatrists	1.18	QS	19 -20	29 -31	It would be better to have something positive on evidence for de-escalation techniques rather than just launching into rapid tranquilisation with no mention of this?	Thank you for your comments. The data source section indicates that the NHS staff survey includes a question on conflict resolution training.
989	Royal College of Psychiatrists	1.19	QS	21	32	This standard again needs to explicitly refer to capacity issues. There is national interest in the extent to which families are involved in care planning / monitoring for people with fluctuating or impaired capacity.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
551	Royal College of Psychiatrists	1.20	QS	general	general	This document has been developed from a younger adult psychiatry perspective. In particular, issues of capacity need to be addressed, and there is much greater involvement of informal carers in decision making, sometimes through power of attorney. Also anything on physical health needs – this is an all adult issue.	Thanks for your comment. The guidance is for service user experience in adult mental health in community and in patient settings; although much will be applicable to other groups and settings, it does not specifically address other groups and settings, such as the elderly in older adult services. Physical health needs is outside the scope of this document.
94	Royal College of Psychiatrists	1.21	Full	general	general	The scope refers to adult mental health, though there is almost no mention of dementia and little evidence that the issues unique to older adults have been considered. In particular there are issues of physical health and mental capacity that need addressing. I’m not sure the guidance development group had any old age psychiatry expertise?	Thank you for your comment, the guidance is applicable for all people using adult mental health services and therefore we are unable to comment on specific conditions. The specialist needs of people with any condition are explored in the respective guidelines.
166	Royal College of Psychiatrists	1.22	Full	5.5.1.5	55	Given the huge problems with discrimination in adult mental health services, the statement in 5.5.1.5 is insufficient to cover this.	Thank you for your comment, the whole of section 1.2 captures many of the principles in the Equality Act 2010: this recommendation is primarily to remind health and social care professionals they should take into account requirements of that act.
184	Royal College of	1.2	Full	6.5.2	67	Awareness of the effect of age on service users	Thank you for your comment, recommendation 1.1.6

	Psychiatrists	3		.3		presentation and social / physical environment needs to be included. It is a protected characteristic alongside race and religion. This comment could be included alongside any point that makes specific reference to race / religion / cultural needs.	(now 1.1.7) and 1.1.7 (now 1.1.8) have been amended to ensure greater awareness of the diverse groups on the experience of care.
205	Royal College of Psychiatrists	1.24	Full	7.5.2.4	90	Another example of a heavily biased younger adults psychiatry view of capacity and consent issues.	Thanks for your comment. The guidance is for service user experience in adult mental health in community and in patient settings; although much will be applicable to other groups and settings, it does not specifically address other groups and settings, such as the elderly in older adult services.
209	Royal College of Psychiatrists	1.25	Full	8	92	This section should recognise the differences in integration between health and social services in younger and older adult services	Thanks for your comment. The guidance is for service user experience in adult mental health in community and in patient settings; although much will be applicable to other groups and settings, it does not specifically address other groups and settings, such as the elderly in older adult services. The transition to these services is outside the scope of this document.
259	Royal College of Psychiatrists	1.26	Full	11	131	I think you could justify a similar chapter on the mental capacity act	Thank you for your comment, however it would not have been possible to do this in the time available,
269	Royal College of Psychiatrists	1.27	Full	12.5.1	174	How about something on user experience for older adults in OPMH or younger adult psychiatry services?	Thank you for your comment, research recommendation 5.5.3.1 has been amended to: For people using adult mental health services, what are the personal and demographic factors associated with late access to services and an increased likelihood of compulsory and intensive treatment, and what are the key themes that are associated with poor engagement? *This should include an examination of factors that impact on access to services among younger people and older adults.* And 10.5.2.1 to: For people using mental health services, what is the experience of discharge from community teams to primary care, and from inpatient settings to community teams and to primary care? The study would aim to characterise the ways in which discharge currently happens and its impact upon the service users' experience, rates of re-admission as these relate to different approaches to discharge, and treatment concordance. *This work should include the experiences of younger people and older adults.*
552	Royal College of Psychiatrists, Wales	28.01	QS	General	General	The 22 Quality Statements are generally uncontroversial. However, they add little from a professional perspective; many reflect good current	Thank you for your comment, we would hope that the statements do reflect good current practice, however it was the experience of the GDG that services vary

						practice.	widely across the country and unfortunately this is not current practice everywhere. The GDG hope these statements will ensure all services are of an equal standard in future.
906	Royal College of Psychiatrists, Wales	28.02	QS	16	25-26	The Quality Statement 16 is over-prescriptive because: • some patients should not be seen on a one-to-one basis because of the risk of violence; • certain patients (e.g. patients with significant cognitive impairment) would not benefit from being seen weekly on a one-to-one basis; and • some patients may not require a full 20 minutes with team colleagues or on a one-to-one basis.	Thank you for your comment. The statement has been amended to emphasise that this is about having access to this level of contact. Not that it is prescriptive for every patient.
907	Royal College of Psychiatrists, Wales	28.03	QS	16	25-26	Quality Statement 16 does not seem to make allowances for the Mental Health Act. Under the MHA, the "Responsible Clinician" may not be a medical "consultant" in the traditional sense. They may be a Clinical Psychologist or a Senior Nurse who may or may not have the title "Consultant".	Thank you for your comment. Traditionally the clinical lead is called the consultant - we have not specified that the consultant is a psychiatrist as it could be consultant nurse.
908	Royal College of Psychiatrists, Wales	28.04	QS	16	25-26	The proposal for arbitrary and mandatory contact with a Consultant may run counter to concepts of recovery and normalisation where clinical inputs are related to *need* rather than *policy*. If a patient is in the recovery stage of their illness and is making uncomplicated progress towards recovery, there is little evidence or justification for mandatory contact with the "Consultant".	Thank you for your comment. The statement has been amended to emphasise that this is about having access to this level of contact. Not that it is prescriptive for every patient.
229	Royal College of Psychiatrists, Wales	28.05	Full	9.2.9 9.4	109 110 112 113	There is a lack of clear evidence to validate Quality Standard 16. The guidance simply refers to "an option of weekly sessions with a consultant" and offers no specific evidence for this.	Thank you for your comment, these requirements were the minimum identified by the service users/carer on the guidance group and were supported by all the professionals. Clearly it will be hard to know what 'evidence' would be required.
291	Sheffield Health & Social Care NHS Foundation Trust	40.01	NICE	general	general	The NICE guidance is clearly written and accessible	Thank you for your comments.
292	Sheffield Health & Social Care NHS Foundation Trust	40.02	NICE	general	general	We believe that following the NICE guidance would result in the delivery of high quality care for service users: it is coherent and covers the majority of key points.	Thank you for your comments.
293	Sheffield Health & Social Care NHS Foundation Trust	40.03	NICE	general	general	We recognise that full implementation has funding implications for mental health service providers, which may be challenging in the current financial context. We would urge the development of commissioning guidance, based on the guidance and standard, which	Thank you, we will pass this information to the NICE implementation team.

						is connected with the Dept of Health led work on Payment by Results for Mental Health	
294	Sheffield Health & Social Care NHS Foundation Trust	40.04	NICE	general and 1.4.2	general and 16	Given the known high prevalence of physical health problems in people receiving mental health services across the age range, and the importance of this issue to many service users, we would wish to see a reference to the inclusion of physical health considerations in care planning and assessment.	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
316	Sheffield Health & Social Care NHS Foundation Trust	40.05	NICE	Person-centred care	5	We strongly support the statement of values on this page, and in particular the statement that 'This guidance aims to promote person-centred care that takes into account service users' needs, preferences and strengths.'	Thank you for your comment.
330	Sheffield Health & Social Care NHS Foundation Trust	40.06	NICE	1.1.1	8	We support the emphasis on working in partnership with people using mental health services, their families or carers. We strongly support the focus on building supportive, empathic and non-judgmental relationships as we see this as the heart of high quality care and treatment	Thank you for your comments.
486	Sheffield Health & Social Care NHS Foundation Trust	40.07	NICE	1.7.1	22	We see the reference to the possible feelings evoked by endings or transitions of treatment as a positive example of a person-centred approach in the guidance	Thank you for your support.
553	Sheffield Health & Social Care NHS Foundation Trust	40.08	QS	general	general	We believe the standards are positive and useful in terms of improving quality and experience of service	Thank you for your comments.
554	Sheffield Health & Social Care NHS Foundation Trust	40.09	QS	general	general	The standards are clear but less accessible than the NICE guidance because they contain more NHS management jargon. However, if the main audience is NHS staff, this may be acceptable.	Thank you for your comment, this guidance will be published with an accompanying booklet called 'Understanding NICE guidance' which is devised for services users, carers, the public etc.
555	Sheffield Health & Social Care NHS Foundation Trust	40.10	QS	general	general	We would welcome more clarity on the linkage or potential linkage with the Care Quality Commission core outcomes. At present NHS mental health providers need to compile extensive evidence of compliance with the 16 core quality and safety outcomes of the CQC. The visions and values of the CQC and the NICE quality standard are similar, but the detail is different. For providers, this risks an additional burden of regulation and audit, as we attempt to provide evidence of compliance with the quality standard and the CQC outcomes	Thank you for your comment. CQC is about basic statements (i.e. essential) and NICE is about excellence (i.e. aspirational). However, in describing excellence it is acknowledged that there may be instances where there is linkage with essential statements. CQC may make use of data on Quality Statements measures in their risk estimation. We expect that further advice about how quality statements and the associated measures should be used by the NHS will come from the National Quality Board and, when it is established from the NHS Commissioning Board. NICE will be producing support for commissioners and others using the guidance and quality standard that will help with the implementation.
556	Sheffield Health & Social Care NHS	40.11	QS	general	general	We would also welcome more clarity on the impact of specific quality measures (e.g. those in quality	Thank you for your comment. We expect that further advice about how quality statements and the

	Foundation Trust					statement 6 p.11) on commissioning intentions. We are pleased to see clear, measurable indicators, and yet we fear that these will become an additional burden to be added to local commissioning Targets and CQUINs. We already have a large number of quality Targets and indicators in addition to CQUINs locally. Failure to meet aspirational Targets derived from the NICE quality standard could result in financial penalties for trusts making serious endeavours to improve the quality of care they provide. The addition of more Targets will require yet more resources to be diverted to collecting and analysing data to meet Targets, rather than to support improvement	associated measures should be used by the NHS will come from the National Quality Board and, when it is established from the NHS Commissioning Board.
CG 557	Sheffield Health & Social Care NHS Foundation Trust	40.12	QS	general	general	The statements to which we would give preference are: 3, 10, 15, 6, 1, 9, 7, 11, 17, 19, 20, 21. We believe the primary focus in the standards should be on the quality and experience of care and treatment	Thank you, the majority of your suggested statements were prioritised into the final 15 statements.
625	Sheffield Health & Social Care NHS Foundation Trust	40.13	QS	2	6	We support the importance of cultural awareness training, but we believe saying that this must be provided by local voluntary sector organisations is too prescriptive	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
672	Sheffield Health & Social Care NHS Foundation Trust	40.14	QS	4	9	We fully support the importance of maintaining relationships, but we do not believe that providing a service through a single, multidisciplinary team is always the best way, and that service users also need access to specialist support. We would propose using CPA to maintain core, continuous relationships. Service users should have the right to request to change team (service user comment.)	Thank you for your comment. The statement has been amended to reference a single multidisciplinary community team. The intention of the statement is to reduce unnecessary transfers of service users to different teams. It was felt by the GDG that it is important to service users to develop and maintain relationships with professionals. It is not advocating removing the right of the service user to change teams if they so request or when necessary for specialist support.
690	Sheffield Health & Social Care NHS Foundation Trust	40.15	QS	5	10	We fully support the use of service user feedback including exit interviews. We support the use of service user volunteers or employees to collect the information and have local evidence to endorse this view. We regret that there is no more specific reference to collecting feedback from the majority of service users whose needs are met in community services	Thank you for your comments. The example of exit interviews by service users is an example only. Services are free to use their own methods of incorporating service user feedback.
71	Sheffield Health &	40.	QS	6	11	We support this statement in principle, and we fully	Thank you for your comment. The measures have

0	Social Care NHS Foundation Trust	16				recognise the importance of timely access for service users. However, we have concerns about the costs of full implementation in the current financial and commissioning context.	been amended in light of consultation comments. It is hoped by the GDG that they remain aspirational yet achievable,
752	Sheffield Health & Social Care NHS Foundation Trust	40.17	QS	8	15	Consideration should be given to training for the service users provide the training (service user comment)	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
777	Sheffield Health & Social Care NHS Foundation Trust	40.18	QS	9	15	We fully support this statement and suggest the consideration of physical health problems and concerns is added to the proposed content of the care plan. We also suggest the consideration of spiritual needs is added (service user comment.) Written copy of care plan vital (service user comment.)	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
909	Sheffield Health & Social Care NHS Foundation Trust	40.19	QS	16	25	We fully support the principle of dedicated time on a regular basis with the named health professional and consultant. However, we believe the detail of this statement may be too prescriptive and inflexible. We would propose as an alternative that reaching agreement about dedicated time could be part of the care plan developed on admission with the service user's active involvement.	Thank you for your comment. The statement has been amended to emphasise that this is about having access to this level of contact. Not that it is prescriptive for every patient.
1001	Sheffield Health & Social Care NHS Foundation Trust	40.20	QS	22	33	We see this statement as positive, but we would not choose to prioritise it in the final version of the quality standard.	Thank you for your comment
29	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.00	All	general	general	The Quality Standards whilst designed to be 'high level quality indicators', will surely only be of much use if they can be broken down to identify areas i.e. wards/teams which are not performing to the required standard. Therefore all the indicators/data sources will need to able to be disaggregated. This issue is demonstrated by information such as the national patient surveys, whilst they will give an overall Trust position and contains patient level information. It is not easy to then use this information to look at team performance. This is due to a number of factors: • The feedback is not specific to a team and some patients will have been in contact with a number of teams. Also if you tried to match the information to teams the patients have been in contact with, due to the small numbers of returns involved at team level it would	Thank you for your comment. The remit of the group was to develop standards rather than make specific recommendations about how they could be used to assess service quality.

						render the results statistically invalid. This standard is thought to be realistic however some concerns were raised with carers as to the needs of carers not being addressed.	
30	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.01	All	general	general	Our service users told us - I am white and middle class. Every time someone visited they made comments about my 'nice house'. Mental health problems strike people in all parts of society. Is there a standard somewhere that ensures that all service professionals are aware of their own cultural identity and how that might have a bearing on how they relate to service users and each other? Our performance team told us The 22 standards potentially represent a lot of information which will need to be brought together to give the overall picture on performance against the standards. Some of them will require collection mechanisms to be created or modified, and whilst well intentioned there is a potential it will introduce a very time consuming, ongoing collection process. our inpatient staff told us – would this apply even if the patient cancelled their appointment we woul always aim to see patients within 10mins but the practicalities of this sometimes make it difficult to achieve if you have emergencies – we would be spending all our time answering complaints	Thank you for your comments. We believe the recommendations in section 1.1 of the NICE guidance cover your first point. However, not all of these recommendations could be made into quality statements, therefore the GDG had to prioritise. Regarding implementation, the NICE implementation team will provide tools to assist assessing performance against the statements. Having reviewed comments on the draft guidance and discussed waiting times in clinics we believe it is important that service users should be seen in a timely manner and that this recommendation is justified.
673	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.02	QS	4	9	[Also general comment on full version] Our service users told us this is a necessary standard which is achievable but it is professional led and would need to mention carers /advocate involvement too. How would this work in practice where a patient is admitted to a ward, as this will be a separate team to that of a community team.	Thank you for your comment. The statement has been amended to state single multidisciplinary community team. The intention of the statement is to reduce unnecessary transfers of service users to different teams. It was felt by the GDG that it is important to service users to develop and maintain relationships with professionals. It is not intending to remove the importance of involving carers/advocates
31	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.03	All	general	general	Our service user told us this is A very important standard Our performance team told us - There a danger that some of the proposed measures will be seen as performance measures/Targets In particular those where times are specified i.e.: • 'People admitted to hospital for mental health treatment & care are formally assessed within 2 hrs of arrival' • 'Evidence of local arrangements to ensure people using mental health services are seen	Thank you for your comment; we are pleased that the service user you refer to thought these were important recommendations. Although we agree there is a danger with timeframes, the GDG were very keen that this should be in the recommendations. For the quality standard, it is also an important way of allowing us to measure the quality of services.

						within 10 minutes of the agreed appointment time' • Proportion of people for mental health treatment & care who saw their consultant on a 1 2 1 basis at least once a week for at least 20 minutes This could lead to creating a 'chasing Targets' culture as seen with the A&E 4 hour target which has now been removed, as there were cases where the need to meet the target created perverse outcomes for patients rather than improving the quality of care they received. Whilst timeliness is critical, good quality assessments and care are more important.	
818	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.04	QS	11	19	Our performance team told us - How will the term' competent professional' be assessed/judged?	Thank you for your comment. The setting out of specific staff competencies goes beyond the remit of this document and the GDG believe that services will understand what competent means.
867	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.05	QS	14	23	Our service users told us - I like this standard. How will it be upheld? It seems to me that many people get into crisis because they are not getting the counselling help they need before they get acute. Our performance team told us How will 'as soon as possible' be quantified and measured	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
972	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.06	QS	20	30	Our performance team told us - The service provider needs to do something with this captured information. • They need to ensure this experience is used in future when caring for that individual, Ideally any common themes and lessons learnt should be captured and cascaded/feed into improving patient care across the provider.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
778	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.07	QS	9	15	Our service user told us – this is an Essential standard the need to involve service users to influence cultures and attitudes. Expert patient needs to be re-launched Our performance team told us - It may not always be appropriate to include details of activities to promote social inclusion	Thank you for your comment, the GDG agrees this is an essential QS.
819	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.08	QS	11	19	Our performance team told us - This assessment should include (i.e. specify it) under their relationships a requirement to ask if they have children or carer responsibilities	Thank you for your comments, this is included under 'practical needs' in quality statement 10 (now QS9).
910	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.09	QS	16	25	Our service users and carers told us - Carer involvement needs to be included here • our performance team told us	Thank you for this suggestion, however the GDG were specifically focusing on contact with staff on wards as this was seen as the priority for improving the experience of care.

927	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.10	QS	17	27	our service users told us -This is achievable for us but electronic systems may present some challenges our performance team told us - What does 'meaningful' mean, will be very subjective	Thank you for your comment. The term 'meaningful' is to emphasise that the activities should be meaningful to the service user, that they should not be generic activities for every service user irrespective of their preferences.
836	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.11	QS	12	21	our service user told us - This is an essential standard our performance team told us - A number of the indicators will be measured by service users survey, but will services users be able to recall the facts without any change to processes • E.g. will they know what an assessment undertaken in a crisis contained (no11). Would we therefore need to provide a copy of this assessment? • Number 16 - asks how long they were seen for? Number 18 - Would a service user recall the notice period of 2 days? Would there therefore be a need to send a letter? Would the service user recall how soon they were seen on a questionnaire. Or recall that it was asap in number 14?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
854	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.12	QS	13	22	our service users told us What does formally assessed mean	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
868	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.13	QS	14	23	Our service users thought this was too simplistic – what does as soon as possible mean	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
881	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.14	QS	15	24	our staff and service users told us this is achievable and measurable	Thank you for your comments.
911	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.16	QS	16	25	Our service user were supportive of this standard but there is concern with our staff on whether this is achievable Our inpatient staff told us – seeing the service users named professional on a 1:1 basis for an hour a day would not be possible to achieve this standard in its current form days off and sick leave would make it impossible this needs to be revised our inpatient staff told us -There would be difficulty	Thank you for your comment. The statement has been amended to "known" professional.

						where consultants have out patient clinics too	
928	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.17	QS	17	27	our inpatient staff told us- Currently this is not achievable due to resource issues our performance team told us - There would be practical difficulties around annual leave, sickness etc. The standard may need to include words 'nominated deputy'. Why are 20mins or an hour selected as the measures?	Thank you for commenting. We believe these comments refer to QS16 (now QS12). Statement 16 (now QS12).has been amended to a “known professional”.
1002	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	45.18	QS	22	33	this is felt by our service users to be realistic	Thank you for your comment
597	Southern Health NHS Foundation Trust	34.01	QS	1	5	The reference to ‘families or carers’ in the **Draft quality statement** opening paragraph seems to exceed the rest of the quality statement content, which is service user focused, and would not be supported by the **Relevant existing indicators** which are similarly user focused**.** If the statement is to include reference to ‘carers’ then suggest the reference to **data sources’** needs to include an additional category: ‘***Local data sources’***	Thank you for commenting. The guidance includes families and carers only in so far as their involvement improves the experience of care for the service user. Therefore, the views and experience of families and carers is not measured.
598	Southern Health NHS Foundation Trust	34.02	QS	1	5	The reference to national surveys as a **Relevant existing indicator** for ‘support’ is logical, but not to ‘supported to feel optimistic’ as described in the first paragraph. This would need evidence from local data sources (see previous suggested addition)	Thank you for your comment. Existing indicators are included to highlight where organisations can use existing mechanisms. Further work may be required in alternative settings to mechanisms.
599	Southern Health NHS Foundation Trust	34.03	QS	1	5	In the light of the above two comments, suggest this standard would benefit from additional **Structure** and **Process** in the **Draft Quality Measure**	Thank you for your comment. Not all quality statements will have an appropriate and legitimate structure and process measure. The most important measure may be the experience of the patient.
644	Southern Health NHS Foundation Trust	34.04	QS	3	8	The reference to ‘engaged in self management’ in the **Draft quality statement** would not be supported by the proposed **Relevant existing indicators.** Suggest the reference to ‘**data sources’** needs to include an additional category: ‘***Local data sources’***	Thank you for your comment. This has been amended.
691	Southern Health NHS Foundation Trust	34.05	QS	5	10	**Re Draft Quality measure. Structure a) :** the particular proposal for evidencing service user monitoring, namely by service users undertaking exit interviews, is too narrow. Service users need to be engaged in a variety of monitoring roles in relation to service performance, and interviews may or may not be the chosen methodology. To allow for this wider flexibility of approach we suggest this Quality Standard draws on the NMHDU’s	Thank you for your comment. The process measure on proportion of people receiving an exit interview has been removed.

						framework 'Paths to Personalisation in Mental Health' 2010 where 'Good Leadership' is highlighted as an outcome. Working with this wider concept of service user engagement would result in **Structure a)** being expanded to: ***'(i) Evidence of local arrangements to have service user monitoring of services throughout the trust, for example through experts by experience roles*** ***(ii) Evidence of user led organizations and networks that provide strong voices'*** The matching **Process** paragraphs would be:' ***(i) the proportion of service user experts by experience who were given opportunities to be involved in performance monitoring*** ***Numerator – the number of service users in the denominator*** ***who were given the opportunity to monitor performance*** ***Denominator – the number of service users known to be willing*** ***experts by experience*** ***(ii) the proportion of user led organizations and networks the Trust worked with to listen to service users voices*** ***Numerator – the number of organizations and networks in the denominator worked with by the Trust*** ***Denominator – the number of user led organizations in the Trust's area'*** An **Outcome,** currently lacking, could then be included of: ***'Evidence of a vigorous partnership approach to assuring that the views of service users are used to help monitor the performance of services'***	
749	Southern Health NHS Foundation	34.06	QS	8	14	The reference to the NHS staff survey as a **Relevant existing indicator** for 'trained in person-centred care	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15

	Trust					and/or customer care'' is logical, but not to that training being delivered 'by service users' as defined in the **Draft quality measure** opening paragraph. This would need evidence from other sources. Suggest the reference to '**data sources'** needs to include an additional category: '***Local data sources'***	statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
558	Southern Health NHS Foundation Trust	34.07	QS	All	All	While it is tempting to define positive experience in as many ways as possible, and arrive at a wide range of standards, we are concerned about the total of 22 quality statements, and feel that is too high. Other NICE Quality Standards have managed to identify around 12 or 13 quality statements	Thank you for your comment, these have been reduced to 15 statements.
559	Southern Health NHS Foundation Trust	34.08	QS	All	All	We would like to see greater consistency across quality statements, in terms of the organizing headings used: Structure, Process, Outcome, Numerator, Denominator	Thank you for your comment. The quality standard will be re-examined to ensure consistency.
461	St Andrew's Healthcare	58.00	NICE	1.6.6	21	Expectation of at least one hour per day with their named healthcare professional is a very high expectation and will be difficult to achieve on a busy ward	Thank you for your comment, the GDG feel this is achievable, although on reflection did agree that it may not be possible to see the same person every day and have therefore amended this to 'a healthcare professional known to them'.
491	St Andrew's Healthcare	58.01	NICE	1.7.6	23	2 days notice of discharge is not possible if discharge is by either the hospital managers or MHRT	Thank you for your suggestion, the recommendation has been amended to read: *When plans for discharge are initiated by the service, give service users at least 48 hours' notice of the date of their discharge from a ward.*
32	Stonewall	43.01	All	General	General	Stonewall are happy to respond to this consultation. Stonewall are a national charity campaigning for the rights of the 3.6 million lesbian, gay and bisexual people in England, Scotland and, Wales. Stonewall work with over 600 employers to improve sexual orientation equality at work and, with over 50 Local Authorities to tackle homophobic bullying in schools. In addition, Stonewall provide support to above 50 NHS organisations ensuring lesbian, gay and bisexual staff can reach their full potential and, lesbian, gay and bisexual people receive appropriate care that reduces health inequalities.	Thank you for your comments.
202	Stonewall	43.02	Full	7.5.1.9	89	Stonewall would like to see this section expanded to include reference to lesbian, gay and bisexual user group and voluntary organisations. Stonewall research (Prescription for Change, 2008) has highlighted the high levels of mental health and	Thank you for your comment. We have now addressed sexual orientation in other areas of the guideline, for example recommendation 1.1.7 (1.1.6 in the consultation version).

						substance misuse problems in the lesbian and bisexual community coupled with 1 in 2 reporting negative experiences of care in the past year. Stonewall believe that mental health services are not nuanced enough to provide for lesbian, gay and bisexual people with mental health conditions. Therefore, Stonewall believe the full guidance must reference the fact that sexual orientation discrimination in early life can lead to mental health problems in later	With regards your second point, whereas we understand this is an important issue, it would be outside the scope of this guideline to comment on the many factors associated with increased risk of mental health problems.
95	Stonewall	43.03	Full	General	General	The recent Government Mental Health strategy (No Health Without Mental Health, 2011) sets out the importance of collecting sexual orientation data across access, experience and outcome. Stonewall believe this guidance should include this action and reference the Stonewall best practice monitoring guide to ensure it is spread throughout the NHS.	Thank you for your comments. Although the points you raise are important, they are essentially outside the scope of this work. However, we have ensured that in the introduction to the NICE guidance and recommendations, characteristics of groups commonly subject to inequalities include sexual orientation.
206	Stonewall	43.04	Full	7.5.2.7	90	Stonewall support the recommendations to promote the inclusion of relatives and carers and would like to highlight the fact that only 10% of lesbian and bisexual women felt their partner is welcome at consultation. As the majority of healthcare settings are not typically inclusive for lesbian, gay and bisexual people it is often assumed that same-sex partners are not welcome. In addition, the lack of clear, visible messages and policies as well as potential lack of awareness on the part of the healthcare professional means LGB people feel their partners are not welcome.	Thank you for your comment, 'families and carers' in this document covers 'relatives, friends, non-professional advocates and significant others who play a supporting role for the person using mental health services', which would include partners of any sex, as specified in the 'person-centred care' section of the NICE guidance.
600	Sussex Partnership NHS Foundation Trust	21.01	QS	1	5	'Optimistic about their care' is a very open ended statement – it need to be made specific for example, that they are optimistic that the care they receive will be effective or improve their quality of life	Thank you for your comment. Quality statement one has been amended to"optimistic that their care will be effective" to give greater clarity and a focus on the outcome.
626	Sussex Partnership NHS Foundation Trust	21.02	QS	2	6	This statement would be clearer and reflect better the general intention of the standard if was expanded to describe training that covered not only cultural awareness training delivered by BME VSOs but also organisations representing other aspects of diversity such as LGBT and disability	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
627	Sussex Partnership NHS Foundation Trust	21.03	QS	2	6	The structure of the measure needs to include expectations around timescales as it is essential that the training is up to date	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

645	Sussex Partnership NHS Foundation Trust	21.04	QS	3	8	Measure should specifically mention the promotion of advocacy as a means promoting active involvement and seek evidence of partnership working with advocacy organisations and PALS internally as proof that statement has been met	Thank you for your comment. QS3 has been amended to read *'People using mental health services are actively involved in shared decision-making and supported in self-management'*. The GDG believe that the appropriate measure should be experience surveys and feedback.
674	Sussex Partnership NHS Foundation Trust	21.05	QS	4	9	This statement is particularly challenging for Primary care Access services (often short term brief intervention) and the wording needs to reflect exactly to whom it applies	Thank you for your comment, but the scope of this guidance covers only adult NHS mental health services.
692	Sussex Partnership NHS Foundation Trust	21.06	QS	5	11	Reactive sources of service user experience such as complaints and PALS data should be used to report on the performance of services along side more proactive sources such as surveys etc. Local voluntary sector and advocacy groups are also valuable sources of information on service user experience and evidence of engagement with them could be part of the measure of adherence to this statement	Thank you for your comment. Local organisations are free to use other existing mechanism to measure attainment of the statement.
750	Sussex Partnership NHS Foundation Trust	21.07	QS	8	14	The structure of the measure needs to include expectations around timescales as it is essential that the training is up to date	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
882	Sussex Partnership NHS Foundation Trust	21.08	QS	15	24	This statement should specifically mention the availability of information about advocacy and seek evidence of staff promoting advocacy to support the involvement of service users in shared decision making	Thank you for this suggestion. The GDG felt that the priority was to improve shared-decision making, therefore the suggested amendment was not made.
990	Sussex Partnership NHS Foundation Trust	21.09	QS	21	32	This statement needs to reflect the intentions of the guidance better – the word 'routinely' should be included to ensure that information sharing is a dynamic process rather than static one off issue	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
380	Sussex Partnership NHS Foundation Trust	21.10	NICE	1.1.15	12	An additional point should be added that even if a service user does not want their family involved in their care the family should not be discouraged from contacting the team to give information even if they cannot be engaged in the ongoing support work.	Thank you for your comment, we don't feel that we can include this in the recommendation as it is somewhat ambiguous and may infringe confidentiality.
495	Sussex Partnership NHS Foundation Trust	21.11	NICE	1.7.7	23	PALS is patient *advice* and liaison – though it can route people to advocacy organisations and is in some trusts involved in wider engagement activity it is an internal 'trouble shooting service' which while able to help with problems around discharge does not offer the	Thank you for your comment, PALs may not offer this service but should be able to broker it. The typo has been amended.

						service implied in this section	
295	Sussex Partnership NHS Foundation Trust	21.12	NICE	General	General	The documents describe service user experience and its improvement in mental health only in terms of an individual's involvement in their own care. Involvement can also extend to i) participation as part of a group of other service users, for example, in training which is touched on, but also in other aspects of trust services for example support groups ii) Involvement in strategic planning and decision making. These other levels of involvement and engagement represent valuable and empowering options for service users in their interaction with statutory and voluntary sector services by offering further opportunity to effect their own experiences inthe future and also promote the interests of other people with similar experiences. They therefore need to be incorporated in the standard	Thank you for your comment, recommendations 1.1.17-1.1.20 (now 1.1.19-1.1.22) all address involving service users in improving services.
336	Tees, Esk and Wear Valleys NHS Foundation Trust	25.01	NICE	1.1.2	8	Our comments are as follows – received from local service user group that they applaud the use of plain language to be used in difficult communication particularly at times of stress as this has not always been the case in their experience.	Thank you for your comments.
352	Tees, Esk and Wear Valleys NHS Foundation Trust	25.02	NICE	1.1.6	9	Our comments are as follows. Whilst fully supportive of the statements regarding equality and diversity needs of service users we feel that this needs to be expanded so that staff are aware of the sexual orientation, gender, trans and disability issues particularly in relation to Deaf/deaf people. All of these groups have higher levels of mental health problems and there is evidence that these are linked to their experiences of harassment and discrimination	Thank you for your comment, recommendation 1.1.6 (now 1.1.7) has been amended to include the issue of wider diverse groups: *When working with people using mental health services:* • *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from different genders, cultural, ethnic, religious or other diverse backgrounds.*
356	Tees, Esk and Wear Valleys NHS Foundation Trust	25.03	NICE	1.1.7.	9	Our comments are as follows that we support the need for increased cultural awareness for all staff. In our area there are a large number of travellers which pose challenges fro engagement. Perhaps more about how we address cultural issues rather than just saying we should for example give links to examples of good practice examples.	Thank you for this suggestion. The GDG had to reduce the number of statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

378	Tees, Esk and Wear Valleys NHS Foundation Trust	25.04	NICE	1.1.14	11	Our comments are as follows – received from local service user group they felt that written information was essential	Thank you for your comment, the GDG agree.
391	Tees, Esk and Wear Valleys NHS Foundation Trust	25.05	NICE	1.1.18	13	Our comments are as follows that whilst employing service users in training is something we do to date this has not been the case for training receptionists and administrators but would be useful to consider	Thank you for your comment.
403	Tees, Esk and Wear Valleys NHS Foundation Trust	25.06	NICE	1.2.4	14	Our comments are as follows the statements regarding equality and diversity needs of service users we feel that this needs to be expanded so that staff are aware of the sexual orientation, gender, trans and disability issues particularly in relation to Deaf/deaf people.	Thank you for commenting, the GDG agreed this was important, and so created a specific recommendation (please see 1.2.5).
433	Tees, Esk and Wear Valleys NHS Foundation Trust	25.07	NICE	1.4.9	18	Our comments are as follows the statements regarding equality and diversity needs of service users we feel that this needs to be expanded so that staff are aware of the sexual orientation, gender, trans and disability issues particularly in relation to Deaf/deaf people.	Thank you for your comment, this is covered by 'other minority groups'.
435	Tees, Esk and Wear Valleys NHS Foundation Trust	25.08	NICE	1.4.10	18	Our comments are as follows that we support the need for increased cultural awareness for all staff.	Thank you.
438	Tees, Esk and Wear Valleys NHS Foundation Trust	25.09	NICE	1.5.1	18	Our comments are as follows – received from local service user group this is important as many people did not know if they had a crisis plan	Thank you.
442	Tees, Esk and Wear Valleys NHS Foundation Trust	25.10	NICE	1.5.7	19	Our comments are as follows – received from local service user group this is especially appealing and essential	Thank you for your comment, we agree crisis plans can be effective in ensuring service users' wishes are respected.
512	Tees, Esk and Wear Valleys NHS Foundation Trust	25.11	NICE	1.8.12	26	Our comments are as follows The idea of people being able to record how they feel in relation to their treatment in their notes is a very honest and immediate way of capturing service users views. This could be carried out following a wider range of interventions than those stated. other that following an episode of re	Thank you for your comment, we agree that it is important for service users to have ready access to their notes and be able to add to them, as recommended in 1.4.6.
296	Tees, Esk and Wear Valleys NHS Foundation Trust	25.12	NICE	General	General	Our comments are as follows – received from local service user group these guidelines when implemented will give service users and carers support and make their journey through the pathway much easier	Thank you for your comments.
297	Tees, Esk and Wear Valleys NHS Foundation Trust	25.13	NICE	General	General	Our comments are as follows that the document is trying to do many things and it is a bit confusing and feels disjointed.	Thank you for your comment, without any specific reference to what you find confusing and disjointed it is difficult to address your concerns.
298	Tees, Esk and Wear Valleys NHS Foundation Trust	25.14	NICE	General	General	Our comments are as follows that the document sets clear standards for what people using mental health services should be able to expect and areas for measurement of patient experience especially in	Thank you for your comments.

						relation to timescales for actions which will be challenging but essential to improve the overall experience of care. Will existing performance frameworks take these standards into account.	
33	The British Association for Counselling and Psychotherapy	53.00	All	General	General	The Mental Health Alliance would like to thank NICE for giving us the opportunity to comment on *Service user experience in adult mental health*, and hope that our recommendations will be of use.	Thank you for your comments.
305	The British Association for Counselling and Psychotherapy	53.01	NICE	Introduction	3	The Mental Health Alliance believes that reference should also be made to the Mental Health Act Commission Biennial Reports. These are available on the Care Quality Commission website.	Thank you for your comment, this introduction is not meant to be a comprehensive review of all the literature in this area, but rather a short introduction. Therefore we will not amend it as you have suggested.
317	The British Association for Counselling and Psychotherapy	53.02	NICE	Person-centred care	5	People under Supervised Community Treatment (SCT), with a Community Treatment Order (CTO) can have capacity to make decisions about their care, but this is over-ridden by the Mental Health Act's powers. This group of people is not currently provided for in the first paragraph of the section and, we believe, they should be.	Thank you for your comment, the section on person-centred care is standard NICE text, but we will send your suggestion to them.
324	The British Association for Counselling and Psychotherapy	53.03	NICE	Draft Quality Statements	6-7	The Mental Alliance believes that an additional draft quality statement should be included around the issue of '*trust'*, specifically the '*trust'* that is required between the patient and the professional.	Thank you for your comment. This statement has now been separated into two: "*People using mental health services, and their families or carers, feel optimistic that care will be effective.*" and "*People using mental health services, and their families or carers, feel treated with empathy, dignity and respect."* As, the GDG felt it would be very difficult to measure trust**.**
328	The British Association for Counselling and Psychotherapy	53.04	NICE	1.1.1	8	The Mental Health Alliance believes this point should be changed to include the word recovery. We recommend an amendment to read: "…*Take time to build supportive, empathic and non-judgemental relationships as an essential part of care and recovery."*	Thank you for your comment, the GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.
432	The British Association for Counselling and Psychotherapy	53.05	NICE	1.4.8	18	The Mental Health Alliance believes that this paragraph should be changed to include the word timely. We recommend a change as follows: *"Ensure that service users have **timely** access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problem in NICE guidance."*	Thank you for your comment, we have added 'timely' to the recommendation to reflect your suggestion.
478	The British Association for Counselling and	53.06	NICE	1.6.12	22	The Mental Health Alliance believes that the term *'routinely visited'* should be clarified within the guidance document, giving details as to how often	Thank you for your comment, in this context routinely means in the ordinary course of events. It would be impossible to specify how often or within what

	Psychotherapy					*'routinely visited'* refers to. i.e. daily, weekly or monthly.	timescale as this will depend on the individual, their particular condition and its severity and the length of admission. With regard to the latter, about half of admissions last less than 1 month, and about half of those about less than 2 weeks. Moreover, some admissions can last for well over a year. I hope it's clear that routinely simply would mean that this should happen in most cases.
276	The International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses (ISPS-UK)	38.01	NICE & QS	General	General	Stronger recommendations to psychological therapies are needed in these guidelines, particularly as many service users commented on the difficulties in accessing psychotherapies in the FULL guidelines, and how they valued psychotherapies. Suggest this document would be helpful for providing access to psychological therapies: Charter of Good Practice in Psychological Therapies for People experiencing Psychoses. www.ispsuk.org/upload/ISPS%20(2).pdf	Thank you for this suggestion. We acknowledge that difficulty accessing psychological interventions was one of the themes that came out of the qualitative and survey evidence. This is why the GDG made the following specific recommendation: *1.4.8 Ensure that service users have timely access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problem in NICE guidance*. Also, please see 1.4.9 and 1.6.8
34	The King's Fund	9.01	All	general	general	Overall we think the guidance recommendations and draft Quality Standards are impressive and should be helpful for providers, professionals and commissioners, and for service users and families. The introduction, setting out what is expected of providers and commissioners, and with caveats about individual differences between patients/service users and the need for professionals to exercise judgement, is very good.	Thank you for your comments.
35	The King's Fund	9.02	All	general	general	It's difficult to work out with the Guidance document and Quality Standards document why there is repetition between the two but also some differences. It would be helpful to make it clearer why they are separate and which is the more significant and for what purpose.	Thank you for your comments. The NICE guidance is a list of the recommendations developed by the guidance development group which is aimed at healthcare professionals to help deliver the best level of care. The Quality Statements provide measures against which these can be assessed.
36	The King's Fund	9.03	All	general	general	The guideline states in the introduction that Lord Darzi's report 'High Quality Care for All' highlighted the importance of the entire service user experience within the NHS, ensuring that people treated with compassion, dignity and respect within a clean, safe and well managed environment. The environment is recognised as a key component of the patient experience in the Picker Institute's dimensions of patient centred care: 'attention to physical and environmental needs'. Although there is a large body	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

						of evidence on the effect of the environment on service users experience, recovery and wellbeing this does not appear to have been recognised in the recommendations or draft standards - for example R. Ulrich (2004) *The role of the physical environment in the hospital of the 21st Century* and B.Lawson (2003) *The architectural healthcare environment and its effect on patient health outcomes.* Much work has been undertaken during the last 10 years to ensure that vulnerable people are treated in safe environments where risk is minimised, their privacy and dignity is respected and the care promotes therapeutic engagement and exercise, yet there is no specific mention of the importance of the environment within the draft standards statements other that reference in QS 17 to meaningful activities and exercise. Current work also indicates that if a supportive environment can be created for people with cognitive problems and dementia there may be a reduction in falls, aggressive incidents and a reduction in the use of antipsychotic medication. Please contact the Enhancing the Healing Environment Programme at The King's Fund for details of this work.	
227	The King's Fund	9.04	Full	9.2.5	107-108, 110-112	Evidence is presented that the physical environment in inpatient units shocks many people who are admitted to them, and their families, and can be violent places. These are fundamentally important observations, but do not carry through into quality standards for the physical environment. Neither do quality standards include making sure inpatients are always safe and feel safe. Please could there be some clarification on why this is. The need for appropriate facilities for families and carers is also highlighted but not followed through. We would suggest a Quality Standard which reinforced the unacceptability of mixed sex wards and of putting adolescent service users on adult wards.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance. However recommendation 1.6.1 does address making service users feel safe on the ward.
182	The King's Fund	9.05	Full	6.5.1.7	67	This indicates that waiting rooms should be comfortable, clean and warm and have areas of privacy - but this is not reflected in the Quality Standards	Thank you for your comment. Not all recommendations could be incorporated into the Quality Standard, therefore the GDG had to prioritise.
196	The King's Fund	9.06	Full	7.2	80	Key problems regarding community care requirements 'attention to physical and environmental needs' is listed. Reference is then made to the lack of privacy	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.

						being a barrier, that day centres may be depressing and boring, and that survey results suggest that physical and environmental needs are poorly catered for. Environmental concerns are recognised in the evidence summary on p.84 and p.86 but they do not appear in the practice recommendations starting on p.88, nor are they reflected in the draft Quality Standards.	
215	The King's Fund	9.07	Full	8.3	96	Assessment and referral. Although no evidence was found for 'attention to physical and environmental needs' this is listed as a key requirement. This aspect is not then referred to in the recommendations, nor reflected in the draft Quality Standards.	Thank you, but the key requirements reflect what the GDG considered would promote a good service user experience. Not all of these were taken forward as recommendations, although in this case recommendation 8.5.1.4 does cover the place of assessment.
261	The King's Fund	9.08	Full	11.2	132 -140	Detention under the Mental Health Act. Attention to physical and environmental needs is listed as a key problem on p.132 and evidence is cited regarding how the hospital environment can be frightening, disorientating and distressing pp136 -137. Mention is made in the evidence summary of the effect of the environment on p.138 yet the only mention on pp139-140 under environmental needs relates to service users' possessions and personal safety. The environment is highlighted in the evidence to the recommendations p.140 but does not then appear in the recommendations themselves, nor in the draft Quality Standards.	Thank you for your comment, specific recommendations about the physical environment are outside the scope of this guidance.
912	The King's Fund	9.09	QS	16	25	This may be controversial! It appears to be based on the consensus view of the standards group, which is fine, but it is not clear why 20 minutes and 1 hour were chosen - it would be helpful if indicated where these figures came from	Thank you for your comment. The statements are meant to be aspirational. With regard to where the figures came from, the quality statements were developed from recommendations (see page 2 of the document). Further information about how the recommendations were developed is provided in the full guidance.
235	The King's Fund	9.10	Full	9.5.1 .2	113	Not clear why giving verbal and written information to service users and their families and carers (as set out on lines 23-31) did not become a Quality Standard? There is clear evidence for it and easily measurable.	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Statements to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience.
257	The King's Fund	9.11	Full & NICE	10.5. 1.5 & 1.7.5	129 23	See no.4 above - this recommendation about information provision could be incorporated into QS18 - if it isn't part of it already (not clear from way document set out)	Thank you for your suggestion. The GDG had to reduce the number of statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.

483	The King's Fund	9.12	NICE	1.6.14	22	Choice of food - could this be a QS? Maybe evidence not strong enough?	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Statements to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience.
601	The King's Fund	9.13	QS	1	5	Could the SURE tool being developed at the Institute of Psychiatry (KCL) be included in 'relevant existing indicators' for this QS and others?	Thank you for your comment. Organisations are free to utilise tools and measures they feel most appropriate.
628	The King's Fund	9.14	QS	2	6	Are local voluntary organisations who work with black and minority ethnic communities to be found across the whole country?	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
646	The King's Fund	9.15	QS	3	8	The outcome here is actually two separate outcomes: 1) actively involved in treatment decisions and shared decision making 2) self-management and therefore need separate indicators to measure them	Thank you for your comment. This has been amended.
515	The King's Fund	9.16	NICE	4	27	Should a research recommendation be to develop indicators where none currently exist for some Quality Standards?	Thank you for your comment, it is not the role of research recommendations to develop indicators. Indicators have been developed to underpin the quality statements for this guidance.
96	The National LGB&T Partnership	50.00	Full	General	General	Any consideration of the different experiences lesbian, gay, bisexual and trans (LGB&T) mental health service users is completely lacking from this document. This is in contrast to other protected characteristics such as issues facing BME communities which are referred to many times throughout the document. This exclusion of LGB&T issues and needs is unacceptable and must be addressed in NICE guidance. Evidence indicates that LGB&T patients' experiences are poorer than that of the general population: • One in five trans people have found their GP to be unhelpful (Whittle, S. Turner, L. and Al-Alami, M. (2007), Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination) • 20% of health care professionals admit to being homophobic (Stonewall (2007), Sexual Orientation Research Review) • Only 1 in 3 older LGBT individuals believes their	Thank you for your comment, the GDG agrees that service users from other diverse backgrounds should be referred to in the document and the recommendation 1.1.6 (now 1.1.7) has been amended to read: *When working with people using mental health services:* - *take into account that stigma and discrimination are often associated with using mental health services* - *be respectful of and sensitive to service users' gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability* - *be aware of possible variations in the presentation of mental health problems in service users from different ages, genders, cultural, ethnic, religious or other diverse backgrounds.*

						health professionals to be positive towards them (Heaphy B., Yip A. and Thompson D. (2004), Shaping futures: LGBT people growing older, p5) NICE and all relevant agencies must start addressing the poorer mental health services experiences and outcomes of LGB&T people.	
560	University Hospitals Birmingham NHS Foundation Trust	46.00	QS	general	general	There are already quality standards that apply to the experience of patients contained within the Care Quality Commission Essential Standards, in particular standard 1. Rather than have a separate set of standards, it would be good to refer to, and incorporate, compliance with the Essential Standards as a way for Trusts to demonstrate that they are providing a quality patient experience. This would reduce the duplication that having another set of standards will bring about.	Thank you for your comment. CQC is about basic statements (i.e. essential) and NICE is about excellence (i.e. aspirational). However, in describing excellence it is acknowledged that there may be instances where there is linkage with essential statements. CQC may make use of data on Quality Statements measures in their risk estimation. We expect that further advice about how quality statements and the associated measures should be used by the NHS will come from the National Quality Board, and when it is established, from the NHS Commissioning Board.
602	University Hospitals Birmingham NHS Foundation Trust	46.01	QS	QS 1	5	Not sure 'mentored for compliance' is the appropriate term	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.
603	University Hospitals Birmingham NHS Foundation Trust	46.02	QS	QS 1	5	It is not practically possible to incorporate compliance with NICE guidance into annual performance assessment for all staff who directly interact with patients. There are Trust values and standards that are already incorporated. A better way of having a direct impact on staff would be to have a measure of how NICE guidelines are incorporated into the Trusts and individual service policies and procedures. For those who have responsibility of staff, implementation and ensuring that appropriate NICE guidelines are incorporated into service development could be included in their job descriptions.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.
621	University Hospitals Birmingham NHS Foundation Trust	46.03	QS	QS 2	7	This needs to be included in patient assessment documentation and a 'flag' included on patient electronic and paper records to alert staff to the additional patient needs.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
676	University Hospitals Birmingham NHS Foundation Trust	46.04	QS	QS 4	10	There is currently only one question in the National Patient Surveys which relates to dignity. The survey needs to be reviewed to include questions on kindness, compassion, courtesy and honesty.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.

						Evidence is also available from other methods of feedback from patients and carers including PALS, Compliments, Complaints, NHS Choices and Patient Opinion.	
729	University Hospitals Birmingham NHS Foundation Trust	46.05	QS	QS 7	13	Involvement of carers needs to be reassessed at various points in the patient journey, not just on first contact as this standard suggests. The level of involvement may change as the patients condition improves or deteriorates, or as they become more or less dependent. The outcome cited may not always be possible, as not all patients are able to provide feedback, therefore an audit of patient records should also be used a method of assessment of compliance. For the relevant existing indicators, there is a question in the National Inpatient Survey (43) which asks if family / carer had an opportunity to speak to the doctor.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.
730	University Hospitals Birmingham NHS Foundation Trust	46.06	QS	QS 7	13	Amend this section to include "…..are established at the first point of contact and continuously ***reviewed and*** respected throughout their care"	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.
753	University Hospitals Birmingham NHS Foundation Trust	46.07	QS	QS 8	15	Service providers should incorporate the guidelines into their consent policy and procedures.	Thank you for your comments, we agree this is an important step to aid implementation.
737	University Hospitals Birmingham NHS Foundation Trust	46.08	QS	QS 8	3	Add in something about ensuring they are given detailed and accurate information to enable them to "choose, accept or decline treatment"	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate QS.
780	University Hospitals Birmingham NHS Foundation Trust	46.09	QS	QS 9	16	This statement appears to be an outcome of the other standards rather than a standard i.e. QS 2, 3, 5,7, 8, 15, 16 & 17.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
781	University Hospitals Birmingham NHS Foundation Trust	46.10	QS	QS 9	16	Amend to "…. tailored to their ***individual*** needs and circumstances	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
805	University Hospitals Birmingham NHS Foundation Trust	46.11	QS	QS 10	17	Description of what this means for Health & Social Care Professionals: obtaining consent from the patient is impractical and unnecessary. We have a duty to share information with those health and social care professionals who are providing care, and do so under the legal requirements of the data protection act and Caldicott. This is essential to ensure the patient receives timely, safe care. To withhold information	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.

						whilst waiting to gain patient consent would be immoral and could cause a delay to essential care. All NHS Trusts have a legal duty which is monitored by the NHSLA for compliance and so introducing this QS is an unnecessary duplication. The timely sharing of information could be monitored so that information is shared effectively reducing any delays in care.	
825	University Hospitals Birmingham NHS Foundation Trust	46.12	QS	QS 12	19	Whilst the idea may be sound this is not always practically possible in an acute setting. Teams of medical staff provide the care to patients and so, as an example, a patient coming for OPD appointments may not always see the consultant, but one of their team. As junior staff rotate as part of their training and development, they may not see the same person again. It is far more important that the healthcare professional is fully appraised of the patient and their on-going care needs, and that the information they give does not conflict with information the patient has been given previously. Anecdotally this is what patients are most concerned about hence the question (40) in the National Inpatient Survey.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
844	University Hospitals Birmingham NHS Foundation Trust	46.13	QS	QS 13	20	"…..demonstrated competency in communication skills" To what standard and how will this be measured	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
859	University Hospitals Birmingham NHS Foundation Trust	46.14	QS	QS 14	21	Most suitable for who? Need to clarify if this means suitable for the patient, the healthcare professional, the type of information being exchanged etc It will be difficult to measure whether specific episodes of communication have been suitable or not unless the understanding is robustly assessed and clearly documented.	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
883	University Hospitals Birmingham NHS Foundation Trust	46.15	QS	QS 15	22	? should be situated near to statement 8 as along similar theme	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
894	University Hospitals Birmingham NHS Foundation Trust	46.16	QS	QS 16	23	Add on "……*in a way that meets their individual requirements"*	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.
917	University Hospitals Birmingham NHS Foundation Trust	46.17	QS	QS 17	24	Add on "…..and are given any necessary information, assistance and support to access and use the tools to their optimum capability	Thank you for commenting, but your comment is about the generic patient experience guidance, developed by the National Clinical Guidelines Centre, which is a separate Quality Standard.

561	Wakefield District PCT	69.00	QS	General	General	The consultation asks for feedback on the document content, format and style and whether the quality standards cover the three dimensions of quality: safety, effectiveness and experience.	Thank you for your comments.
562	Wakefield District PCT	69.01	QS	General	General	These draft quality standards adequately cover the 3 dimensions of quality as applied to adult mental health services. The standards act as a framework to ensure services deliver high standards of care and a positive experience. They will also ensure that decisions about care and treatment are discussed with the service user, in line with the Government strapline "no decision about me, without me".	Thank you for your comments.
37	Wakefield District PCT	69.02	All	General	General	The written guidance considers the patient experience throughout the whole patient journey and across community and in patient settings.	Thank you for your comments.
563	Wakefield District PCT	69.03	QS	General	General	More consideration needs to be made to the choice of content and the actual wording of the 22 quality statements. eg	Thank you for your comment; these have been reduced to 15 statements. They have been amended in response to stakeholders' suggestions for the recommendations and quality statements.
604	Wakefield District PCT	69.04	QS	1	5	*Statement 1:* 'are supported to feel optimistic about their care' Woolly statement. What does this mean? How would a provider be able to evidence this?	Thank you for your comment. It is suggested in the quality measures that services seek the experience of service users to measure this statement.
629	Wakefield District PCT	69.05	QS	2	6	*Statement 2:* cultural awareness training. Seems much narrower than broader 'equality and diversity'. Does the standard want to focus in on cultural diversity to such an extent ignoring other issues such as age, gender etc? Also not sure why the standard distinguishes this should be provided by 'voluntary organisations'. Surely local organisations should suffice.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
716	Wakefield District PCT	69.06	QS	7	11	*Statement 7:* add in 'in a format and way they can understand'. Or 'in plain english'. Also the statement 'and receive emotional support for any sensitive issues'. Again woolley. Also how would a provider evidence? More focus on tailored to needs of the service user, including those with learning disabilities, sight or hearing problems.	Thank you for your comment. The quality standard contains an explanation that explanations should be in an appropriate format. It is hoped that services might ask service users whether they received emotional support.
751	Wakefield District PCT	69.07	QS	8	14	*Statement 8*: does this mean that service users provide / deliver the training?	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
86	Wakefield District	69.	QS	14	23	*Statement 14*: How would this be evidenced?	Thank you for your comment. The GDG had to reduce

9	PCT	08					the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
564	Wakefield District PCT	69.09	QS	General	General	4) There are some elements of patient experience that are omitted from the quality statements eg Nothing in the 22 standards about hospital food / dietary choices / meal times for those admitted to hospital / inpatient stay. Nothing in the 22 standards about patients having access to contact info for out of hours emergencies. Nothing in the 22 standards about ensuring that discussions take place in settings in which confidentiality, privacy and dignity are respected.	Thank you for your comment, whilst the GDG agree that this is important, they had to reduce the Quality Statements to 15 statements which they felt would have the most impact on services and lead to the greatest improvement in service user experience.
565	Wakefield District PCT	69.10	QS	General	General	The layout and readability of the document is in an appropriate format for the majority of the population and is consistent with other NICE publications. However, a companion easy read or 'easy access' version would need to be made available eg for patients with learning disabilities.	Thank you for your comment, this guidance will be published with an accompanying booklet called 'Understanding NICE guidance' which is devised for services users, carers, the public etc.
977	West London Mental Health NHS Trust	19.01	QS	General 21	4	Standard 21: Families and carers. This makes no mention of the children in the families who are, could be both a dependant and a carer. I am concerned that there is not enough (guidance) or reference to these children with a parent who has a mental health diagnosis. These children can often be forgotten and most would not have had a chance to take part in any surveys about their parents mental health treatment and care. Again I feel that this could be a missed opportunity to included the thinking of children in a family.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
994	West London Mental Health NHS Trust	19.02	QS 22	General	4	Standard 22: Stigma. Adult mental health professionals need to be more involved in the care and planning for children of our service users who have children and contact with children i.e. uncle, aunt etc... There is still stigma about mental health service users in children's services. Understandably due to the numbers of serious case reviews where parents have had a mental health illness this has increased raised anxiety but adult mental health services need to be working more closely with children's services to rationalise the anxieties of professionals working in	Thank you for your comment, we agree stigma in mental health is a serious problem that should be addressed by all. Although it was outside the scope to make recommendations for children's services, several recommendations do address issues to do with dependent children (these recommendations were not however developed into quality statements).

						children's services without compromising the safety of the children we are protecting.	
586	West London Mental Health NHS Trust	19.03	NICE	QS1	6	'optimistic about their care' - I should hope so as they are the professionals involved - do they mean optimistic about their lives? Non-judgemental should be a given but you cannot make people be empathetic - professional at all times would be good enough.	Thank you for your comment. The intention of the statement was that health and social care professionals should work to ensure the service users feel optimistic that care will be effective – which does not currently always happen, in the experience of the GDG members. The text has been amended to clarify this.
610	West London Mental Health NHS Trust	19.04	NICE	QS2	6	The organisations don't have to voluntary but should be owned by their communities.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
630	West London Mental Health NHS Trust	19.05	NICE	QS3	6	Ideal - but must include advance planning as in times of crisis this may not be possible.	Thank you for your comment. A different quality statement addresses crisis plans (QS9).
653	West London Mental Health NHS Trust	19.06	NICE	QS4	6	Again ideal, but will mean a major rethink for how Home Treatment is currently delivered	Thank you for your comments, on reflection the GDG felt that whilst it may be preferable for the service user to be treated by one team, this may not always be feasible. Therefore we have added 'normally' to the statement.
677	West London Mental Health NHS Trust	19.07	NICE	QS5	6	Audit and similar areas must be rethought to prioritise this.	Thank you for your comment. It is hoped that services will continue to use service user experience in their audit.
694	West London Mental Health NHS Trust	19.08	NICE	QS6	6	this would mean getting the GPs on board to a far greater extent.	Thank you for your comment
713	West London Mental Health NHS Trust	19.09	NICE	QS7	6	Again, this would be ideal but will there be sufficient resources?	Thank you for your comment. The measures have been amended in light of consultation comments. It is hoped by the GDG that they remain aspirational yet achievable.
731	West London Mental Health NHS Trust	19.10	NICE	QS8	6	Good - and could also provide a stepping stone to vocational rehabilitation.	Thank you for your comments.
757	West London Mental Health NHS Trust	19.11	NICE	QS9	6	We should be doing this already but it is great to see it spelled out - it does however depend on good, accessible educational and employment opportunities being available.	Thank you for your comment and support.
784	West London Mental Health NHS Trust	19.12	NICE	QS10	6	Excellent - plus contact details of significant personal supporters - who may not be family	Thank you for your comment, in this document and the NICE guidance the term 'families and carers' *includes "relatives, friends, non-professional advocates and significant others who play a supporting role for the person using mental health services."*
808	West London Mental Health NHS Trust	19.13	NICE	QS11	6	Only worthwhile if it is reflected in the care plan and actioned.	Thank you for commenting. We are not sure whether you are suggesting a specific change to QS11 (now

							QS10), but there are separate recommendations about using a care plan.
821	West London Mental Health NHS Trust	19.14	NICE	QS12	6	Two completely separate points. Why on earth wouldn't you use the name and title your client prefers? The second point is much more complex - again it would be really helpful but would involve a huge attitudinal shift as well as additional resources to assess.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
838	West London Mental Health NHS Trust	19.15	NICE	QS13	6	This is quite unrealistic and is not what patients need. Of course no one wants to wait but good care can start immediately.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
855	West London Mental Health NHS Trust	19.16	NICE	QS14	7	Agree.	Thank you for your comments.
872	West London Mental Health NHS Trust	19.17	NICE	QS15	7	See point 3.	Thank you for commenting, but we are not clear how point 3 is relevant to QS15 (now QS11).
884	West London Mental Health NHS Trust	19.18	NICE	QS16	7	Again unrealistic and not necessarily the best use of the vast additional resources that would be needed. Many patients would not relish an hour a day of face-to-face contact with a HCP (I am speaking for myself here). One-to-one time with the consultant would definitely be appreciated though.	Thank you for your comment. The GDG has amended this statement to highlight that this is available, not necessarily compulsory.
915	West London Mental Health NHS Trust	19.19	NICE	QS17	7	Yes - this is self-evident to an almost OT!	Thank you for your comments.
929	West London Mental Health NHS Trust	19.20	NICE	QS18	7	Would be good - and unless patient requests a quicker discharge I would have thought it would not be otherwise.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
947	West London Mental Health NHS Trust	19.21	NICE	QS19	7	Surely this is already good practice?	Thank you for your comment, we agree that this should be practiced in every inpatient setting, however the GDG experience highlighted that this was not always the case.
960	West London Mental Health NHS Trust	19.22	NICE	QS20	7	Good - and this should include ECT.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
976	West London Mental Health NHS Trust	19.23	NICE	QS21	7	Yes - especially to be able to exclude interference from unhealthy family members and to be able to choose close friends to be included fully.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should

							be omitted as whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
991	West London Mental Health NHS Trust	19.24	NICE	QS22	7	We all need to do this. Better for MH services to attend to the job in hand. I feel excessive secrecy around individuals can sometimes reinforce stigma (from my own experience again).	Thank you for your comment, we agree stigma in mental health is a serious problem that should be addressed by all.
299	Wish	39.01	NICE	general	general	Wish is concerned that the guidelines do not attend to the important of gender within mental health problems and treatment need. Gender-specific provision should be a requirement of good quality mental health services.	Thank you for your comment, recommendation 1.1.6 (now 1.1.7) has been amended to include diverse groups to address this point: *When working with people using mental health services:* • *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from different genders, cultural, ethnic, religious or other diverse backgrounds.*
300	Wish	39.02	NICE	general	general	Wish is concerned that the guidelines pay insufficient attention to the importance of involvement of workers from voluntary sector mental health organisations that provide continuity of support and specialist skills and knowledge.	Thank you for your comment, we agree voluntary sector workers play a key role in supporting service users, however NICE guidance is only able to make recommendations for health and social care professionals. In regard to this, the GDG felt it was important to make a specific recommendation about mental health services working with voluntary organisations (please see 1.2.4 and 1.4.9).
301	Wish	39.03	NICE	general	general	Wish welcomes the emphasis on involving service users in decision-making and providing them with appropriate information about their rights, options and the restrictions that apply to them.	Thank you for your comments.
302	Wish	39.04	NICE	general	general	Wish is concerned that no reference has been made to the care needs of offenders with mental health problems. They have acute mental health and practical support needs when returning to the community which need to be addressed if cycles of mental health crisis and offending are to be broken.	Thank you for your comment, prisons and forensic settings are outside the scope of this guidance, but mental health services within these settings could use the guidance.
306	Wish	39.05	NICE	Introduction	4	Should make reference to Into The Mainstream (2002) and Working Towards Women's Wellbeing: Unfinished Business (2010) reports which set out the importance of providing gender-specific services for women to address their mental health.	Thank you for your comment, the introduction is not able to review of all the literature in this area. Therefore we will not amend it as you have suggested.

585	Wish	39.06	NICE	QS1	6	Should include reference to the importance of 'a focus on recovery'.	Thank you for your comment, the GDG discussed the 'recovery model' at length but ultimately decided that this can have very different meanings for people and some can have negative experiences of this specific model. It was therefore agreed to outline the principles of good care rather than highlight a specific model.
608	Wish	39.07	NICE	QS2	6	Quality Standard 2 should also make reference to having input from organisation working in a gender-specific way with groups of men or women with mental health needs and the need for training in gender-specific ways of working and its importance.	Thank you for your comment. This quality statement has been removed from the final quality standard. The GDG had to reduce the number of quality statements from 22 to 15. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
647	Wish	39.08	NICE	QS4	6	Consider stating that community-based third sector organisations should be included in the multi-disciplinary team.	Thank you for this suggestion. The GDG agreed that adding the word community would clarify the statement.
693	Wish	39.09	NICE	QS6	6	Consider adding specific reference to the importance of this at a time of crisis.	Thank you for your comment. The statement has not been amended to specifically mention time of crisis as the statement is intended to apply to acute and non-acute access. However the measures contain specific measurement of times of crisis.
758	Wish	39.10	NICE	QS9	6	Consider specifying that the care plan should be designed to meet the individuals access needs.	Thank you for your comment. The GDG considered many suggestions for amending this QS and agreed that it should be changed it to read: *People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy and an agreed date to review it.*
783	Wish	39.11	NICE	QS10	6	Add that there should be consideration for the service users' treatment needs for other health conditions and to address care arrangements for dependants.	Thank you for your comment. This guidance is about the experience of care, not about specific care interventions. Therefore, we are unable to make recommendations specific to improving physical health.
856	Wish	39.12	NICE	QS14	7	Consider adding that SUs should be encouraged to increase their involvement in decisions made about their own treatment and the management of the services they use.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
930	Wish	39.13	NICE	QS18	7	Consider adding that people should be signposted to community organisations and supported to engage with them.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should

							be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
946	Wish	39.14	NICE	QS19	7	Consider adding to this standard that restraint and control should only be carried out when due consideration is given to a person's gender and gender-specific needs.	Thank you for your comment. We would suggest this is covered by the term competent.
959	Wish	39.15	NICE	QS20	7	Consider adding that the gender of the person being restrained or controlled should be taken into account when deciding whether male or female staff should be involved in the restraining.	Thank you for your comment. The GDG had to reduce the number of quality statements from 22 to 15 statements. It was decided that this statement should be omitted as, whilst important, it was not felt to have the most impact on services and lead to the greatest improvement in service user experience.
992	Wish	39.16	NICE	QS22	7	Consider adding 'Work with a variety of group including those working with marginalised groups such as women or black and minority ethnic communities.'	Thank you for your comment, the guideline recommendation behind this statement lists some types of organisations that services should work with – however the list is not exhaustive and would depend on locality.
329	Wish	39.17	NICE	1.1	8	Consider making reference to the importance of building relational security with people using mental health services.	Thank you for your comment, we feel this is reflected in the recommendations as they stand.
335	Wish	39.18	NICE	1.1.2	8	Consider making specific reference to Independent Mental Health Advocates rather than just 'advocate'.	Thank you for your comment, recommendation 1.8.5 has been amended in line with your suggestion.
342	Wish	39.19	NICE	1.1.3	9	Consider changing to 'Refrain from using clinical language…' rather than 'clearly explain any…'. We believe this is preferable because women we work with attest to the role of clinical language and labels in disempowering and frightening them during discussions with medical professional. The over-use of clinical language and jargon inhibits them from sharing decision-making and putting their views forward.	Thank you for your suggested change. The GDG debated this issue, and decided that on balance if clinical language was to be used it should be clearly explained rather simply avoided. That said, the GDG did agree that the process of assessment should be explained in plain language (see 1.2.2).
344	Wish	39.20	NICE	1.1.4	9	Consider adding that service users should be actively supported to engage with local schemes	Thank you for your comment this has been amended to read '*are able to discuss and actively support service users to engage with these resources'.*
345	Wish	39.21	NICE	1.1.5	9	Consider adding 'avoid the use of disempowering language'. A frequent use of disempowering language for female service users is to refer to them as manipulative.	Thank you for your comment, the GDG believes this is implicit in the document and has not amended this recommendation.
353	Wish	39.22	NICE	1.1.6	9	Consider adding the following two points: Be aware of possible variations in the presentation of mental health problems according to gender differences. Be respectful of gender-specific needs of service users (for women this may include caring responsibilities that need addressing, higher likelihood of having	Thank you for your comment, recommendation 1.1.6 (now 1.1.7) has been amended to include the issue of wider diverse groups: *When working with people using mental health services:*

						experienced domestic violence or sexual abuse and the need for relational security)	• *be respectful of and sensitive to service users from different genders, cultural, ethnic, religious or other diverse backgrounds* • *be aware of possible variations in the presentation of mental health problems in service users from different genders, cultural, ethnic, religious or other diverse backgrounds.*
358	Wish	39.23	NICE	1.1.7	10	Consider adding that professionals should also have competence in gender-specific ways of working and an understanding of gender differences in treatment expectation and adherence.	Thank you for your comment, not all services need to be gender specific, and the vast majority are not. Nevertheless we have amended 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) to include recommendations for sensitivity to and competence in dealing with different groups.
374	Wish	39.24	NICE	1.1.13	11	Consider adding that professionals should be non-judgemental about family relationships and not discriminate against same-sex relationships.	Thank you for your comments, recommendations 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) have now been amended to include wider diverse groups. Also, at the beginning of this document (under Person Centred Care) it highlights that 'families and carers' includes any person the service user considers significant in their life.
375	Wish	39.25	NICE	1.1.13	11	Consider adding that professionals should be aware of possible indicators for domestic violence and sexual abuse	Thank you for your suggestion, recommendation 1.1.17 (now 1.1.19) has been amended to address this issue to read: *If the service user does not want their family or carers to be involved in their care:* • *seek consent from the service user, and if they agree give the family or carers verbal and written information on the mental health problem(s) experienced by the service user and its treatments, including relevant 'Understanding NICE guidance'* • *give the family or carers information about statutory and third sector, including voluntary, local support groups and services specifically for families or carers, and how to access these* • *tell the family or carers about their right to a formal carer's assessment of their own physical and mental health needs, and how to access this* • *bear in mind that service users may be ambivalent or negative towards their family for many different reasons, including as a result of the mental health problem or as a result of prior experience of violence or abuse.*

381	Wish	39.26	NICE	1.1.16	12	Wish believes this is a valuable part of the guidelines for women with mental health needs.	Thank you for your comment.
392	Wish	39.27	NICE	1.1.18	13	Consider adding that the service users involved should be provided with supervision and given the support they need to protect their privacy and dignity. Consideration should be given to service users to be involved through a local third sector organisation that can provide them with peer support and supervision.	Thank you for your comment, the GDG feel the current guidance makes sufficient recommendations regarding treating people with dignity. We have added the requirement for training and supervision to the recommendation.
396	Wish	39.28	NICE	1.1.20	13	Consider stating that advocates should have the opportunities to input into the report.	Thank you for your comment, however the GDG did not think it was a priority in this context.
404	Wish	39.29	NICE	1.2.4	14	Consider adding 'Ensure that gender-specific services are available and staff are trained in gender-specific ways of working.'	Thank you for your comment, not all services need to be gender specific, and the vast majority are not. Nevertheless we have amended 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) to include recommendations for sensitivity to and competence in dealing with different groups.
406	Wish	39.30	NICE	1.3	15-16	Consider adding point that there should be safe ways for people to complain about the doctor assessing them with fear of retribution. They should have the option to transfer to another consultant if they wish. In Wish's experience many women are under the care of a consultant that they do not trust but have been told they are not able to change to a different doctor. They feel alienated from decisions about their care but do not feel that it is possible or safe for them to openly seek to change doctor.	Thank you for your comment, we have added a recommendation regarding making complaints without fear of retribution. In regards to changing doctors, this is a very complicated issue and this couldn't simply be on the basis of preference. It is beyond scope of this guidance to say how and when this should be done.
411	Wish	39.31	NICE	1.3.3	16	Suggest relevant support groups and services in the community	Thank you for your comment, this is already covered by recommendation 1.1.4. (now 1.1.5).
422	Wish	39.32	NICE	1.4.5	17	Consider adding that the crisis plan should include the service users preferences about which professionals or workers from third sector organisations should be involved if a crisis develops.	Thank you for your comment, however the GDG did not feel it was appropriate to add this to the recommendation.
416	Wish	39.33	NICE	1.4	16-18	Consider adding that 'mental health and social care professionals inexperienced in working with service users with different gender-specific needs should seek advice, training and supervision from health and social care professionals who are experienced in working in a gender-specific way.'	Thank you for your comment, not all services need to be gender specific, and the vast majority are not. Nevertheless we have amended 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) to include recommendations for sensitivity to and competence in dealing with different groups.
417	Wish	39.34	NICE	1.4	16-18	Consider adding that 'Mental health services should work with local voluntary gender-specific groups to jointly ensure that gender-specific psychological and psychosocial treatments, consistent with NICE guidance and delivered by competent practitioners, are provided to service users from both genders.	Thank you for your comment, not all services need to be gender specific, and the vast majority are not. Nevertheless we have amended 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) to include recommendations for sensitivity to and competence in dealing with different groups.

420	Wish	39.35	NICE	1.4.3	17	Consider adding a reference to the need for care plans to be developed that consider strategies for managing self-injury/self-harm where appropriate.	Thank you for your comment, the guidance is applicable for all people using adult mental health services and therefore we are unable to comment on specific conditions or behaviours. NICE will publish the guideline 'Self-harm: longer term management' in November 2011.
436	Wish	39.36	NICE	1.5	18-20	Consider adding that 'Service users preference for staff/professionals to be present or absent and to specify the gender of the staff working with them should be accommodated wherever possible'	Thank you for your comment, the recommendation has been amended to read: *Immediately before assessing a service user who has been referred in crisis, find out if they have had experience of acute or non-acute mental health services, and consult their crisis plan or advance directive if they have one. Find out if they have an advocate and contact them if they wish. Ask if the service has a preference for a male or female health or social care professional to do the assessment and comply with their preference wherever possible.*
447	Wish	39.37	NICE	1.5.9	20	Wish believes this sections is a valuable part of the guidelines for women with mental health needs.	Thank you for your support.
451	Wish	39.38	NICE	1.6	20-22	Consider adding that hospitals should provide an independent advocacy service for its patients and should consider providing gender-specific and BME community-specific advocacy services, giving due regard to their statutory equality obligations.	Thank you for this suggestion. The GDG believe that several recommendations adequately cover advocacy, including 1.6.13.
456	Wish	39.39	NICE	1.6.2	20	Consider adding that 'how their caring responsibilities for dependants will be addressed'.	Thank you for your comment, these responsibilities are addressed in recommendation 1.1.16 (now 1.1.18)
476	Wish	39.40	NICE	1.6.11	22	Consider adding to this point that health and social care professionals should also be aware of gender-specific or culturally sensitive ways of applying this approach.	Thank you for your comment, not all services need to be gender specific, and the vast majority are not. Nevertheless we have amended 1.1.6 (now 1.1.7) and 1.1.7 (now 1.1.8) to include recommendations for sensitivity to and competence in dealing with different groups.
490	Wish	39.41	NICE	1.7.4	23	This should make reference to the service user's finance and housing situation rather than their 'home situation' because this would encourage consideration of those without housing to return to and the needs of service users regaining benefits on discharge.	Thank you for your comment, the recommendation has been amended in line with your comment to read: *Assess the financial and home situation, including housing, of the service user before they are discharged from inpatient care.*
497	Wish	39.42	NICE	1.8	24-26	Consider adding the principle of good practice that the use of male staff for restraining women should be avoided, especially where there is the possibility that the female service user may have experienced domestic violence or sexual abuse.	Thank you very much, we do think this is an important issue but in the non-forensic acute setting it is unfeasible to make restrictions on gender of staff as there are usually too few members of staff available.

504	Wish	39.43	NICE	1.8.5	24	Service users also need to be made aware of the realistic timeframe for appealing their detention, rather than give them the impression that appeals can be immediately carried forward.	Thank you for your comment, the recommendation has been amended to read: *Inform service users detained under the Mental Health Act (1983; amended 1995 and 2007) of their right to appeal to a mental health tribunal and support them if they appeal, and provide information about the structure and speed of the process involved.*
508	Wish	39.44	NICE	1.8.9	25	Reference should be made to making service users feel as safe as possible when the Mental Health Act is applied.	Thank you for your comment, we have added ensuring the service user feels safe to recommendation 1.6.1.
511	Wish	39.45	NICE	1.8.11	26	Wish is concerned that discussing period of compulsory treatment at the point of discharge would be upsetting to a service user facing change and uncertainty as they move between settings and are likely to be trying to regain control over their life. Reminding them of periods when their autonomy was removed seems unhelpful for this process.	Thank you for your comment, the GDG thought it very important that feedback is gained about this issue, but have modified it to 'offer' so as not to impose this on all service users who may find it distressing.
675	YoungMinds	57.00	QS	4	9	This standard looks at quality of care and addresses the transitional arrangements. We would suggest that this also refers to the transition from children and young people's mental health services to adult mental health services. Continuity of care is a big issue for young people who are making the transition, and often there is no continuity of care.	Thank you, whilst we agree with your comments about the importance of transition into adult services this document is unable to make recommendations for children and young people's services as it is focused on adult mental health services.

These stakeholder organisations were approached but did not respond

2gether NHS Foundation Trust
5 Boroughs Partnership NHS Trust
Action on Postpartum Psychosis
ADDISS
Adult Attention Deficit Disorder - UK (AADD-UK)
African Health Policy Network
Age UK
Anxiety UK
Archimedes Pharma Ltd
Association of British Neurologists
Association of Psychoanalytic Psychotherapy in the NHS
Autism West Midlands
Barchester Healthcare
Barnsley Hospital NHS Foundation Trust
beat
Beating Bowel Cancer
Birmingham and Solihull NHS Cluster

Blackburn with Darwen Teaching Care Trust Plus
BLISS - the premature baby charity
BMJ
Bradford District Care Trust
Bright
British Association for Behavioural & Cognitive Psychotherapies (BABCP)
British Association of Psychodrama and Sociodrama (BPA)
British Dietetic Association
British Lung Foundation
British Medical Association (BMA)
British National Formulary (BNF)
British Psychodrama Association
Camden and Islington Mental Health and Social Care Trust
Camden Link
CCBT Ltd
Central Lancashire PCT
Central South Coast Cancer Network
Cerebra
Cochrane Depression, Anxiety & Neurosis Group
Compass
Connecting for Health
Contact
Craegmoor
Cygnet Health Care
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Dept of Primary Health Care Sciences, University of Oxford
Derbyshire Healthcare NHS Foundation Trust
Dorset Mental Health Forum
Downs Syndrome Research Foundation
East Kent Hospitals University Foundation Trust
East London NHS Foundation Trust
Eli Lilly and Company Ltd
Energy Therapy World-Wide Net
English Community Care Association
Epilepsy Wales
Equalities National Council
Estia Centre, The
Faculty of Dental Surgery
Flintshire County Council
George Eilot Hosptal Trust
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester and Cheshire Cancer Network

Greater Manchester West Mental Health NHS Foundation Trust
Greater midlands cancer network
Hampshire Partnership NHS Foundation Trust
Health Foundation
Healthcare Improvement Scotland
Healthcare Quality Improvement Partnership
Heart UK
Help and Care
Hertfordshire Partnership NHS Trust
Hindu Forum of Britain
Humber NHS Foundation Trust
Inclusive Health
Ipswich Hospital NHS Trust
Kaleidoscope Project
Kent & Medway NHS and Social Care Partnership Trust
Lambeth Community Health
Lewy Body Society, The
Liverpool Community Health
Luton & Dunstable Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Mental Health Nurses Association
Merck Sharp & Dohme Ltd
Mid Yorkshire Hospitals NHS Trust
Middlesex University
Mindwise
Ministry of Defence (MoD)
National Commissioning Group
National Council for Palliative Care
National Lung Cancer Forum for Nurses
National Offender Management Service
National PALS Network
National Patient Safety Agency (NPSA)
National Rheumatoid Arthritis Society, The
National Treatment Agency for Substance Misuse
NEt (North East Together)
NHS Bath and North East Somerset
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Hertfordshire
NHS Milton Keynes
NHS Plus
NHS Sheffield
NHS Western Cheshire
North East London Cancer Network
North Essex Partnership NHS Foundation Trust
North Somerset PCT

North Tees and Hartlepool Acute Trust
Nottingham Support Group for Carers of Children with Eczema
Oxford Health NHS Foundation Trust
Parkinsons UK
Patient Experience Network
Pfizer Limited
Picker Institute Europe
Pierre Fabre Ltd
Pilgrim Projects
Positively Pregnant
Public Health Wales
Ridgeway Partnership
Rotherham NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians London
Royal College of Psychiatrists in Scotland
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society of Great Britain
Royal Society of Medicine
Samaritans
Scottish Intercollegiate Guidelines Network (SIGN)
Sefton Link Support
Sensory Integration Network
Sheffield Children's NHS Foundation Trust
Sheffield Health and Social Care Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
SHP
Social Care Institute for Excellence (SCIE)
Society and College of Radiographers
Solent Healthcare
South London and Maudsley NHS Foundation Trust
South West London and St Georges Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southampton University Hospitals NHS Trust
Specialised Healthcare Alliance
St Wilfrids Hospice
Surrey and Border Partnership Trust
Sutton1in4 Network

Swansea University
Tourettes Action
Turning Point
UK Clinical Pharmacy Association (UKCPA)
UNITE THE UNION-CPHVA
United Lincolnshire Hospitals NHS Trust
University of Edinburgh
Upstream
Urgo Medical Ltd
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West London Gay Men's Project
Western Health and Social Care Trust
Worcestershire PCT
York Teaching Hospital NHS Foundation Trust