Safe staffing for nursing in inpatient mental health settings
Consultation Comments and NICE responses
Consultation period: 1st December 2014 to 4th January 2015

PDG member OR stakeholder organisation	Page Number	paragraph number	Comments Please insert each new comment in a new row	Response - Please respond to each comment
Berkshire Healthcare NHS Foundation Trust	4	List for 1.3.2 [factors affecting staffing]	We would I would like to see something considered regarding the staffing issues associated with other clinical and therapeutic treatments [off ward therapies and ECT].	Thank you for your comment. It is anticipated that delivery of therapeutic and clinical treatments would be included as an outcome (see section 1.6 delivery of nursing care). It is anticipated that provision of other off ward treatments may also fall under organisational factors.
Berkshire Healthcare NHS Foundation Trust	9	List for point 2 - Delivery of nursing care	In the list is Time for pain assessment. Rather than this being a standalone statement could it be better included in a physical healthcare “holistic assessment”	Thank you for your comment. Time to pain assessment has now been removed from section 1.6. Assessment of physical health has now been added to this section.
Berkshire Healthcare NHS Foundation Trust	9	Point 1.6.2 to add to the list	Time for reflective practice and peer support to be added to the list	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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Berkshire Healthcare NHS Foundation Trust	9	Point 3 Other	Re the following in the list • Proportion of service users in crisis who are not seen within 4 hours of referral to secondary care services. • Proportion of people admitted to a place of safety who are not assessed under the mental health act within 4 hours. Proportion of service users in crisis who do not receive a comprehensive assessment (this includes inpatient care). All of these are not in-patient staff roles and are dependent on community staff from different services / agencies – these should be removed from the list. Community staff involvement in the review has already been excluded in page ¾ of the scoping document.	Thank you for your comment. These outcomes generally focus on processes that should occur after assessment by the crisis resolution and home treatment team. Therefore these outcomes have been included as they relate to the timing of being seen within inpatient settings, which are included as part of the scope of this guideline.
Berkshire Healthcare NHS Foundation Trust	7	Point 4 to add to the list	The impact of staff annual leave. The impact of agency staff	Thank you for your comment. The reliance on bank staff is covered as part of staffing factors under the proportion of temporary staff. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer.

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College of Occupational Therapists	3	1	COT strongly feels that the multidisciplinary team are central to the safety and quality of inpatient services and as such, all staff groups should be included in the scope of this review. For example - see point below.	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).
College of Occupational Therapists	14	1	Successive reports by the Care Quality Commission of service users detained under mental health legislation show that the main interventions offered are medication based while occupation/activity and talking based therapies are sadly neglected. COT would like this guideline to be an opportunity to consider both staffing numbers and crucially how staff spend their time in delivering (or not) therapeutic interventions.	Thank you for your comment. The guideline scope includes a review question which aims to examine the core nursing care activities that may impact on staffing decisions (see section 1.5, review question 6).

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College of Occupational Therapists	3	19	The College has produced practice guidelines for Occupational Therapists use of Occupation Focused Practice in Secure Hospitals (2012) (http://www.cot.co.uk/publication/practice-guidelines/occupational-therapists'-use-occupation-focused-practice-secure-hosp). This document reinforces the importance and value of occupational therapists in low and medium secure units and is why we feel that the scope of this guideline should be expanded.	Thank you for your comment. Although NICE recognises the importance of Occupational Therapists in providing care for service users in inpatient mental health settings, these staff members tend to form part of the wider multidisciplinary team rather than the core nursing team. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5).
College of Occupational Therapists	5	23	COT is aware that various models exist in England for staffing ratios and some mental health organisations are trailing, for example, including occupational therapists in the establishment numbers on shifts. This is another reason why it is important that the scope of this guideline is changed.	Thank you for your comment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment. However, Occupational Therapists do not form part of the core nursing team and do not carry out nursing activities, therefore this staff group will not be covered by this guideline.
College of Occupational Therapists	8	31	Delivery of nursing care –one of the main service user led drivers that has pushed for improved quality of care in the past five years has been the Star Wards initiative. This has encouraged particularly nursing staff to recognise, value and provide more therapeutic meaningful activities and talking time with service users. The College would like to see both these items included in delivery of nursing care.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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College of Occupational Therapists	8	31	In addition to the items above, all mental health services should be Recovery orientated and there is no mention of this in delivery of nursing care.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
Cumbria Partnership Foundation Trust	Page 4	Line 24	I would include a lot more environmental factors in the review – such as availability of structured activity programmes, both on and off wards; approach to substance use – evidence shows that they are important determinants of disturbance on in-patient units	Thank you for your comment. The environmental factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors that may impact on nursing staff requirements.
Cumbria Partnership Foundation Trust	Page 4	Line 4	I'm not sure about the reasoning for not including triage wards in this review. The function of triage and acute wards does seem to overlap	Thank you for your comment. The referral from the Department of Health has asked NICE to consider inpatient mental health settings. Triage wards have been excluded from the scope of the current guideline they are not categorised as inpatient wards.
Dorset Health Care	6	1.5 2	Service user factors should also include risk of harm to other patients. On adult mental health wards psychosocial activities will require staff to leave the ward.	Thank you for your comment. The service user factors listed in the scope are examples and are not intended to be a comprehensive list. Risk of violence has now been added as an example of a service user factor in sections 1.3 and 1.5 of the scope. The evidence review will aim to look for all service user factors which may impact on nursing staff requirements.

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Dorset Health Care	6	1.5 3	Ligature and infection control audits and risk assessments may be additional environmental factors	Thank you for your comment. The environmental factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors which may impact on nursing staff requirements.
Dorset Health Care	7	1.5 6	Legal requirements such as Tribunal reports, DOLS, Safeguarding, mental health act impact significantly on staffing levels as do 117, CPA and discharge planning meetings.	Thank you for your comment. As part of the guideline development process the evidence review and experience and expertise of the committee will be used to develop recommendations.
Dorset Health Care	8	1.5 7	Other useful tools are Early Warning Trigger Tool and QuEST	Thank you for the information. The evidence around approaches for identifying safe staffing including toolkits will be considered as part of the evidence review (see section 1.5).
Dorset Health Care	6	1.5.1	Human factors including systems and processes will influence outcomes of staffing levels as well as competency of staff.	Thank you for your comment. It is anticipated that organisational systems and processes will be included as part of the organisational factors review question (review question 5).
Dorset Health Care	8	1.6 1	Prevented incidents and do you feel safe questioning would also be useful outcomes to triangulate with staffing levels. Medicines errors should also be included	Thank you for your comment. Medication errors are included as part of incorrect administration of pharmacological treatments in section 1.6. In addition, reported feedback is also included as an example of an outcome.
Dorset Health Care	General		All other duties of Nursing staff necessary to comply with Trusts policies, procedures and CCG contractual requirements need to be factored. Other quality improvement initiatives / activities undertaken by nursing staff for example; Safe wards	Thank you for your comment. The guideline scope includes a review question which aims to examine the core nursing care activities that may impact on staffing decisions (see section 1.5, review question 6).

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Greater Manchester West Mental Health Foundation Trust	2		Doesn't mention the wider disciplinary team who in some instances may be responsible for staff levels although it is predominantly around nursing.	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).
Greater Manchester West Mental Health Foundation Trust	3		Have given comments about low and medium secure units not being part of this scope.	Thank you for your comment.
Greater Manchester West Mental Health Foundation Trust	4		Ok	Thank you for your comment.
Greater Manchester West Mental Health Foundation Trust	5		Think there should be an emphasis on a stable group of staff and another factor would be increased reliance on Bank staff	Thank you for your comment. The reliance on bank staff is covered as part of staffing factors under the proportion of temporary staff.
Greater Manchester West Mental Health Foundation Trust	6		Peer group dynamics as there is often issues around contagion and invitation in an acute ward setting e.g. Self-Harm.	Thank you for your comment.

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Greater Manchester West Mental Health Foundation Trust	7		Poor Organisational culture can effect care e.g. the notion that anyone can do the job and no consideration of skills needed for specialised service	Thank you for your comment. The evidence relating to organisational factors for safe staffing for the nursing team will be considered as part of the evidence review (see section 1.5).
Greater Manchester West Mental Health Foundation Trust	8 & 9		Seems to be a lot of outcomes around when things go wrong maybe need to balance this with when things have gone really well.	Thank you for your comment. The guideline focuses on the provision of safe nursing care within inpatient mental health settings and therefore the outcomes focus on safety rather than clinical effectiveness and quality of care. However, the outcomes listed in section 1.6 are only examples and are not intended as a comprehensive list. The wording of the beginning text has been amended to make this clearer. It is anticipated that the committee will consider and discuss outcomes identified in the evidence review (both positive and negative) as part of the guideline development process.
Greater Manchester West Mental Health Foundation Trust	10		No comment	Thank you
Greater Manchester West Mental Health Foundation Trust	11		No comment	Thank you
Greater Manchester West Mental Health Foundation Trust	12		No comment	Thank you

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Greater Manchester West Mental Health Foundation Trust	14-18		Summary is very useful however outcomes need to include measures of positive experiences and quality of care	Thank you for your comment. The guideline focuses on the provision of safe nursing care within inpatient mental health settings and therefore the outcomes focus on safety rather than clinical effectiveness and quality of care. However, the outcomes listed in section 1.6 are only examples and are not intended as a comprehensive list. The wording of the beginning text has been amended to make this clearer. It is anticipated that the committee will consider and discuss outcomes identified in the evidence review (both positive and negative) as part of the guideline development process.
ISPS - UK	7	19	The organisational culture needs to be one in which difficulties and mistakes can be acknowledged and discussed rather than (as is often the case) seen as signs of weakness or lack of competence.	Thank you for your comment. There is a review question relating to organisational factors in section 1.5 of the scope. The evidence around organisational factors will be considered as part of the evidence review. It is also anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process.
ISPS - UK	4	22	Reference is made here to availability of support from families/carers/relatives. We (particularly those of our members who are carers) think that even if such support is available and potentially valuable, it is very frequently under-used by staff. Lack of communication from ward staff is repeatedly experienced.	Thank you for your comment. The evidence around service user factors such as availability of support will be considered as part of the evidence review (see section 1.5). It is also anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process.

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ISPS - UK	8	23	Many of the current ward routines and practices on wards actually get in the way of nurses spending time with service users (as clearly acknowledged in the Department of Health's initial response to the Francis Report, cf p.16). In fact they almost seem designed to prevent patient contact (for example time spent in the nursing stations doing admin etc or having to sit in numerous "ward rounds").	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example patient experience may be covered by reported feedback. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
ISPS - UK	4	31	The input of other professions to nursing staff is a key factor. For example, the potential contribution of psychological workers in leading formulation sessions (Johnstone L & Dallos R, Formulation in Psychology and Psychotherapy, 2013, Routledge), or regular case discussion sessions (similar to Schwartz rounds – Goodrich J, 2011, Schwartz Center Rounds: Evaluation of the UK pilot, London: King's Fund) have been shown to be substantial (Collins A, 2011, Doctoral thesis, Salomons Centre). Safe practice requires built-in structures to enable reflection (not only after SUIs), and for such structures to become established and effective the organisation of staffing needs to enable regular attendance by most staff (a weekly meeting of one hour might be an immediately achievable starting point – our experience is that, after an initial phase of doubt, most staff positively embrace and 'own' such sessions).	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).

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ISPS - UK	5	3-11	A critical set of organisational factors that bear on nurses' practice on wards are the competing priorities between responding to patients (or actively initiating therapeutic contact with them) on the one hand, and managing multiple and continuous organisational demands on the other – this is persistently reported by nursing staff to constitute the most serious barrier between them and responsive nursing interventions (Le Boutillier et al, Competing Priorities: Staff Perspectives on Supporting Recovery, Administration and Policy in Mental Health and Mental Health Services Research, online August 2014). For staff to provide compassionate care for patients, they need to be treated compassionately by their managers and the organisation.	Thank you for your comment. The organisational factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors which may impact on nursing staff requirements.
ISPS - UK	4	12-15	We think it important that in considering safety due consideration is given to the extent to which the more actively therapeutic aspects of inpatient care (eg 1:1 sessions, ward-based activities) may prevent the build-up of frustration which tends to increase risk.	Thank you for your comment. The guideline focuses on the provision of safe nursing care within inpatient mental health settings and therefore the outcomes focus on safety rather than clinical effectiveness and quality of care. However, the outcomes listed in section 1.6 are only examples and are not intended as a comprehensive list. The wording of the beginning text has been amended to make this clearer. It is anticipated that the committee will consider and discuss outcomes as part of the guideline development process.

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ISPS - UK	General	General	We see Experiences of Mental Health In-Patient Care (Hardcastle et al. 2007, ISPS/Routledge – commended in the Mental Health category of the BMA medical book competition) as an important resource for this work, with its focus on the experiences of service users and their families and staff	Thank you for your comment. Reported feedback from service users is included as an example outcome in section 1.6 of the scope.
ISPS - UK	General	General	We think it is of fundamental importance that not only is safety considered in terms of staffing levels – important though that is – but also real thought is given to the underlying sense of the ward's purpose (above all, it's relation to clients' recovery) and how that affects safety (Boardman J & Roberts G, 2014, IMROC Briefing 9: Risk, Safety and Recovery, London: Centre for Mental Health and Mental Health Network, NHS Confederation). If there is any question of the ward being seen essentially as a holding pen for clients while medication takes effect, then risk will inevitably be heightened. One problem that will need careful thought is how to maximise safety without risk dominating staff's attitude to an extent that may even increase risk (in that clients feel their needs are unheeded, and become alienated); in considering this Marlow et al, 2014, How can acute and inpatient care be more effective in supporting people in their recovery, Devon: D-RRIG Guidance Note 4) will be a useful resource	Thank you for your comments. As part of the guideline development process, the available evidence around safe staffing will be considered as part of the evidence review (see section 1.5). In addition, it is anticipated that the committee will discuss issues that may impact on staffing requirements. The reference will be forwarded to the appropriate evidence review team for consideration.

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Lancashire Care NHS Foundation Trust (LCFT)	General	General	Prison healthcare often have mental health inpatient beds however does not appear to be included in this scope.	Thank you for your comment. Although NICE recognises the importance of mental health issues in prison settings, this setting has been excluded from the current scope of this guideline. This is because it is considered a specialist unit, where staffing levels may differ considerably to other included inpatient settings.
Lancashire Care NHS Foundation Trust (LCFT)	General (*to NICE consultation process*)	General	It is helpful to have key questions included in the comments sheet as you have done here.	Thank you for your comment.
Manchester Mental Health and Social Care Trust	7	4	Need to ensure clear on assumptions made for cover within staffing levels i.e. for annual leave, sickness, Mandatory and non-mandatory training.	Thank you for your comment. It is anticipated that these areas will be covered by either staffing or organisational factors.
Manchester Mental Health and Social Care Trust	8	10	MMHSCT recorded 186 illicit drug related incidents November 2013- Nov 2014. It had 5 illicit drug related deaths. As noted above drug risk education to patients and detection & management skills are essential.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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Manchester Mental Health and Social Care Trust	6	12	Skills mix must include generalist and specialist competencies and be present on all shifts not measured by presence within the ward team. For example each shift should have a nurse competent in risk management and education relating to detection of drug use and overdose of substances in particular those associated with serious incidents (opiates, alcohol, benzodiazepines and legal highs).	Thank you for your comment. Staff mix is included as an example of a staffing factor and is included within the scope of this guideline (see section 1.5). Staff mix may include the balance of skills as well as proportions of temporary staff and male and female staff.
Manchester Mental Health and Social Care Trust	3	12	Consideration should be given to including peri-natal inpatient and psychiatric assessment units within the scope of the guidance to ensure that this area is considered in setting appropriate nursing staffing levels.	Thank you for your comment. Peri-natal inpatient settings have been excluded from the scope of the current guideline as they are considered specialist units, where staffing levels may differ considerably to other included inpatient settings. However, there is a safe staffing guideline in development which covers maternity settings and may be relevant. Similarly, psychiatric assessment units have been excluded as these services are not classed as an inpatient mental health setting.
Manchester Mental Health and Social Care Trust	6	18	Consideration should be given to understanding the levels of increased observations required by wards. Assumptions on minimum staffing levels should include assumptions on the levels of 1:1 nursing care that is provided to ensure that there adequate regular staff to carry out these observations to reduce the reliance on temporary staffing.	Thank you for your comment. The evidence around service user factors such as the need for 1:1 observation will be will be considered as part of the evidence review (see section 1.5). In addition, the delivery of nursing care is included as an example outcome in section 1.6.

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Manchester Mental Health and Social Care Trust	6	18	Consideration should be given to the level of MHA detained service users – impact on nursing responsibilities around reports and increased levels of escorted leave. Need to ensure that staffing levels enable regular leave to be taken by service users outside of the ward environment to enable supporting back into community.	Thank you for your comment. It is anticipated that the legal status of service users (i.e. whether people are voluntary or compulsory attendees) will be included as a service user factors under case mix and volume, this has now been made explicit in sections 1.3 and 1.5 of the scope.
Manchester Mental Health and Social Care Trust	7	19	Organisational culture – value of transformational leadership, mentorship and clinical supervision equal to meeting performance measures.	Thank you for your comment. The organisational factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors which may impact on nursing staff requirements.
Manchester Mental Health and Social Care Trust	2	19	Clarity required on what assumptions are being made within the guidance around the availability of the MDT and working practices – the MDT. The reliability of the guidance will be made around assumptions on what the practice and availability of other members of the MDT in the care delivery e.g. OT, activity Workers, Psychology, Medics, AHP's.	Thank you for your comment. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss staffing issues such as the availability of multidisciplinary members in further detail at committee meetings.

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Manchester Mental Health and Social Care Trust	6	23	Co-morbidity accounts for longer duration of stay and correlates to high risk of death. MMHSCT audit of NICE guidance (Psychosis & Substance Misuse) discovered only half patients questioned felt information and treatment around drug use was adequate. Clinical notes review demonstrated only one third of practitioners completed satisfactory substance misuse assessments. Prevalence of substance misuse in inpatient setting is 30—60% (numerous references see PSM NICE guide) which means substance misuse competences are frequently required.	Thank you for your comment. The evidence around service user factors such as comorbidities will be considered as part of the evidence review (see section 1.5).
Manchester Mental Health and Social Care Trust	8	23	Key worker, named nurse sessions with therapeutic engagement above and beyond 'monitoring' activities should be emphasised.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example therapeutic engagement may be covered under delivery of nursing care as part of appropriate levels of nurse-service user contact. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
Manchester Mental Health and Social Care Trust	7	28	Behavioural activation and counselling should be available for each patient for at least one hour in total *both intervention combined) per day.	Thank you for your comment. The evidence around outcomes such as delivery of nursing care will be considered as part of the evidence review (see section 1.6).

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Manchester Mental Health and Social Care Trust	6	28	Consideration should be given to smaller units where a patient to nurse ratio may not be most appropriate way of measuring. E.g. units whereby there are a small population of patients – need to ensure appropriate staffing to prevent but also respond to crisis events. Ensuring availability of response staff in case of need for physical interventions.	Thank you for your comment. NICE recognises variation in the size and configuration of inpatient mental health settings. It is anticipated that the committee will discuss issues that may impact on staffing as part of the guideline development process.
Manchester Mental Health and Social Care Trust	9	30	National recruitment strategy required. Ensuring appropriate banding for level of speciality and clinical skill required especially around clinical pathway for nurses at senior bandings.	Thank you for your comment.
Mersey care NHS Trust	3	1.2	Learning disability services and high secure services should be included in the scoping	Thank you for your comment. NICE recognises the importance of high secure services. However, this setting has been excluded from the scope of the current guideline as it is considered a specialist unit, where staffing levels may differ considerably to other included inpatient settings. NICE has received separate referrals from the Department of Health for safe staffing guidelines covering learning disability inpatient units and learning disability in the community.
Mersey care NHS Trust	4	1.3	Include physical health needs and risk of slips, trips and falls in factors effecting safe staffing.	Thank you for your comment. Assessment of physical health and falls are included as examples of outcomes in section 1.6 of the scope.
Mersey care NHS Trust	6	1.5	Patient experience data should be included. Service user factors to include risks of slips, trips and falls and physical health care needs of service users. Include benchmarking data to aid comparison.	Thank you for your comment. Assessment of physical health and falls are included as examples of outcomes in section 1.6 of the scope. Section 1.6 also includes reported feedback, which includes service user experience.

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Mersey care NHS Trust	8	1.6	Replace containment incidents with restrictive practice incidents and episodes. Include safeguarding issues, include supportive observation levels and include supporting service users with mobility issues.	Thank you for your comment. The term restrictive practices have now been included in section 1.6 alongside containment incidents. This is to try to capture the main terms that may be used within practice. However, the outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer.
Mersey care NHS Trust	5	3	Include staff and student mentorship, supervision and reflective practice opportunities and arrangements.	Thank you for your comment. The staff factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all service user factors that may impact on nursing staff requirements.
Mersey care NHS Trust	5	3	Include PDP uptake, mandatory training uptake and continuous professional development uptake. Also include shift pattern arrangements i.e. 12 hour shifts require access to breaks that require staff cover and impact on staffing levels	Thank you for your comment. The staff factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all service user factors that may impact on nursing staff requirements.
Mersey care NHS Trust	10	4	Reported feedback to include how organisations have acted upon the reported feedback from service users, carers, friends and family tests and staff experience /satisfaction ratings. Reference to How staffing levels are displayed / reported and documented actions taken to resolve concerns re safety/quality	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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PDG member OR stakeholder organisation	Page Number	paragraph number	Comments Please insert each new comment in a new row	Response - Please respond to each comment
Mersey care NHS Trust	7	6	To include reference to AND FEEDBACK FROM direct and indirect patient contact reviews for registered nurses and unregistered nursing care staff. Recommend as good practice for all disciplines inputting onto war	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process.
Mersey care NHS Trust	2		Groups that will be covered should include broader definition of health care assistants (to include support workers)	Thank you for your comment. Section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment; this includes non-registered nursing staff such as healthcare support workers and assistant practitioners. It is anticipated that this broader definition will cover all nursing support staff that are part of the nursing establishment.

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Mersey care NHS Trust	3		Other professionals budgeted and working on a shift pattern should be included in the scope.	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).
Mersey care NHS Trust	5		We need to map the input of other members of the multi-disciplinary team into the clinical area in terms of support and clinical contact	Thank you for your comment. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss staffing issues in more detail at the committee meetings.
Mersey care NHS Trust	7		Include supervision and reflective practice in staffing factors effecting staff requirement, including mandatory training and CPD, PDR uptake and review	Thank you for your comment. The staff factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all staffing factors that may impact on nursing staff requirements.

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Mind	General	General	We strongly welcome this guideline development, in part because of serious concerns about current staffing problems in mental health. A recent RCN survey shows the pressures on mental health services in London. One aspect of this was that nurses were increasingly having to work long hours to plug gaps – with 62 per cent saying they worked unplanned overtime every week and 25 per cent saying they worked unplanned overtime every day. It is important that safe staffing levels are achieved through appropriate recruitment to the establishment not through staff working excessive hours which may impact on their own wellbeing and patient safety. Therefore we recommend that safe staff to patient ratios are explicitly based on the assumption of staff working normal shifts.	Thank you for your comment. It is anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process. These issues may include the use of minimum staffing in the various inpatient mental health settings which are included in the scope.
Mind	6	Section 2	The proportion of patients who are detained under the Mental Health Act may also affect staffing needs	Thank you for your comment. Whether service users are voluntary or compulsory attendees has been added to the list of example service user factors in section 1.3 and 1.5 of the scope.
Mind	8	Section 2	Delivery of nursing care – although it is implicit in the first two bullet points it would be worth specifying accompanying people, specifically detained patients, off the ward generally. If people do not have ready access to outdoors / fresh air this will impact negatively on their wellbeing and is likely to increase tensions and frustrations on the ward making it less safe.	Thank you for your comment. Accompanying people out of the ward is anticipated to be included as part of appropriate levels of service user chaperoning. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer.

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Mind	6	Section 3	Ward size and physical layout should also reference access to outdoor space. If people can access fresh air without having to be accompanied (e.g. the ward gives directly onto a private garden) this will affect staffing and quality of life. Not being able to go outdoors negatively impacts on wellbeing but also on safety as it is likely to contribute to tensions and frustrations on the ward. This is specifically relevant to detained patients who cannot leave unaccompanied, though pleasant, accessible outdoor space is of course beneficial to all.	Thank you for your comment. Access to outside areas has been added to sections 1.3 and 1.5 as example environmental factors.
NHS Employers	General		The guideline scope is well laid out. We are content to see that the recommendations don't purely focus on registered nurses and includes the contribution made by healthcare assistants and assistant practitioners.	Thank you for your comment.
NHS Employers	General		There is insufficient evidence for nursing staff levels to be an effective safety measure in its own right, and it lacks reference to the broader evidence of the relationship between staff experience and patient experience, and outcome. With this in mind, and given the unintended consequences of a ratio, we would question the use of one at all.	Thank you for your comment. It is anticipated that the committee will discuss a range of issues that may impact on staffing requirements as part of the guideline development process. These issues may include the use of staffing ratios in the various inpatient mental health settings which are included in the scope.

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NHS Employers	General		Although a more sophisticated approach which recognises the value and contribution of the whole multi-disciplinary healthcare team providing great care would have been more useful, it would be helpful to seek to find a 'middle ground' which is workable for employers. The guidance, as it stands, has a clear driver, which is for safer care, but its implementation will have financial/ market/ workforce implications for the NHS, which is already operating in the context of nursing shortages. This also needs consideration by NICE.	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).
NHS Employers	General		We continue to receive feedback from employers that staffing levels alone fail to reflect the broad evidence base about the links between patient care and outcomes and staff experience.	Thank you for your comment. The focus of this guideline programme is to provide recommendations to inform staffing decisions, with the aim to provide safe care. Therefore the literature search is focused on identifying relevant studies that are related to staffing. As part of the guideline development process, the committee will consider and discuss the evidence review as well as using its own experience and expertise to inform recommendations.
NHS England	2	1.5	you may also wish to consider specifically the risk of violence against staff, and what that means for safe staffing levels	Thank you for your comment. Risk of violence has now been added as an example of a service user factor in sections 1.3 and 1.5 of the scope.

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NHS England	6	General	NHS Protect is the body with responsibility for leading work to tackle crime against the NHS. NHS Protect collect data on assaults on staff in different healthcare settings, and would be keen to work with NICE to provide evidence to support conclusions on guidance reached in due course. The suggested first contact for this is: XXXX	Thank you for your comment. We have noted the information you have provided and will share this information with teams involved in production of evidence review and economic analysis report.
NHS England	General	General	We welcome this exercise as there is no standard formula that enables in patient units to identify a robust, safe staffing establishment. We would like to see in place guidance that would produce a standardised national tool that could be accessed by in-patient services which will ensure good practice and highlight the right skills and bandings in order to provide a safe, high quality service. To this end we felt that this scoping still remains vague in relation to these points.	Thank you for your comment. Review question 7 (section 1.5) aims to examine the processes or tools used to inform staffing decisions. As part of the guideline development process the evidence review and the experience and expertise of the committee will be used to inform the recommendations. It is anticipated that the guideline recommendations could be used as a specification for the development of a toolkit.
NHS Trust Development Authority	1	1	Overall a comprehensive guideline scope which is very welcome.	Thank you for your comment.

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NHS Trust Development Authority	3	1.2	Learning disability services and high secure services should be included in the scoping.	Thank you for your comment. NICE recognises the importance of learning disability and high secure services. However, these settings have been excluded from the scope of the current guideline as they are considered specialist units, where staffing levels may differ considerably to other included inpatient settings. NICE has received separate referrals from the Department of Health for safe staffing guidelines covering learning disability inpatient units and learning disability in the community.
NHS Trust Development Authority	4	1.3	Include physical health needs and risk of slips, trips and falls in factors effecting safe staffing.	Thank you for your comment. Falls are included as an example outcomes in section 1.6 of the scope. Assessment of physical health has now been added to this section.

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NHS Trust Development Authority	6	1.4	Economic Aspects – not sure whether this will infer staffing will be dependent on financial viability. Q1 – Again, not sure outcomes are related only to in-patient staffing levels. I would think the role of the whole MDT is important to patient outcomes. Q2 – Again, the role of the MDT is vital in reviewing the number of staff based on a ward. Q3 – Key factor would be the 24hr cover of other support teams, e.g. crisis management team. Q4 – Agree with all factors but would include leadership at ward level.	Thank you for your comment. Economic aspects are examined as part of the guideline development process. However, this is in addition to an evidence review and committee discussions on safety (and other outcomes). Recommendations will not be made purely on financial viability. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).

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NHS Trust Development Authority	8	1.6	Replace containment incidents with restrictive practice incidents and episodes. Include safeguarding issues, include supportive observation levels and include supporting service users with mobility issues. Point 1 Serious incidents – this should also include an increased number of incidents relating to specific theme – might be just under threshold of SIs but as a cluster e.g. safeguarding incidents. This would certainly be considered by the LA when considering whether they would proceed to LSI. Point 2 Delivery of care – covers falls and should also covers pressure ulcer / damage patient and carer feedback is very pertinent to determining whether the outcomes are satisfactory for the patients' needs.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example pressure ulcers may be covered by assessment of physical health which has now been added to this section. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process. The term restrictive practice has now been included as part of main outcomes (section 1.6 of the scope).
NHS Trust Development Authority	5	3	Include staff and student mentorship, supervision and reflective practice opportunities and arrangements. Include PDP uptake, mandatory training uptake and continuous professional development uptake. Also include shift pattern arrangements i.e. 12 hour shifts require access to breaks that require staff cover and impact on staffing levels	Thank you for your comment. The staffing factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all staffing factors which may impact on nursing staff requirements.
NHS Trust Development Authority	7	6	To include reference to AND FEEDBACK FROM direct and indirect patient contact reviews for registered nurses and unregistered nursing care staff. Recommend as good practice for all disciplines inputting onto ward	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process.

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NHS Trust Development Authority	6	10	Should include level of aggression and violence Patient experience data should be included. Service user factors to include risks of slips, trips and falls and physical health care needs of service users. Include benchmarking data to aid comparison	Thank you for your comment. The staffing factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all staffing factors which may impact on nursing staff requirements. Incidents of physical aggression and violence have been included as example outcomes in section 1.6 under serious incidents. Assessment of physical health has also been added to this section under delivery of nursing care.
NHS Trust Development Authority	9	14	Include completion of clinical records/reports, accompanying service users to CPA and Tribunal, escort to hospital, court and on ground & community leave. Range of administration tasks: Completion of incident reporting, audit, ward data returns, drug and supplies ordering, works requisitions, meal orders	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example completion of clinical records may be covered by assessment of care needs, monitoring and record keeping. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
NHS Trust Development Authority	4	16	Another factor is the specific nature of the ward – is it a specialist service such as eating disorders, or a ward for people with progressed dementia and so on.	Thank you for your comment. Ward type has now been included as an example of an environmental factor in sections 1.3 and 1.5 of the scope.

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NHS Trust Development Authority	2	20	Ward managers are on establishments often and at least in part.	Thank you for your comment. It is understood that there is variation around whether ward managers would be included as part of the nursing establishment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment. In addition, ward managers have been removed from the groups that will not be covered.
NHS Trust Development Authority	3	21	High Secure Services not covered	Thank you for your comment. NICE recognises the importance of high secure services. However, this setting has been excluded from the scope of the current guideline as it is considered a specialist unit, where staffing levels may differ considerably to other included inpatient settings.
NHS Trust Development Authority	14	Last line	This would significantly improve the current unacceptable situation where delays in assessment (and bed availability) extend the amount of time people with mental health problems spend in police cells.	Thank you for your comment.

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NHS Trust Development Authority	2		Groups that will be covered should include broader definition of health care assistants (to include support workers)	Thank you for your comment. Section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment; this includes non-registered nursing staff such as healthcare assistants and assistant practitioners. It is anticipated that this broader definition will cover all nursing support staff who are part of the nursing establishment.
NHS Trust Development Authority	3		We understand that you have been commissioned to review nurse staffing only but remain concerned that a more holistic view of staffing is not being taken in terms of the MDT	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. Multidisciplinary working is also not generally approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups in one guideline. In addition, each staff group will have different establishments and will be rostered separately. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).

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NHS Trust Development Authority	5		We need to map the input of other members of the multi-disciplinary team into the clinical area in terms of support and clinical contact No 2 – says guidance won't cover safe staffing for other members of MDT but will consider how availability of other MDT members affects safe staffing for nursing in inpt MH settings. It isn't clear how this will be captured – will there be a separate set of standards for what MDT expertise should be available and the response times for them to attend when requested? If not this measurement will be very variable and not comparable across organisations.	Thank you for your comment. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss staffing issues in more detail at the committee meetings.
NHS Trust Development Authority	7		Include supervision and reflective practice in staffing factors effecting staff requirement, including mandatory training and CPD, PDR uptake and review.	Thank you for your comment. The staffing factors listed in the scope are examples and are not intended to be a comprehensive list. The literature search and evidence review will aim to look for all service user factors which may impact on nursing staff requirements.
RCSLT	9	1	Addressing the needs of care users should include- perhaps under another heading, the recognition and accommodation to any communication needs they may have.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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RCSLT	15	6	The monitoring of service user interaction- could include an awareness of attuned interactions with staff , perhaps though training in Video Enhanced Reflection on Practise see http://www.videointeractionguidance.net/	Thank you for your comment. As part of the guideline development process the committee will consider all available evidence as well as its own knowledge and expertise.
RCSLT	5 (point 4)	12	I agree that nursing care activities should be considered when determining safe staffing for nursing in inpatient mental health settings. A good example would be screening for swallowing difficulty and additional help with eating and drinking. Regan et al (2006) found a dysphagia prevalence rate of 35% in an inpatients unit compared to 26% of those attending a day hospital. Corcoran and Walsh (2003) provided evidence of an elevated risk of death due to asphyxia in psychiatric inpatients. Fioretti et al (1997) suggest that clinical staff should regularly enquire about swallowing difficulties and that all in-patients should be screened on admission to hospital, with patients who have poly pharmacy and those over 60 years of age being recognised as particularly at risk. all inpatients should	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review. It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process. The reference will be forwarded to the appropriate evidence review team for consideration.
RCSLT	7 (point 4)	line 11	Availability of and care and services provided by other multidisciplinary team members will certainly influence nursing staff requirements. It may be useful to specify minimum numbers with and without certain multidisciplinary staff members e.g. speech and language therapist to support nurses in managing communication difficulties and dysphagia.	Thank you for your comment. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5).

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RCSLT	6 (point 1)	line 14	There is evidence that degree level nurses reduce the risk of unnecessary death during hospital admission. Kirwan M; Scott PA (2013) International Journal Of Nursing Studies [Int J Nurs Stud] 2013 Feb; Vol. 50 (2), pp. 253-63	Thank you for your comment. The evidence relating to associations between nursing staff and patient outcomes will be considered as part of the evidence review (see section 1.5). The reference will be forwarded to the appropriate evidence review team for consideration.
RCSLT	9 (point 3)	line 15	The 'Other' section should include an outcome measure as follows ' Proportion of service users who do not have a plan to meet their communication or dysphagia needs'.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
RCSLT	6 (point 2)	line 20	Service user factors that influence nursing staff requirements should include communication difficulties and dysphagia.	Thank you for your comment. The service user factors listed in the scope are examples and are not intended to be a comprehensive list. The literature search and evidence review will aim to look for all service user factors.
RCSLT			There is evidence that degree level nurses reduce the risk of unnecessary death during hospital admission. Kirwan M; Scott PA (2013) International Journal Of Nursing Studies [Int J Nurs Stud] 2013 Feb; Vol. 50 (2), pp. 253-63.	Thank you for your comment. The evidence relating to associations between nursing staff and patient outcomes will be considered as part of the evidence review (see section 1.5). The reference will be forwarded to the appropriate evidence review team for consideration.

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Rotherham Doncaster and South Humber NHS FT	7	4	Also include level of admin support available to the ward to release clinical staff time for patient contact.	Thank you for your comment. The staffing factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all staffing factors that may impact on nursing staff requirements.
Rotherham Doncaster and South Humber NHS FT	7	5	include what support services are /aren't available to free up clinical staff time (this would include staff such as the ward hostesses to do the patient meals	Thank you for your comment. The organisational factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors that may impact on nursing staff requirements.
Rotherham Doncaster and South Humber NHS FT	4	1.3 Number: 2 bullet: 1	Need to include violence to others	Thank you for your comment. Risk of violence has now been added as an example of a service user factor in sections 1.3 and 1.5 of the scope.
Rotherham Doncaster and South Humber NHS FT	4	1.3 Number:2 bullet: 2	Need to include the need to consider the gender balance of the staff as this is particularly important when providing 1-1 care or working with abuse victims.	Thank you for your comment. The proportion of male and female staff has been added as an example staff factor in section 1.3 and 1.5 of the scope.

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Rotherham Doncaster and South Humber NHS FT	6	1.5 Number:2	Under service user factors they have missed out the following which all influence decisions around staffing levels. • Absconsion risk • Risk of violence. • Level of observation. • Need for escorted leave. • Need to accompany patients to offsite appointments. • Level of patient compliance with treatment. • Delivery of therapeutic activities. • Staff attendance at: o Reviews. o Tribunals. Managers Hearing	Thank you for your comment. The service user factors listed in the scope are examples and are not intended to be a comprehensive list; however risk of violence has now been added as an example of a service user factor in sections 1.3 and 1.5 of the scope. The evidence review will aim to look for all service user factors that may impact on nursing staff requirements. Some of the suggestions provided have also been included in section 1.6 as part of the main outcomes.
Rotherham Doncaster and South Humber NHS FT	6	1.5 Number:3	• Under environmental factors I think they should also include the following: o Access to secure outdoor space without the need for a staff escort. o Availability of quite areas for patients to use.	Thank you for your comment. The environmental factors listed in the scope are examples and are not intended to be a comprehensive list; however access to outside areas has been added to sections 1.3 and 1.5 of the scope.
Rotherham Doncaster and South Humber NHS FT	8	1.6 Number 1	Need to add use of rapid tranquilisation and incidents of restraint.	Thank you for your comment. The use of manual restraint is included as part of containment incidents listed in section 1.6 of the scope. Rapid tranquilisation has now been added to section 1.6.
Rotherham Doncaster and South Humber NHS FT	8	1.6 Number 2	need to add side effects monitoring ,and therapeutic activities	Thank you for your comment. It is anticipated that monitoring of side effects will be included as part of assessment of care needs, monitoring and record keeping in section 1.6 of the scope.

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Rotherham Doncaster and South Humber NHS FT	General		On page 2 it states that registered nurses and healthcare assistants working as part of the crisis and home treatment teams who are not part of the inpatient establishment are excluded from the guidance. However on page 9 as part of the outcomes they have included "Proportion of service users in crisis who are not seen within 4 hours of referral to secondary care services" Also the outcomes "Proportion of service users in crisis who do not receive a comprehensive assessment "and "Proportion of service users who are at risk of crisis and do not have a crisis plan." seem more relevant to crisis and home treatment rather than inpatient staff.	Thank you for your comment. These outcomes generally focus on processes that should occur after assessment by the crisis resolution and home treatment team. Therefore these outcomes have been included as they relate to the timing of being seen within inpatient settings, which are included as part of the scope of this guideline.
Rotherham Doncaster and South Humber NHS FT	General		In the outcomes question the inclusion of "Proportion of people admitted to a place of safety who are not assessed under the mental health act within 4 hours." A 136 assessment is carried out by an AMHP and Section 12 Doctor not inpatient nursing staff so I am unclear as to the relevance of this outcome. In addition a number of 136 assessments do not result in an admission so they will not come under the responsibility of the inpatient services	Thank you for your comment. These outcomes generally focus on processes that should occur after assessment by the crisis resolution and home treatment team. Therefore these outcomes have been included as they relate to the timing of being seen within inpatient settings, which are included as part of the scope of this guideline.

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Rotherham Doncaster and South Humber NHS FT	General		In relation to the outcome "Proportion of service users who do not have daily 1-1 contact with mental health professional who are known to them" . How will this be achieved for patients who are newly admitted to the ward as due to staff shift patterns it may a couple of days before the patient meets everyone.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
Rotherham Doncaster and South Humber NHS FT	General		"Unsafe discharge" How will this be defined and measured. At present we measure the readmission rates and do a clinical review to determine if anything could have been done differently to reduce the risk of readmission.	Thank you for your comment. Readmission has been added to the example outcomes listed in section 1.6 of the scope. Definitions of unsafe discharge will be taken from the evidence review and it is anticipated that the committee will discuss outcomes as part of the guideline development process.
Rotherham Doncaster and South Humber NHS FT	General		In the final guidance they will need to cover the fact that mental health inpatient services are diverse which means that the staffing compliment /skill mixes will need to reflect the needs of the patients. In addition to this due to the nature of acute care and the constantly changing patients profile/ risk level it is important that organisations have systems in place which support the need to flex /increase staff, often at short notice and that staffing needs to be maintained at a level which enables the continued delivery of therapeutic interventions to patients, including escorted leave as any interruption to this can delay a patients discharge.	Thank you for your comment. It is anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process. These issues may include local variations and changes in the needs of service users.

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Rotherham Doncaster and South Humber NHS FT	General		The document doesn't cover privacy and dignity or patients choice.	Thank you for your comment. The guideline focuses on the provision of safe nursing care within inpatient mental health settings and therefore the outcomes focus on safety rather than clinical effectiveness and quality of care. However, the outcomes listed in section 1.6 are only examples and are not intended as a comprehensive list. The wording of the beginning text has been amended to make this clearer. It is anticipated that the committee will consider and discuss outcomes identified in the evidence as part of the guideline development process.
Royal College of Nursing	General	General	No comment	Thank you.
Royal College of Psychiatrists			No comments made	Thank you.
Somerset Partnership NHS Foundation Trust	3	7	Would agree that RGN should be excluded from the establishment. There may be good reason to include RNLD nurses as some specialist roles are available to care for LD patients	Thank you for your comment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment.
Somerset Partnership NHS Foundation Trust	4	13	Environmental factors will need to be considered, impact on single room accommodation has a major impact on the resources required for observation of patients	Thank you for your comment. The environmental factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all environmental factors which may impact on nursing staff requirements.

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Somerset Partnership NHS Foundation Trust	6	14	There is evidence that therapeutic engagement and activities reduces self-harm (Bowers) sufficient staffing levels are required to ensure such activity is delivered.	Thank you for your comment. The evidence relating to safe staffing will be considered as part of the evidence review (see section 1.5).
Somerset Partnership NHS Foundation Trust	8	22	Part of measurement should be patient satisfaction with ward milieu and the nature of interaction with nursing staff. Current study being undertaken into a tool to Measure the level of user satisfaction of therapeutic engagement on inpatient wards (McAndrew, Sue; Chambers, Mary; Nolan, Fiona; Thomas, Ben; Watts, Paul; International Journal of Mental Health Nursing, 2014 Jun; 23, 212-20)	Thank you for your comment. The evidence relating to safe staffing will be considered as part of the evidence review (see section 1.5). The reference will be forwarded to the appropriate evidence review team for consideration.
Somerset Partnership NHS Foundation Trust	7	28	Activities needs to include psychological interventions	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process.
Somerset Partnership NHS Foundation Trust	6	29	The provision of single room accommodation has a significant effect on the staffing requiring to deliver safe observation of patients.	Thank you for your comment. The evidence around environmental factors such as single room accommodation will be considered as part of the evidence review (see section 1.5).

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Somerset Partnership NHS Foundation Trust	2	20 to 26	Would agree that these staff should not be included within safer staffing numbers and should be supervisory. You may wish to consider a % of clinical time worked for the ward manager	Thank you for your comment. It is understood that there is variation around whether ward managers would be included as part of the nursing establishment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment. In addition, ward managers have been removed from the groups that will not be covered.
Somerset Partnership NHS Foundation Trust	General	General	The staffing review will need to take into the rural nature of units that are stand alone and cannot call on support from others Further there could be an issue when patients have to be escorted to other environments (DGH, ECT suites etc.) and the level of observation required, such issues will need taken into account'	Thank you for your comment. The environmental factors listed in the scope are examples and are not intended to be a comprehensive list. The literature search and evidence review will aim to look for all environmental factors.

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South Staffordshire and Shropshire NHSFT	2	1.1	The groups that should be covered should include all those staff who are included in the numbers or without whom the numbers would require increasing. For example OTs working on ward who might normally contribute to ward activity such that in their absence another member of staff the nursing establishment would be required to safely staff the ward for all or part of that shift.	Thank you for your comment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment. However, Occupational Therapists do not form part of the core nursing team and do not carry out nursing activities, therefore this staff group will not be covered by this guideline.
South Staffordshire and Shropshire NHSFT	3	1.2	The status of Mother and Baby units should be clarified to indicate whether this is a specialist area, and therefore excluded, or a type of acute ward.	Thank you for your comment. Specialist units such as mother and baby units have been added to section 1.2 as part of the settings that will not be covered.
South Staffordshire and Shropshire NHSFT	3	1.2	Include and clarify the inclusion of the private and voluntary sectors providing these services commissioned or purchased on behalf of the NHS such as nursing homes or independent rehabilitation and recovery services.	Thank you for your comment. NICE guidelines cover health and care in England. This guideline is primarily for NHS provider organisations or other organisations that provide or commission inpatient mental health services for the NHS. In this case residential care has been excluded from the scope (see section 1.2). However rehabilitation units that are commissioned for NHS settings will be covered.

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South Staffordshire and Shropshire NHSFT	5	3.1.	Acknowledgement and consideration should be given to models of working that affect the nursing demand. In effect this logic is followed by the exclusion of triage wards but the scope risks overlooking wards that might incorporate triage as a function and those wards that use other means of focusing on the specific need of patients.	Thank you for your comment. The referral from the Department of Health has asked NICE to consider inpatient mental health settings. Triage wards have been excluded from the scope of the current guideline as they are not categorised as inpatient wards. However, the evidence around environmental factors such as the existence of other teams will be considered as part of the evidence review. In addition, it is anticipated that the committee will discuss factors that may impact on staffing as part of the guideline development process.
South Staffordshire and Shropshire NHSFT	4	3.1.1	Should not include a minimum ratio as this may overshadow professional judgement and lead to race to the bottom behaviours in some providers.	Thank you for your comment. As part of the guideline development process the committee will consider the included evidence as well as its own knowledge and expertise. it is anticipated that the committee will discuss the appropriateness of minimum staffing ratios during the development of the guideline.
South Staffordshire and Shropshire NHSFT	4	3.1.1	Should not include a minimum ratio as this is likely to overshadow the factors such as environmental considerations etc.	Thank you for your comment. As part of the guideline development process the committee will consider the included evidence as well as its own experience and expertise. it is anticipated that the committee will discuss the appropriateness of minimum staffing ratios during the development of the guideline.

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South Staffordshire and Shropshire NHSFT	7	5.1.1.6	Consideration should also be given to whether therapeutic interventions are being delivered by nursing staff that might be legitimately be conducted by other professions in other models or modes of care e.g. group work, one to one interventions and family work.	Thank you for your comment. Activities that are carried out by registered and non-registered nursing staff are covered by review question 6 (see section 1.5). In addition, the evidence around staffing factors such as the division and balance of tasks between registered and non-registered nursing staff will be considered as part of the evidence review.
South West Yorkshire Partnership NHS Foundation Trust	2	1.1 Who is the focus?	Ward Managers Welcome that scope reinforces “super numere” status, however to exclude other MDT members is not contemporary as some wards are employing, for example, OT’s as permanent members of staff – so whilst they are not nurses, they contribute to the workforce.	Thank you for your comment. Although NICE recognises the importance of Occupational Therapists in providing care for service users in inpatient mental health settings, these staff members tend to form part of the wider multidisciplinary team rather than the core nursing team. However, the evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5).
South West Yorkshire Partnership NHS Foundation Trust	3	1.2 Settings	Re: section 136 Suite; ensure staffing establishment accounts for 136 provisions. These operate typically 24/7/365	Thank you for your comment. As part of the guideline development process the committee will consider the included evidence and it is anticipated that they will discuss issues that may impact on staffing decisions. These issues may include inpatient ward types and operation hours.

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South West Yorkshire Partnership NHS Foundation Trust	4	1.3 Activities, services or aspects of care	Point one: will reference to "minimum" staff encourage the use of minimum staff once this is set. How will this work when different areas have different demands, where is the flexibility in the system?	Thank you for your comment. It is anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process. These issues may include the use of minimum staffing in the various inpatient mental health settings which are included in the scope.
South West Yorkshire Partnership NHS Foundation Trust	4	1.3 Activities, services or aspects of care	Point 4: needs more definition to describe care activities in more detail e.g. complex care tasks that require qualified staff and other care that can be delivered under the supervision of registered nurses (see section 1.5, point 6)	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process.
South West Yorkshire Partnership NHS Foundation Trust	4	1.3 Activities, services or aspects of care	Obvious acuity measures such as violence and aggression; MHA, restraint etc. are omitted from list when other arguably less relevant measures are included? Measuring "experience" under staff factors will be particularly challenging!	Thank you for your comment. The service user factors listed in the scope are examples and are not intended to be a comprehensive list. The evidence review will aim to look for all service user factors which may impact on nursing staff requirements. Incidents of physical aggression and violence and the use of restraint have been included as example outcomes in section 1.6 under serious incidents.
South West Yorkshire Partnership NHS Foundation Trust	5	1.3 Activities, services or aspects of care	3 - Organisation I am not sure how one measures "organisational culture". It should be made clear if this pertains to the "Organisation" or to the culture on the ward	Thank you for your comment. Definitions of organisational factors from the evidence review will be considered by the committee. In addition, it is anticipated that the committee will discuss factors that may impact on staffing decisions as part of the guideline development process.

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South West Yorkshire Partnership NHS Foundation Trust	5	1.3 Activities, services or aspects of care	Areas that will not be covered - seclusion I am not sure why seclusion is omitted from the criteria for measurement. Seclusion is a bona fide therapeutic intervention that requires a minimum of 1:1 nursing observations. This is clearly an intervention that has an impact on staffing	Thank you for your comment. Although the effectiveness of different treatment and management strategies (such as seclusion) are outside the scope of this guideline, seclusion has been included as part of the outcomes that will be considered when searching for and assessing the evidence (section 1.6 of the scope).
South West Yorkshire Partnership NHS Foundation Trust	6	1.5 Review Questions	Does the staffing guideline need to account for future health technology development and the potential complexity of these- linked to outcomes and improving care	Thank you for your comment. Health technologies are covered by other NICE guidance (e.g. clinical guidelines) which assess effectiveness of treatments and quality of care. Although there may be links to other NICE products, the focus of this guideline programme is to provide recommendations to inform staffing, with the aim to provide safe care. Therefore the current scope will not account for future health technology development.
South West Yorkshire Partnership NHS Foundation Trust	6	1.5 Review Questions	Welcome scope reviewing evidence base of impact of staffing ratio's on outcomes. Lacking in MH settings.	Thank you for your comment.
South West Yorkshire Partnership NHS Foundation Trust	7	1.5 Review Questions – section 4	Proportion of temporary staff Temporary staff, bank staff and pool staff can be an invaluable source of quality staff. The issue is not the nature of their contracts but whether they are skilled practitioners. This includes mandatory and statutory training as well as access to supervision and appraisal. In my opinion, a much more important factor in determining the skill set of staff, rather than the detail of their contract	Thank you for your comment. Staff mix is included as an example of a staffing factor and is included within the scope of this guideline (see section 1.5). Staff mix may include the balance of skills, as well as proportions of temporary staff and male and female staff.

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South West Yorkshire Partnership NHS Foundation Trust	8	1.6 Main Outcomes	Do the staffing guidelines need to account for CPD and mandatory training to maintain and develop competence (one of the 6 c's of nursing)? Point 3 sub-section 8 refers to this but does not discriminate between the above types of training. Additionally different competences are required in different areas above and beyond basic training	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. It is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
South West Yorkshire Partnership NHS Foundation Trust	9	1.6 Main Outcomes	Suggest something like "recording of care delivery" is a more contemporary term than "clinical paperwork". Welcome triangulation of using feedback.	Thank you for your comment. No changes have been to the wording of this outcome as clinical paperwork has been used as a general term to include administrative paperwork which includes recording of care delivery.
South West Yorkshire Partnership NHS Foundation Trust	14	3.2 Current Practice	Not sure where "bank nursing staff who regularly work with young people" are going to be found. Recommendation from RCP of more than one qualified MH nurse per shift is welcome but may not be realistic in some areas/environments.	Thank you for your comment. This section aims to provide an overview of current practice and includes recommendations from related organisations.
Tees, Esk and Wear Valleys NHS FT	1	4	Should it not apply to any CQC registered provider who is providing MH nursing care	Thank you for your comment. NICE guidelines apply to all NHS settings in England.

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Tees, Esk and Wear Valleys NHS FT	10	5	Although it is stated this is not a definitive list there are other important factors that are proxy indicators of quality care that reflect the safety and effectiveness of staffing that are not referenced at all – patient experience and patient reported outcome measures satisfaction, lengths of stay , bed occupancy, staff training ,supervision and appraisal levels , staff sickness levels as well as compliance with national guidelines, local pathways and record keeping, poor staffing generally leads to more custodial and task driven care with increased use of restrictive practices, less engagement and less individualised care long before it actually gets unsafe it starts to become more and more ineffective and less person centred . These factors must be reflected in the development of guidance.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example patient experience may be covered by reported feedback. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
Tees, Esk and Wear Valleys NHS FT	1	7	Also Foundation Trust boards of directors	Thank you for your comment. Hospital boards are included as part of groups who may need to take action.
Tees, Esk and Wear Valleys NHS FT	2	9	Is there a need to say residential as well as in-patient –may provide a lop hole or a grey area for some rehabilitation units that does not call themselves in-patient areas	Thank you for your comment. NICE recognises the importance of residential care in mental health services. This setting has been excluded from the scope of the current guideline as it is not an inpatient mental health service.

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Tees, Esk and Wear Valleys NHS FT	2	14	Do you class peer workers as HCAs?	Thank you for your comment. Section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment; this includes non-registered nursing staff such as healthcare assistants and assistant practitioners. It is anticipated that this broader definition will cover all nursing support staff who are part of the nursing establishment.
Tees, Esk and Wear Valleys NHS FT	4	16	All risk issues need to be highlighted -particularly risks of violence as well as self -harm	Thank you for your comment. The factors reported in the scope are examples and are not intended to be a comprehensive list. Risk of violence has now been added as an example of a service user factor in sections 1.3 and 1.5 of the scope.
Tees, Esk and Wear Valleys NHS FT	3	23	And Crisis Houses where they are registered for nursing interventions? Would they not be included ?	Thank you for your comment. NICE recognises the importance of crisis houses in mental health services. This setting has been excluded from the scope of the current guideline as it is not an inpatient mental health service. However, NICE has received a separate referral from the Department of Health for a safe staffing guideline covering mental health in the community.

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Tees, Esk and Wear Valleys NHS FT	3	24	What about Crisis walk -in centres and crisis A&Es that are new types of developments – although aware SLAM have used crisis A&E model for a while – they will require guidance on patient safety staffing level s	Thank you for your comment. NICE recognises the importance of crisis walk in centres and crisis A&E models however, these settings are outside the scope of the current guideline. The referral from the Department of Health covers inpatient mental health settings and these services would not be categorised as inpatient care. However, NICE has received a separate referral from the Department of Health for a safe staffing guideline covering mental health in the community. Therefore these settings may be considered for this future guideline.
Tees, Esk and Wear Valleys NHS FT	4	Area 1.3	No mention being made of the bureaucratic element of nurse administration – we all agree it must be lessened but it must be accounted for as a factor that impacts on the workload and therefore the staffing levels on a ward. The non-direct elements of nursing in supervising HCA and mentoring students also impact on safe staffing.	Thank you for your comment. It is anticipated that administration, supervision and mentoring are included as part of staffing factors.
Tees, Esk and Wear Valleys NHS FT	11	Flow chart	The element of contracted service specification must be included in this flow diagram as often commissioner expectations impact on the outcomes required which in turn place demands on nursing workforce that have to be reflected in the establishment.	Thank you for your comment. The diagram in appendix A aims to provide a pictorial representation of the review questions that will be covered in the guideline. Therefore contracted service specification is not included.
Tees, Esk and Wear Valleys NHS FT	7	Question 6	This relates to my points above that we need to be cognisant of the wider range of activity required apart from direct nursing care .	Thank you for your comment. The evidence around core nursing care activities will be considered as part of the evidence review (see section 1.5). It is anticipated that the committee will discuss issues around nursing care activities as part of the guideline development process.

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Tees, Esk and Wear Valleys NHS FT	18	Summary	WRT the points raised above the summary misses some key elements of factors affecting nursing staff requirements and the outcomes expected form a safe and effective in-patient service –based on this the guidance produced may be over simplistic and not meaningful to the current complex service delivery models we have to manage and staff – a golden opportunity will have then been missed to ensure we have appropriate and helpful guidance to protect tour patients and staff and deliver high quality MH services	Thank you for your comment. The factors reported in the scope are examples and are not intended to be a comprehensive list.
Tees, Esk and Wear Valleys NHS FT			Also high dependency workload due to physical health care (PHC_ co-morbities -increasing amounts of nursing time being taken in the PHC treatments and complex medication regimes some of our patients present with as well as PHC monitoring and implementation of processes like the Deteriorating Patient observations – with parity of esteem the workload for nursing staff has increased significantly (and correctly re holistic patient care)	Thank you for your comment.
UNISON	2	1.1	It's positive to see that crisis resolution and home treatment staff, matrons and ward managers will not be counted in ward numbers.	Thank you for your comment. It is understood that there is variation around whether ward managers would be included as part of the nursing establishment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment.

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UNISON	6	1.4	UNISON believes that economic aspects should never override safety.	Thank you for your comment. Safety outcomes will be examined and discussed in the evidence review and by the committee during the guideline development process. The examination of both safety and economic aspects will be discussed by the committee.
UNISON	General	General	In the acute hospital equivalent, there are red flag indicators. UNISON is interested to see whether the same will be used in inpatient mental health settings.	Thank you for your comment. As part of the guideline development process, the committee will use the evidence review and the experience and expertise of the committee to consider making recommendations relating to red flags and indicators.
UNISON	General	General	UNISON is very concerned that in the acute hospital equivalent, the levels were locally decided. The guide on safe staffing for nursing in inpatient mental health settings should set minimum levels that local negotiations couldn't go below.	Thank you for your comment. It is anticipated that the committee will discuss issues that may impact on staffing requirements as part of the guideline development process. These issues may include the use of minimum staffing in the various inpatient mental health settings which are included in the scope.
West London Mental Health NHS Trust	1	1	Overall a comprehensive guideline scope which is very welcome.	Thank you for your comment.

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West London Mental Health NHS Trust	3	1	I do not understand why other disciplines are to be excluded given that OT staff are becoming increasingly common in some inpatient teams.	Thank you for your comment. Although NICE recognises the importance of other staff members such as Occupational Therapists in providing care for service users in inpatient mental health settings, these staff members tend to form part of the wider multidisciplinary team rather than the core nursing team. The evidence on how the availability of the multidisciplinary team impacts on nursing staff requirements will be considered as part of the evidence review (see section 1.5).
West London Mental Health NHS Trust	15	6	What does staffs assigned to monitor the floor mean?	Thank you for your comment. This wording has been taken from guidance produced by the Royal College of Psychiatrists. A hyperlink to this document has now been added to section 3.2 of the scope.
West London Mental Health NHS Trust	15	6	The persistent absence of many team leaders from the floor is a concern as is their avoidance of responsibility for patient care and leadership.	Thank you for your comment.
West London Mental Health NHS Trust	4	7	I think High Secure services should agree their own variables, so agree to leave them out.	Thank you for your comment.
West London Mental Health NHS Trust	6	10	What about level of aggression and violence?	Thank you for your comment. Incidents of physical aggression and violence have been included as example outcomes in section 1.6 under serious incidents.

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West London Mental Health NHS Trust	9	14	Include completion of clinical records/reports, accompanying service users to CPA and Tribunal, escort to hospital, court and on ground & community leave.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example completion of clinical records may be covered by assessment of care needs, monitoring and record keeping. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.
West London Mental Health NHS Trust	9	14	Range of administration tasks: Completion of incident reporting, audit, ward data returns, drug and supplies ordering, works requisitions, meal orders.	Thank you for your comment. The outcomes listed in section 1.6 of the scope are examples and are not intended to be a comprehensive list. The text at the beginning of section 1.6 has been amended to make this clearer. For example completion of clinical records may be covered by assessment of care needs, monitoring and record keeping. Evidence that meets the inclusion criteria will be assessed for all outcomes and it is anticipated that the committee will discuss outcomes that are reported in the evidence as part of the guideline development process.

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West London Mental Health NHS Trust	5	15	Why can't we do safer staffing for other professionals? E.g. number of psychiatrist to patients?	Thank you for your comment. Although NICE recognises the importance of the wider multidisciplinary team in providing care for service users in inpatient mental health settings, the current safe staffing guideline focuses on the nursing team. This is because the referral from the Department of Health has asked NICE to consider nursing teams. We have however included a review question to consider how the availability of multidisciplinary team members impacts on nursing staff requirements (see section 1.5).
West London Mental Health NHS Trust	4	16	Another factor is the specific nature of the ward – is it a specialist service such as eating disorders, or a ward for people with progressed dementia and so on.	Thank you for your comment. Ward type has now been added as an example environmental factor in sections 1.3 and 1.5 of the scope.
West London Mental Health NHS Trust	13	19	This is very welcome.	Thank you for your comment.
West London Mental Health NHS Trust	2	20	Ward managers are on establishments often and at least in part.	Thank you for your comment. It is understood that there is variation around whether ward managers would be included as part of the nursing establishment. NICE recognises that there is local variation in nursing staff members who form part of the inpatient nursing establishment. Therefore section 1.1 of the scope has been amended to include all nursing staff working in inpatient mental health settings who form part of the nursing establishment.

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West London Mental Health NHS Trust	3	21	High Secure Services not covered.	Thank you for your comment. NICE recognises the importance of high secure services. However, this setting has been excluded from the scope of the current guideline as it is considered a specialist unit, where staffing levels may differ considerably to other included inpatient settings.
West London Mental Health NHS Trust	14	21	Atypical – there needs to be some examples of what this may mean.	Thank you for your comment. This wording has been taken from guidance produced by the Royal College of Psychiatrists. A hyperlink to this document has now been added to section 3.2 of the scope.
West London Mental Health NHS Trust	4	30	I think variable for safe staffing also includes number of Incident reports on violence and self-injury, and under of enhanced observations used.	Thank you for your comment. Incidents of physical aggression and violence and observation have been included as example outcomes in section 1.6.
West London Mental Health NHS Trust	14	Last line	This would significantly improve the current unacceptable situation where delays in assessment (and bed availability) extend the amount of time people with mental health problems spend in police cells.	Thank you for your comment.

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Berkshire Healthcare NHS Foundation Trust	No as they are different care environments looking after different types of patients.	They should be included.	Any ratio specified would need to be based on established MH dependency tools to inform such a figure
College of Occupational Therapists	The College of Occupational Therapists agrees that PICU can also be categorised as low secure units.	The College believe that low and medium secure units should be included as part of the scope particularly as the number of these units has rapidly grown in the past ten years.	The College believes it would be better to set the staffing ratio for all units rather than just for a specific few.
Cumbria Partnership Foundation Trust	Q1 On balance I don't think PICU should be included with low secure units – but this is the point of view is from my perspective as a GA Psychiatrist who sees PICU as part of the pathway for acutely unwell people with psychosis, rather than as part of a step-down rehab pathway for forensic patients.		
Dorset Health Care	No.They no longer share the same national guidance.	No.Low and Medium Secure services have separate national guidance.	There is no specific model for producing medium nursing establishments. These need to be done with professional judgement and based on the principles of risk management
Dr Maureen Deacon	Yes. They tend to provide a service for particularly disturbed acute mentally ill patients. This category may or may not include patients who are hostile but	I think we should include these services and take this opportunity to consider staffing requirements for both safety and overtly therapeutic purposes.	Yes. Services for the acutely mentally ill need to be provided on an evidence based method, rather than on the basis of economics and

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	does not include people who are recognised as formally recorded mentally ill offenders.		historical experience
Greater Manchester West Mental Health Foundation Trust	No – as a low secure unit could mean a long-term placement and doesn't reflect short-term acute service	Excluded as they have specific requirements	Yes – There should be a standard for all important health settings and ratios could be different depending on the complexity / risk of clients
ISPS - UK	We think not – our impression is that PICUs tend to hold patients with higher levels of distress and whose care tends to involve a higher degree of risk – increasingly so since the closure of many acute beds has led to a higher threshold for admission to PICUs than previously.	Perhaps they should be excluded – there certainly are significant differences between these units and general acute inpatient units, and this means that staffing levels will need to be different.	Yes, we believe this would be useful. The minimum staffing level would need to increase when there is an escalation in need (for example, when a patient is placed on Level 3 Observation, when there is a shortage of permanent staff, following an SUI, etc.)
Lancashire Care NHS Foundation Trust (LCFT)	No	Yes they should be included.	Not sure. This would be difficult to set and would depend upon acuity / level of need on the day
Manchester Mental Health and Social Care Trust	No – the degree of security may be similar however the patient needs are widely differential. I.e. Acute and risky versus rehab and risky. Different models of care which would not easily lend themselves to direct comparison due to short term intervention nature of PICU's rather than longer term rehabilitation nature of Low secure units.	No. They are distinct specialities. See RCP guidance.	Yes. However this needs to be dynamic (or contain caveats/exceptions) due to changing demands from day to day and constitution of each given patient cohort. The guidance needs to be clear what the minimum level is set to based on what assumptions of other service, MDT

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			etc. is directly available. Absence of some of the elements within the assumptions (e.g. OT, Psychology, Activity Workers) would have direct impact on the level of nursing intervention to cover these gaps within service provision.
Mersey care NHS Trust	Should be categorised separate to secure services as specialist provision and care pathway with a shorter length of stay and admission criteria.	Low and medium secure units should be included as part of the scope. High secure services should also be included as significant number of in-patient areas in Specialist Trusts. -Important to have consistent approach.	Benchmarking data would be more helpful than setting minimum ratios. Flexibility is required by Clinical Leads in conjunction with Executive Director of Nursing for each organisation.
Mind	I think it would be helpful to be as specific as possible in categorising wards. For example it would not be helpful to treat as equivalent wards that work (or mainly work) as part of a step down pathway for people who have been in medium and/or high secure care and those treating people who are most acutely unwell and unable to be cared for safely on an acute ward.	It would be helpful to have guidance on these settings within the framework of this project, but it is likely to be necessary to differentiate specific considerations that apply to secure units.	Although there is a risk of minimum staffing ratios being regarded as a standard benchmark it would be helpful to have an indication of the staffing level and mix required in inpatient settings in order for care to be good and delivered safely. This would not remove the need for more detailed staff planning but would assist all concerned (including staff, patients, managers, trustees and patient representative organisations) to see how close to a minimum requirement their

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			staffing levels are and, where necessary, trigger action to mitigate risk.
NHS Employers	This is not our area of expertise but believe the difference includes the average length of stay of patients – which may be shorter in PICU.	It is probably helpful to include both types of unit in the scope.	Employers in the NHS maintain that workforce planning needs to be driven by local patient need, and a focus on effective multi-disciplinary team working and adequate skills mix on wards is paramount. You will have seen pieces in the media on behalf of employers, emphasising the point that patient safety is at the heart of the NHS and how vital it is that decisions on staffing are made locally and at the point of care, using robust evidence and looking at the whole picture. This is no easy quick fix solution. It's not just about numbers but the right staff with the right skills. Without a more sophisticated model of care that considers the vital contribution of staff other than nurses, it is clear that the NHS will use a ward nurse ratio, which will come with risks:

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			• A minimum will become seen as a maximum and staff from busier wards will be redeployed to meet ratios • With no additional funding nursing numbers will become protected but cost improvements will have to be found amongst other staff • Skills are important too – will we see more junior members of staff at the expense of specialist nurses?
NHS Trust Development Authority	Should be categorised separate to secure services as specialist provision and care pathway with a shorter length of stay and admission criteria. The service user groups present in a very different way with a very different level of acuity. Service users who use a PICU are in most cases people with the highest level of acuity, there may be very little known about them and they can be unpredictable and for a very short time a high level of danger to themselves or others. Those in a low secure have a known, long term and on-	Low and medium secure units should be included as part of the scope. High secure services should also be included as significant number of in-patient areas in Specialist Trusts. -Important to have consistent approach. However some feel this depends on the tool used If it allows sufficient consideration of the presenting issues then they could be included however if the tool / recommendations are too blunt or overly prescriptive then it may not allow for the variety of presentations and needs in these services.	Benchmarking data would be more helpful than setting minimum ratios. Flexibility is required by Clinical Leads in conjunction with Executive Director of Nursing for each organisation

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	going risk which is most often very well managed within a recovery approach with much time spent in the community.	Given the long term risk of these service users it may be more useful to exclude them in the first phase.	
RCSLT	In my view they are better categorised as medium secure units, given the level of support that patients require.	They should both be included, but high secure dealt with separately given that there are specific legislative requirements for high secure provision.	A minimum staffing ratio for nursing staff should be helpful for all inpatient mental health settings. However, there should also be some requirements for level of expertise; not just numbers.
Rotherham Doncaster and South Humber NHS FT	Yes -as the level of security and potential risks and there is a comparable picture between low secure and PICU.	As these services sit within the specialist commissioning framework and deal with high dependent/risk patients it is felt that they should be excluded from this guidance but will need to be looked at separately.	For Acute inpatient wards it is easier to set a minimum level as you need to have enough staff and of the right skill mix to deal with the unplanned admissions that come onto the ward For Rehabilitation and Recovery wards a minimum staffing level and skill mix is more difficult to set as they will need to be determined on the basis of patient need /level of required support to facilitate safe discharge.
Somerset Partnership NHS Foundation Trust	We would not recommend this as PICU's can be very acute at times and requiring higher staffing levels than low	Would recommend that they are excluded	Having minimum staffing levels is useful, but should not remove the ability of staff to use professional

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	secure units. We have a low secure unit which have more 'settled' patients than our PICU.		judgement to increase staffing levels as required; a minimum trained nurse to patient ratio is also needed. These levels would be required to be set as per setting ie. acute, older persons organic, Tier 4 and PICU
South Staffordshire and Shropshire NHSFT	No, this does not ensure the differences regarding therapeutic need are adequately accounted for.	Yes, both should be included.	No
South West Yorkshire Partnership NHS Foundation Trust	PICUs fulfil a different function and have a different client group from low secure units and although were combined in the original DoH draft guidelines, the final document produced by the Royal College of Psychiatry's Quality Network (2012) sees low secure services as a completely different animal. Many areas of care in psychiatry have locked doors or a policy to govern this eventuality but they should not be considered secure units. The acuity of the patient group and skills required form different need and skill sets/mix with more intensive interventions and should be considered separately for safe staffing purposes.	Low and medium secure services are a significant proportion of the in-patient mental health beds provided within the NHS and as such, both should be included as part of the scope	Minimum levels can be useful from the point of view of ensuring that a unit's staffing never falls below a certain level. However, this term should be used with caution as there would be a tendency to gravitate to this number for all situations and levels of acuity and can arguably undermine high quality care. It is much more accurate to use "optimum" as the baseline figure as this would give you safer staffing levels rather than basic operational levels needed to meet a prescribed minimum standard of care. The optimal number will be

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			dependent on acuity which is why any tool needs to have a degree of flexibility to respond to unplanned work. Even within the same care group acuity can differ widely for any number of reasons.
Tees, Esk and Wear Valleys NHS FT	No – there are different commissioning criteria that relate to PICU and Low Secure as well as clinically different reasons for admission, assessment and treatment.	Yes – as long as it is recognised that the current commissioning criteria and requirements of secure in-patient facilities place additional bureaucratic and 'task' driven activities (such as security and leave procedures) on nursing staff requiring different staff ratios –there is also higher administrative workload associated with 100% mental health act detention rate in secure facilities.	Only if there is a strong evidence base, where it is demonstrated that a minimum staffing level results in a minimisation of patient safety incidents and maximisation of therapeutic work, then yes set minimum staffing ratios. It is however often quality and skill not quantity that should drives any minimum requirements – 6 newly qualified registered nurses may not deliver the same quality of care as 3 experienced RN with post basic training and three experienced HCAs who have completed practitioner certificates (as an example) . Minimum competency sets and skill mix would be an alternative approach. Also the approach where it is identified that a minimum nursing therapeutic offer relevant to the purpose of the service that is used to guide skill mix is useful – e.g. enough registered nursing time where every patient has minimum of one hour direct 1:1 face time daily with an RN.

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			At present from a basic safety approach 2 registered nurses with attendant assist support would seem a minimum requirement yet many services operate with 1 RN at night -sometimes in geographically standalone units - guidance on these issues with minimum requirements would be appropriate for all clinical in-patient facilities. My concern with setting minimum standards is that they would probably be based on that safety level rather than therapeutic and in revenue shortage times the minimum would be set as the standard rather than the point to build upon – the care then becomes custodial and task driven with additional dependency and acuity needs being met by additional staffing - often bank or agency with lower skill sets, less patient knowledge and reduced continuity of care.
The Royal College of Psychiatrists	Although definitions may differ across settings/Trusts, a rough distinction is that PICU in CAMHS are usually considered for short term management of very disturbed behaviours in adolescents who usually return back to open units when their behaviour is	Yes they should be included, as they are all inpatient mental health units. In CAMHS, low security and PICU are closer to open units. Medium security is the highest level of security in CAMHS so probably should be treated	It would be useful for all settings but it is difficult to state that one tariff fits all. A locked rehabilitation unit should not be staffed the same as an acute ward for example, and different types of rehabilitation units, as defined in the Joint Commissioning Guidance for Mental Health document on

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	settled. Low Secure units (LSU) are more often units providing input in the longer term for adolescents who cannot be managed in the community or open wards due to risk issues. PICU are not LSU and security arrangements are not identical given that they manage different patient groups. As such the staffing needs are different. So PICU should not be included with LSU. In addition commissioning, In England, for PICUs lies with CCGs, whereas commissioning for low secure services lies with NHS England.	separately. There are no High Secure Units admitting patients under 18 years of age.	commissioning for rehabilitation units, would require different levels or nursing staffing. Ward nursing staff/patient shift ratios: • High-dependency/high-acuity case: 1:1 to 3:1 for the most highly disturbed • Medium dependency case (10-minute checks, intensive support at meal-times): 1:2 • General observation/maintenance of safety/therapeutic programme times: 1:3 • Minimum of two registered mental health nurses (RMNs) with relevant child and adolescent experience (Grade 5–8a) per day shift; one at night – this will need to increase depending on numbers of in-patients and acuity of case mix on shift; Some children's (<12 years) services may have paediatric nurses with relevant CAMHS experience and training as registered nurses instead of RMNs.
UNISON	Although PICUs and low secure units share similar traits, their differences in function need to be taken into consideration when developing guidance.	Many, but not all of those admitted to low or medium secure units, will have been in touch with the criminal justice system and will have either been charged with or convicted of a	Nurses feel very strongly about minimum staffing ratios, which they believe to be fundamental to patient safety and quality of care. A year on

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	Firstly, admission to PICUs is due to new episodes or to an acute exacerbation of a patient's conditions. In low secure units, patients may be experiencing chronic behavioural disturbance. Secondly, the length of stay in PICUs must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration. In low secure units, patients will be detained under the mental health act and may be restricted on legal grounds needing rehabilitation usually for up to 2 years. Thus, PICUs are for short term care and low secure units for longer term care. Finally, PICUs are managed in the same service line as acute wards and crisis teams. This is where it sits naturally in UNISON's view. Therefore, because PICUs and low secure units are different in function, PICUs should not also be categorized as low secure units.	violent criminal offence. Thus, nurses working in low or medium secure units may be at a higher risk of experiencing violence at work. Nurses that are subjected to violence at work are likely to have less motivation and job satisfaction. Because of the positive role motivation and job satisfaction plays in patient care, this would have a detrimental effect on the service received by the patient. Inadequate staffing levels make it difficult for employers to prevent violence at work. Firstly, adequate staffing levels help reduce stress. Stress results in short tempers, frayed nerves and fatigue. All contribute to an inability to deal with violent situations. Secondly, adequate staffing levels increase surveillance. This makes it easier for staff to raise the alarm when violence occurs. That's why the risk of violence should be considered when determining staffing levels to meet actual needs in low and medium secure units. Therefore, because safe staffing levels help in the prevention of violence - which can have a detrimental effect on patient care - low and medium secure units should both be included as part of the scope.	from the publication of his report into the care failings at Mid Staffordshire Foundation Trust, Sir Robert Francis identified the link between appropriate staffing levels and safe, compassionate care. However, UNISON's report 'Running on empty: NHS staff stretched to the limit' found that 74 per cent of respondents working in inpatient mental health settings did not have adequate time to spend with patients. UNISON is proud to be a founding member of the Safe Staffing Alliance which campaigns for safe staffing levels. Evidence has shown that one registered nurse to eight patients (excluding the nurse in charge) is the level at which there is significant risk of harm occurring. Worryingly, UNISON's report 'Running on empty: NHS staff stretched to the limit' found that 5 per cent of respondents working in inpatient mental health settings were caring for 8 or more patients.

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			UNISON is supportive of international campaigns which seek to secure a ratio of one in four (one registered nurse to four patients) and good care outcomes have been linked to a ratio of one in six. We also recognise that in some areas the ratio level would need to be even lower. In inpatient mental health settings, there should be a minimum staffing establishment on the ward once all other needs have been met. For example, in addition to the nurse in charge of the shift, the bleep holder and anyone undertaking one-to-one or additional observations, there should be a minimum of three staff trained in the prevention and management of aggression to ensure patient safety. becoming heavily dependent on the use of Because of a national shortage of mental health nurses, a lot of NHS provider organisations or other organisations that provide mental health services for the NHS are agency staff. UNISON has received anecdotal evidence that some clinical areas are running on entirely agency staff. This overreliance on agency staff because of

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			understaffing is a false economy. It is frustrating for existing staff because agency staff are often unfamiliar with the ward. It is also unfair on patients who experience a lack of continuity of care. The answer is to ensure that there are sufficient established nursing posts to provide safe dignified and compassionate care. Therefore, a minimum ratio of permanent to agency staff should be included in the guidance. Finally, there should be at least one registered nurse at all times of the day and night on each ward, and provision for cover of breaks. This is particularly an issue at night. UNISON has received anecdotal evidence that some wards on a medium secure unit in one Trust have been running on one nurse per two wards, with no cover for breaks. Therefore, because safe staffing levels are linked to good care outcomes and patient safety, a minimum staffing ratio for nursing staff would be useful for all inpatient mental health settings.
West London Mental Health NHS Trust	Under no circumstances. The service user groups present in a very different way with a very different level of acuity.	The answer to this depends entirely on the tool / recommendations that are developed determine staffing levels. If it	It may be useful for some however it would be useless and potentially risky without the ability to flex

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	Service users who use a PICU are in most cases people with the highest level of acuity, there may be very little known about them and they can be unpredictable and for a very short time a high level of danger to themselves or others. Those in a low secure have a known, long term and on-going risk which is most often very well managed within a recovery approach with much time spent in the community. The higher acuity of the patients in PICU , results in requirement of more support and supervisions and thus more staff.	allows sufficient consideration of the presenting issues then they could be included however if the tool / recommendations are too blunt or overly prescriptive then it may not allow for the variety of presentations and needs in these services. Given the long term risk of these service users it may be more useful to exclude them in the first phase. Low and medium secure should be included; however, the section in 2.2 may not fully reflect current practice. High Secure could be considered. However, but only if the same variables for a acuity and outcome for are agreed between the three high secure providers. If not included the three high secure services can agree a consistent methodology.	staffing depending on presenting risks and acuity.