

Implementation Programme

NICE support for commissioners and others using the guidance and quality standard on service user experience in adult mental health

December 2011

1 Introduction

Implementing the recommendations from NICE guidance and other [NHS Evidence](#) accredited guidance is the best way to support improvements in the quality of care offered to service users in line with the statements and measures that comprise the [NICE quality standards](#). To support implementation, this document:

- considers the cost of implementing the changes needed to implement the guidance and achieve the quality standard at a local level
- identifies where potential cost savings can be made
- groups the guidance recommendations and quality statements together into areas with similar potential cost impact and implications for commissioners
- signposts commissioners and service providers to tools that can assist with the implementation of NICE guidance and service redesign.

[NICE quality standards](#) define high-quality care for patients across a care pathway or clinical area. They are based on NICE guidance and other NHS Evidence accredited guidelines, and are presented as a set of specific, concise statements that represent high-quality care, with associated measures. The NICE quality standard for service user experience in adult mental health was developed by a Guidance Development Group (GDG)

using the best available evidence and was produced collaboratively with the NHS, social care and voluntary organisations, along with their partners and service users.

From 2012/13 the NHS Commissioning Board may draw on the NICE quality standards to translate the national health outcomes into outcomes and indicators that can be applied at a local level. These may be used to hold clinical commissioning groups to account for their contribution to improving outcomes, and will be set out in the NHS Commissioning Outcomes Framework. Trusts and other service providers may refer to the quality standards in their quality accounts in order to assess the quality of their healthcare services and demonstrate quality improvement within their organisation.

NHS commissioners can use the quality standards to improve the services commissioned from providers by including quality statements and measures within the service specification element of the standard contract, by establishing key performance indicators as part of a tendering process and using the indicators when they are provided, in association with incentive payments such as [Commissioning for Quality and Innovation](#) (CQUIN). NICE quality standards can also provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based treatments and care.

The NICE support for commissioners and others on service user experience in adult mental health should be read alongside:

- [Service user experience in adult mental health \(NICE clinical guidance 136\)](#)
- [NICE quality standard for service user experience in adult mental health.](#)

2 Overview of 'Service user experience in adult mental health'

The NICE guidance and quality standard on service user experience in adult mental health outline the level of service that people using NHS mental health services should expect to receive, and cover improving the experience of people using adult NHS mental health services. The accessibility of services, the way that people's problems are assessed, the care and support they receive across all points on the care pathway, care received in a crisis and under the Mental Health Act and care in different healthcare settings all play an important part in service users' overall experience of care¹.

Over the past few years several documents and initiatives, such as [High quality care for all](#) (2008), the [NHS Constitution](#) and the King's Fund [Seeing the person in the patient: the point of care](#) review paper (2008) have highlighted the importance of improving the service user experience. Despite improvements, there is evidence to suggest that further work is needed so that service users receive high-quality care that is clinically effective, safe and provided in a way that ensures that the service user has the best possible experience of care.

There is considerable variation in the commissioning and provision of mental health services nationally. Care is commissioned from a range of NHS organisations, including mental health trusts, local authorities, and private and voluntary sector organisations. Carers and families also provide care for people with mental health problems².

Nationally around 12% of the NHS commissioning budget is spent on mental health services³ with an annual expenditure of around £22.5 billion⁴. The

¹ Service user experience in adult mental health. NICE clinical guidance 136 (2011). Available from www.nice.org.uk/guidance/CG136

² Department of Health (2011) No health without mental health: a cross-governmental mental health outcomes strategy for people of all ages. London: Department of Health

³ Naylor C, Bell A (2010) Mental health and the productivity challenge: improving quality and value for money. London: Kings Fund and the Centre for Mental Health

⁴ McCrone P, Dhanasiri S, Patel A et al. (2008) Paying the price: the cost of mental health care in England to 2026. London: the Kings Fund

costs of treating mental health problems could double in the next 20 years, mainly as a result of an ageing population⁴.

2.1 *Epidemiology of mental health problems*

Mental ill health represents around 23% of the total burden of ill health in the UK and is the single largest cause of disability⁵. One in six adults in England will have a mental health problem at any one time. The most prevalent forms are depressive and anxiety disorders, which affect around 17% of adults at any time⁵. Because the number of older people in our population is increasing, there is a corresponding increase in the number of people at risk of dementia and depression⁵.

Demand for mental health services is increasing. In 2009/10 more than 1.25 million people (2700 per 100,000 population) used NHS specialist mental health services, the highest level since mental health minimum data set collection was started in 2003⁶.

Investment in community-based services and improved integration aims to decrease reliance on inpatient-based care. However, in 2009/10 the number of people who received inpatient care rose, by 5.1% to 107,765, for the first time since 2004/05⁷.

3 Resource implications

NICE clinical guidance 136 makes recommendations on service user experience in adult mental health. This support for commissioners and others using the NICE guidance and quality standard considers the cost impact of the changes needed to implement the NICE guidance and achieve the quality

⁵ McManus S, Meltzer H, Brugha T et al (2007) [Adult psychiatric morbidity survey in England, 2007: results of a household survey](#). London: NHS Information Centre. The APMS is a survey of adults living in private households and is a primary source of information on the prevalence of both treated and untreated psychiatric disorders. It may underestimate disorders that are often managed in an inpatient hospital setting (such as severe psychoses), or in residential or care home settings (such as dementia).

⁶ NHS Information Centre for Health and Social Care (2011) Mental health bulletin: fourth report from mental health minimum dataset (MHMDS) annual returns, 2010. London: NHS Information Centre for Health and Social Care.

⁷ NHS Information Centre for Health and Social Care (2011) Mental health bulletin: fourth report from mental health minimum dataset (MHMDS) annual returns, 2010. London: NHS Information Centre for Health and Social Care

standard at a local level, and identifies where potential cost savings can be made.

Section 4 considers the overarching resource impact of implementing the guidance and achieving the quality standard within the local mental health system.

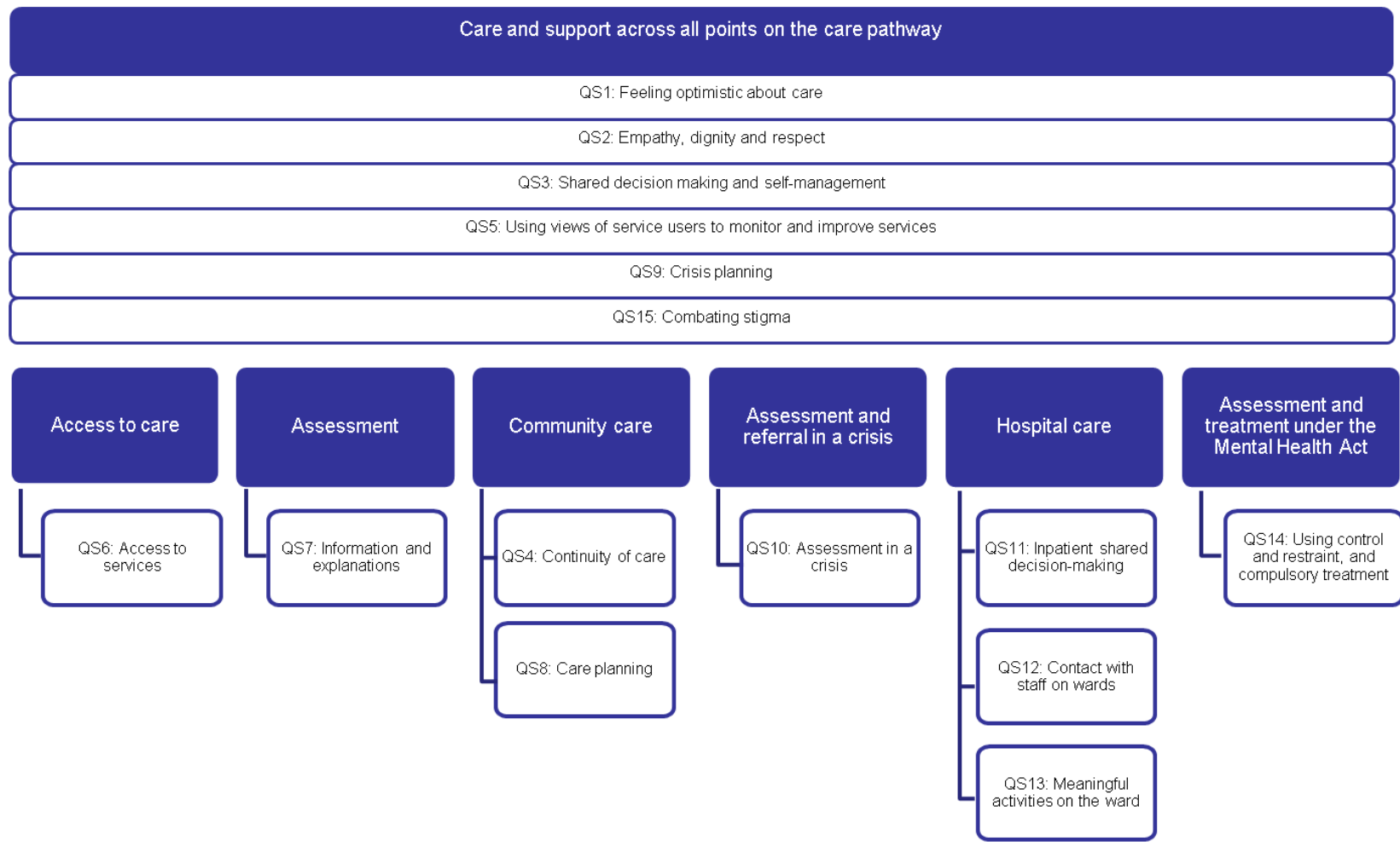
Section 5 considers more specific cost impact and commissioning considerations for the quality statements relating to:

- care and support across all points in the pathway
- access to care
- community care
- assessment and referral in a crisis
- hospital care.

Section 5 also considers the cost impact and commissioning considerations of involving families and carers, which relate to recommendations 1.1.14 to 1.1.16 of the NICE guidance on service user experience in adult mental health.

Figure 1 groups the 15 quality statements according to the cost impact and commissioning considerations of their implementation.

Figure 1 Quality statements from the NICE quality standard for service user experience in adult mental health grouped according to the cost impact and commissioning considerations for their implementation



4 Commissioning implications and cost impact

This section considers the commissioning and cost implications and potential resource impact of implementing the recommendations and achieving the quality standard for Service user experience in adult mental health.

There is unlikely to be significant resource impact associated with achieving this quality standard, although commissioners and providers may need to invest time in activities that support improved service user experience. These activities are likely to include:

- implementing systems and undertaking audit to proactively measure service user experience
- promoting a positive culture of communication and integration
- involving service users in service redesign to improve service user experience.

In some instances this may involve an initial investment of resources, however in the longer term this may lead to savings in resources associated with improved service user experience.

The [national patient choice survey, England](#) revealed that patient experience is one of the key factors for patients when choosing a provider⁸. Although choice may be more limited for some users of adult mental health services, commissioners can ensure that service user experience is integral to their choice of provider when commissioning services. Because the NHS operates in an increasingly dynamic and competitive environment, service user experience will be a key component in the choice of provider, and may affect provider income.

⁸ Department of Health (2010) National patient choice survey, England – February 2010. Available from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116958

4.1 *Improving service user experience: national drivers and legislation*

4.1.1 NHS Outcomes Framework 2011/12 and Mental Health Strategy 2011

Improving service user experience should be integral to all commissioning and service improvement activities. Commissioners and providers should use the quality standard on service user experience in adult mental health as a tool to help them achieve the outcomes defined in the NHS Outcomes Framework 2012/13 and Mental Health Strategy 2011 (summarised in box 1). To improve the quality of services, service user experience should be given equal priority to effectiveness and service user safety in all commissioning activities.

Box 1 National outcomes frameworks relevant to ‘Service user experience in adult mental health services’

NHS Outcomes Framework 2012/13

Domain 4: Ensuring that people have a positive experience of care

Outcome 4.7: Improving experience of healthcare for people with mental illness

Measure 4.7: Patient experience of community mental health services

Mental Health Strategy 2011 No health without mental health: a cross-government mental health outcomes strategy for people of all ages

Outcome: More people will have a positive experience of care and support

Objective: Care and support, wherever it takes place, should offer timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are protected

4.1.2 Quality accounts

NHS trust boards must understand how their service users are experiencing care if they are to effectively translate service users' needs and preferences into higher quality, safer and more efficient services⁹. Quality accounts are a tool to support this.

The Department of Health has introduced legislation requiring all mental health hospital trust boards to publish quality accounts¹⁰. This requirement will later extend to primary care and community healthcare services¹¹. Quality accounts encourage healthcare organisations to assess quality across the entire range of their healthcare services, with the aim of continuous quality improvement¹².

All NHS trust boards should ensure that their quality accounts have equal regard to safety, effectiveness (including efficiency) and service user experience. Clinicians, managers and boards should work together to identify and understand the quality of care they offer, and to formulate plans for improvement.

Commissioners, local involvement networks (LINKs) and local authority overview and scrutiny committees (OSCs) should ensure that they have an opportunity to comment on their providers' quality accounts, and take measures to check the accuracy of data. They should work closely with their providers when they are setting the priorities and measures for service user experience for the forthcoming year. They should use the quality standard on service user experience in adult mental health to define and measure improvements in service user experience.

4.1.3 Care Quality Commission

Every provider of health and adult social care services in England is monitored by the Care Quality Commission (CQC) for their compliance with a regulatory framework of essential standards of quality and safety. Registration with the CQC is dependent upon meeting these standards. The statements and measures in a NICE

⁹ NHS Confederation (2010) Feeling better? Improving patient experience in hospital. London: NHS Confederation

¹⁰ Healthcare Quality Improvement Partnership (2010) [Quality Accounts](#). London: Healthcare Quality Improvement Partnership

¹¹ Department of Health (2010) [Quality Accounts: Roles of Commissioning PCTs, Local Involvement Networks \(LINKs\) and local authority Overview and Scrutiny Committees \(OSCs\)](#). London: Department of Health

¹² Department of Health (2010) Quality Accounts for 2010-11. Available from www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122541.pdf

quality standard together indicate a high quality service. If an organisation is performing poorly on many or all of the quality standard measures it may mean that it is at risk of not meeting CQC's essential standards of quality and safety, and therefore of not complying with regulatory requirements.

4.1.4 NHS Litigation Authority

The NHS Litigation Authority assesses [standards of risk management](#) across the NHS. As part of this process it reviews organisations' systems for implementing and monitoring NICE clinical guidelines. Commissioners and providers should therefore have regard to the NICE guidance on service user experience in adult mental health to ensure that their risk management complies with standard of risk management 5, criterion 8, which states: 'The organisation has an approved documented process for ensuring that agreed best practice as defined in NICE clinical guidelines and interventional procedures, is taken into account in the context of the clinical services provided by the organisation that is implemented and monitored'¹³.

4.2 Improving service user experience: benefits and costs avoided

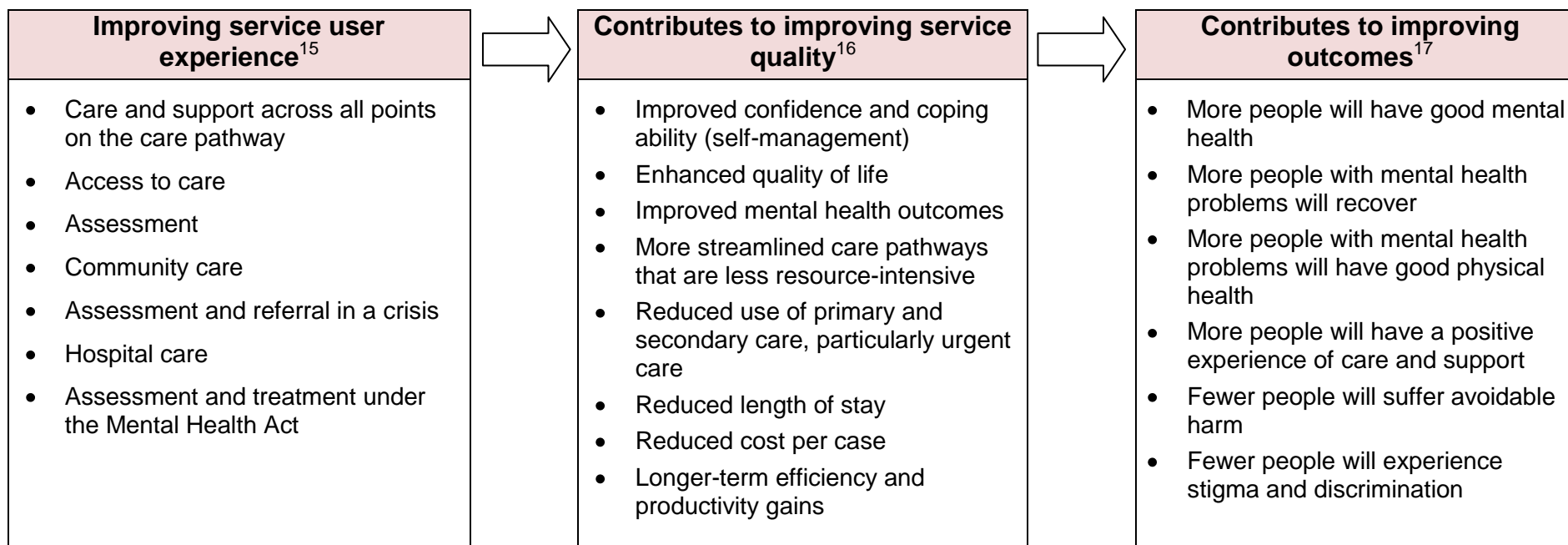
There is a consensus in the literature that improving service user experience is unlikely to incur significant cost, and is more often related to challenging and improving the **values** or **culture** of an organisation¹⁴. The guidance recommendations and quality statements relating to principles of care (such as ensuring that service users are listened to carefully, treated with respect and dignity and given time to discuss their condition, and their views are taken into account), are not anticipated to have significant cost impact because these could be embedded in standard practice. There may be some costs associated with measuring the quality of service user experience, such as data recording and collection. These costs will vary locally. Using information on service users' experience may contribute to

¹³ NHS Litigation Authority (2011) NHSLA risk management standards for NHS trusts providing acute, community, or mental health & learning disability services and independent sector providers of NHS care. Available from www.nhsla.com/Publications/ Go to 'Risk Management Publications' > 'Standards' > 'NHSLA acute, community, MH & LD and independent sector standards 2011/12'

¹⁴ Care Quality Commission (2009) Investigation into mid Staffordshire NHS Foundation Trust. London: Care Quality Commission; NHS Confederation (2010) Feeling better? Improving patient experience in hospital. London: NHS Confederation; Kings Fund (2011) Transforming our health care system. London: Kings Fund

improving the quality and efficiency of services, which may deliver a range of benefits and contribute to improving service user outcomes (see figure 2).

Figure 2 Benefits and outcomes from using NICE guidance and quality standard on service user experience in adult mental health to improve service user experience



¹⁵ Based on NICE quality standard for service user experience in adult mental health (see figure 1).

¹⁶ Kings Fund (2011) How to deliver high quality, patient-centred, cost-effective care: consensus solutions from the voluntary sector. London: Kings Fund; NHS Confederation (2010) [Feeling Better? Improving patient experience in hospital](#). London: NHS Confederation

¹⁷ Department of Health (2011) No health without mental health: a cross-governmental mental health outcomes strategy for people of all ages. London: Department of Health

Some service providers could improve service user experience by re-shaping services to ensure they have the right staff in terms of skill mix and psychiatric expertise, that services are accessible at all times and that there are effective management arrangements and integration with acute care teams (as recommended in the NICE guidance and quality standards). This may not need additional investment, although some local investment in training may be needed to strengthen core principles of care such as social inclusion, service user and carer involvement, and reducing stigma. Re-shaping and integrating services could lead to cost savings in the following areas:

- Integrated care (see recommendations 1.2.3, 1.6.12 and 1.7.1 of the NICE guidance) could reduce acute care bed use while also increasing quality of care. Norfolk and Waveney Mental Health Trust reduced admissions and length of stay, generating savings of around £1 million per year¹⁸.
- Home treatment (see recommendations 1.5.8, 1.5.9 and 1.6.12 of the NICE guidance) alongside inpatient care in an integrated care pathway saves up to £700 per patient per month: with a cost of £2200 for integrated home and inpatient care, compared with approximately £2900 for inpatient care alone¹⁹.
- Effective discharge and transfer of care (see recommendation 1.7.1 to 1.7.6 in the NICE guidance) could lead to shorter lengths of hospital stay. In 2009/10 there were 107,765 people admitted to hospital for mental health care, and the average stay was 78 days for men and 68 days for women. If every day in hospital costs around £300, then a comparatively small reduction in the number of days each person spends in hospital in a year could result in considerable cost savings²⁰.
- Involving service users and their families or carers more in their treatment may keep service users engaged, well, and prevent crises.

¹⁸ Audit commission (2010) Maximising resources in adult mental health. London: Audit Commission

¹⁹ Centre for the economics of mental health 2007 Model to assess the economic impact of integrating CRHT and inpatient services. London: Health Service and Population Research Department. London: King's College London

²⁰ Mental Health Bulletin (2010) Fourth report from Mental Health Minimum Dataset annual returns. London: NHS Information Centre

Improving the experience of care may reduce complaints and could lead to fewer appeals against the inappropriate use of the Mental Health Act.



4.3 *Measuring service user experience*

The Picker Institute considers that the real test of NHS performance is the views and experiences of its users²¹. Collecting accurate information about service user experience in a rigorous, systematic fashion can contribute to service improvement, and to meeting the outcomes in domain 4 of the NHS Outcomes Framework 2011/12.

Providers and commissioners are advised to agree a range of qualitative and quantitative resources to capture service user experience. Examples are detailed in table 2 and box 2.

²¹ Picker Institute (2009) Using patient feedback: a practical guide to improving patient experience. London: Picker Institute

Table 2 Tools for collecting information about service user experience and how this information can be used²²

	Methods for collecting service user experience information	Service user experience data can contribute to:	
Quantitative  Qualitative	Postal surveys		
	Telephone surveys		Regulation
	On-line surveys		Service improvement
	Hand-held technology		Contract management
	Complaints		Pay and incentives
	Compliments		Commissioning
	Comment cards		Performance benchmarking
	On-line communities		Service improvement
	Bedside terminals		Local accountability
	Citizens juries		New service development
	PALS feedback		
	Feedback websites		
	Kiosks		
	Focus groups		
	Patient stories		
	Mystery shoppers		
	Public meetings		
Walking the floor			

²² Adapted from diagram in NHS Institute for Innovation and Improvement (2011) Developing high impact actions for improving patient experience, available from: www.institute.nhs.uk/images/documents/Share%20and%20network/PEN/High%20Impact%20Actions%20for%20Improving%20Patient%20Experience%20-%208th%20Feb%20Slides.pdf

Box 2 Resources that can be used to measure service user experience

Resources that can be used to measure service user experience include:

- Care quality commission [Community mental health services survey](#)
- Department of Health [Experience of NHS patients \(adult inpatient survey\)](#)
- Department of Health [GP patient surveys](#)
- Department of Health [Essence of care](#)
- [Patient Advice and Liaison Scheme \(PALS\)](#)
- Local service user complaints and compliments
- [NHS Litigation authority](#) and local litigation data
- Healthcare Quality Improvement Partnership (HQIP) [clinical audit data](#)
- NHS Institute for Innovation [Productive mental health ward](#)
- Kings Fund [Evidence-based co-design: working with patients to improve health care](#)
- Variation tools, in particular mortality data, from a range of tools such as the [NHS atlas of variation](#) or [Dr Foster](#)

At a local level providers may wish to ensure that they have a range of resources available to proactively measure service user experience. These resources might include rooms available for focus groups, consumables, the use of incentives or expenses for volunteers and electronic systems to capture data and feedback. Local providers may wish to work closely with local community and voluntary services and local involvement networks (LiNKs). In some instances this may need an initial investment of resources. However, in the longer term it may lead to a reduction in future negative service user experiences, improved service user experience and an associated saving in resources.

Commissioners and providers should ensure that their measures capture the experience of as many service users as possible. They should agree systems to collect information from service users whose views may be less easy to gather, such as people with learning disabilities, people whose first language

is not English, vulnerable older people and any recognised groups within a local area who may find it hard to access services.

4.4 Using service user experience information in commissioning and service improvement

Using information from service users is fundamental to all aspects of commissioning. Commissioners should ensure that information about service user experience can be incorporated into a range of practices, such as commissioning, contract management, service delivery and incentive schemes.

Commissioners should ensure that service user experience is included as one of the factors used to judge tenders for services. They should also consider asking for evidence that demonstrates that the provider has systems in place for collecting and using information about service user experience.

Commissioner and providers should strive to develop systems that enable 'real time' measures of service user experience to be collected and made available for discussion at contract review meetings. They should ensure that information about service user experience is used to inform continuous service improvement.

Commissioners may wish to incorporate some or all of the NICE guidance and quality statements for service user experience into their contracts, and agree the frequency for gathering and reporting measures with providers.

Commissioners should audit local practice and can incentivise improvements to service user experience by using the CQUIN scheme and ensure that all CQUIN schemes have a focus on service user experience²³.

Commissioners and others using the NICE recommendations and quality standard on service user experience may wish to refer to the following examples of CQUIN schemes that incorporate patient experience goals.

²³ Department of Health (2011) Using the commissioning for quality and innovation (CQUIN) payment framework – guidance on national goals for 2011/12. London: Department of Health

Exemplar CQUIN goals and summaries of CQUIN indicators are available from the [NHS Institute for Innovation and Improvement](#).

Commissioners may wish to specify the information about service user experience that providers should collect across the whole service pathway, from referral to post-discharge. Commissioners should set out how instances of poor service user experience should be managed. Providers and the commissioner should be made aware of any problems so that they can take action to improve services.

Incremental costs could be incurred for quality statements that need collection of new data. If systems need to be changed to allow accurate times and dates to be captured, there could be costs associated with changing computer systems within existing outsourced contracts. Administration costs will also be incurred for capturing and reporting data. The extent of the costs associated with data collection and reporting need to be assessed locally.

Box 3 outlines resources that commissioners and others may find useful when developing plans to improve service user experience.

Box 3 Resources for developing plans to improve service user experience

Commissioners and others using the quality standard on service user experience in adult mental health may wish to refer to the following resources when developing service user experience plans:

- The King's Fund (2011) [The point of care](#)
- The King's Fund (2011) [How to deliver high-quality, patient-centred, cost-effective care](#)
- King's Fund (2011) [Transforming our health care system: ten priorities for commissioners](#)
- NHS (2010) [The NHS Constitution: the NHS belongs to us all](#)
- The King's Fund (2010) [Mental health and the productivity challenge, London.](#)
- NHS Confederation (2010) [Feeling better? Improving patient experience](#)

[in hospital](#)

- The King's Fund (2009) [The point of care: measures of patients' experience in hospital: purpose, methods and uses](#)
- Picker Institute (2009) [Using patient feedback: a practical guide to improving patient experience](#)
- Healthcare Quality Improvement Partnership (2009) [Patient and public engagement \(PPE\): PPE in clinical audit 2009](#)
- Onyett S, Linde K, Glover G et al. (2006) [A national survey of crisis resolution teams in England](#)

5 Specific costing and commissioning considerations

5.1 *Care and support across all points on the care pathway*

Quality statement 1: Feeling optimistic about care

People using mental health services, and their families or carers, feel optimistic that care will be effective.

Quality statement 2: Empathy, dignity and respect

People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.

Quality statement 3: Shared decision making and self-management

People using mental health services are actively involved in shared decision-making and supported in self-management.

Quality statement 5: Using views of service users to monitor and improve services

People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.

Quality statement 9: Crisis planning

People using mental health services who may be at risk of crisis are offered a crisis plan.

Quality statement 15: Combating stigma

People using mental health services feel less stigmatised in the community and NHS, including within mental health services.

See recommendations 1.1.1, 1.1.2, 1.1.9, 1.1.11, 1.1.12, 1.1.20, 1.1.21, 1.1.22 and 1.4.5 from NICE clinical guidance 136.

Achieving quality statements 1, 2 and 5 is not thought to have a significant cost impact. Commissioners should seek evidence that providers routinely measure service user experience and that there are mechanisms in place for the outcomes to be fed-back to all service users (see sections 4.3 and 4.4 above).

Expert opinion suggests that most providers are working towards quality statement 3 by improving shared decision making and self-management. Increasing the engagement of service users who self-manage may improve health outcomes and recovery, give greater confidence and improve adherence to treatment and medication, which may help prevent crises^{24,25}. Commissioners and providers should explore the local use of self-management plans and consider whether these could be more widely implemented.

Offering people using mental health services who may be at risk of crisis a crisis plan (quality statement 9) would improve crisis planning. Having a crisis plan that identifies personalised relapse indications and early warning signs would help service users, carers and families see when a crisis is developing. This would allow pre-emptive actions such as respite care or appropriate medication to be instigated. Improving crisis planning may result in savings by

²⁶ NHS Confederation (2011) First year study of IAPT initiative reveals key insights. Available from www.nhsconfed.org/Networks/MentalHealth/LatestNews/Pages/Study-of-first-year-IAPT-initiative-reveals-key-insights.aspx

preventing emergency department admissions, the use of the crisis team and inpatient admissions.

Including service users' preferences and practical needs in crisis planning may avoid the escalation of crises. This could reduce the number of complaints and appeals about inappropriate use of the Mental Health Act. In addition, research from the Picker Institute shows that if service users' preferences are respected, treatment adherence and service user outcomes are improved.

Combating stigma (quality statement 15) may increase the uptake of services and promote earlier intervention, especially when strategies are aimed at engaging local groups who do not typically access services. This may increase demands on primary and community-based mental health services, but may also contribute to decreased demand for crisis services and inpatient care.

Commissioners should work with local providers and their local health promotion team to agree ways to reduce the stigma associated with mental health services. This may include the following:

- Using information about service user experience and service user feedback to understand barriers to accessing services among different groups, and using this information to redesign services.
- Exploring language used in written information for service users and in discussion of mental health issues between healthcare professionals and service users, their families and carers.
- Developing pathways that facilitate self-referral. Evidence from the first year of the Improving Access to Psychological Therapies (IAPT) initiative has shown that self-referred service users present with symptoms that are just as severe as service users referred by their GP, but they recover with fewer sessions of treatment. This suggests that offering self-referral

to primary and community mental health services may improve efficiency and promote better access for different sectors of the community²⁶.

- Funding local promotions that support national campaigns to combat stigma. These may be used to increase local awareness of mental health and of local services offered.

Providers could promote or support academic clinical research studies within their organisations, which seek to combat the stigma associated with mental health problems.

A cultural shift and change to common shared values underpin the approach to improving service user care and experience across all points on the pathway. Including service users on interview panels and having a service user representative at board level may facilitate this.

5.2 Access to care

Quality statement 6: Access to services

People can access mental health services when they need them.

See recommendations 1.2.1, 1.2.3, 1.3.6, 1.5.5, 1.5.6, 1.5.7 and 1.8.8 from NICE clinical guidance 136.

Most commissioners and providers are working to improve care pathways for people with mental health problems by offering timely and effective access to mental health services. Commissioners and providers may need to work together to modify aspects of their referral and assessment arrangements, and care pathways, in order to achieve this quality statement.

Commissioners should ensure that providers are working towards achieving each of the relevant quality measures in quality statement 6. This includes ensuring there are agreed referral methods between care sectors, agreed times between referral and appointments, agreed appointment waiting times,

²⁶ NHS Confederation (2011) First year study of IAPT initiative reveals key insights. Available from www.nhsconfed.org/Networks/MentalHealth/LatestNews/Pages/Study-of-first-year-IAPT-initiative-reveals-key-insights.aspx

access to a 24-hour helpline, arrangements for people in crisis and compliance with the Mental Health Act assessment timescales.

Providers may need to explore existing staffing structures and processes for managing referrals, triage and assessment, and local capacity and demand for interventions, to ensure efficiency and productivity is optimised and access objectives are met. Costs could be incurred locally if systems need to be developed to collect more comprehensive data to demonstrate timely access to services.

Expert opinion suggests that incremental costs could be incurred to ensure that helplines are staffed by trained health and social care professionals, and operate for 24 hours a day. Incremental costs may be offset by introducing efficient triage and addressing any reasons for inappropriate waiting times, such as missed appointments.

5.3 Community care

Quality statement 4: Continuity of care

People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.

Quality statement 8: Care planning

People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.

See recommendations 1.4.2 and 1.4.7 from NICE clinical guidance 136.

Quality statement 8 has been developed from recommendation 1.4.2, which states:

Develop care plans jointly with the service user, and:

- include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants

- provide support to help the service user realise the plan
- give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it.

Commissioners should ensure wraparound support and aftercare are components of all pathways they commission for adults with mental health problems, so that service users have access to meaningful activities. They should ensure that pathways identify links to a range of organisations that promote social inclusion and reintegration support. This may contribute to achieving the objective within the Mental Health Outcomes Strategy 2011, of ensuring that more people with mental health problems recover. Improving chances in education and employment are a key component of this objective²⁷. Vocational pathways and assessments may be conducted to better understand service users' needs.

Costs of mental health services can be reduced by half when people with severe mental health problems are supported into mainstream employment. A multi-site European trial found that rates of hospital use were lower for service users who had supported employment opportunities such as individual placement and support than for those in traditional services²⁸. In particular, only 20% of those with individual placement and support were re-admitted to hospital at any time during the 18-month follow-up period compared with 31% of those in traditional services. The figures imply a saving of around £6000 per service user in inpatient costs over the 18-month period, based on the average cost of psychiatric inpatient care in England.

People with severe and long-term mental health problems who are given intensive support to return to the workplace also report fewer and shorter subsequent hospital stays than people receiving usual mental health services²⁹.

²⁷ Department of Health (2011) No health without mental health: a cross-governmental mental health outcomes strategy for people of all ages. London: Department of Health.

²⁸ Burns T, Catty J. (2008) IPS in Europe: the EQOLISE trial. *Psychiatric Rehabilitation Journal* 31: 313–7

²⁹ Bush P, Drake R, Xie H et al (2009). The long-term impact of employment on mental health service use and costs. *Psychiatric Services* 60: 1024–1031, cited in: National Mental Health

5.4 Hospital care

Quality statement 11: Inpatient shared decision making

People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making.

Quality statement 12: Contact with staff on wards

People in hospital for mental health care can have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team.

Quality statement 13: Meaningful activities on the ward

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

See recommendations 1.6.3, 1.6.6 and 1.6.9 from NICE clinical guidance 136.

There are few data about contact time between service users and staff on wards. Experts advised that contact time will vary widely. Some service users may already see a known mental healthcare professional every day for at least 1 hour; this may be spread throughout the day. They may also currently see a doctor once a week for at least 20 minutes, but this may be a trainee doctor under the supervision of the consultant. Experts advised that specialist mental health pharmacists are in place to support prescribing decisions as part of the multidisciplinary team providing care. Services have been reconfigured in line with the Department of Health's 'New way of working' guide and the Productive Ward programme. There may need to be local plans to improve access to a known healthcare professional and consultant on a one-to-one basis or provide the opportunity to meet with a specialist mental health pharmacist.

Achieving quality statement 12 on contact with staff on wards could result in earlier discharge of service users and reduce the number of bed days³⁰.

Expert opinion suggests that more attention may need to be paid to the reasons why appointments are missed either by the service user or the doctor. If the rate of cancelled or missed appointments were to be reduced, this could lead to savings that could be re-invested in other aspects of service delivery.

5.5 Involving families and carers

See recommendations 1.1.14 to 1.1.16 of NICE clinical guidance 136.

Expert opinion suggests it is recognised practice to ensure that service users are asked if and how they want their family and/or carers to become involved in their care. Commissioners and providers should assess local practice to determine any potential impact on care planning and subsequent cost impact.

Commissioners should specify that providers ask people using mental health services whether and how they want their family and/or carers to be involved in their care. If the service user is happy for family and/or carers to be involved, they should specify that providers promote this practice. If family and/or carers are involved in a service user's care they can identify relapse indications early and facilitate early intervention.

Commissioners and others using the NICE quality standard on service user experience in adult mental health may wish to refer to section 3.5.4 of the NICE commissioning guide on [commissioning stepped care for people with common mental health disorders](#) for advice on commissioning services that involve families and/or carers.

³⁰ NHS Institute for Innovation and Improvement (2009) The productive mental health ward. [online] Available from www.evidence.nhs.uk/qipp

6 Conclusion

There is unlikely to be significant resource impact associated with achieving the NICE quality standard on service user experience in adult mental health, although commissioners and providers may need to invest time in activities that support improved service user experience. These activities are likely to include:

- implementing systems and undertaking audit to proactively measure service user experience
- promoting a positive culture of communication and integration
- involving service users in service redesign to improve service user experience.

In some instances this may involve an initial investment of resources, however in the longer term this may lead to savings in resources associated with improved service user experience.

Implementing the NICE guidance on service user experience in adult NHS services, and commissioning and developing services that achieve the quality standard, will be a step towards creating sustainable change that will result in a cultural shift within the NHS towards a truly service user-centred service.

7 Links to national policy documents and other useful resources

Policy documents

- Department of Health (2011) Equity and excellence: Liberating the NHS. London: Department of Health. Available from www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm
- Department of Health (2010) The NHS Constitution for England. London: Department of Health. Available from

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

- HMSO (2009) The Health Act 2009. London: The Stationery Office. Available from www.legislation.gov.uk/ukpga/2009/21/contents
- Darzi A (2008) High Quality Care for all: NHS Next Stage Review Final Report. Department of Health, London. Available from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825
- Goodrich J, Cornwell J (2008) Seeing the person in the patient. The Point of Care review paper pages 6–17. London: Kings Fund
- Department of Health (2005) Delivering race equality in mental health care: an action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett. London: Department of Health. Available from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

NICE implementation support

- [Audit support](#) for 'Service user experience in adult mental health' NICE clinical guidance 136
- [Electronic audit tools](#) for 'Service user experience in adult mental health' NICE clinical guidance 136
- [Baseline assessment tool](#) for 'Service user experience in adult mental health' NICE clinical guidance 136
- [Slide sets](#) for 'Service user experience in adult mental health' NICE clinical guidance 136
- [Slide set](#) for NICE quality standard for 'Service user experience in adult mental health'

NHS Evidence

- [NICE pathway](#) on 'Service user experience in adult mental health'
- [QIPP service models – the Productive Mental Health Ward](#)