

National NHS patient survey programme

2015 Community Mental Health Survey

Statistical release

Published October 2015

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Summary

This report sets out findings from the 2015 Community Mental Health Survey, which surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2014. As the regulator of providers of NHS care in England, the Care Quality Commission (CQC) has published a separate response to the survey, which outlines what this means for the quality of care for mental health patients (see [Appendix E](#)).

Community mental health services in England provide care and treatment for people who require care over and above what primary care services (principally GPs) can provide. Care is provided through a wide range of service models, and through a broad range of interventions. People using these services may receive support over a long period of time or for short-term interventions.

Around one in four people in England are affected by a mental health problem.¹ Understanding people's experiences of the care and treatment they receive is important because it provides key information about the quality of services. It is only through understanding people's experiences that services can use this to drive improvement both nationally and locally. Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively and health outcomes improve.^{2 3}

This document sets out the full findings from the survey, with the results for all questions listed in the reference tables and charts section. Overall messages from the survey linked to national policy and guidelines are set out in the key findings section below.⁴

Key findings

For many of the topics covered by the survey, the majority of respondents reported positive experiences. The majority also said that they felt listened to, involved, and treated with respect and dignity.

As noted throughout this report, many of the existing standards and guidelines for providing mental health care focus on improving people's experiences. The survey results for this year show very little evidence of change from the 2014 survey results.

One of the key aims of the Crisis Care Concordat, established in February 2014, is that 'people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously'. Since the 2014 survey there has been no change in responses to questions about crisis care and out of hours' services.

¹ www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/

² www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

³ <http://bmjopen.bmj.com/content/3/1/e001570.full>

⁴ References for each of these documents are listed in Appendix A.

The National Service Framework for Mental Health and the National Institute for Health and Clinical Excellence (NICE) quality standard for service user experience in adult mental health both refer to timely access to effective mental health services. Over a fifth (22%, compared with 20% in 2014) of respondents said they are not being seen often enough for their needs. More respondents reported that the people they see for the care or services they use had changed in the last 12 months (43%, compared with 41% in 2014), and more respondents said that this change had a negative impact on their care (29%, compared with 27% in 2014).

Likewise, when compared with the previous survey results, more respondents reported negative experiences in terms of being listened to, having enough time to discuss their needs and treatment, and being treated with respect and dignity.

Involving people in their care leads to better outcomes and more effective decisions.^{5 6} On average, around one in 10 respondents reported **not** being fully involved in their care, such as with decisions on agreeing what care they will receive, involvement in discussions about how their care is working, deciding what treatment and therapies to use, and involvement in decisions about which medicines they receive.

Research has shown there is a strong link between social inclusion and recovery. It is important that staff are able to support people with this.⁷ The survey found that of the respondents who wanted or needed this support (and excluding those who already have support in place) many were not receiving help or advice in finding support for physical health needs, financial matters, work, accommodation, peer support and local activities.

⁵ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

⁶ <http://bmjopen.bmj.com/content/3/1/e001570.full>

⁷ www.mentalhealth.org.uk/help-information/mental-health-a-z/r/recovery/

About the Community Mental Health Survey

The 2015 Community Mental Health Survey involved 55 NHS trusts in England⁸ (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services). The results were compiled using data from all trusts.

Similar surveys of community mental health services were carried out between 2004–2008 and 2010–2014.⁹ To reflect changes in policy, best practice and patterns of service, the survey questionnaire was substantially redeveloped and updated ahead of the 2014 survey. New questions were added and existing questions were modified. This means that the results from the 2014 and 2015 surveys are not comparable with the results from previous surveys.

CQC has published a separate response to the 2015 survey, which outlines what this means for the quality of care for people who use mental health services. The community mental health survey is part of a wider programme of NHS patient surveys, which covers a range of topics including acute inpatient, children's inpatient and day case services, A&E (emergency department) and maternity services. To find out more about CQC's response, the survey programme and to see the results from previous surveys, please see the web links in the further information section ([Appendix E](#)).

Who responded?

There were 13,292 respondents to this survey, a response rate of 29%¹⁰. In total, 46,750 people were sent questionnaires.¹¹

Basic demographic information was collected for everyone who took part in the survey and can be found in the 'About the respondents' subsection under the 'Reference tables and charts' section of this document. The tables show that basic demographics for respondents (age, gender and ethnicity) remain similar to the 2014 survey and there have been no statistically significant changes.

⁸ Although 58 trusts were eligible to take part in the survey, two trusts were not able to take part in the 2015 survey as they were unable to draw a sample as specified in the survey instruction manual. The data for one trust that took part in the survey was excluded from the publication as the trust committed an error when drawing their sample which would have introduced bias into their results. For more information please see the Data Limitations section in Appendix D. Tavistock and Portman NHS Foundation Trust (RNK) do not take part in the survey due to the different nature of the services they provide and the population they serve.

⁹ In 2009 a survey of mental health inpatient services took place.

¹⁰ This compares with 13,787 respondents in 2014 (29%), from a total sample of 48,450.

¹¹ Please note that we report the 'adjusted' response rate. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

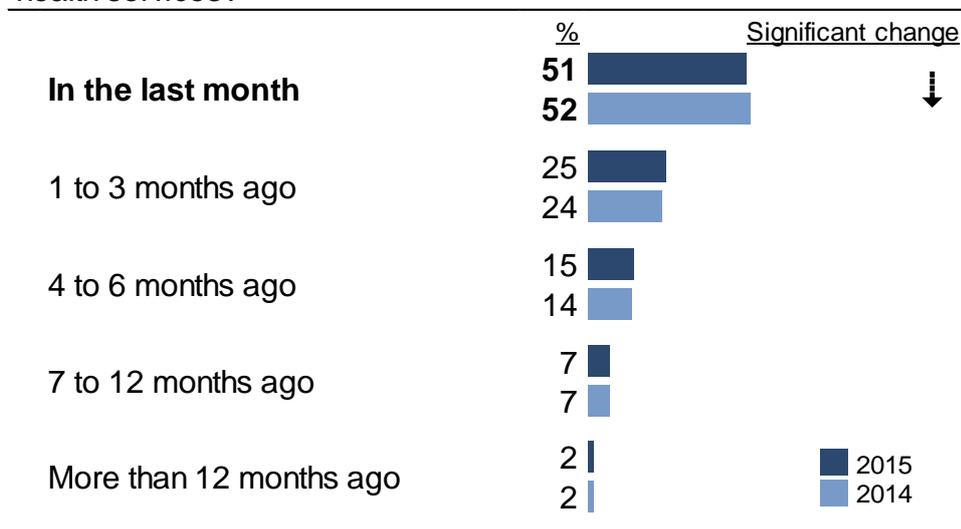
[Appendix D](#) includes information on the profiles of respondents and non-respondents.

Overall, 57% of responses were from women, and 43% from men. Fourteen per cent of respondents were aged between 18 and 35 years, 22% between 36 and 50 years, and 26% were between 51 and 65 years. Thirty eight per cent of all respondents were aged 66 years or older.

Just over half of the people we received responses from (51%), had seen someone from NHS mental health services in the previous month. This was slightly lower than those responding to the 2014 survey (52%, shown in Table 1 below).

Table 1: Most recent contact with mental health services

Q1: When was the last time you saw someone from NHS mental health services?



Answered by all

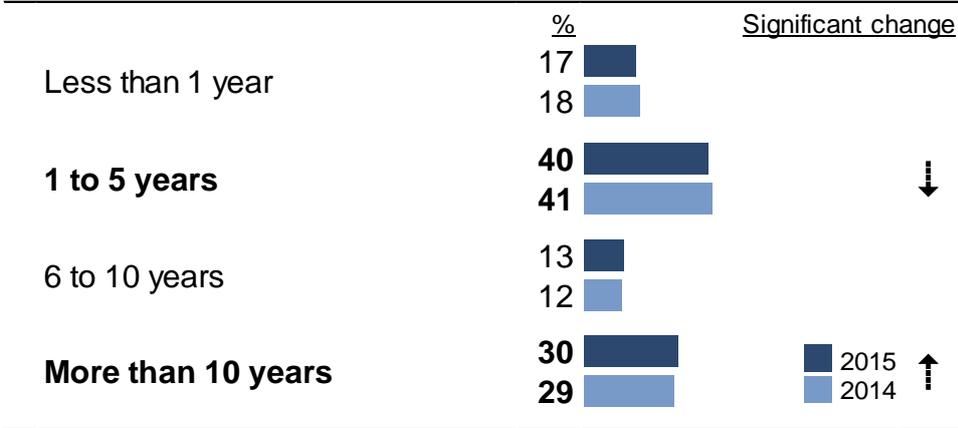
Number of respondents: 2014 – 13,348 & 2015 - 12,836

Note: respondents who stated that they did not know/ could not remember or who have never seen NHS mental health services have been excluded

As shown in Table 2, 17% of people had been in contact with mental health services for less than one year. Less than a third (30%) had been in contact for more than 10 years (compared with 29% in 2014).

Table 2: Length of contact with mental health services

Q2: Overall, how long have you been in contact with NHS mental health services?



Answered by all

Number of respondents: 2014 – 12,839 & 2015 - 12,366

Note: respondents who stated that they did not know/ could not remember or who are no longer in contact with NHS mental health services have been excluded

Of those who knew who was in charge of organising their care, over a third of respondents (35%) said this person was a Community Psychiatric Nurse (CPN), and twenty seven per cent of people said it was a psychiatrist. More said it was a GP (17% compared with 15% in 2014), and more said it was a mental health support worker (again, 17% compared with 15% in 2014). The remainder said that the person organising their care was a social worker (12%), a psychotherapist or counsellor (8%) or ‘another type of NHS health or social care worker’ (6%).¹²

When looking at those on the ‘Care Programme Approach’ (CPA), more respondents said that a GP is responsible for organising their care (11%) when compared with the 2014 survey (8%). Of those not on CPA, more respondents had their care organised by a mental health support worker (16%) than in the 2014 results (14%), and fewer said their care was organised by a psychotherapist (10% compared with 11% in 2014).

Please be aware of the limitations to the data when reading this report; these are discussed in [Appendix D](#).

¹² As some respondents ticked more than one option for question, results may add up to over 100%.

Policy background to the survey

Patient experience: policy background

Around one in four people experience a mental health problem each year.¹³ About half of people with a common mental health problem are no longer affected after 18 months, but poorer people, the long-term sick and unemployed people are more likely to be still affected than the general population¹⁴.

Understanding people's experiences of the care and treatment they receive is important because it provides key information about the quality of services, and that information can drive improvement both nationally and locally.

Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively and health outcomes improve.^{15 16} The importance of people's experiences and the need to continue to improve this is a central theme in various documents, initiatives, policies and quality standards published in recent years, and surveys such as those included in the National Patient Survey Programme are an important way to assess this. For example:

- In *High Quality Care for All*¹⁷ Lord Darzi established patient experience as one of the three elements of high-quality care, alongside clinical effectiveness and safety.
- In February 2012, the NHS National Quality Board (NQB) published the NHS Patient Experience Framework¹⁸. This evidence-based framework outlines elements that are important to patients' experience of NHS services and is intended to help NHS trusts improve this. Included in this framework are: access to care, respect for people's values, needs and preferences, information and communication, emotional support and involving family and friends. All questionnaires in the National Patient Survey Programme have been designed around this framework.
- The National Institute for Health and Clinical Excellence (NICE) outlines existing research and provides guidance for healthcare professional to improve patient experience¹⁹.

¹³ www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/

¹⁴ *Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain*, National Statistics, 2003

¹⁵ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

¹⁶ <http://bmjopen.bmj.com/content/3/1/e001570.full>

¹⁷

<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm>

¹⁸ www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

¹⁹ <https://www.nice.org.uk/guidance/cg136/evidence/cg136-service-user-experience-in-adult-mental-health-full-guideline3>

- Improving the experience of people is at the centre of the *NHS Constitution*²⁰ (published 2012). This document sets out the rights to which patients, public, and staff are entitled. The NHS Constitution requires that NHS services reflect the needs and preferences of people using services, their families and their carers. The Constitution also commits the NHS to encouraging feedback on people's experiences and using this to improve services. Principles from the NHS Constitution underpin all questionnaires in the National Patient Survey Programme. The constitution was updated in July 2015 following a publication consultation and now gives greater prominence to mental health, by committing to close the gap between mental and physical health problems, and reinforce that both are equally important.

Research, including that undertaken in the development work for the surveys, has identified the aspects of care that are important to people using services. These include: being informed and offered options; staff listening to them and spending enough time with them; and being enabled to be involved in their own care²¹. These themes are included in all questionnaires in the National Patient Survey Programme.

Mental health policy background

The community mental health survey questionnaire is continuously developed to ensure that it covers as many aspects about people's experiences of their care and treatment as is reasonable within a limited survey. In reviewing the questionnaire, the need for content change to ensure it remains up to date with current policy must be balanced against the need for trend data to monitor changes in results. The survey aligns, as far as possible, with evidence-based good practice in patient experience (outlined in the previous section) and takes into account current policy and quality standards. This section summarises the policy background to the survey. Links to relevant policy documents and data are in [Appendix A](#).

There have been various national policy documents, reports and quality standards relating to mental health published by different governments and by different organisations. However, central themes underlining these are:

- An aspiration to achieve equality between physical and mental health services.
- The importance of people's experiences of using services.
- The need to improve this.
- The need to actively involve people as partners in their own care.
- The importance of multi-agency working to achieve better outcomes.

Data from the survey will provide valuable information on people's experiences against which the impact of some aspects of these policies can be assessed.

²⁰ www.gov.uk/government/publications/the-nhs-constitution-for-england

²¹ www.institute.nhs.uk/patient_experience/guide/what_matters_to_patients%3F.html

[Appendix C](#) provides more information on how the survey data will be used by different organisations.

Key documents taken into account in the development of the community mental health survey questionnaire in 2014 were the government mental health strategy *No Health Without Mental Health*²² published in 2011, and the NICE guidelines for *Service User Experience in Adult Mental Health*²³ also published in 2011. For more detail on those documents, please see [Appendix A](#).

The Care Programme Approach

The term 'Care Programme Approach' (CPA) describes the framework, introduced in 1990, to support and co-ordinate effective mental health care for people using secondary mental health services. Although the policy has been revised over time,²⁴ the CPA remains the central approach for co-ordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Nationally, 32% of the people who responded to the 2015 survey had their care co-ordinated on CPA. However, it is worth noting that there is enormous variation in the proportion of people on CPA between trusts: for respondents to the 2015 survey this ranged from a low of 8% to a high of 95%, which suggests that there are systematic differences in how trusts interpret and apply the CPA policy locally.

It is expected that there will be some differences in people's experiences depending on whether or not they receive community mental health services under the CPA. This is partly due to the different service requirements for people on CPA who need greater support, and as a result, may have different patterns of care. We therefore also analyse questions by CPA status where policy guidance (*Refocusing the Care Programme Approach*) sets out differences between the care pathway of those who are on CPA and those who are not, as we expect the care provided to vary across the two groups due to their different needs and requirements. These results are shown in charts of a different colour (green) to clearly distinguish them from other results.

Questionnaire design

All questions included in the survey were tested during survey development work to ensure they are important to people who use services, and / or stakeholders. More information on survey stakeholders, and how they use the data can be found in [Appendix C](#).

²² www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

²³ www.nice.org.uk/guidance/qs14/resources/guidance-service-user-experience-in-adult-mental-health-pdf

²⁴ The most recent revision was '*Refocusing the Care Programme Approach - Policy and Positive Practice Guidance*' published by the Department of Health in 2008 and available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

The questionnaire contains sections on: health and social care workers; organising, planning and reviewing care; changes in who people see; treatments and other areas of life. We have provided information in the 'Key findings' section setting out why questions in each section of the questionnaire were included.

Where possible, the same questions are used to enable year-on-year comparisons. However, the questions are reviewed before each survey to determine whether any new questions are needed, to ensure the questionnaire is up to date and in line with current policy and practice. The ongoing work to develop the questionnaire has shown that all survey questions are important to people who use services and/or to other stakeholders who use the survey data in their work, such as NHS England (see [Appendix C](#)).

For 2015, one question was removed although all other questions remain the same. This means that all questions included in the 2015 questionnaire can be compared with 2014.

The survey was substantially redeveloped in 2014 and the development report is here: www.nhssurveys.org/surveys/750. As described above, only minor changes were made to the 2015 questionnaire and the development report is here: www.nhssurveys.org/survey/1542. The final questionnaire for the 2015 survey is here: www.nhssurveys.org/survey/1512.

Survey methodology

As with most surveys in the National Patient Survey Programme, the community mental health survey used a postal methodology. However, in order to ensure the questionnaire was as accessible as possible, people were able to complete the questionnaire over the phone in a language other than English.

Up to two reminders were sent to people who did not respond.

Sampling

Service users aged 18 and over were eligible for the survey if they received specialist care or treatment for a mental health condition, including those who received care under the 'Care Programme Approach', and had been seen by the trust between 1 September 2014 and 30 November 2014. Trusts drew a random sample from their records of 850 people who had been seen at the trust during the sampling period. The sample size was sufficient to allow analysis of results at individual trust level. Full details of the sampling are available in the instruction manual for the survey (see the links in [Appendix E](#)).

All trusts providing community mental health services were eligible to take part in the survey. One trust was excluded from the results as it made an error when drawing its sample. Two trusts were unable to take part in the survey and one trust was not eligible. More detailed information can be found in [Appendix D](#).

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and July 2015.

Analysis methodology

Weighting

Some trusts have a higher response rate than others and would therefore have a greater influence over the average for England if a simple mean was 'calculated' across all respondents. To avoid this, weights are applied to the data. By applying these weights the responses from each trust have an equal influence over the average for England regardless of differences in response rates between trusts.

This weighting has been applied to all questions except for the demographic questions at the end of the report (Q43 to Q48). The demographic questions are presented without weights applied, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than average figures.

The weighting strategy for the results has remained unchanged since the previous survey.

Rounding

The tables present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%. Please note that rounding up or down may make differences between survey years appear bigger or smaller than they actually are.

Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2015 compared with the last time the survey was conducted in 2014.

A 'z-test' set to 95% significance was used to compare data between the two years. A statistically significant difference means it is very unlikely we would have obtained this result by chance alone if there was no real difference.

The charts display 'up' and 'down' arrows to indicate whether there has been a 'statistically significant' change between 2015 and 2014. The response(s) that have had a statistically significant change are shown in **bold**.

↑ shows that there has been a statistically significant increase in results.
↓ shows that there has been a statistically significant decrease in results.

We also carried out statistical tests to determine whether there were any statistically significant differences between people who receive services on CPA, and those who do not receive services under CPA for some questions. The response(s) that have statistically significant differences are shown in **bold**.

These charts are shown in a different colour (green) to clearly distinguish them from other results.

In these tables and charts we use a ✓ show that there is a statistically significant difference in results between the two groups

Due to the relatively large number of respondents, small changes in results may show to be statistically significant. Such small changes do not necessarily indicate a longer-term trend.

However, in other cases there may be a visible change in the results between survey years but this is not significant. There are a number of reasons for this, such as:

- Rounding figures up or down makes a difference appear larger than it actually is.
- Generally speaking, the larger the sample size, the more likely that findings will be statistically significant, and we can be more confident in the result. Conversely, the fewer people that answer a question, the greater the difference has to be in order to be statistically significant.
- The amount of 'variance' also affects whether the difference is significant. 'Variance' means the differences in the way people respond to the question. If there is a lot of variance then differences are less likely to be statistically significant.

Interpreting the results

This document provides the results from the 2015 Community Mental Health Survey, and compares them with those from the 2014 survey where possible. Results for each question are presented in the order in which they appear in the questionnaire.

Results are presented using tables and charts. Where there has been no statistically significant change results are presented using a table. Where there has been a statistically significant change results are shown using a chart.

Where results are shown in tables, each table shows the year of the survey at the top and the responses for each question on the left. The number of respondents shown on the bottom row is the number of people on which the results are based.

The tables and charts show all specific responses to a question. Responses such as "don't know / can't remember" are not shown. These responses are designed for when a respondent cannot remember, or does not have an opinion. For other questions, we also excluded other responses which means that a question is not relevant to a respondent. For example, at Q31 (*In the last 12 months, did NHS mental health services give you any help or advice with finding support for*

physical health needs?) we excluded people who said that they ‘do not have physical health needs’, or that they ‘already have support in place and did not need help/advice to find it’ or that they ‘did not need support for this’ as the question is not relevant to them.

As noted in the ‘policy background section’, we have broken down the results for some questions by CPA status, where policy guidelines suggest different service requirements for people on CPA who need greater support, and as a result, may have different patterns of care. These results are shown in charts of a different colour (green) to clearly distinguish them from other results.

Comparability of results with previous years

The results for all questions from the 2015 survey are comparable with the 2014 survey.

Over time there have been a number of changes made to the survey, including revisions to the eligible age range and major developments to revise the methodology and the questionnaire content, which affect historical comparability:

- The 2004 and 2005 surveys included people aged 16-65 years. In 2006 the age range for the survey was extended to include people aged over 65. This means that to compare results with earlier surveys older respondents must be excluded from the analyses.
- In 2012 the sampling criteria changed to **exclude** 16 and 17 year olds as the National Information Governance Board which awarded section 251 approval²⁵ at that time did not grant approval for the inclusion of 16 and 17 year olds in the survey. This means that it is necessary to exclude respondents aged 16 and 17 years from the 2010 and 2011 surveys in order to fairly compare the results to the more recent surveys.
- The survey has undergone two major redevelopments ahead of the 2010 and 2014 surveys to reflect changes in policy, best practice and patterns of service. This means that the 2015 survey is only comparable with the 2014 survey. Surveys carried out between 2010 and 2013 are comparable with each other but not with any previous surveys, due to the re-development in 2010.

Filter questions

Not all of the questions in the survey are intended to be answered by all respondents. Some questions are not applicable to everyone: for example, if a respondent had not been receiving any medicines for their mental health needs in the last 12 months (Q23) they were instructed to skip questions 24-28, which ask about this, and go straight to Q29.

Notes on specific questions

This section provides information about the analysis of particular questions:

²⁵ For more information on section 251 approval please see: www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/

Q8: (Is the person in charge of organising your care and services...)

As some respondents ticked more than one option for this question, results may add up to over 100%²⁶.

Q9 and Q10: Q9 (Do you know how to contact this person if you have a concern about your care?) and Q10 (How well does this person organise the care and services you need?)

Respondents who stated at Q8 that their GP is in charge of organising their care and services have been removed from the base for these questions. This is because results will not be attributable to the mental health trust.

Q14: (In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?)

Respondents who stated at Q2 they had been in contact with mental health services for less than a year have been removed from the base for this question. This is because it is not fair to penalise trusts for not having reviewed a person's care, if they have not been in contact with services for long enough.

²⁶ The questionnaire did not instruct respondents to 'tick all that apply' however, as a large number of respondents did this, data has been treated as multiple response.

Key findings

The following sections summarise the survey results in the order in which they appear in the questionnaire.

Results are grouped according to the section of the questionnaire in which they appear.

Each section includes text summarising the results and describing any other related data sources. Please see [Appendix A](#) for further information about policy and guidance documents referred to in the text.

The full set of results (tables and charts) follows the summary.

Please note that comparisons to the 2014 survey are only presented in the key findings text when a change was statistically significant.

Section 1: Care and treatment

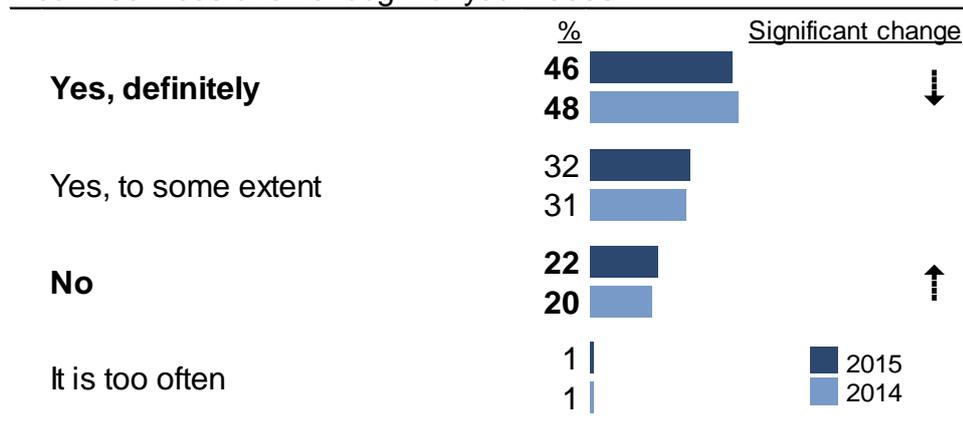
We asked the first three questions in the questionnaire to understand how long respondents have been in contact with services, and if they felt they have seen mental health services often enough for their needs.

To receive treatment, people must be able to access services. The right to access effective mental health care has been set out in various governmental policy documents over the years, as well as the National Institute for Health and Clinical Excellence (NICE) Quality standard for service user experience in adult mental health, which includes a recommendation that people should be able to access mental health services when they need them.

Development work for the survey revealed that people using services felt that their contact with NHS mental health services can be too limited in terms of frequency, length of appointments and number of instances of contact. It is therefore important to include questions covering these issues.

Recent policy publications such as *Closing the Gap*²⁷ and *Achieving better access to mental health services by 2020*²⁸ have called for immediate improvements in access to mental health services. Forty-six per cent of respondents to the survey said that they had ‘definitely’ seen someone from NHS mental health services often enough for their needs compared with 48% in 2014. There was a corresponding change in the results for those saying they had **not** had enough contact with mental health services to meet their needs since 2014 (20% in 2014 and 22% in 2015).

Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?



Answered by all

Number of respondents: 2014 – 13,055 & 2015 - 12,585

Note: respondents who stated that they did not know have been excluded

27

www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

28 www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020

Section 2: Health and social care workers

These questions asked respondents about the health and social care workers they saw for their most recent appointment, to understand about their experiences of interactions with the health and social care workers they see as part of their care.

Research shows that having staff who listen and spend time with people is important to people who use services²⁹. People's experiences are clearly dependent upon their interactions with the staff providing their care, and we expect that a good relationship with staff is therefore likely to be important when it comes to providing a positive experience for people who use services.

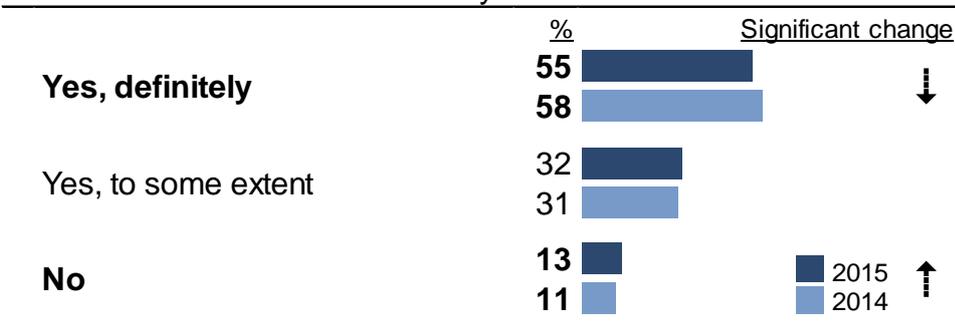
Respondents were asked whether the person or people they saw most recently listened carefully to them. The majority (70%) said they 'definitely' did, compared with 73% in 2014. The remainder responded 'yes, to some extent' (24% in 2015 and 21% in 2014) or 'no' (7% in 2015 and 5% in 2014).

Sixty-two per cent said that they were 'definitely' given enough time to discuss their needs and treatment compared with 66% in 2014. The remainder responded 'yes, to some extent' (26% in 2015 and 24% in 2014) or 'no' (11% in 2015 and 9% in 2014).

Consultation with people who use services during survey redevelopment work revealed an important aspect of the relationship between people using services and staff was the quality of those relationships. In particular, staff's consideration and understanding of their lives as a whole.

Fifty-five per cent of respondents to the survey said that the person or people they saw 'definitely' understood how their mental health needs affect other areas of their life compared with 58% in 2014.

Q6: Did the person or people you saw understand how your mental health needs affect other areas of your life?



Answered by all

Number of respondents: 2014 – 12,770 & 2015 - 12,258

Note: respondents who stated that they did not know/ could not remember have been excluded

²⁹ www.institute.nhs.uk/patient_experience/guide/what_matters_to_patients%3F.html

Section 3: Organising care

We asked these questions to understand if respondents have been told who is in charge of organising their care, and how effectively their care is organised.

Guidance on coordinating the care of people who use services, as set out in *Refocusing the Care Programme Approach*, says people should have a single person (or team) with an identified lead professional responsible for planning and reviewing their care. Sometimes this person is known as a 'care coordinator' or a 'lead professional'. This person will oversee their care and keep in contact with them.

For those receiving mental health services under CPA, the role of the care coordinator is pivotal and involves keeping in regular contact with the person using services; co-ordinating and overseeing their care and liaising with the various professionals and agencies involved in their care and treatment. People who are not on CPA should only require the support of one agency and may only see one person. They are allocated a 'lead professional' responsible for facilitating their care.

The importance of the care coordinator or lead professional is also set out in NICE documents:

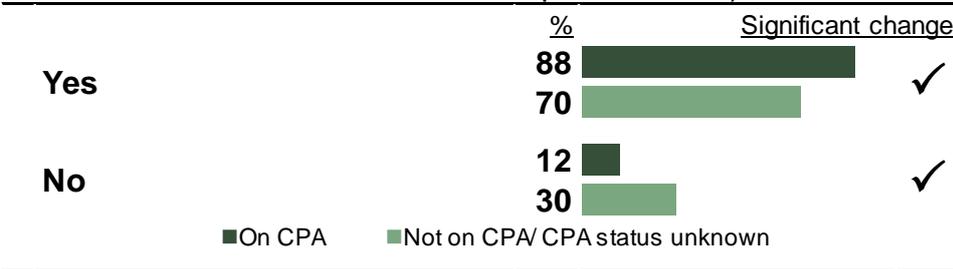
- The NICE commissioning guidance for people with common mental health disorders states that people should know who the person is that organises their care and how to contact them.
- The NICE quality standard for service user experience in adult mental health recommends that people using community mental health services are supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.

As the care coordinator will oversee people's care and keep in contact with them, it is important that people using services know who this person is, and that this person does their job effectively. We therefore asked about people's experiences of this in the survey.

Over three-quarters of all respondents said that they were told who was in charge of organising their care and services (76%).

Respondents on CPA (88%) were more likely than those not on CPA (70%) to say that that they have been told who is in charge of organising their care and services.

Q7: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”.)



Answered by all

Number of respondents: On CPA – 3,729 & Not on CPA/ CPA status unknown - 7,150

Note: respondents who stated that they were not sure have been excluded

Of those respondents who had been told who is in charge of organising their care and services:³⁰

- The vast majority knew how to contact that person if they had a concern about their care (96%).
- Most said that the person who organises their care and services does this ‘very well’ (59%). The remainder responded ‘quite well’ (32%), ‘not very well’ (6%) or ‘not at all well’ (3%).

³⁰ Respondents who told us (at question eight in the questionnaire) that their GP is in charge of organising their care and services have been removed from the base for these questions. This is because results will not be attributable to the mental health trust.

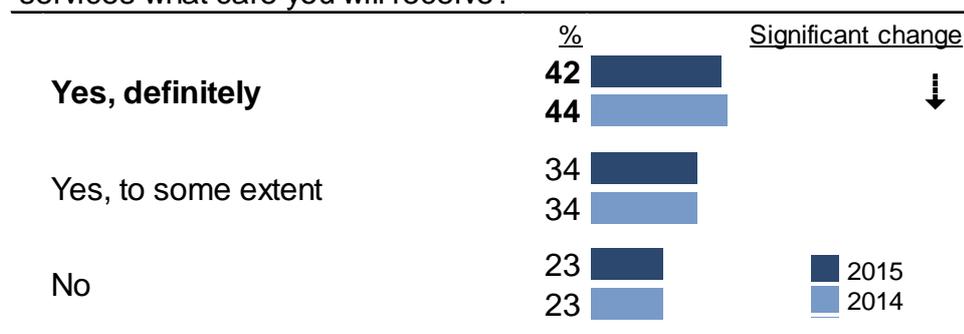
Section 4: Planning care

We asked these questions to understand if respondents have agreed with someone from mental health services what care they will receive and how involved they were with this process.

Guidance on coordinating the care of people who use services, as set out in *Refocusing the Care Programme Approach*, says everyone receiving care from specialist mental health services should have agreed with someone what care they will receive. This may be known as a ‘care plan’ or a ‘recovery plan’ and should have been developed jointly with mental health and social care professionals. This plan should set out their individual mental health needs, plans and goals for their care and treatment. In line with national guidance, there are different practice expectations for people on CPA and those not on CPA, and we would therefore expect to see differences in the survey results. People on CPA should have a comprehensive formal written care plan detailing their care and treatment. In the case of those who are not on CPA, there is no formal requirement to have a written care plan or review. However, people should have a clear understanding of how their care and treatment will be carried out and by whom.

When asked whether they had agreed with someone from NHS mental health services what care they will receive, 42% of all respondents said they ‘definitely’ had, compared with 44% in 2014.

Q11: Have you agreed with someone from NHS mental health services what care you will receive?

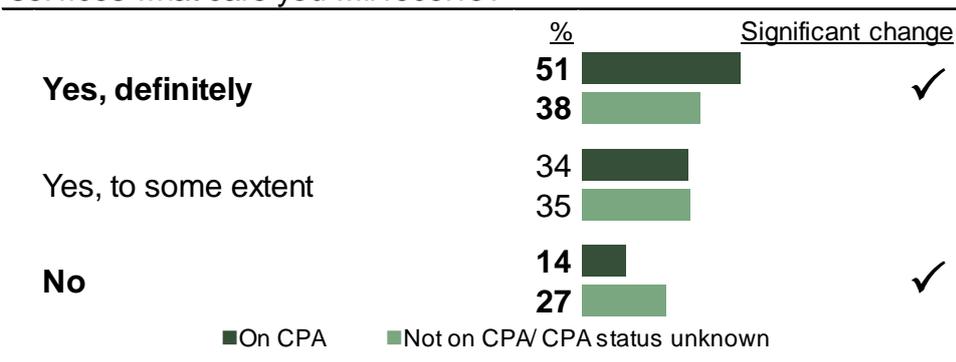


Answered by all

Number of respondents: 2014 – 13,198 & 2015 - 12,695

Respondents on CPA (51%) were more likely than those not on CPA (38%) to say that they have ‘definitely’ agreed with someone from NHS mental health services what care they will receive.

Q11: Have you agreed with someone from NHS mental health services what care you will receive?



Answered by all

Number of respondents: On CPA – 4,110 & Not on CPA/ CPA status unknown - 8,585

Involving people in their own care is important as research suggests it can lead to more effective decision making and better health outcomes.^{31 32} The right to be involved in planning and making decisions about healthcare has been set out in various governmental policy documents over the years including the NHS Constitution. As noted in the policy background section, themes of involvement and being active partners in care are prominent in all recent policy documents.

This is also reflected in the NICE quality standard for service user experience in adult mental health, which recommends that people using mental health services jointly develop a care plan with mental health and social care professionals. The standard also states that people must be actively involved in decision making processes stating that people using mental health services should be actively involved in shared decision making and supported in self-management.

We asked about the experiences of the respondents who said they were involved in agreeing what care they would receive from NHS mental health services:

- Over half (56%) said they were ‘definitely’ involved as much as they wanted to be. The remainder responded ‘yes, to some extent’ (37%) or ‘no, but I wanted to be’ (7% in 2015 and 6% in 2014).
- The majority (59%) said their personal circumstances were ‘definitely’ taken into account, (61% in 2014). The remainder responded ‘yes, to some extent’ (34%) or ‘no, but I wanted to be’ (7%). Respondents on CPA (61%) are more likely than those not on CPA (58%) to say that their personal circumstances were ‘definitely’ taken into account.

³¹ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

³² <http://bmjopen.bmj.com/content/3/1/e001570.full>

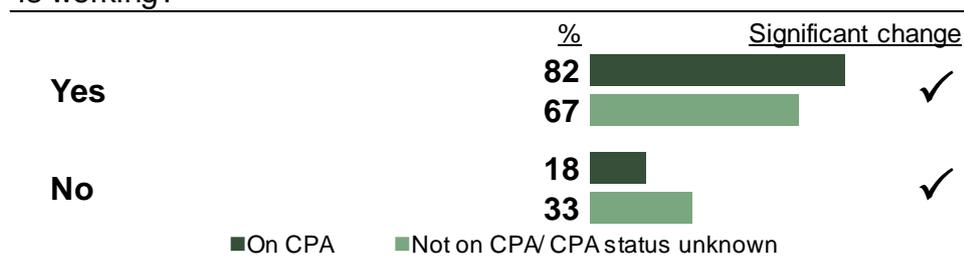
Section 5: Reviewing care

We asked these questions to understand whether respondents have had their care reviewed in the last 12 months and how involved they were with this process.

Guidance on coordinating the care of people who use services as set out in *Refocusing the Care Programme Approach* says that people receiving care under CPA should receive a formal review at least once a year, although this could be needed more regularly. Those not on CPA should receive ongoing reviews as their needs require. We would therefore expect to see differences in the survey results for this question, depending on whether respondents are receiving care under CPA or not.

Respondents on CPA (82%) were more likely than those not on CPA (67%) to say that their care had been reviewed in the last 12 months.

Q14: In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?



Answered by all

Number of respondents: On CPA – 3,548 & Not on CPA/ CPA status unknown - 6,510

Note: respondents who stated that they did not know / could not remember or who have been in contact with NHS mental health services for less than a year have been excluded

Involving people in their own care is important as research suggests it can lead to more effective decision making and better health outcomes.^{33 34} A collaborative approach to reviewing care is emphasised in the NICE quality standard for service user experience in adult mental health, which recommends that 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. The standard also states that people using mental health services should be actively involved in shared decision making and supported in self-management.

³³ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

³⁴ <http://bmjopen.bmj.com/content/3/1/e001570.full>

We asked about the experiences of the respondents who had said that in the last 12 months they had had a formal meeting with someone from NHS mental health services to discuss how their care was working:

- 61% said that they were 'definitely' involved as much as they wanted to be in discussing how their care was working. The remainder responded 'yes, to some extent' (32%) or 'no, but I wanted to be' (7%).
- Likewise, 61% of said that decisions were 'definitely' made together by them and the person they saw during the discussion on their care (62% in 2014). The remainder responded 'yes, to some extent' (32%, compared with 29% in 2014) or 'no, but I wanted to be' (8%, compared with 9% in 2014).

Section 6: Changes in who people see

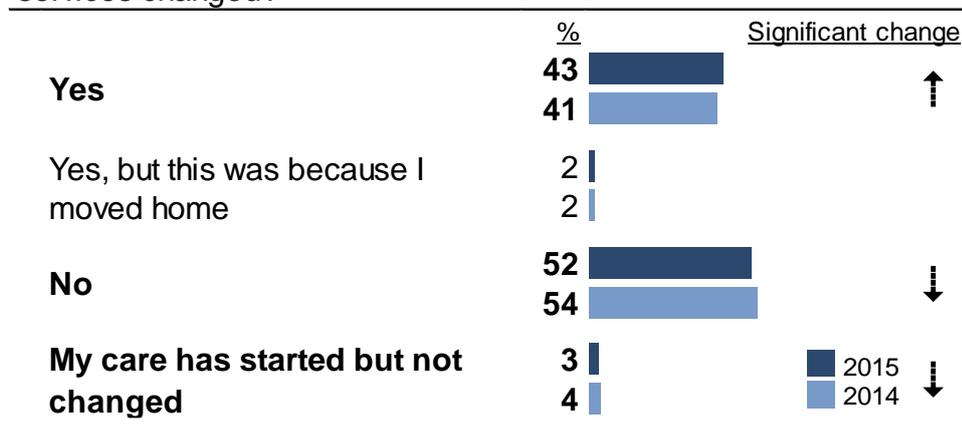
We asked these questions to understand whether respondents experienced changes in the staff that they see, and the impact this had on their care.

NICE guidance states that changes in staffing can be disruptive to care and it is therefore important that services maintain continuity of individual relationships wherever possible. Where changes are necessary, people should be provided with appropriate and accessible information about what is happening.

This is reflected in findings from a consultation with people who use services as part of the development work for the survey (for more information, please see the 2014 survey development report available at: www.nhssurveys.org/surveys/750). Continuity was a strong theme in discussions, as people found that it was only through long-term, continuous relationships with staff that they could build up the positive dynamics they found most beneficial to their care. People who did not see the same members of staff, but instead had their care handled by a series of new people, found this detrimental, not just to their relationships with staff but to their health as a whole.

The survey asked respondents if the people that they see for their care or services had changed within the previous 12 months and about the impact this had on their care. Forty-three per cent said that in the last 12 months, the people they see for their care and services had changed compared with 41% in 2014.

Q17: In the last 12 months, have the people you see for your care or services changed?



Answered by all

Number of respondents: 2014 – 12,031 & 2015 - 11,579

Note: respondents who stated that they did not know / not sure have been excluded

Of those respondents³⁵ whose care had changed (but not including those for whom this change was caused by them moving house or starting care):

- A quarter (25%) said that their care got better following the change. Forty-six per cent said that 'it stayed the same'. Twenty-nine per cent said their care 'got worse' (27% in 2014).
- Over half (55%) said that they knew who was in charge of organising their care while this change was taking place, leaving 45% who did not.

³⁵ 4,952 respondents said 'yes' at Q17

Section 7: Crisis care

A mental health crisis is an emergency and it is important that people know who to contact and receive effective care. Questions in this section asked respondents if they know who to contact if they have a crisis and, if they have contacted this person or team, if they then got the help that they needed.

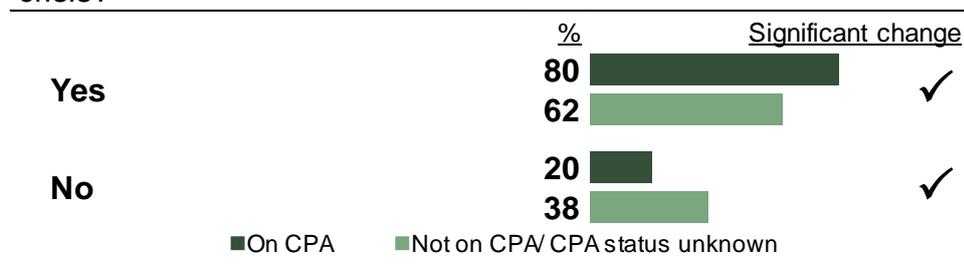
People using mental health services who are at risk of crisis should have a crisis plan which has been developed jointly with their care coordinator. As recommended by NICE guidance this should contain information about 24-hour access to services and named contacts.

Guidance on coordinating the care of people who use services, as set out in *Refocusing the Care Programme Approach*, says that people on CPA should have explicit crisis and contingency plans, which are part of their care plan, and explain what they should do. Although there is not the same policy requirement for people not on CPA, they should be aware of who to contact in the event of a crisis.

Sixty-eight per cent of all respondents said that they knew who to contact out of office hours if they have a crisis, leaving almost a third (32%) who do not.

Respondents on CPA (80%) were more likely than those not on CPA (62%) to say that they know who to contact out of office hours if they have a crisis.

Q20: Do you know who to contact out of office hours if you have a crisis?



Answered by all

Number of respondents: On CPA – 3,816 & Not on CPA/ CPA status unknown - 7,645

Note: respondents who stated that they were not sure have been excluded

The Crisis Care Concordat sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. As noted in the Crisis Care Concordat, as well as knowing how to access crisis care, it is important that people also receive effective care. Of those respondents who knew who to contact out of office hours, over a third (39%) had tried to contact that person or team within the last 12 months because their condition was getting worse. These respondents were asked whether they got the help they needed, when they tried to make contact. Forty-four per cent said they 'definitely' got the help they needed, 32% said they did 'to some extent', 22% responded 'no' and a further 3% said they could not contact them.

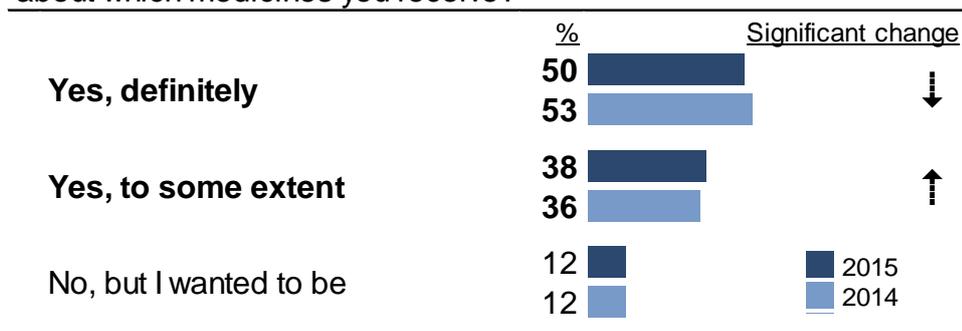
Section 8: Treatments

Questions in this section asked about treatments that respondents may receive for their mental health conditions (such as medicines, and / or treatments that do not involve medicines) and people's experiences in relation to them.

Most respondents (84%) said that in the last 12 months they had been receiving medicines for their mental health needs.

NICE guidelines on adherence to medication recommend involving people in decisions around which medicines to take, which can help improve compliance with taking medicines. We asked people if they were involved as much as they would like to be in decisions around which medicines they receive. Of those who wanted to be involved in decisions, half (50%) said that they 'definitely' were compared with 53% in 2014.

Q24: Were you involved as much as you wanted to be in decisions about which medicines you receive?



Answered by all who received medicines in the previous 12 months

Number of respondents: 2014 – 10,064 & 2015 - 9,775

Note: respondents who stated that they did not know/ could not remember or who did not want to be involved have been excluded

People who are receiving treatment should be given information about that treatment, including any side effects. The NICE quality standard for service user experience in adult mental health states that written information should be available in an appropriate language or format, and staff should clearly explain any clinical language and check that the person understands what is being said.

Forty-six per cent of respondents said that in the last 12 months they had been prescribed new medicines for their mental health. Of these people, 52% were 'definitely' given information about it in a way they could understand.

Q26: The last time you had a new medicine prescribed for your mental health needs, were you given information about it in a way that you were able to understand?

	2014	2015
Yes, definitely	53%	52%
Yes, to some extent	32%	33%
No	12%	11%
I was not given any information	3%	3%
Number of respondents	5,202	5,025

Answered by all who were prescribed new medicines in the previous 12 months

Note: no significant changes between 2015 and 2014

NICE guidelines on adherence to medication state that people on long-term medicines should have them reviewed at regular intervals. Similarly, the NICE commissioning guidance for people with common mental health problems recommends regular review of medicines. The majority (87%) of respondents had been taking medicines for their mental health needs for 12 months or longer. Of these people, 78% said that in the last 12 months, an NHS mental health worker had checked with them about how they are getting on with their medicines. Just over a fifth (22%) said this had not happened.

Effective care for mental health conditions may involve providing a range of different treatments or therapies. Mostly commonly these involve NICE recommended medicines and psychological ('talking') therapies, but this could also include relaxation or art therapies, or alternative therapies such as massage or acupuncture for example. All respondents were asked if they had received any treatments or therapies for their mental health needs that did not involve medicines in the last 12 months. Less than half (47%) said that they had. A quarter (25%) said 'no, but I would have liked this' leaving 28% who responded 'no but I did not mind'.

Of those respondents who had received treatments or therapies that did not involve medicines, and who wanted to be involved in decisions, 55% said they were 'definitely' involved as much as they wanted to be in deciding what treatments or therapies to use.

Q30: Were you involved as much as you wanted to be in deciding what treatments or therapies to use?

	2014	2015
Yes, definitely	55%	55%
Yes, to some extent	36%	36%
No, but I wanted to be	9%	9%
Number of respondents	4,737	4,449

Answered by all who received in the previous 12 months treatments or therapies that did not involve medicines

Notes:

respondents who stated that they did not know/ could not remember or who did not want to be involved have been excluded

no significant changes between 2015 and 2014

Section 9: Other areas of life

People who are using specialist mental health services sometimes have wider needs, for example with their finances, housing or employment.

There is a strong link between social inclusion and recovery. Research has found that important factors influencing recovery include factors such as financial security and work, and it is important that staff are able to support people with this if needed³⁶.

Addressing these wider needs can be a key part of their recovery. Questions in this section asked respondents about other areas of life, and the support mental health services help them to find, if they needed this. While NHS mental health services do not necessarily provide this support directly, they should help people to find support from other sources, such as by 'signposting' them to other services.

Physical health needs

The link between physical and mental health is made explicitly in *No Health Without Mental Health* which includes an objective that that 'more people with mental health problems will have good physical health'. It is therefore important that people with physical health needs receive support for this, if needed or wanted. The NHS Constitution (updated in July 2015) notes the importance of ensuring that mental health and physical health problems are equally addressed.

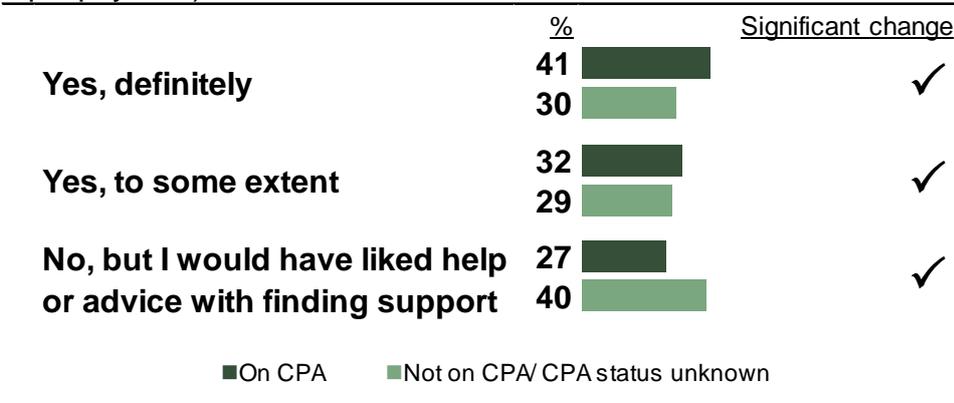
National guidance, as set out in *Refocusing the Care Programme Approach*, states that people receiving care under CPA should receive support with physical health needs if they need it. This need should be identified in an initial assessment.

We excluded respondents who said that they 'have support in place and did not need help or advice with finding support', or that they 'did not need support' or that they 'do not have any physical health needs'. Of those respondents who wanted or needed help or advice with finding support, 34% said that that in the last 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for physical health needs and 30% responded 'yes, to some extent'. Thirty-five per cent responded 'no, but I would have liked help or advice with finding support'.

Respondents on CPA (41%) were more likely than those not on CPA (30%) to say that in the last 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for physical health needs.

³⁶ www.mentalhealth.org.uk/help-information/mental-health-a-z/r/recovery/

Q31: In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc.)?



Answered by all

Number of respondents: On CPA – 2,437 & Not on CPA/CPA status unknown - 4,256

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this, or who did not have physical health needs have been excluded

Financial advice or benefits, work, and accommodation

National guidance, as set out in *Refocusing the Care Programme Approach*, states that people receiving care under CPA should receive support with employment, housing and finance from mental health services, if they need it. These needs should be identified in an initial assessment that should cover all needs and risks. For those people not on CPA, the focus is more on clinical needs rather than providing support for a wider range of needs. Nevertheless policy guidelines state that they should receive a full assessment ‘including risk assessment’ to identify if they have these needs.

We excluded respondents who said that they ‘have support in place and did not need help or advice with finding support’ or that they ‘did not need support’. Of those respondents who wanted or needed help or advice with finding support:

- 32% said that in the last 12 months, NHS mental health services ‘definitely’ gave them help or advice with finding support for financial advice and benefits.
- 25% said that in the last 12 months, NHS mental health services ‘definitely’ gave them help or advice with finding support for finding or keeping work.
- 33% said that in the last 12 months, NHS mental health services ‘definitely’ gave them help or advice with finding support for finding or keeping accommodation.

In the last 12 months, did NHS mental health services give you any help or advice with finding support for...

	Finding or keeping accommodation?	Financial advice or benefits?	Finding or keeping work?
Yes, definitely	33%	32%	25%
Yes, to some extent	24%	25%	28%
No, but I would have liked help or advice with finding support	43%	43%	47%*
Number of respondents	2,959	7,006	3,326

*Significant difference compared with 44% in 2014

Answered by all

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this, or who are currently not in/ seeking work have been excluded

We looked at the results for these questions by whether respondents received care under CPA or not. We excluded respondents who said that they 'have support in place and did not need help or advice with finding support' or that they 'did not need support'. Of those respondents who wanted or needed help or advice with finding support, respondents on CPA were more likely than respondents not on CPA to say that they 'definitely' received help or advice with finding support for:

- financial advice or benefits: (42% on CPA and 26% not on CPA)
- finding or keeping work: (33% on CPA and 20% not on CPA)
- finding or keeping accommodation: (45% on CPA and 24% not on CPA)

Social inclusion

Research has shown that support provided by voluntary sector organisations and / or support groups is important to people who use services³⁷. Promoting the social inclusion of people with mental health problems has been set out in various governmental policy documents over the years including the *National Service Framework for Mental Health*. It is particularly a theme in recent publications such as *No Health Without Mental Health*. The NICE quality standard for service user experience in adult mental health states that care plans should include activities that promote social inclusion such as employment, volunteering, and other aspects such as leisure activities.

Respondents were asked if someone from NHS mental health services supported them in taking part in an activity locally. We excluded respondents who said that they 'did not want or need this'. Of those respondents who needed or wanted this, 28% said that someone from NHS mental health services had 'definitely' supported them in taking part in an activity locally.

³⁷ www.institute.nhs.uk/patient_experience/guide/what_matters_to_patients%3F.html

Q35: Has someone from NHS mental health services supported you in taking part in an activity locally?

	2014	2015
Yes, definitely	30%	28%
Yes, to some extent	29%	30%
No, but I would have liked this	41%	42%
Number of respondents	6,221	6,153

Answered by all

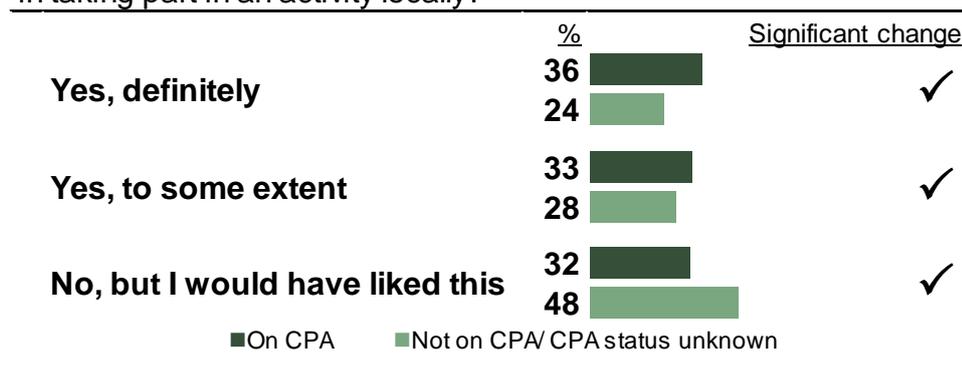
Notes:

no significant changes between 2015 and 2014

respondents who stated that they did not want or need this have been excluded

We looked at the results for this question by whether respondents received care under CPA or not. We excluded respondents who said that they 'did not want or need this'. Respondents on CPA (36%) were more likely than those not on CPA (24%) to say that someone from NHS mental health services had 'definitely' supported them in taking part in an activity locally.

Q35: Has someone from NHS mental health services supported you in taking part in an activity locally?



Answered by all

Number of respondents: On CPA – 2,305 & Not on CPA/ CPA status unknown - 3,848

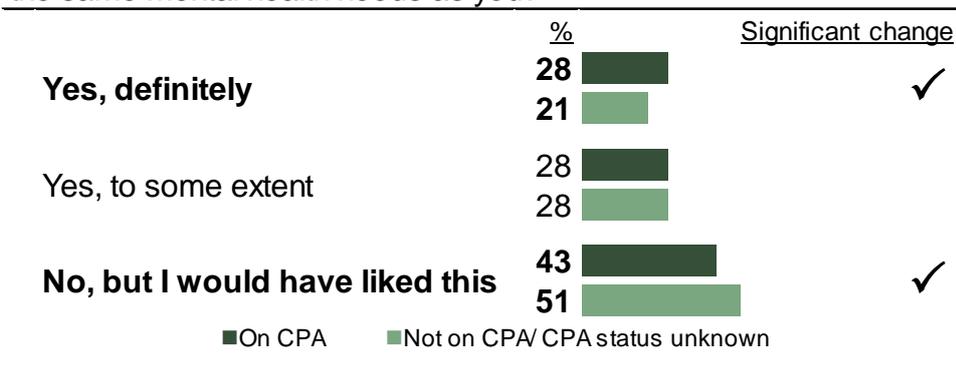
Note: respondents who stated that they did not want or need this have been excluded

The NICE quality standard includes a number of statements relating to people's wider lives, including that people using services should also be informed of appropriate local user-led support organisations or options for peer support.

Respondents were asked if they had been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as them. We excluded respondents who said that they 'did not want this'. Of those respondents who wanted this, less than a quarter (24%) had 'definitely' been given this information and 28% had 'to some extent'. Almost half (48%) did not receive this information but would have liked it.

Respondents on CPA (28%) were more likely than those not on CPA (21%) to say that they had 'definitely' been given this information.

Q37: Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?



Answered by all

Number of respondents: On CPA – 2,500 & Not on CPA/ CPA status unknown - 4,961

Note: respondents who stated that they did not want this have been excluded

Involving friends or family

The NICE quality standard for service user experience in adult mental health states that NHS mental health services should welcome the involvement of friends or family in the care of those using services, if this is what they want. We asked respondents if NHS mental health services involved a member of their family or someone else close to them as much as they would like. We excluded people who said that ‘my friends or family did not want to be involved’, that they ‘did not want my friends or family to be involved’ or that ‘this does not apply to me’. Of those who wanted friends or family involved, the majority said that a member of their family, or someone else close to them, had ‘definitely’ (55%) been involved as much as they would like.

Q36: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

	2014	2015
Yes, definitely	55%	55%
Yes, to some extent	25%	25%
No, not as much as I would like	17%	17%
No, they have involved them too much	3%	3%
Number of respondents	8,849	8,398

Answered by all

Notes: respondents who stated that family/ friends did not want to be involved, who did not want their family/ friends involved or felt it did not apply to them have been excluded
no significant changes between 2015 and 2014

Relationships with staff

The NICE quality standard for service user experience in adult mental health says that people using mental health services should feel optimistic that care will be effective. This was reflected in findings from the development work³⁸ for the

³⁸ for more information, please see the 2014 survey development report available at: www.nhssurveys.org/surveys/750

survey which revealed that an important aspect of the relationship between people who use services and staff was staff’s understanding of their lives as a whole, with the interaction between their mental health and the rest of their life clearly understood.

Around two-fifths of all respondents said that the people they see through NHS mental health services ‘always’:

- understand what is important to them in their life (41%, compared with 43% in 2014)
- help them with what is important to them (41%, compared with 42% in 2014)
- help them feel hopeful about the things that are important to them (38%).

Do the people you see through NHS mental health services...

	understand what is important to you in your life?	help you with what is important to you?	help you feel hopeful about things that are important to you
Yes, definitely	*41%	**41%	38%
Yes, to some extent	41%	39%	40%
No, but I would have liked help or advice with finding support	18%	20%	***22%
Number of respondents	12,302	12,270	12,205

Answered by all

*significant difference compared with 43% in 2014

** significant difference compared with 42% in 2014

*** significant difference compared with 20% in 2014

Section 10: Overall experiences of care and treatment

Summary

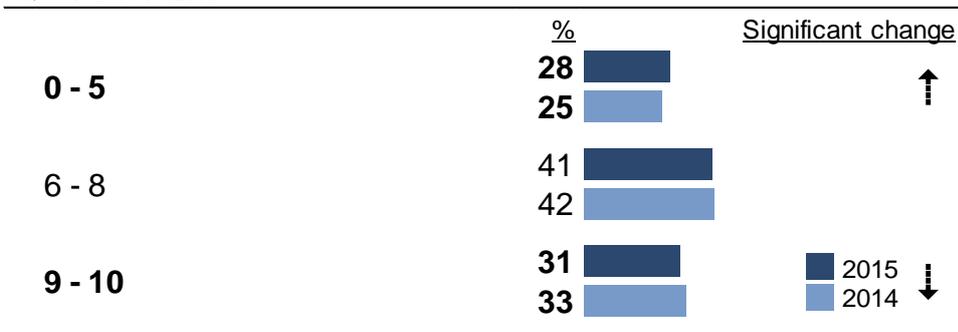
This final section looked overall at respondents' experiences of care and treatment.

We asked all respondents to evaluate their overall experience on a scale of 0-10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience').

Although almost a third (31%) of respondents reported that, overall, they had a very good experience of care from mental health services (rating it as 9 or 10 out of 10): this means two-thirds of respondents did not.

The survey shows an increase in respondents reporting a poorer experience, giving a rating of five or lower (28% compared with 25% in 2014).

Q41: Overall...

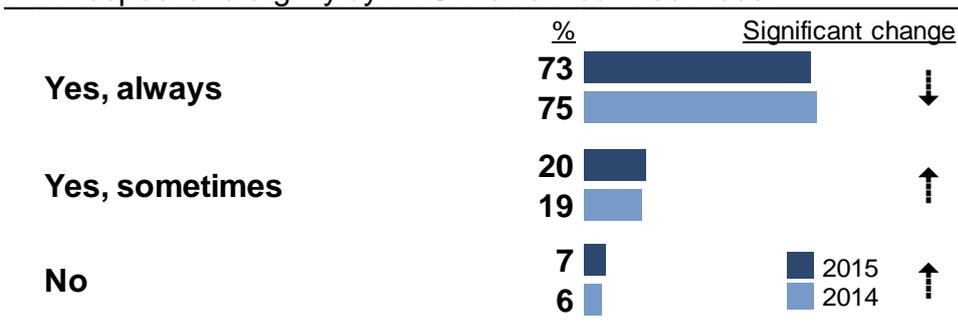


Answered by all

Number of respondents: 2014 – 12,679 & 2015 - 12,146

People's right to be treated with respect and dignity is set out in the NHS Constitution. This is also reflected in the NICE quality standard for service user experience in adult mental health, which states that people using mental health services, and their families or carers, should feel they are treated with empathy, dignity and respect. Almost three-quarters (73%) of respondents said that overall, in the last 12 months they 'always' felt that they were treated with respect and dignity by NHS mental health services, compared with 75% in 2014.

Q42: Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?



Answered by all

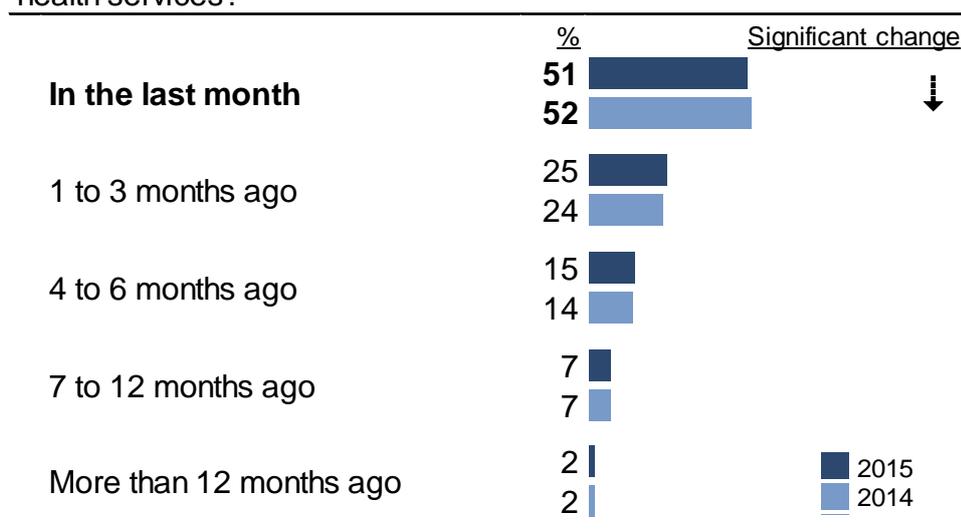
Number of respondents: 2014 – 13,145 & 2015 - 12,667

Reference tables and charts

This section includes tables and graphs presenting the survey results for all questions.

Care and treatment

Q1: When was the last time you saw someone from NHS mental health services?

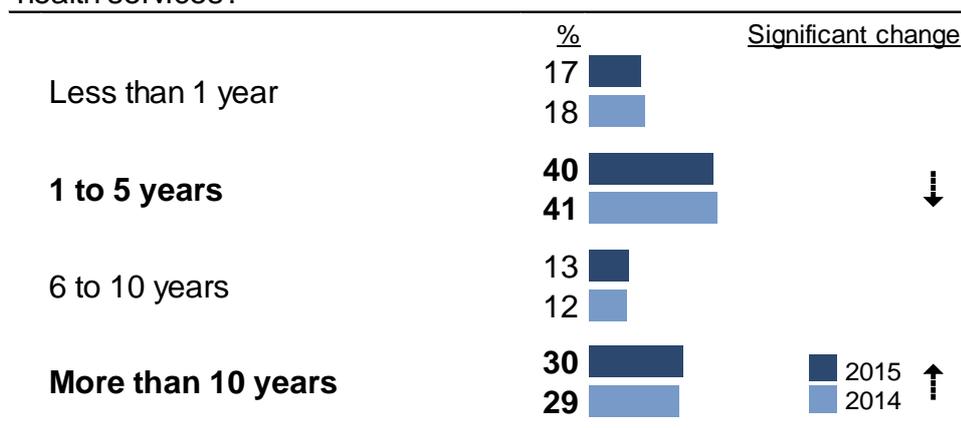


Answered by all

Number of respondents: 2014 – 13,348 & 2015 - 12,836

Note: respondents who stated that they did not know/ could not remember or who have never seen NHS mental health services have been excluded

Q2: Overall, how long have you been in contact with NHS mental health services?

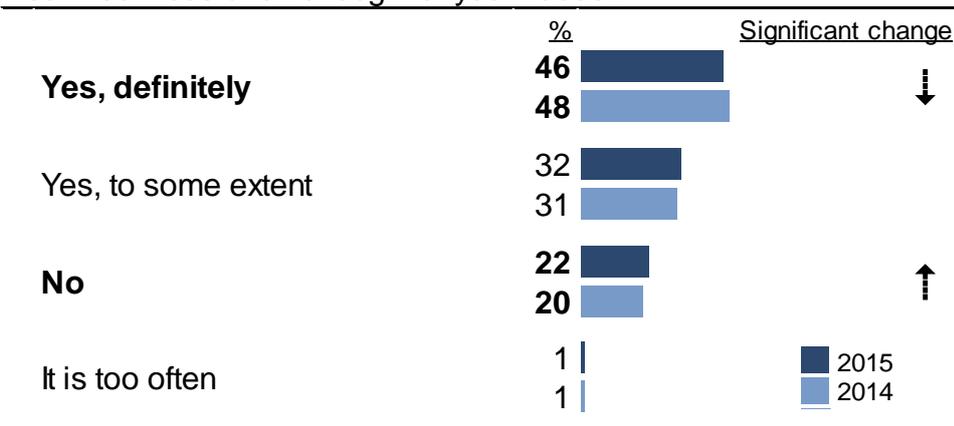


Answered by all

Number of respondents: 2014 – 12,839 & 2015 - 12,366

Note: respondents who stated that they did not know/ could not remember or who are no longer in contact with NHS mental health services have been excluded

Q3: In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?



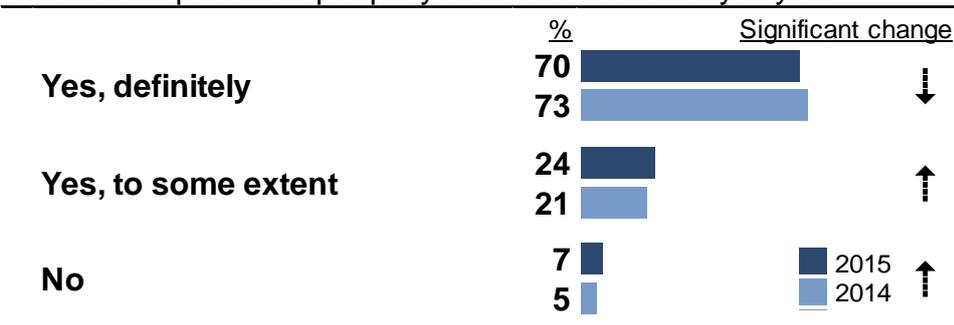
Answered by all

Number of respondents: 2014 – 13,055 & 2015 - 12,585

Note: respondents who stated that they did not know have been excluded

Health and social care workers

Q4: Did the person or people you saw listen carefully to you?

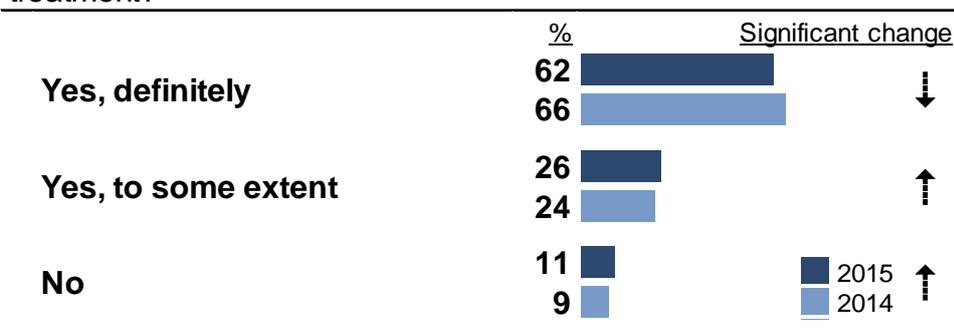


Answered by all

Number of respondents: 2014 – 13,159 & 2015 - 12,655

Note: respondents who stated that they did not know/ could not remember have been excluded

Q5: Were you given enough time to discuss your needs and treatment?

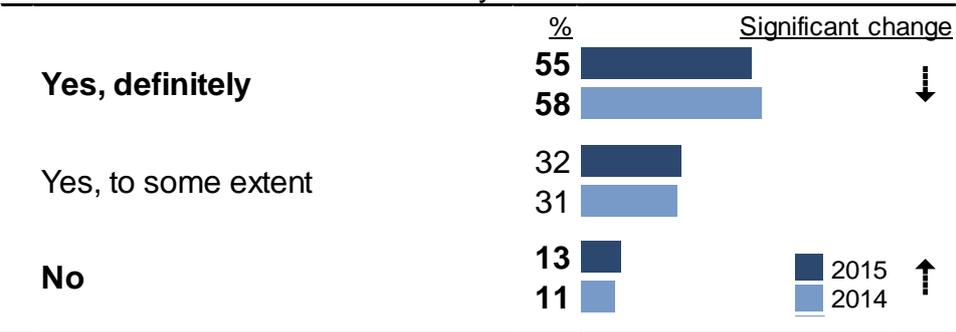


Answered by all

Number of respondents: 2014 – 13,071 & 2015 - 12,409

Note: respondents who stated that they did not know/ could not remember have been excluded

Q6: Did the person or people you saw understand how your mental health needs affect other areas of your life?



Answered by all

Number of respondents: 2014 – 12,770 & 2015 - 12,258

Note: respondents who stated that they did not know/ could not remember have been excluded

Organising care

Q7: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”.)

	2014	2015
Yes	77%	76%
No	23%	24%
Number of respondents	11,335	10,879

Answered by all

Notes:

respondents who stated that they were not sure have been excluded
no significant changes between 2015 and 2014

Q8: Is the person in charge of organising your care and services...



Answered by all who were told who was in charge of their care and services

Number of respondents: 2014 – 8,434 & 2015 - 8,006

Notes:

respondents who stated that they did not know have been excluded

as some respondents ticked more than one option, results may add up to over 100%

Q9: Do you know how to contact this person if you have a concern about your care?

	2014	2015
Yes	97%	96%
No	3%	4%
Number of respondents	7,497	6,936

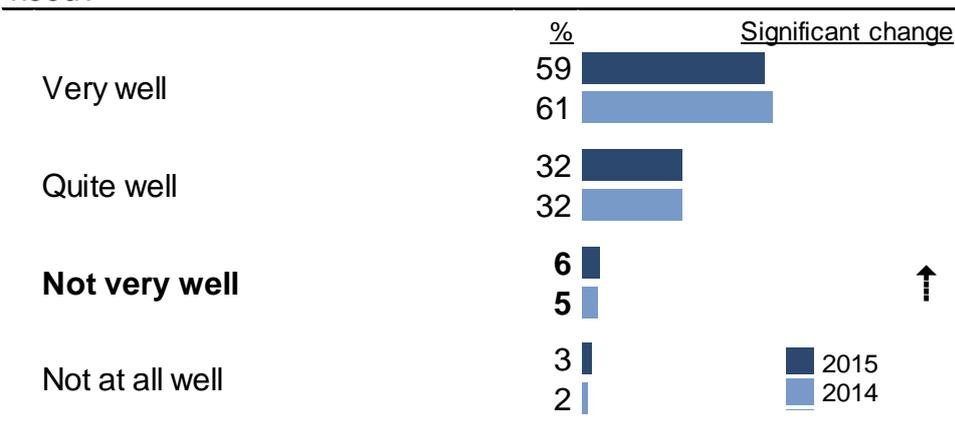
Answered by all who were told who was in charge of their care and services

Notes:

respondents who stated that they were not sure, or who stated that their GP was in charge of organising their care and services have been excluded

no significant changes between 2015 and 2014

Q10: How well does this person organise the care and services you need?



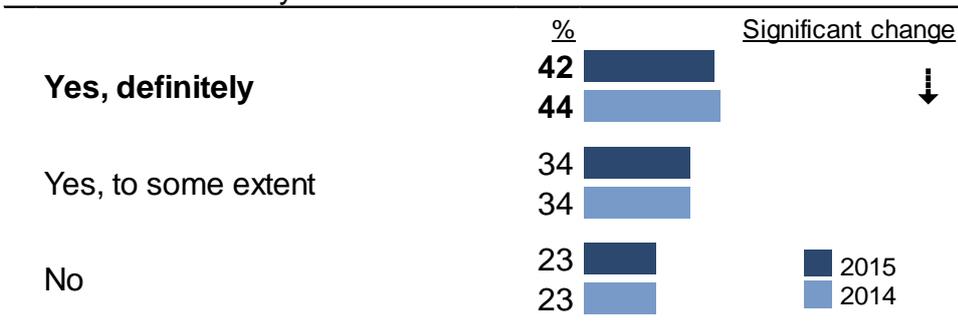
Answered by all who were told who was in charge of their care and services

Number of respondents: 2014 – 7,650 & 2015 - 7,074

Note: respondents whose GP is in charge of their care and services have been excluded

Planning care

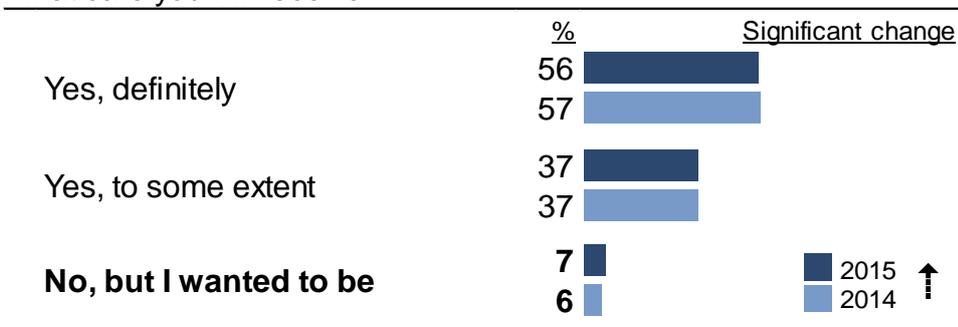
Q11: Have you agreed with someone from NHS mental health services what care you will receive?



Answered by all

Number of respondents: 2014 – 13,198 & 2015 - 12,695

Q12: Were you involved as much as you wanted to be in agreeing what care you will receive?

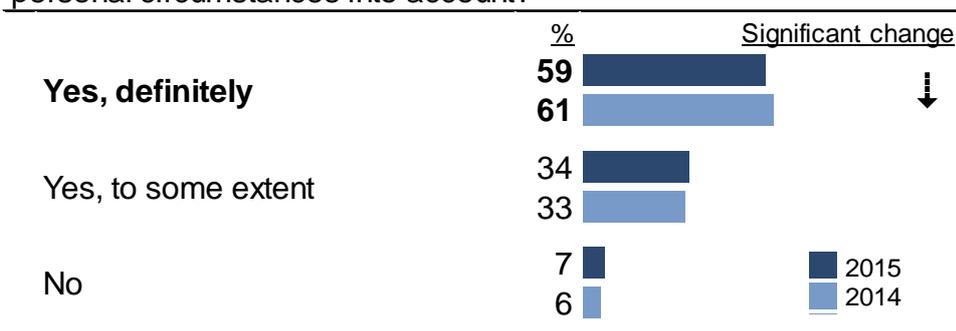


Answered by all who had agreed with NHS mental health services what care they would receive

Number of respondents: 2014 – 9,793 & 2015 - 9,379

Note: respondents who stated that they did not know / could not remember and those who did not want to be involved have been excluded

Q13: Does this agreement on what care you will receive take your personal circumstances into account?



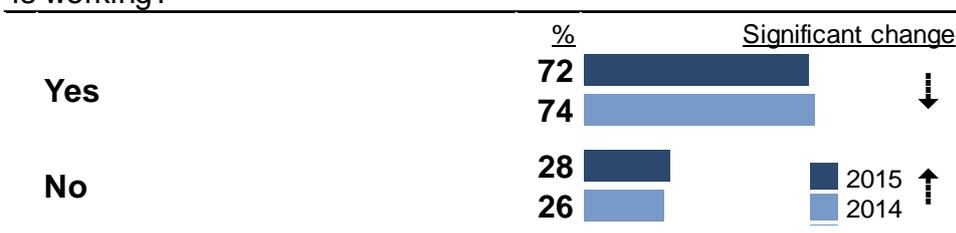
Answered by all who had agreed with NHS mental health services what care they would receive

Number of respondents: 2014 – 9,699 & 2015 - 9,227

Note: respondents who stated that they did not know / could not remember have been excluded

Reviewing care

Q14: In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?



Answered by all

Number of respondents: 2014 – 10,267 & 2015 - 10,058

Note: respondents who stated that they did not know / could not remember or who have been in contact with NHS mental health services for less than a year have been excluded

Q15: Were you involved as much as you wanted to be in discussing how your care is working?

	2014	2015
Yes, definitely	60%	61%
Yes, to some extent	33%	32%
No, but I wanted to be	7%	7%
Number of respondents	8,767	8,266

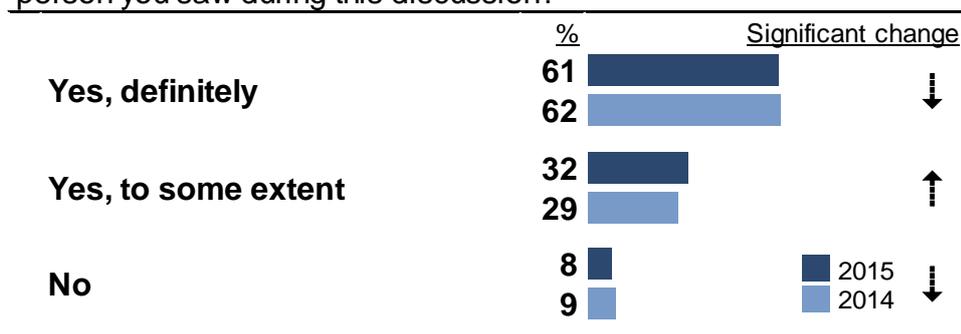
Answered by all who had a formal meeting to discuss their care with NHS mental health services in the previous 12 months

Notes:

respondents who stated that they did not know / could not remember and those who did not want to be involved have been excluded

no significant changes between 2015 and 2014

Q16: Did you feel that decisions were made together by you and the person you saw during this discussion?



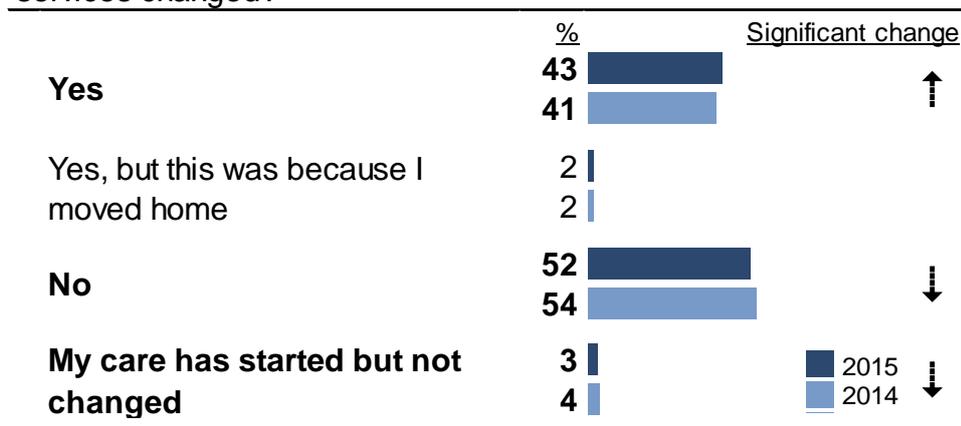
Answered by all who had a formal meeting to discuss their care with NHS mental health services in the previous 12 months

Number of respondents: 2014 – 8,823 & 2015 - 8,242

Note: respondents who stated that they did not know / could not remember or did not want to be involved in making decisions have been excluded

Changes in who you see

Q17: In the last 12 months, have the people you see for your care or services changed?

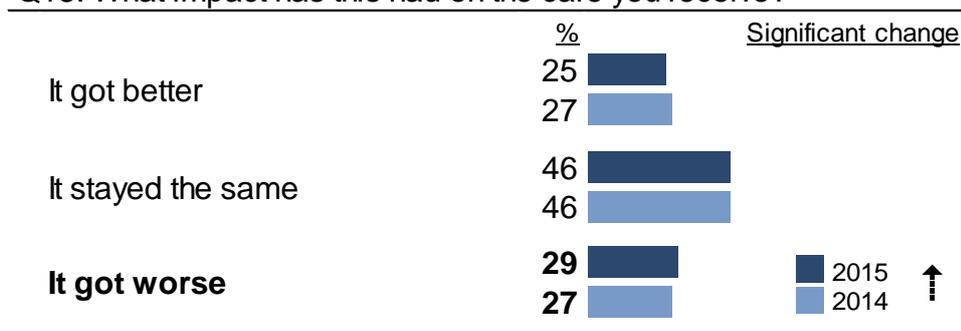


Answered by all

Number of respondents: 2014 – 12,031 & 2015 - 11,579

Note: respondents who stated that they did not know / not sure have been excluded

Q18: What impact has this had on the care you receive?



Answered by all for whom the person they see had changed in the previous 12 months

Number of respondents: 2014 – 4,413 & 2015 - 4,381

Note: respondents who stated that they were not sure have been excluded

Q19: Did you know who was in charge of organising your care while this change was taking place?

	2014	2015
Yes	55%	55%
No	45%	45%
Number of respondents	4,223	4,273

Answered by all for whom the person they see had changed in the previous 12 months

Notes:

respondents who stated that they were not sure have been excluded
no significant changes between 2015 and 2014

Crisis care

Q20: Do you know who to contact out of office hours if you have a crisis?

	2014	2015
Yes	68%	68%
No	32%	32%
Number of respondents	11,860	11,461

Answered by all

Notes:

respondents who stated that they were not sure have been excluded
no significant changes between 2015 and 2014

Q21: In the last 12 months, have you tried to contact this person or team because your condition was getting worse?

	2014	2015
Yes	39%	39%
No	61%	61%
Number of respondents	7,814	7,582

Answered by all who knew who to contact out of hours in a crisis

Notes:

respondents who stated that they could not remember have been excluded
no significant changes between 2015 and 2014

Q22: When you tried to contact them, did you get the help you needed?

	2014	2015
Yes, definitely	46%	44%
Yes, to some extent	32%	32%
No	20%	22%
I could not contact them	2%	3%
Number of respondents	3,008	2,960

Answered by all who had tried in the previous 12 months to make contact with this person/team

Note: no significant changes between 2015 and 2014

Treatments

Q23: In the last 12 months, have you been receiving any medicines for your mental health needs?

	2014	2015
Yes	84%	84%
No	16%	16%
Number of respondents	13,284	12,764

Answered by all

Note: no significant changes between 2015 and 2014

Q24: Were you involved as much as you wanted to be in decisions about which medicines you receive?

	%	Significant change
Yes, definitely	50	↓
	53	
Yes, to some extent	38	↑
	36	
No, but I wanted to be	12	
	12	

Answered by all who received medicines in the previous 12 months

Number of respondents: 2014 – 10,064 & 2015 - 9,775

Note: respondents who stated that they did not know/ could not remember or who did not want to be involved have been excluded

Q25: In the last 12 months, have you been prescribed any new medicines for your mental health needs?

	2014	2015
Yes	46%	46%
No	54%	54%
Number of respondents	11,135	10,731

Answered by all who received medicines in the previous 12 months

Note: no significant changes between 2015 and 2014

Q26: The last time you had a new medicine prescribed for your mental health needs, were you given information about it in a way that you were able to understand?

	2014	2015
Yes, definitely	53%	52%
Yes, to some extent	32%	33%
No	12%	11%
I was not given any information	3%	3%
Number of respondents	5,202	5,025

Answered by all who were prescribed new medicines in the previous 12 months

Note: no significant changes between 2015 and 2014

Q27: Have you been receiving any medicines for your mental health need for 12 months or longer?

	2014	2015
Yes	87%	87%
No	13%	13%
Number of respondents	10,931	10,562

Answered by all who received medicines in the previous 12 months

Notes:

respondents who stated they were not sure have been excluded
no significant changes between 2015 and 2014

Q28: In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicine? (That is, have your medicines been reviewed?)

	2014	2015
Yes	78%	78%
No	22%	22%
Number of respondents	9,078	8,711

Answered by all who had been receiving medicines for 12 months or longer

Notes:

respondents who stated that they did not know / could not remember have been excluded
no significant changes between 2015 and 2014

Q29: In the last 12 months, have you received any treatments or therapies for your mental health needs that do not involve medicines?

	2014	2015
Yes	47%	47%
No, but I would have liked this	26%	25%
No, but I did not mind	28%	28%
Number of respondents	10,376	9,884

Answered by all

Notes:

respondents who stated that they did not know/ could not remember or for whom it was not appropriate have been excluded
no significant changes between 2015 and 2014

Q30: Were you involved as much as you wanted to be in deciding what treatments or therapies to use?

	2014	2015
Yes, definitely	55%	55%
Yes, to some extent	36%	36%
No, but I wanted to be	9%	9%
Number of respondents	4,737	4,449

Answered by all who received in the previous 12 months treatments or therapies that did not involve medicines

Notes:

respondents who stated that they did not know/ could not remember or who did not want to be involved have been excluded

no significant changes between 2015 and 2014

Other areas of life

Q31: In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc.)?

	2014	2015
Yes, definitely	36%	34%
Yes, to some extent	30%	30%
No, but I would have liked help or advice with finding support	35%	35%
Number of respondents	6,503	6,693

Answered by all

Notes:

respondents who stated that they already have support and did not need advice, or who did not need support for this, or who did not have physical health needs have been excluded

no significant changes between 2015 and 2014

Q32: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

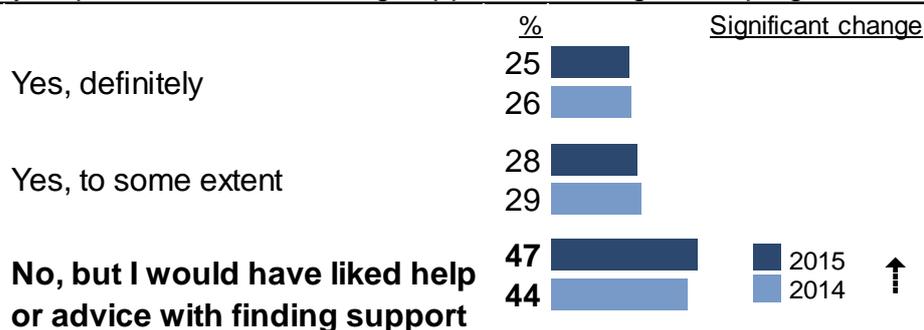
	2014	2015
Yes, definitely	32%	32%
Yes, to some extent	25%	25%
No, but I would have liked help or advice with finding support	43%	43%
Number of respondents	7,230	7,006

Answered by all

Notes: respondents who stated that they already have support and did not need advice, or who did not need support for this have been excluded

no significant changes between 2015 and 2014

Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?



Answered by all

Number of respondents: 2014 – 3,329 & 2015 - 3,326

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this, or who are currently not in/ seeking work have been excluded

Q34: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?

	2014	2015
Yes, definitely	32%	33%
Yes, to some extent	25%	24%
No, but I would have liked help or advice with finding support	42%	43%
Number of respondents	3,101	2,959

Answered by all

Notes:

respondents who stated that they already have support and did not need advice, or who did not need support for this have been excluded

no significant changes between 2015 and 2014

Q35: Has someone from NHS mental health services supported you in taking part in an activity locally?

	2014	2015
Yes, definitely	30%	28%
Yes, to some extent	29%	30%
No, but I would have liked this	41%	42%
Number of respondents	6,221	6,153

Answered by all

Notes:

respondents who stated that they did not want or need this have been excluded

no significant changes between 2015 and 2014

Q36: Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

	2014	2015
Yes, definitely	55%	55%
Yes, to some extent	25%	25%
No, not as much as I would like	17%	17%
No, they have involved them too much	3%	3%
Number of respondents	8,849	8,398

Answered by all

Notes:

respondents who stated that family/ friends did not want to be involved, who did not want their family/ friends involved or felt it did not apply to them have been excluded
no significant changes between 2015 and 2014

Q37: Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?

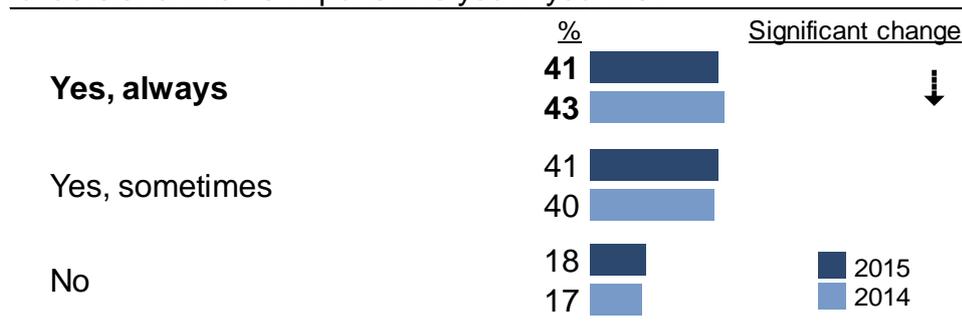
	2014	2015
Yes, definitely	23%	24%
Yes, to some extent	27%	28%
No, but I would have liked this	50%	48%
Number of respondents	7,699	7,461

Answered by all

Notes:

respondents who stated that they did not want this have been excluded
no significant changes between 2015 and 2014

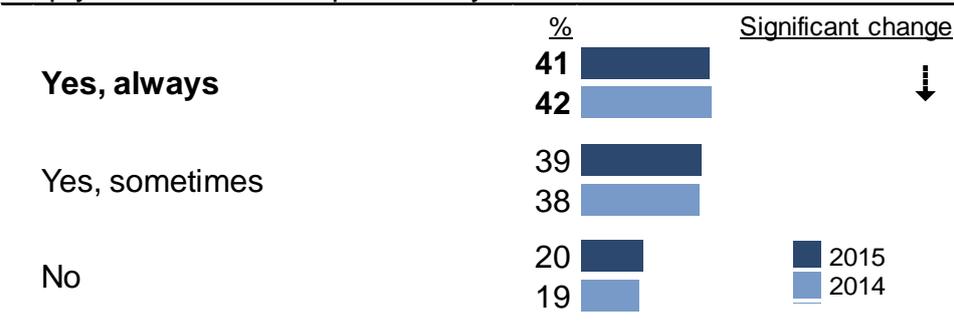
Q38: Do the people you see through NHS mental health services understand what is important to you in your life?



Answered by all

Number of respondents: 2014 – 12,856 & 2015 - 12,302

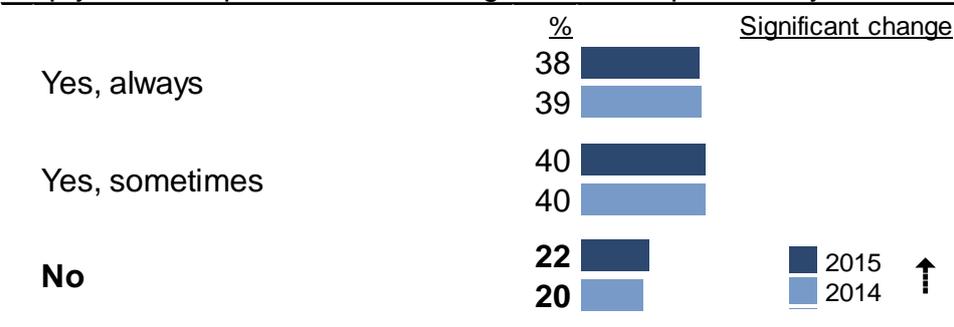
Q39: Do the people you see through NHS mental health services help you with what is important to you?



Answered by all

Number of respondents: 2014 – 12,775 & 2015 - 12,270

Q40: Do the people you see through NHS mental health services help you feel hopeful about the things that are important to you?

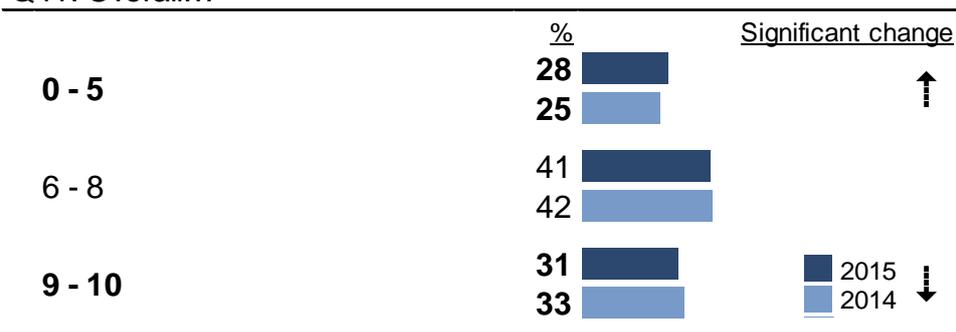


Answered by all

Number of respondents: 2014 – 12,642 & 2015 - 12,205

Overall

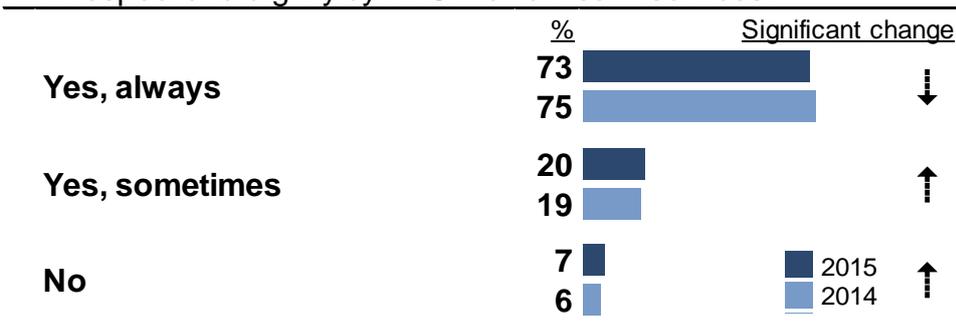
Q41: Overall...



Answered by all

Number of respondents: 2014 – 12,679 & 2015 - 12,146

Q42: Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?



Answered by all

Number of respondents: 2014 – 13,145 & 2015 - 12,667

About the respondents

Q43: Who was the main person or people that filled in this questionnaire?

	2014	2015	<u>Significant Change</u>
The person named on the front of the envelope	65%	66%	
A friend or relative of the service user / client	20%	20%	
Both service user/client and friend / relative together	11%	11%	
The service user/client with the help of a health professional	3%	3%	
Number of respondents	13,217	12,651	

Answered by all

Note: no significant changes between 2015 and 2014

Q44 Are you male or female?

	2014	2015	<u>Significant Change</u>
Male	44%	43%	
Female	56%	57%	
Number of respondents	13,787	13,292	

Answered by all. Data taken from sample data³⁹ if response data is missing.

Note: no significant changes between 2015 and 2014

³⁹ Trust sample files contain all people selected to take part in the survey and includes information such as age, gender and ethnicity.

Q45 What was your year of birth?

	2014	2015	<u>Significant Change</u>
18-35 year olds	14%	14%	
36-50 year olds	23%	22%	
51-65 year olds	25%	26%	
66+ year olds	38%	38%	
Number of respondents	13,787	13,292	

Answered by all. Data taken from sample data if response data is missing. Age calculated from year of birth

Note: no significant changes between 2015 and 2014

Q46 What is your religion?

	2014	2015	<u>Significant Change</u>
No religion	21%	21%	
Buddhist	1%	1%	
Christian	68%	66%	
Hindu	1%	1%	
Jewish	1%	1%	
Muslim	3%	3%	
Sikh	1%	1%	
Other	2%	3%	↑
I would prefer not to say	3%	4%	
Number of respondents	13,315	12,728	

Answered by all

Q47: Which of the following best describes how you think of yourself?

	2014	2015	<u>Significant Change</u>
Heterosexual / Straight	90%	89%	↓
Gay / Lesbian	2%	2%	↑
Bisexual	2%	2%	
Other	1%	1%	
I would prefer not to say	5%	6%	↑
Number of respondents	13,016	12,399	

Answered by all

Q48: Which of the following best describes how you think of yourself?

	2014	2015	<u>Significant Change</u>
White	91%	90%	
Mixed	2%	2%	
Asian or Asian British	4%	4%	
Black or Black British	3%	3%	
Arab or other ethnic group	0%	1%	
Number of respondents	13,244	12,745	

Answered by all

Note: no significant changes between 2015 and 2014

Results by CPA status

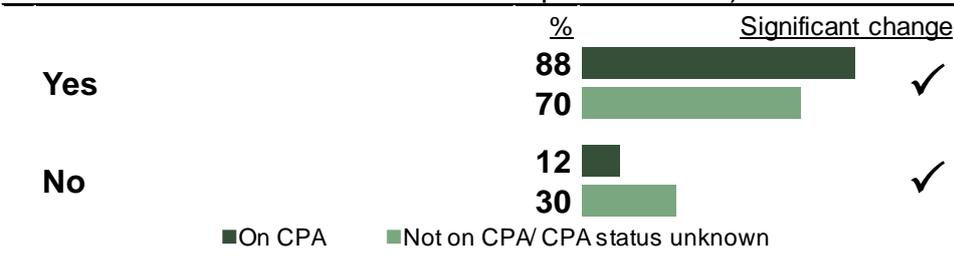
The survey asked a series of questions where we would expect there to be differences in responses based on whether the respondent receives services under the Care Programme Approach (CPA) or not. This is partly due to the different service requirements for people on CPA who need greater support, and as a result, may have different patterns of care.

The below graphs show the results for questions by CPA status. The questions selected for this analysis are where different needs and requirements have been set out in the policy document *Refocusing the Care Programme Approach*.

We carried out statistical tests (using a 'z-test') on the data to determine whether there were any 'statistically significant differences' between the two groups. A 'z-test' is a type of statistical significance test which determines whether the difference between two proportions is statistically significant. 'Statistically significant' means that we can be very confident that the difference between the results reflects a real difference in the population and is not due to chance.

Nationally, 32% of the people who responded to the 2015 survey had their care co-ordinated under CPA.

Q7: Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”.)

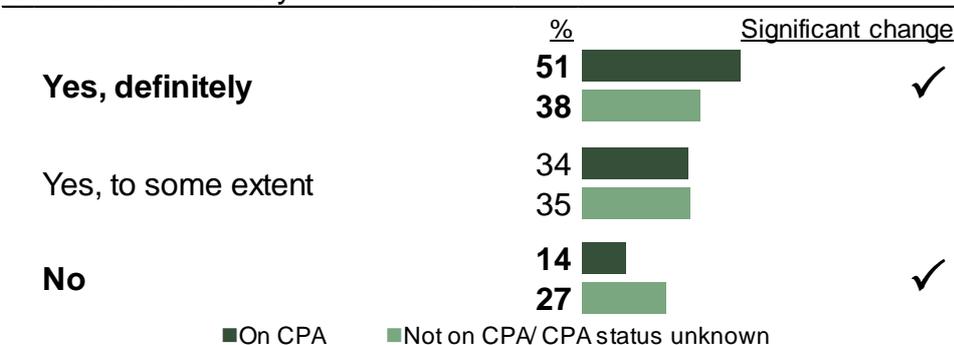


Answered by all

Number of respondents: On CPA – 3,729 & Not on CPA/ CPA status unknown - 7,150

Note: respondents who stated that they were not sure have been excluded

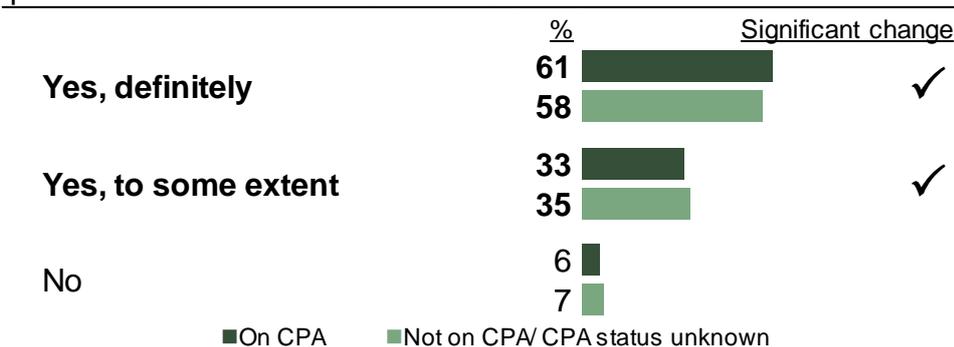
Q11: Have you agreed with someone from NHS mental health services what care you will receive?



Answered by all

Number of respondents: On CPA – 4,110 & Not on CPA/ CPA status unknown - 8,585

Q13: Does this agreement on what care you will receive take your personal circumstances into account?

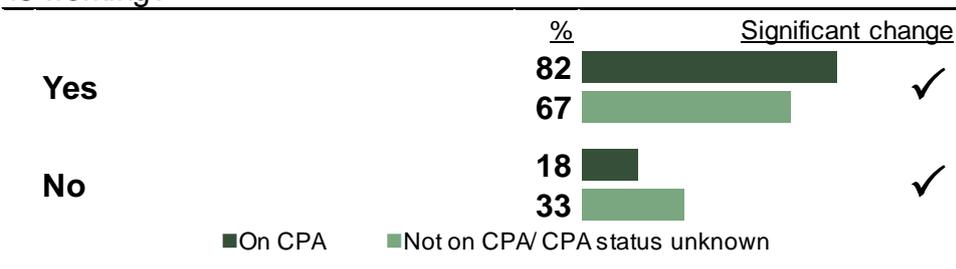


Answered by all who had agreed with NHS mental health services what care they would receive

Number of respondents: On CPA – 3,376 & Not on CPA/ CPA status unknown - 5,851

Note: respondents who stated that they did not know / could not remember have been excluded

Q14: In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?

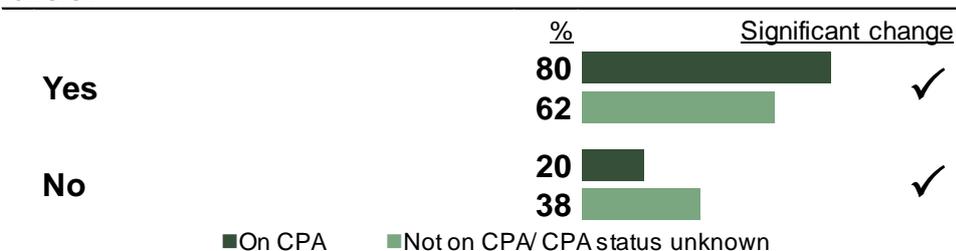


Answered by all

Number of respondents: On CPA – 3,548 & Not on CPA/ CPA status unknown - 6,510

Note: respondents who stated that they did not know / could not remember or who have been in contact with NHS mental health services for less than a year have been excluded

Q20: Do you know who to contact out of office hours if you have a crisis?

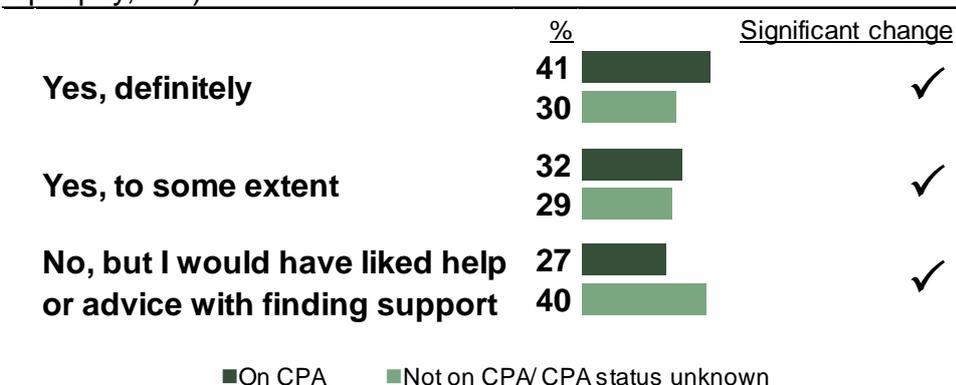


Answered by all

Number of respondents: On CPA – 3,816 & Not on CPA/ CPA status unknown - 7,645

Note: respondents who stated that they were not sure have been excluded

Q31: In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc.)?

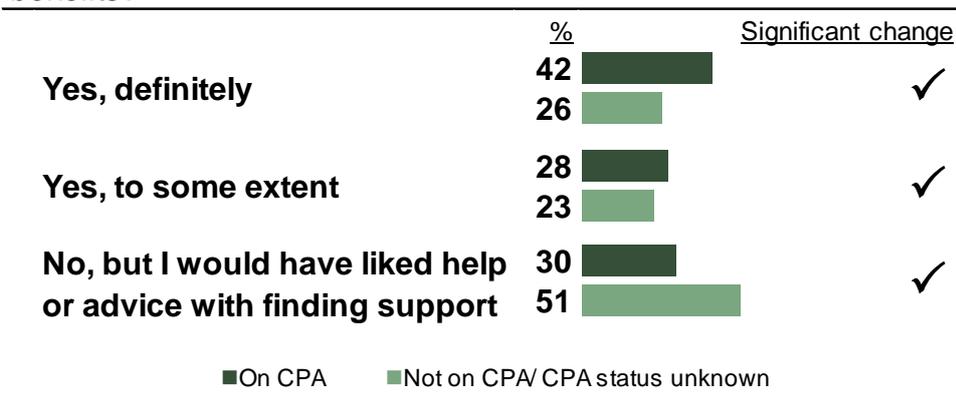


Answered by all

Number of respondents: On CPA – 2,437 & Not on CPA/ CPA status unknown - 4,256

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this, or who did not have physical health needs have been excluded

Q32: In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

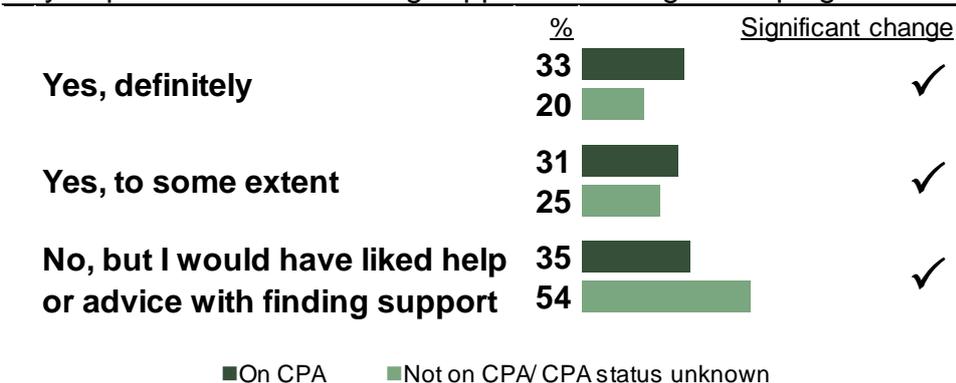


Answered by all

Number of respondents: On CPA – 2,526 & Not on CPA/ CPA status unknown - 4,480

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this have been excluded

Q33: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?

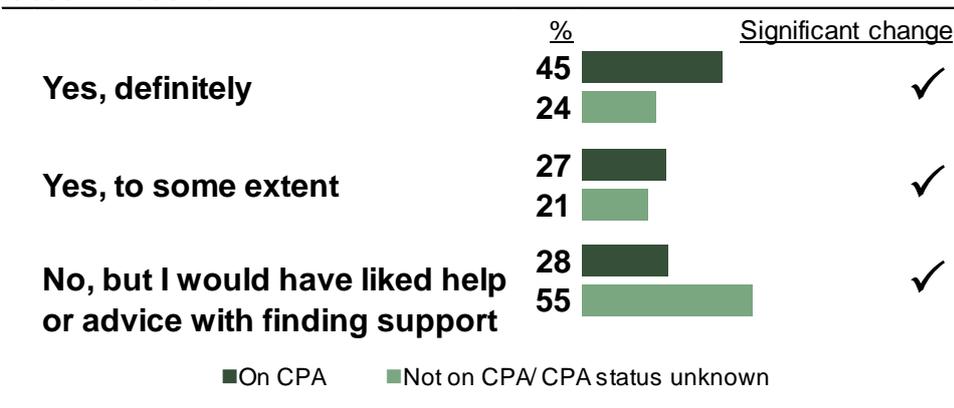


Answered by all

Number of respondents: On CPA – 1,285 & Not on CPA/ CPA status unknown - 2,041

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this, or who are currently not in/ seeking work have been excluded

Q34: In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?

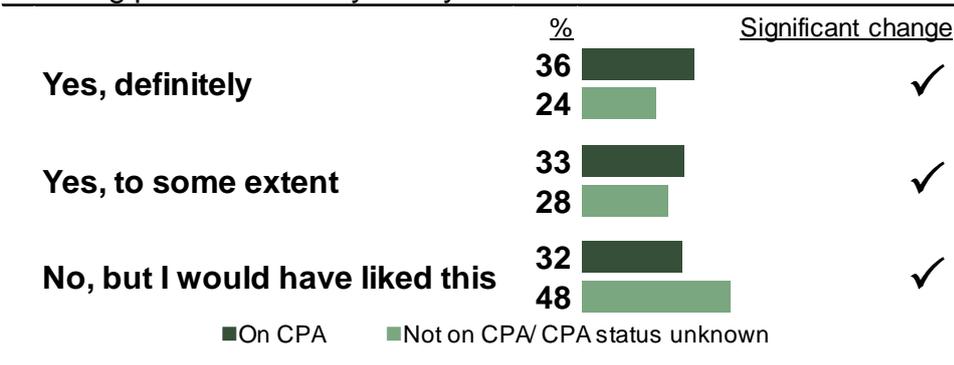


Answered by all

Number of respondents: On CPA – 1,295 & Not on CPA/ CPA status unknown - 1,664

Note: respondents who stated that they already have support and did not need advice, or who did not need support for this have been excluded

Q35: Has someone from NHS mental health services supported you in taking part in an activity locally?

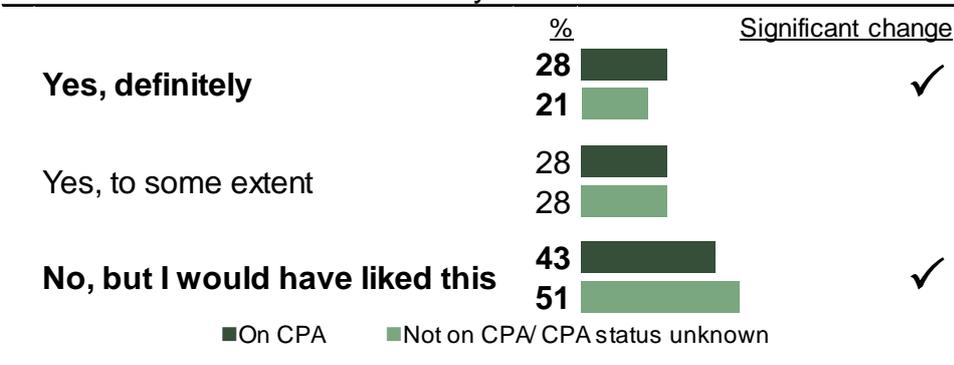


Answered by all

Number of respondents: On CPA – 2,305 & Not on CPA/ CPA status unknown - 3,848

Note: respondents who stated that they did not want or need this have been excluded

Q37: Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?



Answered by all

Number of respondents: On CPA – 2,500 & Not on CPA/ CPA status unknown - 4,961

Note: respondents who stated that they did not want this have been excluded

Appendix A: Other sources of information related to the key findings

This appendix lists the documents that have been referred to throughout this report.

Achieving better access to mental health services by 2020

Achieving better access to mental health services by 2020 pledges to introduce access and waiting times standards for mental health services, and to allocate more money for service provision.

For more information see the following link:

www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020

Closing the Gap

Closing the Gap identifies 25 areas where immediate change and improvement is required from providers. These 25 areas are grouped under four key themes: increasing access to mental health services, integrating physical and mental health care, early promotion of mental health wellbeing to prevent mental health problems, and improving the quality of life for people with mental health problems.

For more information see the following link:

www.gov.uk/government/publications/mental-health-priorities-for-change

Making recovery a reality

The government's mental health strategy, as set out in *No Health Without Mental Health*, is framed around the 'recovery approach' to mental health care. This approach moves away from a medicalised treatment model around maintenance and the relief of symptoms, towards a more individualised approach which focuses on each person's goals and priorities.

For more information see the following link:

www.centreformentalhealth.org.uk/making-recovery-a-reality

No Health Without Mental Health

In 2011 the government published its mental health strategy *No Health Without Mental Health*⁴⁰. It is a wide-ranging document that sets out the government's intentions to promote mental health and wellbeing in the general population, and how different organisations (such as schools, employers etc.) need to work together to achieve this. One of the strategy's two overall aims is to improve outcomes for people with mental health problems through high quality services that are equally accessible to all. It sets out six key objectives for improved mental health in England, which includes commitments that 'more people with mental health problems will recover', 'more people with mental health problems will have good physical health' and 'more people will have a positive experience of care and support'. Also recognised is that people using services must be involved in planning and decision making about their care. These are key areas which the survey can help to measure.

This document sets out the government's mental health strategy. For more information see the following link:

www.gov.uk/government/publications/the-mental-health-strategy-for-england

No Health Without Mental Health: implementation framework

The implementation framework was established in partnership with various mental health charities and sets out how the government mental health strategy (as set out in *No Health Without Mental Health*) will be implemented. For more information see the following link:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/137645/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

NICE Commissioning stepped care for people with common mental health disorders

This guidance helps commissioners and staff in mental health settings to commission and provide high quality and evidence-based care to people using mental health services. The guidance highlights the importance of a partnership approach. For more information see the following link:

www.nice.org.uk/guidance/cm41

NICE Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence

This guidance is about enabling people to make informed choices by involving and supporting them in decisions about prescribed medicines. For more information see the following link:

<https://www.nice.org.uk/guidance/cg76>

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

NICE quality standard for service user experience in adult mental health

NICE quality standards are statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They make evidence-based recommendations on a range of topics which should be used by staff as appropriate, with the aim to promote individualised and integrated care.

The quality standard *on Improving Service User Experience in Adult Mental Health* published by NICE outlines the level of service that people using the NHS mental health services should expect to receive, and aims to provide the NHS with clear commissioning guidance on the components of a good patient experience. The standard contains 15 statements setting out what high quality care looks like. Mental health care and treatment provided in England should be based on this standard. Many issues covered in these statements are reflected in the questionnaire.

For further information on the NICE quality standard see the following link:
www.nice.org.uk/guidance/qs14/resources/guidance-service-user-experience-in-adult-mental-health-pdf

Refocussing the care programme approach: policy and positive practice guidance

Following a consultation, this document sets out updated policy on implementing the care programme approach. For more information see the following link:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

The Crisis Care Concordat

The *Crisis Care Concordat*⁴¹ is a national agreement that sets out how people who experience a mental health crisis can get the help that they need. The concordat focusses on four main areas, two of which (first and third bullet points below), while not a direct measure due to different wording in the survey questions, are asked about in the survey:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.

⁴¹ www.crisiscareconcordat.org.uk/about/

- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

This is a national agreement that sets out how people who experience a mental health crisis can get the help that they need. For more information see the following link:

www.crisiscareconcordat.org.uk/

The NHS Constitution

This document sets out the rights to which patients, public and staff are entitled. For more information see the following link:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/448466/NHS_Constitution_WEB.pdf

Appendix B: Comparisons to other data

This is the only survey of community mental health services currently conducted in the UK. Therefore, findings cannot be compared with data from Scotland, Wales or Northern Ireland.

Very few surveys are carried out related to this topic, and where they are undertaken, these tend to be to establish prevalence of mental health issues rather than focused on care received.

There are, however, other surveys carried out in the UK out by various organisations. While results are not directly comparable due to different methodologies, these other surveys may be of interest as they provide further information on mental health:

Mental Health and Learning Disabilities data set (MHLDS)

The Mental Health and Learning Disabilities Data Set (MHLDS) contains record-level data about the care of people using secondary mental health services, including people with learning disabilities. It includes data on topics asked about in the survey including:

- data for people on CPA who had a 12 month review
- data for people with a crisis plan in place
- data on the demographics of people who use services.

Please note that this data set is **not directly comparable** with survey results because:

- It is a different type of data: the survey data is about people's experiences of services whereas the MHLDS data set contains factual data submitted from trusts records.
- The survey covers only community mental health services whereas MHLDS also cover mental health inpatient services.
- The sample for the survey has certain exclusions, for example, we exclude people with learning disabilities. For full details of the survey inclusion and exclusion criteria, please see the instruction manual available at: www.nhssurveys.org/surveys/824

For more information on MHLDS please see:

www.hscic.gov.uk/mhldsreports

www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/mental_health_and_learning_disabilities_data_set_fr.asp?shownav=1

National Audit of Schizophrenia

The National Audit of Schizophrenia (NAS) is an initiative of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). The aim of the National Audit of Schizophrenia is to find out about the quality of care and support people with schizophrenia and their carers are getting from NHS community mental health services.

The second round of the audit was published in 2014. The audit obtained a final database of 5,608 records (an 88% response rate). Each trust was asked to submit data on a random sample of 100 adults under their care, with diagnoses of either schizophrenia or schizoaffective disorder, who had been under the care of mental health teams in the community for at least 12 months. Trusts also distributed a survey to service users who, in turn, distributed a carer survey form to the individual they considered to be their closest carer.

Although there are some questions that are similar across the two methods of data collection, results are not directly comparable with the Community Mental Health Survey because the National Audit for Schizophrenia focuses only on people who have schizophrenia, whereas the survey includes a much wider range of conditions. The audit also uses a different questionnaire and sampling strategy. The comparisons listed below are for descriptive purposes only, and have not been tested for statistically significant differences due to the limitations in comparability:

- The audit asked about overall experience of care, and 88% of all service users said they were 'very' or 'fairly' satisfied with their care and 4% were reportedly 'not satisfied at all'. The 2015 survey uses a different format of question, and found that 64% of people rated their care as 7 or above, out of 10 (Q41).
- In terms of help with looking for work, the audit results show that of those who were interested in looking for work, just over half reported that they did not receive any help towards this (52%). Forty-seven per cent of respondents to the 2015 survey reported a similar answer.

For more information please see:

www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit.aspx

Adult Psychiatric Morbidity Survey

The Adult Psychiatric Morbidity Survey (APMS) provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over.) The survey is carried out every seven years.

Results are not directly comparable with the Community Mental Health Survey because the Adult Psychiatric Morbidity Survey uses a different questionnaire, sampling strategy and methodology (interview survey). The surveys also have different purposes: the Adult Psychiatric Morbidity Survey aims to estimate prevalence of mental health disorders, whereas the Community Mental Health Survey aims to understand people's experiences of using services.

For more information please see:

www.hscic.gov.uk/article/3739/National-Study-of-Health-and-Wellbeing

Appendix C: Main uses of the survey data

This appendix lists known users of data from the Community Mental Health Survey and how they use the data.

The CQC is currently reviewing the use of all survey data to identify data users, and will focus on the use of survey data by patient and carer groups, to better understand how those groups use survey data and to identify whether any further measures can be taken to support their use.

NHS trusts and commissioners

Trusts, and those who commission services, use the results to identify and make the improvements they need to improve the experience of people who use their services.

Patients, their supporters and representative groups

The survey data is made available on the CQC website for each participating NHS trust, under the organisation search tool. The data is presented in an accessible format for the general public to examine how services are performing, alongside their inspection results. The search tool is available from the CQC home page:

<http://www.cqc.org.uk/>

Care Quality Commission (CQC)

The Care Quality Commission will use the results from the survey in the regulation, monitoring and inspection of mental health trusts in England. Survey data will be used in the Intelligent Monitoring system, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs produced for inspections. Results will also form a key source of evidence to support the judgements and ratings published for trusts. For more information see the following link:

www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services

NHS England

NHS England use questions from the NHS National Patient Survey Programme (specifically the Inpatient, Outpatient, Community Mental Health and A&E surveys) to produce a separate index measure called [the Overall Patient Experience Score](#). The score forms part of a regular statistical series that is updated alongside the publication of each respective survey. More information is available here:

<http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/>

The scores are calculated in the same way each year, so that the experience of NHS users can be compared over time. As part of the supporting documentation, NHS England also produce and publish a [diagnostic tool](#) to help NHS managers and the general public understand what feeds in to the overall scores and to see how scores vary across individual NHS provider organisations. The tool is available at:

<http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/>

Department of Health

The Government's strategy sets out a commitment to measure progress on improving people's experiences via Domain 4 of the NHS Outcomes Framework 'ensuring people have a positive experience of care' which includes results from the community mental health survey, among other data sources.

The Framework sets out the outcomes and corresponding indicators that the Department of Health uses to hold NHS England to account for improvements in health outcomes, as part of the government's Mandate to NHS England. The Outcomes Framework survey indicators are based on the standardised, scored trust level data from the survey (similar to that included in the CQC benchmark reports), rather than the England level percentage of respondents data that is contained within this report.

For more information see the following link:

www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016

NHS Trust Development Authority

The [NHS Trust Development Authority](#) will use the results to inform quality and governance activities as part of its Oversight Model for NHS Trusts. Their website is:

<http://www.ntda.nhs.uk/>

Appendix D: Data limitations and revisions

This appendix sets out data limitations and revisions. More detail on the issues outlined below is available in the 2015 Community mental health survey Quality and Methodology document, available at www.cqc.org.uk.

Data limitations

Context

Please be aware of the limitations to the data when reading this report.

As with any survey, statistics based on results from the community mental health survey are subject to different sources and types of error and this must be considered in the survey responses and / or survey design. While there are a number of potential sources of error, these are carefully controlled through rigorous development work behind the questionnaire design and sampling strategy, and extensive quality assurance at every stage.

These statistics relate to people who used community mental health services at a particular point in time and the results are an indication of the average or typical quality of experience for that population. Each participating NHS trust selected people who had been seen by community mental health services during September, October or November 2014.

The focus of this document is on England level results. A different technique is applied to analyse the trust data and standardised scores are provided at NHS trust level. A technical document is published setting out the methodology used for the trust scores (please see further information section, Appendix E).

Seasonal effects

In determining the sample period for the survey, seasonal effects were considered. The sampling period (1 September to 30 November) has remained the same since the community mental health survey was first implemented in 2004.

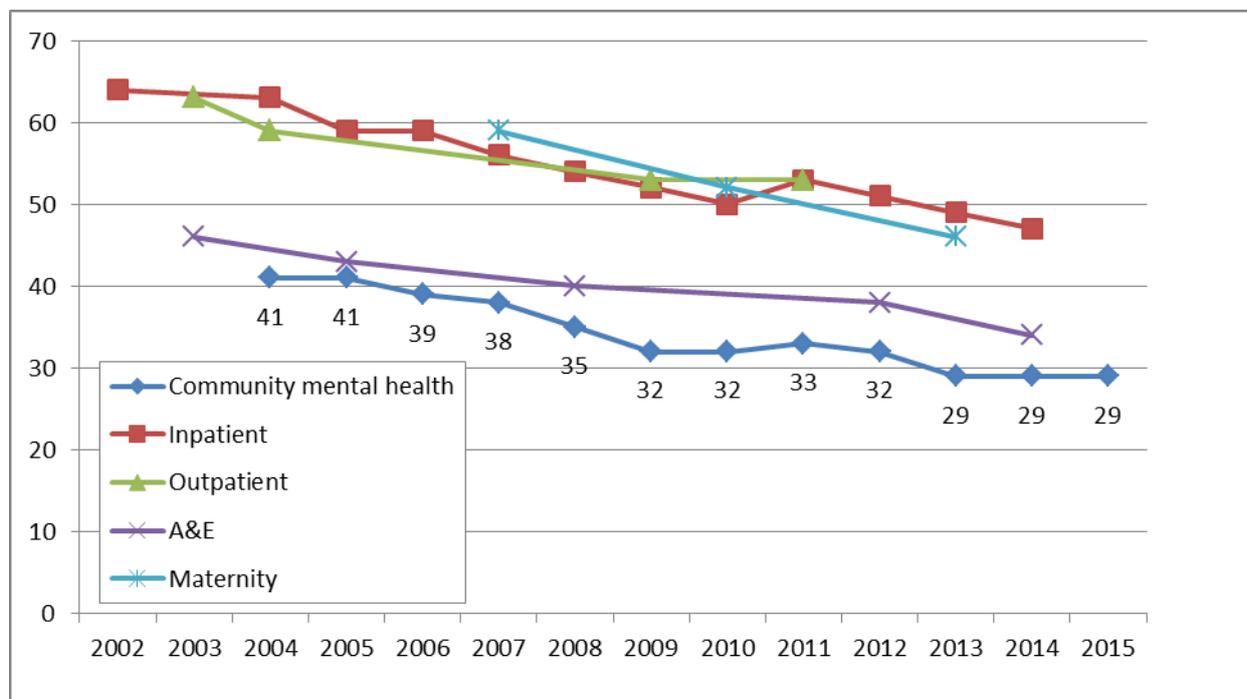
Due to the sampling approach, seasonal effects are unlikely to be an issue. The community mental health survey samples are drawn from people who have recently had contact with mental health services, during the specified sample period. Those individuals are likely to have maintained contact with services during a longer time period than the sample period itself, and hence are less likely to be affected by any variation in the time of year. In addition, respondents are directed within the questionnaire to think about events over the previous 12 months, which negates any effect that there may be in service provision across a given year.

Response rates

Response rates for the survey have dropped since it was first launched. This is consistent both with other surveys in the National Patient Survey Programme and industry wide trends in social and market research.

Figure D1 below illustrates response rate trends for the more established surveys in the National Patient Survey Programme. Please note that not all types of surveys have been carried out annually. There is a clear downwards trend across all surveys. The acute inpatient survey generally has the highest response rates and the community mental health and A&E surveys the lowest. The community mental health survey has, however, sustained a 29% response rate for the last three years. There are no appropriate surveys to compare the response rate with, due to differences in the sampled populations and the year of implementation of the surveys.

Figure D1: response rates for established surveys in the National Patient Survey Programme



We have previously made changes across the survey programme as a whole based on pilot work. For example, in 2007 the survey fieldwork was extended to 18 weeks to maximise responses from minority groups, since our pilot work⁴² had shown that these groups can take longer to respond.

To further improve the survey, CQC is currently reviewing the response rates for the community mental health survey, and we are currently reviewing which changes could be usefully piloted. We are therefore reviewing the budget and timetable of the ongoing community mental health survey work within the

⁴² www.nhssurveys.org/survey/513

programme to schedule in pilot work at the earliest opportunity, to enable successful methods to be implemented. More detail on those plans are available in the Quality and Methodology report (see Appendix E for the link).

Non-response bias

One of the main issues that affects the survey results is non-response bias.

As the response rates for surveys decline, the risk of non-response bias increases. Non-response bias is caused when sampled individuals are unwilling to take part in a survey causing the risk that those who chose to respond are different from those who chose not to respond. This type of bias might arise, for example, if people with more negative views of the service were more likely to respond.

However, whether we do have non-response bias is difficult to assess, as we do not have any way of knowing how those people who did not respond would have answered.

A further factor is that we do not always know the split between those who did not receive a questionnaire, and hence could not respond, versus those who chose not to respond. The number of questionnaires that were 'returned undelivered' was logged during the course of the survey. However, there may be another group of individuals who had changed address but not informed the trust, and therefore did not receive the questionnaire. When logging the outcome of sending a questionnaire, those individuals are placed in the group 'Outcome unknown', alongside others who have chosen not to return the questionnaire nor notify us of their decision not to. For that group, we cannot determine whether each individual received a questionnaire or not. Therefore an unknown proportion of the samples from trusts have chosen not to respond – and they may have a variety of reasons for doing so. More detail on this is provided in the Quality and Methodology report (see Appendix E for the link).

As NHS trusts hold the names and address details, we are limited in terms of assessing the data quality of the samples that were drawn, as patient confidentiality prevents us from accessing those details.

It is worth noting that these are known biases and there may be other types of bias influencing results which cannot be established due to their implicit nature.

Table D1 shows respondents and non-respondents. Table D2 shows the demographic profile for the sample as a whole (everyone selected for inclusion on the survey) and respondents. This shows that females are more likely to respond than males, respondents aged 51-65 are more likely to respond compared with other age groups and white respondents are more likely to respond compared with those from other ethnic groups. In interpreting these tables it should be borne in mind that it is very likely that there are also inter-relationships between these groups.

Please note that tables D1 and D2 are based on information from trust sample files⁴³ only so will differ from response rates published elsewhere which are a combination of responses to the demographics questions or sample file information if the response is missing. We cannot use respondent provided information to calculate response rates, as we do not have this for non-responders. The response rate is based on the adjusted response rate, which means we have removed anyone who died, or anyone for whom the questionnaire was undeliverable, from the base.

Table D1: respondents and non-respondents to the 2015 community mental health survey by key demographics

Demographics	Responded (%)	
	Yes	No
Gender		
Male	28.3	71.7
Female	30.4	69.6
Age		
18-35	19.4	80.6
36-50	27.7	72.3
51-65	37.4	62.6
66+	32.0	68.0
Ethnicity		
White British / Irish / Other	30.5	69.5
Mixed / Multiple	21.0	79.0
Indian / Pakistani / Bangladeshi / Other Asian	23.8	76.2
African / Caribbean / Other	23.3	76.7
Chinese or other	28.3	71.7

Table D2: sample and demographic profile for the 2015 community mental health survey

Demographics	Profile (%)	
	Sample	Respondent
Gender		
Male	44.4	42.5
Female	55.6	57.5
Age		
18-35	20.8	13.6
36-50	23.6	22.4
51-65	19.8	25.5
66+	35.8	38.5
Ethnicity		
White British / Irish / Other	86.8	89.3
Mixed / Multiple	1.4	1.0
Indian / Pakistani / Bangladeshi / Other Asian	5.2	4.2
African / Caribbean / Other	4.4	3.5
Chinese or other	2.2	2.1

⁴³ Trust sample files contain all people selected to take part in the survey and includes information such as age, gender and ethnicity

Non-response bias, along with other forms of measurement and coverage error, should be minimised as far as possible by the methodological approach to the survey. They cannot be entirely negated, though, and the sum of the remaining error components – often referred to as the ‘total survey error’ – represents the difference between a survey estimate and the actual population parameter. This error can be difficult to precisely quantify but should be taken into account when interpreting the survey results. However, results still provide a good basis for estimating how all people experience the care and services provided by mental health trusts, and similarly they provide a good means of comparing providers.

Survey design and implementation

The survey programme implements general principles of good survey practice. The programme has put in place a number of measures to help ensure a good response rates and these include:

- Up to two reminders are sent to non-responders.
- A Freephone language line provides translation services. MENCAP also provides support for people with learning difficulties.
- Questionnaires are written using simple and clear language.

The survey is based on a postal survey methodology that includes sending questionnaires after their healthcare experiences. This helps to reduce the effects of ‘gratitude bias’ which can arise when people give feedback either direct to staff, or while on trust premises.

Other measures to ensure robustness include: service user and stakeholder involvement in the design of questionnaires; cognitive testing on the relevant population; the use of a standardised methodology for implementation of the survey; and penalties (such as exclusion of data) imposed when errors are made by NHS trusts in implementing the surveys.

Thorough piloting of sampling and methodology, as appropriate, also ensures that the design is suitable and effective. There is an ongoing programme of pilot work as part of the acute inpatient survey looking at improving response rates, and additional work is being planned by CQC to implement a similar piloting exercise for the community mental health survey.

Sampling error

The sample for the community mental health survey was a random sample of 850 people who had been seen by community mental health services during the sampling period (September to November 2014). NHS records are large enough to minimise any sampling error (for example, errors arising by chance, by selecting a set of people who happened to have a more positive experience). The number of received responses is also large, usually around 13,000 for the community mental health survey, and sufficient to ensure that sampling error is very small.

Samples can be considered representative of the population of all people using services providing the sample period is not atypical. This is unlikely given the size of samples selected. The risk of sample bias is therefore small.

Errors in drawing samples

Multi-stage sample checks minimise the chances of errors being made by trusts when drawing their samples (sampling mistakes); for example, mistakes arising from incorrect sampling, such as by accidentally excluding certain people.

Measures to avoid trusts making mistakes when drawing their samples include:

- Sampling checklists, for trusts to complete
- Checks undertaken by an approved survey company
- Central checking carried out by the Co-ordination Centre.

The Quality and Methodology report outlines in detail the sampling mistakes that were made for the 2015 community mental health survey (See Appendix E). That information is also provided below.

A report is produced each year of these errors and is published on the NHS surveys website (available here for the 2015 survey: www.nhssurveys.org/surveys/873). Trusts and approved contractors are encouraged to review this report to minimise recurrence of previously detected errors. The incidence of both major and minor errors have decreased since centralised sample checking was introduced in 2006.

When errors in drawing samples are identified, the CQC Surveys team and the Survey Co-ordination Centre at the Picker Institute Europe examine all relevant detail to determine whether the error should be classed as 'minor' or 'major'. Minor errors mean that the data can be included in the full dataset, and trust level report. Major errors will automatically lead to data being excluded for the relevant trust, due to the scale of the effect on data quality and comparability. The process applied to the information gathering and analysis is outlined in the Quality and Methodology document.

Errors in drawing the community mental health survey sample

Fifty-eight trusts were eligible to take part in the 2015 Community Mental Health Survey.

Two trusts were excluded from participation in the survey as they were unable to draw a sample as specified in the survey instruction manual (Northamptonshire Healthcare NHS Foundation Trust, and Somerset Partnership NHS Foundation Trust). One trust that took part in the survey was unable to be included in the 2015 data set due to a sampling error ([Nottinghamshire Healthcare NHS Trust](#)). More information on these trusts is provided below.

This means that the results for the 2015 Community Mental Health Survey are based on 55 trusts.

2015

For the 2015 community mental health survey, one trust out of 56 made a major error in drawing their sample, which resulted in data for the trust being excluded from the publication:

Nottinghamshire Healthcare NHS Trust (RHA)

When extracting the sample for the survey, the trust excluded anyone who had ever been an inpatient, which was around a third of their eligible population⁴⁴. As the trust had not only excluded such a large group of its service users, but a specific group who can reasonably be assumed to have more complex needs, it was the assessment of the Surveys Team at the Care Quality Commission, in conjunction with the Surveys Co-ordination Centre (The Picker Institute Europe) that this error would substantially bias the results for this trust.

Due to this error, results for Nottinghamshire Healthcare NHS Trust were excluded from the 2015 publication: no results are available for this trust and the data has been excluded from the full data set.

2014

Four trusts were found to have introduced error into their sampling in 2014, out of the 57 trusts that participated in that survey:

Nottinghamshire Healthcare NHS Trust (RHA)

In 2014, the trust incorrectly included around 20 people (out of a total sample of 850) who used services that are excluded from the sample for the survey (forensic, learning disabilities and Improving Access to Psychological Therapies or IAPT).

As the response rate for the survey nationally is around 30% it can reasonably be assumed that only around a third of these, or less, will have responded. Due to the very small number of people involved it was the assessment of the Surveys Team at the Care Quality Commission, in conjunction with the Surveys Co-ordination Centre (The Picker Institute Europe) that this error would have little impact on the 2014 results for the trust which may be considered as valid.

North Essex Partnership University NHS Foundation Trust (RRD)

In 2014 the trust manually removed around 10 people who had dementia from their sample who were eligible to be included in the survey.

Due to the very small number of people that were removed (10 out of a total sample of 850) it was the assessment of the Surveys Team at the Care Quality Commission, in conjunction with the Surveys Co-ordination Centre (The Picker Institute Europe) that this error would have little impact on the 2014 results for the trust which may be considered as valid.

⁴⁴ The eligible population is all people seen at the trust during the sampling months (September-November 2014) excluding those not eligible for participation. For more information on the survey inclusion and exclusion criteria, please see the instruction manual available at:

www.nhssurveys.org/surveys/824

The trust also had a large decrease in its eligible population which the trust attributed to having reviewed its records / migrated its clinical systems and having discharged some people who use services. The difference in the eligible population could not be externally verified due to patient confidentiality – neither CQC, the Co-ordination Centre, or the approved contractor could legally view the original data to verify the information that was received from the trust.

Greater Manchester West Mental Health NHS Foundation Trust (RXV)

The trust applied the survey inclusion criteria incorrectly in 2014 and wrongly excluded a large proportion of people who use their services. In 2015, the trust declared their eligible population as 7,323 which is comparable to that given in 2013 (7,095). In 2014, the trust declared 4,956. In 2014 the trust explained the difference in their eligible population compared with 2013 as due to investment in particular services though has subsequently accepted this was down to human error, whereby an error was made in copying, pasting and filtering data.

Analysis by Surveys Co-ordination Centre (The Picker Institute Europe) showed that the 2015 eligible population size, gender profile and CPA breakdown for the trust profile closely matched the 2013 figures. It was evident that as a result of the error, the profile of the service users in the 2014 sample was different than expected.

The assessment of the Surveys Team at the Care Quality Commission, in conjunction with the Surveys Co-ordination Centre (The Picker Institute Europe) is that the 2014 trust level data for Greater Manchester West Mental Health NHS Foundation Trust is erroneous and not comparable with their 2015 data. This means that in the benchmark report for this trust, we are not able to include comparative data to 2014.

However, we did not remove the data for this trust from the full data set for 2014, which was used to compare the findings between 2015 and 2014 for this report. We assessed whether including the results from this trust in the 2014 national data set had an impact on the 2014 England level results. Our findings indicate that when including the trusts' data in the 2014 pool of results this does not bias the England level results.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust (RRE)

The eligible population for the 2015 survey was significantly smaller than it was for the trust compared with the 2014 survey. In 2015 the trust declared their eligible population to be 2,250 whereas in 2014 this was 6,296. The trust had previously outsourced its clinical data which was bought in-house in 2015. The trust has confirmed that data quality improvements have been made and are confident their 2015 sample is correct. As the trust could not explain the large difference in eligible population between 2015 and 2014, and were unable to replicate the 2014 sample data, the trust concluded that there was an error in their sample for 2014.

This difference in eligible population could not be externally verified due to patient confidentiality – neither CQC, the Co-ordination Centre, or the approved

contractor could legally view the original data to verify the information that was received from the trust.

The assessment of the Surveys Team at the Care Quality Commission, in conjunction with the Surveys Co-ordination Centre (The Picker Institute Europe) is that the 2014 trust level data for South Staffordshire and Shropshire Healthcare NHS Foundation Trust is erroneous and not comparable with their 2015 data. This means that in the benchmark report for this trust, we are not able to include comparative data to 2014.

However, we did not remove the data for this trust from the full data set for 2014, which was used to compare the findings between 2015 and 2014 for this report. We assessed whether including the results from this trust in the 2014 full data set had an impact on the 2014 results for England as a whole. Our findings indicate that when including the trust's data in the 2014 pool of results this does not bias the results for England.

Excluded trusts

Two trusts were excluded from participation in the 2015 community mental health survey as they were not able to draw a sample for the survey as specified in the survey instruction manual. These trusts are:

- Northamptonshire Healthcare NHS Foundation Trust (RP1)
- Somerset Partnership NHS Foundation Trust (RH5).

Both trusts had introduced an 'opt-in' consent policy meaning people using their services have to explicitly agree to take part in research such as surveys. This is commendable in terms of good practice in following Data Protection and patient confidentiality requirements. However, the wording of the consent approach in both trusts meant that it did not align with the requirements of the National Patient Survey Programme, which has received support under section 251 of the NHS Act 2006, thus providing a legal basis to survey people without obtaining prior consent.

As the two trusts had not explicitly explained to their service users whether or not their details would be used for the 2015 community mental health survey, it meant that all service users who refused to give consent had to be excluded from the samples for the survey (to avoid 'overriding any previous indications of dissent', as stipulated as a condition of the section 251 support). This significantly reduced the number of people eligible to be selected to take part in the survey and was therefore considered to introduce an unacceptable level of bias in the sample for the survey (details are provided in the Quality and Methodology report, linked to in Appendix E). This bias could be due to a number of factors, including:

- differences between those likely to provide consent and those who choose not to
- differences in teams or areas for whom the consent system has been applied

- other unknown and as yet unquantified factors such as inconsistency in how the consent form has been presented to service users.

The Care Quality Commission has worked closely with those trusts and the Co-ordination Centre, to find a resolution that will allow the two trusts to participate in the 2016 survey. In preparing for the 2016 survey, a pro-active approach will be taken with trusts in communicating the alignment of their consent systems with the National Patient Survey Programme, to identify and resolve any similar issues at other trusts.

Revisions and corrections

CQC publishes a [Revisions and Corrections Policy](#) relating to these statistics. The National Patient Experience Survey data is not subject to any scheduled revision as they capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised.

This policy sets out how CQC will respond if an error is identified within this and it becomes necessary to correct published data and/or reports.

Appendix E: Further information and feedback

Further information

The report outlining the CQC response, and the trust level results can be found on the CQC website. You can also find a 'technical document' here which describes the methodology for analysing the trust level results, and a 'quality and methodology' document which provides information about the survey development and methodology

www.cqc.org.uk/cmhsurvey

The **trust results** from previous community mental health surveys that took place 2004-8 and 2010-2014⁴⁵ are available at the below link. Please note that due to redevelopment work, results from the 2015 survey are only comparable with 2014⁴⁶:

www.nhssurveys.org/surveys/290

The **results for England** from previous community mental health surveys that took place 2004-2008 and 2010-2014 are available at the below link. Please note that due to redevelopment work, results from the 2015 survey are only comparable with 2014⁴⁷:

nhssurveys.org/surveys/872

Full details of the methodology for the survey, including questionnaires, letters sent to people who use services, instructions on how to carry out the survey and the survey development report, are available at:

www.nhssurveys.org/surveys/820

More information on the patient survey programme, including results from other surveys and a programme of current and forthcoming surveys can be found at:

www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the Community Mental Health Survey 2015. The guidance above should help answer any questions you have about the programme and you are advised to review that information carefully. However, if you wish to contact the

⁴⁵ In 2009 a survey of mental health inpatient services took place

⁴⁶ Please note that the survey was also substantially redeveloped in 2010. This means that results from the 2010 survey are not comparable with those from 2004-2008.

⁴⁷ Please note that the survey was also substantially redeveloped in 2010. This means that results from the 2010 survey are not comparable with those from 2004-2008.

Team directly please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk

Feedback

We welcome all feedback on the survey findings and the approach we have used to reporting the results, particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how this publication could be improved, please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk

The information you provide will be reviewed by CQC and used, as appropriate, to improve the statistics that we publish across the National Patient Survey Programme.