NHS patient survey programme

2016 Community Mental Health Survey

Statistical release

Published November 2016

Independent Data Analysis

Contents

Summary of findings

The 2016 Community Mental Health Survey received feedback from 13,254 people, and had a response rate of 28%.

Results for all questions in the 2016 survey are published in the Open data section on our website, www.cqc.org.uk/cmhsurvey.

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2016 compared with the last time the survey was conducted in 2015 and 2014.[ab] Comparisons with 2014 and 2015 results appear alongside the result for 2016 only where any difference between the results is statistically significant. Where results for 2014 or 2015 are not provided, there has been no statistically significant change. Generally, many aspects of people's experiences of care have remained relatively stable between 2015 and 2016, with very few statistically significant changes, though results for some questions have shown a decline compared with 2014. Due to this, the report makes more comparisons between 2016 and 2014 rather than between 2016 and 2015. Please note that due to the relatively large number of respondents, small changes in results may show to be statistically significant; and, results from three surveys may not necessarily indicate the emergence of a longer-term trend. Therefore, results do not necessarily indicate a pattern of decline in people's experiences of services.

Current policy, standards and guidelines for providing mental health care focus on improving people's experiences. However, survey results suggest that there is still considerable progress needed to ensure that everyone using these services receives good quality care in line with the standards and policies.

As might be expected, the survey findings show differences between people on the Care Programme Approach (CPA) and those not on the CPA for some question results. This is partly due to the different service requirements for people on the CPA who need greater support, and therefore, may have different patterns of care. Please see page 10 for details about the Care Programme Approach.

Positive experiences

Overall, around two thirds of respondents reported a positive experience of care: when asked to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience') 65% rated their overall experience with a score of seven or above (64% in 2015). This

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[a] The weighting strategy for the England level results has changed from the 2014 and 2015 survey. The revised weighting takes account of changes in the demographic profile over the comparable years of the survey, and means that if this has changed, we can compare results more fairly. For more detailed information please see Appendix A.
[b] A 'z-test' set to 95% significance was used to compare data between survey years. For more information on statistical significance, please see Appendix A.

does however leave over a third (35%) who rated their overall experience with a score of six or below.

Some questions asking about contact with staff were positive and respondents said that they:

- were 'always' treated with respect and dignity (74%)
- had been told who is in charge of organising their care and services (76%). Of these people, the vast majority of respondents (97%) said that they knew how to contact this person, if they had a concern about their care.

Areas for Improvement

The survey results suggest scope for further improvements in a number of areas:

Involvement in care

Questions asking about involvement in care show that while the majority of respondents are involved in their care as much as they want to be, scope remains to include some people more fully:

- Of those who had agreed with someone from NHS mental health services what care they would receive: 56% were 'definitely' involved as much as they wanted to be in agreeing what care they will receive.
- Of those who had a formal meeting to discuss their care in the previous 12 months: 61% were 'definitely' involved as much as they wanted to be in discussing how their care is working.
- Of those who had received medicines within the previous 12 months: 53% were 'definitely' involved as much as they wanted to be in decisions about which medicines they receive (50% in 2015).
- Of those who had received treatments or therapies (not involving medicines) within the previous 12 months: 56% were 'definitely' involved as much as they wanted to be in deciding what treatments or therapies to use.

Crisis care

Recent policy has included a focus on improving services for people who experience a mental health crisis, which should be treated with the same urgency as a physical health crisis. Almost a third of all respondents (32%) said that they do **not** know who to contact out of office hours if they had a crisis. People who were not receiving services on the CPA were more likely to say this (37%) compared with those on the CPA (20%).

Survey results suggest that some people are not getting the help they need in a crisis. Of those respondents who knew who to contact out of office hours if they have a crisis, and had tried to contact that person or team within the last 12 months, almost a quarter (24%) said that they did **not** get the help they needed (21% in 2014).

Care planning

Everyone receiving care from specialist mental health services should have an identified lead professional responsible for jointly developing their care plan and reviewing care.

Almost a quarter of all respondents (24%) said they had **not** been told who was in charge of organising their care and services. People who were not receiving services under the Care Programme Approach (CPA) were more likely to say they had not been told this (29%), compared with those on the CPA (12%).

Almost a quarter of all respondents (23%) said that they had **not** agreed with someone from NHS mental health services what care they received. People who were not receiving services on the CPA were more likely to say they had **not** agreed this (27%), compared with those on the CPA (14%).

Reviews

It is good practice to review care plans and long-term medication at appropriate intervals.

Just over a quarter of all respondents (27%) said that in the last 12 months they had **not** had a formal meeting with someone from NHS mental health services to discuss how their care was working. People who were not receiving services on the CPA were more likely to say this (32%) compared with those on the CPA (18%).

Over a fifth (22%) of people on long-term medication for their mental health needs said that in the last 12 months an NHS mental health worker had **not** checked with them how they were getting on with their medicines.

Introduction

Community Mental Health Services

Community mental health services provide care and treatment for people who require mental health care over and above the services provided by primary care. Most mental health services are based within the community (rather than in hospitals), though some specialist outpatient clinics may operate from hospital sites. Mental health services in England care for people with a wide range of conditions. The most common mental health conditions that people seek treatment for are depression, anxiety disorders, phobias, obsessive-compulsive disorder (OCD) and panic attacks.[1]

Nearly 1 in 4 people in England will experience a mental health problem every year. Certain groups of people are more likely to experience mental health issues, for example; people from certain minority ethnic groups, transgender people, those in unemployment, and people in prison.[2]

Everybody's experience of a mental health condition is different. Some people may have a single, one off episode of a mental health issue and have a short contact with mental health services; whereas others may have multiple or long term experiences of varying severity throughout their lives, which may involve either on-going or intermittent contact with mental health services.

About the Community Mental Health Survey

The Community Mental Health Survey is part of a wider programme of NHS 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 the survey programme and to see the results from previous surveys, please see website links in the further information section (Appendix F).

The 2016 survey of people who use community mental health services involved 58 providers of NHS mental health services in England (including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide mental health services). People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1st September 2015 and 30th November 2015, and were not a current inpatient. Fieldwork took place between February and June 2016. We received responses

from more than 13,200 people, a response rate of 28%.[c] In total, 49,300 people were sent questionnaires.[d]

For more information on the survey methodology, see Appendix A. This covers the development of the survey, the analysis of results, and comparability with previous surveys. More detailed information on the limitations of the data is provided in the Quality and Methodology Report (see link in Appendix F).

The survey collected basic demographic information from all people who took part, and this is available in the 'About the respondents' section within the Open data published on the CQC website (see link in Appendix F). The 'about the respondents' section in the Open data shows that the basic demographic characteristics of respondents remain similar to the 2015 and 2014 surveys for age, gender and ethnicity. In 2016, 20% of respondents had been in contact with mental health services for less than a year, an increase from 18% in both 2014 and 2015. Thirty-nine per cent had been in contact for between 1 and 5 years (a decrease from 41% in 2014). The remainder had been in contact for between 6 and 10 years (12%), or more than ten years (29%).

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[c] 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.
[d] This compares with 11,695 respondents in 2015 (29%), from a total sample of 41,650. These figures are taken from the report reissued in September 2016, which removed data from 6 trusts who during the preparations for the 2016 survey, were found to have committed an error in 2015.

Background to the Community Mental Health Survey

It is important to note the climate in which the survey took place. This section summarises the main policies, standards and guidelines.

The importance of people's experiences

Understanding what community mental health care is like for people who receive it provides key information about the quality of services across England. This understanding can be used to encourage improvements both in England as a whole, and locally amongst providers and commissioners of services.

The importance of positive patient experience is increasingly recognised both within the NHS and in government health policy. The NHS Constitution, published in 2012 and updated in 2015, commits the NHS to encourage people to give feedback of their experiences and to use this to improve services.[3] The NHS Patient Experience Framework, published by the NHS National Quality Board in 2012, outlines elements that are important to people's experiences of NHS services with the intention to help NHS trusts improve.[4] It states that "information, communication, and education on clinical status, progress, prognosis, and processes of care" are necessary "in order to facilitate autonomy, self-care and health promotion."

The Department of Health's NHS Mandate for 2016/17 includes a goal to reduce inequalities in people's experience of the health system.[5] Domain 4 of the NHS outcomes framework also highlights the need for ensuring people have a positive experience of care.[6]

Shared decision-making is seen as key to improving patient experience and is now enshrined in law. The Health and Social Care Act 2012 states that those who commission services must promote and facilitate the involvement of patients and carers in decisions about their care and treatment.[7]

Research, including that undertaken in the development work for the NHS Patient Survey Programme, has identified many aspects of care that are important to people using services. These include being informed and offered options; staff listening to and spending enough time with them, and being involved in their own care.[8]

Evidence from academic research suggests that when people are involved in their care, decisions are made more effectively and health outcomes improve.[9] Academic research further suggests that patient experience is positively associated with patient safety and clinical effectiveness.[10] All questionnaires used in the NHS Patient Survey Programme are designed to reflect these themes.

Mental health policy

The following key areas show some of the main challenges for community mental health care within current policy and practice.

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 include:

- An aspiration to achieve equality between physical and mental health services (sometimes known as 'parity of esteem').
- The importance of people's experiences of using services, and 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 (integrated care).

Increased activity

Mental health services are operating under increasing pressure: according to the NHS Confederation's Key facts and trends in mental health, average numbers of referrals to mental health teams have increased in recent years.[11] However, despite this, the Kings Fund reported that funding for mental health services has been cut in recent years, with their analysis finding that "around 40 per cent of mental health trusts experienced reductions in income in 2013/14 and 2014/15."[12]

The mental health strategy for England

No Health Without Mental Health (published 2011) is a wide-ranging document that set out the coalitions government's intentions to promote mental health and wellbeing in the general population and how different organisations (such as schools and employers) need to work together to achieve this.[13] It also sets out the government's intention to improve mental health services for those who need them through the provision of high quality services that are equally accessible to all. It sets out six key objectives for improved mental health in England, some of which the survey can help to measure. The six key objectives are:

- more people will have good mental health
- more people with mental health problems will recover
- more people with mental health problems will have good physical health
- more people will have a positive experience of care and support
- fewer people will suffer avoidable harm
- fewer people will experience stigma and discrimination.

Equality between physical and mental health services

Giving mental health equal priority to physical health is often referred to as parity of esteem. It was enshrined in law in the Health and Social Care Act 2012, and has become a central objective for all recent government policy.

No Health Without Mental Health made explicit the government's objective to give equal priority to mental and physical health, stating "….we are clear that we expect parity of esteem between mental and physical health services".

The government's *Mandate to NHS England* (first published in 2012 and refreshed annually) sets the government's objectives for the NHS. The Mandate includes specific requirements to achieve parity of esteem, to ensure that mental and physical health conditions are given equal priority. The NHS Constitution was updated in July 2015 to reflect the government's commitment to parity of esteem, stating "….the [NHS] service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard".

This ambition to achieve parity of esteem continues to be reinforced in more recent policy publications, such as *Closing the Gap* (published 2014)[14] and the *Five Year Forward View for Mental Health* (published 2016).[15]

Accessing Services

In 1999, the *National Service Framework for Mental Health*[16] set out the then government's quality standards for mental health. It set out a ten year agenda which aimed to improve quality and remove variation in care. The framework included seven standards, including the aim that people must be able to access effective treatments and services. Subsequent policy documents have built on and clarified ambitions contained in this document.

Recent policy publications have called for immediate improvements in access to mental health services. *Closing the Gap* identifies 25 areas where immediate change and improvement is required from providers in order to meet the objectives set out in the government's strategy *No Health Without Mental Health*. These 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. Standards on access and waiting times for mental health services, and the allocation of more money for service provision, are both pledged within *Achieving better access to mental health services by 2020* (published 2016).[17]

The *Five Year Forward View for Mental Health* is a wide-ranging strategy and sets out a number of priority areas for action. This includes that people facing a crisis should have access to mental health care seven days a week and 24 hours a day, in the same way that they are able to get access to urgent physical health care. *Implementing the Five Year Forward Plan for Mental Health* (published 2016)[18] provides further details on key commitments to greater funding for mental health services pledged in the *Five Year Forward View for Mental Health* detailing how funding will be made available and delivered.

People's Experiences

Recent mental health policy continues to reinforce the importance of involving people in their care and treatment. *No Health Without Mental Health* includes an objective that '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.

The National Institute for Clinical Excellence ([NICE](#)) have developed a series of quality statements, indicators and accompanying clinical guidelines to help commissioners and providers improve quality of care. Whilst quality standards are not mandatory, they are available for use in the planning and delivery of services to achieve the best possible care. Their Quality Standard for *service user experience in adult mental health services* (published 2011)[19] outlines the level of service that people using NHS mental health services should expect to receive. The *Community Mental Health survey questionnaire* reflects many of the issues covered in those statements.

Co-ordinated Care

Co-ordinated care is a key priority to ensuring that services are well placed to provide effective care. The *Five Year Forward View for Mental Health* highlights the importance of integrated care. It recommends eight principles to underpin reform, one of which is that care must be co-ordinated across health and social care spanning people's physical, mental and social needs.

The Care Programme Approach (CPA)

The [Care Programme Approach](#) (CPA) is the framework that organises mental health care. People that have more complex needs and need ongoing support are put on the CPA. Although the [policy](#) has been revised over time, 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. [20]

Twenty nine percent of the people who responded to the 2016 survey had their care co-ordinated on the CPA. However, it is worth noting that there is enormous variation in the proportion of people on the CPA between trusts: this ranged across trusts from a low of 3% respondents on the CPA to a high of 73% in the 2016 survey, which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy.

For some of the questions in the survey, 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 the CPA who need greater support, and therefore may have different patterns of care. We therefore also analyse questions by CPA status where [policy guidance](#) sets out differences between the care pathway of those who are on the 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 figures of a different colour (brown) to clearly distinguish them from other results from the survey.

Results from the Survey

This section presents the results from the 2016 Community Mental Health Survey. It highlights statistically significant differences between the results from the most recent survey (2016) and the results from previous surveys in 2014 and 2015.

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2016 compared with the last time the survey was conducted in 2015 and 2014.[e,f] Comparisons with 2014 and 2015 results appear alongside the result for 2016 only where any difference between the results is statistically significant. Where results for 2014 or 2015 are not provided, there has been no statistically significant change. Generally, many aspects of people's experiences of care have remained relatively stable between 2015 and 2016, with very few statistically significant changes, though results for some questions have shown a decline compared with 2014. Due to this, the report makes more comparisons between 2016 and 2014 rather than between 2016 and 2015. Please note that results from three surveys may not necessarily indicate the emergence of a longer-term trend, and therefore do not necessarily indicate a decline in people's experiences of services.

Due to the relatively large number of respondents, small changes in results may show to be statistically significant. 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.
- The larger the sample sizes, the more likely that differences 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.

The figures shown are the evaluative responses to a question. Responses such as "don't know / can't remember" are not included in the percentages. These responses are included within the set of question responses to allow someone to respond to the question when they cannot remember, or does not have an opinion, to distinguish those reasons from all others and to avoid people making a 'best guess'.

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[e] The weighting strategy for the England level results has changed from the 2014 and 2015 survey. The revised weighting takes account of changes in the demographic profile over the comparable years of the survey, and means that if this has changed, we can compare results more fairly. For more detailed information please see Appendix A.
[f] A 'z-test' set to 95% significance was used to compare data between survey years. For more information on statistical significance, please see Appendix A.

For some questions, we also excluded other responses that indicate that a question is not relevant to a respondent. For example, Q33 asks: "In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?" We did not include responses from people in the results for that question if they said that they 'do not have physical health needs'; 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 directly relevant to those people.

Results for all questions in the 2016 survey are published in the Open data section on our website, www.cqc.org.uk/cmhsurvey.

Survey results are organised under the following key themes:

1. Care and treatment
2. Health and social care workers
3. Organising care
4. Planning care
5. Reviewing care
6. Changes in who people see
7. Crisis care
8. Treatments
9. Support and well being
10. Overall

1: Care and treatment

To receive appropriate treatment, people must be able to access services when they need to. The right to access effective mental health care has been set out in various governmental policy documents over the years, and the NICE quality statement 6 includes a recommendation that people should be able to access mental health services when they need them.

Development work for the 2014 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. [21] It is therefore important to include questions covering these issues.

Recent policy publications such as *Closing the Gap, Achieving better access to mental health services by 2020* and the *Five Year Forward View for Mental Health* have all called for immediate improvements in access to mental health services.

However, less than half (46% in 2016 and 48% in 2014) of respondents to the survey said that they had 'definitely' seen someone from NHS mental health services often enough for their needs.

Figure 1
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?
(Answered by all)
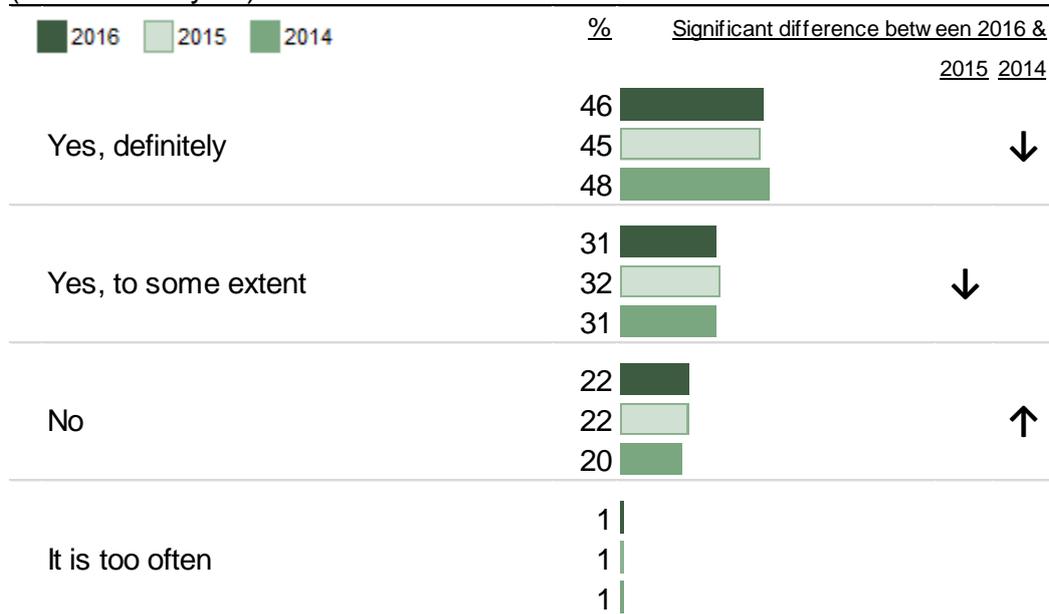
Number of respondents: 2014 (13,061), 2015 (11,063) and 2016 (12,580)
Note: those who answered 'Don't know' were excluded from the analysis.

Though the questionnaire does not ask directly about waiting times, more information on recent policy in this area can be found on Appendix A.

2: Health and social care workers

People receiving mental health care in the community may be supported by a Community Mental Health Team. These teams may include a variety of different health and social care staff such as psychiatrists, psychologists, community psychiatric nurses, social workers, and occupational therapists. Depending on their needs, people may see a whole team as part of their care or just one or two professionals.

Questions in this section asked respondents about the health and social care workers they saw for their most recent appointment. 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.

The majority of respondents gave positive answers to questions asking about contact with staff.

Respondents were asked whether the person or people they saw most recently had listened carefully to them. The majority (70% in 2016 and 73% in 2014) said

they 'definitely' did. The remainder responded 'yes, to some extent' (23% in 2016 and 21% in 2014) or 'no' (7% in 2016 and 5% in 2014).

Sixty-three per cent said they were 'definitely' given enough time to discuss their needs and treatment (66% in 2014). The remainder responded 'yes, to some extent' (26% in 2016 and 24% in 2014) or 'no' (11% in 2016, and 9% in 2014).

Consultation with people who use services during survey redevelopment work in 2014 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 was important.[22]

Fifty-six per cent of respondents said that the person or people they saw 'definitely' understood how their mental health needs affect other areas of their life (58% in 2014). The remainder responded 'yes, to some extent' (31%) or 'no' (13% in 2016 and 11% in 2014).

3: Organising care

We asked these questions to understand whether respondents had been told who was in charge of organising their care, and how effectively their care had been organised.

Research suggests that a positive relationship between people who use services and mental health staff can improve outcomes.[23] 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 the person does their job effectively.

NICE quality statement 4 recommends that people using community mental health services are supported by staff from a single multidisciplinary community team that is familiar to them, and with whom they have a continuous relationship.

Guidance on coordinating the care of people who use services 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 on the 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 the 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.

Over three-quarters of all respondents said they were told who was in charge of organising their care and services (76%), leaving 24% who said they had not been told.

Respondents on the CPA (88%) were more likely than those not on the CPA (71%) to say that that they had been told who was in charge of organising their care and services.

Figure 2
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)
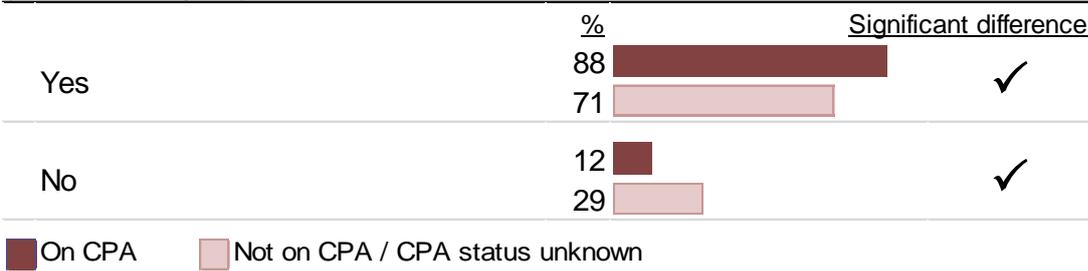
Number of respondents: On the CPA (3,402) and Not on the CPA/ CPA status unknown (7,439)
Note: those who answered 'Not sure' were excluded from the analysis.

Of all respondents who had been told who was in charge of organising their care and services:[9]

- The vast majority knew how to contact that person if they had a concern about their care (97%).

- Most said that the person who organised their care and services did this 'very well' (60%). The remainder responded 'quite well' (31%), 'not very well' (6% in 2016 and 5% in 2014) or 'not at all well' (2%).

4: Planning care

Questions were asked to understand whether respondents had agreed with someone from mental health services what care they would receive and how involved they were with this process.

Guidance on coordinating the care of people who use services recommends that everyone receiving care from specialist mental health services should agree 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.
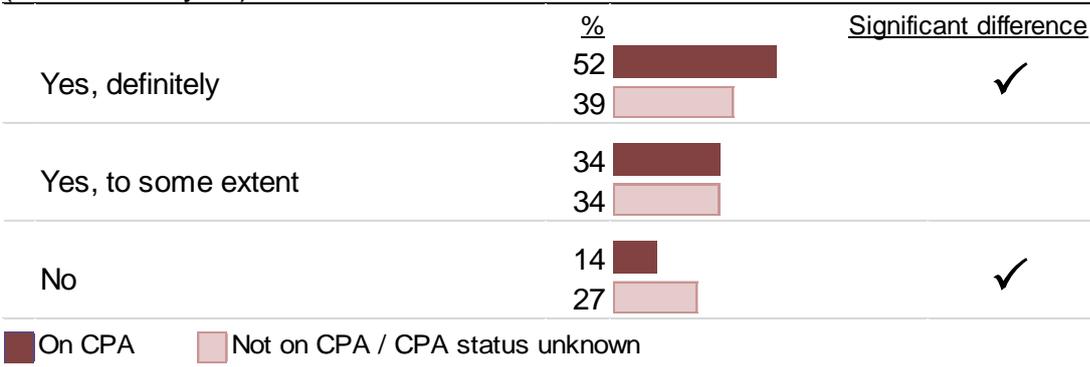
[9] Respondents who told us (at Q8 in the questionnaire) that their GP is in charge of organising their care and services have been removed from the analysis for these questions. This is because results will not be attributable to the mental health trust.

When asked whether they had agreed with someone from NHS mental health services what care they will receive, less than half of all respondents (43%) said they 'definitely' had and just over a third (34%) said they had 'to some extent'. This leaves almost a quarter (23%) who said they had not agreed with someone from NHS mental health services what care they will receive.

In line with national guidance, there are different practice expectations for people on the CPA and those not on the CPA, and we would therefore expect to see differences in the survey results. People on the CPA should have a comprehensive formal written care plan detailing their care and treatment. In the case of those who are not on the 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.

Respondents on the CPA (52%) were more likely than those not on the CPA (39%) to say that that they had 'definitely' agreed with someone from NHS mental health services what care they would receive.

Figure 3
Q11 Have you agreed with someone from NHS mental health services what care you will receive?
(Answered by all)

	%		Significant difference
Yes, definitely	52		✓
	39		
Yes, to some extent	34		
	34		
No	14		✓
	27		

■ On CPA   ■ Not on CPA / CPA status unknown

Number of respondents: On the CPA (3,728) and Not on the CPA/ CPA status unknown (8,963)

Recent guidance on care planning stresses the importance of collaborative care planning to encourage healthcare professionals, and people using services, to work together to understand what is important to an individual. It is essential to helping people to be involved in their own care and to manage their condition.[24]

A collaborative approach to agreeing care plans is also emphasised in NICE quality statement 8, which recommends that people using mental health services jointly develop a care plan with mental health and social care professionals, and that a copy of the plan is given to people with an agreed date to review it.

We asked about the experiences of respondents who said they had agreed with someone from NHS mental health services what care they will receive:

- Over half (56%) said they were 'definitely' involved as much as they wanted to be in agreeing what care they will receive. The remainder responded 'yes, to some extent' (36%) or 'no, but I wanted to be' (7% in 2016 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% in 2016 and 33% in 2014) or 'no, but I wanted to be' (7% in 2016 and 6% in 2014).

5: Reviewing care

These questions were included in the survey to understand whether respondents had their care reviewed in the previous 12 months and how involved they were in this process.

As the question specifies a time period of 'the last 12 months' we have removed people who said they have been in contact with mental health services for less than a year (based on their responses to question two[h]) from the data set, and they are therefore not included in the analysis for the questions reported in this section. This is because they have not been in contact with services long enough to reasonably expect them to have had a care review.

Guidance on coordinating the care of people who use services says that people receiving care on the CPA should receive a formal review at least once a year, although this may be needed more regularly. Those not on the 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 on the CPA or not.

Overall, 73% of all respondents said that in the previous 12 months, they had had a formal meeting with someone from NHS mental health services to discuss how their care was working, leaving 27% who said they had not.

As may be expected, there are differences by CPA: respondents on the CPA (82%) were more likely than those not on the CPA (69%) to say that that their care had been reviewed in the previous 12 months.

[h] Respondents who selected option one (*'less than a year'*) at Q2 *(Overall, how long have you been in touch with NHS mental health services?)* were removed from the analysis of Q14, Q15 and Q16 as reported in this section.

Figure 4
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)

	%	Significant difference
Yes	82 / 69	✓
No	18 / 32	✓

■ On CPA   □ Not on CPA / CPA status unknown
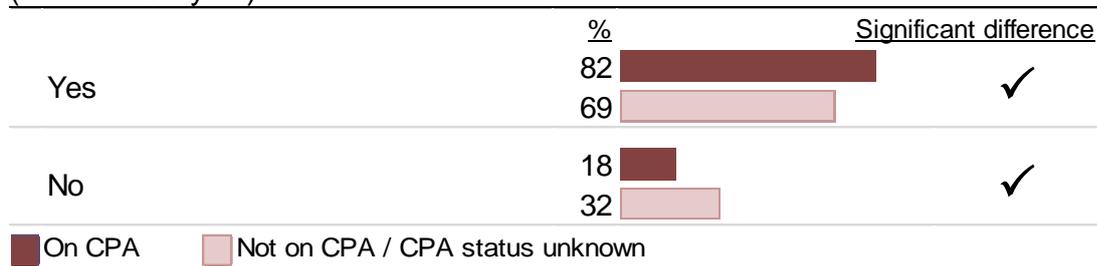
Number of respondents: On the CPA (3,099) and Not on the CPA/ CPA status unknown (6,624)
Note: those who answered 'Don't know / can't remember' and those who had been in contact with NHS mental health services for less than a year were excluded from the analysis.

Involving people in their own care is important as research suggests it can lead to more effective decision making and better health outcomes. This is also reflected in NICE quality statement 3 which emphasises a collaborative approach to decision-making.

We asked about the experiences of the respondents who had said that in the previous 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' (8% in 2016 and 6% in 2014).

- 60% 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' (31% in 2016 and 30% in 2014) or 'no, but I wanted to be' (9%).

6: Changes in the staff who people see

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

There is some evidence that continuity of care positively affects people's experiences.[25,26] NICE quality statement 4 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.

This is reflected in findings from a consultation with people who use services as part of the development work for the survey. 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.

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

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-one per cent said that in the last 12 months, the people they see for their care and services had changed.

Looking at the respondents[i] who had experienced a change in the people they see for their care or services in the previous 12 months:

- Less than half (48%) said that the reasons for this change were 'completely' explained to them at the time. The remainder responded 'yes to some extent' (29%) or 'no' (23%).

- Just over a fifth (22%) said that their care got better following the change. Forty-seven per cent said that 'it stayed the same' and 31% said their care 'got worse'.

- Over half (54%) said that they knew who was in charge of organising their care while this change was taking place, leaving 46% who did not.

7: Crisis care

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

Recent policy has included a focus on improving services for people who experience a mental health crisis. The _Five Year Forward View for Mental Health_ was published during the survey fieldwork, and includes a priority that people facing a crisis should have access to mental health care seven days a week and 24 hours a day, in the same way that they are able to get access to urgent physical health care.

Guidance on coordinating the care of people who use services says that people on the 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 the CPA, they should be aware of who to contact in the event of a crisis. This is also reflected in NICE quality statement 9,

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[i] These questions are only answered by respondents who selected the first response option 'Yes' at Q17.

which states that people who are at risk of a crisis should have a crisis plan that has been developed jointly with their care coordinator, and should include information about 24-hour access to crisis services.

Just over two thirds (68%) of all respondents said that they knew who to contact out of office hours if they had a crisis, leaving almost a third (32%) who did not.

Respondents on the CPA (80%) were more likely than those not on the CPA (63%) to say that they knew who to contact out of office hours if they had a crisis.

Figure 5
Q21 Do you know who to contact out of office hours if you have a crisis?
(Answered by all)

On CPA | Not on CPA / CPA status unknown
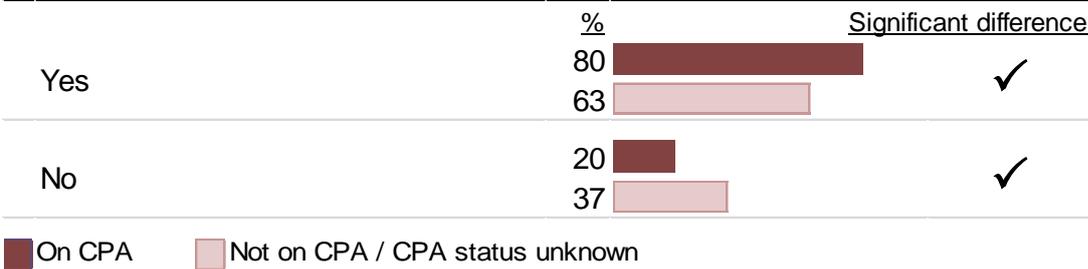
Number of respondents: On the CPA (3,440) and Not on the CPA/ CPA status unknown (7,941)
Note: those who answered 'Not sure' were excluded from the analysis.

As well as knowing how to access crisis care, it is important that people also receive effective care. One of the key aims of the *Crisis Care Concordat* (established in February 2014) is to ensure that mental health emergencies are treated with the same urgency as physical health emergencies. The concordat challenges those responsible for commissioning, providing and delivering the services to commit to a set of core principles around crisis care, to make sure that people get the help they need when they are having a mental health crisis.

CQC's recent report *Right here, right now* looks at people's experiences of crisis care. This report found that the quality of care experienced by a person in crisis varies greatly depending on where they are and what help they need. [27] Many people also experienced problems getting help when they needed it, and some healthcare professionals sometimes lacked compassion and warmth when caring for people who are having a crisis.

Survey results suggest that some people are still not getting the help they need in a crisis.

Of those respondents who knew who to contact out of office hours, over a third (38%) had tried to contact that person or team within the previous 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-three per cent said they 'definitely' got the help they needed, and 30% said they did 'to some extent'. Over a quarter said that they either did not get the help that they needed (24% in 2016 and 21% in 2014) or that they 'could not contact them' (3%).

Figure 6
Q23. When you tried to contact them, did you get the help you needed?
(Answered by all respondents who had tried in the previous 12 months to make contact with this person/team)
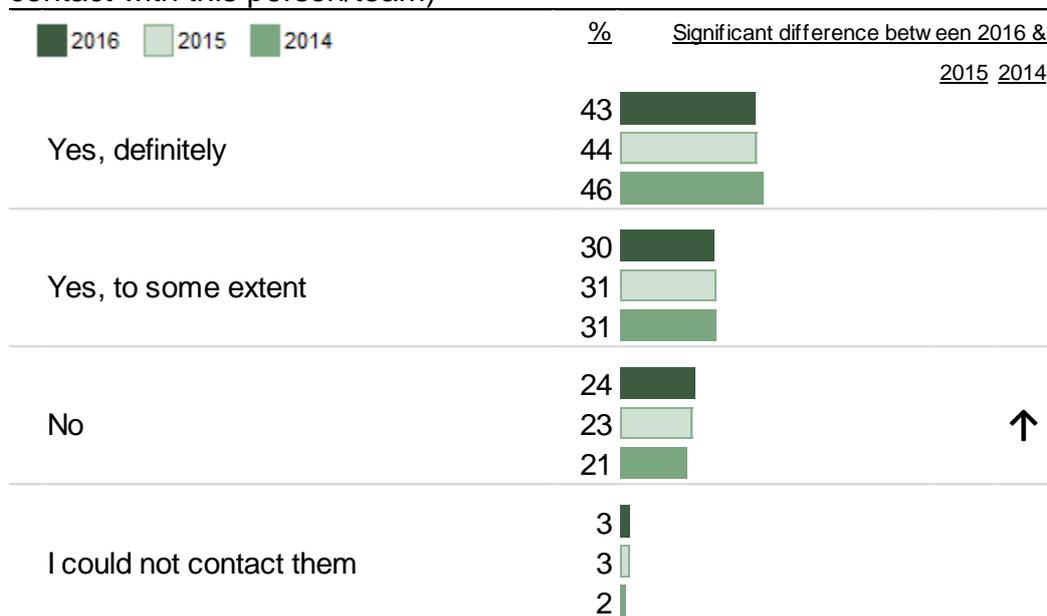
Number of respondents: 2014 (2,984), 2015 (2,604) and 2016 (2,887)

8: Treatments

Questions in this section asked about treatments that respondents may receive for their mental health conditions (such as medicines and 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.

Guidance from NICE on adherence to medication recommends involving people in decisions around which medicines to take, which can help improve compliance with taking medicines. [28] Of those respondents who wanted to be involved in decisions about which medicines they receive for their mental health needs, more than half said that they 'definitely' were involved (53% in 2016 and 50% in 2015). The remainder responded 'yes to some extent' (36% in 2016 and 37% in 2015) or 'no' (11% in 2016).

People who are receiving treatment (medicines or therapies) should be given information about that treatment, including any side effects. The NICE quality statement 7 says that people should be given information and explanations on their assessment, diagnosis and treatment options in a way in which they can understand. The NHS Constitution also makes a commitment to offer people easily accessible, reliable and relevant information in a form they can understand, and support them to use it.

Forty-seven per cent of respondents said that in the previous 12 months they had been prescribed new medicines for their mental health. Of these people, 54% said that they were 'definitely' given information about it in a way they could understand. Of the remainder, 32% responded 'yes, to some extent', 12% said 'no' and 3% reported that they were 'not given any information'.

The NICE guidance on adherence to medication states that people on long-term medicines should have them reviewed at regular intervals. The majority (86%) 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 were getting on with their medicines, leaving just over a fifth (22%) who said this had not happened.

Effective care for mental health conditions may involve providing a range of different treatments or therapies. Most commonly these include 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 (46%) said that they had. Just over a quarter (26%) said 'no, but I would have liked this', leaving 28% who responded 'no but I did not mind'.[j]

Looking at the experiences of respondents who, in the previous 12 months, had received treatments or therapies for their mental health needs that did not involve medicines:

- Most (68%) said that the treatments or therapies were 'completely' explained to them in a way they could understand. Twenty-eight per cent said they were 'to some extent' and 4% said that they were not.
- Over half (56%) were 'definitely' involved as much as they wanted to be in deciding which treatments or therapies to use. Thirty-four percent were 'to some extent' (36% in 2015 and 2014), with a tenth (10%) responding 'no, but I wanted to be' (8% in 2014).

9: Support and wellbeing

People using specialist mental health services sometimes have wider needs, such as with their finances, housing or employment. Questions in this section asked respondents about the support mental health services provided to help them to find this, if they needed it. 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 guiding them to other services.

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[j] Please note that people who responded 'this was not appropriate for me' were excluded from the analysis for this question

Physical health needs

There are strong links between physical and mental health problems. The King's Fund reported that people with long-term health problems are more likely to also have a mental health problem and almost half of people with a mental health problem also have a long-term physical health problem.[29]

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

We asked respondents whether, in the last 12 months, NHS mental health services gave them help or advice with finding support for physical health needs. Of those who needed or wanted this type of support, 36% said that they 'definitely' received this and 29% said 'yes, to some extent'. Thirty-five per cent responded 'no, but I would have liked help or advice with finding support'.[k]

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

Respondents on the CPA (43%) were more likely than those not on the CPA (33%) to say that in the previous 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for physical health needs.

Figure 7
Q33. 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)

	%		Significant difference
Yes, definitely	43		✓
	33		
Yes, to some extent	30		
	29		
No, but I would have liked help or advice with finding support	26		✓
	39		

■ On CPA ▢ Not on CPA / CPA status unknown

Number of respondents: On the CPA (2,174) and Not on the CPA/ CPA status unknown (4,366)
Note: those who answered 'I have support and did not need help/advice to find it', 'I do not need support for this' and 'I do not have physical health needs' were excluded from the analysis.

[k] 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'.

Social Inclusion

People with mental health conditions, particularly severe conditions, are more likely to be socially isolated.[30] Research suggests that contributing to, and being part of, the community (such as by through employment and taking part in social activities) can support people to regain control over their lives.[31]

Promoting the social inclusion of people with mental health problems has been set out in various governmental policy documents over the years. It is a particular theme in recent publications such as *No Health Without Mental Health*. NICE quality statement 8 states that care plans should include activities that promote social inclusion such as employment, volunteering, and other aspects such as leisure activities.

Financial advice or benefits and employment

Living with a mental health condition can sometimes make managing money and finding work more difficult. Mental health services should provide help with finding advice and support for this, if needed.

National guidance, as set out in Refocusing the Care Programme Approach, states that people receiving care on the CPA should receive support with employment 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 the CPA, the focus is more on clinical needs rather than providing support for a wider range of needs. Even so, policy guidelines state that they should receive a full assessment 'including risk assessment' to identify if they have these needs.

We asked respondents whether, in the last 12 months, NHS Mental Health Services gave them any help or advice with finding support for financial advice and benefits, and finding and keeping work.[i] Of those respondents who wanted or needed help or advice with finding support:

- 32% said that in the previous 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for financial advice and benefits, and a quarter (25%) received this 'to some extent'. This leaves over two-fifths (43%) who responded 'no, but I would have liked help or advice with finding support'.

- 28% said that in the previous 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for finding or keeping work (25% in 2015). Twenty-nine per cent responded 'yes, to some extent'. However, this leaves over two-fifths who responded 'no, but I would have liked help or advice with finding support' (43% in 2016 and 47% in 2015).
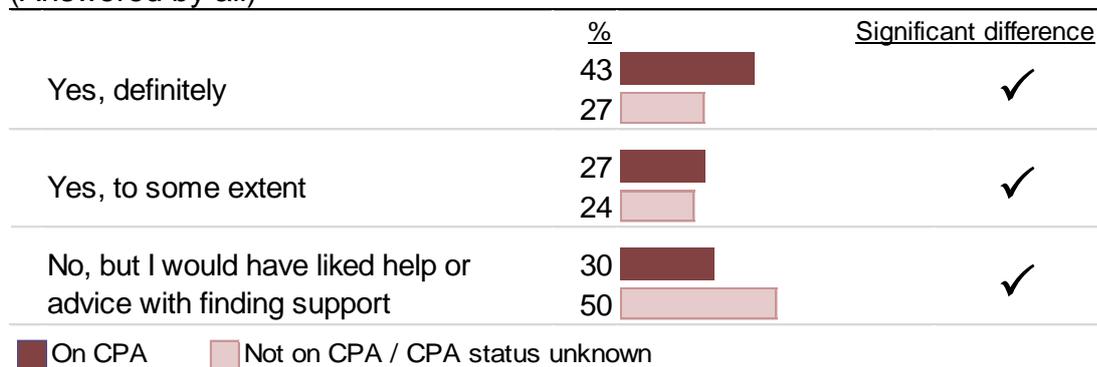
Respondents on the CPA were more likely than respondents who were not on the CPA to say that they 'definitely' received help or advice with finding support for financial advice or benefits, and for finding or keeping work.

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[i] 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'.

Figure 8
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?
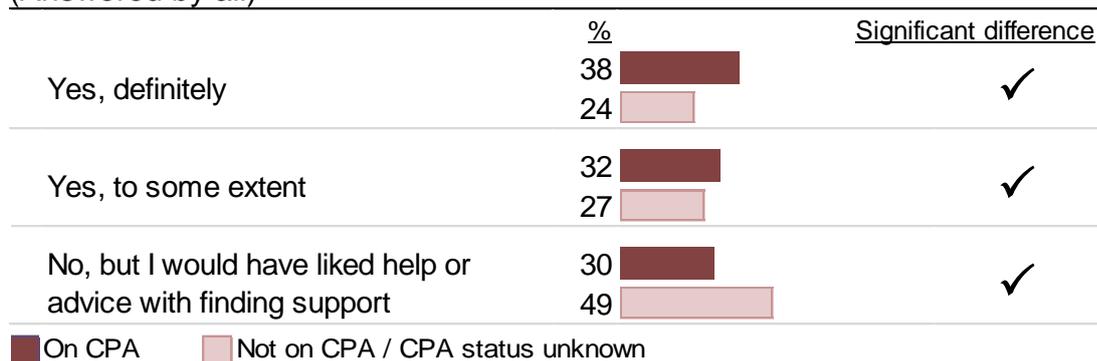(Answered by all)

	%		Significant difference
Yes, definitely	43		✓
	27		
Yes, to some extent	27		✓
	24		
No, but I would have liked help or advice with finding support	30		✓
	50		

■ On CPA   ☐ Not on CPA / CPA status unknown

Number of respondents: On the CPA (2,337) and Not on the CPA/ CPA status unknown (4,585)
Note: those who answered 'I have support and did not need help/advice to find it' and 'I do not need support for this' were excluded from the analysis.

Figure 9
Q35. 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)

	%		Significant difference
Yes, definitely	38		✓
	24		
Yes, to some extent	32		✓
	27		
No, but I would have liked help or advice with finding support	30		✓
	49		

■ On CPA   ☐ Not on CPA / CPA status unknown

Number of respondents: On the CPA (1,132) and Not on the CPA/ CPA status unknown (2,068)
Note: those who answered 'I have support and did not need help/advice to find it', 'I do not need support for this' and 'I am not currently in or seeking work' were excluded from the analysis.
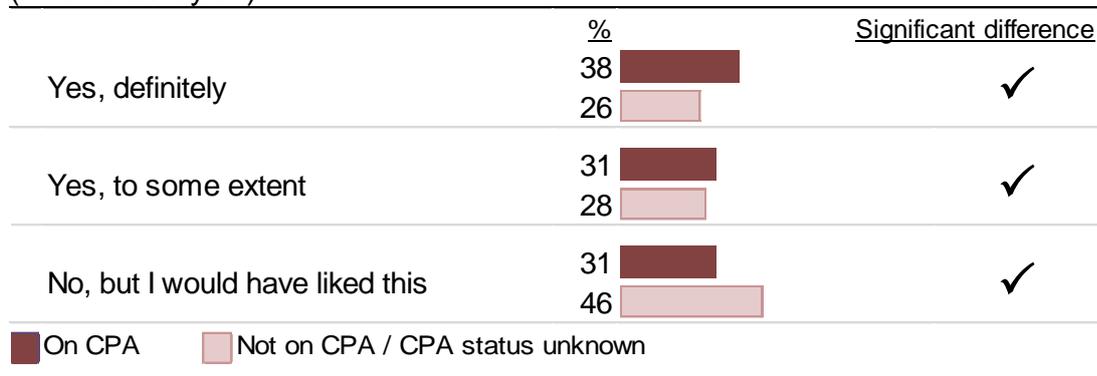
Community / social activities

Respondents were asked whether someone from NHS mental health services supported them in taking part in an activity locally. Of those respondents who needed or wanted it, 30% said that someone from NHS mental health services had 'definitely' supported them in taking part in an activity locally (28% in 2015).

Respondents on the CPA (38%) were more likely than those not on the CPA (26%) to say that someone from NHS mental health services had 'definitely' supported them in taking part in an activity locally.

Figure 10
Q36. Has someone from NHS mental health services supported you in taking part in an activity locally?
(Answered by all)

	%		Significant difference
Yes, definitely	38		✔
	26		
Yes, to some extent	31		✔
	28		
No, but I would have liked this	31		✔
	46		

■ On CPA ☐ Not on CPA / CPA status unknown

Number of respondents: On the CPA (2,154) and Not on the CPA/ CPA status unknown (4,127)
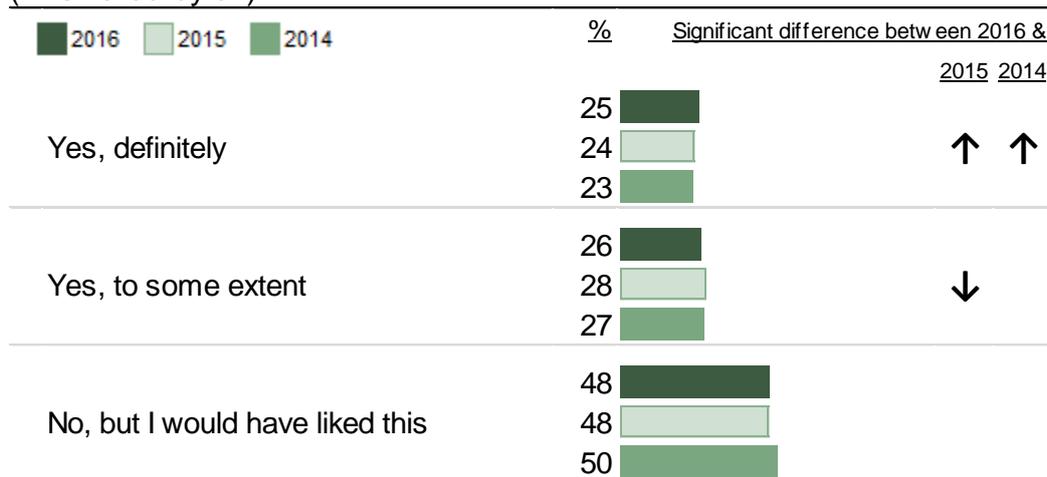**Note:** those who answered 'I did not want this / I did not need this' were excluded from the analysis.

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

Respondents were asked whether 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. Of the respondents who wanted this, a quarter (25%) had 'definitely' been given this information (24% in 2015 and 23% in 2014).

Figure 11
Q38. 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)

	%	Significant difference between 2016 &	
		2015	2014
■ 2016 ☐ 2015 ■ 2014			
Yes, definitely	25		
	24	↑	↑
	23		
Yes, to some extent	26		
	28	↓	
	27		
No, but I would have liked this	48		
	48		
	50		

Number of respondents: 2014 (7,641), 2015 (6,585) and 2016 (7,630)
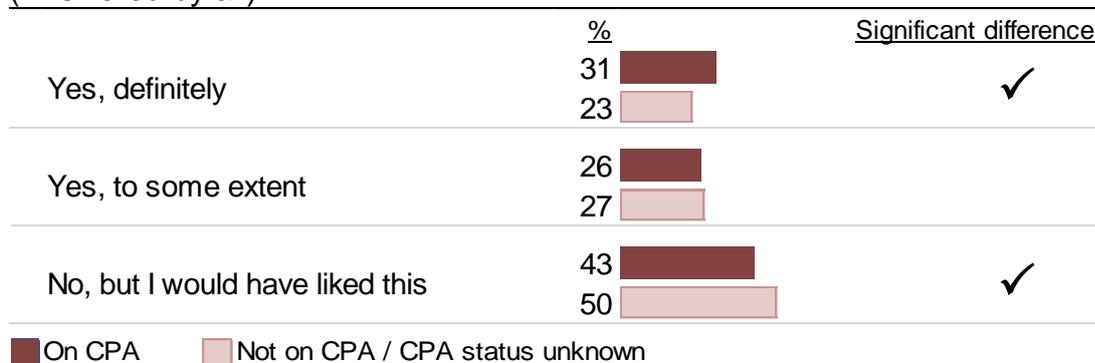**Note:** those who answered 'I did not want this' were excluded from the analysis.

Respondents on the CPA (31%) were more likely than those not on the CPA (23%) to say that they 'definitely' had been given this information.

Figure 12

Q38. 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 the CPA (2,278) and Not on the CPA/ CPA status unknown (5,336)
Note: those who answered 'I did not want this' were excluded from the analysis.

Involving family or friends

The involvement of family (or someone else close to them), when wanted, is an essential component of providing good care. Research suggests such involvement can increase people's knowledge, confidence and understanding in dealing with health issues.

NICE guidance 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 whether NHS mental health services involved a member of their family or someone else close to them as much as they would have liked them to. Of those who wanted friends or family involved, the majority (55%) said that a member of their family or someone else close to them had 'definitely' been involved as much as they would have liked them to be. The remainder responded with 'yes to some extent' (24%), 'no, not at much as I would like' (17%) or 'no, they have involved them too much' (3%).[m]

Understanding of wider life

NICE quality statement 1 says that people using mental health services should feel optimistic that care will be effective. This was reflected in findings from the development work for the survey in 2014, which revealed that an important aspect of the relationship between people who use services and staff was the staff's understanding of their lives as a whole, with the interaction between their mental health and the rest of their life clearly understood.

We asked respondents if the people they saw through NHS mental health services helped them with what is important to them. Less than half (46%) said they 'always' did, 36% that they 'sometimes' did and 17% said they did not.

[m] 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'.

10: Overall

This final section asked about respondents' experiences of care and treatment overall.

We asked all respondents to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'). Just under two thirds rated their overall experience with a score of seven or above out of 10 in 2016 (65% in 2016, 64% in 2015).

Figure 13
Q40. Overall……
(Answered by all)
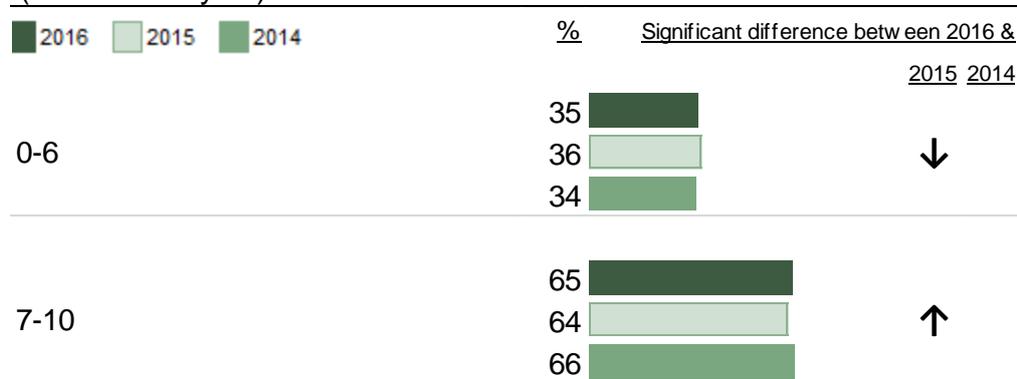
Number of respondents: 2014 (12,668), 2015 (10,677) and 2016 (12,207)
Note: Respondents were asked to rate their overall experience on a 0-10 scale where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'.

The NHS Constitution states that patients have the right to be treated with respect and dignity. This is also reflected in NICE quality statement 2, 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 (74%) of respondents said that overall, in the last 12 months, they felt that they were 'always' treated with respect and dignity by NHS mental health services. Almost a fifth (19%) said they 'sometimes' were and 7% said they were not (6% in 2014).

Appendix A: Survey Methodology

Questionnaire Design

The same questions are included to enable year-on-year comparisons where possible. However, 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 to other stakeholders who use the survey data in their work. More information on survey stakeholders and how they use the data can be found in Appendix D.

Changes made to 2015 questionnaire:
- removed three questions
- added two questions
- made a minor amendment to one question (new response option)
- changed the title of one of the questionnaire sections.

This means that most questions included in the 2016 questionnaire can be compared with results from the 2015 and 2014 surveys. All new questions are tested with people who have recently used services to ensure they are understood as intended.

For more detailed information please see:

- The 'Development Report for the Community Mental Health Survey 2016' available here:
  www.nhssurveys.org/survey/1730.
- The final questionnaire for the 2016 survey available here:
  www.nhssurveys.org/surveys/887.
- The questionnaire was substantially redeveloped in 2014 and the development report is available here: www.nhssurveys.org/surveys/750.

Survey Method

As with most surveys in the NHS 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

People aged 18 and over were eligible for the survey if they received specialist care or treatment for a mental health condition and had been seen by the trust between 1 September 2015 and 30 November 2015. 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 is 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 links in Appendix F).

All providers of community mental health services were eligible to take part in the survey.

Certain groups of people were excluded from the survey before providers drew their samples, including:

- Anyone who was a current inpatient.
- Anyone seen only once for an assessment.
- Anyone seen for assessment only through a liaison service.
- Anyone primarily receiving the following services: drug and alcohol; learning disability; forensic; psychological treatments from Improving Access to Psychological Therapies (IAPT); Chronic Fatigue/ME; Psychosexual Medicine (sexual dysfunction); Gender Identity.
- People who have only been in contact via telephone or email, and have not been seen in person at all.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2016.

For more detailed information on the sampling instructions, and inclusion and exclusion criteria, please see the [instruction manual](#) for the survey.[32]

Analysis methodology

Weighting

The weighting strategy for the England level results has changed from the 2014 and 2015 survey analysis to adopt the approach applied to other recently published surveys reporting on more than two years of data.

The revised weighting takes account of changes in the demographic profile over the comparable years of the survey, and means that if this has changed, we can compare results more fairly. The revised weighting strategy has been applied to the 2014 and 2015 data published in this report. This means that there may be small differences for some survey results between the figures published here and those published at the time in 2014 and 2015.

For more detailed information, please see the Quality and Methodology report published on the [CQC website](#).

Some trusts have a higher response rate than others and would therefore have a greater influence over the England average 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 England average, regardless of differences in response rates between trusts.

Trust weights are useful for calculating the figures for England because they describe the results of the hypothetical 'average trust' for a given year. As they are intended to produce a single estimate, they do not take into account any of the individual level variables that are related to how people respond – such as age and gender. This is acceptable when comparing year-on-year results because of the relatively limited annual change in the demographic profile of the overall set of respondents. However, over longer periods, the small annual changes accumulate and need to be taken into account, and further standardisation needs to be applied. Due to this, the weighting strategy has been changed for the 2016 survey to also include a demographic weight. A similar approach has been used in other surveys including the NHS acute inpatient survey.

Results for 2015 and 2014 presented in this statistical release are weighted to the demographic profile of 2016 in terms of age and sex. These are applied at trust level rather than for England. There are 8 unique weights per trust per year, one for each of the age/sex groups.

Both sets of weights are then multiplied together to produce a single combined weight for the data tables that underpin the analysis.

This weighting has been applied to all questions that assess patient experience in any way. All questions that have been weighted are also 'scored' questions, as seen in the scored questionnaire available here.

All other questions, including the demographic questions in the 'About You' section (Q42-Q47) are not weighted, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than adjust figures.

Please note that where we analyse questions by CPA, this data is also unweighted. CPA is interpreted and applied very differently between trusts: for respondents to the 2016 survey the proportion on the CPA ranged from a low of 3% to a high of 73%. It is therefore not appropriate to apply weights.

Rounding
The results 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 2016 compared with the last time the survey was conducted in 2015, and likewise in 2014.

A 'z-test' set to 95% significance was used to compare data between survey years and between different groups. 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 figures display 'up' and 'down' arrows to indicate whether there has been a 'statistically significant' change between 2016 and 2015; and between 2016 and 2014.

↑ 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 the CPA, and those who do not receive services on the CPA, for some questions. These figures are shown in a different colour (brown) to clearly distinguish them from other results.

In these figures 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.

Notes on specific questions

This below table provides information about the analysis of particular questions:

Table A1: analysis applied to particular questions

Question	Analysis applied
Q8:[n] Is the person in charge of organising your care and services…	Respondents may have ticked more than one option to this question. Results are presented as percentages for each option, out of all those eligible to answer that question, because some respondents will have selected more than one category. This means that the results may add up to over 100%. Though this question is not included in this report, you can find the results to this question in the Open data available on the CQC website.
Q9 and Q10: Q9 Do you know how to contact this person if you have a concern about your care? 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 analysis 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?	As the question specifies a time period of 'the last 12 months' we have removed people who said they have been in contact with mental health services for less than a year (based on their responses to $Q2^o$) from the data set, and they are therefore not included in the analysis for this question. This is because they have not been in contact with services long enough to reasonably expect them to have had a care review.
Q15 and Q16: Q15 Were you involved as much as you wanted to be in discussing how your care is working? Q16 Did you feel that decisions were made together by you and the person you saw during this discussion?	This year we have revised the analysis rules for Q15 and Q16, to be consistent with that applied to Q14. This new approach removes respondents who stated at Q2 they had been in contact with mental health services for less than a year from the data set and they are therefore not included in the results for Q15 and Q16 (as well as for Q14) because we cannot be certain that respondents were referring to a care review.

[n] 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.
[o] Respondents who selected option one (*'less than a year'*) at Q2 *(Overall, how long have you been in touch with NHS mental health services?)* were removed from the analysis of Q14, Q15 and Q16 as reported in this section.

	The results from the 2015 survey for these questions have been rerun to match the revised approach.

Comparability with previous years

The results for most questions from the 2016 survey are comparable with the 2015 and 2014 survey. The following questions are **not comparable** for the reasons outlined below:

Table A2: comparability with previous years

Question	Reason not comparable with 2015 and 2014
Q17: In the last 12 months, have the people you see for your care or services changed?	A new response option (*yes, but this was because I requested this change*) has been added to this question. It is therefore not possible to compare the results for this question with 2015 or 2014.
Q18: Were the reasons for this change explained to you at the time?	This is a new question for 2016, and it is therefore not possible to compare the result for this question with 2015 or 2014.
Q19: What impact has this had on the care you receive? **Q20:** Did you know who was in charge of organising your care while this change was taking place?	Only people who answer 'yes' to Q17 answer these questions, with all other responses being routed past (to Q21). A new response option has been added to Q17 (*yes, but this was because I requested the change*), which will have changed the number of people who go on to answer Q19 and Q20, meaning results are no longer comparable with 2015 or 2014.
Q31: Were these treatments or therapies explained to you in a way you could understand?	This is a new question for 2016, and it is therefore not possible to compare the result for this question with 2015 or 2014.
Q39: Do the people you see through NHS mental health services help you with what is important to you?	Two questions that came before and after this question were removed for 2016. As it cannot be known if any change in the result for this question in 2016 was caused by a change in the ordering of the questions, this question is not comparable with 2015 or 2014.

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.

- 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.

Appendix B: Other sources of information related to survey results

The below provides links to other sources of data related to mental health services. Please note that the below do not measure patient experience and are therefore not directly comparable to findings presented in this report.

NHS Outcome Framework Indictors

The indicators in the NHS Outcomes Framework have been designed to provide national-level accountability for the outcomes that the NHS delivers and drive transparency, quality improvement and outcome measurement throughout the NHS. They do not set out how these outcomes should be delivered; it is for NHS England to determine how best to deliver improvements by working with clinical commissioning groups (CCGs) to make use of the tools available.

For more information about the NHS Outcome Framework, please visit NHS Digital (formerly the Health and Social Care Information Centre) and GOV.UK websites:

http://content.digital.nhs.uk/m/nhsof

www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

http://content.digital.nhs.uk/mhldsmonthly?tabid=2

Staffing

Statistics on staffing numbers are provided in NHS Digital's statistical release on NHS Workforce Statistics. Please note this data covers all trust types, such as acute and community trusts, as well as mental health providers. For more information, please see:
http://digital.nhs.uk/workforce.

Statistics on the use of mental health services

The Mental Health and Learning Disabilities Data Set (MHLDS) is released monthly and 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 the 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 and learning disability services.
- The sample for the survey has certain exclusions, for example, we exclude people with learning disabilities, certain specialities such as forensic services, and people under the age of 18. For full details of the survey inclusion and exclusion criteria, please see the instruction manual available at www.nhssurveys.org/surveys/891.

For more information on MHLDS, please see: http://digital.nhs.uk/mhldsreports.

Waiting times

The government has committed to introducing access and waiting time standards for mental health services. For more information, please see: www.england.nhs.uk/mentalhealth/resources/access-waiting-time/.

Appendix C: Comparisons with other surveys

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 related to community mental health services are carried out. The surveys that are carried out tend to be to establish prevalence of mental health issues rather than focused on experiences of care received.

There are, however, many other surveys carried out in the UK 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. Some of the larger surveys are summarised below:

The Health Survey for England

The Health Survey for England is a series of annual surveys designed to measure health and health related behaviours in adults and children. It covers a wide variety of topics that vary from year to year. In 2014, the survey included questions on the prevalence of mental health issues in England, and found around a quarter (26%) of adults reported having ever been diagnosed with at least one mental illness.

For more information, please see:
http://healthsurvey.hscic.gov.uk/support-guidance/public-health/health-survey-for-england-2014/mental-health-problems.aspx

National Audit of Schizophrenia

The National Audit of Schizophrenia (NAS) is an initiative of the Royal College of Psychiatrists' Centre for Quality Improvement. 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 of 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 2016 survey uses a different format of question, and found that 65% of people rated their care as seven or above, out of 10 (Q40).

- 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-three per cent of respondents to the 2016 survey reported a similar answer, saying they did not receive help or advice but would have liked to, down from 47% in the 2015 survey (but no statistically significant change from 44% in the 2014 survey). Note: the survey results exclude those who said they already have support and did not need help, those who did not need any support, and those currently not seeking work.

The National Audit of Schizophrenia was contracted for two rounds and no further updates are expected.

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.

The 2014 survey found demographic inequalities in those who received treatment, with people from Black and minority ethnic groups (BME) having particularly low treatment rates. Socio-economic inequalities were less evident.

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:
http://natcen.ac.uk/our-research/research/adult-psychiatric-morbidity-survey/.

Mental Health of Children and Young People in Britain

This survey was first carried out in 2004, and will be repeated in 2016. It aims to check the prevalence of three main childhood mental disorders: conduct disorder, hyperactivity and emotional disorders. The sample is drawn from child benefit

records and used an interview methodology. Data was collected from adults and teachers, or children aged 11-16.

Results are not directly comparable with the Community Mental Health Survey due to the different sample, methodology and question content.

For more information, please see:
www.natcen.ac.uk/taking-part/studies-in-field/mental-health-of-children-and-young-people-2016/.

Appendix D: 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.

Care Quality Commission (CQC)

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's Insight, an intelligence tool that indicates potential changes in quality of care to support decision-making about our regulatory response. Survey data will also form a key source of evidence to support the judgements and inspection ratings published for trusts.

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-2016-to-2017.

NHS England

NHS England use questions from the NHS Patient Survey Programme (specifically the Inpatient, Community Mental Health and Emergency Department 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.

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.

More information is available here:
www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/.

NHS Improvement

On 1 April 2016, the NHS Trust Development Authority became part of NHS Improvement. NHS Improvement oversees NHS trusts and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high-quality, compassionate care within local health systems. NHS Improvement will use the results of the adult inpatient survey to inform quality and governance activities as part of its Oversight Model for NHS Trusts.

For more Information about NHS Improvement, please see: https://improvement.nhs.uk/.

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 public to examine how services are performing, alongside their inspection results. The search tool is available from the CQC home page:
www.cqc.org.uk/.

Appendix E: Quality and methodology

Quality and Methodology

All detail on data limitations can be found in the Quality and methodology document, available at www.cqc.org.uk/cmhsurvey.

Revisions and corrections

CQC publishes a Revisions and Corrections Policy relating to these statistics. The NHS Patient Survey Programme 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 or reports.

Appendix F: Further information and feedback

Further information

This report, together with 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 results from previous community mental health surveys that took place between 2004 and 2008,[p] and between 2010 and 2013, are available at the link below. Please note that due to redevelopment work, results from the 2016 survey are only comparable with 2015 and 2014[q]:
www.nhssurveys.org/surveys/290.

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/877.

More information on the NHS Patient Survey Programme, including results from other surveys and a programme of current and forthcoming surveys can be found at:
www.cqc.org.uk/content/surveys.

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the Community Mental Health Survey 2016. The guidance above should help answer any questions you have about the programme. However, if you wish to contact the Team directly please contact Paul Williamson, User Voice Development Manager, at 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, at Patient.Survey@cqc.org.uk.

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[p] In 2009 a survey of mental health inpatient services took place
[q] Please note that the survey was also substantially redeveloped in 2010. This means that surveys carried out between 2010 and 2013 are comparable with each other but not with any other surveys

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

References

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[24] www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

[25] http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-145

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[32] www.nhssurveys.org/surveys/891