



Benchmarking Network

# Mental Health Benchmarking

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## NHS Benchmarking Network Mental Health Benchmarking 2014



## Report for Trust: T00

Comparison with all respondents, unweighted population





# Mental Health Benchmarking

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## Executive Summary

This year's Mental Health Benchmarking Report analyses data from 1st April 2013 to 31st March 2014 across all Mental Health Trusts in England, all Local Health Boards in Wales, and a number of independent sector providers of inpatient care. Comparisons are available between organisations nationally and within local geographical peer groups using former SHA boundaries. Where relevant, data from 2011/12 and 2012/13 is included in key indicators to show the trends of the past few years.

This report confirms the reduction in acute beds between 2011/12 and 2012/13 has continued and this year's figures for adult and older adult acute beds are lower than any previously reported. Length of stay has not changed significantly in adult services, while bed occupancy has continued to rise. This is an expected result of the increased pressure of operating a reduced bed base.

A detailed analysis of the mental health workforce is provided and shows wide variation between different specialisms. The specialties with the highest staffing are PICU, secure services and mother and baby units. In the community, the highest staffed teams are Early Intervention and Crisis Resolution and Home Treatment.

Cluster data illustrates higher acuity of patients within acute beds compared to previous years. This is consistent with bed closures resulting in higher thresholds for admission and thus the typical patient cohort being more acutely unwell than in previous years. A further impact of this may be an increased pressure on community services. Analysis of this area confirms an increased demand for community teams, shown by higher caseloads.

Quality data looks at measures such as serious incidents, patient feedback, violence, use of seclusion and restraint. Rates have generally increased this year, although it is likely that this is, in part, due to more thorough reporting of incidents at the local level.

The overall theme of this year's report is increased pressure on both community and bed-based services on a national scale. The Mental Health Toolkit which accompanies this report provides a great number of benchmarking comparisons that look in more detail at some of the points raised here.

We would like to thank all of our members for their contributions to the 2014 benchmarking process.





Benchmarking Network

## Introduction

This report summarises the main findings from the 2014 benchmarking process that has taken place across NHS mental health services in England and Wales. This year we are delighted to report that participation levels are at record levels with all English NHS Trusts and Foundation Trusts who are providers of secondary mental health services taking part, along with all NHS providers of secondary mental health services within the NHS in Wales. For the first time we also have involvement from independent sector mental health providers. The high levels of involvement, and comprehensive submissions position for England and Wales, make the 2014 findings particularly compelling.

The benchmarking process has been member driven from inception and we would like to acknowledge the contribution made by the mental health reference group who have shaped the content of the project and definitions used to ensure like for like comparisons have been developed. We would also like to acknowledge the significant input of member organisations who took time to collect and validate data. All comparisons within the report use the financial year 2013/14 which creates a highly timely picture of the mental health sector across England and Wales.

In addition to the 78 specific comparisons presented in the report, we would also like to reference the supporting mental health benchmarking toolkit which will be made available to all contributors. This is a bespoke software tool that allows around 5,000 individual comparisons to be viewed for each contributor. This guarantees a richness of content and understanding which can be used to fully profile local services and positions against peers.

This version of the report looks at metrics benchmarked against a weighted population measure. Respondents also receive a report using a GP registered population. The interactive toolkit allows users to view a still wider range of metrics, with both weighted and registered population views.

Edward Colgan  
Chief Executive  
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& Chair of NHSBN Mental Health Reference Group

Stephen Watkins  
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NHS Benchmarking Network





## Mental Health Reference Group Members

The following people advised on the benchmarking process throughout and also shaped the content of this report.

Edward Colgan	Somerset Partnership NHS Foundation Trust
Tracy White	Central and North West London NHS Foundation Trust
Jayne Flynn	Coventry and Warwickshire Partnership NHS Trust
Jennifer Illingworth	Northumberland, Tyne & Wear NHS Foundation Trust
Catherine Magee	Berkshire Healthcare NHS Foundation Trust
Ian Minto	Manchester Mental Health & Social Care Trust
Toby Rickard	Avon & Wiltshire Mental Health Partnership NHS Trust
Lee Cornell	Somerset Partnership NHS Foundation Trust
Chris Lanigan	Tees Esk and Wear Valleys NHS Foundation Trust
Gordon Folkard	Avon & Wiltshire Mental Health Partnership NHS Trust
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Mel Conway	South Essex Partnership NHS Foundation Trust
Nick Jenvey	Dorset Healthcare NHS Foundation Trust
Sally Wilson	Hertfordshire Partnership NHS FT
Wendy Copeland Blair	Mersey Care NHS Trust
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Emma Baker	Dorset Healthcare NHS FT
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Anne Forbes	Devon Partnership NHS Trust
Rony Arafin	Devon Partnership NHS Trust
Joanne Pinnington	5 Boroughs Partnership NHS Foundation Trust
Alan Davies	Cardiff and Vale University Health Board
Shane Mills	Cardiff and Vale University Health Board
Esther Provins	Dorset Healthcare NHS Foundation Trust
Mark Landau	Hertfordshire Partnership NHS Foundation Trust
Adrian Clarke	NHS Wales
Neil Griffiths	Cheshire and Wirral Partnership NHS Foundation Trust





## Terms of Reference

The terms of reference for the project have been developed by the mental health benchmarking reference group. The terms of reference reflect the project's overall objectives and are reviewed by the project reference group on an on-going basis.

The terms of reference for the Mental Health benchmarking project are;

- \* To develop a specification for benchmarking mental health services
- \* To support members in collecting consistent data
- \* To process data and produce comparisons for member organisations
- \* To validate data and ensure comparisons are robust
- \* To produce detailed analysis reports for members
- \* To support a desktop benchmarking toolkit and other reporting formats for members
- \* To develop conclusions on the results of mental health benchmarking
- \* To help identify and share good practice amongst member organisations
- \* To support on-going improvements within the mental health sector
- \* To facilitate networking and communications amongst member organisations

Wider objectives around contributing to continuous service improvement will be taken forward by the NHS Benchmarking Network through the knowledge exchange and networking services provided by the network.

Mental health is an important aspect of the NHS Benchmarking Network's wider work programme and will continue as an on-going area of project work in future years. The commitment to further enhance and develop the network's mental health workstream in future years provides an excellent platform for future service provision to members and engagement with the wider member community.

Members should also note that additional products are available to mental health providers that support additional analysis on other aspects of services offered by many mental health providers. Examples include CAMHS benchmarking which is now in its fifth cycle. New projects for 2014 also include projects on learning disabilities and pharmacy which contains elements of relevance to many Trusts. All of these products can be accessed from the NHS Benchmarking Network's website

[www.nhsbenchmarking.nhs.uk](http://www.nhsbenchmarking.nhs.uk)





## Participants

This year, 66 participants have taken part in the benchmarking cycle. This is an increase from 57 organisations last year and 42 in 2012. This includes English Mental Health Trusts and Welsh Local Health Boards. In addition, we have some new private sector members who have taken part for the first time.

Participant organisations in the 2014 benchmarking study are as follows:

2gether NHS Foundation Trust  
5 Boroughs Partnership NHS Foundation Trust  
Abertawe Bro Morgannwg UHB  
Aneurin Bevan UHB  
Avon and Wiltshire Mental Health Partnership NHS Trust  
Barnet, Enfield and Haringey Mental Health Trust  
Berkshire Healthcare NHS Foundation Trust  
Betsi Cadwaladr UHB  
Birmingham and Solihull NHS Foundation Trust  
Black Country Partnership NHS Foundation Trust  
Bradford District Care Trust  
Cambridgeshire and Peterborough NHS Foundation Trust  
Camden and Islington NHS Foundation Trust  
Cardiff & Vale UHB  
Central and North West London NHS Foundation Trust  
Cheshire & Wirral Partnership NHS Foundation Trust  
Cornwall Partnership NHS Foundation Trust  
Coventry & Warwickshire Partnership Trust  
Cumbria Partnership NHS Foundation Trust  
Cwm Taf LHB  
Derbyshire Community Health Services NHS Trust  
Derbyshire Healthcare NHS Foundation Trust  
Devon Partnership NHS Trust  
Dorset HealthCare University NHS Foundation Trust  
Dudley & Walsall Mental Health Partnership NHS Trust  
East London NHS Foundation Trust  
Greater Manchester West Mental Health NHS Foundation Trust  
Hertfordshire Partnership University NHS Foundation Trust  
Humber NHS Foundation Trust  
Hywel Dda UHB  
Isle of Wight NHS  
Kent and Medway Partnership Trust  
Lancashire Care NHS Foundation Trust  
Leeds and York NHS Partnership Trust  
Leicestershire Partnership NHS Trust  
Lincolnshire Partnership NHS Foundation Trust





Manchester Mental Health & Social Care Trust  
Mersey Care NHS Trust  
Norfolk and Suffolk NHS Foundation Trust  
North East London NHS Foundation Trust  
North Essex Partnership NHS Foundation Trust  
North Staffordshire Combined Healthcare NHS Trust  
Northamptonshire Healthcare Foundation Trust  
Northumberland, Tyne & Wear NHS Foundation Trust  
Nottinghamshire Healthcare NHS Trust  
Oxford Health NHS Foundation Trust  
Oxleas NHS Foundation Trust  
Pennine Care NHS Foundation Trust  
Plymouth Community Healthcare (CIC)  
Priory Group  
Rotherham Doncaster and South Humber NHS  
Sheffield Health and Social Care NHS Foundation Trust  
Solent NHS Trust  
Somerset Partnership NHS Foundation Trust  
South Essex Partnership NHS Trust  
South London and Maudsley NHS Foundation Trust  
South Staffordshire & Shropshire Healthcare NHS Foundation Trust  
South West London & St George's Mental Health NHS Trust  
South West Yorkshire Partnership NHS Foundation Trust  
Southern Health NHS Foundation Trust  
St Andrews Healthcare  
Surrey and Border Partnership NHS Foundation Trust  
Sussex Partnership NHS Foundation Trust  
Tees, Esk and Wear Valleys NHS Foundation Trust  
West London Mental Health Trust  
Worcestershire Health and Care NHS Trust

The level of participation in 2014 covers 100% of NHS provider organisations in England and Wales. We are also delighted that the 2014 project includes data contributions from specialist mental health providers in the independent and charitable sectors.







## Analysis overview

The analysis in this report provides an overview of the metrics benchmarked this year, and commentary on key indicators common to many providers such as length of stay in both adult acute and specialist beds. The related mental health toolkit provides further, more detailed analysis of the full data set collected. Over comparisons are possible from this toolkit. The project covers all aspects of community mental health services. Where population based demographics are used, these use weighted populations. These weightings have been provided by NHS England and are consistent with the mental health element of CCG allocations.

They key domains covered by this project are activity, finance, workforce and quality and a selection of metrics from each area is included here. The report also contains detail on specialist services such as PICU and Eating Disorders, allowing providers to see at a glance how their services compare.

While this report contains a short section on community services, further analysis of the different teams operating in the community is available in the mental health toolkit.

Similarly, an overview of staffing positions is included in this report, including benchmarks of consultant psychiatrists and of qualified nurses. A full breakdown of ward and community skill mix can be reviewed in the toolkit. This allows organisations to see not only how they compare in terms of numbers of qualified or unqualified staff, but also their proportion in each level of seniority compared to peers.

Mental Health service models are complex and different local solutions have emerged over time, meaning provision can vary on a local and regional level with no two Trusts or Health Boards offering an identical mix of core, specialist and community services. The diagram below shows the overall profile both of your individual organisation and the English and Welsh mental health systems as a whole. On average, organisations find that approximately 45% of their beds are specialist, 21% are for older peoples' services and 34% are general acute inpatient beds for working age adults, though this varies dramatically between organisations, with some providers having very few specialty beds.

In Figure 1, the inner ring represents the reported split in your organisation, and the outer ring reflects the English and Welsh average.

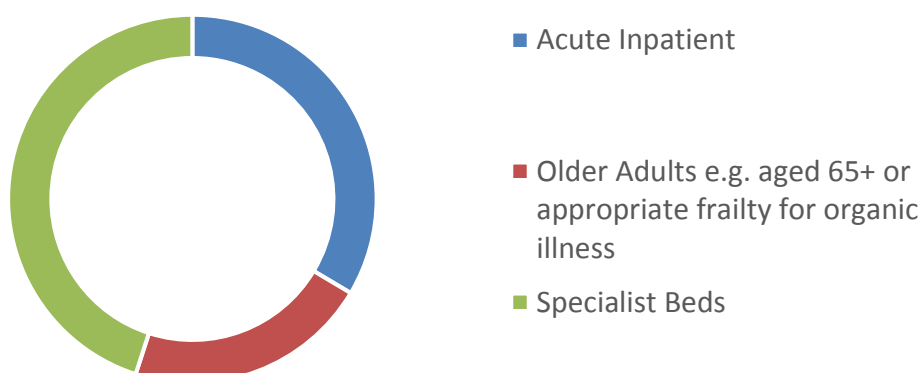


Figure 1





## Bed provision - Adult Acute beds

The number of Adult Acute beds per Trust/LHB is shown here per 100,000 registered population of working age adults. Additional reports are available which use a weighted population measure derived from the Department of Health. This considers the impact on demand for mental health services from a variety of factors including age, sex, ethnicity and mortality. A small number of Trusts and Health Boards have local populations whose mental health needs are higher than the normal range of need in the NHS, and some have local populations whose mental health needs are lower. These Trusts and Health Boards will find it useful to consider the weighted population analysis alongside the registered population analysis to gain a complete picture of their position when benchmarked nationally and against their local peers.

Provision across the NHS ranges from 11 beds per 100,000 population to 39 beds per 100,000 population, with a median position of 19. This compares to a median position of 22.6 beds per 100,000 population in 2013 and a median of 23 beds per 100,000 population in 2012.

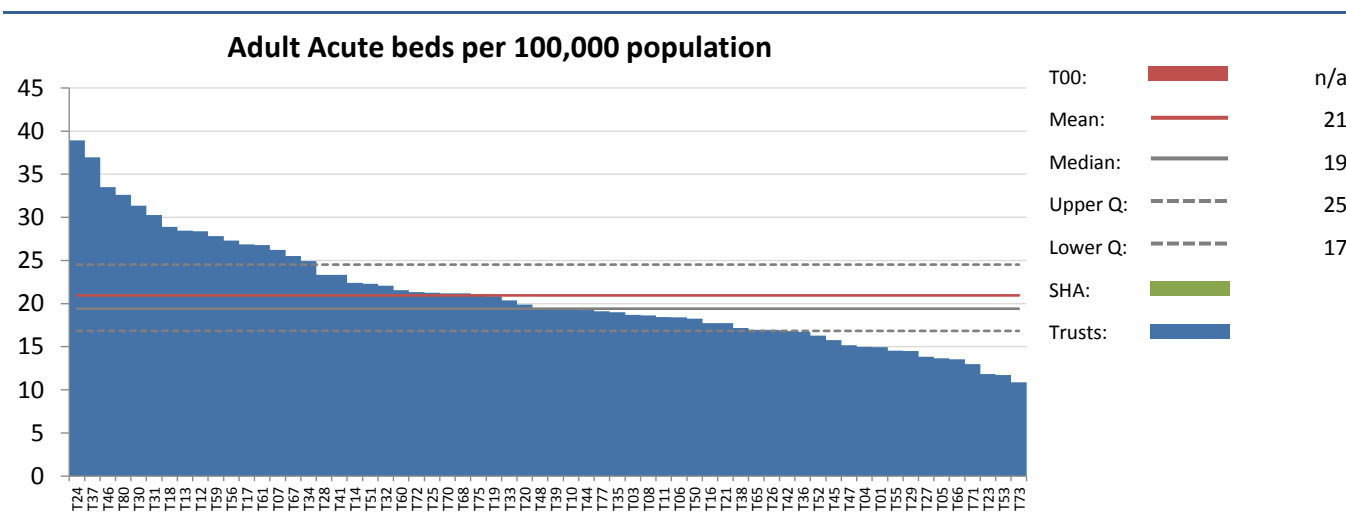


Figure 2

The Royal College of Psychiatrists suggests a bed occupancy rate of 85% is optimal as it enables patients to be admitted in a timely fashion, reducing the risk of deterioration which may occur if a patient has to wait for a bed to become available. Similarly, this level allows flexibility for patients to take leave without the risk of losing a place in the same ward should that be needed.

Bed occupancy for Adult Acute beds, shown in Figure 3, is consistently high with a median occupancy this year of 93%. This compares to a median bed occupancy of 89% in 2013 and 91% in 2012. This increase in bed occupancy rates of around 4% should be seen in the context of the reduced number of beds reported in figure 2. The range is relatively low, with a lower quartile of 88% and an upper quartile of 97% indicating that while the majority of organisations are above the RCPsyc recommended threshold, most are within a few percentage points of their peers on this measure. These figures relate to bed occupancy excluding leave, although comparisons including leave are also reported and are provided in the Mental Health toolkit.





The chart shows actual bed occupancy and has not been adjusted for any long or short stay outliers in the data. The Mental Health toolkit can be used to adjust for the impact of long and short stay outliers on a number of metrics in adult acute care.

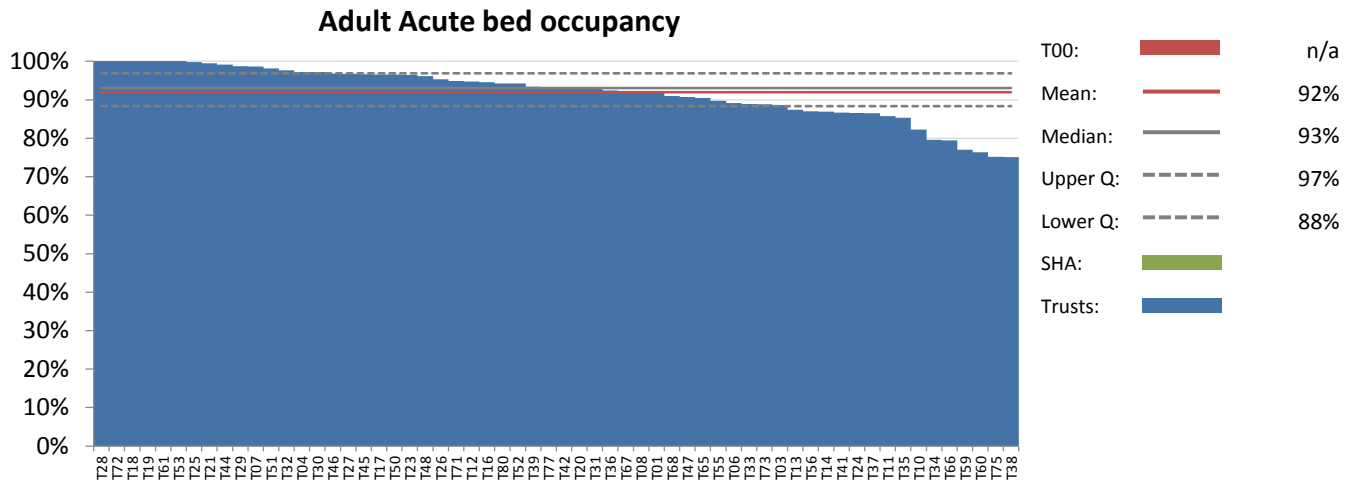


Figure 3





## Adult Acute Admissions

The number of admissions to acute adult beds is shown per 100,000 registered population. This figure should be considered along side factors such as total number of beds provided by each Trust/LHB, length of stay of patients and the needs of the local population served by the Trust/LHB.

The median position is 229 admissions per 100,000 registered population of working age adults. This can be compared to a median figure of 236 admissions per 100,000 population in 2013, and a median figure of 234 admissions per 100,000 population in 2012. Thus, although the number of beds is reducing (Figure 2), number of admissions into those beds has not changed significantly over the last 3 years.

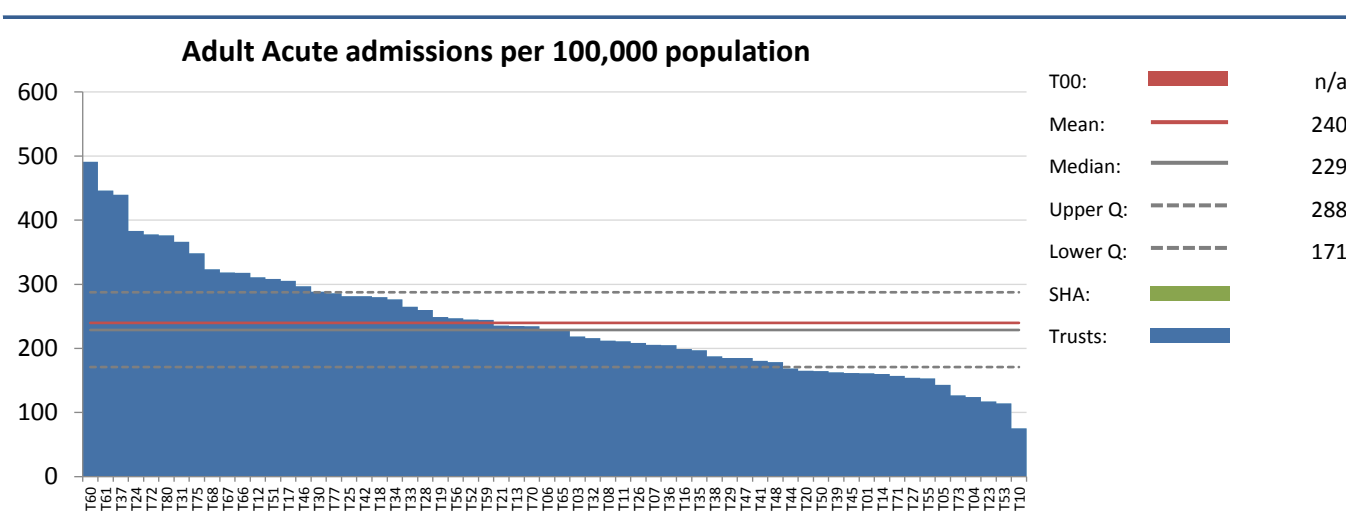


Figure 4

Data on occupied bed days for adult acute beds is shown in Figure 5. This data excludes patient leave and the range is influenced by both the number of beds available and the average length of stay of patients in those beds. A measure of bed days is used to allow comparisons between organisations with varying sizes of catchment area.

In 2013 the mean position reported was 8098 occupied bed days per 100,000 registered population. Notable change has been observed this year, with a 2014 mean position of 7,183 bed days per 100,000 population. The median position has dropped to 6,765 bed days in 2014, from 7087 in 2013. This is likely to be due to the inclusion of new contributors for the first time which has skewed the distribution of the data.

The reduction in occupied bed days in the last year is largely consistent with the reduced number of beds available, despite the growth in bed occupancy.



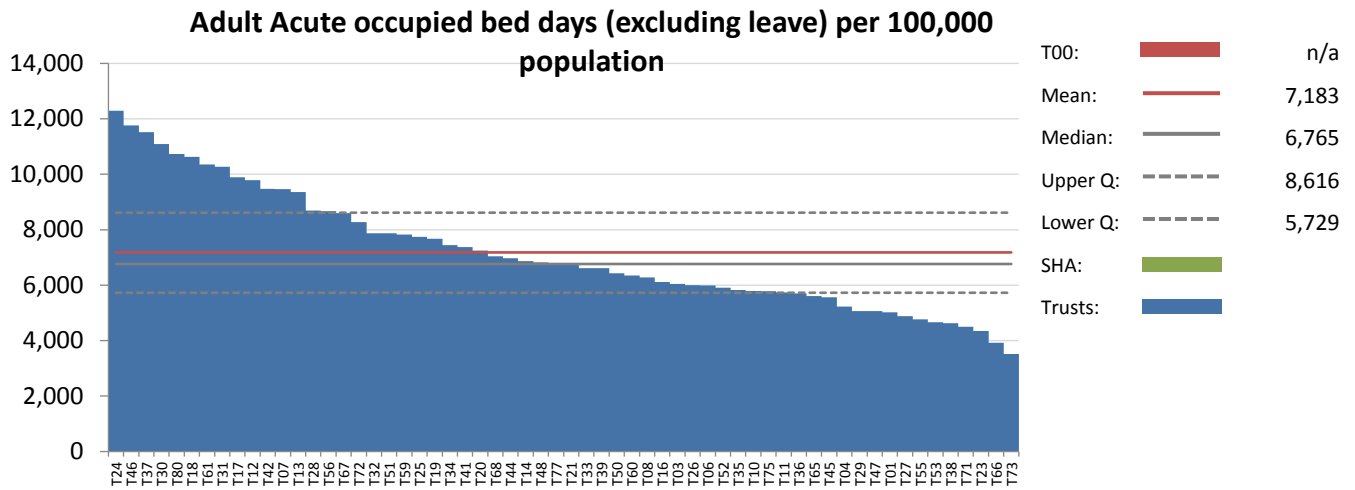


Figure 5





## Length of stay and delayed transfers

Average length of stay is a key performance measure used by mental health providers. It can be a measure of efficiency but is also used to assess whether appropriate patients are being admitted into beds. A number of factors influence length of stay and explain the variation between providers. These can include the capacity and range of community services available to which patients can be discharged, the acuity of the caseload, the number of patients subjected to delayed transfers of care and the length of these delays, and the number of beds available. In mental health services, Trusts and LHBs with fewer beds will often report longer average lengths of stay due to the acuity of patients who are admitted. Thresholds for admission can be higher when resources are limited.

This year, the mean length of stay is 32.4 days, compared to 30.2 days in 2013 and 32 days in 2012. It must be noted that the data in Figure 6, below, is the reported mean length of stay excluding leave and has not been adjusted for outliers (long-stay and short-stay patients). The mental health benchmarking toolkit includes alternative comparisons in these areas.

It should also be noted that the participants in 2014 are slightly different to 2013 and include 9 organisations who are providing data for the first time this year. The fact that 2014 data includes all NHS statutory providers in England and Wales will provide an excellent and stable platform for measuring future changes in average length of stay. This will provide the ability to actively monitor the impact of new initiatives such as the introduction of admission avoidance schemes and short stay assessment facilities.

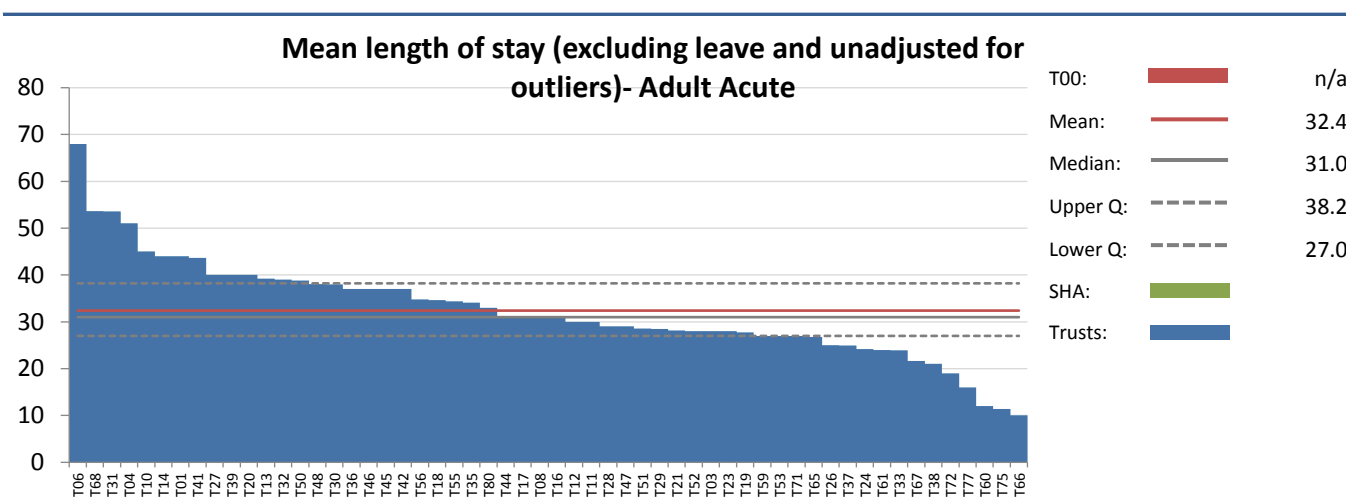


Figure 6





When there is pressure on beds and demand surpasses supply, delayed discharges can be frustrating for ward teams. Additionally patients and carers may express dissatisfaction and, in a worst case scenario, patients can deteriorate during this time.

Delays can be caused by patients who are fit for discharge being forced to wait for a bed or place elsewhere or for an alternative package of care to be agreed and put in place to facilitate discharge. The data for 2014 is shown below. In a number of cases there has been little change compared to previous years, with some organisations consistently reporting either above average or below average delays.

Delayed transfers of care are calculated as the number of bed days lost due to delays as a percentage of all occupied bed days. This takes into account both a few patients with long delays and also a situation where many patients, perhaps the majority, have a short to medium delay at the end of their stay.

In 2013 the median position for delayed transfers of care was 3.8%, a slight increase from 3.5% in 2012. This figure appears to have increased again this year, with a median of 3.9% shown in Figure 7 below. The range has also increased slightly this year with organisations reporting between 0.3% and 10.8% of their adult acute bed days lost to delays. This compares to a range of 0.7% to 10.8% last year.

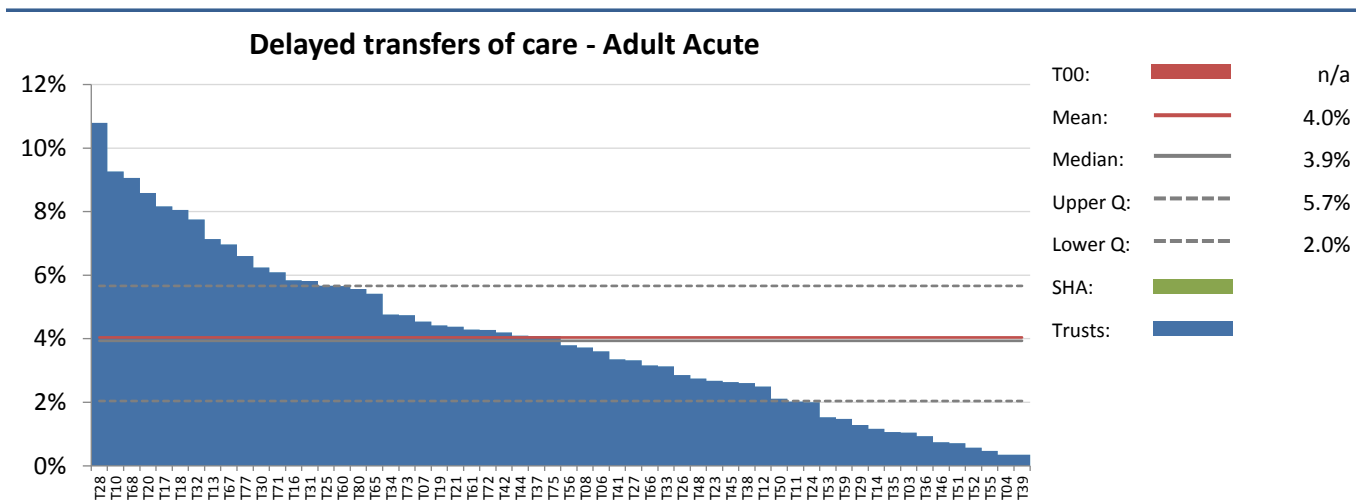


Figure 7





## Adult Acute emergency readmissions within 30 days of discharge

The number of patients who have an unplanned readmission within 30 days of discharge from inpatient care is a key performance measure across health care organisations for all types of hospital services. Readmissions can occur when a patient is discharged without an adequate care package or with an insufficient level of community support, or when discharge occurs too early. It is important to consider readmission rates along side length of stay to ensure that organisations who have successfully reduced length of stay have not seen a related rise in their readmission rates.

There is significant range in the readmission rates from contributors, as Figure 8 shows, with figures from 0.6% to 15.9% being reported. The median position is 8.8%, which is a marginal reduction on data from previous years (a median of 9% in 2013, and 10% in 2012). This is a positive finding for Trusts and Health Boards with readmissions reducing year on year.

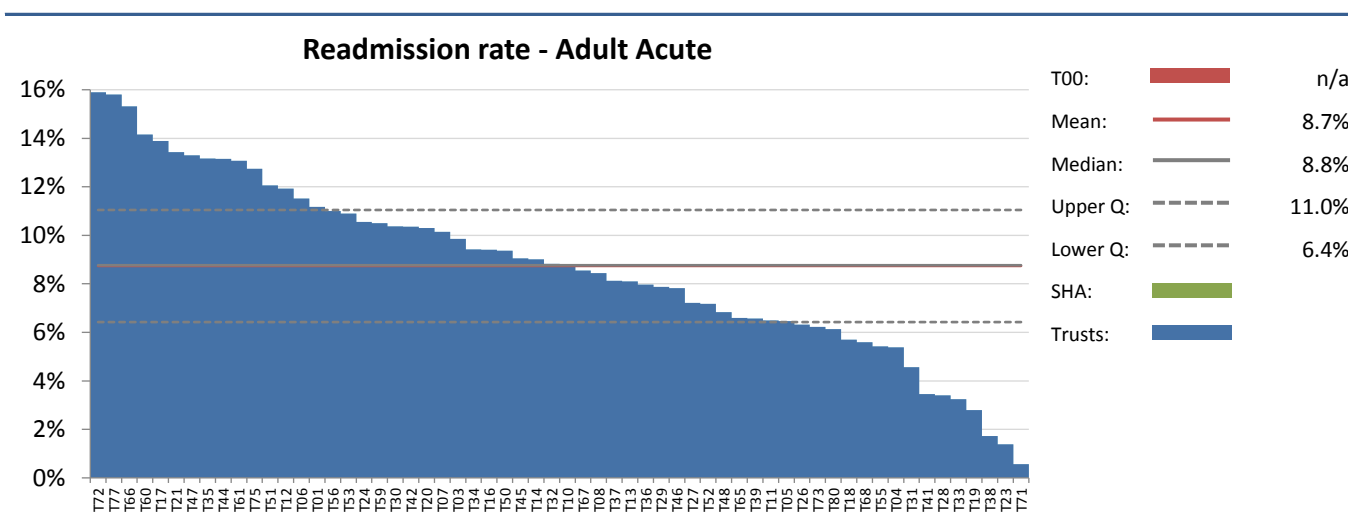


Figure 8







## Bed Provision - Older Adult beds

The provision of Older Adult beds is a significant part of the business of specialist mental health providers and the second largest category of bed provision after Adult Acute services.

Older Adult services treat patients aged 65 years or older. Some Trusts and Health Boards operate an "ageless service" where patients are allocated to beds based on a functional / organic split rather than by age. Where an age profile was unavailable, these organisations are excluded from the data below.

In 2014, members reported a median position of 47 beds per 100,000 registered population aged 65+. This compares to a median of 60 beds in 2013 and 62 beds in 2012 and confirms the on-going shift of care into community based provision and the subsequent reduction in number of inpatient beds. The reduction of bed numbers of around 20% in the last year also suggests fundamental service redesign has taken place in some health systems.

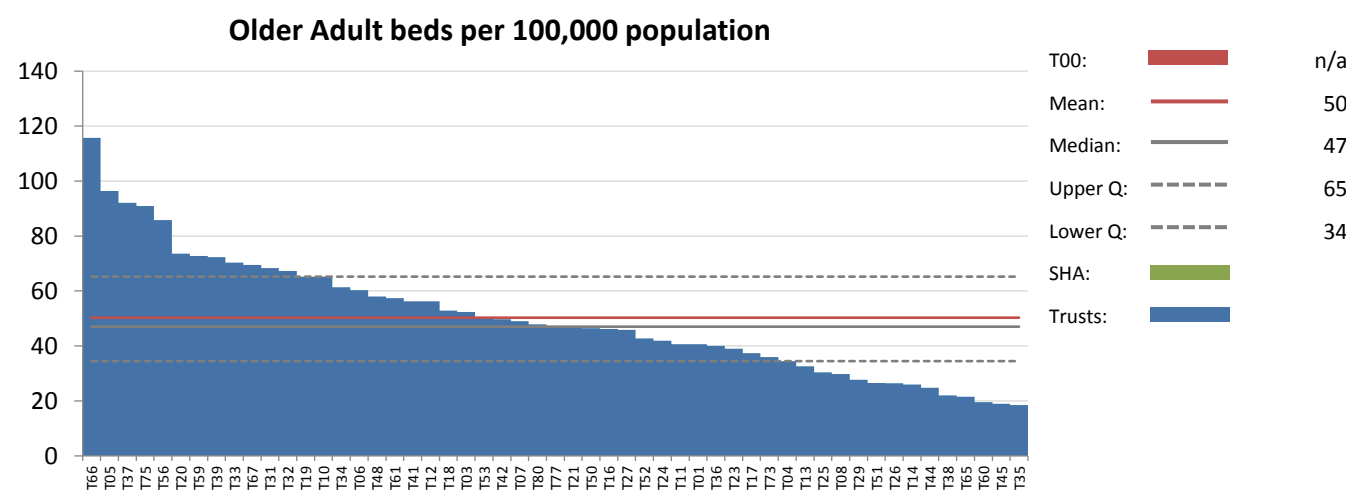


Figure 9

Once again, bed occupancy figures appear to have been influenced by the reduction in number of available beds. Figure 10 shows a median occupancy rate of 85.3% for older adult beds, an increase from 83% in 2013 and 82% in 2012. As the number of beds decreases and bed occupancy rises, organisations move towards the optimal number of beds for their local population, allowing good access to beds when needed but without excess provision in this area. Organisations will be able to interpret what this represents for them individually and use this information in future service planning.



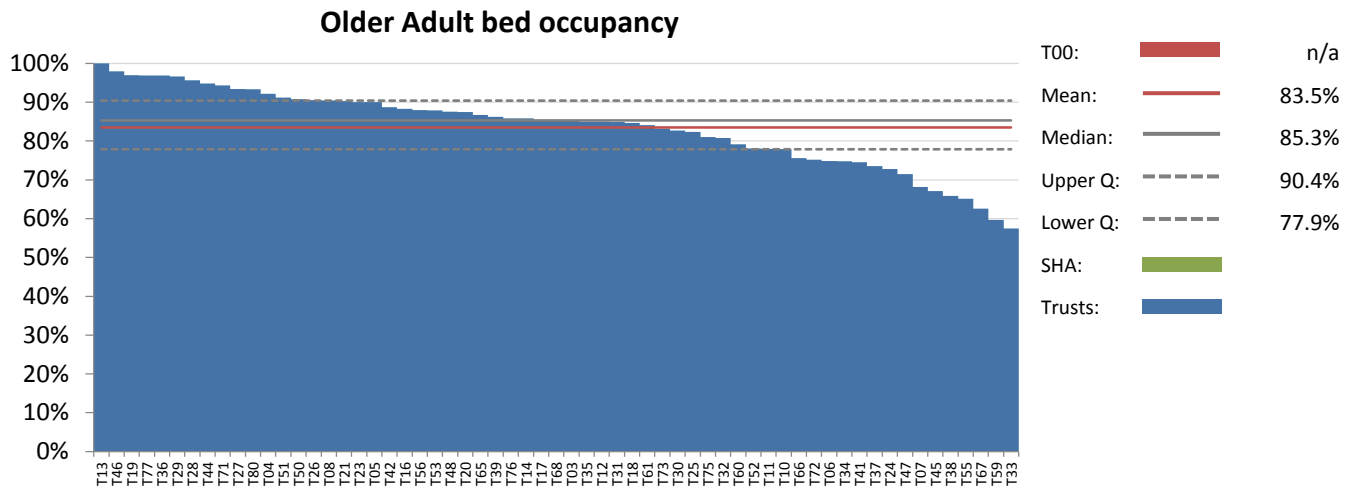


Figure 10





## Older Adult - Length of stay and delayed transfers

Figure 11 shows the mean length of stay for older adult beds, excluding leave. This figure has not been adjusted for outliers (long and short stay patients) but an analysis which excludes these patients is available in the Mental Health toolkit.

This year, the mean length of stay in older adult beds is 72 days. In 2013 it was 67 days and in 2012 a 70 day length of stay was reported.

There is still significant variation in ALOS amongst participants which should provide opportunities for discussion and sharing of good practice in this area.

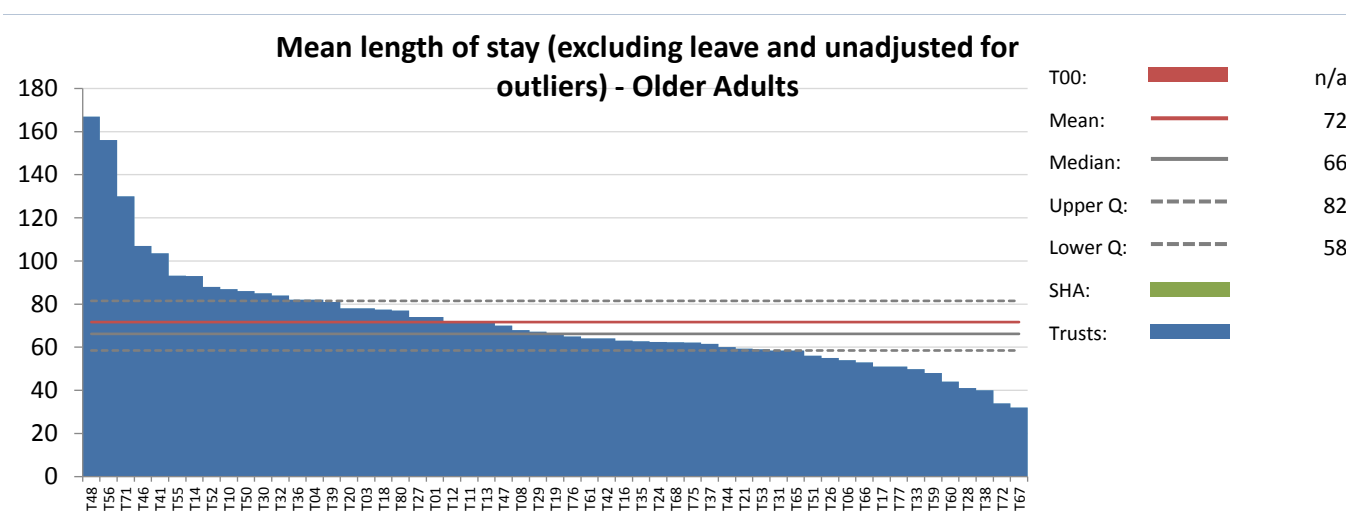


Figure 11

Delayed transfers of care are particularly prevalent on older people's wards. This year a mean position of 6.8% was reported. This is the percentage of all days spent on a ward which were the result of a delayed transfer of care and can be compared to a mean position of 7% last year. Delays often occur when older people are discharged home and require a package of care to be arranged, or when patients are transferred directly from an inpatient bed to a nursing or residential home placement and a period of waiting occurs until an appropriate bed is available.

The mental health toolkit allows additional analysis of the reasons for delays, whether due to internal or external factors.



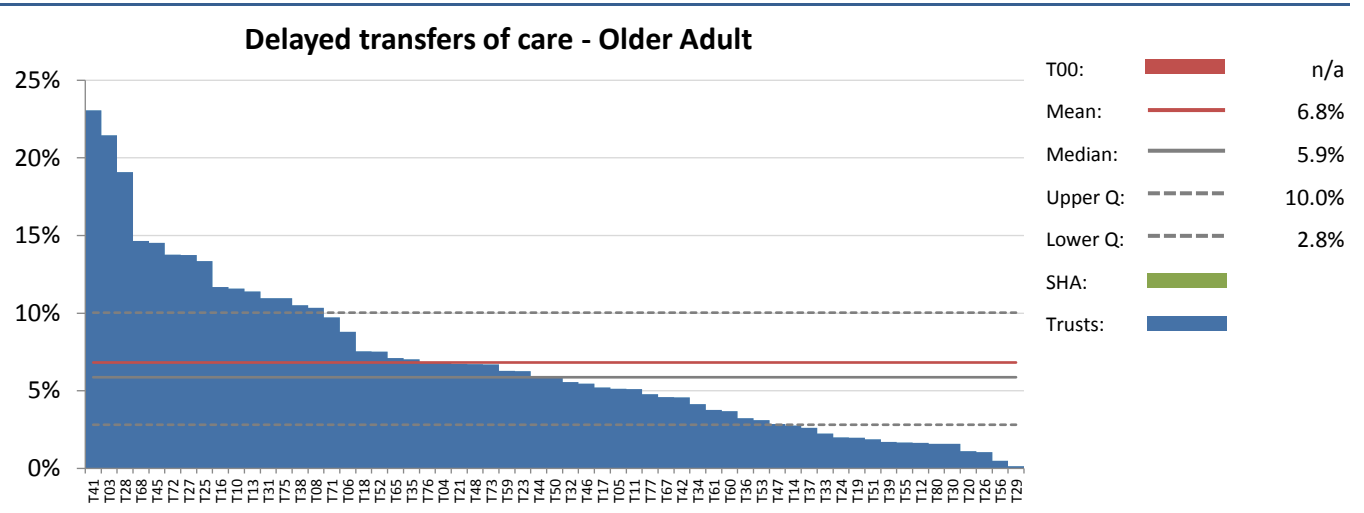


Figure 12





## Older Adult Admissions

The rate of older adult admissions per 100,000 registered population is shown in figure 12. This year, the median reported figure is 227 admissions per 100,000 population, compared to 243 in 2013 and 258 the previous year. This is linked to the sizeable reduction in available older adult beds demonstrated earlier, and the increased system pressures suggested by the average lengths of stay reported in 2014.

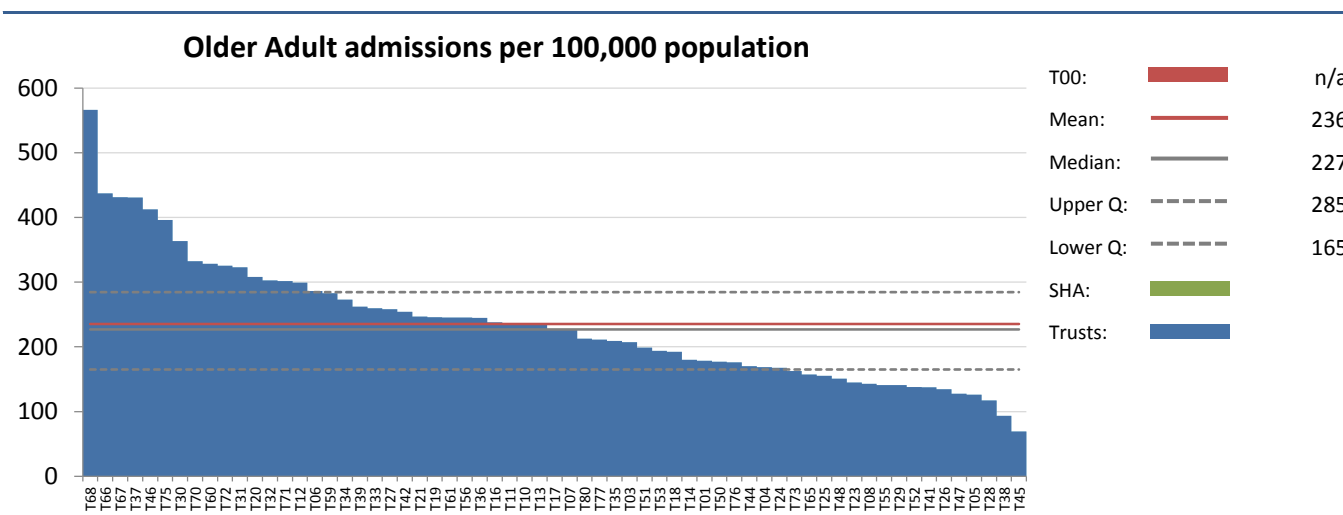


Figure 13

Older adult bed days have a median position of 15,398 per 100,000 registered population for ages 65 and over this year, compared to 18,141 in 2013. This figure can be considered along with the number of older adult admissions in figure 13 and length of stay shown in figure 11. This data confirms reduced levels of provision of inpatient care for older people in 2014 although admitted patients are staying longer. This position can be compared with the level of community based care for older people in the Mental Health toolkit.

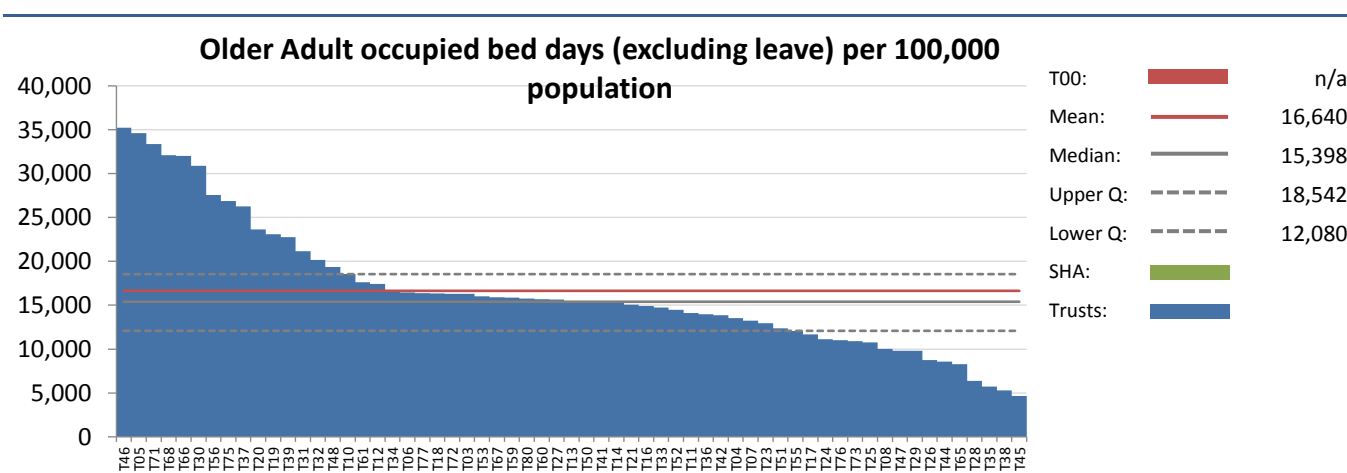


Figure 14





## Older Adult - emergency readmissions within 30 days of discharge

This indicator focuses on unplanned emergency readmissions and excludes readmissions associated with planned discharges to receive physical healthcare from other NHS providers.

Readmissions remain an important indicator of service performance, and organisations whose rate of emergency readmission within 30 days is high may wish to examine local systems or processes which contribute to this figure.

There has been a slight decrease in emergency readmissions to older adult beds, from 4% in 2013 to 3.6% this year. The rate of older adult readmissions is also lower than that for acute adult beds, shown in figure 8 (a mean figure of 8.7%). This may be due to the longer lengths of stay for older adult beds, and the relatively lower bed occupancy for older adults suggesting demand for beds, and therefore to discharge patients sooner, is less of a pressure in older adult wards than on adult acute wards.

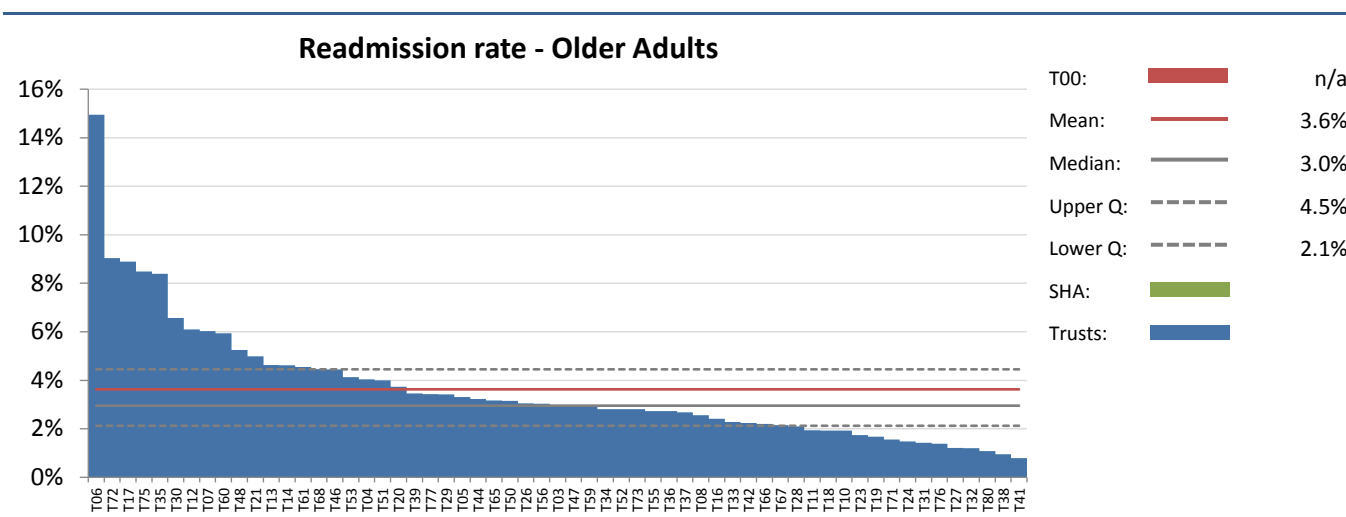


Figure 15





## Specialist beds

This section has been expanded this year at the request of members, to reflect the importance of specialist beds and the significant proportion of resources (budget and workforce) that are invested in these areas.

Specialist beds can be delivered for both core district populations and also for external populations. Beds can be commissioned locally or through specialist commissioning routes, and these beds are sometimes also traded commercially. Due to the varied range and coverage of specialist bed portfolios it is not possible to robustly benchmark them on a per capita population basis. However, it is possible to draw comparisons of bed provision, utilisation, and length of stay which will add value to the knowledge base of Trusts and Health Boards. The benchmarking toolkit explores many of these areas in great detail.

The following chart shows Trust and Health Board positions for specialist beds against average provision rates for peers. Although there may be a level of ambiguity for individual Trusts / LHBs regarding the definition of specialist beds in local circumstances, the standard definition used for benchmarking purposes is that specialist beds are “all beds except Adult Acute and Older Adult beds”, and complies with the Mental Health Network’s guidance on bed definitions. The figure below shows your organisation's proportion of beds in each category as a percentage of all your specialist beds (inner ring) compared to the national average of beds in each category (outer ring). Typically, many specialist beds are in low and medium secure services which together account for over 40% of specialist bed provision. This report, and related mental health toolkit, will allow participants to test their provision and service models against both peers and wider market averages.

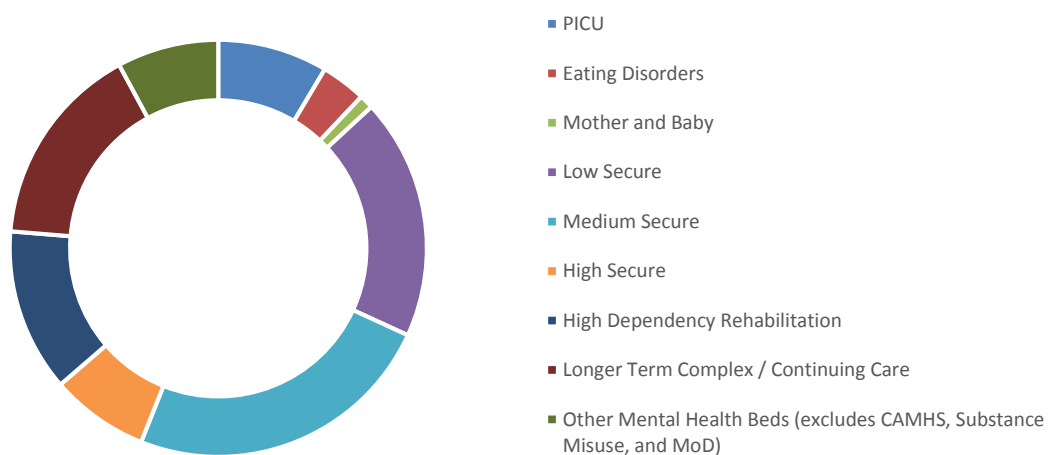


Figure 16

The following pages analyse specialist bed provision by mean length of stay and bed occupancy and consultant psychiatrists and qualified nurses per 10 beds.

Where an organisation is missing from the data, they have either not reported figures in this area or do not provide these specialist services.





## PICU

Around 80% of contributors provide Psychiatric Intensive Care Units. The length of stay in PICU beds is shown in the chart below. This relates solely to the period of time spent in PICU beds, which may be part of a longer admission. The mean length of stay across all member organisations with these beds is 42.6 days. This compares to a mean of 48 days last year.

This year's data shows a quartile range of 28.6 to 48.0 days which is also a reduction compared to last year (31 to 52 days). The full data range, however, runs from 15.0 to 119.0 days which illustrates differing approaches to the use of these beds between organisations. Long stays demonstrate opportunities for Trusts and LHBs in stepping down patients more rapidly.

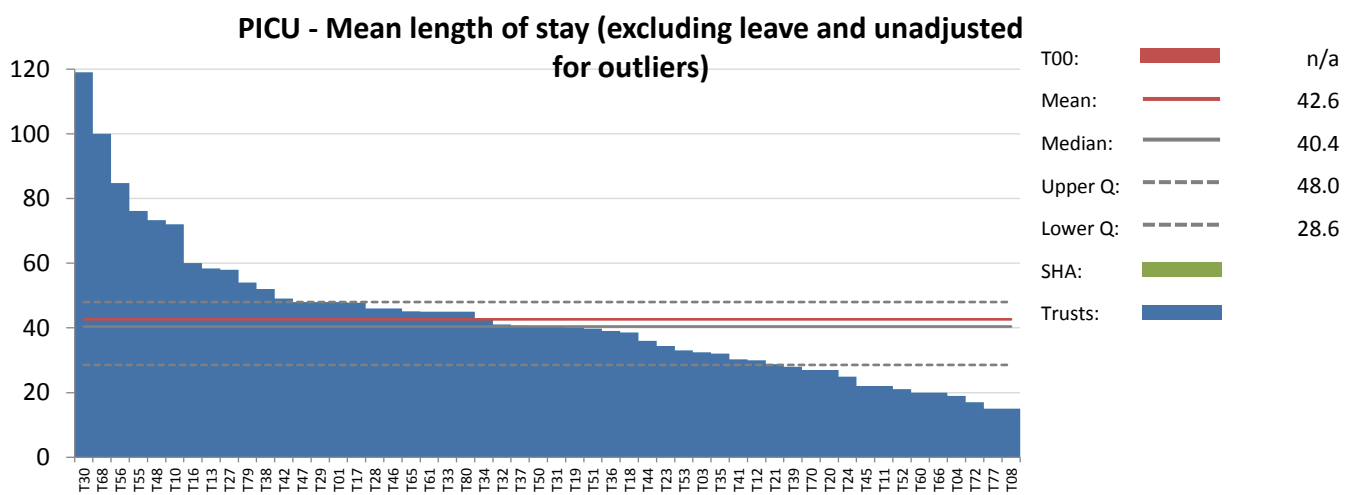


Figure 17

PICU bed occupancy is, on average, lower than bed occupancy of adult acute beds (the PICU median is 85.5% compared to the adult acute median of 93%). Providers and commissioners must try to strike the right balance between availability of beds for new admissions and good levels of occupancy. PICU bed occupancy has however still increased from 82.3% in 2013.

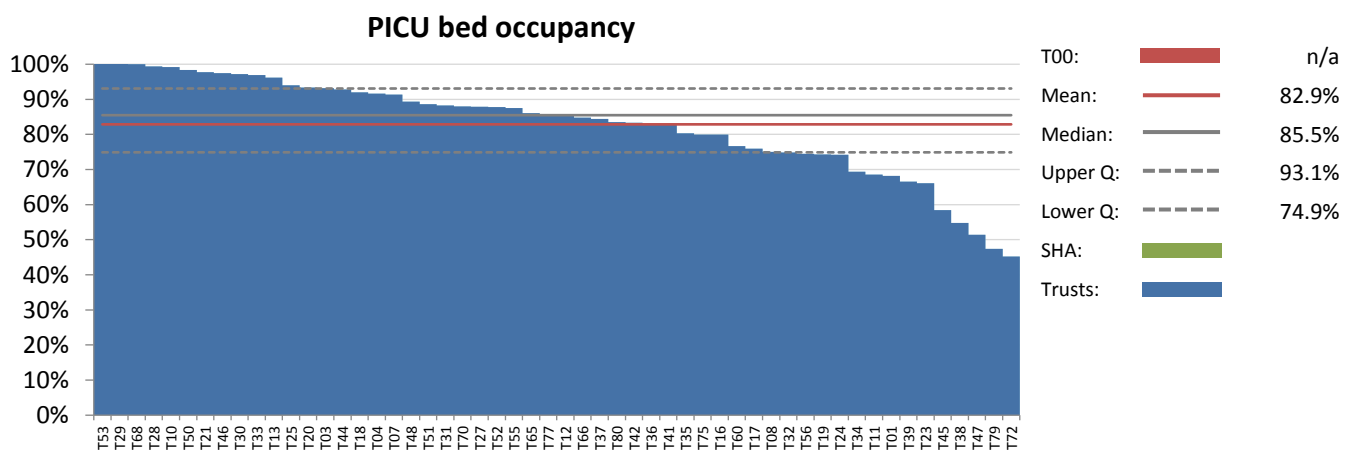


Figure 18







The following graphs show the number of whole time equivalent (WTE) consultant psychiatrists and nurses per 10 PICU beds. These denominators are used to allow for accurate comparisons between organisations of different sizes who provide PICU beds.

For PICU the mean number of consultant psychiatrists per 10 beds is 0.7 but the range is from 0.1 to 2.0 consultants per 10 beds showing that in some organisations, patients in PICU beds may receive significantly more senior medical input. There may also be some variation between how medical staff are allocated in different organisations, with some specialties having dedicated consultant input and others having consultants who work across several specialties.

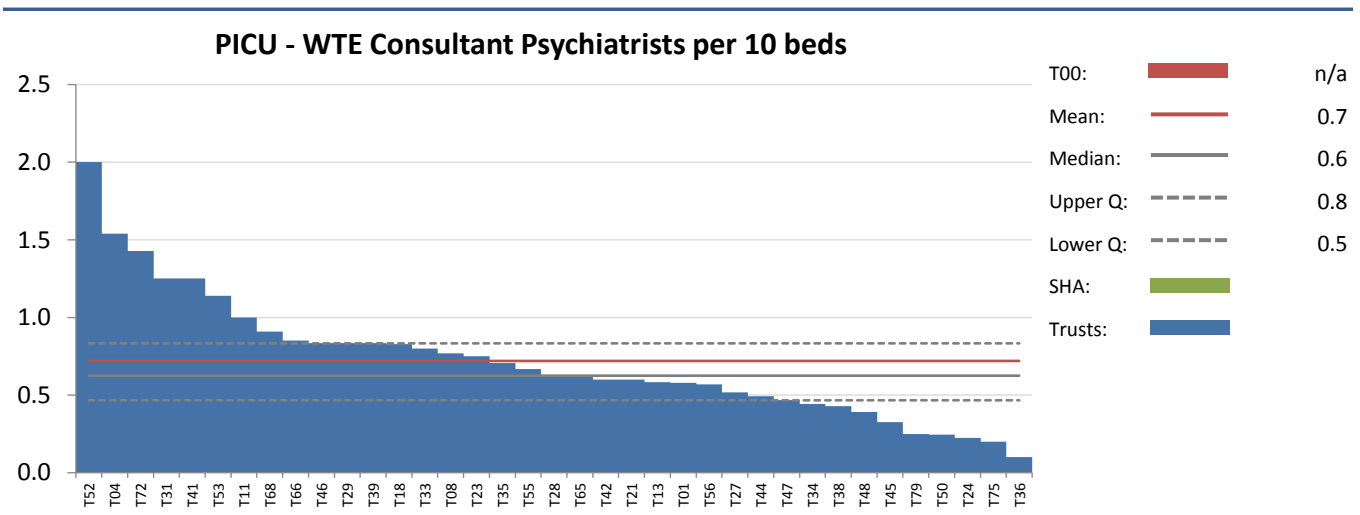


Figure 19

The number of qualified nurses per 10 beds is also a useful benchmark for comparison. Figure 20, below, shows a WTE total for qualified nurses (incorporating Agenda for Change Band 5 and above). For PICU beds, the mean is 14.4 qualified nurses per 10 beds.

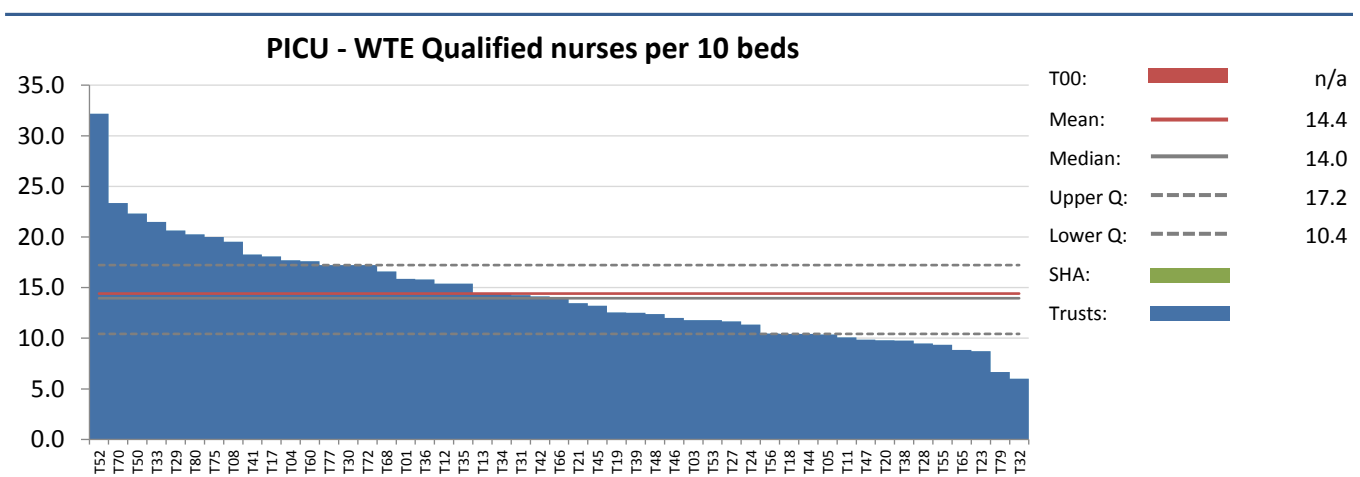


Figure 20





## Eating Disorders

Eating Disorders beds are identified in this adult focused report although it is acknowledged that some may be occupied by patients from a slightly younger age group where CAMHS provision in this specialty is not available. The mean length of stay in an Eating Disorders bed is 91 days although the Trust with the shortest stays report a LOS of just 42 days, less than half the national mean. Fewer than one third of participants report provision of specialist beds for eating disorders (17 of the 66 contributors).

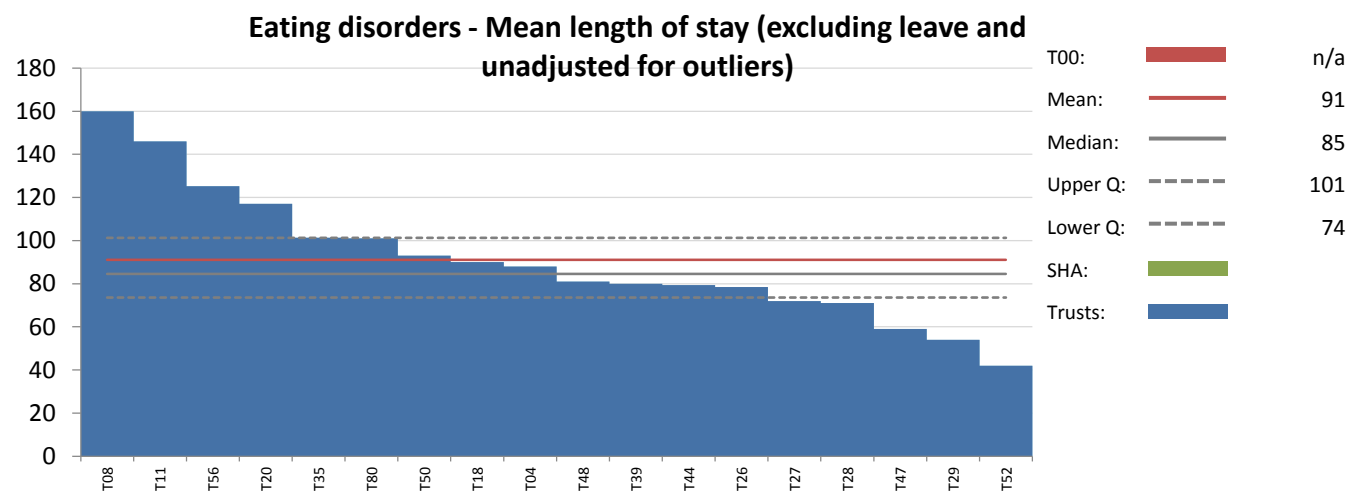


Figure 21

Bed Occupancy for Eating Disorders beds is shown below. On average, median bed occupancy sits at 80.5% which is lower than some other specialist services. This would suggest that access to beds should be good, and spaces should typically be available when admission is required. However it is noted that the relatively small number of providers offering inpatient facilities for Eating Disorders patients means that equitable access to local care cannot be certain across all areas of England and Wales. The MH toolkit can also be used to explore the extent to which community based Eating Disorders services are provided by participants.

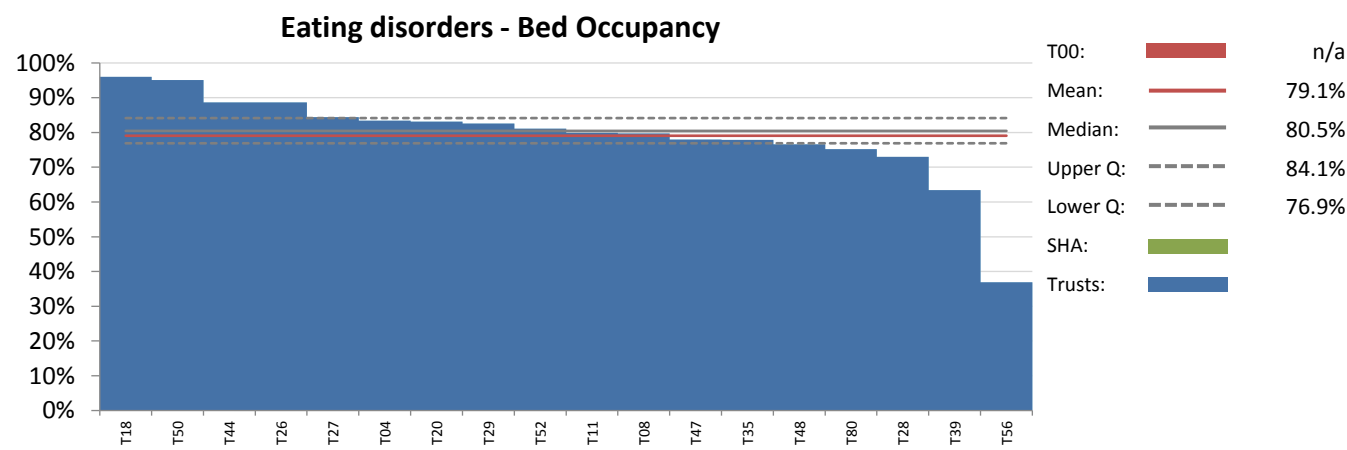


Figure 22



Medical input for patients in Eating Disorders beds is an important measure, and can be seen in the chart below. The mean figure reported is 0.6 WTE consultants per 10 beds which is comparable with senior medical input to PICU and low secure beds.

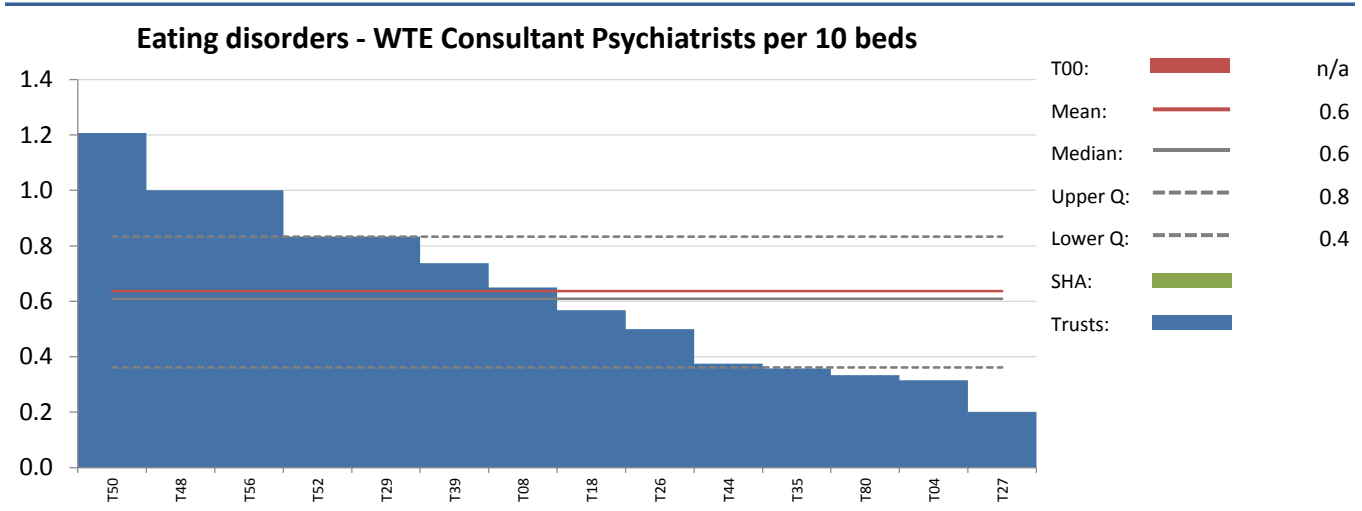


Figure 23

The skill mix in Eating Disorder services is frequently different from other inpatient units. This graph shows the combined number of WTE clinical psychologists and OTs, which has a mean value of 1.8 WTE per 10 beds. It is useful to see the impact access to psychology and occupational therapy may have on length of stay in these beds. Specialist therapists are therefore three times more prevalent on Eating Disorders beds than consultant medical staff.

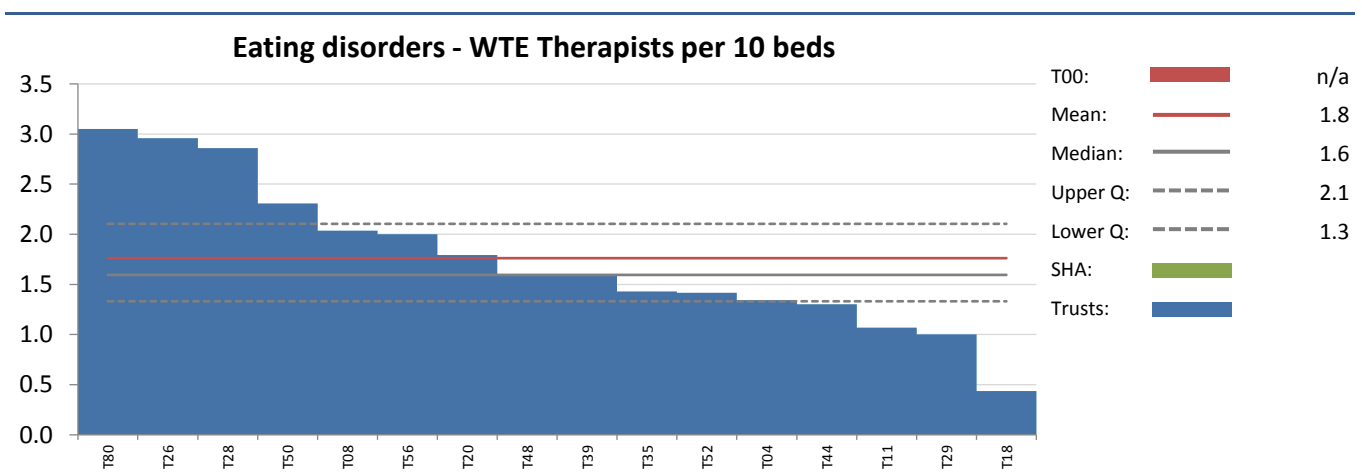


Figure 24





## Low Secure

Low secure services treat patients who have been identified as requiring secure hospital admission for assessment or treatment but do not require intensive care. Low secure services can also be used as a step down from medium secure services. The length of stay measure relates to the time spent in a low secure bed which may be shorter than the patient's whole admission. Around two thirds of participants have provided data on low secure provision.

The mean length of stay across all organisations is 487.5 days, compared to 471 days in 2013. The upper and lower quartiles of 696.5 and 269.0 days respectively indicate significant variation of more than one year across organisations.

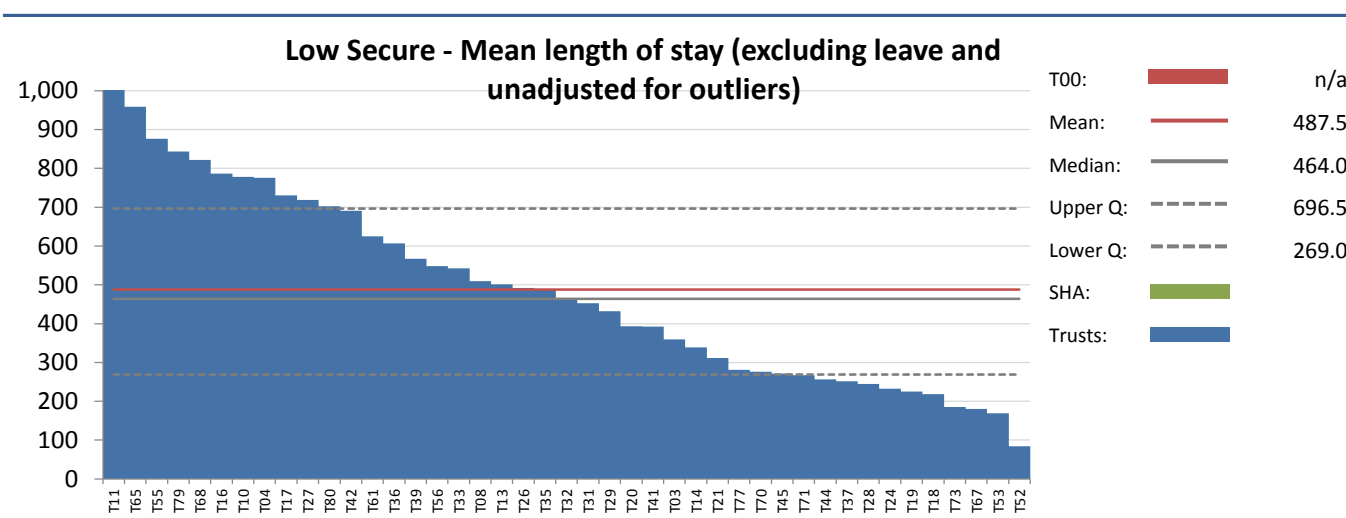


Figure 25

The median bed occupancy figure reported for low secure beds is 90.0%. This is less than the adult acute bed occupancy rate of 93% and the medium secure bed occupancy rate of 91.5%

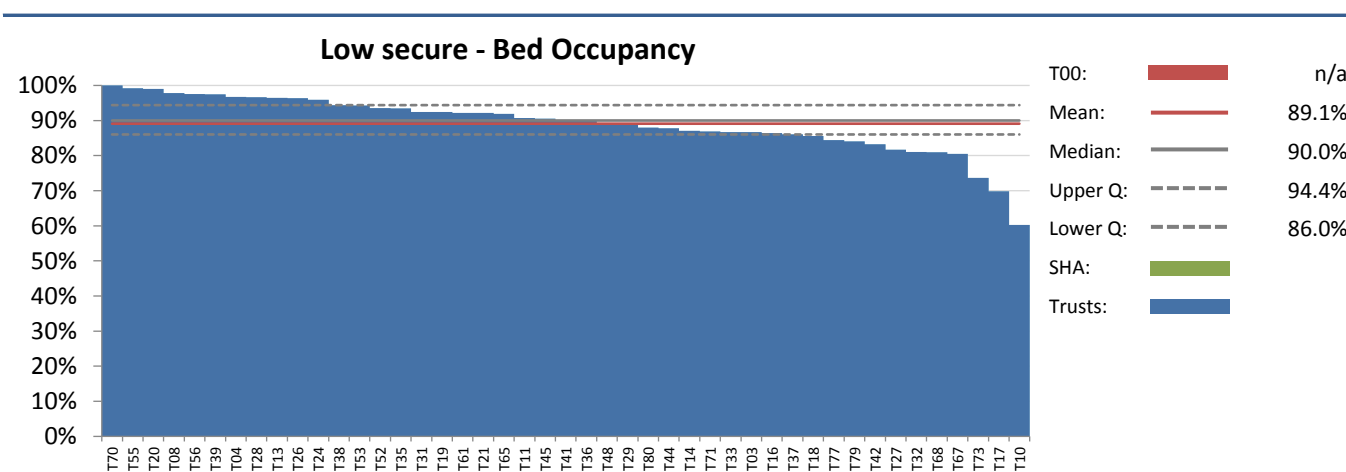


Figure 26





The number of Consultant Psychiatrists per 10 beds is shown in Figure 27 below and demonstrates a mean of 0.7 consultants per 10 beds but with a range from 0.1 to 1.5 consultants per 10 beds. The organisational mean average is virtually identical to PICU beds where patients typically have a length of stay ten times shorter than low secure beds as PICU targets the most acute phase on an illness.

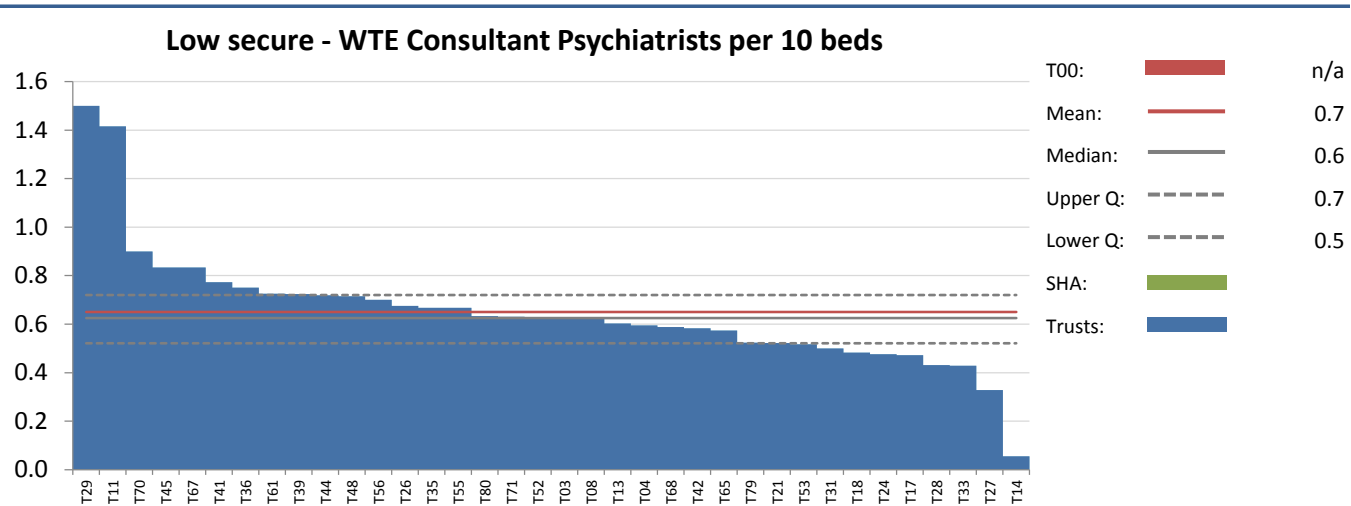


Figure 27

The number of qualified nurses per 10 low secure beds is illustrated below. The mean number of nurses per 10 low secure beds is 9.1 WTE which is less than on PICU (14.4 WTE per 10 beds), indicating that while senior medical input between the two specialties is comparable, nursing ratios are lower for patients in low secure beds who, as a cohort, are likely to be less acutely unwell.

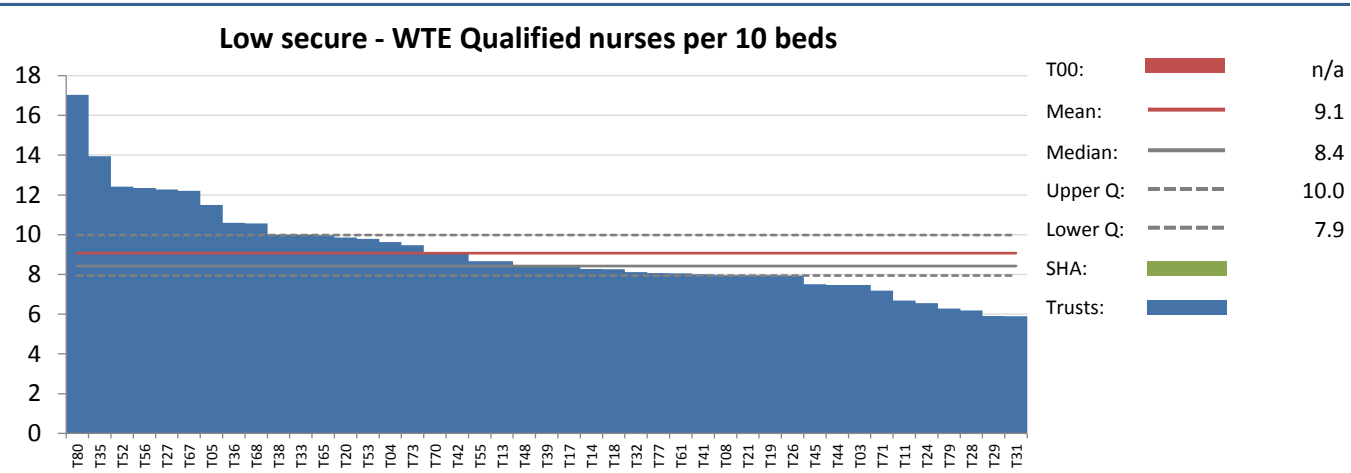


Figure 28





## Medium Secure

Medium secure services data has been provided by 24 of the project's 66 participant organisations confirming this as a specialist service provided by around one third of NHS mental health providers with additional input from independent sector providers.

Medium secure services generally have a longer length of stay than less secure services. Member organisations reported a median position of 543 days for length of stay this year. This compares to 464.0 days for low secure services, although the range for medium secure bed LOS is significant, from 158 to 958 days across all organisations. The mean LOS in medium secure beds has decreased this year, from an average 574 days in 2013

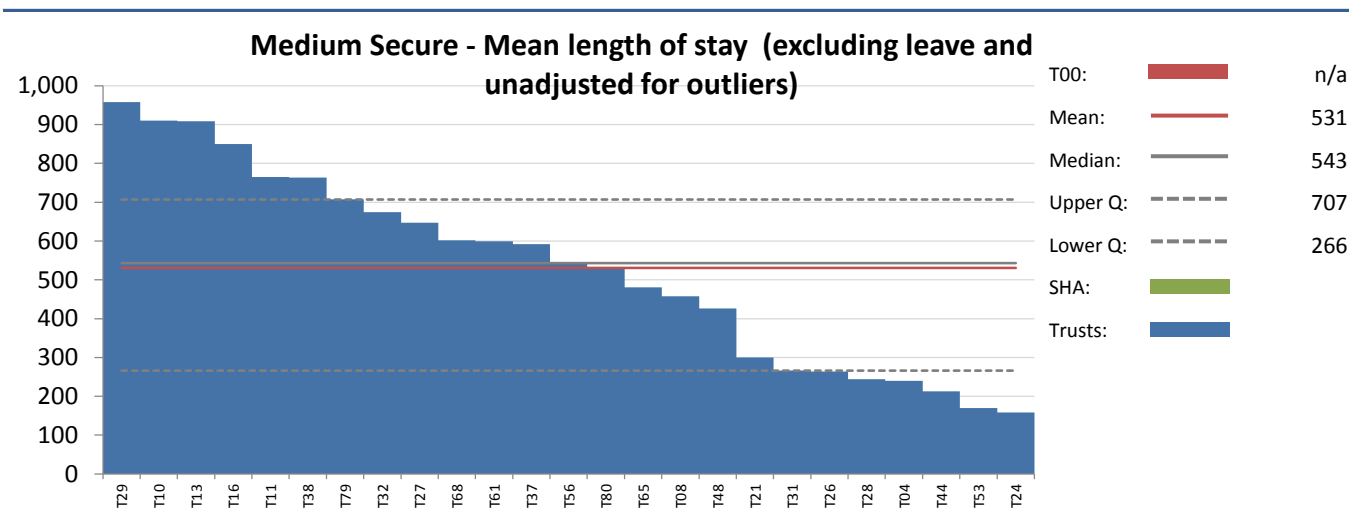


Figure 29

Bed occupancy for medium secure beds is one of the highest reported this year, with a median figure of 91.5% across participants, similar to the rate for adult acute beds. There is minimal variation here, with approximately two thirds of participants reporting bed occupancy rates of 90% or above, and the median figure has not changed since 2013.

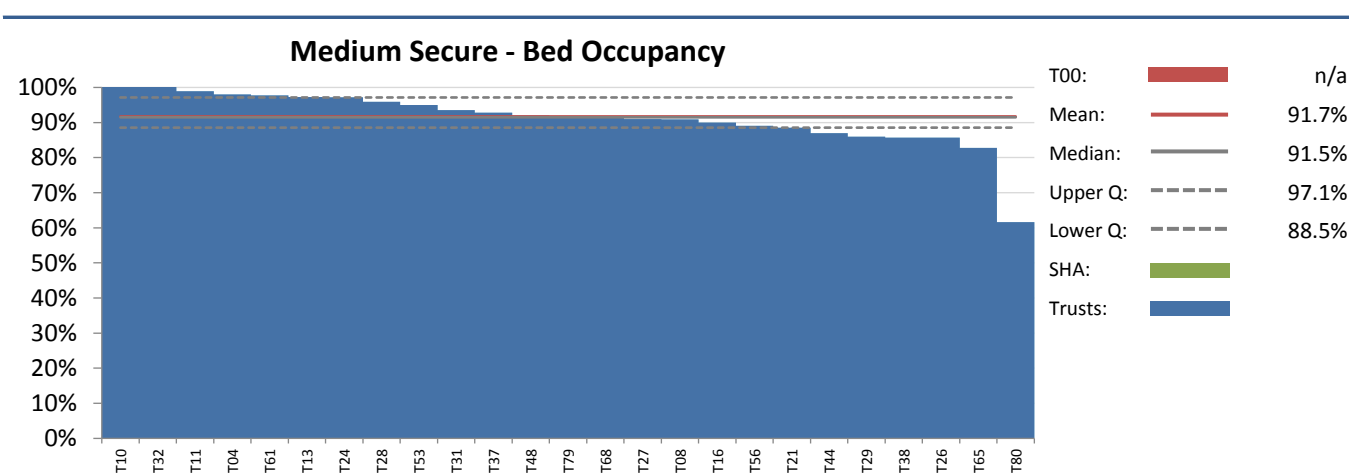


Figure 30





Consultant medical input to medium secure beds is virtually identical to such input in low secure services and PICU, with all reporting a mean figure of 0.6 to 0.7 WTE consultant psychiatrists per 10 beds.

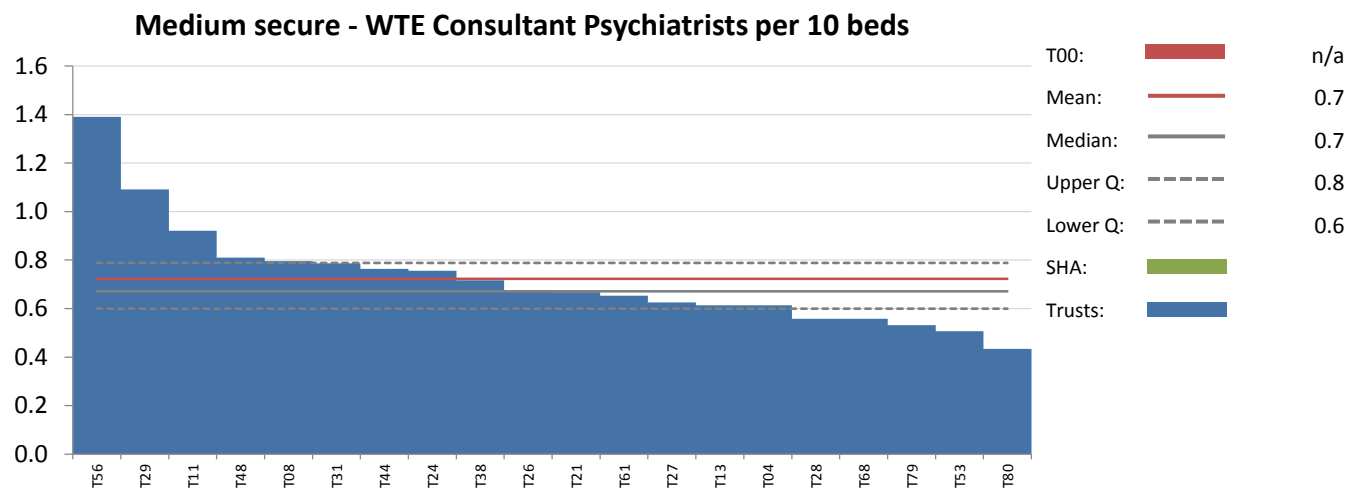


Figure 31

Qualified nurses per 10 medium secure beds is shown below. With a mean figure of 9.4 this is only marginally higher than the nursing ratio of 9.1 WTE nurses per 10 low secure beds. There is some variation on an organisational level, with some respondents reporting fewer qualified nurses on their medium secure wards than on their low secure equivalents.

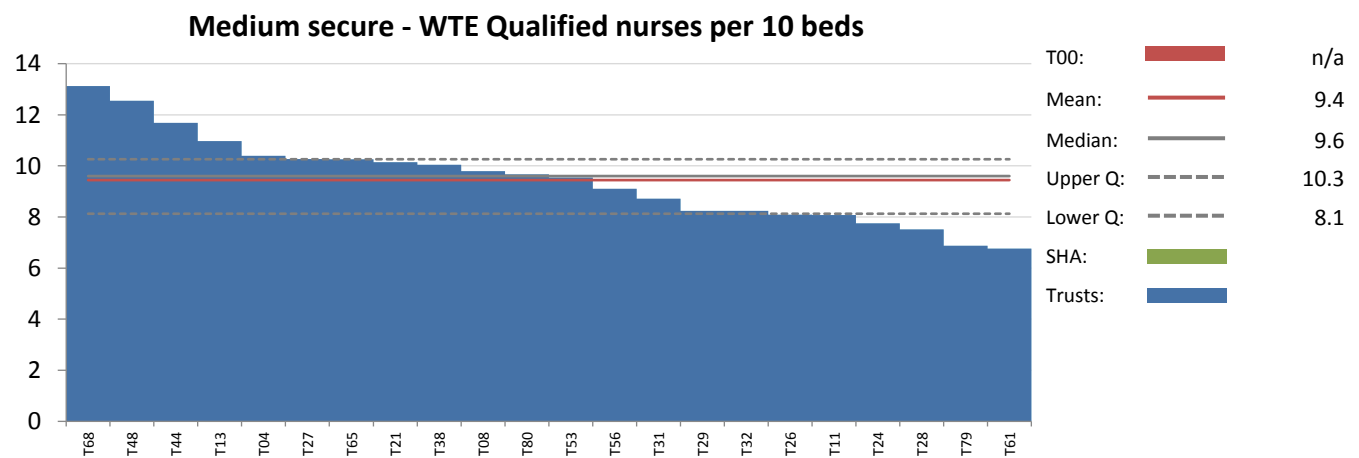


Figure 32





## High Dependency Rehabilitation

High Dependency Rehabilitation services provide rehabilitation to clients with active symptoms, more complex needs and challenging behaviours. The usual aim of treatment is to prepare patients to step down to other rehabilitation services prior to independent or supported living.

The mean length of stay for patients in these beds is shown here. With a mean position across all providers of 477 days it is clear that patients in these beds typically have complex rehabilitation needs requiring long lengths of stay. There is significant variation between members, however, with stays ranging from 49 days to 1,784 days for the lowest and highest providers. Patients can be admitted into these beds from a variety of sources, including secure services, PICUs and directly from the community. Average length of stay positions may be influenced by small numbers of extremely long stay patients.

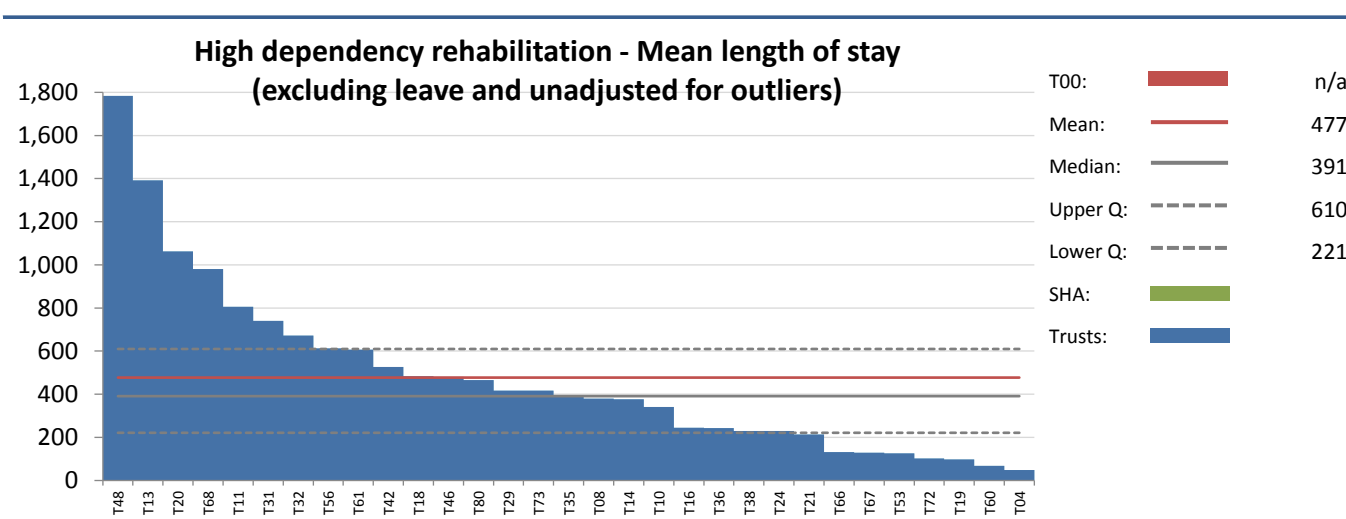


Figure 33

Bed occupancy for High Dependency Rehabilitation beds is lower than in the majority of other services and the median position reported across members is 86.8%. Over two thirds of members report occupancy levels of below 90%.

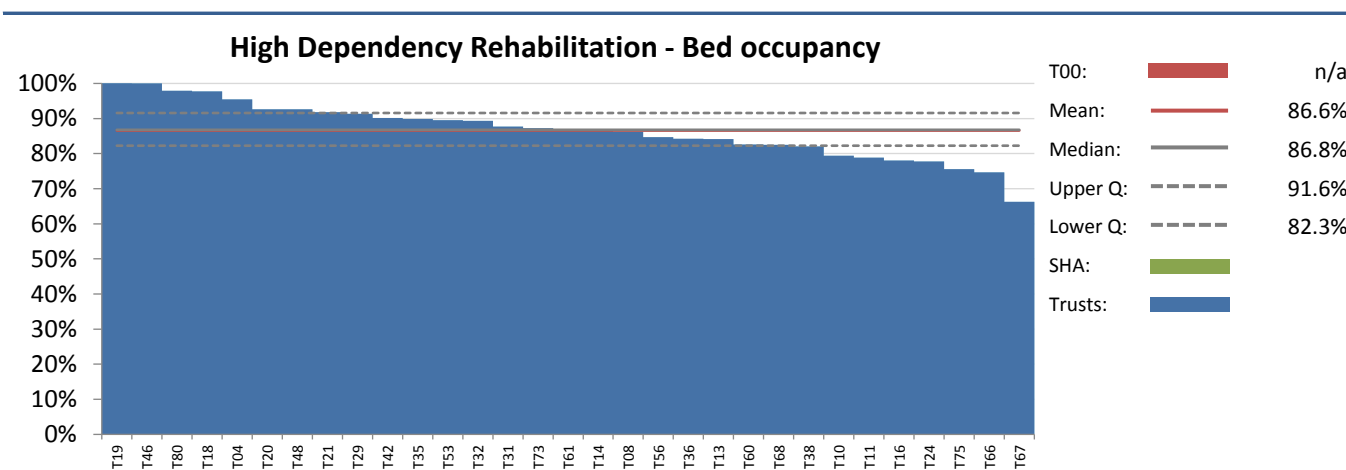


Figure 34







The number of Consultant Psychiatrists, measured per 10 High Dependency Rehabilitation beds, is among the lowest when compared to other services, with a mean position of 0.4 WTE Consultants per 10 beds. This indicates that senior medical input to these beds is limited and infrequent compared to other services.

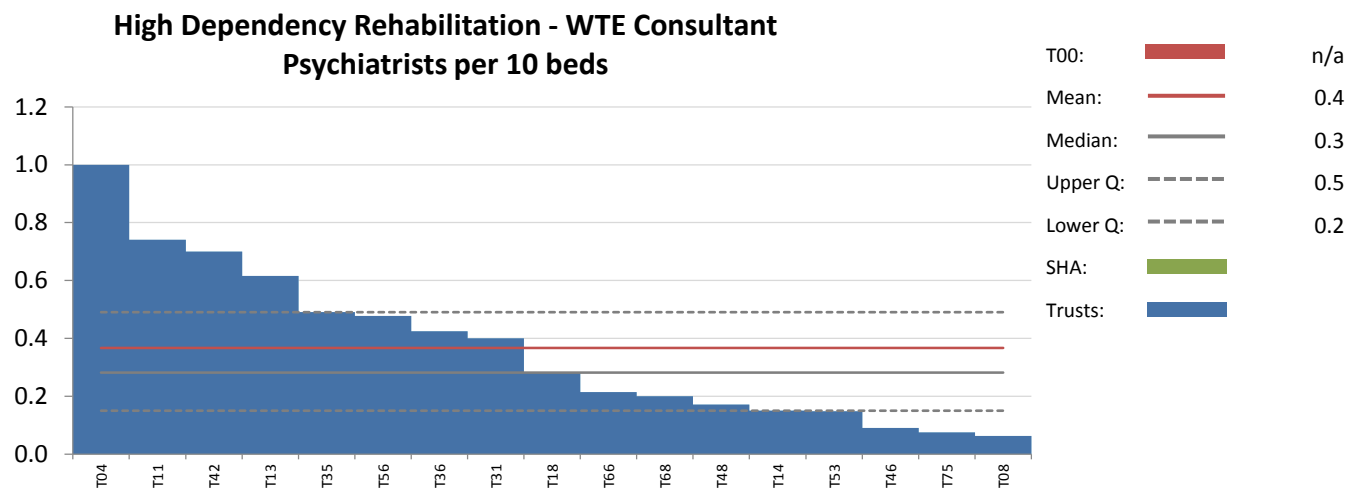


Figure 35

The number of qualified (band 5 or above) nurses per 10 High Dependency Rehabilitation beds is illustrated in Figure 33. The mean figure reported by members is 7.5 qualified nurses per 10 beds which represents one of the lowest staffing levels reported this year across all services.

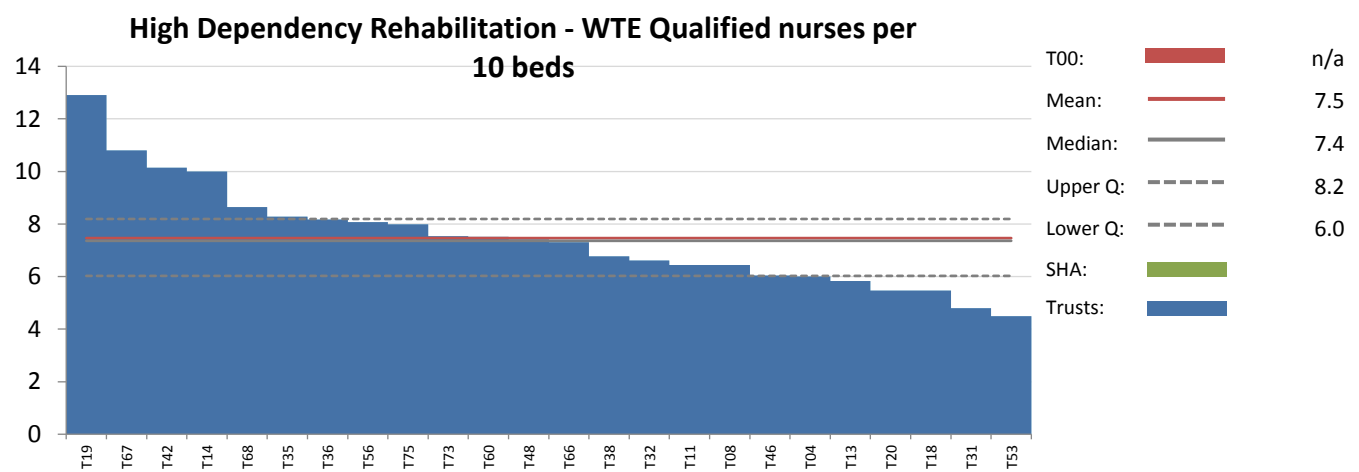


Figure 36





## Longer Term Complex / Continuing Care

Longer Term Complex Care services care for patients who have high levels of disability from complex mental health conditions. These patients may have limited potential for future improvement and contain significant risk to their own health or safety or that of others.

By its very definition, length of stay in longer term complex or continuing care is typically greater than in most other types of inpatient services. The median length of stay reported this year by members was 529.0 days which compares to 391 days for high dependency rehab beds.

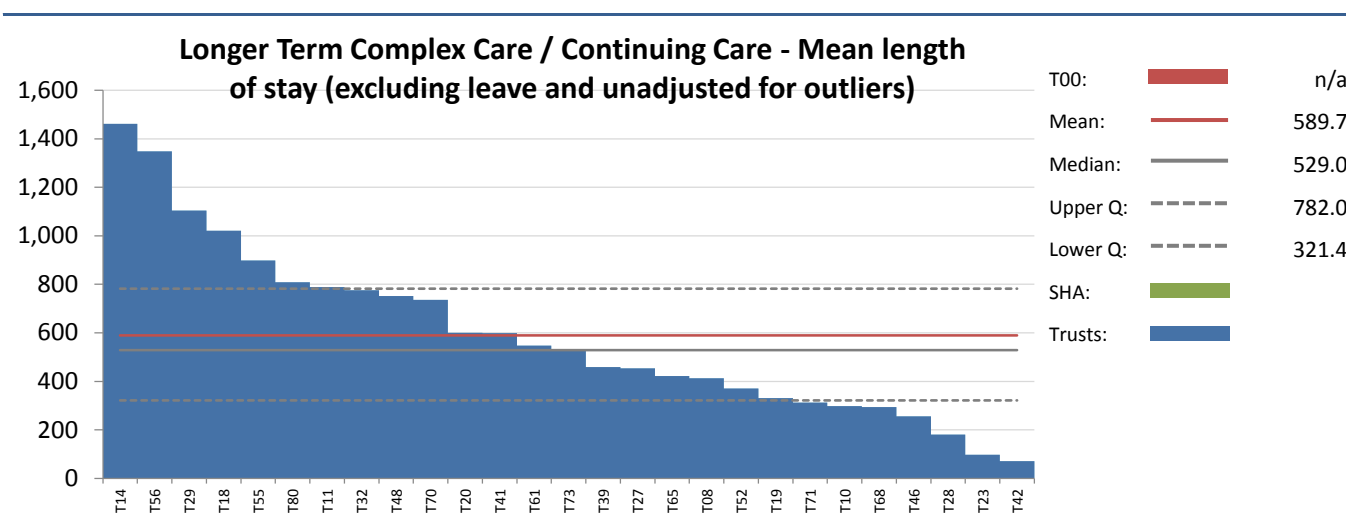


Figure 37

Bed occupancy in this area has a median position of 88.1%, comparable to 86.8% for high dependency rehabilitation beds.

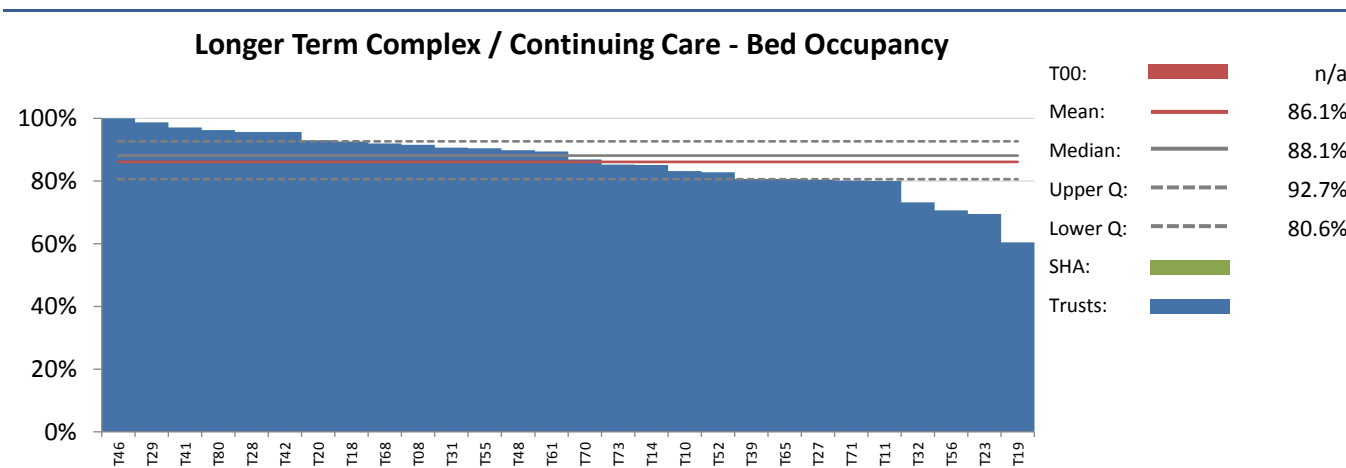


Figure 38





The mean number of consultant psychiatrists reported is 0.2 WTE per 10 beds, the lowest figure reported for any service. This means that in a typical provider, 1 consultant could look after up to 50 beds or, more likely, a smaller ward would have a part time consultant who also worked in other areas.

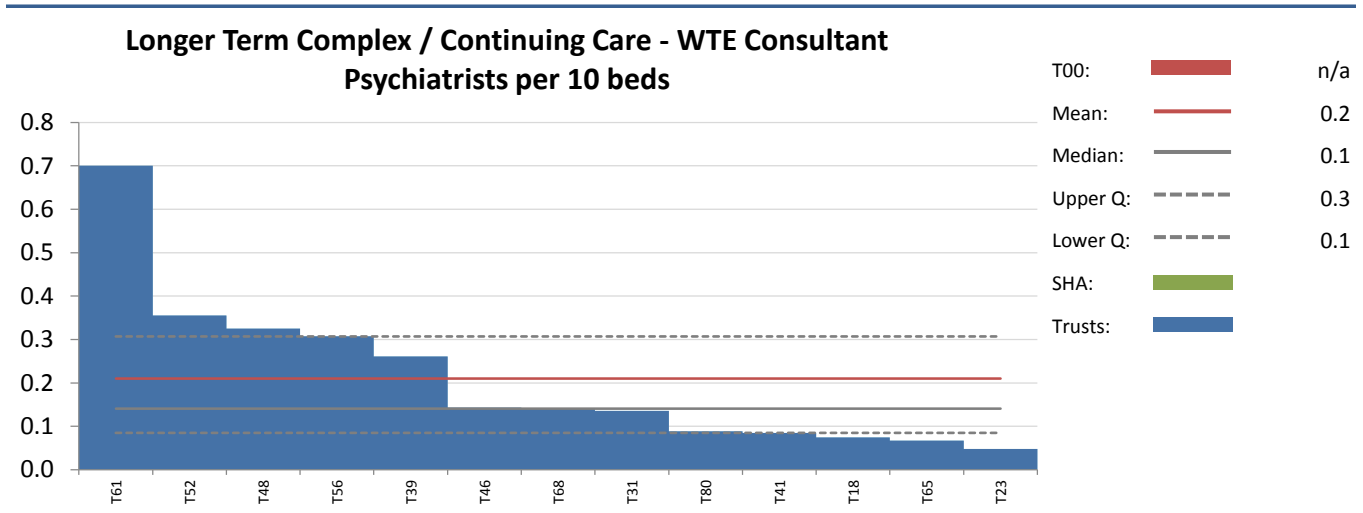


Figure 39

Nurse staffing ratios for this area are also the lowest of any service, with a mean number of WTE qualified nurses reported as 7.0 per 10 beds. It is noted that the level of medical, nursing and therapy input for longer term complex and continuing care is much lower than for other services. This may raise questions for providers on the appropriateness of the level of care provided.

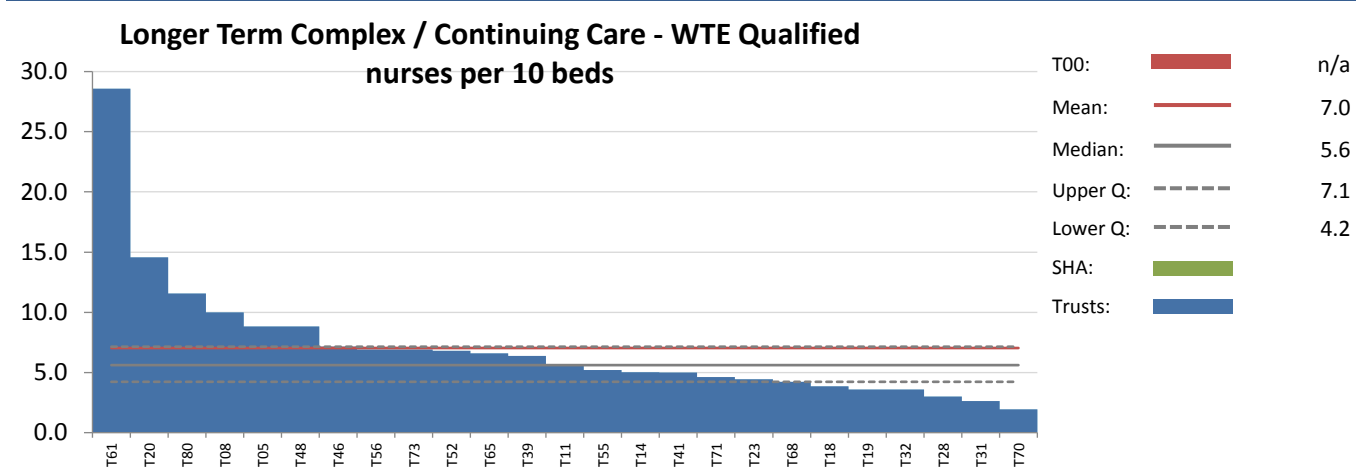


Figure 40





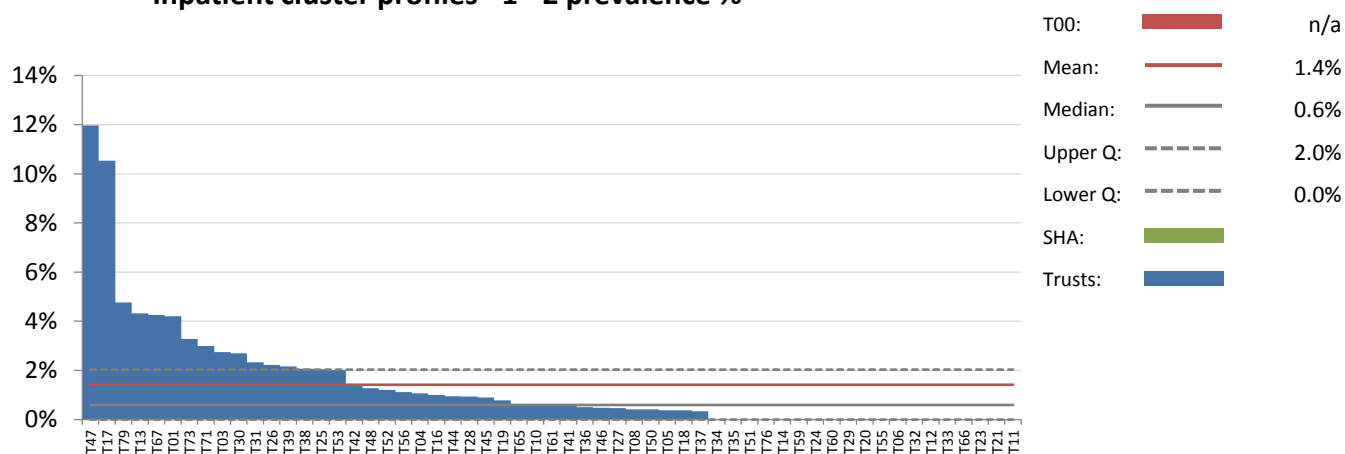
## Clustering

The use of mental health clusters adds huge potential to the benchmarking project for mental health providers operating within England. Cluster data was collected from Trusts and used a bed census date of 31st March 2014. It is noted that providers can now access detailed clustering data from the Health and Social Care Information Centre. Comments are therefore welcomed from members as to whether this content should continue into 2015 benchmarking reports.

The calculation of prevalence of patients in each cluster group is based on the percentage of patients in clusters 0 to 21 who are defined in each cluster group. The benchmarking calculation excludes patients who had not yet been clustered from the overall denominator. Where an organisation has confirmed that 0% of their admissions fell into a particular category, this information is illustrated on the graph.

Figure 41 below shows the percentage of patients occupying inpatient beds (all specialties) on the day of the census, who were classified as cluster 1 or 2 (non-psychosis, mild). This illustrates a range of between 0% and 12.0% with a median prevalence of 0.6%. This suggests service users with less severe mental health problems are being treated more and more in community services, with inpatient beds reserved for those who meet a higher threshold. This is consistent with reductions in bed numbers seen earlier. Therefore, the overall acuity of admitted patients in beds is likely to be increasing each year and ward staff may feel the impact of this on a day to day basis.

**Inpatient cluster profiles - 1 - 2 prevalence %**



**Figure 41**

Figure 42 shows the percentage of patients in inpatient beds who fell within clusters 1 to 4 (non-psychosis, mild to moderate). The median position of 7.6% is a further decrease compared to 10% in both 2013 and 2012. This metric should be considered alongside the number and types of beds available in individual organisations, and availability and caseloads of community services in those areas.





### Inpatient cluster profiles - 1 - 4 prevalence %

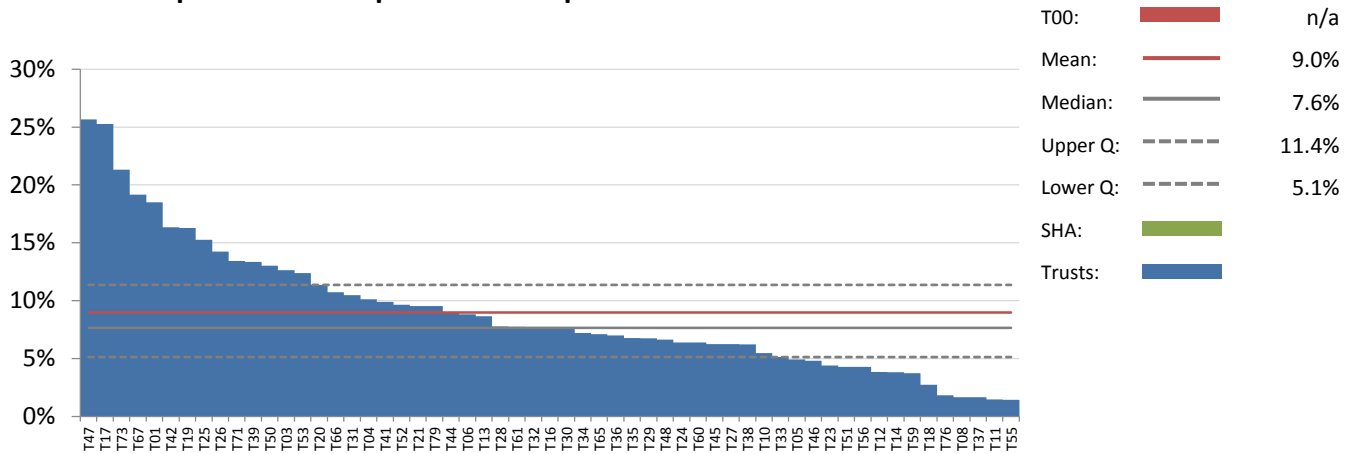


Figure 42

Figure 43 shows the prevalence of all patients with a non-psychosis diagnosis (clusters 1 to 8) which can account for up to 44.4% of patients in beds. The median figure is 23.6%. This is a minor change compared to last year (22%). When viewed in conjunction with the two previous charts, this shows that where patients are still being admitted with non-psychosis diagnoses, these patients tend increasingly to be in clusters 5-8 and therefore of greater acuity than in previous years.

### Inpatient cluster profiles - 1 - 8 prevalence %

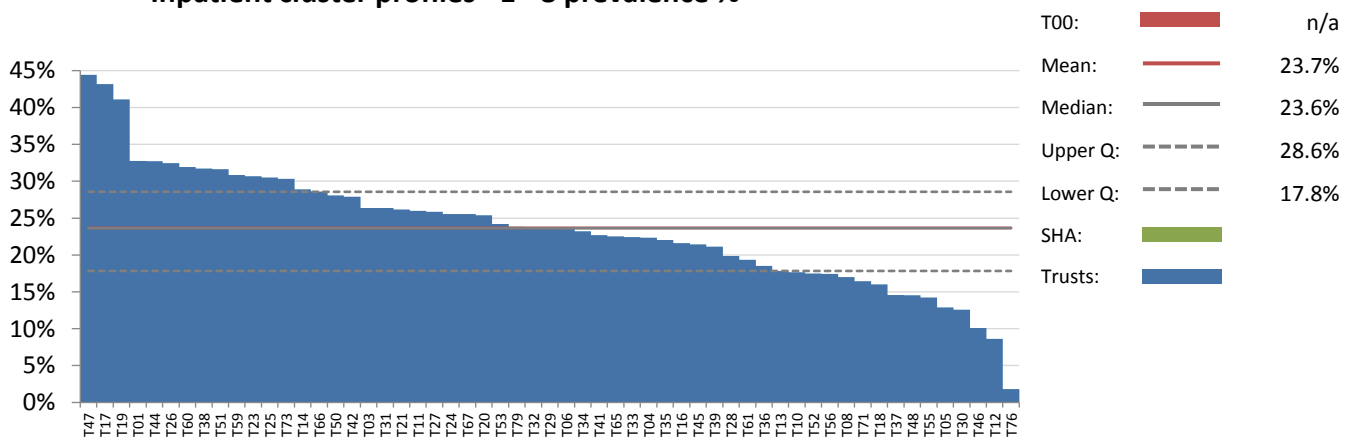


Figure 43





In previous years, a measure of all patients with psychosis was used, however this year patients in cluster 17 ( Psychosis and Affective Disorder) have been analysed separately at the request of the Mental Health Reference Group. Figure 44 shows patients in clusters 10 to 16. This group can account for up to 76.7% of adult acute bed occupants, though the median figure is 51.5%. Combined with the measure for cluster 17 in Figure 45 which follows (6.1%) this suggests little variation from the 57% reported as the 2013 median for clusters 10 - 17.

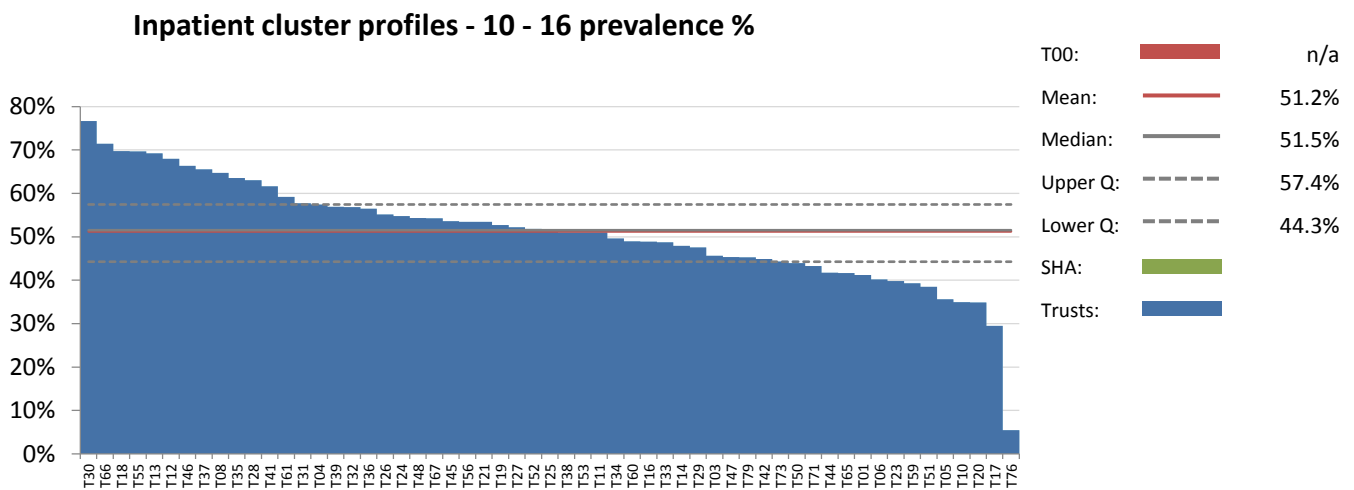


Figure 44

Figure 45, below, shows the prevalence of patients in cluster 17 occupying adult acute beds on 31st March 2014. These patients occupy a significant number of beds in some organisations with a median of 6.1% of beds solely for this one cluster.

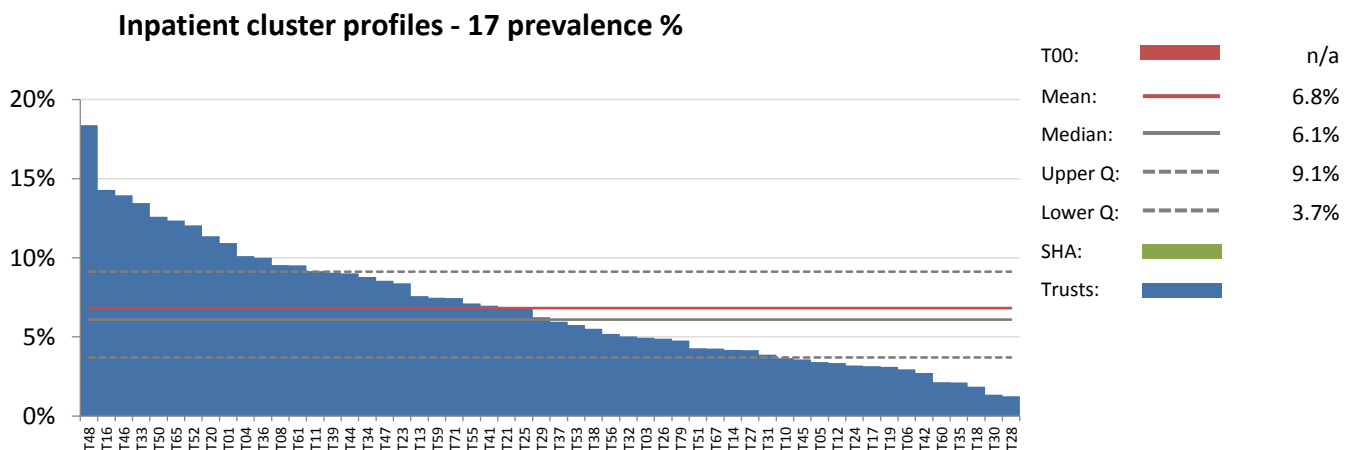


Figure 45





Clusters 18 to 21 relate to organic disorders such as cognitive impairment or dementia. Figure 44 shows a median position of 14.5% across all organisations which has changed little from last year (15%). These clusters can refer to typical older adults illnesses but also to working age adults with enhanced frailty. This can be explored further in the mental health benchmarking toolkit. The outlying organisation here predominantly provides older adult mental health services and therefore this level of clustering is to be expected.

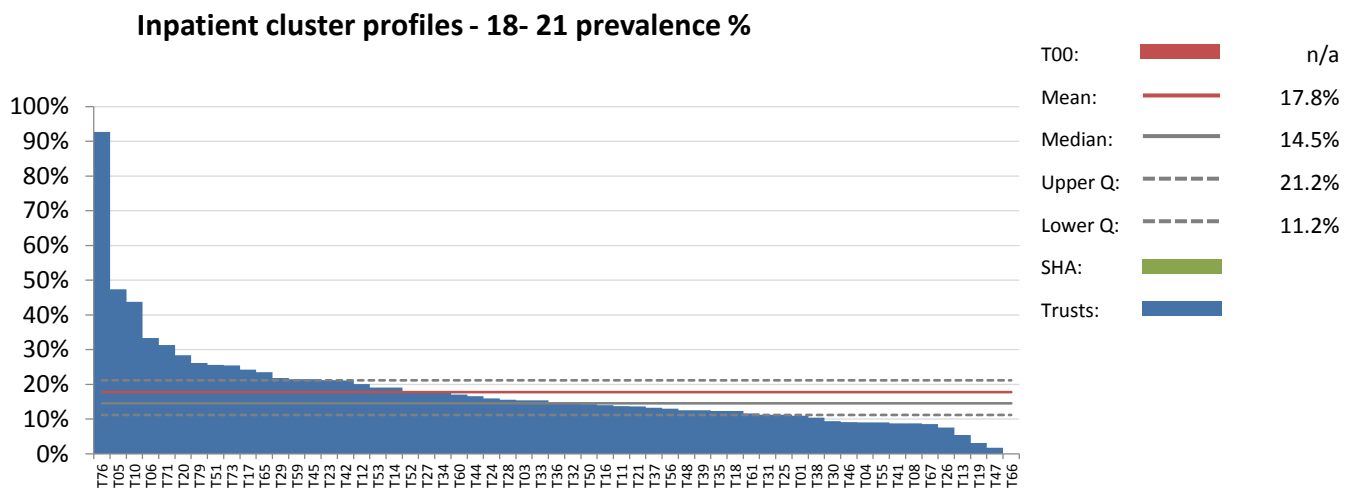


Figure 46





## Use of the Mental Health Act

The extent to which patients occupying beds are there as the result of a Mental Health Act section being applied gives useful background, in conjunction with the clustering analysis shown earlier. It is also important to consider these alongside bed occupancy rates and average length of stay.

Figure 47 below shows the percentage of patients in adult acute beds whose admissions were enforced under the Mental Health Act. The mean figure is 29.8% compared to 29% in 2013 and 25% in 2012. The increasing use of compulsion will have implications for bed availability for patients not admitted under a section and may limit spaces available to this cohort. Organisations who have seen a rise in line with the average increase may also find that acuity of patients has increased as patients detained under the Mental Health Act may have more complex needs.

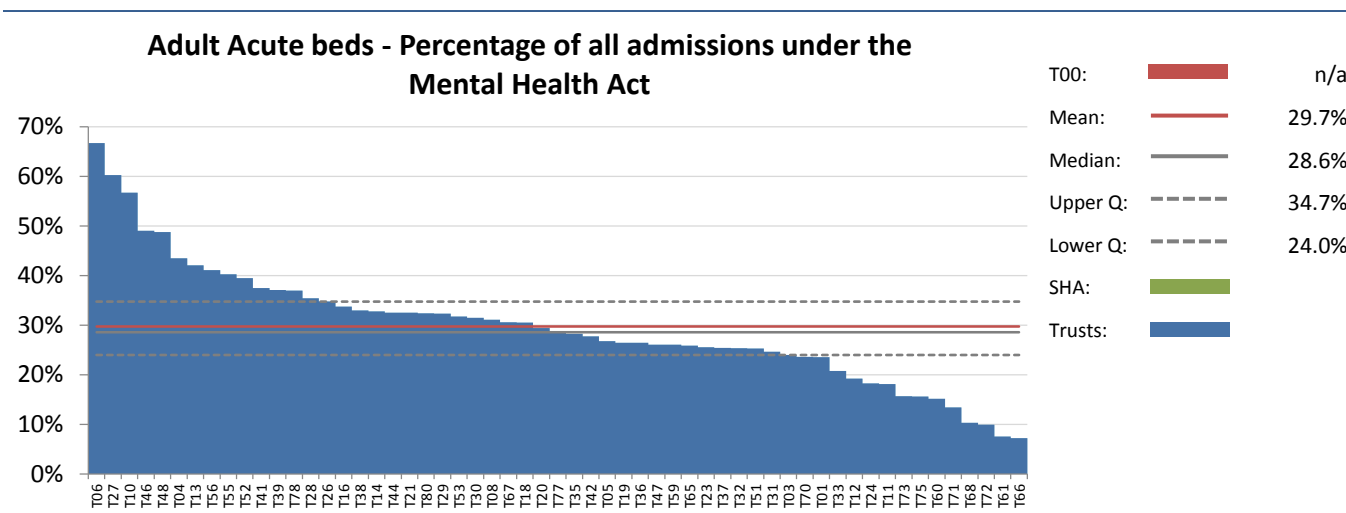


Figure 47

Figure 48 below shows how your organisation's use of the different parts of the Mental Health Act compares to the average nationally. The inner ring represents your organisation, and the outer ring is the average for all organisations, showing of uses of the Act, what proportion were attributable to each section. If only one ring is shown, this indicates your organisation did not provide data on this metric. Section 2 and Section 3 are the most frequently used sections accounting for over 90% of sections.

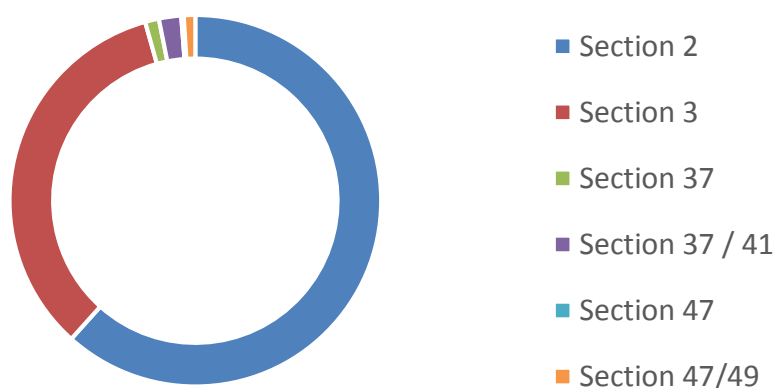


Figure 48







## Community Services

A substantially greater number of mental health service users access community mental health services than occupy inpatient beds at any given time. Some patients may move between inpatient and community care, while others may never be admitted to hospital and be cared for entirely in the community. Although acuity of this caseload can be less than that of the inpatient cohort, it should be noted that most inpatients are also users of community mental health services. Community mental health services play an important role in non-bed based service delivery with step up and step down models of care clearly established in specialist mental health services. The term “community mental health services” can be interpreted in different ways. For the purposes of this report community mental health services are defined as services that support service users outside of the hospital context, often in a domiciliary or community clinic location. Community mental health services work with people with severe and enduring mental illness through well-defined care pathways and protocols. Although it is recognised that services have evolved since the publication of the National Service Framework in 1999, the reference group have adopted a definition of community mental health services that recognises the core principles and shape of the NSF. The following core services have been included within the definition of community mental health services:

- \* Community Mental Health Teams (generic CMHTs)
- \* Crisis Resolution and Home Treatment (CRHT)
- \* Assertive Outreach
- \* Early Intervention (including early onset psychosis)
- \* Assessment and Brief Intervention (including Primary Mental Health Teams)
- \* Rehabilitation and Recovery
- \* Older People
- \* Memory services
- \* Other Adult Community Mental Health Teams

Each of these services is analysed in detail across many domains within the benchmarking toolkit. Areas explored include:

- \* Activity and caseloads
- \* Referrals
- \* DNAs
- \* Access and waiting times
- \* Complaints
- \* Incidents
- \* Finance
- \* Workforce



Figure 49, below, details the total combined caseload for all community mental health teams, benchmarked per 100,000 population. This is an aggregate figure which includes total caseload across all teams listed in the introduction to this section. The mean position this year is 2,231 compared to the figure of 1781 service users on the caseload per 100,000 population reported in 2013. The overall reported prevalence ranges from 967 to 5,094 service users per 100,000 population showing significant variation across different parts of the England and Wales. The growth in reported caseloads requires further validation with participants. Although IAPT data is excluded from the benchmarking project, reference group members observed that the impact of IAPT may be reflected in new, larger caseload volumes. Reference group members also noted that discharging service users from community caseloads is becoming increasingly difficult.

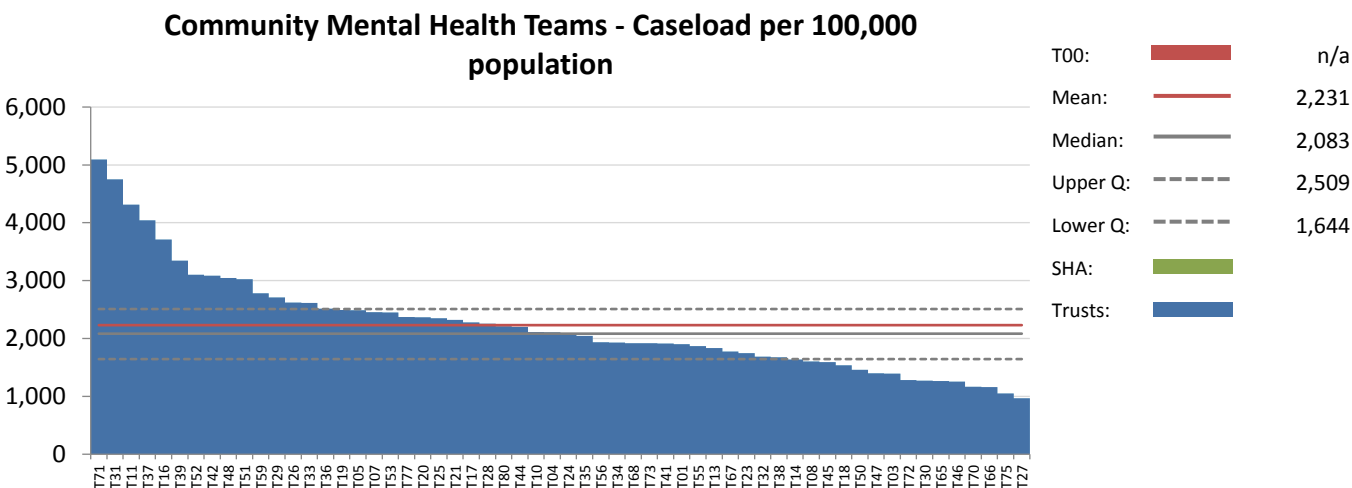
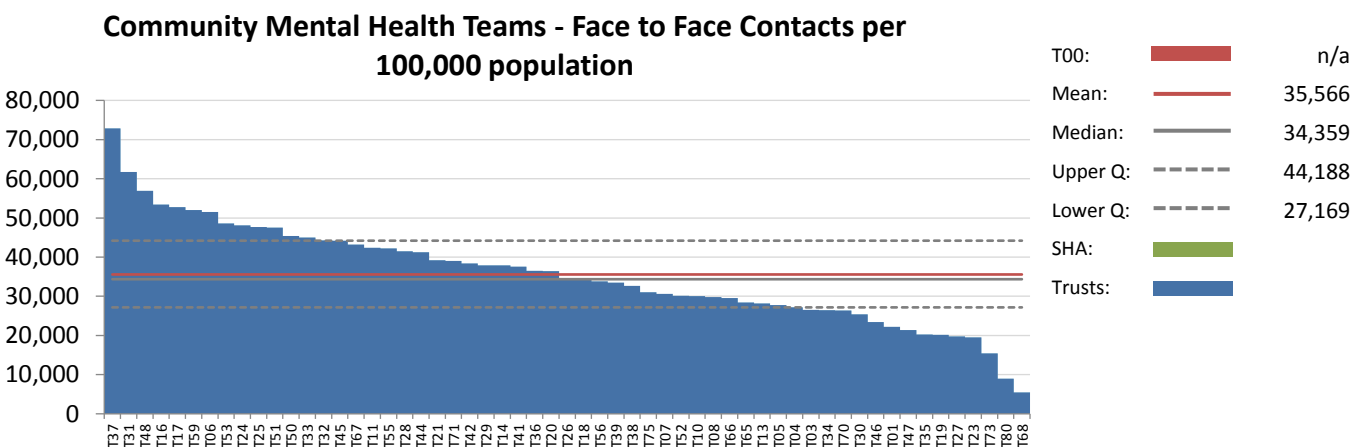


Figure 49

Organisations report both their face to face and non-face to face contacts. The graph below shows the total number of face to face contacts across all community mental health teams. While the caseload, shown above, has increased over the last year, the number of contacts has grown marginally from 36,329 in 2013 to 35,566 per 100,000 population this year. This suggests that individual patients will be receiving fewer contacts, perhaps because the mental health workforce has not increased in line with the increase in demand noted from the caseload numbers. Other factors noted by mental health reference group members include the reduction in the number of Assertive Outreach teams and Older People's CMHTs as new service models emerge.





The benchmarking toolkit provides detail on the range of community services on offer, including caseloads, contacts and waiting times. In this report, the Early Intervention Teams and Crisis Resolution Home Treatment service have been selected to highlight examples of the metrics available in the toolkit.

Figure 51, below, shows the maximum reported waits for a first routine appointment in Early Intervention services, which has a mean average of 8.8 weeks. Waiting times for urgent appointments show a median average of 5 days for Early Intervention services. The Mental Health toolkit provides further graphs which show average waiting times for routine appointments and also for urgent appointments. This is available for a wide range of other community services.

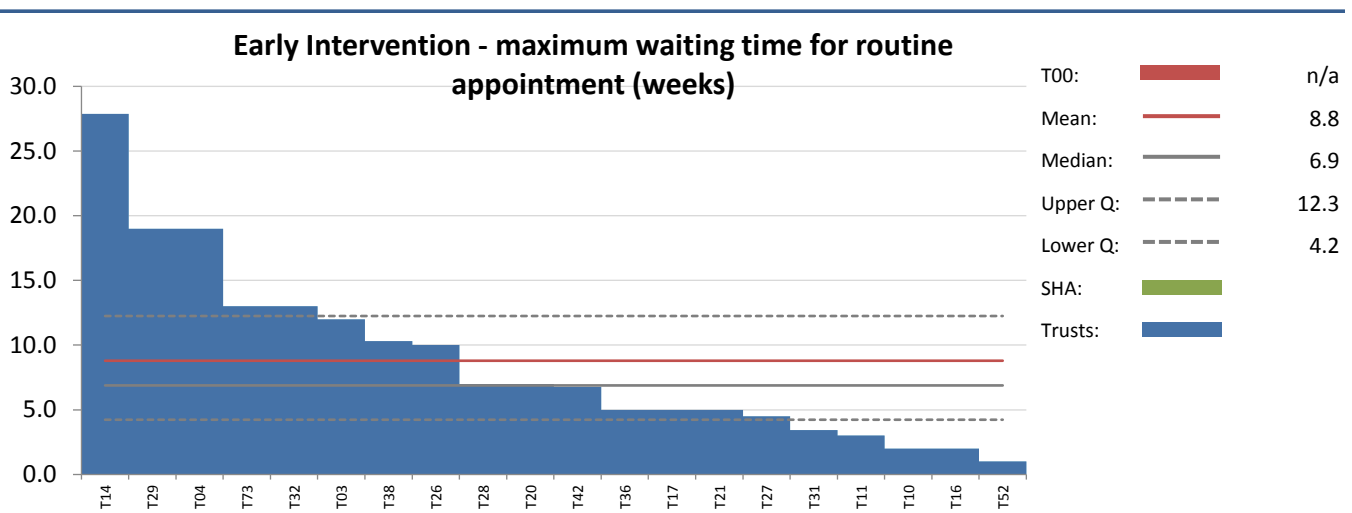


Figure 51

The number of face to face contacts for CRHT teams has decreased minimally this year, from 4392 to 4,339 on average, per 100,000 population served.

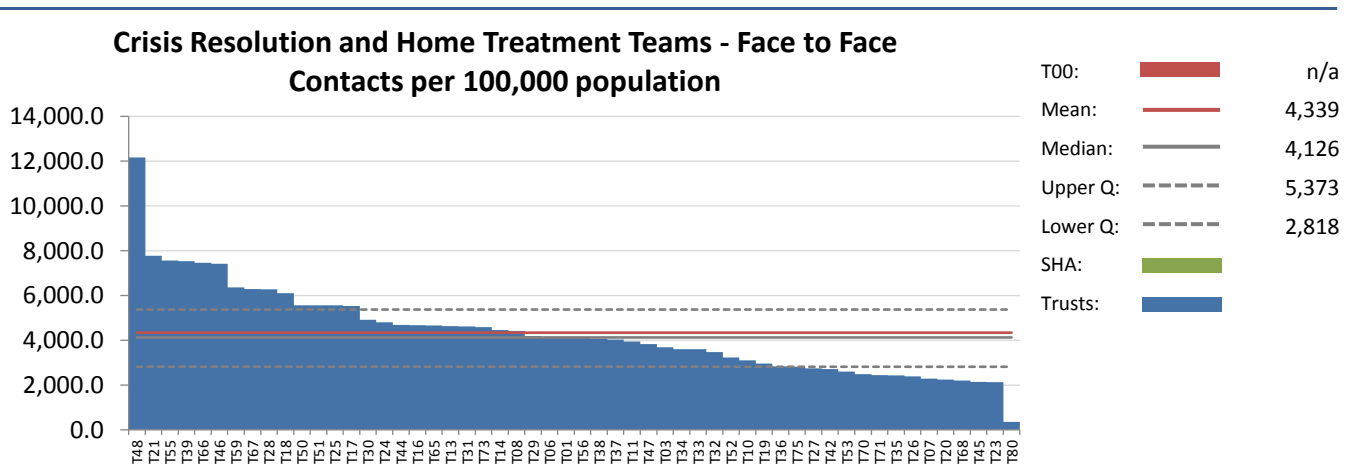


Figure 52

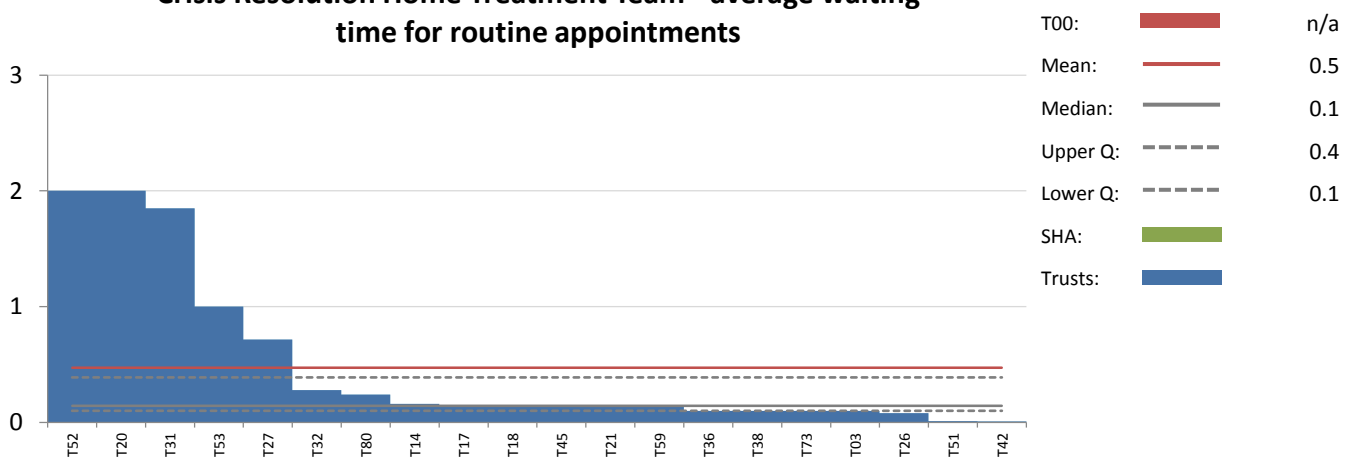




The ability of a CRHT team to respond swiftly to demand for services is an important indicator. CRHT services play an important role in gate keeping admissions to bed based services, and the successful avoidance of hospital admission depends on good, prompt access to this service.

This year, the average waiting time for a routine appointment with as CRHT team was 0.5 weeks, or approximately 3 to 4 days. This compares to an average waiting time of 1 week in 2013. The toolkit can be used to examine average waiting times for urgent appointments, and waiting times for other community services, both routine and urgent.

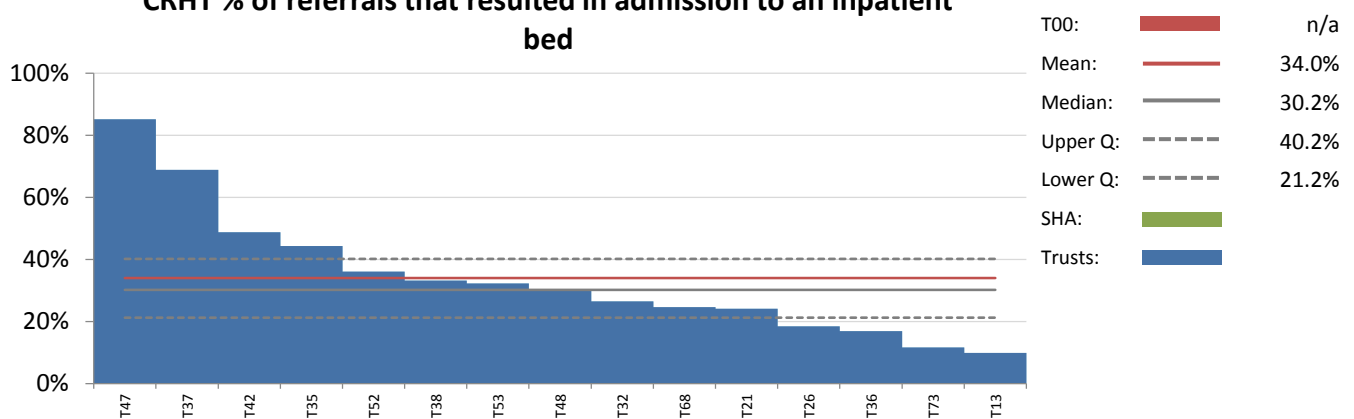
**Crisis Resolution Home Treatment Team - average waiting time for routine appointments**



**Figure 53**

CRHT teams work hard to prevent avoidable admissions, an important role when access to beds is limited (or bed occupancy is high), or when treatment in the community is more advantageous for a patient. The chart below shows the percentage of all referrals to the CRHT team from other community teams which subsequently resulted in the patient being admitted to an inpatient bed. In 2013, organisations reported a mean figure of 27%, which has increased to 34.0% this year. This may reflect patient acuity as well as a more central role played by CRHTs as an admission triage service.

**CRHT % of referrals that resulted in admission to an inpatient bed**



**Figure 54**





## Mental Health Services Workforce

The 2014 benchmarking programme expands on the commitment to review the mental health workforce and provide a wide range of comparisons for participants. The data provided allows detailed profiling of both inpatient and community workforce. A wide range of sub-analysis is also possible including analysis by professional group and Agenda for Change pay bandings. For non-NHS organisations, staff have been mapped based on salaries and equivalent levels of responsibility. A small number of comparisons are presented in the report to illustrate the potential of workforce benchmarking. Network members should refer to the benchmarking toolkit for more detailed workforce comparisons in these and other areas.

The following commentary for adult acute inpatient services relates to core district services and excludes specialist inpatient beds (which can be explored in the benchmarking toolkit). The first chart presented is the WTE number of clinical staff employed in inpatient services. The definition of clinical staff includes Nursing, Medical, Psychology, Occupational Therapy, Other Therapists, Social Workers, Support Workers, and Mental Health Practitioners. A denominator of 100,000 bed days is used for these workforce benchmarks. In practice very few Trusts / Health Boards will generate 100,000 bed days which would require around 300 beds, but this consistent denominator should allow participants to factor their own positions.

The mean position reported is 492 WTE clinical staff per 100,000 bed days in adult acute services (figure 55) compared to 498 WTE in 2013.

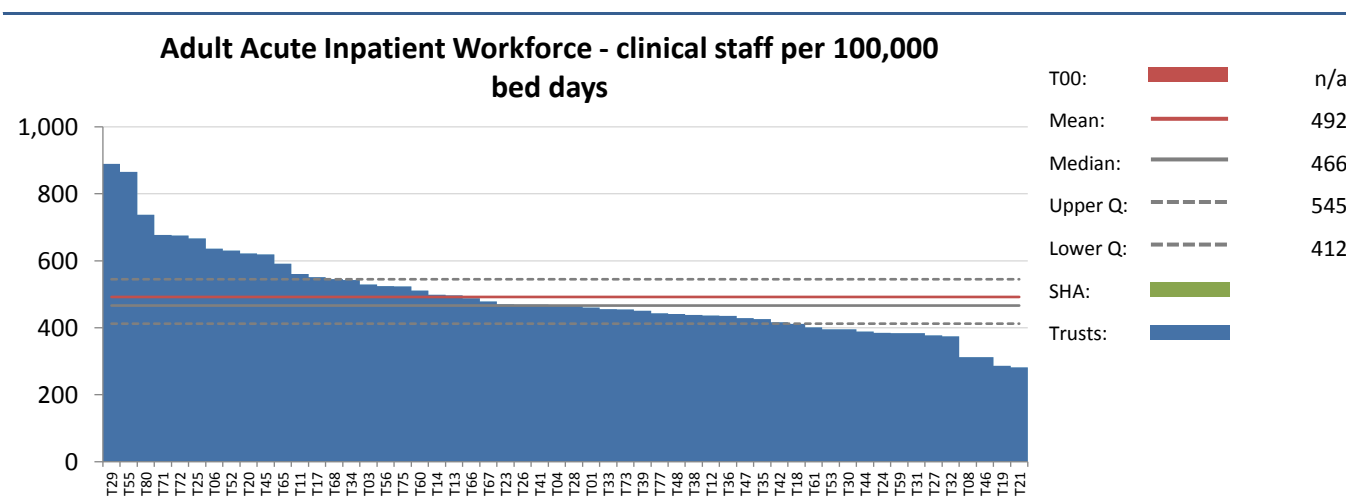


Figure 55





Analysis of Consultant Psychiatrists per 100,000 bed days in adult acute beds is shown below. The mean position of this measure has changed only slightly this year, from 14.4 to 15.1 WTE per 100,000 bed days. Last year's spread has remained virtually unchanged, with this year's quartiles ranging from 10.6 to 18.6 WTE suggesting continued substantial variation between organisations.

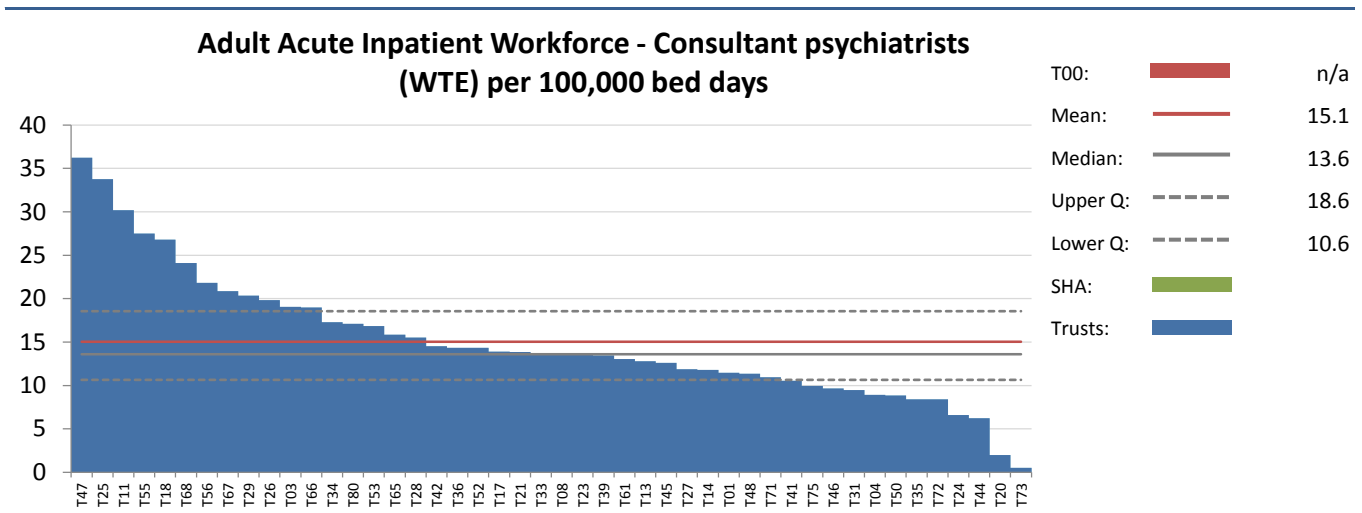


Figure 56

Nursing staff ratios are discussed in detail in the specialist services section of this report and in the toolkit. The figure below shows the number of WTE qualified nurses (AfC bands 5 and above) per 100,000 adult acute bed days. This has a mean position of 235 WTE compared to the 261 WTE reported in 2013. There continues to be discussion nationally regarding the optimal staffing for inpatient wards. Until national guidance is available for Mental Health, this sort of comparison is useful to show organisations how they compare to peers on a regional and national basis.

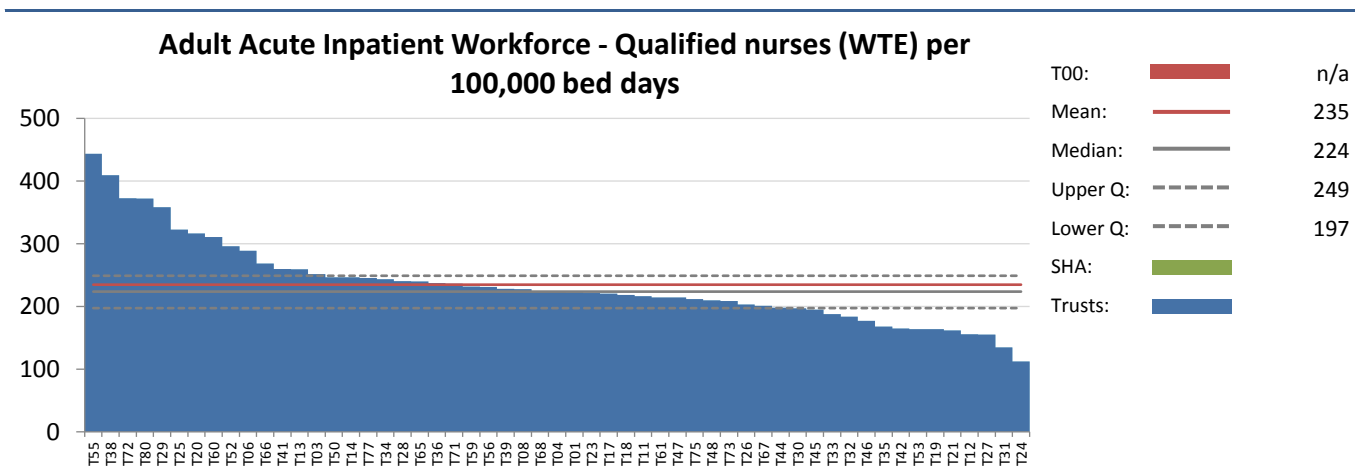


Figure 57





Participants can use the mental health toolkit to explore themes impacting on nurse staffing levels including the level and role of support workers and the use of bank and agency staff.

Figure 58 shows the vacancy rates for all staff as a percentage of WTE in establishment. In 2013, the mean position was 13% compared to 12.4% this year. Again, the variation is significant, with a lower quartile of 6.5% and an upper quartile of 17.5% which indicates there may be regional variation with some organisations finding it more difficult to recruit and retain suitably qualified staff. Vacancy rates are a useful measure for wards who may use bank or agency staff to fill gaps, or operate at a reduced staffing level. In some circumstance, the result may be a detrimental patient experience such as more violence or increased use of restraint as patients are cared for by staff less familiar with them or receive less supervision than is optimal.

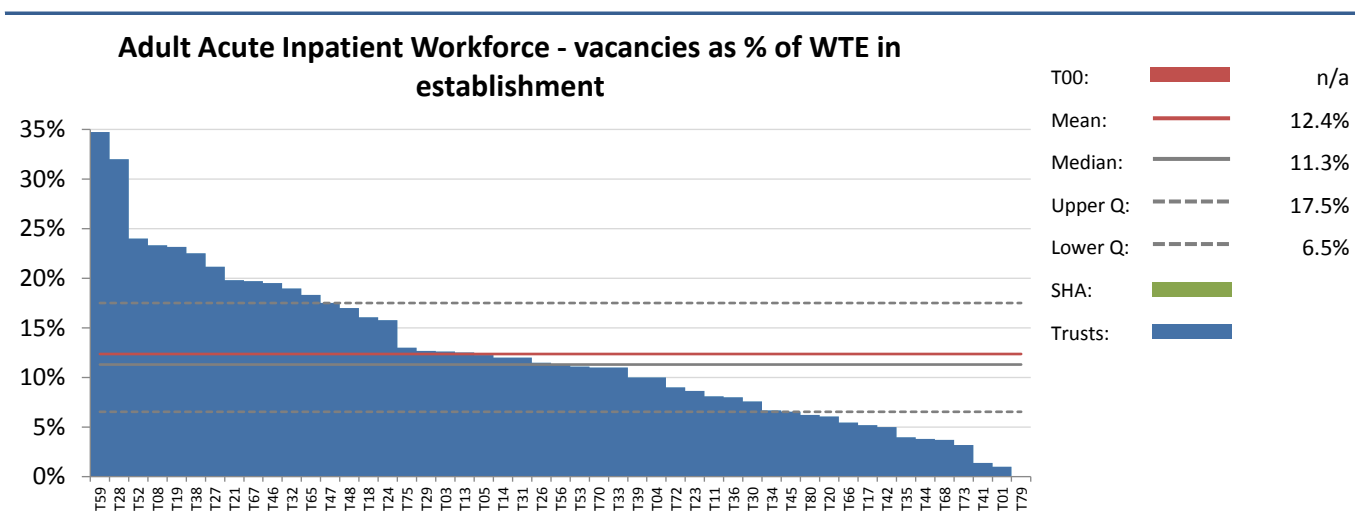


Figure 58





## Finance

Costs of providing both inpatient and community services are collected as part of the benchmarking process and analysed in great detail in the toolkit. A selection of metrics are also included here. Finance is one of the four key domains used in this benchmarking work (others being activity, workforce and quality measures) and gives organisations the chance to reflect on the cost of delivering the services they provide, how this compares nationally, and whether outcomes for patients (from length of stay to number of serious incidents) are impacted by the amount of money invested.

Figure 59 shows the costs per adult acute bed, including all direct, indirect, overhead and corporate costs. This has a mean position of £117,708 which is an increase compared to £104,000 per bed in 2013. Spending is relatively similar across England and Wales and, as was the case last year, the quartile thresholds remain relatively narrow at an annual cost of £108,096 and £139,937 per bed. Increased costs per bed in the last year may suggest that overall inpatient service costs have not reduced despite the reduction in bed numbers.

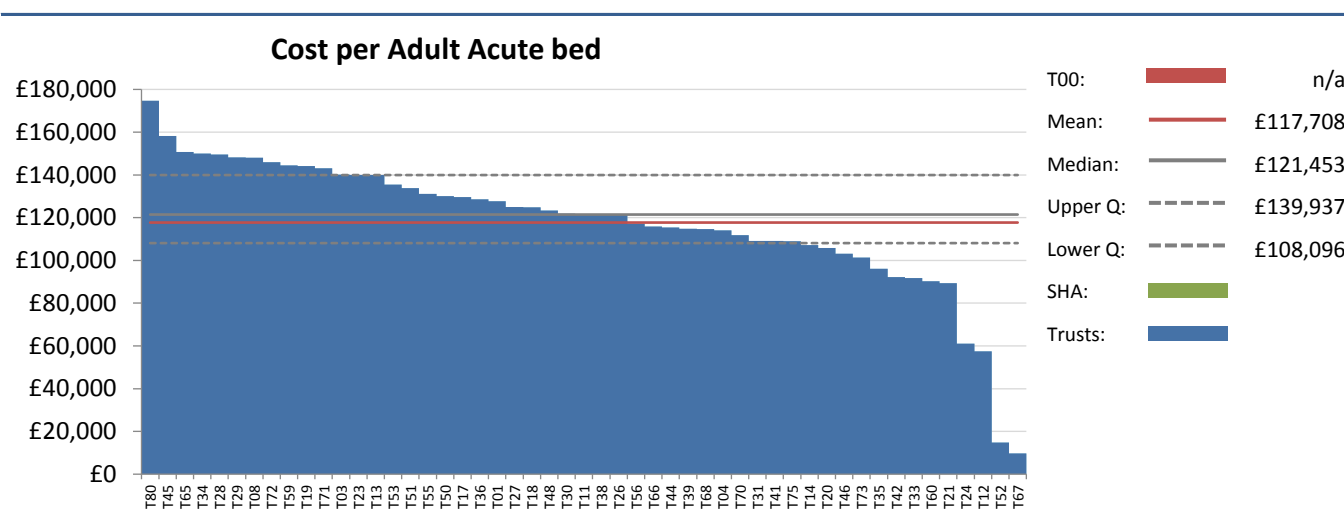


Figure 59







Cost per bed day is also a useful measure for comparison. In 2013 the mean position was £352 which compares to a mean figure of £352 this year.

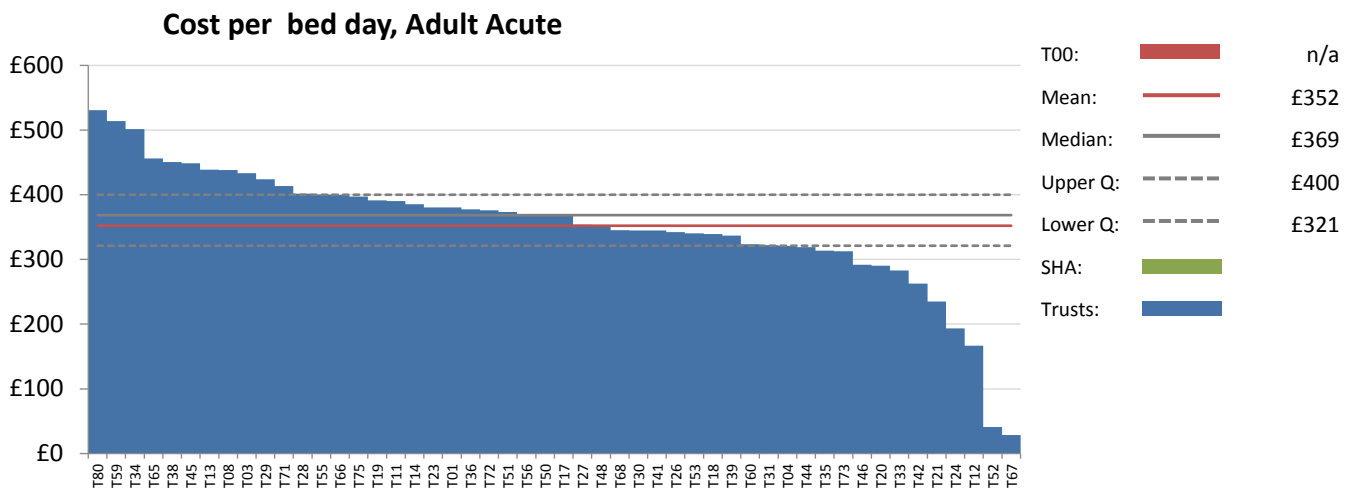


Figure 60

Costs per bed day in all specialist services can be reviewed in the benchmarking toolkit which supports detailed analysis benchmarked in a number of ways including average cost per bed, average cost per admissions and average cost per occupied bed day.

Psychiatric Intensive Care Units are typically high cost services and analysis shows these costs are rising. An example for PICU beds is shown here. The cost per PICU bed day was £677 on average in 2013. This has risen to £707 this year. This should be considered in conjunction with data on staffing levels and bed occupancy in these units, shown earlier in the Specialist Beds section of the report.

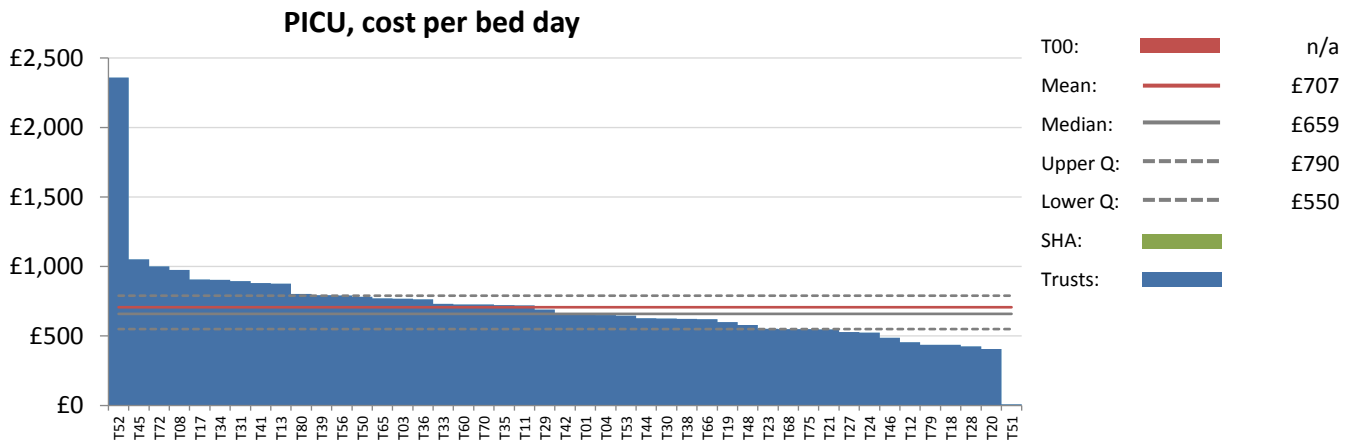


Figure 61





Detailed community metrics are also available in the toolkit, and a small sample are included here. The data can be analysed in a number of ways including cost per contact, cost per patient on the caseload, or cost per 100,000 population served. Figure 62 below shows the cost of Generic CMHT services per 100,000 registered population . In 2013 the mean cost was £2,923,893 per 100,000 population. In 2014 this figure has reduced to £2,459,967 per 100,000 population

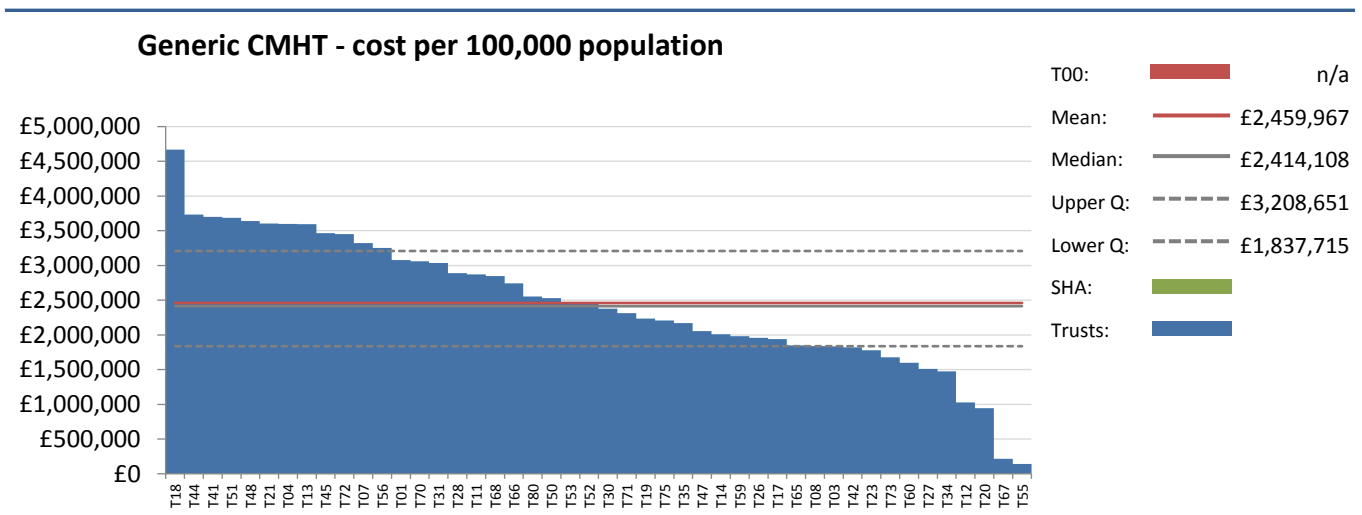


Figure 62

In 2013 the average cost per patient on the caseload was £3,340. This has reduced this year to £2,962. This is consistent with the community metrics highlighted earlier which confirm an increase in average per capita caseloads and also suggest service users have received fewer contacts on average this year than in 2013 although the change may also be due to the inclusion of additional contributors this year.

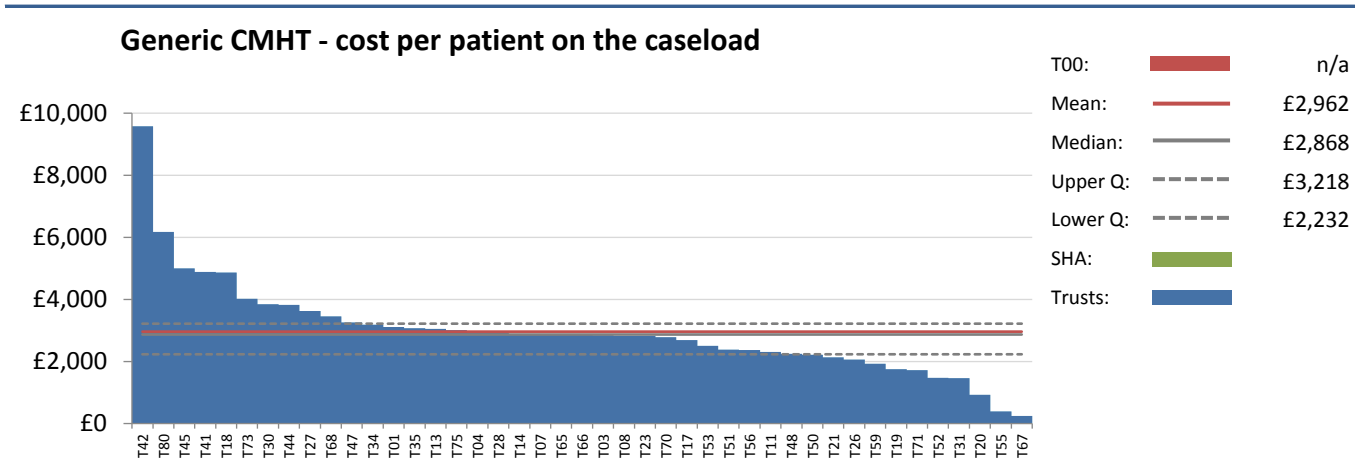


Figure 63



## Quality



Benchmarking Network

The quality agenda is of ever increasing importance in the NHS and this year the benchmarking process included the largest ever number of quality metrics to allow Trusts and LHBs to see how they compare against local and national peers.

Patient and staff satisfaction is an important measure of what it is like to be treated in a service, or to provide care in the service. Patient satisfaction in community mental health teams is shown in Figure 64 below. This is taken from the CQC survey and measures the overall view of mental health services (percentage of patients feeling that overall they had a good experience). The mean figure is 73.1% and has changed positively since 2013 (70%)

Data from the NHS friends and family test will be included in the benchmarking review as soon as this is extended to mental health and data becomes available.

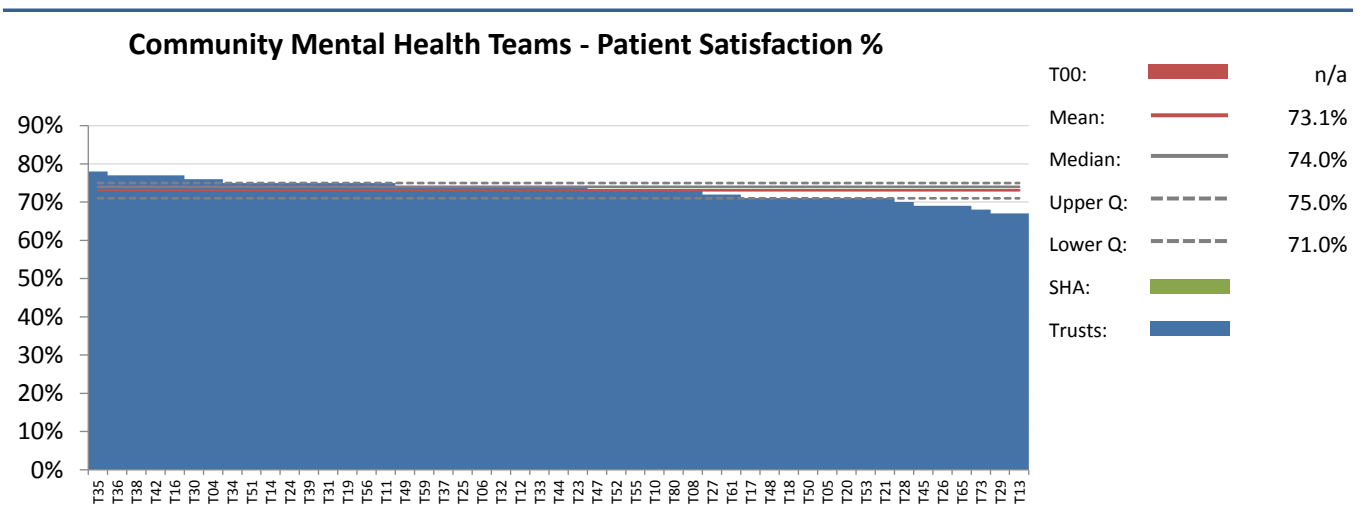


Figure 64





The data for Figure 65 on staff satisfaction is taken from the NHS staff survey and demonstrates a mean satisfaction rate of 76.3% which again has changed positively from the 74% reported last year. This survey measures the extent to which staff are satisfied with their work and the support they receive to do their jobs effectively and safely. It is pleasing to see satisfaction rates increasing in the past year.

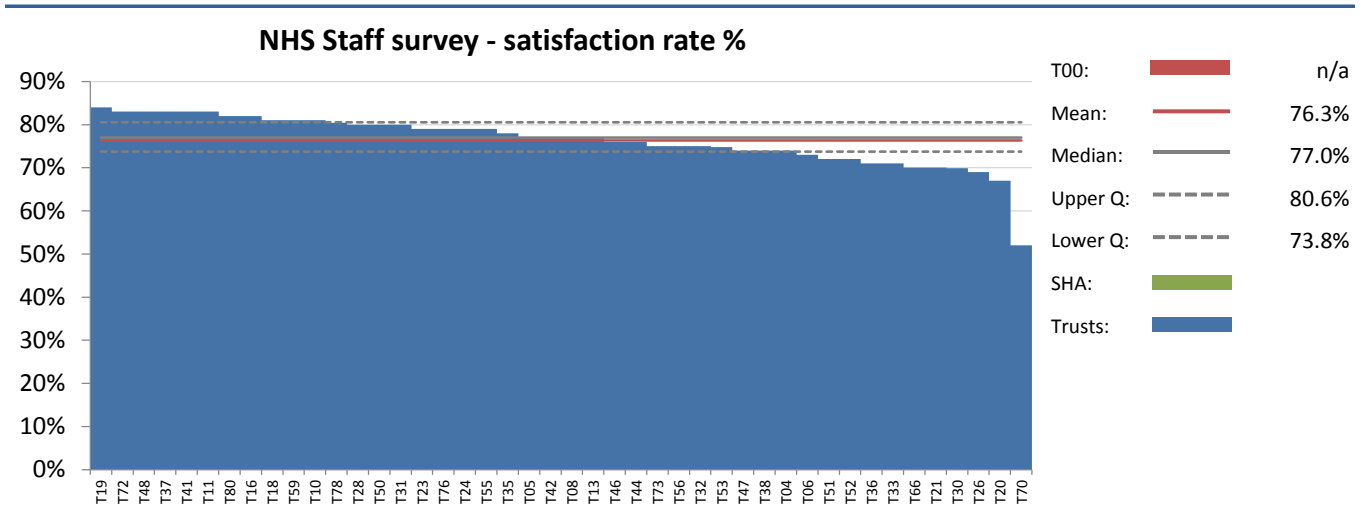


Figure 65

The following measures are compared per 100,000 occupied bed days including all ward types reported. They give a good indication of the level of incidents that are occurring on wards and the overall quality and safety of services.

Trusts and Health Boards may wish to consider this information when they are looking at staffing levels, number of wards and beds, bed occupancy and other figures.

Serious incidents are shown in Figure 66 and have a mean measure of 78 compared to 75 per 100,000 bed days in 2013. This uses a definition consistent with STEIS data collection in England. The increase may be due to both additional incidents and more comprehensive reporting systems and reporting culture being in place.



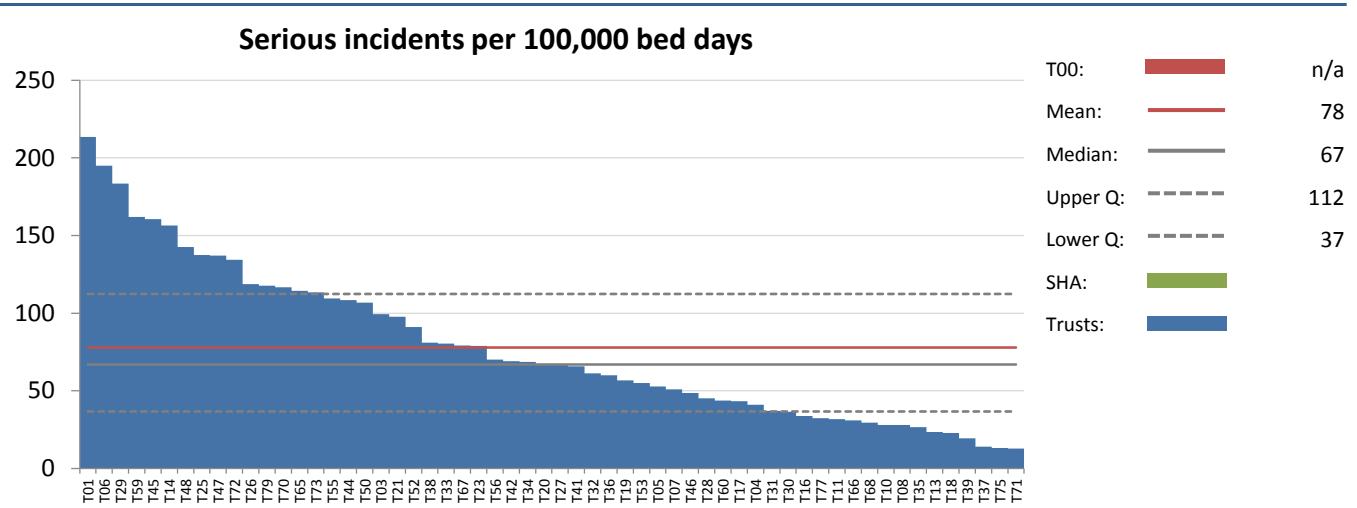


Figure 66

Drug administration errors are shown here per 100,000 bed days and show a mean of 145 compared to 115 per 100,000 bed days in 2013. This change may directly reflect an increase in the error rate, or highlight that identification and reporting of errors is more accurate than in previous years.

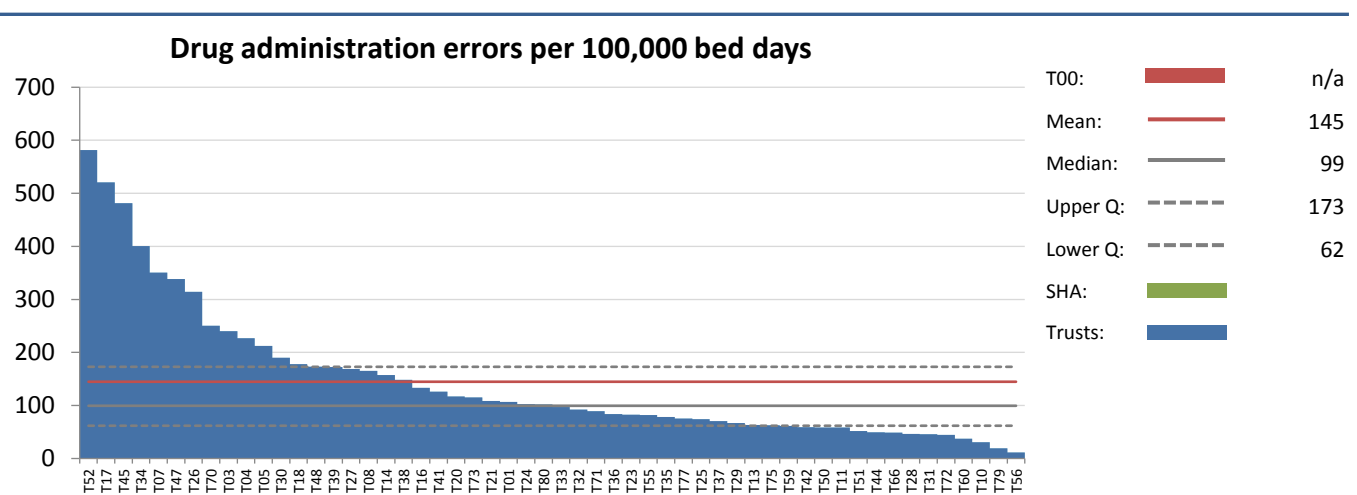


Figure 67



Complaints can provide useful feedback to organisations, and seen alongside patient satisfaction can give a more complete picture of the extent to which service users and their carers are content with a service. The number of complaints per 100,000 bed days is shown here with a mean of 175, a slight increase compared to 161 in 2013.

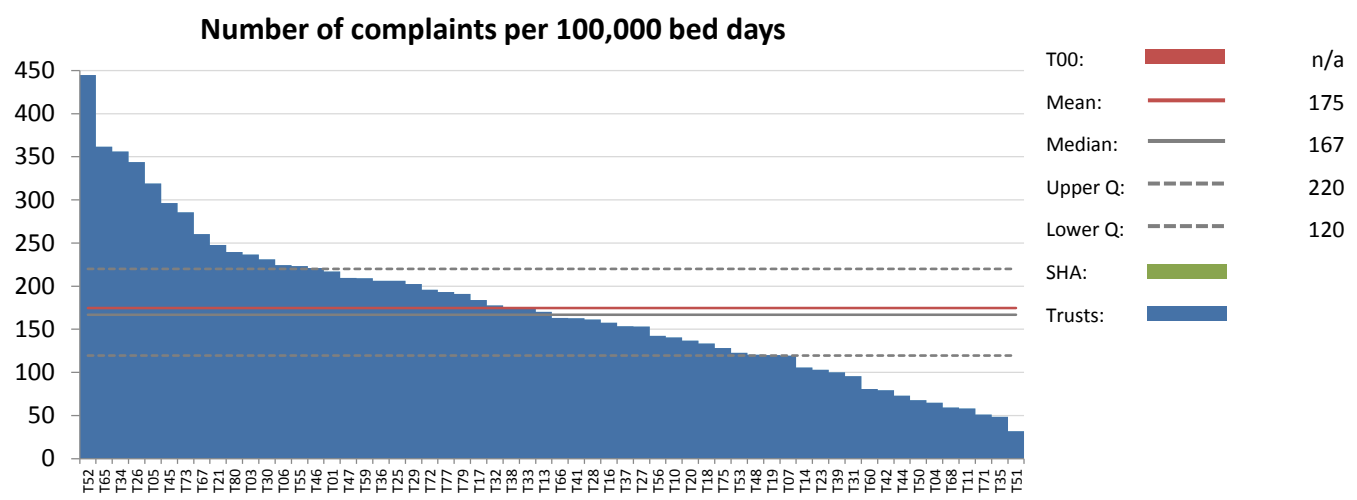


Figure 68

Ligature incidents on inpatient wards are a major risk management issue and subject to systematic review and learning by staff, governance teams and regulators such as the CQC. The number of ligature incidents reported has increased significantly this year to a mean position of 129 from 72 ligature incidents per 100,000 bed days in 2013. Where individual organisations have seen a sizeable increase in their own figures compared to last year, they may wish to drill down further to determine the locations of these incidents and the nature of the ligatures and ligature points being used to see if there is anything that can be learned to prevent further rises in the future.

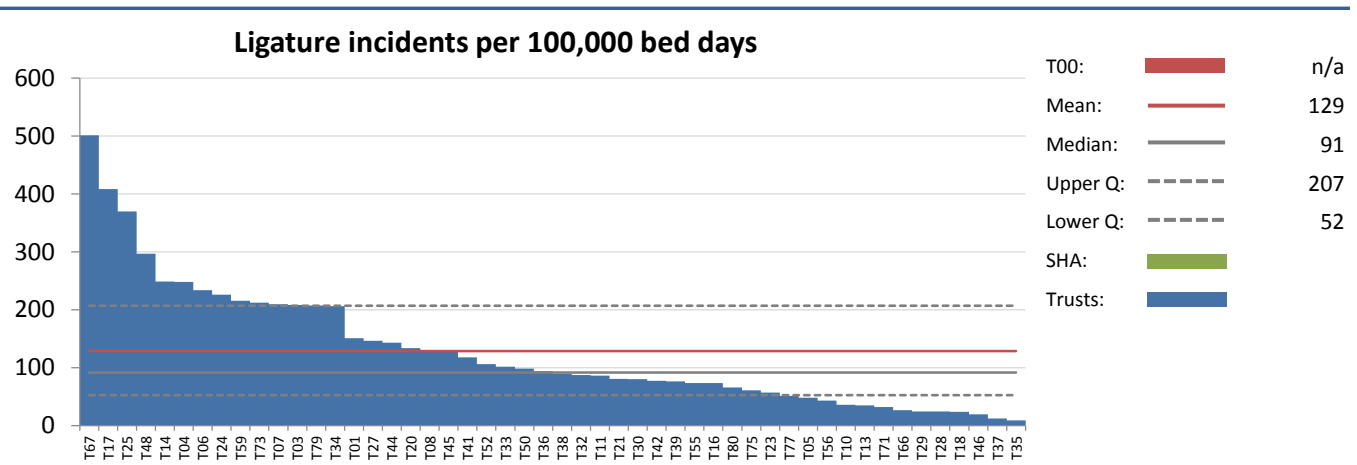


Figure 69





Patients on mental health wards may be the victims or perpetrators of violence and this data is reported both in terms of violence towards other patients, and violence towards staff.

Figure 70 shows a mean figure of 288 incidents of physical violence to patients per 100,000 bed days. This is an increase from 241 incidents per 100,000 bed days in 2013.

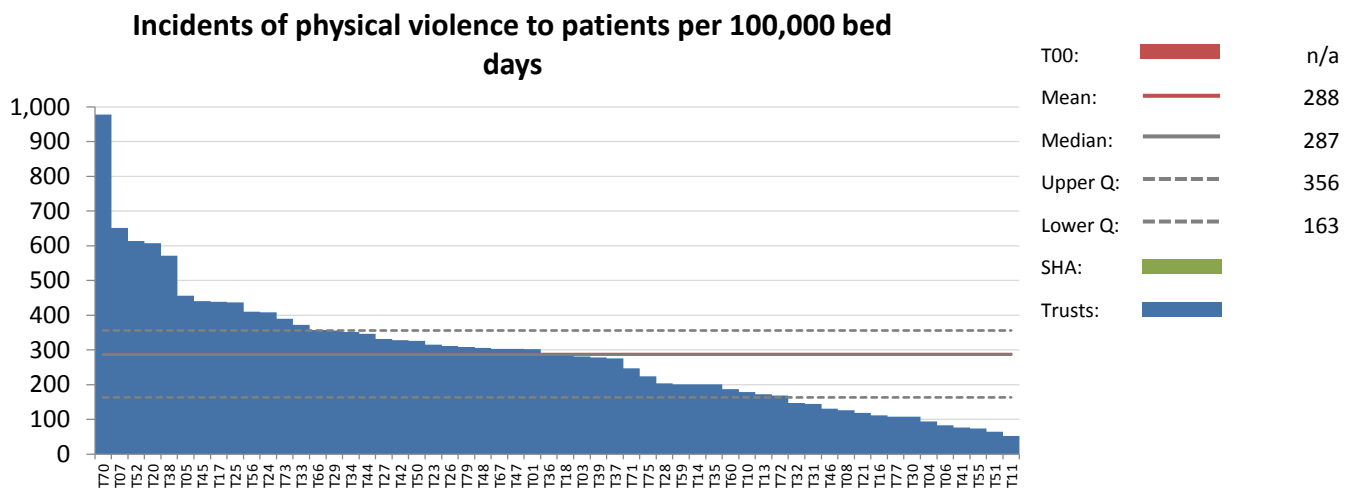


Figure 70

In 2013, incidents of physical violence to staff had a mean figure of 449 per 100,000 bed days. This has increased to 588 incidents per 100,000 bed days in 2014. The increase in violence towards staff and towards other patients correlates with the higher acuity of patients admitted (shown earlier in the analysis of clustering profiles) whose behaviour may be more challenging and harder for staff to control. This may also contain an element of increased reporting through wider use of reporting systems.

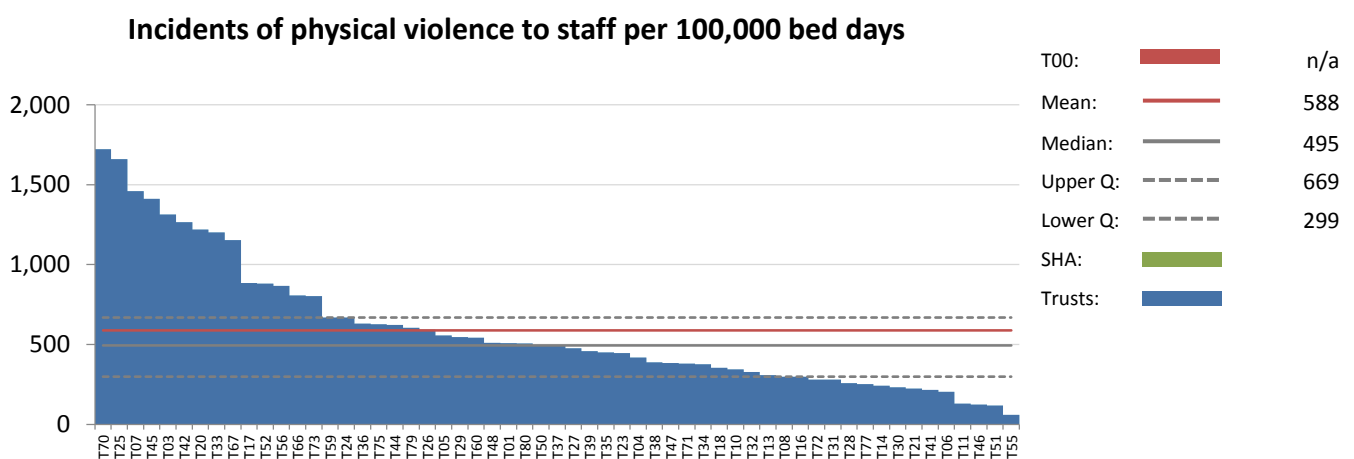


Figure 71



Many organisations have developed policies and protocols to try to reduce the use of seclusion and restraint by employing other approaches to de-escalate situations. However, as with other quality metrics, these figures have continued to rise. Seclusion was, on average, used 194 times for every 100,000 occupied bed days in 2013/14. This compares to 153 uses of seclusion per 100,000 occupied bed days last year.

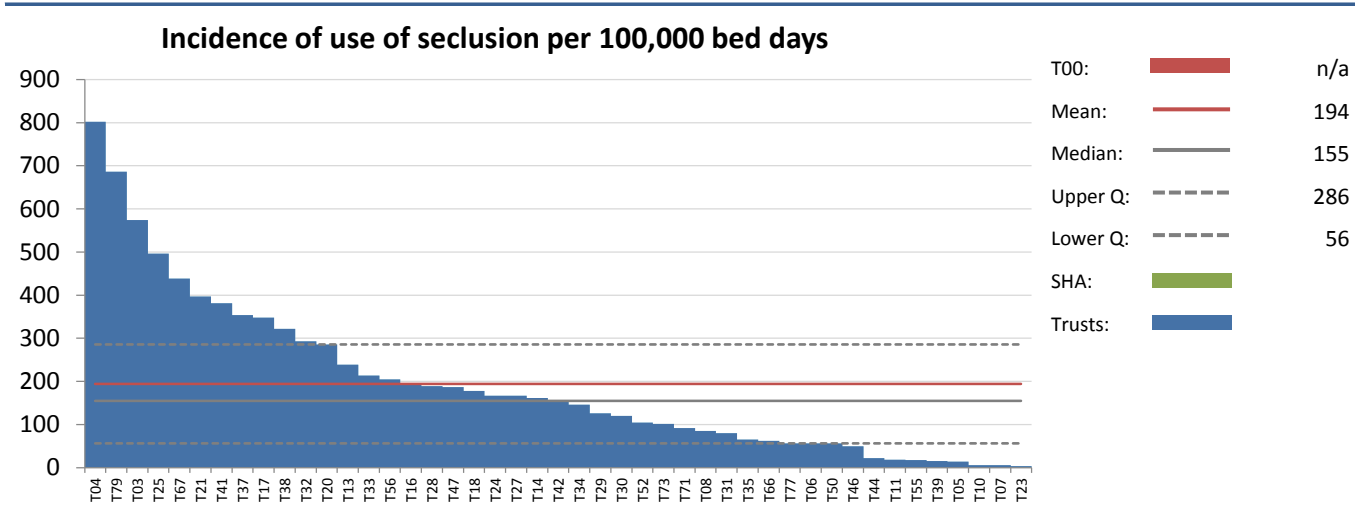


Figure 72

Several organisations have reported similar levels of restraint to last year, with those using restraint most and least often last year occupying the same position on the graph this year. Overall, rates of restraint have continued to rise, to 826 on average this year compared to 654 documented incidences of restraint per 100,000 bed days in 2012/13.

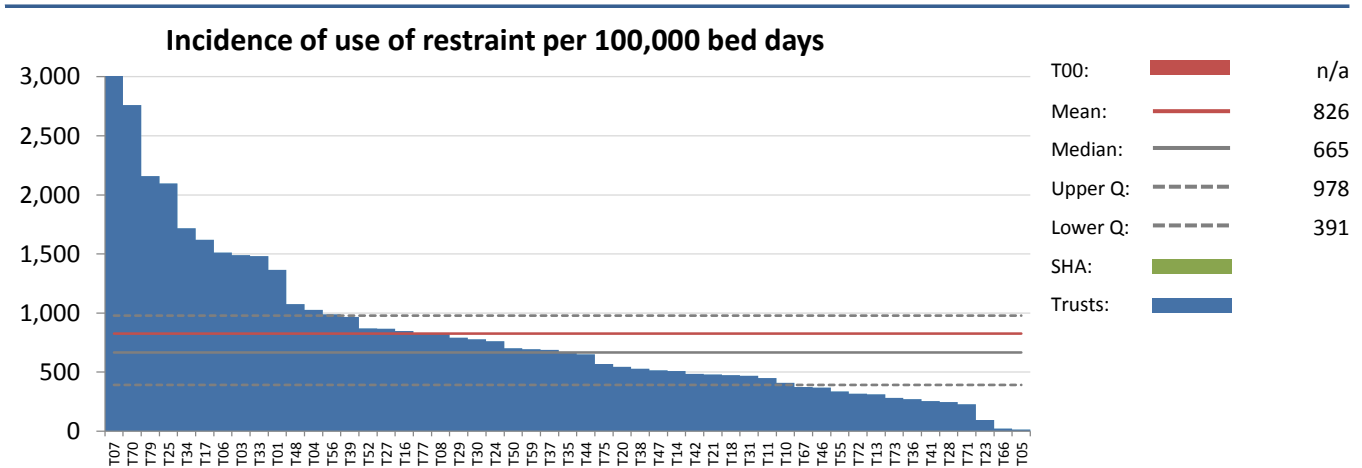


Figure 73







Use of face down restraint has been collected for the first time this year as a new measure requested by Trusts and Health Boards. This type of restraint is more controversial and often associated with poorer outcomes for patients, so organisations will be interested to see how they compare on a scale of 100,000 bed days. Face down restraint is less common than restraint not in a prone position, and this year the mean position reported was 233 incidences of face down restraint per 100,000 bed days.

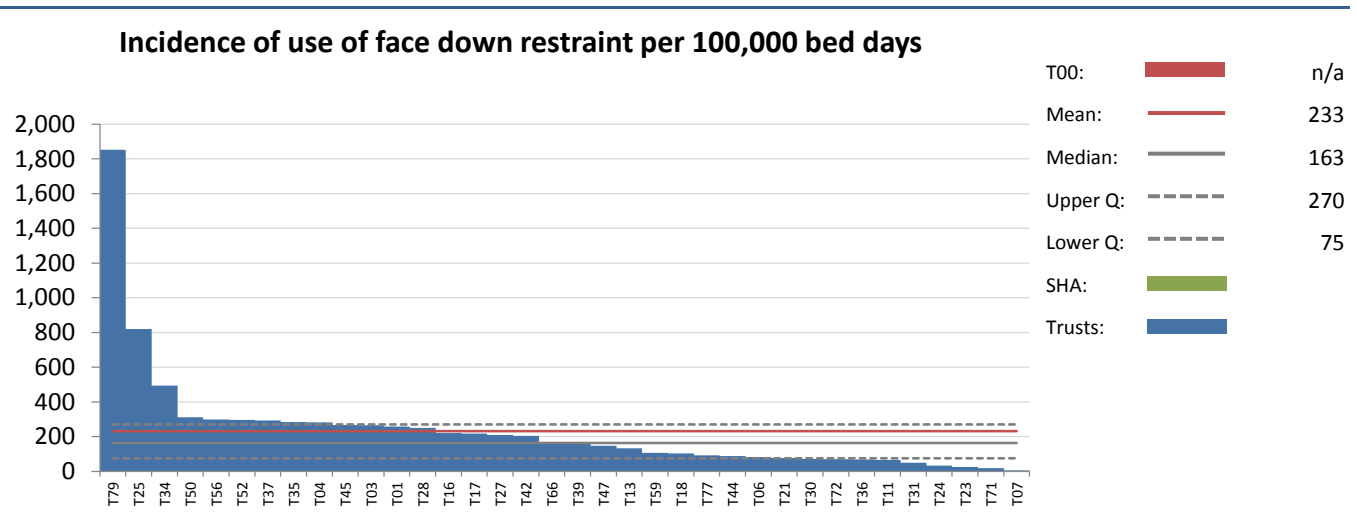


Figure 74

Feedback from mental health reference group members on the issue of restraint suggests that only from April 2014 will data on restraint and other incidents become robust and complete. Information systems have become more comprehensive in recent years which may explain the growth reported in many categories of incidents observed in this year's benchmarking report.





## Balance of care between inpatient and community services

The vast majority of Trusts and Health Boards provide both inpatient and community services and the trend in recent years has been towards reducing the number of available inpatient beds. At the same time, community based teams have seen an increase in their caseloads. There is no agreed universal figure regarding the correct balance between bed based and community services and this is very much influenced by local needs and existing provision.

Figure 75 below shows the balance of financial investment between core inpatient services (adult acute and older adult) and community based services. The typical profile sees on average 50% of total funding being allocated to inpatient services.

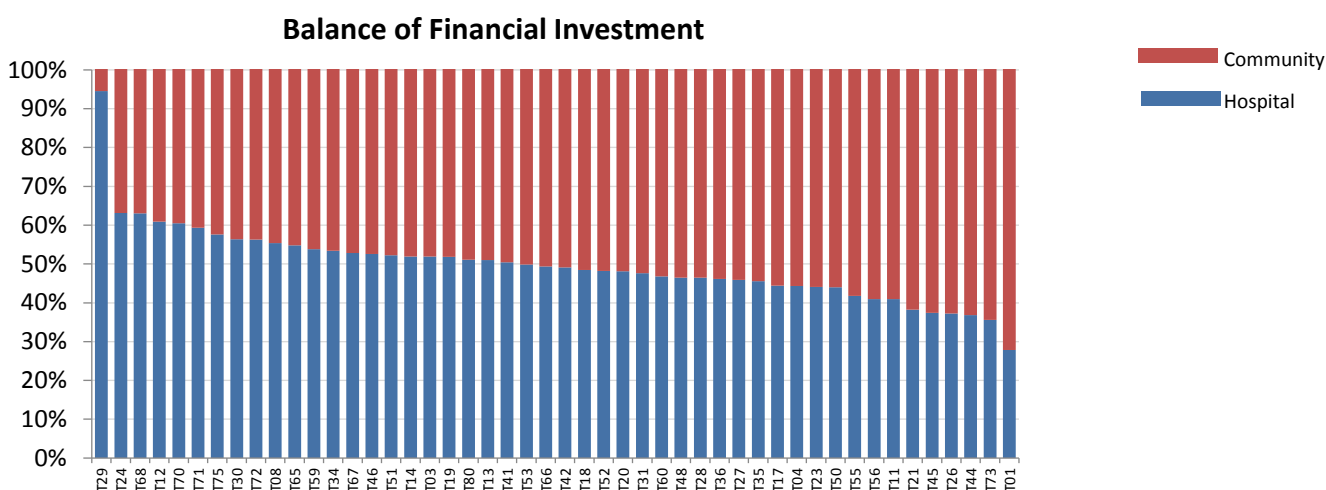


Figure 75





In 2013, the average split between inpatient activity (calculated as number of admissions to adult acute and older adult beds) and community (caseload for all teams) was 10% hospital to 90% community. In 2014 this has shifted slightly to 14% hospital care and 86% community care. This may reflect the different mix of participants in this year's study as well as increased pressure in the inpatient sector.

This does, however, continue to show the high cost of acute services compared to community services, as 86% of activity takes place in the community, but only 50% of the funding is spent there.

### Balance of Activity

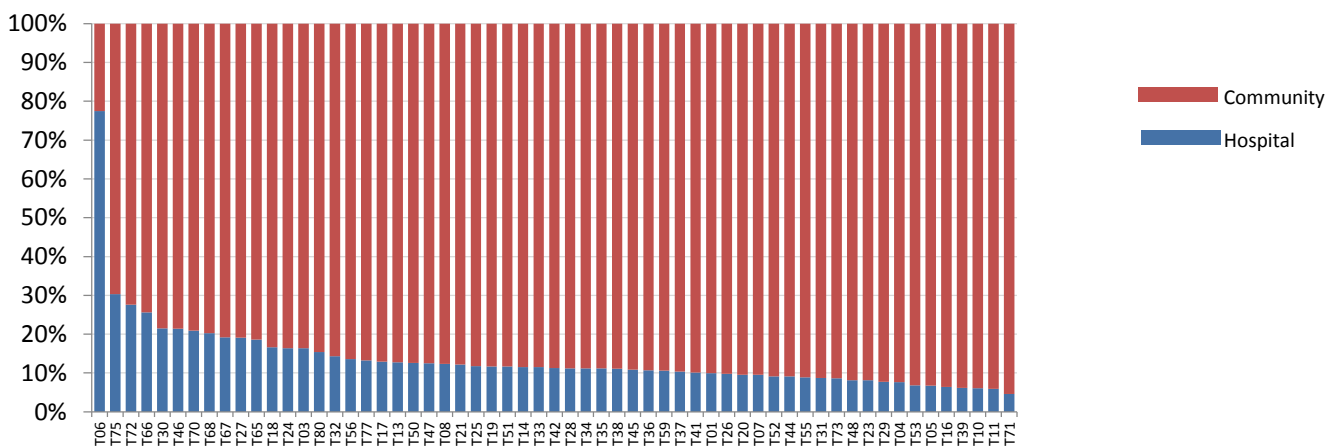


Figure 76

In the census taken on 31st March 2014, on average 98% of service users under the care of Trusts / LHBs were on a community basis, compared to just 2% occupying inpatient beds on that day. These figures have not changed since last year.

### Balance of care - Activity Census

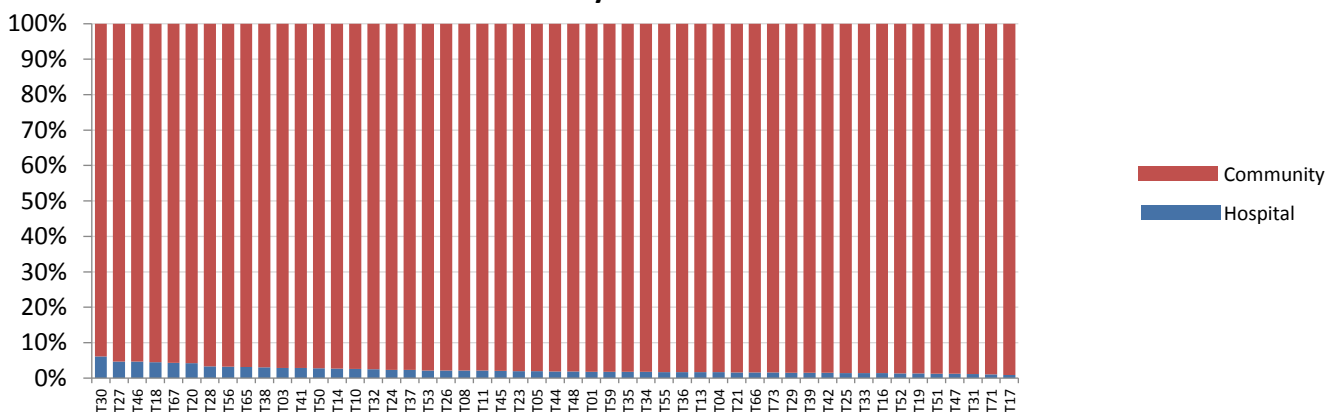


Figure 77





The split of workforce between inpatient and community settings is also interesting, and shown here in Figure 78. The average figure has not changed since last year and remains 38% inpatient to 62% community.

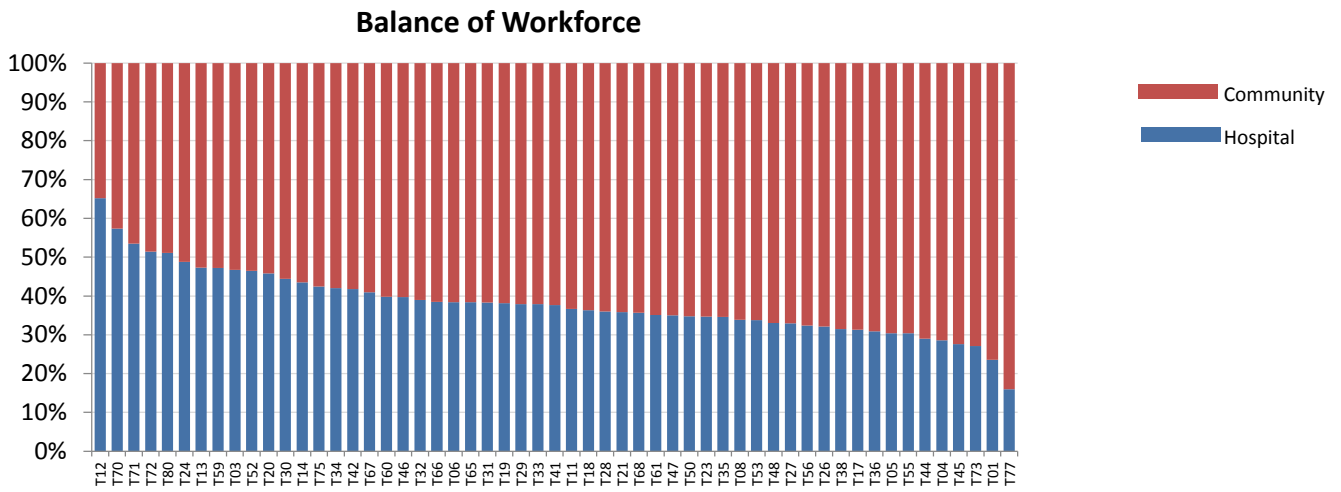


Figure 78





## Conclusion

The findings from the 2014 cycle of mental health benchmarking provide an authoritative platform against which changes in mental health provision can be measured. The involvement of all NHS providers in England and Wales is particularly pleasing and provides a definitive baseline for future comparisons. We also welcome the involvement of specialist providers from the independent sector in the 2014 project. We would like to express our thanks to all 66 member organisations who provided data.

The content of the project covers all the key benchmarking domains of activity, workforce, finance, safety and quality. The inclusion of these themes aims to provide a one-stop shop capability for participants in evaluating mental health services provision and performance. The ability to cross compare across domains will be important in gaining a full understanding of the story behind this year's data.

As in previous years, the report shows levels of variation across the NHS in both service demand and provision arrangements. Services are utilised at different rates potentially reflecting local commissioning priorities, service development decisions, and history and practice. Members should actively use the 2014 desktop benchmarking toolkit to further understand the headline comparisons introduced in this report. The benchmarking toolkit will allow the local evidence on mental health service provision and performance to emerge for each participant organisation. The toolkit provides an ability to cross refer between inpatient and community services to draw conclusions about the overall balance of care between bed and community based care. The 2014 analysis has also expanded significantly into new areas around liaison psychiatry, home treatment, use of the mental health act, and additional quality indicators. The comparisons within the report also allow some inter-year comparisons to be drawn with positions reported in previous benchmarking cycles. We aim to enhance this facility in future years.

Headline findings for 2014 for inpatient services confirm an ongoing reduction in the number of inpatient beds. These reductions are particularly marked in adult acute services and older adult services. Reductions in bed numbers have been achieved against a backdrop of steady state levels of inpatient activity. This again suggests increases in efficiency have been delivered by mental health providers. Trends from previous years in observed reductions in length of stay have not taken place in the last year for adult acute and older peoples services. Efficiency has instead been driven through ongoing increases in bed occupancy. Anecdotes on mental health beds and bed occupancy abound but this year's evidence confirms increases in occupancy on an already restricted bed capacity that now reports occupancy equivalent to 93% of all available mental health bed days, an astonishing level when compared with other areas of the NHS.

This increase in efficiency through bed occupancy should be viewed in the context of improvements in both readmission rates and delayed transfers of care, both of which have fallen in the last year for older adult beds. In adult services, meanwhile, readmissions have also reduced, although an increase in delayed transfers of care has been illustrated.

Specialist inpatient services also report increases in demand for beds. Services such as PICU, low and medium secure all report increases in bed occupancy. PICU demonstrates a notable 10% reduction in average length of stay although low and medium secure services both report increases in average length of stay in the last year. Participants will be able to review all their specialist services through the report and related toolkit.





Data on community services has been provided in great detail by participants. Our analysis suggests that caseloads have increased in the last year for many community teams. We also provide analysis of access arrangements and waiting times in mental health. We are all cognoscente of the definitional work which is still to take place on many areas of mental health access systems. In advance of this we can report that average waits in many services are well below 18-weeks, however, many providers report a long tail on waiting lists with large numbers of people waiting significantly longer than 18-weeks to access non-urgent care.

Analysis of the mental health workforce reveals interesting findings. Absolute workforce levels have not reduced in the last year and users can access detailed profiles of medical, nursing and therapy input for specific inpatient and community services. However, it is evident that less acute services demonstrate significantly lower workforce levels than we might expect to see. For example, staffing levels for longer term complex and continuing care are much lower than for other services with low staffing levels evident for medical, nursing and therapies. The low intensity of workforce can be compared to the long average lengths of stay seen in this service.

Detailed costing data can be accessed in the report which compares both aggregate and unit costs across participants. Variation is again a theme.

The collection of service quality data has been facilitated by the inclusion of a suite of metrics that explore incidents, risks, harm, and patient and staff satisfaction. Positions on service user and staff satisfaction both show improvements on previous years. Analysis of incidents shows growth in the number of incidents in many areas. This is clearly an area to keep under close scrutiny although feedback from members and the mental health reference group suggests an increase in the completeness of incident reporting may be a major factor in this growth.

Variation in demand and provision is evident in all sectors of the NHS and the question of “what does good look like?” for mental health services remains a challenge. The benchmarking work provides a strong evidence base from which this discussion can be taken forward. The initial findings from the 2014 benchmarking report were discussed with the mental health reference group in early September. Participants were invited to feedback on the analysis and conclusions in their reports prior to the release of findings at the national conference on 7<sup>th</sup> November 2014.

The NHS Benchmarking Network now involves 100% of Mental Health Trusts and Local Health Boards in its work programme and provides an excellent network through which the pursuit of good practice and continuous improvement can be taken forward.

We would like to express our thanks to NHS Benchmarking Network member organisations for providing data to the 2014 mental health benchmarking project. Members have been actively engaged in the project throughout. We would also like to express our thanks to the mental health reference group for their input in shaping the project. We look forward to progressing the mental health benchmarking work in partnership with members during 2014/15 and beyond.





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