Trust: T41 (Weighted population)
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Introduction

This report summarises the results of the benchmarking exercise for inpatient mental health services that took place in July and August 2013.

The project received contributions from 57 NHS Mental Health providers and provides up to date information on provision arrangements for mental health services. Contributions were received from NHS Trusts and Foundation Trusts in England, and also from Local Health Boards in NHS Wales. We are grateful for the data supplied by participants which has created a comprehensive resource of up to date comparative data for use by member organisations. This report introduces some of the headline comparisons from the benchmarking process and should be used alongside the desktop benchmarking toolkit that will also be made available to members to allow detailed drill-down into all benchmarking comparisons.

The comparisons within the report use a 2012/13 year end timescale for reporting on a range of benchmarks. This is supplemented by a ward census which was conducted during March 2013. The ward census outlines which patients were occupying beds at this point and also shows mental health clusters and main diagnosis groups. A parallel census was also undertaken for patients on the caseload of community based mental health teams.

As well as reviewing inpatient services, this report takes stock of all community based secondary mental health services. The report includes comparisons of; services provided, activity, finance, the mental health workforce and a wide range of quality markers.

The content and direction of the mental health benchmarking project was discussed with NHS Benchmarking Network members throughout its development. Specific contributions were made by the mental health benchmarking reference group who worked to supervise the content and delivery of the mental health benchmarking work programme. The reference group shaped the direction of the mental health benchmarking projects including their coverage, content, analysis, and products available to members.

The mental health benchmarking reference group contains 30 members drawn from a range of backgrounds within mental health services. The group is chaired by Edward Colgan, Chief Executive of Somerset Partnership NHS Foundation Trust. The group meets on a quarterly basis with its membership drawn from Network members. We are grateful for the contribution of reference group members throughout 2013.

The NHS Benchmarking Network would like to thank members for their contributions to this cycle of benchmarking and look forward to discussing the results with members. Members have been able to comment on a previous draft of this report to ensure that the data items reported are validated with each participant organisation. Further discussions with the Network's full mental health provider membership took place at a national mental health benchmarking conference held in London on 8th November 2013.
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 will be 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 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.
Participants

Participants in this cycle of benchmarking totalled 57 organisations. This is an increase on the 42 organisations that took part in 2012. Of the 2013 participants, 39 organisations (68%) also took part in the 2012 benchmarking process. A total of 18 organisations (32%) took part for the first time in 2013. Only 3 organisations that took part in 2012 did not supply data in 2013.

Participant organisations in the 2013 benchmarking study are as follows;

- 2gether NHS Foundation Trust
- 5 Boroughs Partnership NHS Foundation Trusts
- Abertawe Bro Morgannwg UHB
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Barnet, Enfield and Haringey Mental Health Trust
- Berkshire Healthcare NHS Foundation Trust
- Betsi Cadwaladr Local Health Board
- Black Country Partnership NHS Foundation Trust
- Bradford District Care Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Camden and Islington NHS FT
- 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 Local Health Board
- 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
- Isle of Wight NHS Trust
- Kent and Medway Partnership Trust
- Lancashire Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation 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 FT
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
Pennine Care NHS Foundation Trust
Plymouth Community Healthcare (CIC)
Rotherham Doncaster and South Humber NHS

Sheffield Health and Social Care NHS FT
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South Essex Partnership NHS Trust
South Staffordshire & Shropshire Healthcare NHS FT
South West London & St George's Mental Health NHS Trust
South West Yorkshire Partnership NHS FT
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS FT
West London Mental Health Trust
Worcesthershire Health and Care NHS Trust
Analysis overview

The analysis presented in this report aims to provide a comprehensive introduction to mental health service provider comparisons across the NHS. The related mental health benchmarking toolkit provides further detailed analysis of the high level headlines outlined in this report.

The mental health benchmarking reference group has for 2013 aimed to integrate the benchmarking of inpatient and community based services. This more integrated approach to mental health benchmarking provides an ability to compare service models across providers. The final section of this report also explicitly explores the question of the balance of care between community and bed based services.

The analysis presented in the report contains the following core elements;

- Bed provision
- Admissions
- Length of stay
- Delayed transfers of care
- Readmissions
- DNA rates
- Activity
- Clustering
- Caseloads
- Finance
- Workforce
- Quality indicators

Examples from each of these areas are provided in the report. These are supplemented with a large amount of additional benchmarking comparisons in the parallel desktop benchmarking toolkit which has also been issued to all participating organisations.

The analysis covers the following sectors;

- Adult Acute inpatient care
- Older Adult inpatient care
- Specialist inpatient care
- Community based mental health services

Benchmarking comparisons are shown with your individual Trust / Local Health Board position highlighted in red on all charts. A peer group of other Trusts or Health Boards within your SHA / geographical area is also shown (highlighted through red diamonds on each relevant bar on individual histogram charts).
This version of the report uses weighted population as the denominator wherever population based benchmarking metrics are used. Weighted populations use the methodology developed by the Department of Health in their Exposition Book to provide an alternative view on service provision and benchmarking performance. The Exposition Book weights for a number of factors including population age, sex, ethnicity, prevalence and needs. Weightings have been developed using the formulas within the Exposition Book for providers within the English NHS. The NHS in Wales does not yet have a similarly structured methodology for profiling weighted population needs so registered populations have been used for Local Health Board providers in most cases.

Where relevant we have made comparisons between benchmarking results for both 2013 and 2012. It should be noted that some of these comparisons are impacted by the slightly different mix of participants that have taken part in 2013 compared to 2012. We have therefore focused our observations on inter-year comparisons on areas where trends are more clear and comparisons robust.

It should be noted that there are a number of important exclusions from the scope of the project and subsequent analysis. These exclusions are as follows:

- Substance Misuse services
- Child and Adolescent Mental Health services
- Learning Disability services

Child and Adolescent Mental Health Services (CAMHS) benchmarking is currently available in a separate report available to download from the NHS Benchmarking Network website.

www.nhsbenchmarking.nhs.uk

Learning Disability benchmarking will be taken forward through a separate project which will take place later in 2013/14.
Bed provision

The number and type of beds provided by Mental Health Trusts exhibits variation across the NHS. This reflects a number of factors including; history and practice, local commissioning priorities, local needs, and Trust decisions on service development. The provision of beds is profiled in figure 1 which shows the selected Trust / LHB profile of bed provision against that for the “average” profile of Mental Health providers included in this benchmarking study. Data on bed numbers referred to throughout this report refers to positions recorded at the date of the bed census which took place on 13th March 2013.

![Figure 1](image)

The profile of beds has been analysed using the bed categories developed by the NHS Confederation’s Mental Health Network in 2011/12;

- Adult Acute
- Psychiatric Intensive Care Unit (PICU)
- Eating Disorders
- Mother and Baby
- Low Secure
- Medium Secure
- High Secure
- Older Adults
- High Dependency Rehabilitation
- Longer Term Complex / Continuing Care
- Other Adult Mental Health beds

The chart uses absolute bed numbers rather than specific benchmarks and reveals an order of scale of provision which is influenced by Trust size. The largest number of beds are typically provided for Adult Acute services, followed by Older Adult services, Low and Medium Secure services. PICU,
Eating Disorders, and Mother and Baby services typically have the lowest number of beds. High Secure beds are provided in only a small number of specialist Trusts.

The chart in Figure 2 introduces benchmarking concepts and shows how the provision of beds compares on a percentage basis across all participant Trusts. This gives a view on local provision priorities and allows Trusts to compare their provision arrangements against those from the group average of the 57 contributing organisations.

Not all Trusts provide beds in each service category although general Adult Acute and Older Adult beds are provided by all participants.
Bed provision benchmarked – Adult Acute beds

The number of Adult Acute beds has been benchmarked per 100,000 weighted population (working age adults). Additional reports are also available covering benchmarking assessments that use registered population as an alternative benchmarking denominator. Weighted population denominators use the Department of Health’s exposition book which highlights the impact of mental health weightings for a variety of factors including population age, sex, ethnicity, deprivation and prevalence. A small number of Trusts have local populations that demonstrate levels of mental health need that is much higher than the normal range of needs exhibited in the NHS. For these organisations this weighted population based benchmarking report may provide a more useful basis for comparisons. Similarly, some Trusts providing services to populations with below average mental health needs will find the impact of weighting on benchmark positions useful.

Benchmarking analysis reveals variation in provision across the NHS from 11 beds per 100,000 population to 63 beds per 100,000 population. The median position for adult acute beds is 22.6 beds per 100,000 population (figure 3), with a lower quartile position of 20 beds and an upper quartile position of 28 beds. The median position in 2012 was 23 beds per 100,000 population which points to a marginal reduction in bed numbers in the last year. The marginal nature of the reduction in adult acute beds may be influenced by the profile of the new contributors to the 2013 benchmarking project which includes a number of organisations who appear in the top decile for number of beds provided.

![Adult acute beds per 100,000 weighted population](image)

**Figure 3**

Analysis of bed occupancy data for Adult Acute beds reveals a median occupancy rate of 90% across participants (figure 4). The range in occupancy is relatively low with lower quartile at 84% and upper quartile at 95%. Three participants report occupancy levels of less than 80% and two also report occupancy at 100% or over. This position is reported for occupancy excluding leave. Median occupancy in 2012 was 91%; this suggests that bed occupancy pressures may be marginally less in 2013 than they were in 2012.
It should be noted that the bed occupancy positions outlined in this report exclude the impact of leave on occupied days. All charts relating to occupancy, bed days, and average lengths of stay use actual incurred bed days rather than positions including leave. The related mental health benchmarking toolkit does though provide participants with the opportunity to explore the impact of a number of factors that impact on occupancy and length of stay including the impact of leave and the impact of removing long and short stay outliers from the benchmarking comparisons.

Figure 4
Adult Acute Admissions

The number of admissions to acute adult beds has been benchmarked per 100,000 weighted population. This reveals a range of utilisation across the NHS. Key determinants of the number of admissions will include local needs, the number of beds provided by each Trust, and the length of stay of patients and availability of beds for new admissions. This is profiled below in figure 5 and shows a median position of 247 admissions per 100,000 working age adult population, and a mean position of 247 admissions per 100,000 population. Comparisons with 2012 can be made, where 2012 had a median position of 234 admissions per 100,000 working age adult population, almost identical to the 2013 position. The number of admissions is therefore almost identical between the two years but has been achieved from a marginally reduced bed portfolio which suggests reduced lengths of stay are being achieved by participant organisations.

![Figure 5](image)

The number of occupied bed days for adult acute beds is shown in figure 6 per 100,000 population. The data used for this comparison relates to bed days incurred and excludes patient leave. The range on this benchmark is influenced by the number of beds provided and the average length of stay of patients. A six fold range is observed across the distribution with from around 2,900 occupied bed days per 100,000 population to over 13,000 bed days per 100,000 population. The mean position reported is 7,806 beds per 100,000 population with quartile ranges from 6,559 to 8,605 bed days per 100,000 population. Cross referencing to the extent of community services provision will also inform the debate on what the appropriate balance of care is between hospital and community based mental health services. In 2013 a median position for bed day use of 7,622 days is observed, this compares with a median position in 2012 of 8,125 occupied bed days per 100,000 working age adult population. This suggests reduced use of inpatient beds compared to 2012 which is a position consistent with the marginally fewer beds now reported by participants. The extent of the gap between 2013 and 2012 may also be influenced by the slightly different mix of Trusts and Health Boards that have taken part in the benchmarking project over the 2 years.
Figure 6

Adult acute bed days per 100,000 weighted population

2012/13

Median

Mean

Upper Percentile

Lower Percentile

SHA
Length of stay and delayed transfers

Average length of stay for adult acute admissions is a key performance measure for mental health providers. Mean length of stay averages 30.5 days across the participant Trusts (32 days in 2012). Mean length of stay has reduced since 2012. The scale of this reduction is in line with the reduction in bed numbers, and the reduced number of bed days reported per 100,000 population, despite the static number of admissions. This position may be influenced by the slightly different mix of Trusts and Health Boards that have taken part in the 2013 project compared to 2012. However, the reported reduced lengths of stay and bed days used also suggests an increase in efficiency within core adult inpatient services.

The range in mean length of stay reported is interesting with outliers identified at both ends of the spectrum (figure 7). Length of stay is influenced by a number of variables including: the acuity of the caseload, extent of delayed transfers of care, and ability to hand patients over to community based services. Trusts with fewer beds tend to have greater pressure on length of stay due to potentially higher acuity levels in patients that are admitted to beds. This benchmarking comparison can be cross referenced with the PbR cluster caseload profile of the Trust which is shown later in this report in figures 22-27.

Please note that the comparisons shown below in figure 7 show mean length of stay excluding leave. This position has not been adjusted for outliers (long-stay and short-stay patients). The mental health benchmarking toolkit will allow participants to view these alternative benchmarking perspectives locally.

![Mean length of stay - Adult acute](image_url)

Data on delayed transfers of care shown in figure 8 reveals a median position of 4.1% for adult acute services which compares with the 2012 position of 3.5%. The overall mean position for delayed transfers of care is 3.9% of total bed days which includes eight Trusts that report delayed transfers of care as accounting for over 8% of total bed days. This is presented as the percentage of total bed days lost due to delayed transfers. Delays are for patients who are appropriate to be discharged and can be delayed due to a number of reasons including waiting for a bed or place elsewhere or
alternative packages of care to be agreed and put into place. It should be noted that 14 providers achieve delayed transfer of care rates at less than 2% of total bed days impacted.

The principles of sharing good practice through benchmarking will be taken forward with member organisations in coming months to help share the practice and learning of those organisations that perform best on this indicator.
Adult Acute emergency readmissions within 30 days of discharge

The number of patient readmissions is a key performance measure for providers and commissioners and can be used as a proxy for service quality. This benchmark focuses only on unplanned readmissions within 30 days of discharge. Reasons for readmissions can include patients being discharged to receive secondary medical services, and in some cases patients being discharged too early or a lack of appropriate community support. Figure 9 shows a median position for readmissions of 8% (which compares to a 10% position in 2012) with quartile ranges from 6% to 11% (also reductions on previous year levels). The overall rate for readmissions is very close to that reported in other healthcare sectors.

In 2012 the lowest readmissions position reported by any Trust was 4% readmissions. For 2013 eight Trusts have managed to report readmission rate percentages of 4% or less. This suggests an improvement has been achieved in readmission rates over the period.

Participants in this year’s benchmarking are supportive of the concept of a “best quartile” group where Trusts who perform particularly well on certain measures, for example readmissions or DNAs, are willing to share their contact details and practice with Trusts who wish to network and learn. This process will help stimulate a continuous improvement cycle across participant organisations.
Bed Provision Benchmark Older Adult beds

The provision of Older Adult beds is a significant part of the business of specialist mental health Trusts and the second largest category of bed provision after Adult Acute services. The balance of provision between adult and old age beds is an interesting line of enquiry for Trusts as is the relative position on the level of provision when assessed against other Trusts.

A small number of member organisations have developed the concept of “ageless services” which do not specify Older Peoples beds but instead work on a functional / organic split. Some of these Trusts were therefore unable to provide data around specific services for Older Adults.

The benchmark denominator used here is the number of older adults expressed per 100,000 weighted population aged 65+. The profile of number of beds provided is outlined in figure 10. The mean rate of provision is 61 beds per 100,000 population aged 65+. The median level of provision is 57 beds per 100,000 population (aged 65+) (compared to 62 in 2012) with 2013 quartile ranges from 45 to 73 beds. There has been a reduction in average bed numbers since 2012 which is a message consistent with comments made by many member organisations that service redesign projects and an on-going shift of care into community based provision has reduced the number of Older Adult mental health beds in the last year.

The reduction in bed numbers may also have contributed to an increase in bed occupancy recorded since 2012. Analysis of occupancy rates for Older Adult beds is shown in figure 11. This reveals median occupancy rates of around 82% (the same as 2012), which is lower than the 90% reported for working age Adult Acute beds. The quartile ranges are from 74% occupancy to 91% occupancy. The lower occupancy rates compared to working age adult services were explored with reference group members. Reasons for this position included the existence of transitional bed models where service models are in the process of change and the impact of cost improvement programmes on the number of beds that can be staffed. Members recognised the phenomena of reducing numbers of absolute beds on older age mental health services. A number of members also reported...
movement towards ageless models of care and clearer distinctions between functional and organic models of care.
Older Adult admissions

The number of admissions per 100,000 weighted population for Older Adult services is shown in figure 12 and has a median position of 247 (figure 12) compared to a position of 258 in 2012. Quartile ranges for 2013 are from 201 to 308 with an overall mean position of 267 admissions per 100,000 population aged 65+. A small number of outliers are identified which have been discussed with participants.

Figure 12

The number of admissions will be influenced by both local needs and local capacity. Trusts with higher levels of capacity tend to have higher levels of admissions. Length of stay within older adult bed based services is also a relevant indicator in comparing provision and utilisation arrangements.

The extent of provision arrangements for continuing healthcare beds in Local Authority and independent sectors will also impact for demand on the NHS for older people’s mental health beds.

Figure 13
Analysis of the number of occupied bed days per 100,000 population is shown in figure 13. The median position is 17,453 (compared to 18,682 in 2012). The reduction in occupied bed days is above that expected from the reduced number of beds reported by participants. The number of occupied bed days can also be compared with average lengths of stay which are reported in figure 14.

The number of occupied bed days reported has quartile ranges from 2013 of 13,365 to 21,388. A small number of outliers are evident at the top of the range. The number of occupied bed days links with the number of beds provided and Trust occupancy levels.
Older Adult – length of stay and delayed transfers

Analysis of length of stay for older adult beds is shown in figure 14. The positions presented here have not been adjusted for outliers (long and short stay patients) and reflect the actual number of bed days used during 2012/13. Length of stay in old age beds is generally longer than for acute adult services and links to the conditions being managed and the prevalence of many long-stay patients on older people’s wards. Analysis of participants’ data confirms a mean length of stay of 68 days on old age wards. The median length of stay observed is 64 days with quartile ranges from 53 days to 76 days. The range noted amongst participants should provide opportunities for participants to learn from the practice that has for some Trusts managed to reduce lengths of stay significantly in recent years. Lengths of stay are lower than the levels reported in 2012 where median length of stay was 70 days.

![Mean length of stay - Older adults](image14.png)

Delayed transfers of care do make a major contribution to extended stays on older people’s wards. Figure 15 profiles the data for delayed transfers of care and shows a range from less than 1% up to 19%, this uses a benchmark whereby the number of days attributable to delayed transfers of care are divided by the total number of occupied bed days for older adults. The mean position is 7% of bed days are attributable to delayed transfers of care on older adult mental health wards. The quartile range is from 2.6% to 12%. It is expected that this data is robust as it is based on SITREP returns for monitoring delayed transfers of care. The relatively wide quartile range suggests there is scope for learning from good practice sites with potential for benefits for those participants with on-going pressures and high rates of delayed transfers of care. Six participant organisations manage to achieve delayed transfers of care at 2% or less of total bed days for older people’s mental health services.
Figure 15: Delayed transfers of care - Older adults 2012/13

- Median
- Mean
- Upper Percentile
- Lower Percentile
- SHA
Older Adult emergency readmissions within 30 days of discharge

Analysis of readmissions (figure 16) uses the same methodology as for adult acute re-admissions outlined in figure 9. The number of patient readmissions is a key performance measure and can be used as a proxy for service quality. This benchmark focuses only on unplanned readmissions within 30 days of discharge. Reasons for readmissions can include patients being discharged to receive secondary medical services, and in some cases patients being discharged too early or a lack of appropriate community support. The data provided shows reduced levels of readmissions when compared to working age adult wards. Readmission rates average 4% (mean position) and have a quartile range from 2% to 6% which suggests a narrowing of last year’s range which was from 3% to 9%. A small number of outliers exist within the data set which require validation with participants.
Specialist Beds

Mental health reference group members agreed to include specialist beds within the scope of the 2013 benchmarking project. 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, 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 (figure 17) shows Trust positions for specialist beds against average provision rates for peers within SHA areas and also against the total database average. 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.

Specific categories of beds can be explored in detail in the desktop benchmarking toolkit. A wide range of detailed data views are available for each bed category. To illustrate the potential of the toolkit a small number of examples are shown in the report relating to Psychiatric Intensive Care Unit (PICU) and low secure bed provision. Figure 18 shows the mean length of stay in PICU beds across participant organisations. This item relates just to the PICU element of the patient stay and is actual bed days including short and long stay patients. The data shows a mean length of stay across all participants of 48 days with quartile ranges of 31 and 52 days. The full data range is from 7 to 135 days highlighting the potential for further review of PICU utilisation and pathways in future benchmarking cycles.
PICU bed occupancy is a much discussed performance measure with providers keen to ensure appropriate patient flow and good levels of occupancy. PICU wards typically have high staffing to patient ratios in line with the intensive care model and are key contributors to local system demand management arrangements.

Figure 18

Figure 19 explores PICU bed occupancy. PICU services have expanded in recent years with the NHS making great advances in developing its own local capacity and reducing the need to refer to the private sector for patients who have higher level of needs. In many health systems this has been so successful that very few patients now need to be referred to the private sector for intensive care placements. Occupancy rates in PICUs show a mean occupancy of 81% (against an average occupancy of 82% in 2012). There is a relatively narrow quartile range from 75% to 93% occupancy. Ten Trusts achieve occupancy rates of 95% or higher for PICU. There will be further analysis of PICU demand and utilisation in future benchmarking reports. The desktop benchmarking toolkit also provides a range of additional PICU comparisons.
Figure 20 explores average length of stay for low secure provision. Over two thirds of participant organisations provide low secure beds. The mean length of stay is 471 days with quartile ranges from 275 days to 584 days. Further comparisons for low secure beds can be accessed in the desktop benchmarking toolkit as can comparisons for medium and high secure services.

Figure 21 shows similar comparisons for longer term complex / continuing care beds. These beds are provided for patients with complex and ongoing needs. This category of beds may include a broad range of services reflecting the diversity of local provision. The average length of stay reported is 430 days, a small number of outliers have been removed from this comparison. The median length of stay for this service is 433 days.
Clustering

The use of mental health clusters adds huge potential to the benchmarking project for NHS Trusts within England. Cluster data was collected from Trusts and used a bed census date of 13th March 2013. This was a mid-week day and avoided taking a bed census over Easter which included 31st March in 2013. Cluster completion rates show around 80% of Trust inpatient payment by results caseloads are now clustered (see benchmarking toolkit). This 80% of inpatients clustered may reflect an emerging ceiling on cluster rates given that some categories of patients (e.g. Forensic) are excluded from payment by results clustering.

The calculations of prevalence of patients in each cluster group is based on a calculation which assesses the percentage of patients in clusters 0 to 21 who are defined in each cluster group. The benchmarking calculation excludes patients who have not yet been clustered from the overall denominator.

Analysis of clustering by Trust reveals interesting positions on which clusters are predominant in Trust caseloads. Clusters 1-2 (non-psychosis, mild) are shown in figure 22 and have a median prevalence position of 2% (this is a reduction on the 3% position reported in 2012). This cluster group includes patients with mild to moderate conditions and potentially a number of patients who are close to discharge. The range reported is from 0% to 9%. The number of service users recorded in these clusters has fallen slightly since 2012 (when it was 3%). This may reflect a marginal increase in acuity across Trust caseloads which is also supported by a slight increase in the number of patients reported within the psychosis cluster groups.

Clusters 1-4 (non-psychosis, mild to moderate) are shown on figure 23 and have a median prevalence position of 10% (identical to 2012), the quartile range reported from 5% to 14% is also similar to the 2012 position.
Wider analysis of cluster 1-8 (non-psychosis) is shown in figure 24. The median prevalence position is 23% of adult beds attributed to patients in these clusters. This marks a reduction on the 24% position reported in 2012 with an increase in acuity therefore apparent across all cluster groups.

Analysis of clusters 10 to 17 (Psychosis) in figure 25 reveals higher prevalence reflecting the pressures many Trusts are under in managing an increasingly acute caseload. The median position is that 57% of patients in beds fall into this category (56% in 2012). The quartile range is from 51% to 65%. These clusters contain the most patient admissions and attributable bed days.
Analysis of clusters 18-21 (Organic) across all bed types in figure 26 shows a median position of 15%. The quartile range is from 12% to 20%. The benchmarking toolkit can be used to undertake more detailed analysis on this cluster group including the ability to review the extent to which this demand is due to older adults and also the element attributable to working age adults with enhanced frailty.

Figure 26 shows the overall profiling position for each Trust for all inpatients. The percentage allocation to each cluster is shown against the average position across all the Trusts taking part in the benchmarking process. Further detailed analysis of all inpatient clustering can be performed through the benchmarking toolkit.
Figure 27

Proportion of patients in Clusters

- Cluster 0
- Cluster 1
- Cluster 2
- Cluster 3
- Cluster 4
- Cluster 5
- Cluster 6
- Cluster 7
- Cluster 8
- Cluster 9
- Cluster 10
- Cluster 11
- Cluster 12
- Cluster 13
- Cluster 14
- Cluster 15
- Cluster 16
- Cluster 17
- Cluster 18
- Cluster 19
- Cluster 20
- Cluster 21

Not yet clustered

0% 5% 10% 15% 20% 25%

T41 (%) Participant (%) SHA (%)
Community Mental Health Services

Community mental health services in numeric terms contain the largest group of mental health service users. 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
- 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
It should be noted that the following categories of service have been excluded from the content of the community services benchmarking. These items were included in the project’s data collection phase and some comparative analysis is possible in the desktop benchmarking toolkit. However, on reviewing the data submitted, the mental health reference group has decided to exclude these services from the line-up of core district community services as these services tend to be more specialised and are not provided by all Trusts and Health Boards.

- Forensic
- Eating Disorders
- Mother and Baby

The following pages of the report introduce highlights from the analysis although participants should refer to the benchmarking toolkit for a more detailed review of service provision and performance issues.

As there is considerable variation in how services are delivered we have reviewed overall service models for community mental health services. Figure 28 shows some of the overall operating arrangements for community teams. These teams show a high level of compliance on issues such as; the use of protocols, liaison with other mental health teams, supporting carers, and inclusion of dedicated medical support within CMHTs. All of these areas have over 90% compliance across the 57 providers that took part in the benchmarking project. The only area with a lower degree of compliance is the use of a single point of entry into services which has an 80% compliance rate.

Other service model issues are reviewed in figure 29. High compliance rates are again reported on a range of issues including; Community Team involvement in discharge planning, audit, and use of outcome measures which all score over 90% compliance. The only service model issue with slightly lower compliance rates is the use of protocols for the emergency transfer of patients which reports an 84% compliance rate.
The extent to which community mental health services are provided is an important benchmarking issue with variation reported across participants. In many cases this may reflect local needs but will also be closely linked to the balance of care with inpatient based services and the level of mental health funding from commissioners.

Figure 30 explores the range of provision by examining the total caseloads of all community teams per 100,000 population served. The analysis used here consolidates the totality of service provision for the services highlighted earlier in this section i.e. Generic CMHTs, Crisis Resolution and Home Treatment, Assertive Outreach, Early Intervention / Early Onset Psychosis, Assessment and Brief Intervention, Rehabilitation and Recovery, Older People, Memory Services, and other adult CMHTs. The denominator used is the total catchment population served by each Trust or Health Board for community mental health services. It is recognised that local service models for community mental health will contain variation across participants. The methodology adopted by the reference group is to offset this variation by grouping all district based community activity, service user cohorts, costs, workforce and quality indicators. Within this grouped package of community service Trusts and Health Boards should be able to obtain assurance as to the strength of a series of high level comparisons. More detailed team specific comparisons are available in the desktop benchmarking toolkit.

The mean position reported is that 2,098 service users are included in total CMHT caseloads per 100,000 population served (an overall rate of 1.8% of catchment population). The quartile range is from 1,381 to 2,250. The overall reported caseload prevalence range is from a low of 0.5% to a high of 6%.
The absolute level of activity in terms of contacts delivered to service users shows a similar level of variation across participant Trusts and LHBs. Figure 31 presents this range which is again shown with units of 100,000 population served. The range of provision is from a low of 13,175 contacts provided to a high 64,858. The mean position is 38,4934 contacts per 100,000 population served. This is an important benchmark which can be compared to other metrics including caseloads and contacts per staff member, and the provision and utilisation of inpatient services. This comparison includes all contacts, face to face and non-face to face. The desktop benchmarking toolkit includes more detailed analysis of specific teams and specific contact types.

The benchmarking toolkit provides the ability to drill down into any specific CMHT grouping to explore a number of performance metrics. Figure 32 shows the caseload per 100,000 population for Crisis Resolution and Home Treatment Teams. Caseloads for community mental health services can reveal intelligence on service eligibility as well as capacity and demand. Focus within this report has been placed on those community teams that are more likely to be in place across a large number of Trusts, such as Crisis Resolution and Home Treatment Teams. All other teams can be selected and explored locally through the desktop benchmarking toolkit. Analysis of CRHT caseload for 2012/13
confirms a mean caseload of 40 per 100,000 population served, reflecting the relatively short-term of CRHT involvement with patients and high intensity of input.

Figure 32
Crisis Resolution and Home Treatment teams play an important role in managing urgent referrals and gate keeping admissions to bed based services. Care pathways also include the provision of intensive input to service users in the domiciliary setting. These contacts are typically intensive and delivered through a rapid response either in a crisis centre, emergency department, or patient’s home. Figure 33 outlines the contact rates per 100,000 population served which have a mean position of 4,561. A seven-fold contact range is observed across participant organisations from 1,906 to 11,917 contacts per 100,000 population. Analysis of CRHT activity rates can also be supplemented through the benchmarking toolkit which reports on a range of CRHT quality measures including the speed of response (4 hours and 24 hours) and the ability to avoid hospital admission through CRHT intervention. Data from the toolkit confirms that an average of 27% of patients referred to CRHTs were admitted to an inpatient bed during 2012/13.

Figure 33
Referrals to community mental health teams are analysed in detail in the benchmarking toolkit. This also shows the extent to which referrals are made from specific sources (e.g. GPs, Social Care, Justice
Average referral rates are 4,864 per 100,000 population served with a number of outliers at both ends of the scale (figure 34).

Reference group members were keen to explore the extent to which referrals are accepted. This is analysed in figure 35 which shows a mean position of 85% of all referrals to CMHTs being accepted. Eighteen organisations accept over 95% of referrals, whilst four organisations accept 50% or less of referrals (figure 35).

The proportion of patients that fail to attend scheduled attendances with CMHTs is explored in detail in the benchmarking toolkit. Figure 36 presents this data in summarised form which shows a pooled average DNA rate for all community teams. A mean DNA position of 10% across participants. The quartile ranges are from 6% to 12%. The DNA position for adult community services in 2012 was 9% which suggests a marginal growth in DNAs over the period. This area is also one where the “best quartile group” concept can be developed with Network members to help identify those Trusts and Health Boards that perform best and encourage the sharing of practice across the Network’s full membership.
A census of the community services caseload was undertaken to align with the parallel inpatient census. The census date for community services was 31st March 2013. The emphasis of the census was to explore cluster profiles across participants and relates only to those community patients that fall into the categories covered by mental health payment by results. Each participant is able to test their community cluster profile against other Trusts / LHBs within their geographic area, and also against the wider average of all participants. This is outlined in figure 37. The clusters with the most overall prevalence are clusters 3, 4, 11, 12, 18 and 19. This confirms a more even spread of patients within the community caseload, with organic clusters well evident, along with non-psychosis clusters. The overall demand from psychosis clusters 10-17 is less than that observed with the inpatient cohort.
Mental Health Services Workforce

The 2013 benchmarking programme includes a commitment to review the mental health workforce and provide a wide range of comparisons to 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. A small number of comparisons are presented in the report to illustrate the potential of workforce benchmarking. Network members should though refer to the benchmarking toolkit for more detailed workforce comparisons.

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, however, this consistent denominator should allow participants to factor their own positions. The mean position reported is 498 WTE clinical staff per 100,000 bed days in adult acute services (figure 38) with variation around this figure.

More detailed analysis is also presented on the number of Consultant Psychiatrists employed within adult acute inpatient services (figure 39). The mean position reported is 16.8 WTE Consultant Psychiatrists per 100,000 bed days. There is substantial variation around this figure with quartile ranges from 11.3 WTE to 16.8 WTE.
Figure 39

Analysis of Nursing staff per 100,000 adult acute bed days also shows interesting findings. The mean position reported is 243 WTE Nurses per 100,000 bed days (figure 40). The variation reported is less than that for Consultant Psychiatrists with quartile ranges being from 189 WTE to 284 WTE. Further detailed analysis can be undertaken of all Nursing grades and the split between qualified and unqualified staff through the benchmarking toolkit. The workforce analysis also provides potential for aligning workforce profiles with other performance metrics on length of stay, readmissions, and financial performance. The desktop benchmarking toolkit supports a wide range of workforce analysis around staffing per units of beds and bed days.

Figure 40

Clinical staff vacancies are examined in the benchmarking toolkit. Figure 41 shows the vacancy rates apparent in 2012/13 in adult acute services. The mean position reported is 60 clinical staff vacancies per 100,000 bed days. This equates to an average vacancy rate of 13% for clinical staff in inpatient services. This level of vacancies is higher than that typically reported on NHS Benchmarking Network studies in other healthcare sectors.
Figure 41

Figure 42 shows the community workforce using a denominator of 100,000 contacts. The mean level of WTE clinical staff employed is 216 WTE per 100,000 community contacts (face to face and non-face to face). Quartile ranges are from 168 to 256.

Figure 42

The benchmarking toolkit allows detailed analysis of all clinical grades within community mental health services. This is illustrated with the following chart (figure 43) which shows the number of Consultant Psychiatrists per 100,000 community contacts. The mean position is 11.4 WTE Consultant Psychiatrists per 100,000 community contacts (face to face and non-face to face). This is a positive finding which illustrates the transition of the Consultant workforce towards community based activity. The quartile ranges are from 7.8 to 14.5 WTE. This comparison can be cross-referenced to the reported Consultant Medical staffing for inpatient services (figure 39) and a range of other comparisons provided in the benchmarking toolkit including readmission rates, number of incidents, use of the Mental Health Act and the Care Programme Approach.
Figure 43

Community Workforce - Consultant Psychiatrists (WTE) per 100,000 contacts

- 2012/13
- Median
- Mean
- Upper Percentile
- Lower Percentile
- SHA
Finance

The 2013 benchmarking includes analysis of finance indicators for mental health services. This includes analysis of the costs of inpatient and community services. In developing the finance analysis we have complied with the costing principles outlined by the Healthcare Financial Management Association. The inclusion of finance comparisons provides another interesting dimension to use in relating findings from elsewhere on the benchmarking project including service capacity, utilisation, staffing, quality and productivity.

A large number of finance comparisons have been produced and we refer participants to the detailed analysis within the benchmarking toolkit. This section of the report outlines a small number of summary comparisons. Costs for inpatient services unless specified, relate solely to non-specialist adult and older adult acute bed provision.

Figure 44 shows the costs per adult acute bed. This has a mean position of £105,757 per bed and includes all direct, indirect, overhead and corporate costs. The quartile ranges on this indicator are relatively narrow at £91,000 and £126,000.

Analysis of the costs of providing 100,000 inpatient bed days shows an average full cost position of £32.7m (figure 45). The quartile range is from £27.1m to £38.1m. The median position is £32.6m per 100,000 bed days with a small number of outliers skewing the mean.
The benchmarking analysis contains a high level of granular detail on service costings. To illustrate this figure 46 shows the average cost per bed day in PICU across participants. The mean average provider cost reported is £6,888 per PICU bed day. This includes all costs of PICU provision including, pay, non-pay, and corporate costs and overheads.

The level of detailed analysis within the benchmarking toolkit supports for each type of bed, analysis of:

- Average cost per bed
- Average cost per admission
- Average cost per occupied bed day

Analysis of community mental health services has been conducted using a wide range of metrics. The summary metric used in the report is the cost per 100,000 population served. This is illustrated in figure 47 with a mean average figure of £6.2m per 100,000 population. As on all the community
metrics the range of positions on this chart is relatively wide which reflects the differing levels of investment and capacity of community mental health services across the NHS.

Figure 47
Further analysis of the costs per service user on the CMHT caseload shows an average cost of around £3,749 per service user (figure 48). Further analysis by team is presented in the benchmarking toolkit including average cost per service user for each specific type of community team. The mental health reference group have advised that this approach of aggregating community mental health team costs up to the level of all community teams may be a more reliable basis for comparison due to differences in service models at team level.

Figure 48
Quality

Reference group members and the wider NHS Benchmarking Network member community have been keen to explore quality metrics within the benchmarking process. A wide range of new metrics relating to service quality and safety were included in the 2013 benchmarking specification in light of the Francis report.

This section of the analysis summarises some of the main comparisons. A denominator of 100,000 bed days has been used. This uses data from all categories of inpatient beds with the exception of high secure services which have been excluded from the analysis. Further detailed analysis is also contained in the benchmarking toolkit.

Analysis of the number of admitted patients detained under the Mental Health Act is contained in figure 49, this relates to Adult Acute services. Additional analysis of Older People admitted under the Act is possible from the desktop benchmarking toolkit. The mean position reported is 29% of patients are admitted under the Act. This represents an increase on the 25% figure reported in 2012. The quartile ranges are from 22% to 34%. A very small number of outlier Trusts exist at each end of the range. The range in observed data may illustrate a number of different factors including; degree of acuity of patients, availability of beds, and local practice on detention. Data should be reconciled with KP90 returns to ensure on-going validation and consistency across Trusts.

![Percentage of admitted patients detained under the Mental Health Act](image)

Patient satisfaction remains a key service quality marker. Figure 50 shows performance on the national CMHT patient satisfaction survey across participants. The mean position of 70% of patients...
satisfied or very satisfied with services compares well to performance levels on other national patient surveys.

Analysis of staff satisfaction levels is shown in figure 51 with data sourced from the NHS staff survey. The mean satisfaction score is 76%. This metric provides another perspective on service quality and safety and should be compared with other quality metrics within this section of the report and the desktop benchmarking toolkit.

The occurrence and reporting of incidents is a highly relevant service quality marker. Extensive debate has taken place across the NHS about “what does good look like” for this issue with recognition that transparency around incident reporting is key. Figure 52 shows the number of serious incidents per 100,000 bed days with a mean position of 80 serious incidents reported per 100,000 bed days.
Drug administration errors are reported to the National Patient Safety Agency. These have been benchmarked per 100,000 bed days and show a mean position for 2012/13 of 125 errors per 100,000 bed days. Further analysis of medication incidents and prescribing errors is available in the toolkit.
Complaints have been assessed using a number of denominators. Figure 54 shows the number of complaints per 100,000 bed days which have a mean position of 159 complaints per 100,000 bed days.

Ligature incidents are a major risk management issue for inpatient care and subject to systematic review by Trust staff, governance teams, and regulators such as the Care Quality Commission. The number of ligature incidents reported have been assessed per 100,000 bed days and are shown in figure 55. The mean position is 82 ligature incidents per 100,000 bed days.
The issue of violence to both service users and staff is a relevant service quality issue and one that is explored in the benchmarking toolkit. Incidents of physical violence to patients have been assessed per 100,000 bed days. The mean position is 250 incidents per 100,000 bed days (figure 56).

Incidents of physical violence to staff average 464 per 100,000 bed days. This is outlined in figure 57.
Use of seclusion is also a quality metric of relevance to participants. Trusts and LHBs strive to minimise the use of seclusion. Data collected from the benchmarking study for 2012/13 (figure 58) show a mean average position of 162 uses of seclusion per 100,000 bed days.

Mental Health providers also requested that the use of restraint be included within the benchmarking specification for 2013. Analysis of the incidences of the use of restraint per 100,000 bed days shows a mean average position of 678 incidents of use of restraint per 100,000 bed days (figure 59).

It is acknowledged that throughout this service safety and quality section that a reported number of incidents can be variable across Trusts and depend on local clinical practices and reporting practices. For example, the use of restraint is systematically recorded by Trusts but contains a number of different types of categories of restraint. Further work on these metrics will take place in advance of the 2014 benchmarking cycle to ensure enhanced consistency of data collection across Trusts.
Balance of care between bed and community based services

Mental health services have been reducing the number of inpatient beds for many years. This has been matched by a parallel increase in community based resources in line with the aspirations of the National Service Framework and commissioning strategies. There is ongoing debate as to what the right balance of care is between bed and community based services. This debate also includes discussion of whether there are enough inpatient beds to meet patient needs. The following section of this report aims to provide interesting views on data that compares the balance of care between the bed and community sectors.

**Figure 60**

Figure 60 introduces this concept by showing the relative scale of financial investment between core district inpatient services (adult acute and older adult services) and community based services. The average profile is 60% community investment versus 40% inpatient investment.

Figure 61 reviews the balance of care from an activity perspective and compares the number of inpatient admissions (adult acute and older adults) in 2012/13 against the community caseload for the same period. This analysis reveals that around 90% of activity is community based with the remaining 10% taking place in hospital.
Figure 62 shows this issue in even more acute terms by analysing the results of the patient census taken in March 2013. Around 98% of service users under the care of Trusts / LHBs were within the community caseload with approximately 2% being in an adult acute or older adult inpatient bed.

The final view of the balance of care is obtained from reviewing the mental health workforce (figure 63). This reveals that around 60% of the clinical workforce is employed in community services and around 40% are employed on the wards. This comparison aligns with the balance of resources chart provided at figure 60.
Figure 63

Balance of Workforce

Inpatient
Community

0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

T74
T68
T70
T32
T03
T13
T24
T42
T72
T34
T52
T17
T31
T50
T06
T56
T30
T28
T05
T41
T14
T36
T19
T38
T67
T60
T27
T37
T66
T10
T26
T21
T44
T18
T65
T04
T08
T73
T29
T16
T35
T11
T47
T55

0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Conclusion

The findings from the 2013 cycle of mental health benchmarking make interesting reading for participants. We are grateful to the 57 Mental Health Trusts and Local Health Boards who contributed to the project.

One of the main benefits from this year’s project is the integration of inpatient and community services into a single analysis. This also provides an ability to cross refer between the two areas of provision to draw conclusions about the overall balance of care between bed and community based care. The 2013 analysis has also expanded significantly into new areas around productivity, finance, workforce 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 data submitted provides up to date information on provision arrangements for mental health services from 2012/13. The comparisons within the report also allow some inter-year comparisons to be drawn with positions reported on the 2012 benchmarking project. The headline comparisons between the two years show a reduction in core adult and older people’s inpatient bed provision between 2012 and 2013, however, activity levels appear to be consistent across the two years. This steady state level of activity with a reduced bed base demonstrates increases in efficiency with reductions in length of stay evident and some improvements in readmission rates and delayed transfer of cares. The inpatient census hints at an increase in acuity between the two years with less inpatients clustered with mild mental health problems and more prevalence in the psychosis group. This may be a natural progression of the reduction in bed capacity across participant organisations. The inclusion of specialist targeted inpatient services for the first time in 2013 creates an ability to map the provision and utilisation of more specialist services over coming years.

The report shows interesting 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 benchmarking toolkit to further understand the headline comparisons introduced in this report. The benchmarking toolkit will allow the local story of mental health service provision and performance to emerge for each participant organisation.

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 2013 benchmarking report were discussed with the mental health reference group and individual participants. The national conference on 8th November also offered an opportunity for wider discussion of findings and trends within the mental health sector.

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.
The findings from the 2013 benchmarking cycle and the future direction of the mental health projects were discussed with NHS Benchmarking Network members at the Mental Health Benchmarking conference in London on 8th November. This event reviewed this year’s findings and on-going aims to shape the future direction of mental health benchmarking projects. It is expected that issues around service quality and safety will be paramount in these discussions.

We would like to express our thanks to NHS Benchmarking Network member organisations for providing data to the 2013 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 2013/14 and beyond.