Mental Health Benchmarking

NHS Benchmarking Network
Inpatient and Community Mental Health Benchmarking
2016

Report for MH07
Weighted population report November 2016
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Executive Summary

Adult Acute and Older Adult Acute Services

**Bed Numbers Stabilising**

The rapid reduction in both adult acute and older adult bed numbers seen since 2012 has now begun to level off. (Figures per 100,000 weighted)

<table>
<thead>
<tr>
<th>Year</th>
<th>Older Adult beds</th>
<th>Adult Acute beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>62</td>
<td>24</td>
</tr>
<tr>
<td>2013</td>
<td>57</td>
<td>22.6</td>
</tr>
<tr>
<td>2014</td>
<td>47</td>
<td>21</td>
</tr>
<tr>
<td>2015</td>
<td>28</td>
<td>19.9</td>
</tr>
<tr>
<td>2016</td>
<td>27</td>
<td>19.9</td>
</tr>
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**Bed Occupancy Remains High**

Bed occupancy (excluding leave) remains high.

- Adult Acute = 94%
- Older Adult = 87%

Both are higher than the 85% recommended by the RCPsyc

**Mean Length of Stay Increasing**

Both Older Adult and Adult Acute length of stay are now the longest they have been in the last 5 years.

**Mental Health Act**

35% of admissions to adult acute beds are now involuntary. In 2012 this figure was 25% of admissions.

**Mental Health Benchmarking**

NHS Benchmarking Network 2016
Patient Cohort

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Inpatient</th>
<th>Community</th>
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<tr>
<td>1-8</td>
<td>23%</td>
<td>40%</td>
</tr>
<tr>
<td>10-17</td>
<td>62%</td>
<td>44%</td>
</tr>
<tr>
<td>18-21</td>
<td>15%</td>
<td>16%</td>
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Patients with psychosis continue to occupy the largest number of bed days (across all specialties) and receive the most community contacts. While patients in clusters 1-8 do not regularly get admitted, and consume under a quarter of all available bed days, they receive more support in the community. 40% of community contacts are delivered to this patient cohort.

Early Intervention in Psychosis

**EIP Teams are busier**

- 12% increase in referrals
- 10% increase in caseload
- 9% increase in staffing

The new access and waiting time standard for first episode psychosis has led to greater referrals to EIP teams. Caseloads for these teams have also increased as a result. There has been investment in staffing levels in these teams which is a positive finding and should provide Trusts with more resource to provide NICE concordant therapies.
The average NHS mental health provider has a bed speciality profile similar to that shown above. A number of specialities have very few providers (high secure, perinatal, eating disorders and neuropsychiatry). Adult Acute and Older Adult account for over half of all beds in the system.

Independent Sector providers are largely excluded from this count. Provision in this area accounts for around 15% of all mental health beds across England.

CAMHS beds are reported separately through the NHSBN CAMHS collection. There are just over 1,000 CAMHS beds in the system, representing less than 4% of the overall bed stock.
Workforce and Finance

**Inpatient costs rising faster than community costs**

<table>
<thead>
<tr>
<th>Cost per Adult Acute bed per year</th>
<th>Cost per Generic CMHT year of care</th>
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<tbody>
<tr>
<td>£131,267</td>
<td>£2,880</td>
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an increase of 6% since 2015  
an increase of 3% since 2015

1 adult acute bed = a year of support for 46 patients on a Generic CMHT caseload

Figures show the cost of providing specialist secondary mental health services. Costs of other services such as GP and A&E are in addition to the above.

**Staffing levels largely stable**

There has been little change in staffing levels for inpatient wards in the last year. Average values remain 0.5 WTE Consultant Psychiatrists and 7.5 WTE qualified nurses per 10 adult acute beds

**Temporary staffing 20% of overall pay costs**

Bank and Agency usage account for approximately 20% of pay costs. Within this, two thirds is spent on Bank staff and one third on Agency staff.
Introduction

This report summarises the main findings from the 2016 benchmarking process that has taken place across NHS mental health services.

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. Additionally we welcome participants from Scotland, Northern Ireland and the States of Jersey. We are also pleased to report that we again have involvement from independent sector specialist mental health providers.

The high levels of involvement and data completion levels make the 2016 findings compelling. The key to any successful benchmarking project is securing critical mass of data submissions so that findings have both rigour and authority. We feel this has been achieved in 2016 and are grateful to member organisations for their submissions.

This is the NHS Benchmarking Network’s 5th cycle of mental health benchmarking and the depth of the database developed with members has been used in the report to make observations on time series comparisons and trends evident in NHS mental health services.

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 are 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 2015/16 which creates a highly timely picture of the mental health sector across England, Wales, Scotland, Northern Ireland and the States of Jersey.

In addition to the 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 10,000 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 is a final, validated version of the report using GP weighted populations. Reports for registered population based benchmarks, and the Mental Health Toolkit, are also available to all participants.

Julian Emms
Chief Executive
Berkshire Healthcare NHS Foundation Trust
& Chair of NHSBN Mental Health Reference Group

Stephen Watkins
Director
NHS Benchmarking Network
Mental Health Reference Group

We wish to thank the members of our mental health reference group who advised on the benchmarking process throughout, and who shaped the content of this report:

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Tracy White  Central and North West London NHS Foundation Trust
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Anna Foster  Northumberland, Tyne & Wear NHS Foundation Trust
Anne Thompson  Lancashire Care NHS Foundation Trust
Anushta Sivananthan  Cheshire & Wirral Partnership NHS Foundation Trust
Catherine Magee  Berkshire Healthcare NHS Foundation Trust
Charlotte Hunt  Oxford Health NHS Foundation Trust
Cheryl Adams  North Staffordshire Combined Health
Chris Lanigan  Tees Esk and Wear Valleys NHS Foundation Trust
Corey Clarke  South London and Maudsley NHS Foundation Trust
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Joanna Wood  South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Kate Richard  Dorset Healthcare NHS Foundation Trust
Kevin Daley  North Staffordshire Combined Healthcare NHS Trust
Lee Cornell  Somerset Partnership NHS Foundation Trust
Lindsey White  Dorset Healthcare NHS Foundation Trust
Philip Graham  Manchester Mental Health & Social Care Trust
Prof Max Marshall  Lancashire Care NHS Foundation Trust
Rony Arafin  Devon Partnership NHS Trust
Sally Wilson  Hertfordshire Partnership NHS Foundation Trust
Shane Mills  NHS Wales
Steve Moore  2gether NHS Foundation Trust
Suzanne Robinson  North Staffordshire Combined Healthcare NHS Trust
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Tom Woodcock  Greater Manchester West Mental Health NHS Foundation Trust
Tracey Cotterill  Black Country Partnership NHS Foundation Trust
Wendy Copeland Blair  Mersey Care NHS Foundation Trust

We are also grateful for input provided by:

Dr A Antonysamy - Oxleas NHS Foundation Trust
Andy Bell - Centre for Mental Health
Paula Reid - Rethink Mental Illness

Mental Health Benchmarking
NHS Benchmarking Network 2016
Terms of Reference

The terms of reference for the project have been developed by the Mental Health Benchmarking Reference Group. They reflect the project's overall objectives and are reviewed by the 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 of contributing to continuous service improvement are 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 enhance and develop the network’s mental health workstream in upcoming 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 further analysis on other aspects of services offered by many mental health providers. Examples include CAMHS benchmarking, now in its seventh cycle, and a range of bespoke projects undertaken with members, including a second national stocktake of Perinatal mental health services, a review of Forensic patients and pathways, our audit of Early Intervention services, and our stocktake of CAMHS workforce and skills.

Further projects of interest to mental health provider organisations include projects on learning disabilities and pharmacy which contain elements of relevance to many Trusts and Health Boards. All of these products can be accessed from the NHS Benchmarking Network’s website.

www.nhsbenchmarking.nhs.uk
Participants

This year, participants include 100% of English Mental Health Trusts, 100% of Welsh University Health Boards and representation from Scotland, Northern Ireland, the Channel Islands and the Independent Sector.

Participant organisations for 2016 are as follows:

**England**

2gether NHS Foundation Trust
5 Boroughs Partnership NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield and Haringey Mental Health Trust
Berkshire Healthcare NHS Foundation Trust
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
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
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 NHS Partnership Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Manchester Mental Health & Social Care Trust
Mersey Care NHS Foundation 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

**Wales**

Abertawe Bro Morgannwg University Health Board
Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff & Vale University Health Board
Cwm Taf University Health Board
Hywel Dda University Health Board

**Scotland**

NHS Greater Glasgow and Clyde

**Northern Ireland**

Belfast Health and Social Care Trust

**Channel Islands**

States of Jersey

**Other**

The Huntercombe Group
Livewell South West
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
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
Surrey and Border Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valley NHS Foundation Trust
West London Mental Health Trust
Worcestershire Health and Care NHS Trust

Wales
Abertawe Bro Morgannwg University Health Board
Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff & Vale University Health Board
Cwm Taf University Health Board
Hywel Dda University Health Board

Scotland
NHS Greater Glasgow and Clyde

Northern Ireland
Belfast Health and Social Care Trust

Channel Islands
States of Jersey

Other
The Huntercombe Group
Livewell South West
Overview

This report provides an overview of key mental health metrics for inpatient and community services. These include measures of:

**ACTIVITY**

Including bed numbers, admissions, length of stay and delayed transfers of care; and community services activity including referrals, caseloads, contacts and waiting times

**WORKFORCE**

Including measures of medical, nursing and therapy input to inpatient wards and community services

**CLUSTERING**

Including inpatient and community census data showing the utilisation of services by patients in each of the Mental Health clusters

**FINANCE**

Including costs of both inpatient and community provision

**QUALITY**

Including staff and patient satisfaction, serious incidents, violence and the use of restraint

This year a bespoke report section analysing Early Intervention Teams provides participants with additional data to support the delivery of the new Access and Waiting Time targets for first episode psychosis. A further detailed area on Crisis Care has also been included.

The related Mental Health Toolkit provides further, more detailed analysis of the full data set collected. Over 10,000 comparisons are possible from this toolkit. These include detailed analysis of specialist bed types and specialist community teams, and a large range of workforce metrics including skill mix and discipline mix of inpatient specialties and community teams.

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 report enables participants to view how their service models and investment levels impact on service provision and performance, and outcomes.
Typically, organisations find that approximately 45% of their beds are specialist, 20% are for older peoples’ services and 35% are general acute inpatient beds for working age adults, though this varies notably between organisations, with some providers having very few specialty beds.

In the charts which follow, organisations are shown as red bars. Green bars highlight the other participants from the same regional group (typically a historic SHA area for England, or the whole of Wales) and blue bars represent the remainder of participants. Where an organisation is omitted from a chart, no data was received from them for that metric. Organisations from Scotland, Northern Ireland and Jersey have no geographic peer group in this report, but are able to create bespoke peer groups of similar organisations in the toolkit. Additionally, the toolkit can be used to show analysis on an STP level.
Adult Acute Care Pathway Trends

Adult Acute Trends
2012-2016

Figure 1

Mental Health Benchmarking
NHS Benchmarking Network 2016
**Adult Acute Beds**

Adult acute bed numbers have been falling steadily in recent years, with a decrease of 17% seen between 2012 and 2015.

This year, however, the trend of decline appears to have stopped, with a median position of 19.9 beds per 100,000 weighted population which remains unchanged from last year.

There continues to be variation between providers, with a range from 10.6 to 30.8 adult acute beds per 100,000 weighted population reported.

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**Figure 2**

**Population Figures**

This report uses a weighted population. This takes a GP registered population and applies a weighting for need. Data is aggregated to CCG level, and these CCGs are then mapped to their corresponding Mental Health provider Trust. Need levels reference the PRAMH methodology used by NHS England in CCG baseline funding. Weighted populations are available for England. In other parts of the UK, a GP registered population is used for this report.

A second version of this report is available which uses a GP registered population.

Adult Acute metrics use a working age population for ages 16-64. Later sections on Older Adult care use a population of 65+.
The map below shows the spread of adult acute beds across England and Wales. Darker blue areas represent organisations with larger numbers of beds. This chart shows beds per 100,000 weighted population, and uses the bed numbers shown on the previous page.
### Adult Acute Bed Occupancy

Both bed numbers and bed occupancy figures have stabilised this year.

Bed Occupancy shows how full beds were during the year, with a maximum figure of 100% excluding leave (every available bed occupied on every day of the year). This year’s median figure of 94.2% is equal to the figure reported in 2015, and demonstrates a sustained increase since 2012 when a median figure of 91% was reported.

For every year the NHS Benchmarking Network has undertaken this exercise, the bed occupancy rate for adult acute beds has remained above the 85% level referenced by the Royal College of Psychiatrists in their report *Do the right thing: how to judge a good ward*. In this document they state:

"Very high bed occupancy militates against quality and safety of in-patient care. Bed utilisation is at its most efficient when bed occupancy is at 85%. This means that patients can be admitted in a timely fashion to a local bed, retain the connections with their social support network and take leave without the risk that they cannot return to their ward should they need a longer period of in-patient care. It allows functioning space to accommodate those newly admitted and to provide proper treatments to current patients. Delays in admission to hospital can result in patients becoming more distressed and unwell, and likely to need more long-term care."

Increasingly, demand for inpatient services means beds are not being kept vacant while patients are on leave, and are instead being used to accommodate new admissions. Thus, when the total of patients on leave and patients on the ward are included, bed occupancy rises above 100%.

This year’s figure of 102.0% shows that there may occasionally be limits on a patient’s ability to return from a period of leave and find a bed available for them. It is however an improvement from last year’s position of 104%.

### References

Khan, M., Daw, R. and Hampson, Dr M. *Do the right thing: how to judge a good ward* (Royal College of Psychiatrists, 2011)
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This year’s figure of 102.0% shows that there may occasionally be limits on a patient's ability to return from a period of leave and find a bed available for them. It is however an improvement from last year’s position of 104%.
Adult Acute Admissions

The rate of admissions shows the demand for inpatient services and should be considered in context with the number of beds available, bed occupancy and length of stay on those units.

In 2016, the rate of admissions to adult acute beds was 209.4 per 100,000 weighted population. This figure is similar to last year, and represents a sustained decrease, from 247 per 100,000 weighted population in 2013.

The declining rate of admissions can be referenced to the reduction in bed numbers observed in recent years and increases in average length of stay over this period.

![Adult Acute admissions per 100,000 weighted population](image)

Figure 6

Mental Health Benchmarking
NHS Benchmarking Network 2016
While there is some regional variation, on average 16% of patients admitted were not known to the Trust’s mental health services prior to admission. Last year this figure was 13%.

Strong community services can offer support to patients out of hospital, but where patients are unknown to an organisation it can be the case that their first contact with mental health services will be through an inpatient admission rather than community care, especially if they present at a point of crisis requiring urgent and intense intervention.

For patients who have no fixed abode, discharge arrangements may be more complex and require more planning. Participants reported a mean position of 2% of patients admitted being of no fixed abode. This figure has not changed since last year.
Adult Acute Length of Stay

The length of stay in adult acute beds reached an average position of 33.4 days in 2016, an increase from 32.3 days in 2015. In part this may reflect the continued increase in beds occupied by patients detained under the Mental Health Act, whose length of stay is typically longer than those admitted to the same ward on a voluntary basis. This is explored later in the report.

This chart shows the mean length of stay for patients discharged in year from each provider. It excludes time spent on leave, but has not been adjusted for outliers (patients whose length of stay is unusually long or short).

There is a four fold range in average length of stay when explored at provider level, from under 20 days to over 70 days.

Opportunities exist for providers in exploring bed capacity, average length of stay, use of the Mental Health Act and the number of people supported by community mental health team caseloads.

Figure 9
Some organisations are only able to measure length of stay including days spent on leave. A period of leave may be used as part of a phased discharge process, allowing a patient to return home with the safety net that they have not yet been discharged and can return to an inpatient bed if needed. The average length of stay including leave this year was 35.9 days.

Figure 10

Adult Acute length of stay including leave

MH07: 38.0
Mean: 35.9
Median: 36.1
Upper Q: 40.8
Lower Q: 31.0
Region: 
Trusts: 

Mental Health Benchmarking
NHS Benchmarking Network 2016
Mental Health Act

While the majority of admissions to inpatient adult acute beds are on a voluntary basis, an increasing proportion of admissions are for patients being detained under the Mental Health Act.

This year’s figure of 35.1% is an increase from 32.9% last year. Since 2012, this figure has increased by over a third. In some areas this may be due to increasing use of the Mental Health Act. In other areas, however, sectioning rates have remained largely steady but the proportion of admissions that are involuntary has increased as bed numbers and overall admission rates have fallen.

Patients who are detained under the Mental Health Act typically have a longer length of stay than those patients admitted on an involuntary basis. The increase in the use of the Mental Health Act links to the increased acuity observed in acute patients, with almost two thirds of bed days used for people with a Psychiatric illness. The main area for discussion appears to be the variation in clinical practice observed across the UK, reflected in the wide interquartile range which extends from 24.6% to 42.9% of admissions to adult acute bed detained under the Mental Health Act. The map on the next page shows the regional variation in this measure.

Figure 11
Most people admitted to Adult Acute beds under the Mental Health Act are admitted under Section 2 which allows for detention of up to 28 days. However, length of stay for this patient cohort is typically longer than this, with this year’s mean position 44.6 days, compared to an average length of stay for all patients admitted to adult acute beds of 33.4 days.

In addition to the 35.1% of admissions to adult acute beds that were admitted on an involuntary basis, around half of participants were able to provide data on the extent to which voluntary patients were subsequently subject to Mental Health Act section. The mean position is 15%. Where participants could therefore provide data on both detention rates on admission and at a later point during the stay, this suggests an overall detention rate of around 50% for adult acute admissions.

Figure 12
In addition to the 35.1% of admissions to adult acute beds that were admitted on an involuntary basis, around half of participants were able to provide data on the extent to which voluntary patients were subsequently subject to Mental Health Act section. The mean position is 15%. Where participants could therefore provide data on both detention rates on admission and at a later point during the stay, this suggests an overall detention rate of around 50% for adult acute admissions.

Most people admitted to Adult Acute beds under the Mental Health act are admitted under Section 2 which allows for detention of up to 28 days. However, length of stay for this patient cohort is typically longer than this, with this year’s mean position 44.6 days, compared to an average length of stay for all patients admitted to adult acute beds of 33.4 days.
The use of the differing parts of the Mental Health Act is shown here. The inner ring represents an individual organisation position, and the outer ring the NHS average. Where only one ring is shown, this is the NHS average as local data for your organisation was unavailable.

Section 2 and Section 3 remain the most common parts of the Act in use. Together they represent 93% of Mental Health Act activity at a national level.

This chart represents admissions under the Mental Health Act to all bed types (not just Adult Acute admissions).
Adult Acute Delayed Transfers of Care

Patients who are medically fit for discharge may have a delayed transfer of care if they are unable to leave the ward at that point. There are a number of factors which contribute to DTOCs including awaiting a bed of another specialty to become available, a nursing home placement to be agreed or a package of care at home to be put in place. DTOCs can be more complex, and harder to define, in mental health than in physical healthcare. It is acknowledged that this data may somewhat underestimate the full extent of DTOCs in some areas.

There continues to be notable variation between providers on this issue, which measures the number of bed days attributed to DTOCs as a percentage of all occupied bed days. The mean position of 5.0% of bed days lost to DTOCs illustrates the pressure that exists in the acute pathway and community services. The mental health benchmarking toolkit allows participants to explore the reasons for delayed transfers, including the extent to which these are driven by internal transfers within a provider, or external factors including waiting for suitable accommodation and packages of care.

It should be noted that the lower quartile rate of 1.7% confirms a successful approach to DTOC management in a quarter of providers.

This year’s median figure of 3.7% is the lowest that has been reported in the last 3 years.
Adult Acute Emergency Readmissions

The rate of unplanned readmission within 30 days of discharge can be a key performance indicator for Trusts. There may be a number of causes including a patient who was discharged too early or where planned follow up and care in a community setting has not been sufficient.

This year’s figure of 8.4% is the lowest seen since data collection of this metric began in 2012, when a readmission rate of 10% was reported.

There continues to be variation between providers, and the interquartile range this year is identical to that reported last year, suggesting this range is not changing. Readmission rates of 8.4% are very similar to those reported in the NHS for physical healthcare.
Older Adult Care Pathway Trends

Older Adult Trends 2012-2016

Length of stay (days)

Beds per 100,000 registered population

Delayed Transfers of Care (% bed days lost)

Emergency Readmissions (%)

Figure 18

Mental Health Benchmarking
NHS Benchmarking Network 2016
Older Adult Beds

In this report, "older adult" beds refers to acute admission beds for older adults over the age of 65. Longer stay specialist rehabilitation and continuing care beds are not included in these figures.

In recent years, older adult beds have been reducing at a faster pace than adult acute beds. This year sees a 4th consecutive year of bed reductions, though the median position of 27 beds per 100,000 weighted population is only slightly below last year’s figure of 28 beds. Over the 4 years since this metric was first reported, older adult beds have decreased from 62 per 100,000 population.

As beds of this type typically serve a dedicated older population, the population benchmark applied here is that for the weighted population aged 65 and older.

![Older Adult beds per 100,000 weighted population chart]

**Figure 19**
The map below shows the spread of older adult acute admission beds across England and Wales. Darker blue areas represent Trusts with larger numbers of beds relative to population size. This chart shows beds per 100,000 weighted population, and uses the bed numbers shown on the previous page.
Older Adult Bed Occupancy

Bed Occupancy can give a measure of how demand for beds sits against available supply. While bed reductions have been notable in recent years, bed occupancy has increased at a slower pace as models of care move more towards support in a community setting.

This year’s figure of 87.1% is a further increase from 85.3% last year, and from a starting position of 82% in 2012.

Figure 21
Older Adult Admissions

Rates of admission can be driven by numbers of beds and length of stay for patients who are admitted. This year participants reported a median position of 101 admissions per 100,000 weighted population aged 65+. This compares to a figure of 117 last year.

Figure 22

Older Adult admissions per 100,000 weighted population

- MH07: 56
- Mean: 142
- Median: 101
- Upper Q: 152
- Lower Q: 83

Region: Trusts:
Due to complex conditions, co-morbidities and the need for more dedicated support following discharge, older people admitted to acute beds typically stay longer than their working age counterparts.

This year, participants reported an average length of stay of 75 days, which is an increase from last year’s figure of 72 days. Again, notable variation is evident with the interquartile ranges stretching from 62 to 94 days.
Older Adult Delayed Transfers of Care

Following discharge from an inpatient stay, many older service users require ongoing support in the community, either in their own homes or in a specialist residence. The coordination of this support may lead to delayed transfers of care, where a patient who has been agreed as fit for discharge by their lead clinician remains on the ward until sufficient arrangements are in place.

Within older adult wards, approximately 9.5% of bed days were attributed to DTOCs this year. This compares to 8.1% last year and suggests growing pressure on the system.

Figure 24
Older Adult Readmissions

Where a package of care is insufficient to meet the enhanced needs of the patient, or where a placement has failed, patients may require readmission to an inpatient setting.

Here, emergency readmissions are those which occur within 28 days of discharge from a unit, and are unplanned. The median position of 2.5% compares to 2.8% last year.

Emergency admissions are less frequent in older adult settings than in adult acute, where the emergency readmission rate this year was 8.4%.
Specialist Beds

Specialist beds can be delivered for both core district populations and also for external populations where specialist beds of that type have not been commissioned locally or where demand exceeds capacity. For this reason, specialist beds are not shown with a population benchmark as patients can come from any area of the country. Beds can be commissioned locally or through specialist commissioning routes, and these beds are sometimes also traded commercially.

The following chart shows individual participant positions for specialist beds against average provision rates for peers. The standard definition used for benchmarking purposes is that specialist beds are “all beds except Adult Acute and Older Adult Acute beds”, and complies with the NHS Confederation’s guidance on bed definitions.

High Secure beds are excluded from this analysis. Bespoke analysis is available for High Secure providers in a separate report.

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.

References

Symington, J (Chair) Defining mental health services: Promoting effective commissioning and supporting QIPP (Mental Health Network, NHS Confederation, 2012)
Psychiatric Intensive Care beds typically form part of a longer pathway that may include time in acute or specialist beds. The chart here shows the time spent specifically in PICU beds, though a patient’s whole length of stay will usually be longer with stays in other beds before and/or after the PICU episode.

The average position reported is 50 days, which compares to 45 days last year.

**Figure 27**

Bed Occupancy in PICU was reported as 86.2% this year excluding leave, virtually unchanged from 86.7% last year.

PICU beds typically operate at a lower bed occupancy than adult acute beds (94.2% this year) but are still slightly above the 85% recommendation detailed by RCPsyc.

**Figure 28**

Bed Occupancy within Eating Disorder beds is typically lower than that within some other specialist bed types. This year’s median figure of 81.3% represents a small but sustained increase from 80.5% in 2013/14.
Eating Disorder

Relatively few providers have specialist beds for Eating Disorders, and there is additional provision within the independent sector which is not fully reflected here.

Length of stay in these beds varies between 39 and 199 days, with a mean position of 108 days. This compares to an average position of 100 days last year and 88 days the year before. Providers with Eating Disorder beds serving children and young people may find it helpful to compare with data in this year’s CAMHS report.

![Eating Disorders length of stay excluding leave](image)

Figure 29

Bed occupancy within Eating Disorder beds is typically lower than that within some other specialist bed types. This year’s median figure of 81.3% represents a small but sustained increase from 80.5% in 2013/14.

![Eating Disorders bed occupancy excluding leave](image)

Figure 30
Low Secure

Length of stay is calculated from patients discharged in year, and certain bed types such as forensic or rehabilitation may have only a small number of discharges within this period. As such, one or two patients who have been discharged after unusually long lengths of stay may skew an organisation’s mean position.

Last year, the mean position for low secure care was 594 days. This year it is 584 days.

Low secure beds have seen a further increase to bed occupancy rates excluding leave this year, with an increase from 90.7% last year to 91.3% this year.
Medium Secure

There is notable variation in length of stay for medium secure services, with a mean position of 620 days. This compares to 548 days last year.

![Medium Secure length of stay excluding leave](image)

**Figure 33**

Three quarters of participants with medium secure services report a bed occupancy of over 90%. The median position of 93.9% compares to 92.7% last year.

![Medium Secure bed occupancy excluding leave](image)

**Figure 34**
High Dependency Rehabilitation

High dependency rehabilitation services may operate different care models and pathways, leading to variation in length of stay between providers. Additionally, last year only one provider reported an average length of stay in excess of 1000 days, whereas 4 providers did this year.

This year’s mean of 499 days compares to 409 days last year.

![Figure 35](image)

Bed occupancy for High dependency rehabilitation beds has risen this year, from a median position of 86.2% last year to 87.7% this year.

![Figure 36](image)
Longer Term Complex / Continuing Care

Long term complex and continuing care beds reported a mean length of stay of 760 days last year. This has fallen to 546 days this year. The impact of a few providers with long lengths of stay is also evident, with a notably lower median position across all providers of 435 days.

Bed occupancy for longer term complex and continuing care beds has decreased slightly for the third consecutive year. Last year’s figure of 86.2% is now 84.2%.
Care clusters are used in the NHS in England to capture the needs of most people who use mental health services. These clusters can be grouped into 3 main categories:

**Non-Psychosis**
1. Common mental health problems (low severity)
2. Common mental health problems
3. Non-psychotic (moderate severity)
4. Non-psychotic (severe)
5. Non-psychotic (very severe)
6. Non-psychotic disorders of overvalued ideas
7. Enduring non-psychotic disorders (high disability)
8. Non-psychotic chaotic and challenging disorders

**Psychosis**
10. First episode in psychosis
11. Ongoing recurrent psychosis (low symptoms)
12. Ongoing or recurrent psychosis (high disability)
13. Ongoing or recurrent psychosis (high symptom and disability)
14. Psychotic crisis
15. Severe psychotic depression
16. Dual diagnosis (substance abuse and mental illness)
17. Psychosis and affective disorder difficult to engage

**Organic**
18. Cognitive impairment (low need)
19. Cognitive impairment or dementia (moderate need)
20. Cognitive impairment or dementia (high need)
21. Cognitive impairment or dementia (high physical or engagement)

The charts here show how beds were occupied and by whom. Calculated on a daily basis, this shows the cluster each patient was in for each bed day during their stay.
In most organisations, very few bed days are attributed to clusters 1 and 2. This year the figure was below 1%, a similar finding to last year.

The proportion of bed days occupied by patients in non-psychosis clusters is likely to fall as bed numbers reduce, as it is often feasible and more desirable for these patients to be treated in the community. Last year, 8.6% of bed days were occupied by patients in these clusters. This year this has fallen to 7.4%.
Clusters 1 to 8 represented 23.7% of occupied bed days last year. This year, the figure was 22.9%.

There is variation in the levels of Personality Disorder seen in different areas, however this patient cohort can be challenging and their care complex. Last year 5.5% of bed days were attributed to patients in this cluster, but this has risen this year to 5.9%.
Last year patients in psychosis clusters occupied 55.3% of all available bed days. This figure has not changed this year.

Cluster 17 is shown separately as it is one of the most disabling psychosis clusters and references service users who are most difficult to engage. Last year patients in this cohort occupied 6.5% of all available bed days. This year the figure was 6.8% though there continues to be notable variation between providers.
Clusters 18-21 represent cognitive impairment and organic mental illness and typically effect older people, though working age adults can also be assigned to these clusters. Last year's mean of 14.5% has remained virtually unchanged this year.

Figure 45

Occupied Bed Days - Cluster 18-21

MH07: 10.1%  
Mean: 15.0%  
Median: 13.9%  
Upper Q: 17.8%  
Lower Q: 11.2%  
Region:  
Trusts:  

Mental Health Benchmarking  
NHS Benchmarking Network 2016
Community Overview

Far more 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 most may never be admitted to hospital and be cared for entirely in the community.

The Mental Health Taskforce recommended that "The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as closely to home as possible"

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, our Mental Health 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

References

Farmer, P. and Dyer, J. (Chairs) The Five Year Forward View (The Independent Mental Health Taskforce, 2016)
Community Caseloads

A substantial part of specialist mental health care is delivered in the community, with very few service users experiencing an inpatient admission during a year. This is explored further in the balance of care section later in this report.

The sustained reductions in inpatient beds must be viewed alongside capacity to provide specialist care to service users in a community setting.

Across all community mental health teams, participants reported an average caseload of 1,527 per 100,000 weighted population (age 16+).
Some community teams specifically serve particular age groups. Included in the chart below are the teams who predominantly work with service users age 16-64. The total caseload for all these teams is shown against a population benchmark of working age adults.

The mean position of 1,410 can be compared to a position of 1,426 per 100,000 weighted population aged 16-64 which was reported last year.

Caseloads for Older Adult CMHTs and Memory Services are shown here, against an older adult (65+) population benchmark.

The mean position reported this year was 1,824, compared to 1,853 per 100,000 population aged 65+ last year. The median position has decreased, from 1,557 per 100,000 population last year to 1,506 this year.
There is variation in community provision across England and Wales, as shown in the map below. On the whole, London reports lower community caseloads, and higher numbers of beds, when a benchmark of weighted population is used.
Community contacts are a count of the activity delivered to patients on the caseload of community services. These include individual and group sessions, and can be face to face or non-face to face contacts.

The charts in this section measure total contacts (face to face and non-face to face) against a population benchmark. The Mental Health Toolkit allows participants to explore further metrics including different contact types and contact levels for different community teams.

The mean number of contacts delivered in 2015/16 was 29,715 per 100,000 population age 16+.
Contacts for community teams which predominantly serve working age adults are shown here. Once again, older adult CMHT and memory services contacts are excluded. Both face to face and non face to face contacts are reported by participants. This chart shows total contacts, however positions for different contact types can be explored in the 2016 Mental Health Toolkit.

The mean position of 32,762 per 100,000 weighted population aged 16-64 compares to a position of 34,452 in 2015.

In 2014/15 participants reported 24,213 contacts in older adult and memory services teams per 100,000 older adults age 65+. This year the figure is 22,986.
Early Intervention

Last year participants reported receiving 49 referrals per 100,000 weighted population. This year that figure has risen to 55.

![Bar chart showing Early Intervention referrals received per 100,000 weighted population.](image)

**Figure 53**

This year participants accepted an average of 85% of referrals that were received. This compares to 86% last year.

![Bar chart showing Early Intervention referral acceptance rate.](image)

**Figure 54**

Caseloads for Early Intervention teams have marginally increased this year, to a mean position of 56.9 service users on the caseload per 100,000 weighted population age 16. Last year’s position was 56. The median position for team size, when benchmarked by weighted population, has not changed in the last year.

On average, Early Intervention teams employ 6.0 WTE staff per 100,000 population age 16. Last year’s figure was 5.7 WTE, suggesting recent investment in staff working within EI. Increases in workforce have risen slightly faster than increases in caseload, suggesting teams may be becoming better resourced to manage the complex patient cohort and meet the standards for offering NICE concordant therapies.
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The median position for team size, when benchmarked by weighted population, has not changed in the last year.

On average, Early Intervention teams employ 6.0 WTE staff per 100,000 population age 16-64.

Last year’s figure was 5.7 WTE, suggesting recent investment in staff working within EI. Increases in workforce have risen slightly faster than increases in caseload, suggesting teams may be becoming better resourced to manage the complex patient cohort and meet the standards for offering NICE concordant therapies.
Patients typically remain in Early Intervention teams for up to 3 years, and the intensity of input may vary during this time depending on how unwell a patient is.

The number of contacts per patient on the caseload is a good proxy for how much activity these teams are generating, and the intensity of support that can be offered to patients. This year, in an average team a patient might receive 37.1 contacts per year. This compares to 38 contacts per patient last year.

Last year participants reported an average DNA rate for Early Intervention teams of 10.1%. This year's figure is 11.3%.
In February 2016, Old Problems, New Solutions included as one of its recommendations that "Commissioners, providers and Strategic Clinical Networks...ensure that they have an appropriate number of beds as well as sufficient resources in their Crisis Resolution and Home treatment teams to meet the need for rapid access to high quality care by October 2017"

Data on Crisis Resolution and Home Treatment Teams going back to 2013 shows, however, an ongoing reduction in the number of contacts being delivered, per 100,000 weighted population. In 2013, 4,392 contacts were reported. This fell to 4,339 in 2014 and then to 4,041 last year. This year’s figure is 3,936.

CRHT face to face contacts per 100,000 weighted population

MH07: 3,214
Mean: 3,936
Median: 3,491
Upper Q: 5,120
Lower Q: 2,760
Region: Trusts:

In Implementing The Five Year Forward View for Mental Health it is acknowledged that "The majority of CRHTTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission".

The chart on the next page shows the total staffing for CRHT teams. This year’s figure of 16.3 WTE compares to 14.6 WTE last year.

References


Murdoch, C. and Kendall, T. Implementing The Five Year Forward View for Mental Health (NHS England, 2016)
MH07: ...  
Mean: 16.3  
Median: 16.1  
Upper Q: 20.9  
Lower Q: 11.0  
Region:  
Trusts:  

Figure 60

Total Staff working in CRHT teams per 100,000 weighted population

Last year, 44.2 Section 136 assessments per 100,000 weighted population were undertaken by participants. This year the figure is 50 per 100,000 weighted population. Participants also provided data on further indicators including the number of Section 136 suites. This can be explored in the Mental Health Benchmarking Toolkit.
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The provision of beds in crisis houses is frequently raised as an important consideration when reviewing crisis pathways. However, relatively few participants report providing crisis houses. For those who do, the number of beds available in each area is shown here.

A total of 10 providers reported dedicated Crisis House capacity. The number of places reported are equivalent to less than 1% of total Mental Health bed capacity across the UK.
Community Clustering

Clustering is used by English NHS providers to categorise patients at different points during their illness. Some patients may move from one cluster to another over the course of their time with specialist mental health services.

These charts show the proportion of community patients in each cluster on the day of the census (31st March 2016) and the proportion of contacts delivered to each cluster group over the course of the year.

Last year’s census showed 35.1% of patients on community caseloads were in clusters 1-8. This year the figure is 36.2%.

Last year 38.6% of contacts were delivered to this patient cohort, compared to 39.9% of contacts this year.

Figure 63

Figure 64
In 2015, 29.5% of patients on community caseloads on the date of the census were assigned to clusters 10-16. This compares to 32.6% this year.

Last year 39.3% of community contacts were for patients in clusters 10-16. This year the figure is 36.9%
Last year 1.8% of patients occupied cluster 17. This year the figure is 1.5%.

Last year 3.7% of contacts were delivered to patients in cluster 17. This year the figure is 3.2%.
Organic illness continue to represent approximately a third of patients on community caseloads, with a slight increase from 30.7% last year to 31.6% this year.

Additionally, there has been a slight increase in contacts delivered to this cohort. Last year 14.1% of community contacts were for patients in clusters 18-21. This year the figure is 15.9%.
Workforce

Workforce is the largest, richest and most expensive resource in an organisation, and staffing levels, discipline and skill mix can have a direct impact on patient experience and outcomes. The Mental Health Toolkit has a wide range of workforce measures for each bed type and community team including:

- Staffing levels e.g. nurses per 10 beds
- Discipline mix e.g. ratio of different job roles including medical, nursing and therapy
- Skill mix e.g. rates of weighted and unweighted nurses, and seniority
- Vacancy rates
- Staff turnover
- Bank and Agency usage
- Pay costs and non-pay costs

The following sections provide some high level workforce indicators, but participants are encouraged to use the toolkit to perform "deep dives" into any areas of specific interest to them.
Consultant Psychiatry input has remained steady on adult acute and older adult bed types over the last few years, with an average position of 0.5 - 0.6 WTE per 10 beds. The slight variation between providers suggests most wards have an average of 1 WTE Consultant Psychiatrist regardless of whether they are an 18, 20 or 22 bedded unit.

**Figure 71**

**Adult Acute Consultant Psychiatrists per 10 beds**

- MH07: 0.5
- Mean: 0.6
- Median: 0.5
- Upper Q: 0.6
- Lower Q: 0.4

**Region:**

- Trusts:

**Figure 72**

**Older Adult Consultant Psychiatrists per 10 beds**

- MH07: 0.4
- Mean: 0.5
- Median: 0.4
- Upper Q: 0.6
- Lower Q: 0.3

**Region:**

- Trusts:

The following charts show the Consultant Psychiatry input into different specialist bed types. Further breakdown of medical staffing (including junior doctors) can be found in the Mental Health Benchmarking Toolkit.
PICU Consultant Psychiatrists per 10 beds

MH07: 1.3
Mean: 0.8
Median: 0.8
Upper Q: 1.0
Lower Q: 0.6
Region: Trusts:

Eating Disorders Consultant Psychiatrists per 10 beds

MH07: ...
Mean: 0.6
Median: 0.5
Upper Q: 0.6
Lower Q: 0.4
Region: Trusts:

Low Secure Consultant Psychiatrists per 10 beds

MH07: 0.8
Mean: 0.7
Median: 0.7
Upper Q: 0.8
Lower Q: 0.5
Region: Trusts:

Figure 73

Figure 74

Figure 75
**Medium Secure Consultant Psychiatrists per 10 beds**

MH07:
- Mean: 0.7
- Median: 0.7
- Upper Q: 0.7
- Lower Q: 0.6

Region: Trusts:

**High Dependency Rehabilitation Consultant Psychiatrists per 10 beds**

MH07:
- Mean: 0.4
- Median: 0.3
- Upper Q: 0.5
- Lower Q: 0.2

Region: Trusts:

**Longer Term Complex / Continuing Care Consultant Psychiatrists per 10 beds**

MH07:
- Mean: 0.1
- Median: 0.2
- Upper Q: 0.5
- Lower Q: 0.1

Region: Trusts:

Figure 76

Figure 77

Figure 78

Mental Health Benchmarking

NHS Benchmarking Network 2016
Levels of qualified nursing (Agenda for Change band 5 and above) have remained largely unchanged in recent years, though there continues to be variation between different specialist bed types.

Further analysis is available in the Mental Health Benchmarking Toolkit which includes profiles by different AfC bands.
**PICU Qualified nurses per 10 beds**

MH07: 22.8
Mean: 14.2
Median: 13.5
Upper Q: 16.4
Lower Q: 11.1
Region: Trusts:

**Eating Disorders Qualified nurses per 10 beds**

MH07: ...
Mean: 8.9
Median: 8.1
Upper Q: 10.1
Lower Q: 7.5
Region: Trusts:

**Low Secure Qualified nurses per 10 beds**

MH07: 9.1
Mean: 8.4
Median: 7.7
Upper Q: 9.4
Lower Q: 6.8
Region: Trusts:

**Figure 81**

**Figure 82**

**Figure 83**
### Medium Secure Qualified nurses per 10 beds

- **MH07:** ...
- **Mean:** 9.5
- **Median:** 9.5
- **Upper Q:** 11.2
- **Lower Q:** 7.9

#### Figure 84

### High Dependency Rehabilitation Qualified nurses per 10 beds

- **MH07:** ...
- **Mean:** 7.4
- **Median:** 7.2
- **Upper Q:** 8.8
- **Lower Q:** 5.8

#### Figure 85

### Longer Term Complex / Continuing Care Qualified nurses per 10 beds

- **MH07:** 6.1
- **Mean:** 6.8
- **Median:** 6.4
- **Upper Q:** 7.1
- **Lower Q:** 5.0

#### Figure 86
The workforce vacancy rate for both last year and this year has remained at 13%. Analysis of the extent to which bank and agency are used to cover vacant shifts is explored in the next section.

Staff sickness absence rates in adult acute were reported as 6% last year. This year the figure is 7%.
Turnover of staff has implications for continuity of care for patients, and skills within a team as new recruits require an induction period and time to adapt to local processes and procedures. The turnover rate has reduced slightly, from 13% last year to 12% this year.

**Figure 89**

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**Adult Acute staff turnover %**

MH07: 9%
Mean: 12%
Median: 11%
Upper Q: 15%
Lower Q: 8%
Region: [Legend]
Trusts: [Legend]
Bank and Agency

The use of Bank and Agency staff to fill staffing rotas continues to be an area of scrutiny across different areas of the NHS. The chart below shows spend on Bank and Agency for Adult Acute wards, as a percentage of spend on total staffing for those wards.

Adult Acute Spend on Bank and Agency (as a % of total spend on staffing)

<table>
<thead>
<tr>
<th>MH07:</th>
<th>11%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean:</td>
<td>19%</td>
</tr>
<tr>
<td>Median:</td>
<td>20%</td>
</tr>
<tr>
<td>Upper Q:</td>
<td>24%</td>
</tr>
<tr>
<td>Lower Q:</td>
<td>13%</td>
</tr>
</tbody>
</table>

Figure 90
The use of (internal) bank staff is often deemed a better option than (external) agency staffing when vacant shifts need to be covered. The key reason for this is the potential for enhanced continuity of care for patients.

In the charts below, organisations can explore their positions on each measure.

On average, participants reported 12% of total pay costs were spent on bank staff versus 8% on agency staff.

![Adult Acute Spend on Bank staff (as a % of total spend on staffing)](chart1)

![Adult Acute Spend on Agency staff (as a % of total spend on staffing)](chart2)
Adult acute bed costs have risen steadily over recent years, with a mean figure of £131,267 compared to £123k last year and £118k the year prior to that.

This figure is the total cost for adult acute services for the year, divided by the total number of adult acute beds, and represents the cost of running one adult acute bed for a year.

Older adult bed costs, however, have seen a decrease since last year. In 2014/15 a mean average of £135k per bed per year was reported, compared to £131,966 this year.

Mental Health Benchmarking
NHS Benchmarking Network 2016
Bed day costs remained steady for a few years, before increasing to £374 last year and now £390.

The cost per admission has risen further this year, a reflection of the ongoing increase in annual bed costs and the longer lengths of stay reported. Last year’s figure of £11,962 is now £12,198.
A year of care for a patient on a Generic CMHT caseload is now £2,874. This is comparable to last year’s figure of £2,816.
Quality

The safety and quality of NHS care remains a priority for providers, commissioners and policy makers alike. The Mental Health Benchmarking toolkit includes a wide range of quality metrics allowing providers to compare their position with that of their peers. Highlights from this analysis are shown here.

The score for patient satisfaction comes from the CQC survey and the question "Overall view of mental health services for feeling that overall they had a good experience". This metric has consistently been between 69% and 73% in recent years. This year’s figure is 70.8%.

Staff satisfaction has also varied little in recent years. This year’s figure of 77.5% compares to 76% in 2015 and 2014, and 74% in 2013.

Mental Health Benchmarking
NHS Benchmarking Network 2016
Many types of incidents in mental health services can occur in both inpatient and community settings. Therefore these metrics are shown against a benchmark of total activity (face to face community contacts across all community teams and inpatient occupied bed days across all bed types).

Last year was the first time this methodology was included, and serious incidents averaged 26 per 100,000 occupied bed days and face to face contacts. This year the figure is 24.

Figure 100

Last year, participants reported 65 complaints per 100,000 occupied bed days and face to face contacts. For 2015/16 the figure was also 64.

Figure 101
Ligature incidents are measured here against a benchmark of 100,000 occupied bed days excluding leave. The mean of 168 signifies the fourth year in a row for which this figure has risen. Last year, participants reported 157 ligature incidents per 100,000 occupied bed days.

Figure 102

Ligature Incidents per 100,000 occupied bed days (excl leave)

- MH07: 192
- Mean: 168
- Median: 149
- Upper Q: 214
- Lower Q: 91
- Region: Trusts:
Reported physical violence to patients decreased this year, to a mean position of 104 incidents per 100,000 community contacts and occupied bed days.

Last year this figure was 113.

Rates of physical violence to staff continue to be notably above the rates of physical violence to other patients, with a mean position of 207 reported this year. This compares to 206 incidents per 100,000 community contacts and occupied bed days in 2015.
From 2014 to 2016 the NHS Benchmarking Network worked with the Department of Health to undertake regular stocktake audits of the use of restrictive interventions. This work highlighted the notable variation in restraint usage on different ward types, with adult acute, older adult and forensic wards reporting lower use of restraint and PICU wards reporting higher use. In particular, female PICUs reported the most restraint use. Participants should keep this in mind when reviewing the following charts which use a benchmark of occupied bed days across all ward types. Organisations whose bed complement includes female PICU beds may find their overall restraint use higher than organisations who do not have this specialty. Reported use of restraint has risen in recent years, from 781 incidences per 100,000 occupied bed days in 2014 to 841 last year and now 954. However during this period the use of prone (face or chest down) restraint has demonstrated a reduction from 231 incidences per 100,000 occupied bed days in 2014 to 199 last year and now 160. This is a positive finding as a reduction in the use of Prone restraint was a goal set out in the document  Positive and Proactive Care: reducing the need for restrictive interventions.

**Figure 105**

**Incidences of Restraint per 100,000 occupied bed days (excluding leave)**

**Figure 106**

**Incidences of Prone Restraint per 100,000 occupied bed days (excluding leave)**

**References**

Social Care, Local Government and Care Partnership Directorate  *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014)
Balance of Care

Providers can use the following charts to review their balance of provision between bed-based and community care. The vast majority of Trusts and Health Boards provide both inpatient and community services. Recent years have seen a reduction in bed numbers, and this is reflected in this year’s figures below.

The balance of financial investment shows the cost of providing inpatient services versus the cost of providing community ones. There has been little variation in these figures over the last few years, with 48% - 50% of spend within an average organisation going on inpatient services, compared to 50 - 52% on community care.

**Figure 107**

Balance of Financial Investment

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<td>MH07</td>
<td>48.5%</td>
<td>51.5%</td>
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<tr>
<td>Mean</td>
<td>49.9%</td>
<td>50.1%</td>
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<tr>
<td>Median</td>
<td>52.4%</td>
<td>47.6%</td>
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The balance of activity shows the ratio of number of admissions to inpatient beds against number of patients on community caseloads. Inpatient admissions continue to represent only a small proportion of specialist mental health care, at just under 15%. This is a similar figure to last year.

It should be noted, however, that due to the resource intensive nature of bed-based care, 49.9% of funding is spent on inpatient services, to deliver 14.1% of overall activity.

Due to the residential nature on inpatient services, higher staffing levels are required to support service users in a safe environment 24 hours a day. On average, 45.6% of an organisation’s WTE are based in an inpatient setting, compared to 54.4% in community based services. These figures have not changed since last year.
Conclusion

We are grateful to all providers who have submitted data to the 2016 mental health benchmarking project. This is the fifth year of the NHS Benchmarking Network’s project which has extended its coverage each year and is now the most authoritative reference point for mental health services in the UK. The scope and depth of data contributions generates a high level of confidence in this year’s results. For the third consecutive year the project has received submissions from 100% of statutory NHS mental health providers in England and Wales. This year’s project coverage is also enhanced by additional submissions from Scotland and Northern Ireland, as well as further data from the States of Jersey and independent sector providers in England.

The data in the report has been subject to validation from the NHS Benchmarking Network team and provider organisations. This report should be read alongside the Registered Population report.

The 2016 findings are compelling and build on previous years’ work. Data from providers and discussions with member organisations confirms another challenging year for providers with capacity tight in both inpatient care and community services. However, services appear to have responded to this challenge and key quality measures around service user and staff satisfaction rates both show improvements this year.

Inpatient services continue to experience high levels of utilisation and report the highest levels of bed occupancy of any NHS clinical specialty. Recent trends of bed reductions evident for the last 4 years in adult acute services now appear to have stabilised with adult acute bed numbers increasing marginally in the last year. However, wider bed reductions in other specialties including Older Adult, Rehabilitation, and Complex and Continuing Care have continued in the last year. Bed numbers for secure care are stable following the ongoing moratorium on commissioning new beds in these specialties.

The utilisation of bed capacity is high with increases in bed occupancy levels observed in many areas. Patient acuity is also observed to be high with care cluster data confirming ongoing high demand from patients with psychosis. Use of the Mental Health Act also increased for the fourth consecutive year with detention rates in adult acute services now one third higher than they were in 2012. Average length of stay has also increased for most bed types.

The difficult position for inpatient mental health services confirms the value of ensuring appropriate capacity is available in the community. The bulk of mental health care is delivered in the community with 97% of all people under the care of specialist mental health services being managed in the community at any one time.
The workforce challenge for the NHS is as evident in mental health as it is in other clinical specialties. Workforce numbers appear to be stable but vacancy levels remain high at 12% in acute services. Most providers demonstrate a reliance on Bank and Agency staff with around 20% of inpatient staffing costs attributable to Bank and Agency use.

Quality indicators show improvements in a number of areas; most notably in the increased scores for patient and staff satisfaction, the reduction in the use of prone restraint, and the reduction in the incidence of violence to both patients and staff in the inpatient setting. However, the wider reporting of both the use of restraint and ligature incidents both show increases in the past year.

Of course these summary findings represent just a few of the many thousands of data items covered by the project. Members will be able to explore these findings in detail with the parallel mental health benchmarking toolkit.

Variation within the NHS remains a live discussion point with the data from this project providing a key resource for providers to use in exploring variation and identifying good practice. The NHS Benchmarking Network team work actively with members to share good practice and encourage the adoption of innovation.

Mental health services have experienced a challenging year in 2016 in the context of NHS wide financial pressures. The demand for mental health services continues to increase and a range of strategic developments are planned across the UK to improve access to care.

The NHS Benchmarking Network’s wider mental health work programme can be referenced to track progress on these strategic priorities including projects on; CAMHS, Perinatal Mental Health, Forensic Care, and services for people experiencing a first episode of psychosis.
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