BOARD OF DIRECTORS MEETING (Open)

Date: **11 December 2019** **Item Ref:** **05**

TITLE OF PAPER	**Mental Health Benchmarking**
TO BE PRESENTED BY	**Mr P Easthope, Interim Deputy Chief Executive**
ACTION REQUIRED	Members to receive the report for information and assurance.

OUTCOME	Members are advised of the national NHS Benchmarking Network resource, remit, and reporting, and to receive a summary analysis of the mental health benchmarking report for SHSC in relation to the year 2018/19.
TIMETABLE FOR DECISION	To be received at December Board of Director's meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	Performance and Quality Framework update; Board Performance Reporting
STRATEGIC AIM STRATEGIC OBJECTIVE **BAF RISK NUMBER & DESCRIPTION**	Strategic Objective A1 02: Deliver safe care at all times BAF Risk No: A1 02ii. "Inability to provide assurance regarding improvement in the safety of patient care". Strategic Objective: A1 03: Provide positive experiences and outcomes for service users.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Benchmarking data should focus our thinking on service performance and quality targets and indicators for our own internal purposes as well as external reporting.
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	A better understanding of the Trust position alongside national comparators allows for evidencing good practice (clinical and financial) and enables the identification of areas for improvement and increased efficiency across the Trust.
CONSIDERATION OF LEGAL ISSUES	None identified.

Author of Report	Deborah Cundey
Designation	Service Development Manager
Date of Report	December 2019

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Subject: **Mental Health Benchmarking**

Author: **Deborah Cundey, Service Development Manager, Clinical Operations**

1.	**Purpose**					
	For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
					✓	
2.	**Summary**					
	This paper and accompanying presentation summarises the work of the NHS Benchmarking Network and Getting it Right First Time (GIRFT) in mental health, and the returns that we submit as a Trust. Also provided is a summary analysis of the 2018/19 mental health benchmarking report for the organisation, allowing comparison amongst peers, and over time. **The NHS Benchmarking Network** is a member led organisation and all subscription fees fund the benchmarking work programme. Its aim is to support members improve the quality of health and social care services through the use of a unique, high value benchmarking service, by sharing excellent practice, and to inform national policy. We have been a member organisation of the network for a number of years, and currently represented on the network reference group for mental health. **Getting It Right First Time** is a collaborative initiative designed to improve the quality of care within the NHS by reducing unwarranted variations. GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. The Getting It Right First Time Mental Health programme is divided into three separate workstreams; Crisis and Acute Mental Health, Psychiatric Rehabilitation, and Child and Adolescent Mental Health Services (CAMHS). We have been asked to complete individual supplemental questionnaires for Crisis and Rehab services. In both cases, the data in the supplemental questionnaires help the GIRFT team to make best use of the national datasets that we routinely complete, including the NHSBN data collection. Bespoke Trust datapacks are then produced by the team which will be discussed with both senior/executive management team and front line personnel at deep dive sessions during 2020. **NHSBN Collections** As well as supporting the GIRFT programme and data collections, the main focus of the NHSBN from the Trust perspective is the MH and Learning Disability collections and reports. There are 2 LD collections; the first is for LD provider services, seeking to compare the main service portfolios of providers and quantify the nature and shape of services provided across					

the country. We completed this submission in November 2019 and expect our annual report in March 2020. The second collection is an Improvement Standards review commissioned by NHS England and NHS Improvement and run by the NHS Benchmarking Network. The data collection has been designed to understand the extent of Trust compliance with the recently published NHSE & NHSI Learning Disability Improvement Standards and identify improvement opportunities.

NHS Benchmarking Network Mental Heath 2018/19 Report Summary

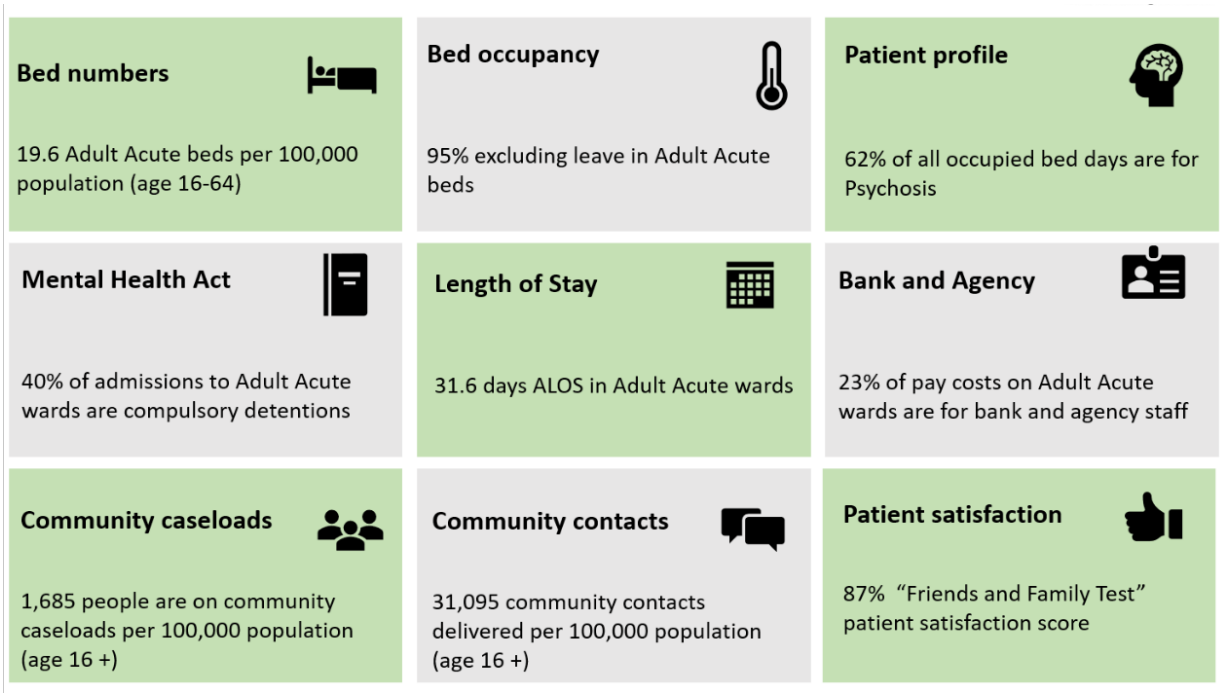
As a result of 8 years of annual benchmarking, the Network can make firm conclusions about overall trends in service demand and provision across the UK over this period. Data from 2018/19 shows a stabilisation in capacity for adult inpatient services and a slowdown in the rate of bed reductions for inpatient Older People's care. Admission rates to Adult services have been reducing steadily over recent years, and this year participants reported a further reduction in capacity in this area in conjunction with an increase in length of stay. Bed occupancy across most inpatient bed types is now high, with Adult Acute, Older People, PICU, Low Secure, Medium Secure and High Dependency Rehabilitation beds all averaging above the 85% target suggested by RCPsych and the CQC.

Benchmarking results reaffirm the position that most service users receive their care in the community setting. Although increases in caseload size for both adult and older adult teams were reported in 2018/19, it should be noted that this year's data set includes representation from all Health and Social Care Trusts in Northern Ireland for the first time. Northern Irish providers typically provide greater levels of community support per capita than peers in England. The background rate for England this year appears static, though this should be considered in the context of IAPT services which continue to grow and now support around 1.1 million people per annum in England. Waiting times for community services show much variation by team, with most rapid access provided by Early Intervention in Psychosis and Assertive Outreach services. For Generic CMHTs, the median referral to treatment time is now 7.5 weeks.

The workforce in 2018/19 demonstrates many of the characteristics evident in previous years' data with providers relying on high levels of bank and agency staff in the inpatient environment. Variations are evident in workforce size and shape which link closely to wider trends in the UK labour market. The gradual switch of registered to unregistered nursing posts also continues.

Analysis of service quality metrics reveals a stable position across most providers. Data from the Friends and Family test in England confirms that 87% of service users say they would recommend services to their friends and family. There is a commitment to transparency in reporting of adverse incidents. Further reductions in the use of prone restraint are particularly pleasing as is a potential "topping out" in the overall level of use of restrictive interventions.

Nationally key findings in this year's collection were:



SHSC position for national key findings

Adult Acute Bed numbers – nationally bed numbers have increased, we show a slight decrease since 17/18 and have the lowest bed numbers per 100,000 weighted population of all UK providers, at nearly half the average.

Adult Acute Bed occupancy – nationally bed occupancy rates have increased from 91.7% to 93%. Ours have also increased more than the national average from 95% to 97%, just shy of the top quartile.

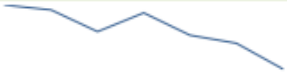
Patient Profile – Psychosis cluster patients (cluster 10-17) represent 70% of Adult Acute bed days in SHSC, compared to 62% nationally.

Adult Acute admissions under the Mental Health Act – as with bed occupancy, nationally admissions under MHA have increased since last year from 37.3% to 40% of all admissions. SHSC have increased further from 73% to 79% and as expected, given our low outlying position in bed numbers, our detention rates are a high outlier, and the highest of all providers.

Adult Acute Length of Stay – again the small national increase is replicated but to a greater extent in our own organisation. Nationally risen from 31.3 to 31.6 average LoS for discharged patients. Our own LoS has increased from an average 31 to 34 days. Last year we were around about the national average, this year we are slightly above.

Bank and Agency costs – at 36% the proportion of pay costs for Adult Acute wards for bank and agency staff is significantly we are significantly higher than the average 23% and higher than last year, when the Trust proportion was 24%.

Community Caseloads and Community Contacts

	MH07	Mean	Median	National trend
Total community caseload per 100,000 weighted population	1,188	1,483	1,323	
Working age adult teams - community caseload per 100,000 weighted population	665	1,464	1,314	
Older adult teams - community caseload per 100,000 weighted population	2,441	1,632	1,241	
Total community contacts per 100,000 weighted population	25,471	27,091	25,300	
Working age adult teams - community contacts per 100,000 weighted population	25,560	30,490	27,777	
Older adult teams - community contacts per 100,000 weighted population	25,257	20,880	17,594	

The high level collation shows SHSC adult caseloads to be very favourable compared to the national average and significantly higher in Older Adult services, however the type and nature of services that are included in our community MH teams (e.g. Memory Service, Social Care Only packages) skew these figures in national comparisons. We may be able to get more accurate detailed comparable data when the toolkit is released.

Patient Satisfaction – we show a favourable position on FFT positive results at 98% this year, which is also an improvement on last year's 95%; however we know that the response numbers for the services included in this data collection are relatively low.

Other key findings to note

Adult Acute
We show with high rates of nurses per 10 beds, very low vacancy rates and yet high bank and agency spend.

We appear to have high restraint numbers but low prone restraint numbers, as we have seen in previous years. There are no seclusion figures in the benchmarking report.

We benchmark low for emergency readmission rates (readmission to any acute or PICU within 28 days of discharge from any acute or PICU).

Specialist Inpatient
Rehabilitation – We appear in the lowest quartile for Length of Stay for inpatient mental health rehab, our provision at Forest Close, with an average discharged LoS of 213 days in 2018/19. The average LoS has been steadily increasing since February 2019 however; at the end of October 2019, the 12 month rolling average LoS was 297 days.

PICU - We are in the top quartile for bed occupancy rates at 99%, an increase from 93% last year – a more substantial increase than the 1% nationally from 85 to 86%. Length of Stay appears in line the national average. However we also know that we have had to access a number of out of city PICU beds over the current financial year, especially over the summer and into current months.

Older Adult Inpatient
This ward type refers to Dovedale (functional) and G1 (organic/dementia) for SHSC. The types of ward are not distinguished in the benchmarking figures.
Nationally older adult beds have shown a marginal decline, though rates relative to population size are still much larger than for adult acute. Older adult admission rates reflect bed

availability and higher length of stay in the old age sector.

This plays out in our Trust with admissions proportionate to bed numbers, as we operate with a low older adult bed stock and slightly higher occupancy rates. We are in the lowest quartile for bed numbers, but not as low as the adult beds. Our length of stay is slightly below the national average and has reduced from 104 days to 68 since last year.

We do show a large delayed transfer figure, significantly higher than the average. This may be an area worthy of further investigation.

Community Services
The two NHSBN key measures of community capacity are caseloads and contacts. Caseload provides a snapshot of open cases on 31st March 2019. Contacts is a measure of the number of face to face and non face to face contacts delivered by a community team to patients on their caseload, and to those who are being assessed. Nationally, community caseloads and contacts, for both working age and older adults, have seen declines in recent years.

Adult CMHT
National comparisons difficult to understand – e.g. integrated health and social care service plays in here. However, caseload increase from 567 to 665 per 100,000 population indicates increased activity which we see in local reporting and narrative.

OA CMHT
Again, national comparisons are complicated by the diversity of service provision, but our figures show an increase from last year from 1584 to 2441.

Early Intervention
As the only part of adult mental health services currently subject to national waiting time standards, there continues to be a focus on Early Intervention in Psychosis services. Nationally there is a continued growth in referrals to these services, to 69 in 2018/19. Referral rate data suggests this year's referral acceptance rate dips below the pattern seen from 2013/14 and may signify the start of increases in thresholds for treatment as a response to rising demand.

	MH07	Mean	Median	National trend
Early Intervention referrals received per 100,000 weighted population	158	84	69	
Early Intervention referral acceptance rate	47%	80%	87%	
Early Intervention caseload per 100,000 weighted population	95	64	60	
Total staff working in Early Intervention per 100,000 weighted population	10	7	6	
Early Intervention teams contacts per patient on the caseload	34	35	33	
Early Intervention team DNA rate	11%	11%	11%	
Length of time on Early Intervention team caseload (months)	6	14	11	

Comparing our figures to last year's benchmarking we can see an increase in referrals from 98 to 158 and increased caseload from 81 to 95. This appears to be commensurate with the increased investment and capacity in EIP.

	For further information and detail, please refer to: • ***Annex A – Summary Report Slides*** • ***Annex B – SHSC 2019 Registered Population Final Report*** • ***Annex C - SHSC 2019 Weighted Population Final Report*** • ***Annex D – SHSC LD Provider Services Report March 2019***
3	**Next Steps**
	1. Carry out further in-depth analysis of MH benchmarking data when the interactive toolkit is released to members. 2. Use the benchmarking data and network to identify points for investigation and peer learning. 3. Utilise most recent available benchmarking information in Trust reporting where appropriate. 4. Ensure engagement with the GIRFT processes. 5. Summarise and present Learning Disability findings in 2020 (April/May 20).
4	**Required Actions**
	1. To note the content of the summary report and associated appendices.
5	**Monitoring Arrangements**
	Updates and further summaries/analysis through the: • Performance & Quality Framework Programme • Clinical Operations • EDG/Trust Board as required
6	**Contact Details**
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