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Mental Health Bulletin

Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2010

11th January 2011

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Contents

Experimental Statistics
The statistics introduced in the first two Mental Health Bulletins (October 2008 and March 2009) were published as 'experimental'. But it is no longer correct to apply the "experimental" label to the whole publication. There are some (new) elements of this publication which are experimental and these are clearly labelled within the publication. For further information about the methodology for the analyses and data quality issues affecting the MHMDS as a whole are covered in the *MHMDS Statistics: Data Quality and Methodology* document.

We welcome feedback on the statistics presented in the report and what might usefully be included in future. Please send any comments to mhmds@ic.nhs.uk.

Acknowledgements
Jo Simpson, Senior Project Manager in the Mental Health and Community Care Team at the NHS Information Centre wrote this report.

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Steve Burrows developed the cost weighting methodology described in the first part of the Special Feature.

We are grateful to Professor Matt Sutton of the University of Manchester for allowing us to summarise parts of the Report of the Resource Allocation for Mental health and Prescribing (RAMP) Project

Trusts MHMDS submissions are processed by the Systems and Service Delivery Team at Connecting for Health.

Foreword by Hugh Griffiths

This fourth annual Mental Health Bulletin from the NHS Information Centre provides descriptive analysis of information recorded about the care of people using adult specialist mental health services. This data flows from clinical systems via the Mental Health Minimum Dataset, or MHMDS, which provides a comprehensive source of information about the majority of services provided through the Department of Health's Mental Health Programme. The data covers inpatient, outpatient and, most importantly, community activity. As the data show, less than ten percent of people who use these services spend any time as an inpatient.

This is the reason that the MHMDS has been used this year to develop proposals for a new mental health formula to be used in weighted capitation that is used to help determine allocations to Primary Care Trusts.

Good quality operational data (and the MHMDS continues to improve) can be used not only to describe what has happened – the numbers of people in contact with services and the services they received. It can also be analysed and then modelled to help commissioners and other stakeholders predict the likely need for services, and to derive outcome measures for both different groups of patients and different care providers. For example, new analysis in this report suggests a correlation between age and gender and the amount of time spent in hospital. It also provides fresh evidence on the issue of whether patients from Black and Minority Ethnic (BME) groups are more likely to spend time in hospital than other mental health service users.

When good quality, comprehensive data is flowing, the requirement for ad hoc data collections to answer the questions of policy makers, commissioners and front line staff is reduced. So this report also indicates some of the areas where the MHMDS can reduce the burden on the NHS in providing data through other collections.

Dr Hugh Griffiths
Acting National Clinical Director for Mental Health
Department of Health

Introduction

This fourth annual report presents analysis of annual data from the Mental Health Minimum Dataset (MHMDS).

The seven standard sets of analysis produced in previous years are included in the release. The report also includes some further analysis, prompted by feedback from users and to ensure consistency with the routine reports of quarterly MHMDS data that are now well established. These quarterly reports include service performance indicators for mental health trusts, as well as activity data which is also provided to the NHS Board to support the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

For the first time this year's bulletin includes:

- Time series analysis
- More detailed analysis of the data by age and gender
- Some age and gender standardised rates
- More detailed analysis of inpatient data
- Experimental analysis of Health of the Nation Outcome Scales (HoNOS) and diagnosis data
- Examples of how MHMDS has been combined with costing information

In response to the recommendations of the UK Statistics Authority this year the national analysis is released as a supporting spreadsheet file, so that the data is readily available for further analysis www.ic.nhs.uk/pubs/mhbmhmds0910.

This report is also accompanied by:

- National reference tables

- Organisation level data tables, where providers and commissioners can compare their figures with others

- The largest ever release of aggregate mental health service activity data, in accordance with the Government's public data agenda. This provides organisation level detail by providers, by commissioners for most of the basic units of mental health service activity, bed days and contacts with different professional staff groups

- Organisation level time series analysis presented graphically on MHMDS Online (http://www.mhmdsonline.ic.nhs.uk), as in previous years, for the main elements of the analysis

- Trust level data quality reports for a selection of key data items in the dataset

- An update to the Data Quality and Methodology document which describes progress in addressing some historic data quality issues and a description of the methodology used the analysis.

The format of this report has been adjusted to make a clear distinction between the first part, which provides descriptive analysis about the people who use adult specialist mental health services and the second, which provides information about the services delivered.

Changes to the MHMDS due to be implemented over the next year to support Payment by Results (PbR) will make it possible to analyse the data in many different ways, so there will be further changes to this annual release in future and some of the existing analyses will no longer be produced.

This report is intended to be used by policy makers, commissioners, mental health service users, members of the public and any other readers for whom a comprehensive national picture of the use of specialist mental health services in England will be useful.

Executive Summary

This fourth annual report on NHS adult specialist mental health services and the people who use them, covers five years with the most recent information being for 2009/10.

The latest figures show that the number of people spending time in an NHS mental health hospital increased for the first time in five years in 2009/10 to 107,765.

Key findings for 2009/10 are:

Services delivered in the community, as well as in hospital

- Over 1.25 million people used NHS specialist mental health services, the highest number since this data collection was started. This represented a rate of access of approximately 2,700 per 100,000 population.

- Overall this was a 4.0 per cent rise from 2008/09 and numbers rose for men and for women in all adult age categories and all ethnic groups.

- Over 90 per cent of people who used services did not spend any time as an inpatient during the year and the care they received outside hospital included nearly 12.5 million contacts with health and social care professionals.

Inpatient services

- While the number of people using specialist mental health services has been rising, until this year the number of these people who spent time in hospital was steadily falling. This year, however, the number of people who received inpatient care rose by 5.1 per cent to 107,765, the first increase since 2003/04-2004/05 and they represented 8.5 per cent of the total number using services.

- The average number of days spent in hospital during the year per inpatient was 68 days for women and 78 days for men.

- The rise in the number of people spending time in hospital was due to a 30.1 per cent rise in the number of people being compulsorily detained in hospital under the Mental Health Act, from 32,649 in 2008/9 to 42,479 in 2009/10. The number of voluntary patients has been falling for the last four years and fell by 6.6 per cent between 2008/09 and 2009/10.

Detentions in hospital under the Mental Health Act

- 39.4 per cent of the people who spent time in hospital were detained there under the Mental Health Act (MHA), a rise of 7.6 percentage points on the proportion detained in the previous year.

- The number of women detained under the MHA who came into hospital via prison or the courts rose by more than 85 per cent since 2008/09 to 830[1] and women were a larger proportion of the people detained in hospital via the criminal justice system in 2009/10 than in previous years (22.0 per cent in 2009/10 compared with 16.6 per cent in 2008/09). The number of men in this category rose by 48.1 per cent since the previous year from 1,982 to 2,935.

- The proportion of inpatients who were detained during the year rose across all ethnic groups, but this was particularly noticeable for the Black group, of whom 66.3 per cent were detained in 2009/10 (compared with 53.8 per cent in 2008/09).

- These figures suggest that NHS mental hospitals are increasingly used to care for and contain people who pose a risk to themselves or others.

Further differences between people from different ethnic groups in use of services

- Whilst the number of people using services rose across all ethnic groups, the percentage rise was noticeably larger for the Mixed ethnic group (a rise of 17.7 per cent). The Mixed and the Black and Black British groups now both have rates of access to services that are over 40 per cent higher than for the majority White group (at approximately 3,800 per 100,000 population compared with about 2,700 for the White group).

- However, the rate of access to inpatient hospital care for BME mental health service users appears not to be so different from the majority White group as some other studies have shown[2] and the number inpatients in the Black or Black British group fell by 6.6 per cent between 2008/09 and 2009/10.

- This was due to a sharp drop in the number of voluntary inpatients from the Black and Black British group, which was greater than the rise (by more than 600) in the number of people in this ethnic group being detained in hospital.

This release is accompanied by the largest ever release of underlying data about the use of mental health services, in accordance with the Government's public data agenda.

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[1] The number of women detained under the MHA who came into hospital via prison or the courts rose from 394 in 2008/09 to 830 in 2009/10, a rise of over 100 per cent. However, ninety five of these women were detained in hospitals which failed to provide information on legal status in the appropriate format in 2008/09, which suggests part of this increase is due to improving data quality. Nevertheless, even if these are discounted from the calculation, the number of women detained via the Criminal Justice System this year still rose by 86.5 per cent since 2008/09.

[2] The most recent Count Me In census report (2009) found rates of admission were over three times higher than average for the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups and nine times higher in the Other Black group.

People using NHS specialist mental health services for adults

Data quality and rounding conventions

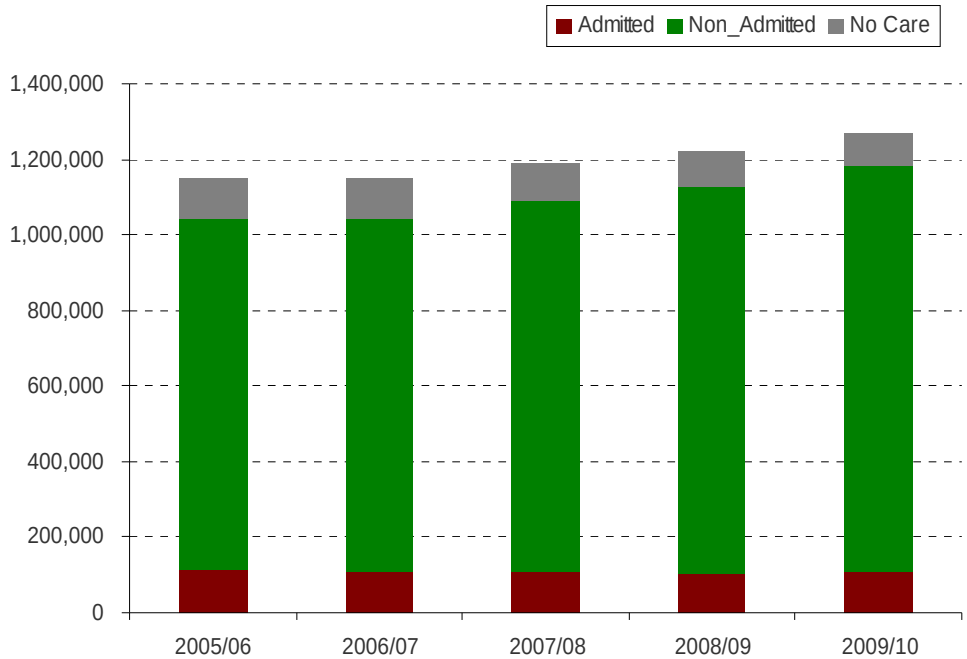
As in previous years, any data quality issues that might have an impact on the findings in this report are explicitly mentioned. If no data quality issue is mentioned, the data are considered reliable.
Whole numbers are stated precisely and percentages are presented to one decimal point accuracy.

Number of people using services

The number of people using mental health services has been rising ever since comprehensive national information started to be collected through the MHMDS. Despite the possibility that improving data quality contributed to this increase in 2004/05 and 2005/06, each year since 2005/06 the rise in the number of people using services has nevertheless been accompanied by a reduction in the proportion of these people who spent time in hospital as shown in Figure 1 below. However, the latest figures show, for the first time, an increase in the proportion of people using these services who spent time in hospital during the year.

Table 1.1 in the supporting national reference tables shows that the number of people spending time as an inpatient has been on a downward trend since 2004/2005, from 114,435 in 2004/05 to 102,571 in 2008/09. This year, however, this decline was reversed and the number of people spending time in an NHS mental hospital increased by 5.1 per cent to 107,765. In 2009/10 8.5 per cent of the total number of people using services spent time as an inpatient, compared with 8.4 per cent in 2008-09.

Fig 1: Number of people using mental health services, by year



Data source: Table 1.1 from the supporting national reference tables

The increase in the overall number of people in contact with mental health services shown in Figure 1 above was the largest increase in four years, at 4.0 per cent. The number of people in the 'No Care' category, which means they had an open spell of care but there was no evidence of contact with services, continues to reduce. This is probably due to improving data quality but may include inappropriate referrals, people who did not attend for appointments and people whose treatment is yet to start.

The percentage increase was larger for women than for men across the range of services.

The number of women spending time in hospital was 6.1 per cent higher in 2009/10 than in the previous year, compared with 4.5 per cent for men, and the number of women who used community services, but did not spend time in hospital, was 5.3 per cent higher in 2009/10 than in 2008/09, compared with a rise of 4.8 per cent for men.

Fig 2: Number of people spending time in hospital, by gender, by year

Data source: Table 1.2 from the supporting national reference tables

For both men and women the rise in the number of people spending time in hospital was most noticeable amongst working age adults (aged 18-64), but it was larger for women, an increase of 8.2 per cent compared with 5.7 per cent for men.

Analysis of MHMDS data about people accessing services was published on The Office for National Statistics (ONS) Neighbourhood Statistics web site for the first time in April 2010, providing figures at local authority level

Counting people

People who use these services may have more than one spell of care during the year and receive services from more than one provider. In this analysis they are counted once only in the year, regardless of how many times they came into contact with services, and when they are categorised they are shown in the highest ranking category that applied to them during the year, so people who spent time in hospital are counted in the 'admitted' category even if they also used community services.

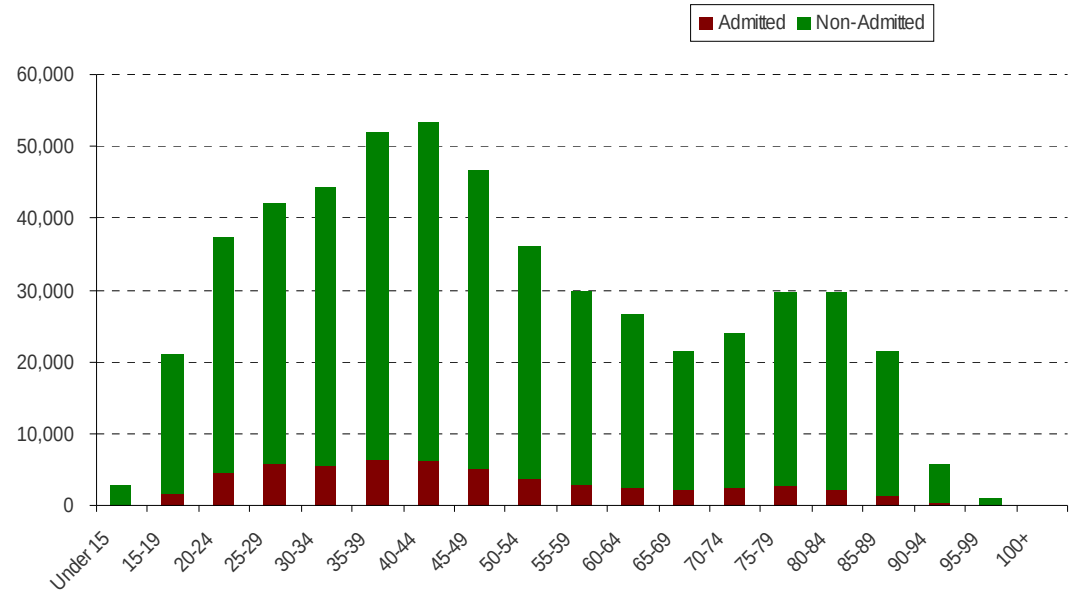
A recent ONS[3] study of this data confirms that use of specialist mental health services varies quite dramatically by age.

A new table in the supporting national reference tables (Table 1.3) provides a detailed age breakdown of the number of men and women using services, as shown in Figures 3 and 4 below.

The pattern of service use is similar for both sexes to the extent that the lowest number of people accessing either hospital or community services are in the 65-69 year age band. This coincides with the retirement age.

However amongst older people the number of women who only use community services is much larger than men. Among working age adults the highest numbers are in the 40-44 year age band. The highest numbers of men spending time in hospital are in the 35-39 year age band.

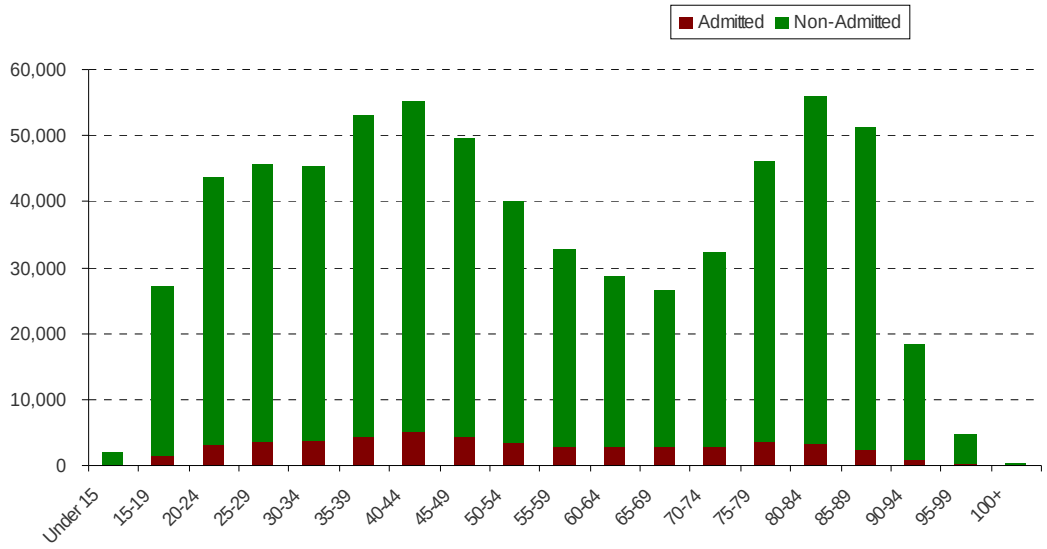
Fig 3: Number of men using mental health services by age and category of care, 2009/10



Data source: Table 1.3 from the supporting national reference tables

[3] Patterns of Specialist Mental Health Service Usage In England, ONS)

Fig 4: Number of women using mental health services by age and category of care, 2009/10



Data source: Table 1.3 from the supporting national reference tables

Service use appears to be patterned by age and gender and The Adult Psychiatric Morbidity Survey provides further detail about how prevalence of different mental health problems varies according to age and gender.

Using information about the age and gender of a population to help predict how many of them will use mental health services is helpful for people planning and commissioning services.

However an adjustment needs to be made for age and gender when comparing rates of access to services across different groups, to make it possible to provide a fair comparison.

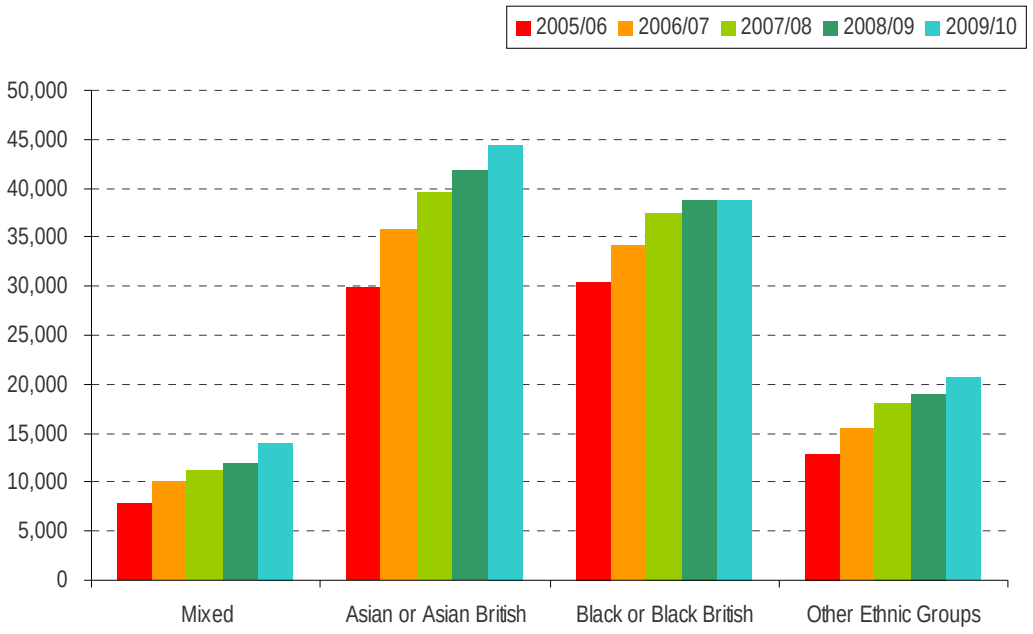
For this reason as well as providing basic counts of people using mental health services by different ethnic groups, this report also provides age and gender standardised rates of usage, to allow for the fact that the age and gender profile of a particular population will have an impact on the number of people using services. These standardised rates are available by PCT (see maps on pages 18 and 19) and by ethnic group.

Use of mental health services by people from black and minority ethnic groups

Information on the ethnicity of people using services is now almost complete for people who spend time in hospital (97.4 per cent) and 87.3 per cent complete for people who did not spend time in hospital. This means that analysis by ethnic group is considered quite reliable.

The number of people using mental health services has been rising over the last four years across all five broad ethnic groups and not just in the White group (which is not shown in Figure 5 below for reasons of scale). There has been a steady upward trend in the number of Asian or Asian British people using services. In the Mixed group the rise was sharpest in the most recent year at 17.7 per cent and in the Black or Black British group the upward trend almost halted, between 2008/09 and 2009/10.

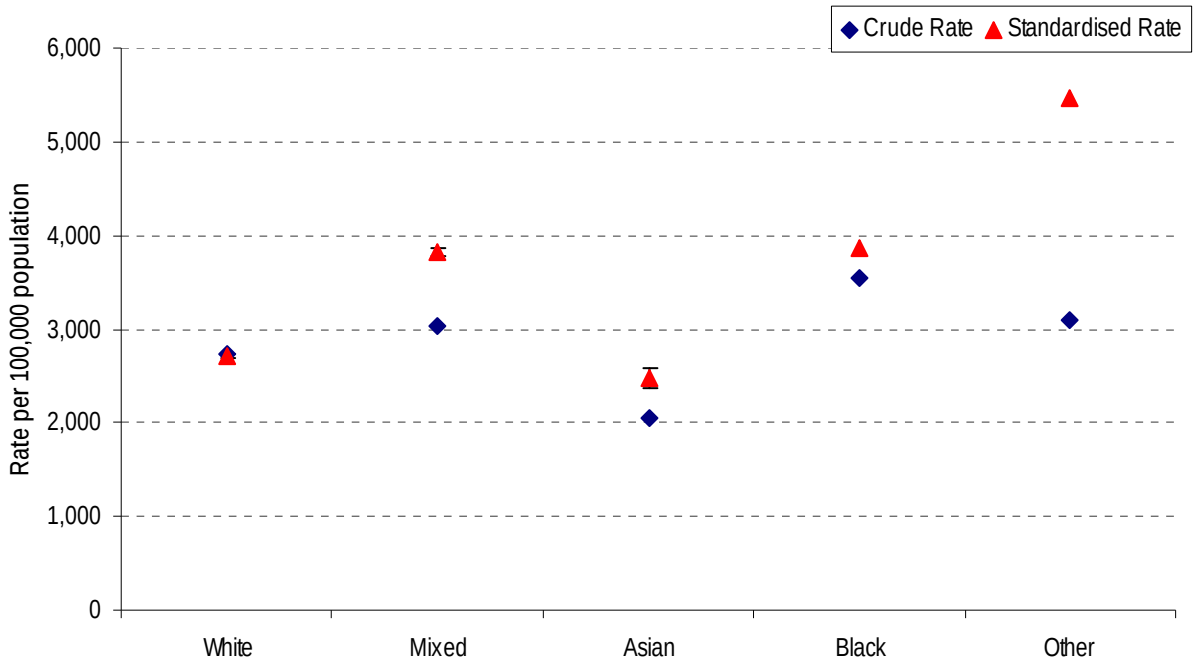
Fig 5: Number of people using mental health services, by minority ethnic group, by year



Data source: Table 1.4 in the supporting national reference tables

Last year's report included experimental analysis of rates of access by age and gender and ethnic group. To assist in comparing rates of access for different ethnic groups, by removing the element of difference that will be due to the age and gender of the population, this year rates of access by ethnic group have been standardised for age and gender.

Fig 6: Rates of access to mental health services per 100,000 population, by ethnic group, 2009/10



Data source: Table 1.5 from the supporting national reference tables

Rates of access for all groups except the White group are higher when age and gender are taken into account. Figure 6 above shows that the standardised rates for people using mental health services are almost identical for the Mixed and Black or Black British populations at 3,825 and 3,870 per 100,000 respectively, once age and gender are taken into account. For comparison, the rate for all groups is 2,713 per 100,000 population.

While the overall number of people who spent time in hospital was steadily decreasing up until 2008/09, within the non white ethnic groups the pattern has been reversed.

Table 1: Number of people spending time in hospital, by ethnic group, by year

				Number of People	
Broad Ethnic Group	2005/06	2006/07	2007/08	2008/09	2009/10
White	89,863	88,982	87,454	83,827	89,468
Mixed	1,397	1,533	1,586	1,603	1,920
Asian or Asian British	4,052	4,347	4,524	4,560	4,830
Black or Black British	6,695	6,881	7,085	7,466	6,970
Other Ethnic Groups	1,605	1,492	1,688	1,614	1,808

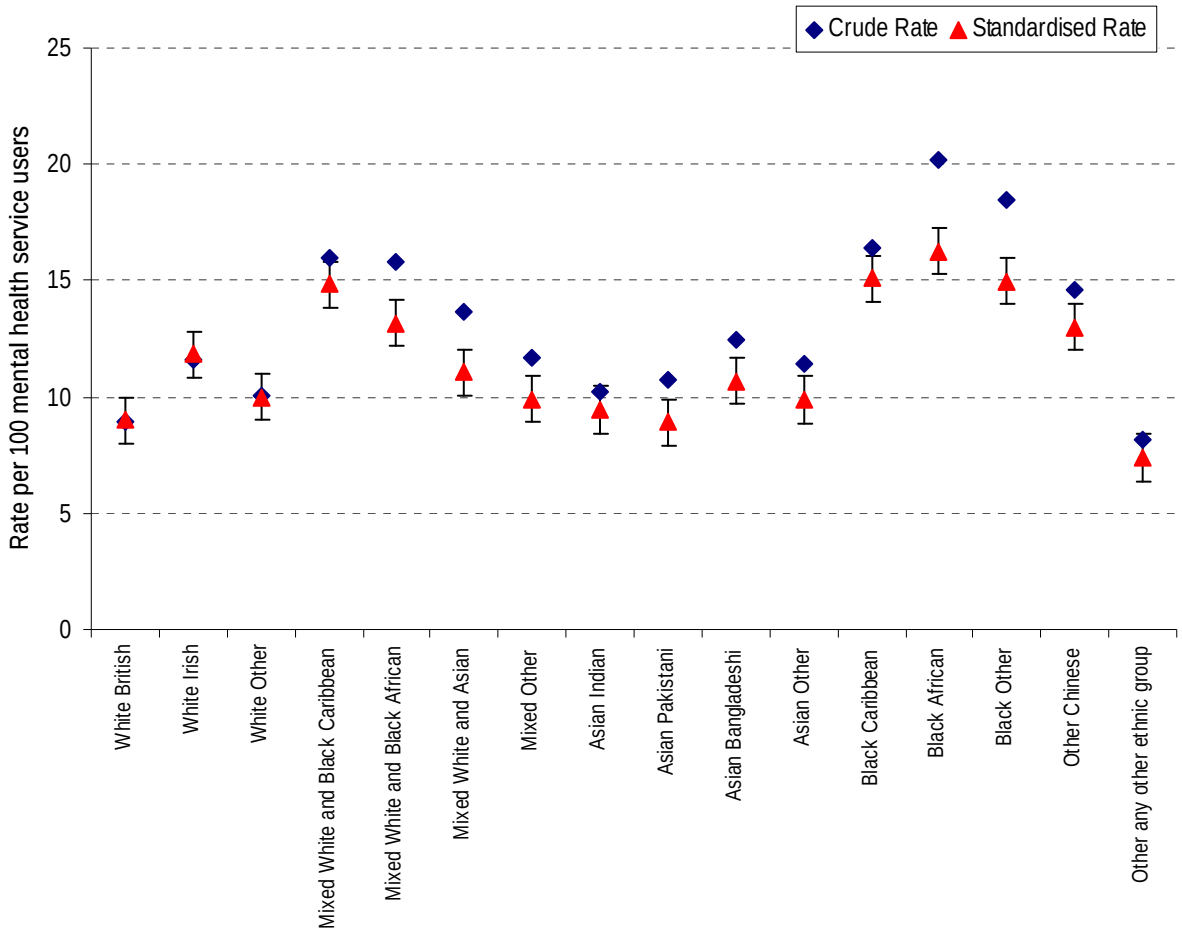
Data source: Table 1.4 from the supporting national reference tables

Table 1 above shows that while the number of people in the white group who spent time in hospital reduced each year for three years up until 2008/09, over the same period the numbers of people in the Mixed, Asian or Asian British and Black or Black British groups was rising. Between 2007/08 and 2008/09 the number of Black or Black British people spending time in hospital rose by 5.4 per cent.

Two changes stand out this year. The first is that the number of people in the Black or Black British group that spent time in hospital during the year has fallen, by 6.6 per cent. The next section about the number of people detained in hospital shows that this is a reduction in the number of people spending time as a voluntary inpatient. However, in all the other ethnic groups, (including the majority White group) the numbers have risen, but this is particularly noticeable in the Mixed group, where the number of people spending time in hospital rose by 19.8 per cent.

The rate of access to hospital inpatient care varies for different ethnic groups. However, if age and gender are taken into account, then the difference between the ethnic groups is somewhat reduced, as shown in figure 7 below. The highest rate was for Black Africans at 16.3 per cent.

Fig 7: Rates of access to hospital inpatient care per 100 mental health service users, by ethnic group, 2009/10



Data source: Table 1.6 from the supporting national reference tables

The data shows that rates of access to mental health services, shown in Figure 6, are significantly higher for all BME groups, except the Asian group and once in contact with services the rates of access to hospital inpatient care is higher for the same groups. For example, the rate of access to hospital inpatient care per 100 mental health service users in the Black Other group was 15.0 per cent, compared to 9.0 per cent for the White British group.

However these differences in rates of access to hospital care provide an interesting contrast to the 2009 Count Me In Census report, which found rates of admission were over three times higher than average for the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups and nine times higher in the Other Black group.

Differences in these findings are to be expected because the Count Me In provides a one day snapshot (on 31 March 2009 for the admission rates quoted above) and the MHMDS figures include everyone who spent time in hospital during the year. Nevertheless it's possible that information about rates of access to mental health services as a whole for different ethnic groups can provide useful context for investigating different patterns of service use for some minority ethnic groups.

Local rates of access to specialist mental health services

The maps on pages 18 and 19 show the rate of access per 100,000 population for each Primary Care Trust (PCT) area and the proportion of these people who spent time in hospital. These rates have been directly standardised to account for the differences due to age and gender to assist in making benchmarking comparisons. The underlying data can be found in Tables 1c and 1d of the supporting organisational level data tables and further detail about the methodology for calculating these rates can be found in the Data Quality and Methodology document.

The ONS report 'Patterns of Specialist Mental Health Service usage in England', mentioned above also showed a relationship between deprivation (using English Indices of Multiple Deprivation) and the likelihood of people accessing these services. However deprivation did not fully explain the differences and the report also used rural/urban classifications to investigate the differences. It could be that ethnic group is also a factor affecting rates of access, or that other inequalities within areas have an impact on the need for mental health services.

A comparison of the figures for individual PCTs shows that high rates of access to services do not necessarily correspond with a higher proportion of service users receiving treatment in hospital. In fact the reverse seems to be true for some of the PCTs with the highest rates of access to services.

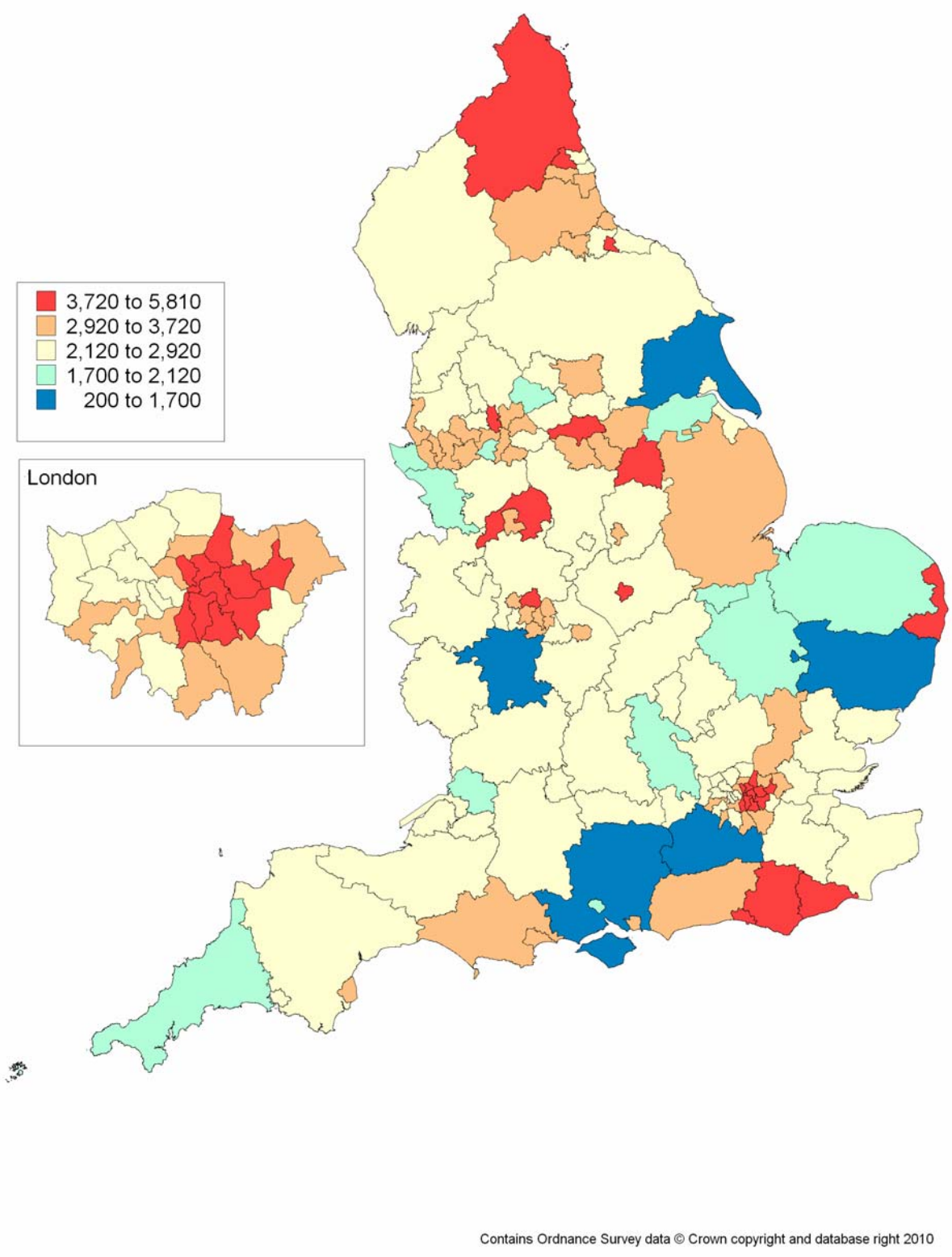
For example, 5JE (Barnsley PCT), 5ET (Bassetlaw PCT), 5C2 (Barking and Dagenham PCT) and 5LQ (Brighton and Hove City PCT) all have amongst the highest rates of access per 100.000 population, but amongst the lowest rates of access to hospital care.

Conversely, 5PN (Peterborough PCT) and 5NR (Trafford PCT) have amongst the highest proportion of service users spending time in hospital, but the lowest rates of access to services per 100,000 population.

Rates for the Isle of Wight should be treated with caution as no information about patient gender was collected.

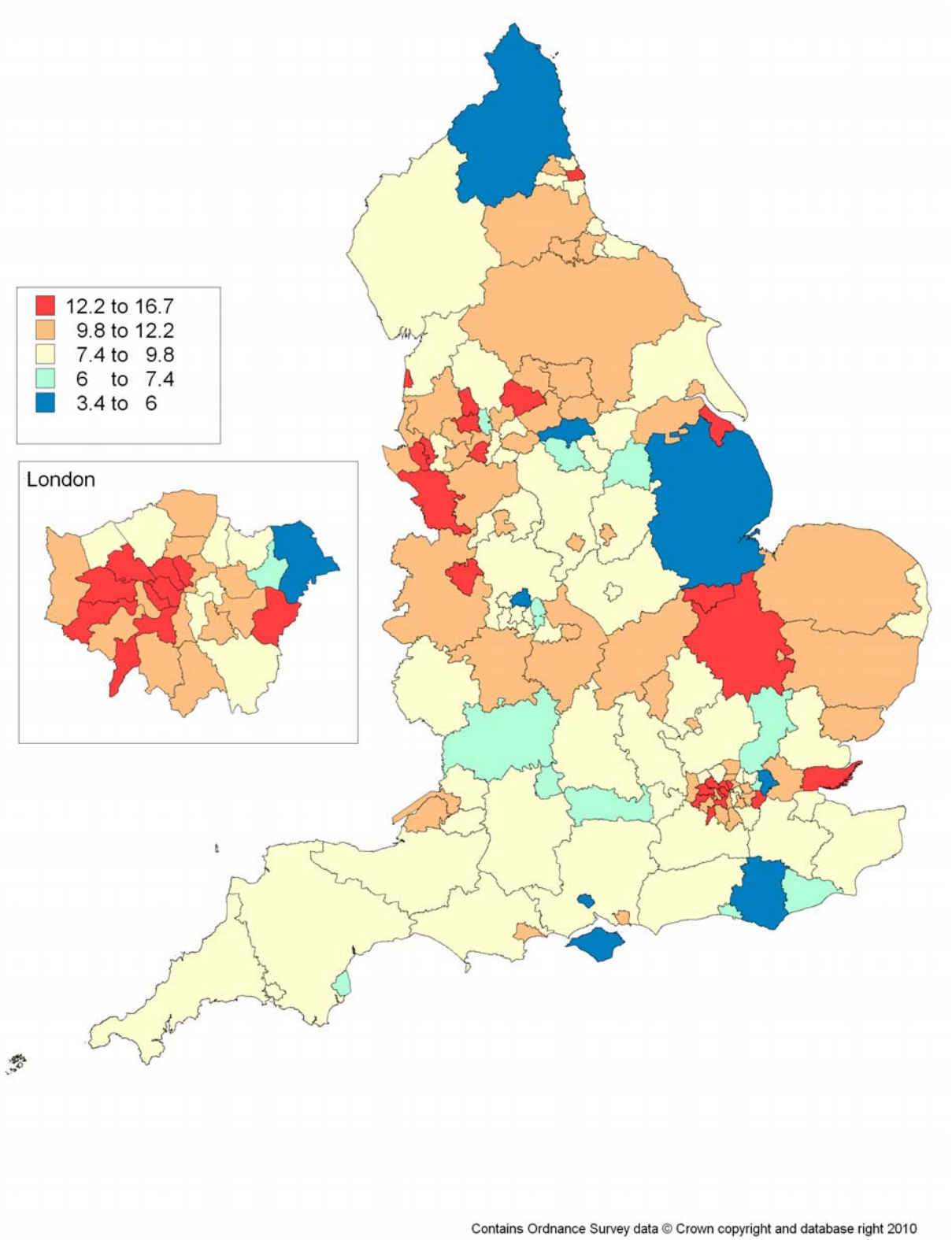
These rates are provided at PCT level on MHMDS Online as well as in the supporting national reference tables.

Fig 8: Standardised* rates of access per 100,000 population to adult specialist mental health services by PCT, 2009/10



* *rates were standardised for age and gender*

Fig 9: Standardised* rates of access to hospital inpatient care during the year, per 100 mental health service users, 2009/10



** the rates were standardised for age and gender*

People detained in psychiatric hospitals

The rise in the number of people spending any time as an inpatient between 2008/09 and 2009/2010 is accounted for by a 30.1 per cent increase in the number of people detained in hospital during the year. Figure 10 below shows that the number of people who spent time as a voluntary inpatient actually decreased between 2008/09 and 2009/10 by 6.6 per cent, continuing a four year downward trend.

Fig 10: Number of people spending time in hospital, by most restrictive legal status, by year

Data source: Table 2.1 from the supporting national reference tables

Table 2 below provides detailed figures, categorising detained patients by the most restrictive legal status that applied to them during the year and counting each person once, regardless of how long they spent in hospital and how many times they were admitted and regardless of whether they were still in hospital at the end of year.

In 2009/10 39.4 per cent of the people who spent time as an inpatient spent some time during the year detained under the Mental Heath Act 1983 (MHA). This is a 7.6 percentage point increase on the proportion of inpatients who were detained in the previous year.

Table 2: Percentage of inpatients detained in hospital, by year

	Not detained		Formally detained					**All inpatients**
	Total	%	Place of safety	Part 2	Court and prison disposals	Total	%	
2005/06	82,913	74.6%	457	25,603	2,115	28,175	25.4%	**111,088**
2006/07	78,367	73.5%	501	25,795	1,898	28,194	26.5%	**106,561**
2007/08	73,165	69.2%	857	29,465	2,232	32,554	30.8%	**105,719**
2008/09	69,922	68.2%	910	29,362	2,377	32,649	31.8%	**102,571**
2009/10	65,286	60.6%	1,461	37,249	3,769	42,479	39.4%	**107,765**

Data source: Table 2.1 from the supporting national reference tables

The number of people who spent time in hospital as a result of being detained via the criminal justice system (Court and prison disposals under Part 3 of the Mental Health Act) rose by 58.6 per cent, the number detained under Part 2 (civil detentions) rose by 26.9 per cent.

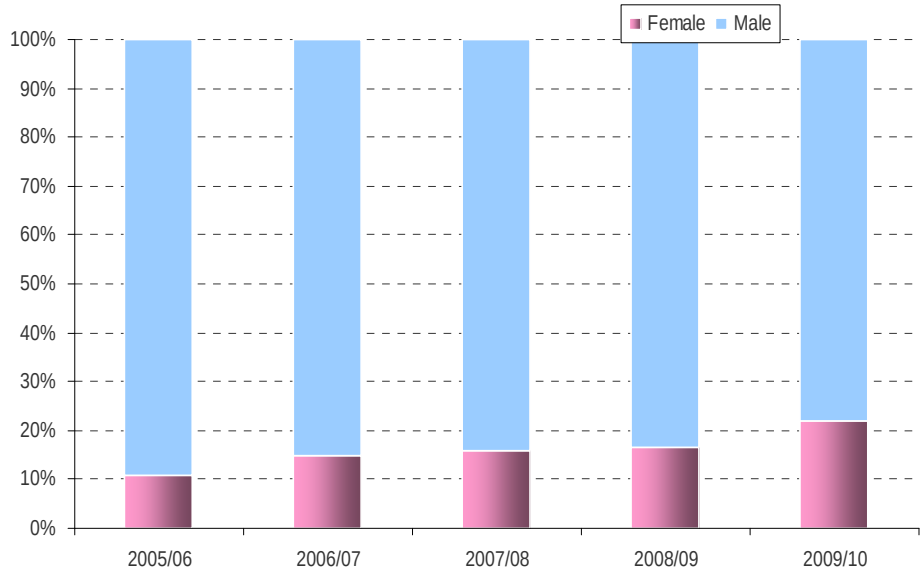
The number of patients who accepted voluntary admission after being brought to hospital under a Place of Safety Order rose by 60.5 per cent to 1,461. This figure does not include people brought to hospital under a Place of Safety Order who did not also spend time as a voluntary inpatient, since the population for this set of figures is people who spent time as an inpatient.

The increase in the number of people detained in hospital in 2009/10 can be partly attributed to improvements in recording details of uses of the MHA in MHMDS, because in 2008/09 six trusts failed to include this information in their annual return and in 2009/10 only one hospital failed. Nevertheless these figures appear consistent with the latest National Statistics about uses of the MHA[4]. These showed a marked increase in the number of formal admissions under Part 2 of the MHA between 2008/09 and 2009/10 and a continuing increase in the number of people in a snapshot count of people detained in hospital on the 31 March.

The figures suggest that the apparent increase in the number of people subject to compulsory treatment in hospital has resulted in an overall increase in the number of people spending time as inpatients in NHS mental health services during the year and the proportion of people who are being treated voluntarily in hospital is steadily reducing. This suggests that NHS psychiatric hospitals are increasingly used to care for and contain people who are seriously mentally ill and who are considered to pose a risk to themselves or others.

Gender and age of people detained in hospital

Fig 11: People spending time in hospital as a results of a detention via the criminal justice system, by gender, by year



Data source: Table 2.2 from the supporting national reference tables

[4] In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/10 (KP90 collection)

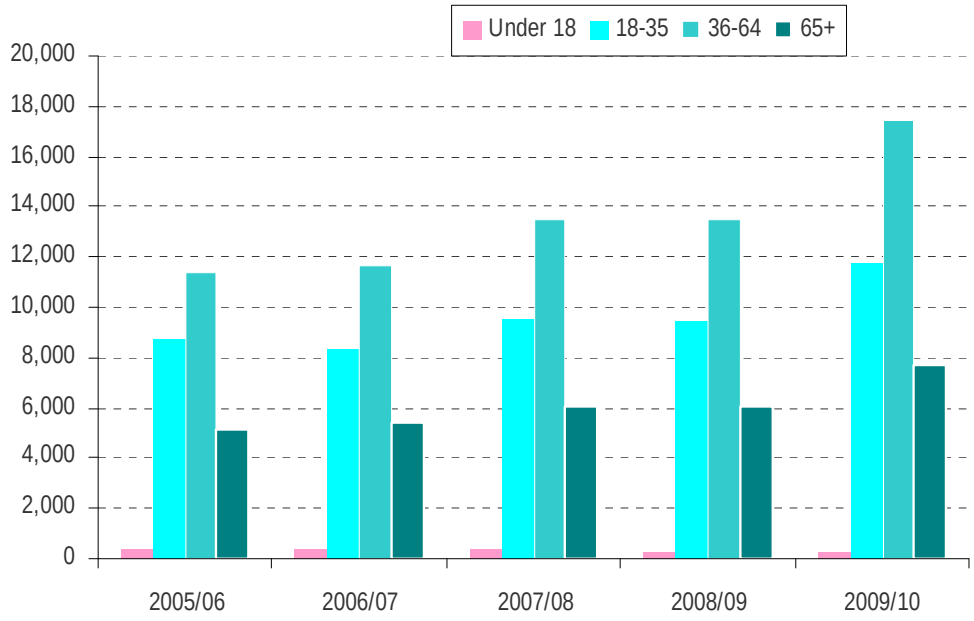
Figure 11 shows that women make up an increasing proportion the total number of people held in hospital as a result of a detention via the criminal justice system, up from 16.6 per cent in 2008/09 to 22.0 per cent in 2009/10.

While the number of men who spent time in hospital as a result of being detained via the criminal justice system during 2009/10 was 48.1 per cent higher than the previous year, the data in table 2.2 of the supporting national reference tables shows that the number of women in this category rose from 394 to 830. Ninety five of these women were detained in hospitals which failed to provide information on legal status in the appropriate format in 2008/09. However, even if these are discounted from the calculation, the number of women detained via the criminal justice system this year still rose by 86.5 per cent since 2008/09.

The detailed figures also show the difference between the number of men and women detained under Part 2 of the act reducing as well. The number of men in this category rose between 2008/09 and 2009/10 rose by just under 4,000 and the number of women by just over 4,000.

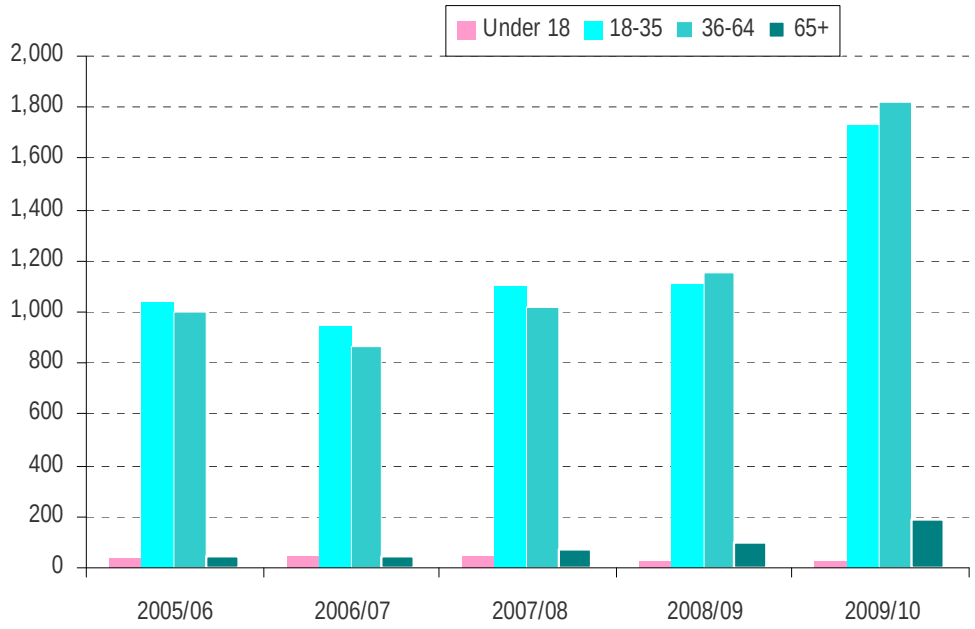
Figs 12 and 13 below show the age profile of people detained under Part 2 and Part 3 (detentions via the criminal justice system) of the act over the last 5 years. The National Statistics on uses of the MHA do not include information about age, so this is additional information not available elsewhere.

Fig 12: Number of people detained in hospital under Part 2, by age and year



Data source: Table 2.2 from the supporting national reference tables

Fig 13: Number of people detained in hospital under Part 3, by age and year



Data source: Table 2.2 from the supporting national reference tables

As well as highlighting the increase in numbers, these show that a larger proportion of people detained via the criminal justice system, as compared with Part 2 detentions, are in the younger working age adult category. But in the most recent two years there was a change in the age profile of people in hospital as a result of detention via the criminal justice system, with more people in the 36-64 age group than in the younger working age group.

Ethnicity of detained patients

The number of people who were compulsorily detained in hospital during the year rose between 2008/09 and 2009/10 across all ethnic groups, as shown in Table 3 below. This is the third annual rise in the number of people detained in hospital in the Mixed, Asian or Asian British and Black or Black British groups.

Details of the ethnicity of all the people who were detained during the year are provided in table 2.3 of the supporting national reference tables. Further analysis of this data provided in table 3 below, shows that an increasing proportion of people from BME groups who spent time in hospital were detained under the MHA.

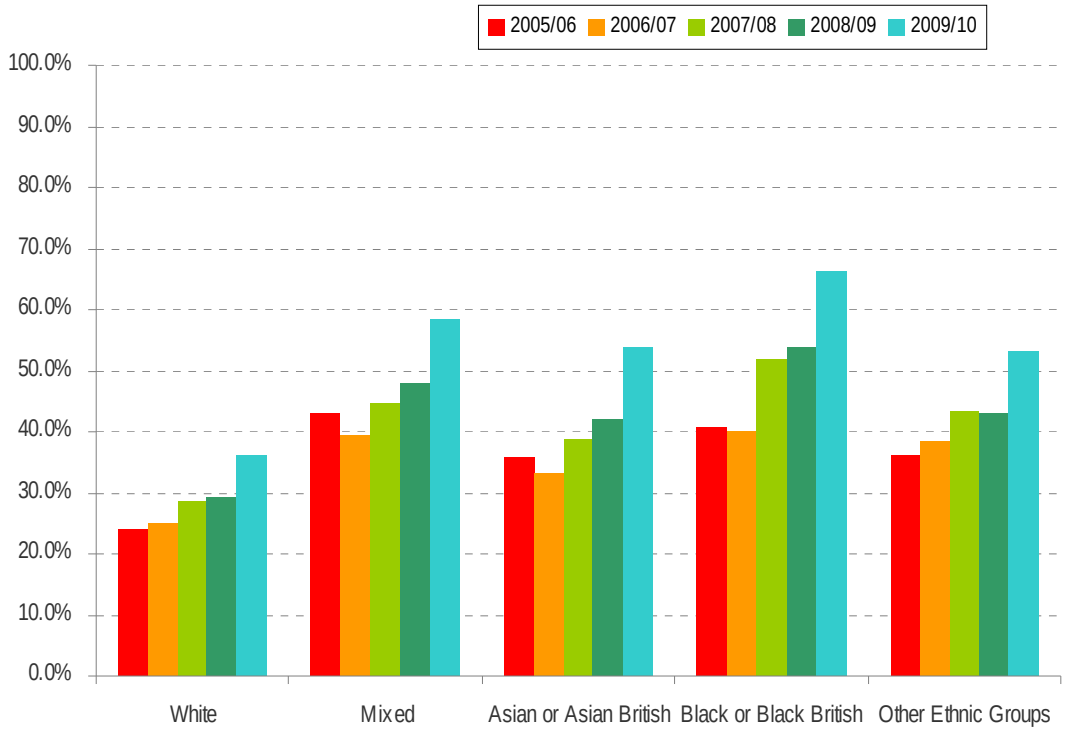
Table 3: Number of inpatients by legal status, by ethnic group, by year

	2005/06			2006/07			2007/08			2008/09			2009/10		
	Total inpatients	Formally detained	%	Total inpatients	Formally detained	%	Total inpatients	Formally detained	%	Total inpatients	Formally detained	%	Total inpatients	Formally detained	%
Total inpatients	**111,088**	**28,175**	**25.4%**	**106,561**	**28,194**	**26.5%**	**105,719**	**32,554**	**30.8%**	**102,571**	**32,649**	**31.8%**	**107,765**	**42,479**	**39.4%**
White	89,863	21,612	24.0%	88,982	22,289	25.0%	87,454	24,926	28.5%	83,827	24,515	29.2%	89,468	32,131	35.9%
Mixed	1,397	601	43.0%	1,533	603	39.3%	1,586	702	44.3%	1,603	768	47.9%	1,920	1,125	58.6%
Asian or Asian British	4,052	1,452	35.8%	4,347	1,442	33.2%	4,524	1,749	38.7%	4,560	1,915	42.0%	4,830	2,602	53.9%
Black or Black British	6,695	2,731	40.8%	6,881	2,761	40.1%	7,085	3,662	51.7%	7,466	4,018	53.8%	6,970	4,624	66.3%
Other Ethnic Groups	1,605	579	36.1%	1,492	574	38.5%	1,688	734	43.5%	1,614	695	43.1%	1,808	962	53.2%

Data source: Table 2.1 and 2.3 from the supporting national reference tables

For the last three years the proportion of inpatients who were detained has increased across every group, except the Other Ethnic group (where it fell slightly between 2007/08 and 2008/09). The fall in the number of people from the Black or Black British group who spent time in hospital, mentioned earlier, is a net fall made up of a reduction of over 1,100 in the number of voluntary inpatients, while the number of people who were compulsorily detained actually rose by over 600.

Fig 14: Percentage of people spending time in hospital during the year who were compulsorily detained, by ethnic group, by year



Data source: Table 3 above

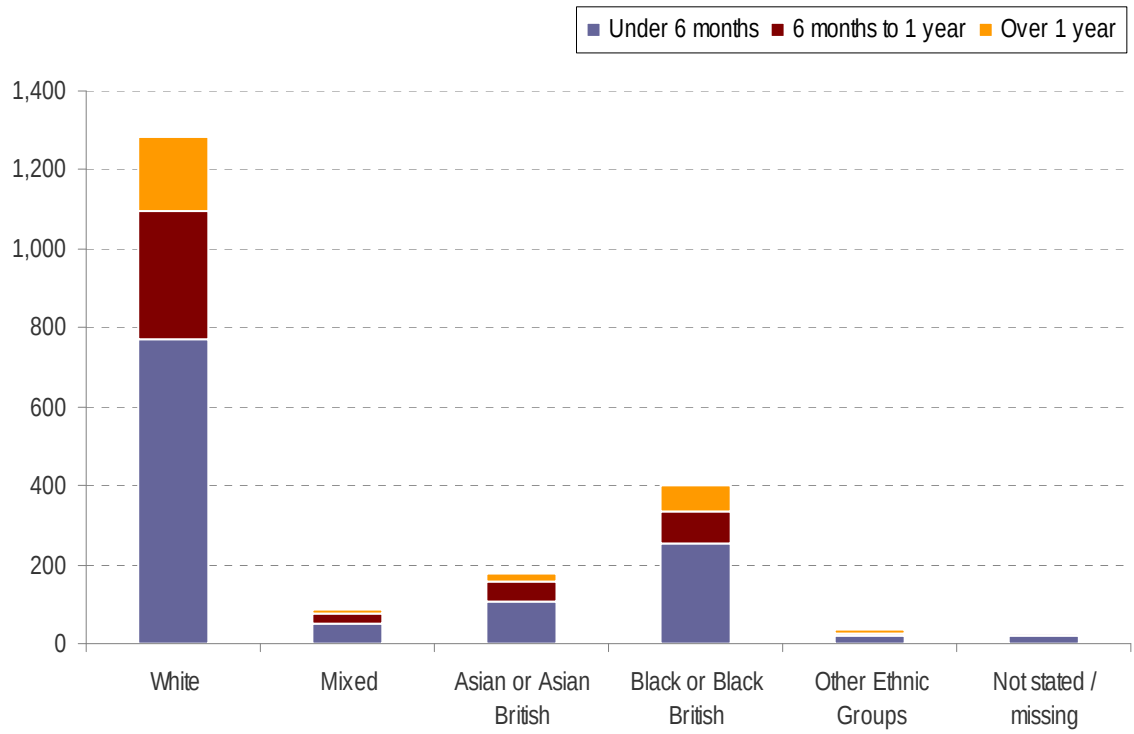
Indeed Figure 14 above shows that the largest increase between 2008/09 and 2009/10 is actually for the Black and Black British group, for whom the proportion that were detained rose from 53.9 per cent in 2008/09 to 66.3 per cent in 2009/10.

Experimental statistics: People on Supervised Community Treatment

In 2009/10 only 68 per cent of providers included any information about patients on Supervised Community Treatment in their return and so the information presented here is known to be incomplete. However MHMDS is potentially capable of adding value to the National Statistics about SCT as it includes information about the age and ethnic group of people on SCT and the time they had spent on a SCT at the end of the year. The data is provided in table 2.4 of the supporting national reference tables and figure 15 below gives an example of the type of information that could be provided.

These figures show that, in those providers that returned data, 14.8 per cent of people who were on SCT at the end of 2009/10 had been on SCT for more than a year and of these people, 37.2 per cent were not from the majority White ethnic group.

Fig 15: Number of people on SCT at the end of the year, by duration of SCT, 2009/10



Data source: 2.5 from the supporting national reference tables

These figures are consistent with the Care Quality Commission's (CQC) findings[5] that a larger proportion of some Black and minority ethnic patients than might be expected from the detained population is liable to be issued with a Community Treatment Order. CQC's report also raised concern about the potentially very broad use of the coercive powers of the Community Treatment Order. Information from MHMDS could support further study of how these powers are being applied, in the overall context of patients' care.

Table 2.5 in the supporting national reference tables also shows the number of people on SCT at the end of the year whose care was being coordinated under the Care Programme Approach. The figures suggest that not all people on SCT at the end of the year were on the Care Programme Approach (CPA) (86.9 per cent were on CPA). People requiring support in engaging with the service after discharge from hospital would be expected to be on CPA. The absence of the support that would be provided under the CPA, suggests that SCT might be used by services simply as a mechanism for enforcing a service user's compliance with a medication regime.

Comment on statistics about uses of the Mental Health Act

The information in this report has been designed to complement the National Statistics on uses of the Mental Health Act. Rather than counting uses of the Mental Health Act, it counts people subject to the Act and provides analysis by age and ethnic group. Such information is not part of the collection that provides the source data for the National Statistics (known as the KP90 collection).

[5] Monitoring the use of the Mental Health Act in 2009/10, Care Quality Commission

In order to reduce the burden of data collection on provider organisations the intention is to discontinue the KP90 collection once all the data necessary to produce the National Statistics is being flowed through the MHMDS. However some further work is required to align the scope of MHMDS to include all eligible hospitals (including high secure hospitals, learning disability services and CAMHS services, for example). In addition, not all organisations that provide MHMDS include all relevant Mental Health Act information in their submission at present, as described in the accompanying Data Quality and Methodology document.

In particular, there is evidence that information about Supervised Community Treatment in MHMDS is currently incomplete. For example, in the 2009/10 KP90 collection 72 NHS organisations submitted some data about Supervised Community Treatment (SCT), including some acute trusts, which do not complete the MHMDS return. 66 of these 72 trusts currently submit MHMDS and one of them failed to return information about legal status in their 2009/10 return.

Whilst all but one trust is returning some information about legal status in their MHMDS return (and the information about detained patients provided in the previous section is considered reliable), information about Supervised Community Treatment is not yet included by all providers. Information about SCT was added to the MHMDS data standard in 2008, but in the 2009/10 MHMDS submission only 45 organisations submitted any information about SCT (68 per cent) and this is why the information about SCT is described as experimental statistics.

In order to monitor the data quality of information about Supervised Community Treatment some analysis of SCT data has been added to the routine quarterly MHMDS reports for 2010/11. In time this should support regular monitoring of the use of Community Treatment Orders, which users of these statistics have requested.

People on Care Programme Approach

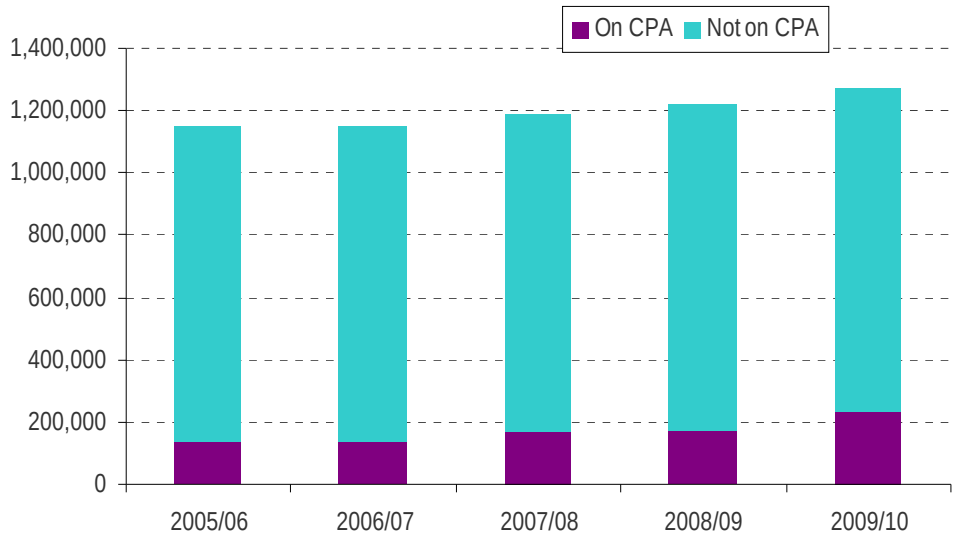
MHMDS data is currently rich in demographic and service activity data, but does not yet provide comprehensive information about the presenting problems of service users or the kinds of treatment they receive. This information will be vital for developing tariffs for different patient pathways or packages of care to support Payment by Results (PbR) for mental health.

However, since the CPA is used to manage the care of people with more complex mental health problems identifying patients on CPA is one way of defining a group of people who are likely to be heavier users of mental health services. In addition, people on CPA are the denominator population for several well established indicators used to measure the performance of mental health providers and this is probably why some data items, such as the Health of Nation Outcome Scales (HoNOS), are more comprehensively recorded for these people.

So, as well as providing information about the number and characteristics of people on CPA, this year's report also introduces elements of the data, which could be useful in future. Further advice from users is required to define the precise requirements for any detailed analysis.

The number of people using specialist mental health services who were recorded as being on the CPA rose by over 59,000 (34.7 per cent) between 2008/09 and 2009/10. Some of this increase is due to improving data quality because we have been informed many trusts had problems recording CPA in 2008/09, because of system changes.

Fig 16: Number of people accessing services and of which those on CPA, by year

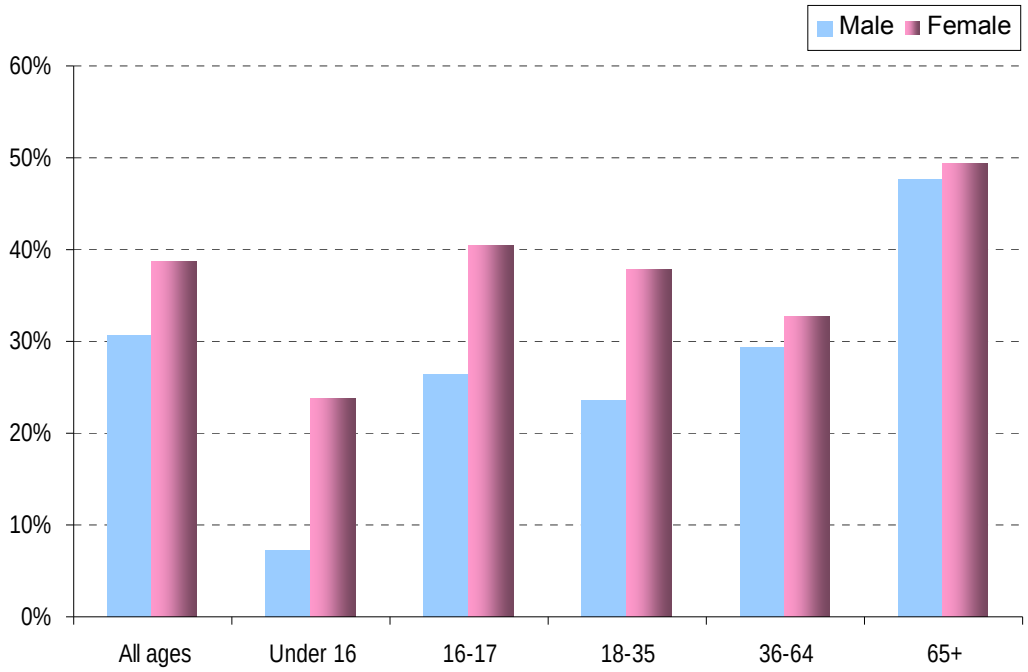


Data source: 3.1 from the supporting national reference tables

Figure 17 below shows however that this rise was not spread evenly across the age and gender categories and so the data could also be reflecting changes in clinical practice or the changing profile of people who need to be cared for under CPA.

The highest rises were for people in the 65 and over age band (a 47.6 per cent rise in this group for men and 49.4 per cent for women) and the rises were higher for women than men across all age bands. The difference in the percentage increase in the number of men and women on CPA in the last year was most noticeable in the younger age groups

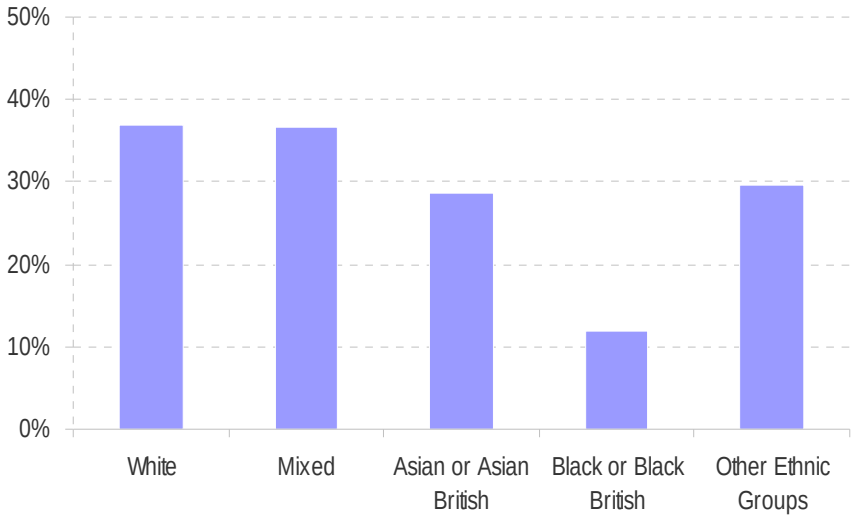
Fig 17: Percentage increase in the number of people on CPA by age, gender between 2008/09 and 2009/10



Data source: Table 3.2 from the supporting national reference tables

For example, although the number of young people aged 16-17 on CPA was relatively small (944 women and 829 men in 2009/10), this was a 40.5 per cent increase for young women between 2008/09 and 2009/10 and an increase of 26.4 per cent for young men.
The largest increases for any ethnic group (except Not stated or not known) was for the majority White group (36.8 per cent) and the smallest for the Black or Black British group, which rose by 11.8 per cent.

Fig 18: Percentage increase in the number of people on CPA by ethnic group between 2008/09 and 2009/10



Data source: Table 3.3 from the supporting national reference tables

Experimental statistics about people on CPA

A number of indicators were introduced during 2009/10, using quarterly MHMDS data. Some of these used people on CPA as the denominator group and the annual data shows how this focus has improved the data quality. Table 4 below shows not only the number of people recorded as being on CPA increasing every year since 2005/06, but it also shows the number of people on CPA for whom other important detail about their care were recorded is (mostly) rising as well.

Table 4: Data quality for people on CPA, various data items, by year

Number of people

Measure	2005/06	2006/07	2007/08	2008/09	2009/10
Total number of people on CPA	**131,983**	**135,040**	**164,998**	**171,248**	**230,608**
At least 1 valid HoNOS	14,584	17,358	18,108	33,774	74,081
Valid first and most recent HoNOS	10,848	155	14,451	28,078	64,510
Review conducted in at least the last 12 months	93,114	101,603	123,182	126,679	179,970

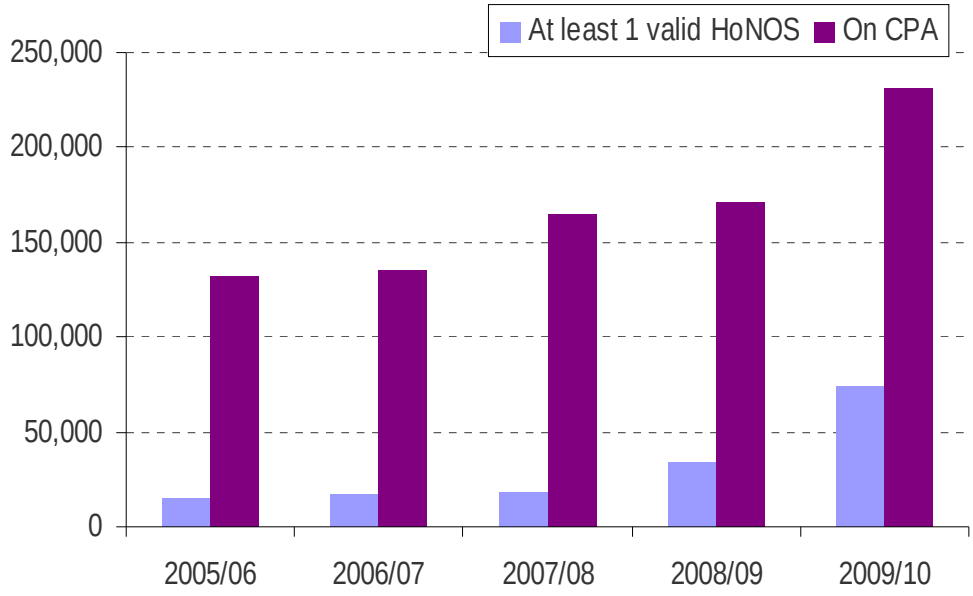
Source: Mental Health Minimum Dataset (MHMDS) annual returns 2005/06-2009/10

Both the DH's service performance framework for non Foundation mental health trusts and the CQC's indicators, which were used in their former Periodic Review for mental health trusts, focus on the recording of HoNOS scores for people on CPA.

HoNOS is a tool for measuring the health and social functioning of people with severe mental illness that was developed by the Royal Society of Psychiatrists. A HoNOS rating is produced by assessing the patient's state in twelve separate scales including 'problems with activities of daily living' and 'non-accidental self-injury', for example. A valid HoNOS record includes a score for each of the separate scales and so the potential number of ways in which the data might be analysed is very large.

Figure 19 below shows that the number of records for people on CPA who had a valid HoNOS record more than doubled between 2008/09 and 2009/10.

Fig 19: Number of people on CPA with at least one valid HoNOS record, by year



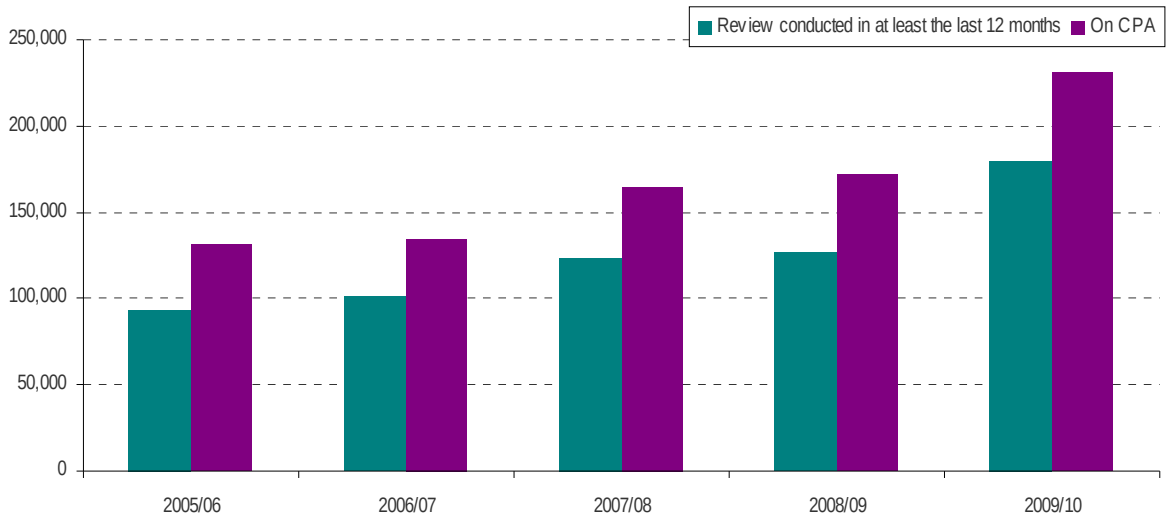
Data source: Table 4 above

Table 4 above shows that of the 74,081 people who had a valid HoNOS record in 2009/10, 64,510 had two separate HoNOS records, and these could potentially be used to measure whether services have helped patients to recover, because they would show changes in the scores for separate scales within the record.

As HoNOS is a component of the Mental Health Clustering Tool planned to support PbR for mental health, the improving quality of the data is encouraging.

The DH service performance framework also includes an indicator to show whether patients on CPA have had a review with their Care Co-ordinator in the last 12 months. Figure 19 below shows a marked increase in the numbers recorded between 2008/09 and 2009/10.

Fig 19: Number of patients on CPA who had a review with their care coordinator in the last 12 months, by year



Data source: Table 4 above

Further work is needed to understand the information requirements of providers and commissioners in relation to people on CPA and outcomes data. Then a method will need to be developed for producing this information from the data.

NHS Specialist Mental Health Service Activity

Uses of service activity data

Since April 2010 the NHS Information Centre has been supplying the NHS Management and Operations Boards with regular information providing an overview of NHS system health, to help in monitoring the NHS response to current economic challenges facing the NHS. Quarterly activity data from MHMDS provides the mental health component of this set of indicators for the 'Quality, Innovation, Productivity and Prevention (QIPP) Dashboard'. The same national and Strategic Health Authority (SHA) level activity data forms part of the routine quarterly MHMDS statistics, released on the NHS Information Centre web site.

These quarterly mental health activity figures provide counts of the basic units of mental health service activity covering inpatient, outpatient and community services. At national level these can be used for year on year comparisons across the service. At provider level the same activity data provides an indication of how local services are configured and, at commissioner level, the data gives some indication of how the local mental health programme budget is being spent. At the most basic level, it will give some indication of the split between inpatient activity, measured by bed days, and community services, using contacts with healthcare staff outside hospital.

This year's annual release includes whole year counts of bed days for the first time, in line with the quarterly releases initiated this year. This data is provided at national and local level and supplements the existing annual analysis on inpatient and community activity. At national level the information is available by age and gender and described below.

New low level aggregate mental health activity data

At local level the data is also available for the first time for individual provider and commissioner combinations in the largest release of all England NHS mental health service activity data ever made. This is low level, aggregate data, in machine readable format and it will enable interested parties to perform their own local level and comparative analysis.

Sample data from the mental health activity file

Annual	Code_of_Provider	IC_MHD_PCT	Bed Days Total Activity	OutPatient Contacts Total Activity	Community Contacts Total Activity
A 2009/10	RV3	5L1	0	0	18
A 2009/10	RV3	5L3	0	1	32
A 2009/10	RV3	5LA	44537	4	20219
A 2009/10	RV3	5LC	62321	12	21853
A 2009/10	RV3	5LD	98	0	329
A 2009/10	RV3	5LE	209	1	133
A 2009/10	RV3	5LF	201	0	52
A 2009/10	RV3	5LG	214	0	258
A 2009/10	RV3	5LH	0	0	18
A 2009/10	RV3	5LQ	22	0	47

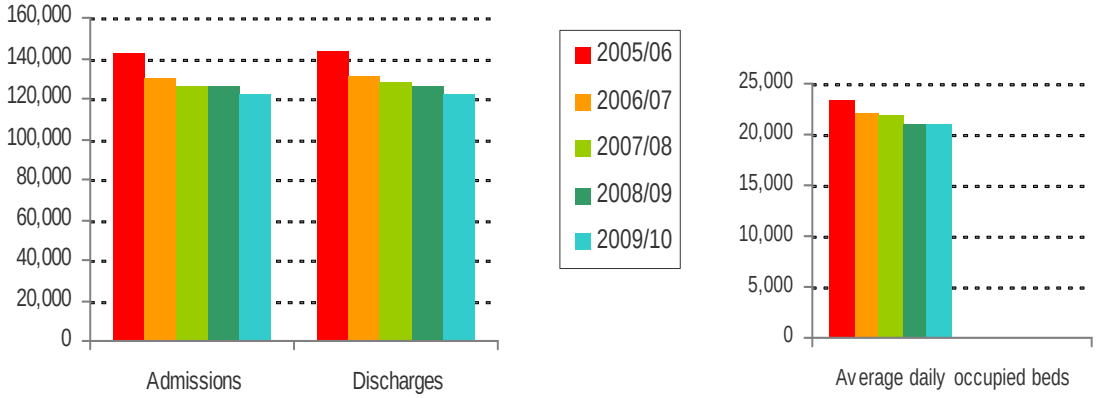
Mental health service activity data from MHMDS has been used this year to develop a new weighted capitation formula for the PCT funding allocations for mental health. The research team commissioned by the Advisory Committee on Resource Allocation (ACRA) at DH to undertake this work produced a dataset of costed mental health service activity for their calculations. This was developed using DH reference costs and MHMDS. The Special Feature at the end of this report includes some information about this work, as well as a description of some of the work undertaken by the NHS Information Centre to map MHMDS to DH reference costs.

Mental health services inpatient activity

The figures for 2009/10 show there was no increase in the number of NHS psychiatric bed days in England despite an extra 5,194 people who spent time in hospital.

The increase in the number of people spending time in hospital in the most recent year's data might be expected to be accompanied by a rise in the number of NHS beds available in mental health services. However, using the average number of daily occupied beds as a proxy for available beds, this year's figures suggest that there has been no increase in NHS capacity. The number of beds in 2009/10 was similar to the previous year at approximately 21,000, as shown in figure 20.

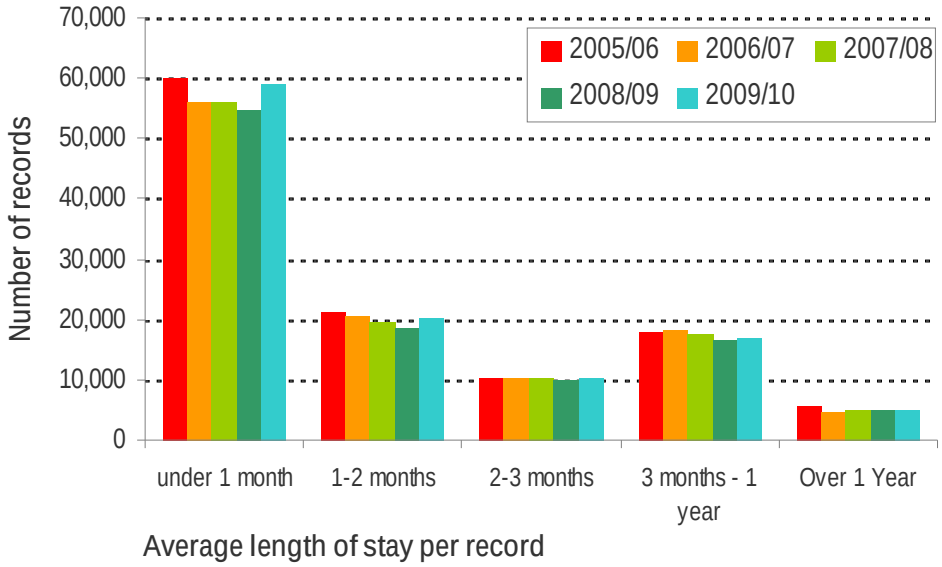
Fig 20: Admissions, discharges and average daily occupied beds, by year



Data source: Table 5.1 in the supporting national reference tables

If the capacity in NHS mental health inpatient services is similar to last year, but more people are spending time in hospital, then patients must be spending fewer days in hospital than last year. Figure 21 shows an increase of about 4,000 in the number of records where the average lengths of stay was less than a month and this could support this premise.

Fig 21: Average length of inpatient stay during the year, per MHMDS record, by year



Data source: Table 4.1 in the supporting national reference tables

Data quality checking of provider level data shows that one trust completely failed to provide information from which a number of admissions could be derived this year and two others provided very incomplete information, and this could explain why the number of admissions, at national level, did not increase as expected. The accompanying Data Quality and Methodology document gives more detail about this data quality issue. Information about the number of bed days used during the year is considered more reliable, however, than information about the number of admissions and discharges as it is derived from different source information.

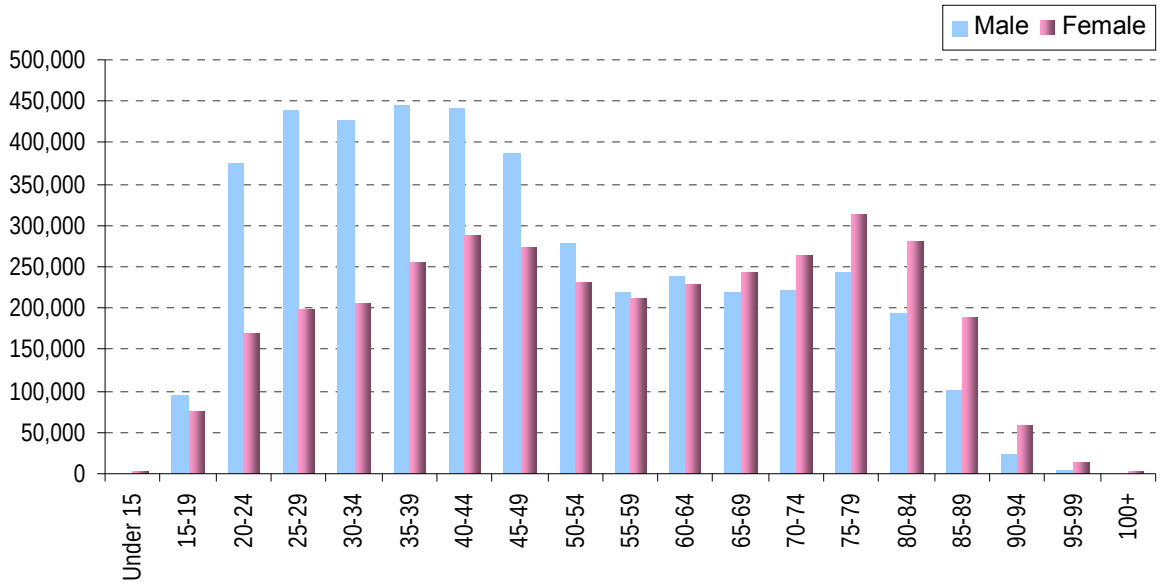
Overall this information suggests there may have been some pressure on beds during 2009/10 and any information which helps providers and commissioners understand the factors involved in longer lengths of stay or higher use of inpatient services will be of interest.

The profile of people spending more days in hospital

As bed days are the most expensive units of mental health activity being able to profile groups of patients who require more prolonged inpatient care could help to highlight areas where changes in practice, for example earlier intervention, might improve care for patients and achieve savings. For context, the DH's reference costs for 2008/09, give the national average unit reference cost for a unit of local psychiatric intensive care at £644 (per day) and a unit of adult acute inpatient care at £288.

Figure 22 below shows the total number of days spent in hospital during the year ('bed days') by age and gender. These figures include time in hospital regardless of whether the hospital stay had finished before the end of the year.

Fig 22: Total bed days by age and gender, 2009/10



Data source: Table 4.2 in the supporting national reference tables

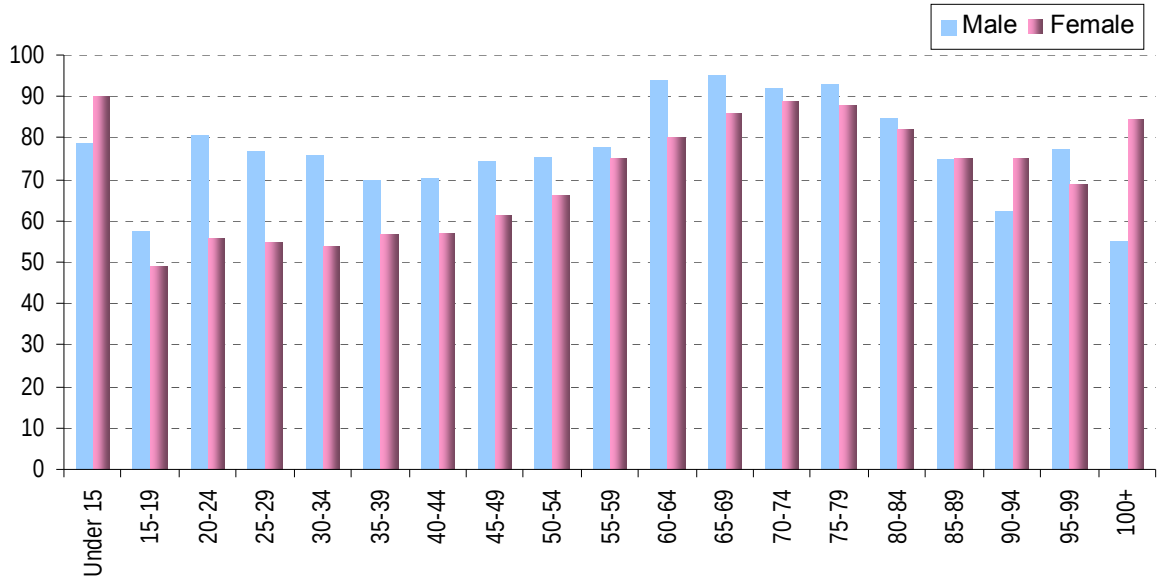
Figure 22 shows very clearly that working age men spent more time in hospital during the year than women. The difference between the number of bed days used by men and women was most striking for people in their 20s. There were 54.3 per cent more men than women who spent time in hospital in this age group (10,346 men compared with 6,703 women, as shown in table 1.3 of the supporting national reference tables), but men in this age group spent twice as many days in hospital in 2009/10 as the women.

Overall 8.4 per cent more men than women spent time in hospital in 2009/10, but they used 24.2 per cent more bed days (as the figures in Table 4.2 of the supporting national reference tables demonstrate).

This suggests that in general, and particularly in younger age groups, men spend more time in hospital than women. This might be because men are less likely to make contact with services before they are seriously ill and are therefore more likely to end up being admitted and spending longer in hospital. Or it could be that men have similar lengths of stay to women but are more likely to be re-admitted, making a greater total time in hospital for the year than women. It might also be because more men than women are detained via the criminal justice system, with longer lengths of detention. There may be other reasons, including diagnosis. Some initial analysis of inpatient activity by diagnosis is included below, but this is an area where further analysis may be developed in a future release.

Figure 23 below shows the average number of bed days for the same age and gender categories and shows that working age adult men in every age band have a higher average number of bed days than women. The men with the highest average number of bed days were those in the 65-69 year age band. Overall the average number of days in hospital per person was 78 for a man compared with 68 for a woman. If every day in hospital costs around a minimum of £300, then a comparatively small reduction in the number of days each person spends in hospital in the year (there were 107,765 people in 2009/10) could result in considerable cost savings.

Fig 23: Mean bed days per person that spent time in hospital, by age and gender, 2009/10



Data source: Table 4.3 in the supporting national reference tables

The move from block commissioning to a more disaggregated currency for mental health (payment per patient, per unit of service activity, or by pathway or 'care cluster') will make commissioners and providers more aware of what care is being delivered for individual patients and enable them to investigate any gaps or blockages in services, and any service outliers. The data could show, for example, patients with unusually long lengths of stay or providers whose patients generally spend longer in hospital.

The Audit Commission used Health Episodes Statistics[6] (HES) data to investigate variations in the use of inpatient beds in mental health services this year and found wide variation in the use of inpatient beds between PCTs, even after adjusting for the needs of different populations. Their paper showed how providers and commissioners might use data to consider whether their acute care pathway was working as efficiently as it could. They also calculated that the equivalent of £215 million per annum could be saved for re-investment in mental health services if all providers could achieve the median rate of bed days (an overall reduction by 15 per cent).

At present the lack of comprehensive information about diagnosis makes it difficult to make useful comparisons of the activity data for individual providers.

[6] Maximising resources in adult mental health, June 2010, Audit Commission

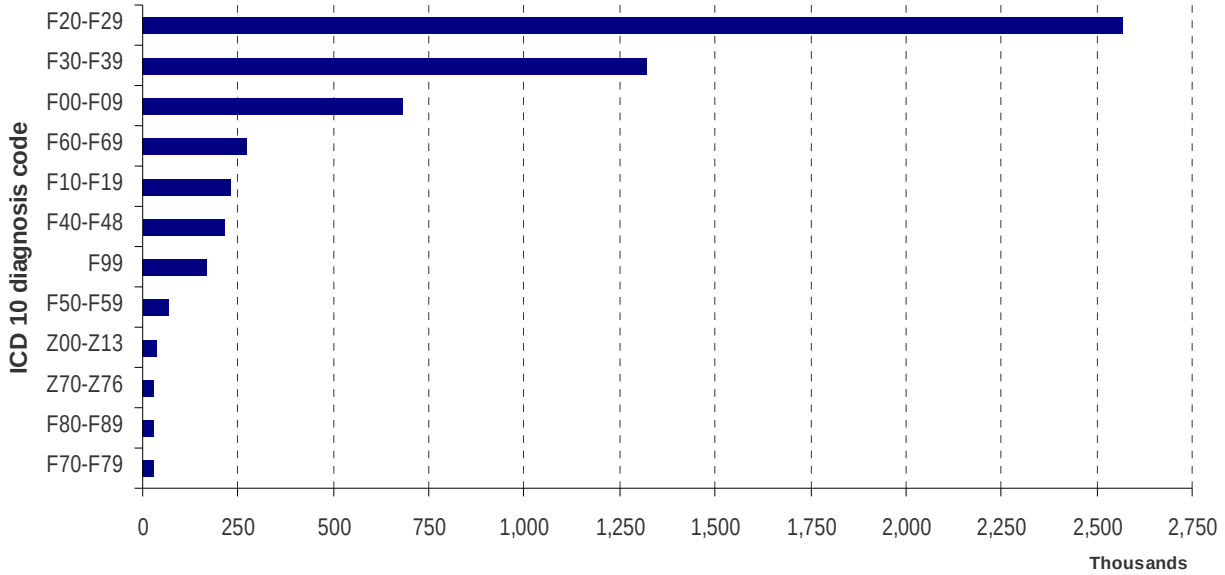
Inpatient activity by diagnosis

Although information about diagnosis is not comprehensive for all inpatients, it is improving (further information about data quality can be found in the annual VODIM data quality reports for 2008/09 and 2009/10 at http://www.ic.nhs.uk/services/mhmds/dq.

In 2009/10 32.7 per cent of the bed days used during the year (over 2.5 million out of a total of approximately 7.9 million bed days in the year, as shown in table 4.4 of the supporting national reference tables) were for people with a diagnosis in the broad ICD10 section 'Schizophrenia, schizotypal and delusional disorders' (F20-F29).

Figure 24 below shows that where records for people who spent time in hospital included diagnosis, people with schizophrenia used by far the most bed days compared with the other main diagnosis sections. It's interesting that for nearly 5.8 per cent of bed days there was a diagnosis that was not a mental health diagnosis.

Fig 24: Bed days by diagnosis, using ICD10 sections, (where the total number of bed days allocated to the ICD10 section was > 20,000), 2009/10



Diagnosis code key

F20-F29 Schizophrenia, schizotypal and delusional disorders
F30-F39 Mood [affective] disorders
F00-F09 Organic, including symptomatic, mental disorders
F60-F69 Disorders of adult personality and behaviour
F10-F19 Mental and behavioural disorders due to psychoactive substance use
F40-F48 Neurotic, stress-related and somatoform disorders
F99 Unspecified mental disorder
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors
Z00-Z13 Persons encountering health services for examination and investigation
Z70-Z76 Persons encountering health services in other circumstances
F80-F89 Disorders of psychological development
F70-F79 Mental retardation
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
Z80-Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status
Z40-Z54 Persons encountering health services for specific procedures and health care
Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z20-Z29 Persons with potential health hazards related to communicable diseases
Z30-Z39 Persons encountering health services in circumstances related to reproduction

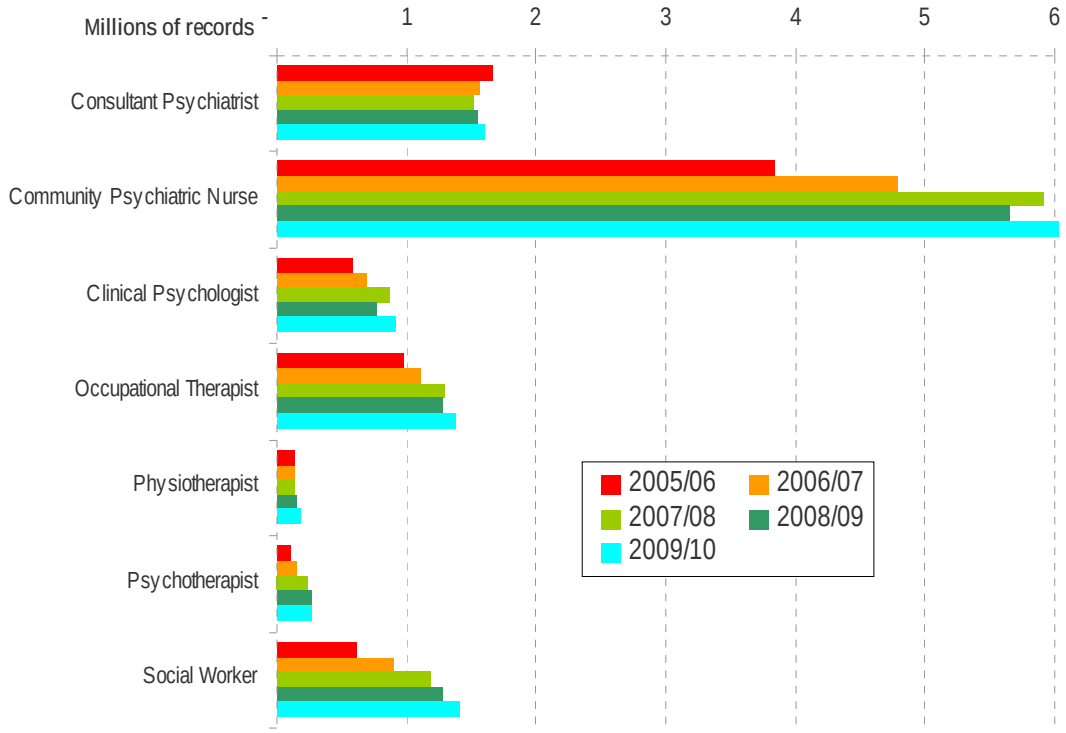
Data source: Table 4.4 in the supporting national reference tables

Community based activity

This release includes the same underlying data tables as in previous years. The counts of contacts with different professional staff groups shown in Table 6.1 of the supporting national reference tables provides a breakdown of the community activity which is now included In the in quarterly MHMDS release.

Figure 25 below shows a breakdown of these categories in the annual data. These figures show that the total number of contacts with health and social care professionals rose overall between 2008/09 and 2009/10 to approximately 12.5 million contacts. This could be due to more comprehensive recording of activity or it could show an increase in activity.

Fig 25: Number of contacts with healthcare professionals, by staff group, by year



Data source: Table 6.1 in the supporting national reference tables

The way in which the MHMDS is currently processed, which provides aggregate counts of contacts for a finite list of staff groups, does not provide much detail about the way services are organised (for example, different types of mental health team) or the sequence of events in a patient's pathway. However these basic metrics do show which patients are in contact with community based services and the volume of service that they received. These shortcomings are due to be addressed in the next version of MHMDS (version 4) and will make it possible to analyse the data in a variety of different ways. For example, the data could potentially show the number of people taken on by early intervention teams, which is information currently provided by PCTs from a different data source.

Comparing inpatient activity with community services

During 2010, we undertook a piece of work to see if it was possible to calculate some kind of price proxy for mental health activity in MHMDS that would assist in making comparisons across the full range of specialist mental health services, for example to compare the volume of services delivered in hospital with the volume delivered in the community. The first part of

the Special Feature that follows describes how this was done. The Special Feature also describes how MHMDS was used to develop a dataset of costed mental health activity for use in the development of a new weighted capitation formula for PCT funding allocations.

Special Feature

1. Using NHS reference costs to develop patient level costing for mental health activity

During 2010, the Mental Health team at the NHS Information Centre undertook a piece of work to see if it was possible to match the NHS reference costs for 2008/09[7], published by the Department of Health, to activity in the Mental Health Minimum Dataset 2008/09 data. The intention was to see if it were possible to develop some kind of price proxy for units of activity recorded in MHMDS that would assist in making comparisons across the full range of specialist mental health services, for example to compare the costs of service delivered in the community with the costs of inpatient services.

The first step was to map currencies in the reference costs to elements of mental health service activity in MHMDS, looking for comparable volumes of activity at provider and at national level. Some elements of mental health reference costs were excluded automatically, because the services are not in the scope of the present MHMDS return: all child codes, non-face-to-face activity, secure units, autistic spectrum disorder and drug & alcohol services, and currencies where the supplier type was COM (Commissioner) and OUT (Non-NHS Provider).

In some cases a one to one mapping was created, and in others a group of reference cost currencies were mapped to a single data element in the MHMDS, as shown below.

Currencies from NHS reference costs for 2008-2009, mapped to MHMDS data items[8]

RC Currency Code	RC Currency Description	MHMDS matching activity
MHIPA1	Adult : Intensive Care	
MHIPA2	Adult : Acute Care	
MHIPA3	Adult : Rehabilitation	
MHIPEDC	Eating Disorder Services : Adults	
MHIPMB	Mother and Baby Units	
SCU2	Low Level Secure Services	
	Total of the above	**MHD_Bed_Days_Mental_Health when IC_Age between 16 and 64**
MHIPE1	Elderly	MHD_Bed_Days_Mental_Health when IC_Age between 65 and 111
SCU1	Local Psychiatric Intensive Care Units	MHD_Bed_Days_Mental_Health_Intensive when IC_Age between 16 and 64
SCU3	Medium Level Secure Services :	MHD_Bed_Days_Mental_Health_Medium _Secure when IC_Age between 16 and 64

[7] NHS Reference Costs 2008-2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111591

[8] Further details of MHMDS data items can be found in the accompany Data Quality and Methodology document

Some elements of MHMDS activity, such as Bed Days, were segmented for different ages before being mapped to relevant reference cost currencies.

Using these principles the following elements of MHMDS service activity were mapped to reference costs: inpatient bed-days and contacts with: consultant psychiatrists, community psychiatric nurses, clinical psychologists, occupational therapists, physiotherapists and consultant psychotherapists.

The next step was to calculate a proxy price from the reference costs. This was done by dividing the total cost of the activity in reference costs that could be mapped to MHMDS activity, by the total MHMDS activity (for example, the total costs for Medium Level Secure services by the number of Medium Secure Bed Days in MHMDS, for people aged 16-64).

$$\frac{\text{sum (Provider unit cost x Provider activity) from DH MH Reference Costs}}{\text{total MHMDS activity}}$$

Using this method a set of price proxies was developed as shown in the figure below:

Price proxies (average unit costs) developed from MHMDS and DH Reference costs, 2008/09

Bed Days

Reference Cost code	MHMDS	Average unit cost
MHIPMHIPA	Adult MHD_Bed_Days_Mental_Health	£310.13
MHIPMHIPE1	Elderly MHD_Bed_Days_Mental_Health	£289.22
MHSUSCU3	Adult MHD_Bed_Days_Mental_Health_Medium_Secure	£480.64
MHSUSCU1	Adult MHD_Bed_Days_Mental_Health_Intensive	£644.65

Outpatient contacts

Reference Cost code	MHMDS	Average unit cost
MHCSOPA	Adult total MHD_Out_Patient_Attendance_Consultant	£166.71
MHCSOPE	Elderly total MHD_Out_Patient_Attendance_Consultant	£178.55

Community contacts

	Average unit cost	
	Adult	Elderly
Community Psychiatric Nurse	£93.99	£135.19
Clinical Psychologist	£129.23	£185.88
Occupational Therapist	£90.07	£129.56
Physiotherapist	£90.07	£129.56
Consultant Psychotherapist	£121.40	£174.62

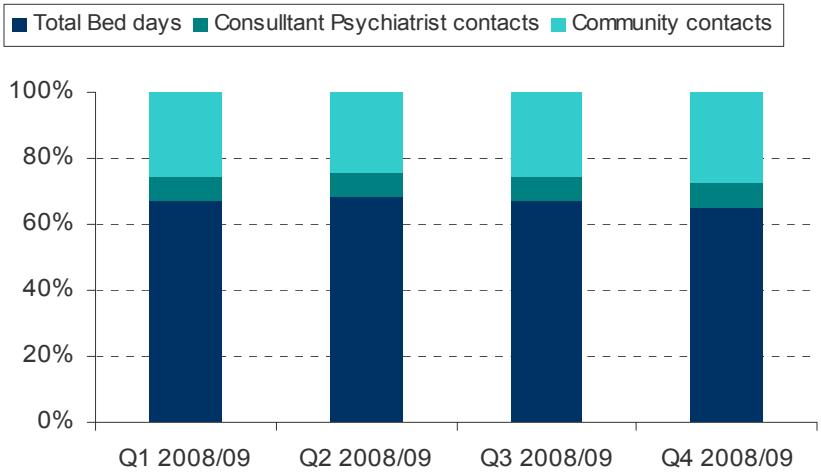
Using these price proxies it's possible to start to make comparisons across the full patient pathway. For example in the table of sample data below a proxy price provides a common unit of measurement across inpatient services and services delivered in the community.

Experimental statistics: mental health activity and costings, by quarter, all providers

Quarter	Total Bed days	Cost	Consulltant Psychiatrist contacts	Cost	Community contacts	Cost
Q1 2008/09	2,019,539	£614,100,111.63	395,411	£65,976,442.22	2,144,711	£231,064,827.12
Q2 2008/09	2,040,756	£623,249,383.88	402,240	£67,172,529.30	2,063,127	£223,442,807.56
Q3 2008/09	1,947,058	£592,927,531.24	391,143	£65,261,261.61	2,082,373	£225,912,142.15
Q4 2008/09	1,798,130	£541,940,637.84	402,851	£67,220,537.27	2,083,648	£225,930,713.41

The price proxies make it possible to show the costs of different elements of mental health services as a proportion of total costs, as shown in the figure below. These experimental figures for 2008/09 show that bed days made up a reducing proportion of the costs of activity between Q1 2008/09 and Q4 2008/09.

Costed mental health service activity, by type of activity, by quarter, 2008/09



No further analysis has been undertaken using MHMDS 2009/10 data as the 2008/09 Reference Costs are the most recent available. Further development work will depend on funding being made available.

This methodology was shared with the research team working on a new formula for the funding allocation for mental health, and part of this work is described in the next section.

2. Using Mental Health Minimum Dataset to develop a new funding formula for mental health services

This feature about use of MHMDS in developing a funding formula for mental health is taken from the full report of the RAMP project[9] which was published by the DH on 15 December 2010 with the NHS Operating Framework and PCT Allocations for 2011-12.

Background

Weighted capitation formulae have been used in England since the 1970s to distribute NHS resources between health care organisations. Under these formulae, more resources are directed to organisations that serve larger populations, older populations, populations with worse health and more socioeconomic deprivation, and that commission services delivered in high cost areas. The information on these factors should be rich, robust and as up-to-date as possible.

The effects of these factors on funding needs are estimated separately for various types of health care, including mental health services and a formula for mental health services was introduced in 1996 and (with an update in 2002) is still in use for distributing funds to PCTs from the DH Mental Health Programme. However, this formula is based on quite out of date information: inpatient services activity from 2000-01 HES, the national average costs per bed-day from the National Reference Cost Schedule 2000 and population characteristics from the 1991 Census.

New data for the formula

Last year the DH's Advisory Committee on Resource Allocation (ACRA) commissioned a group of researchers led by Matthew Sutton, Professor of Health Economics at the University of Manchester, and including MHMDS experts from the NHS Information centre, to estimate new, robust, up-to-date equations for the age and additional needs components of the mental health services formula, taking advantage of more recent data, including MHMDS and the annual Service Mapping dataset The MHMDS contains substantial activity in the community that is not captured in HES and was therefore not considered in previous estimates of the needs component of the mental health services resource allocation formula. This meant that the allocation of funds could not be aligned with current mental health policy, which aims to treat people in the community, avoiding the need for a hospital admission, where possible.

The research team collated up-to-date statistics on cost-weighted utilisation for mental health services, a wide range of potential additional needs variables and small area populations and applied a number of methodologies to this dataset.

They used the service mapping data to construct supply variables and these were augmented with information derived from the *Count Me In Census* [10]and GMS Statistics

[9] RARP Paper 035: Report of the Resource Allocation for Mental health and Prescribing (RAMP) Project
Matthew Sutton,1 William Whittaker,1 Stephen Morris,2 Gyles Glover,3 Mark Dusheiko,4 John Wildman,5 Hugh Gravelle,4 Stephen Burrows,6 Jo Simpson,6 Eduardo Fé-Rodríguez,1 Stephen Birch,1 Peter C. Smith7,
http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515

2004-2008. The method they used for developing cost-weighted data on service utilisation, using MHMDS, is described below.

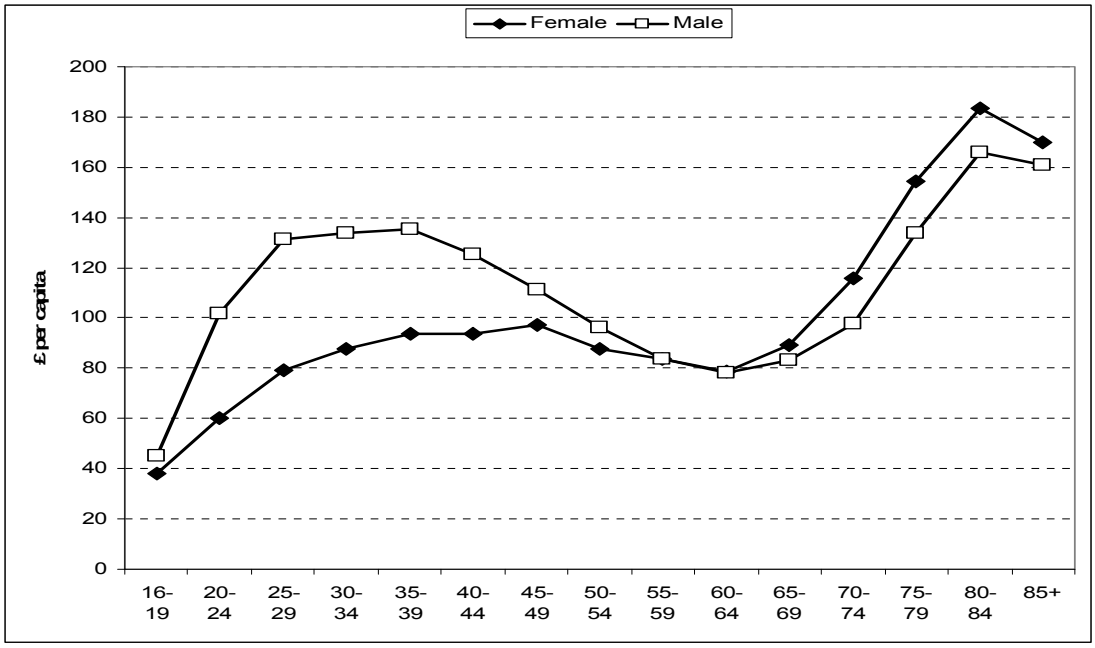
The approach eventually selected by the team for modelling resource allocation for mental health care is a 'utilisation-based' approach, which maps, as far as possible, complete national geographical patterns in the numbers of people using mental health services and the level of their use. It then uses models of the association between these and factors known to be associated with mental health problems to identify and make allowance for highs and lows attributable to extremes of service style or provision rather than population need. Taking such factors into account should support a fairer distribution of funds according to need.

Developing cost weighted service utilisation data

The research team were interested in using MHMDS to supply the utilisation data for their model, because they recognised that mental health services users have different patterns of interaction with services and they needed a way to show this in quantitative detail.

For example, some people have one or a small number of clinic visits to see a single practitioner, whilst other mental health service users receive quite complex packages of care, including time spent in hospital. As MHMDS collates all this information into a single record for each patient, this provides an estimate of all the components of each individual's care, within a given time frame, such as a year. This gives a basis for reasonably comprehensive costing of the NHS input. The figure below shows these summary costings averaged by age and gender. This shows different age profiles of costs for males and females under the age of 65 years. Costs rise with age at a similar rate for males and females amongst the population aged over 65 years.

Average costs per capita by gender and age group, mental health service utilisation



[10] Count Me In Census, published by Care Quality Commission, http://www.cqc.org.uk/guidanceforprofessionals/mentalhealth/countmeincensus.cfm

The research team used seven measures of service utilisation from annual MHMDS records: inpatient bed-days and contacts with: consultant psychiatrists, community psychiatric nurses, clinical psychologists, occupational therapists, physiotherapists and consultant psychotherapists, in combination with demographic details such as age, gender and ethnicity and information derived from the postcode. The data used was annual MHMDS records for 2008/09 and 2007/08.

Costings for this activity were calculated using average costs reported in 2008/9 annual DH Reference Costs[11]. To avoid geographical differences being distorted by variations in the costs of service provision, national average unit costs have been used for each provider. For each type of activity, total costs were rescaled so that the total cost in the dataset equates to the totals for the same activities reported in Reference Costs.

The items included from Reference Costs are: inpatients (adult intensive care, acute care & rehabilitation, elderly services, and specialist services for eating disorders and mother and baby units); consultant services in both outpatient and community settings; the activities of mental health community teams and mental health specialist teams (crisis resolution home treatment teams, assertive outreach teams, early intervention in psychosis services, homeless mental health services, A&E mental health liaison services, crisis accommodation services, emergency duty teams and emergency clinics/walk in clinics); and some mental health secure units (local psychiatric intensive care units, low level secure services and medium level secure services). This represents £4.4bn of NHS expenditure in 2008/09.

The following expenditure was excluded from the analysis: activity in primary care (which represents approximately £1.4bn of £10.8bn PCT spend on mental health[12]) and services commissioned by Local Authorities (approximately £1.9bn[13]) The following lines from Reference Costs were also excluded: child and adolescent services (£476m), high secure care (£215m), drug and alcohol services (£244m), autism (£0.8m) and day care facilities (£167m), and non-NHS provided services (£204m) because these items were either not included in MHMDS or, for day care facilities, the data were not considered sufficiently robust.

The seven measures of service utilisation from MHMDS are included in the routine annual statistics produced from MHMDS as inpatient and community activity and are included in the routine quarterly MHMDS releases.

[11] As Reference Costs do not distinguish between contacts with different types of community staff these were proxied by their relative unit costs reported by PSSRU (PSSRU, 2009). No figures are reported for psychotherapists by PSSRU, so psychotherapy contacts were costed using a weighted average of unit costs for Occupational Therapists and Clinical Psychologists. The weights reflected the distribution of the three staff groups across Agenda for Change bands reported in the Service Mapping dataset.

[12] http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

[13] http://www.mentalhealthstrategies.co.uk/go/autumnreview/documents/FMGuide2009.pdf

Recommendations

As a result of their work, the research team has made recommendations to ACRA for a new formula, which takes account of factors that were shown to have a positive correlation with service usage, including work incapacity due to a mental health diagnosis, mortality rates where a mental health condition is recorded and the proportion of the population from Black ethnic groups. A separate model for people over the age of 65 also factors in information about benefits and income deprivation.

Appendices

National reference tables

Table	Title
Table 1.1	Number of people using adult and elderly NHS secondary mental health services, 2003/04 - 2009/10
Table 1.2	Number of people using adult and elderly NHS secondary mental health services by gender and age, 2005/06 - 2009/10
Table 1.3	Number of people using adult and elderly NHS secondary mental health services by 5 year age band and gender, 2009/10
Table 1.4	Number of people using adult and elderly NHS secondary mental health services by ethnic group, 2005/06 - 2009/10
Table 1.5	Rates of access to adult specialist mental health services per 100,000 population by ethnic group, 2009/10
Table 1.6	Rates of access to hospital inpatient care per 100 mental health service users, by ethnic group, 2009/10
Table 2.1	Most restrictive legal status of people who were inpatients during the year, 2005/06 - 2009/10
Table 2.2	Number of people detained in hospital under the Mental Health Act 1983 by legal status, gender and age, 2005/06 - 2009/10
Table 2.3	Number of people detained in hospital under the Mental Health Act 1983 by legal status and ethnic group, 2005/06 - 2009/10
Table 2.4	Number of people on Supervised Community Treatment (SCT) at 31st March 2009/10 by number of days on SCT, CPA status, gender and age
Table 2.5	Number of people on Supervised Community Treatment (SCT) at 31st March 2009/10 by number of days on SCT, CPA status and broad ethnic group
Table 3.1	The number of people accessing services and those on CPA, 2005/06 - 2009/10
Table 3.2	The number of people on CPA by gender and age, 2005/06 - 2009/10
Table 3.3	The number of people on CPA by ethnic group, 2005/06 - 2009/10
Table 4.1	Average length of stay in psychiatric hospital, per record, by year, 2005/06 - 2009/10
Table 4.2	In year bed days by age and gender, 2009/10
Table 4.3	Mean in year bed days by age and gender, 2009/10
Table 4.4	Bed days by diagnosis, using ICD10 sections, 2009/10
Table 5.1	Inpatient activity by year, 2005/06 - 2009/10
Table 5.2	Admissions and discharges by gender and age, 2009/10
Table 6.1	Outpatient and community activity by year, 2005/06 - 2009/10
Table 7.1	Team type for care spells which included a CPA review, 2005/06 - 2009/10

Organisation level data tables

Table	Title
Table 1a	Number of people using adult and elderly NHS secondary mental health services by mental health provider, 2008/09 - 2009/10
Table 1b	Number of people using adult and elderly NHS secondary mental health services by NHS commissioner, 2008/09 - 2009/10
Table 1c	Rates of access to adult specialist mental health services per 100,000 population by PCT, 2009/10
Table 1d	Rates of access to hospital inpatient care per 100 mental health service users, by PCT, 2009/10
Table 2a	Number of people detained in hospital under the Mental Health Act 1983 by mental health provider, 2008/09 - 2009/10
Table 2b	Number of people detained in hospital under the Mental Health Act 1983 by NHS commissioner, 2008/09 - 2009/10
Table 3a	The number of people on CPA by mental health provider, 2008/09 - 2009/10
Table 3b	The number of people on CPA by NHS commissioner, 2008/09 - 2009/10
Table 3c	The settled accommodation indicator recorded for adults aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach, by mental health provider, 2008/09 - 2009/10
Table 3d	The settled accommodation indicator recorded for adults aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach, by NHS commissioner, 2008/09 - 2009/10
Table 3e	The employment status recorded for adults aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach, by mental health provider, 2008/09 - 2009/10
Table 3f	The employment status recorded for adults aged 18 to 69 who are receiving secondary mental health services, who are on the Care Programme Approach, by NHS commissioner, 2008/09 - 2009/10
Table 4a	Average length of stay in psychiatric hospital, per record, by mental health provider, 2008/09 - 2009/10
Table 4b	In year bed days by gender and mental health provider, 2009/10
Table 4c	In year bed days by gender and NHS commissioner, 2009/10
Table 5a	Inpatient activity by mental health provider, 2008/09 - 2009/10
Table 5b	Inpatient activity by NHS commissioner, 2008/09 - 2009/10
Table 6a	Outpatient and community activity by mental health provider, 2008/09 - 2009/10
Table 6b	Outpatient and community activity by NHS commissioner, 2008/09 - 2009/10
Table 7a	Team type for care spells which included a CPA review, by mental health provider, 2008/09 - 2009/10
Table 7b	Team type for care spells which included a CPA review, by NHS commissioner, 2008/09 - 2009/10

Trusts that submitted an annual MHMDS return 2003-2010

Mental health provider		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
5AN	NORTH EAST LINCOLNSHIRE PCT			✔	✔	✔		
5AT	HILLINGDON PCT	✔	✔	✔				
5CD	NORTH DORSET PCT	✔	✔	✔				
5CN	HEREFORDSHIRE PCT	✔	✔	✔	✔	✔	✔	✔
5CQ	MILTON KEYNES PCT	✔	✔	✔	✔	✔	✔	✔
5CY	WEST NORFOLK PCT	✔	✔	✔				
5DD	MORECAMBE BAY PCT	✔	✔	✔				
5E2	SELBY AND YORK PCT	✔	✔	✔	✔			
5EF	NORTH LINCOLNSHIRE PCT			✔	✔	✔		
5F1	PLYMOUTH TEACHING PCT	✔	✔	✔	✔	✔	✔	✔
5FD	EAST HAMPSHIRE PCT	✔	✔	✔				
5FE	PORTSMOUTH CITY TEACHING PCT	✔	✔	✔	✔	✔	✔	✔
5HV	DUDLEY BEACON AND CASTLE PCT	✔	✔	✔				
5JE	BARNSLEY PCT	✔	✔	✔	✔	✔	✔	✔
5KH	HAMBLETON AND RICHMONDSHIRE PCT	✔	✔	✔	✔			
5KJ	CRAVEN, HARROGATE AND RURAL DISTRICT PCT	✔	✔	✔	✔			
5M2	SHROPSHIRE COUNTY PCT	✔		✔	✔			
5M3	WALSALL TEACHING PCT	✔	✔	✔	✔	✔		
5MD	COVENTRY TEACHING PCT	✔	✔	✔	✔			
5MP	NORTH WARWICKSHIRE PCT	✔	✔	✔	✔			
5MQ	SOUTH WARWICKSHIRE PCT	✔	✔	✔	✔			
5MV	WOLVERHAMPTON CITY PCT	✔	✔	✔	✔	✔	✔	✔
5NV	NORTH YORKSHIRE AND YORK PCT					✔	✔	✔
5PE	DUDLEY PCT				✔	✔		
5QM	DORSET PCT				✔	✔	✔	✔
5QT	ISLE OF WIGHT NHS PCT							✔
RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RDR	SUSSEX COMMUNITY NHS TRUST	✔	✔	✔				
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RGD	LEEDS PARTNERSHIPS NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RKL	WEST LONDON MENTAL HEALTH NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RMY	NORFOLK AND WAVENEY MENTAL HEALTH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RNK	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RNN	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RNP	NEWCASTLE, NORTH TYNESIDE AND NORTHUMBERLAND MENTAL HEALTH NHS TRUST	✔	✔	✔				
RNU	OXFORDSHIRE AND BUCKINGHAMSHIRE MENTAL HEALTH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RPG	OXLEAS NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RR2	ISLE OF WIGHT HEALTHCARE NHS TRUST	✔	✔	✔	✔	✔	✔	
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RRD	NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔

Mental health provider		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
RT2	PENNINE CARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RT6	SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RTC	COUNTY DURHAM AND DARLINGTON PRIORITY SERVICES NHS TRUST	✔	✔	✔				
RTJ	SURREY HAMPSHIRE BORDERS NHS TRUST	✔	✔					
RTM	EAST KENT NHS AND SOCIAL CARE PARTNERSHIP TRUST	✔	✔	✔				
RTN	SURREY OAKLANDS NHS TRUST	✔	✔					
RTQ	2GETHER NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RTV	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RV7	BEDFORDSHIRE AND LUTON MENTAL HEALTH AND SOCIAL CARE PARTNERSHIP NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RV9	HUMBER NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RVX	TEES AND NORTH EAST YORKSHIRE NHS TRUST	✔	✔	✔				
RW1	HAMPSHIRE PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RW4	MERSEY CARE NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RW7	NORTH WEST SURREY MENTAL HEALTH NHS PARTNERSHIP TRUST	✔	✔					
RW8	WEST SUSSEX HEALTH AND SOCIAL CARE NHS TRUST	✔	✔	✔				
RW9	SOUTH OF TYNE AND WEARSIDE MENTAL HEALTH NHS TRUST	✔	✔	✔				
RWC	DONCASTER AND SOUTH HUMBER HEALTHCARE NHS TRUST	✔						
RWK	EAST LONDON NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RWN	SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RWQ	WORCESTERSHIRE MENTAL HEALTH PARTNERSHIP NHS	✔	✔	✔	✔	✔	✔	✔
RWR	HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RWT	BUCKINGHAMSHIRE MENTAL HEALTH NHS TRUST	✔		✔				
RWV	DEVON PARTNERSHIP NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST				✔	✔	✔	✔
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST				✔	✔	✔	✔
RX4	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST				✔	✔	✔	✔
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RXD	EAST SUSSEX COUNTY HEALTHCARE NHS TRUST	✔	✔	✔				
RXE	ROTHERHAM, DONCASTER AND SOUTH HUMBER MENTAL HEALTH NHS FOUNDATION TRUST		✔	✔	✔	✔	✔	✔
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RXJ	WEST KENT NHS AND SOCIAL CARE TRUST	✔	✔	✔				
RXM	DERBYSHIRE MENTAL HEALTH SERVICES NHS TRUST	✔	✔	✔	✔	✔	✔	✔
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RXV	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST			✔	✔	✔	✔	✔
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST				✔	✔	✔	✔
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST				✔	✔	✔	✔
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST						✔	✔
TAD	BRADFORD DISTRICT CARE TRUST	✔	✔	✔	✔	✔	✔	✔
TAE	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	✔	✔	✔	✔	✔	✔	✔
TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
TAH	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
TAJ	SANDWELL MENTAL HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	✔	✔	✔	✔	✔	✔	✔
TAN	NORTH EAST LINCOLNSHIRE CARE TRUST PLUS						✔	✔

Feedback from users of MHMDS

In Spring 2010 we conducted a review of the third Mental Health Bulletin published in November 2009. A questionnaire was sent to a selection of stakeholders and all MHMDS data providers.

Of those questionnaires returned 90 per cent were aware of the Bulletin, 80 per cent found the level of detail about right, 50 per cent found it very useful, and 20 per cent found it fairly useful.

Comments received on which part of the Bulletin were most relevant included:

'Having just used the MHMDS I would like to say that I found it very useful in providing an overview of the organisations performance'.

'The information is fascinating for someone like me trying to benchmark and plan services'.

'The MHMDS is a quantum step forward in terms of mental health data, including the potential for analysis that the information about ethnicity offers'.

The following comments were received on the proposals for the fourth bulletin:

'Service managers would prefer to see that sort of comparison in the bulletin rather than an overview position which doesn't really mean much on its own, particularly in light of the issues'.

'They seem to represent an advance. I am very supportive of what the bulletin represents, and I think it is essential to promote the potential value of the data'.

'Age and gender have profound effects on all epidemiological measures, and standardisation for them is pretty much the norm - so glad to see the IC moving down that route'.

As a result of the consultation we added the age and gender standardised rates in this release.

A new version of MHMDS (version 4) has been submitted to the NHS Information Standards Board for approval. The proposed changes are designed to support Payment by Results for mental health and address some of the recommendations arising from the Mental Health Information Review undertaken by the NHS Information Centre in 2008.

New arrangements for processing the data will be implemented for the new version of the data standard and these will provide more detailed and granular information about the care pathway of mental health service users. This means that after 2010/11 there may be new analyses in this annual release and some existing analysis may be discontinued.

Mental Health Information from NHS Information Centre

The Adult Psychiatric Morbidity Survey 2007: results of a household survey
http://www.ic.nhs.uk/pubs/psychiatricmorbidity07

In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/10 (KP90 collection)
http://www.ic.nhs.uk/pubs/inpatientdetmha0910

Mental Health Bulletin, Third Report from MHMDS annual returns, 2004-2009
MHMDS Statistics: Data Quality and Methodology
http://www.ic.nhs.uk/pubs/mhbmhmds0809

MHMDS Online:
http://www.mhmdsonline.ic.nhs.uk/

MHMDS Data Tables from annual data:
http://www.ic.nhs.uk/pubs/mhbmhmds/dd

Mental Health Minimum Dataset and data quality reports:
http://www.ic.nhs.uk/services/mhmds/dq

Mental Health section of the IC web site:
http://www.ic.nhs.uk/services/mental-health

MHMDS Specifications:
Includes input specification for the Intermediate Database, details of the MHMDS output dataset and guidance for Trusts
http://www.ic.nhs.uk/services/mental-health/mental-health-minimum-dataset-mhmds/specifications-and-guidance

Routine Quarterly MHMDS Reports:
http://www.ic.nhs.uk/services/mhmds/quarterly

Glossary of Abbreviations

BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CPA	Care Programme Approach
CQC	Care Quality Commission
CTO	Community Treatment Order
DH	Department of Health
HES	Health Episodes Statistics
HoNOS	Health of the Nation Outcomes Scale
	ADL Problems with activities of daily living
	BEH Overactive, aggressive, disruptive of agitated behaviour
	COG Cognitive Problems
	DEP Problems with depressed mood
	DIS Physical illness or disability problems
	DSH Non accidental self injury
	HAL Problems associated with hallucinations or delusions
	LIVC Problems with living conditions
	OCC problems with occupation and activities
	OTH Other symptoms
	RELS Problems with relationships
	SUBS Problem drinking or drug taking
IC	NHS Information Centre for Health and Social Care
KP90	Annual data collection which provides aggregate source data for the *In-patients formally detained in hospitals under the Mental Health Act 1983* annual bulletin.
MHA	Mental Health Act 1983 – covers matters relating to the treatment of mentally disordered people and provides the legislation by which people suffering from a mental disorder can be detained in hospital and have their disorder assessed or treated against their wishes
MHMDS	Mental Health Minimum Dataset
MH Services	Mental Health Services. Means NHS Services for working age adults and people aged 65 and over with severe and enduring mental health problems.
NHS providers	Trusts that provide specialist mental health services for working age adults and people over the age of 65 who should submit the MHMDS
ONS	Office for National Statistics
PBR	Payment By Results
PCT	Primary Care Trust
SCT	Supervised Community Treatment
SHA	Strategic Health Authority

Related links

- Care Quality Commission
  http://www.cqc.org.uk/
  The Care Quality Commission is the new health and social care regulator for England.

- Count Me In census, 2009
  http://www.cqc.org.uk/guidanceforprofessionals/mentalhealth/countmeincensus/countmeincensus2009.cfm

- Department of Health NHS Reference Costs
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111591

- Developing Payment by Results for mental health
  http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_4137762
  The Department of Health's pages on Payment by Results for mental health

- HoNOS Assessments, The Royal College of Psychiatrists
  http://www.rcpsych.ac.uk/quality/honos/secure.aspx
  HoNOS-secure *version 2b* is the latest version of what was previously known as HoNOS-MDO*. It is specifically designed for use in health and social care settings such as secure psychiatric, prison health care and related forensic services, including those based in the community.

- Hospital Episodes Statistics (HES) Online
  http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
  HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

- Improving Access to Psychological Therapies (IAPT)
  www.iapt.nhs.uk
  The Improving Access to Psychological Therapies programme aims to improve access to evidence based talking therapies in the NHS through an expansion of the psychological therapy workforce and services.

- Maximising resources in adult mental health, June 2010, Audit Commission
  http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/100623maximisingresources.aspx

- Mental Health Act 1983
  http://www.cqc.org.uk/guidanceforprofessionals/mentalhealth/workingwithpeoplewhoserightsarerestricted/mentalhealthact1983.cfm
  The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.

- Monitoring the use of the Mental Health Act in 2009/10, Care Quality Commission
  http://www.cqc.org.uk/_db/_documents/CQC_Monitoring_the_use_of_the_Mental_Health_Act_in_200910_Main_report_Tagged.pdf

- NHS Data Dictionary
  http://www.datadictionary.nhs.uk/
  The NHS Data Model and Dictionary provides a reference point for assured information standards to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS.

- National Statistics Code of Practice
  http://www.ons.gov.uk/about-statistics/ns-standard/cop/index.html
  Code of Practice for Statistics that sets out the professional standards which official statistics are expected to me

- Office for National Statistics Mid-2009 Population Estimates
  http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

- Office for National Statistics Mid-2007 Population Estimates by Ethnic Group
  http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14238&Pos=3&ColRank=2&Rank=192

- Patterns of Specialist Mental Health Service Usage in England, ONS
  http://neighbourhood.statistics.gov.uk/dissemination/Info.do?page=analysisandguidance/analysisarticles/patterns-of-specialist-mental-health-service-usage-in-england.htm

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