



52: Adult and older adult mental health services 2012-2016

An analysis of Mental Health NHS Benchmarking Network data for England and Wales

Summary

This report summarises the results of a collaboration between Centre for Mental Health and the NHS Benchmarking Network. The NHS Benchmarking Network (NHSBN) is a member-based organisation of NHS commissioners and providers who collect and analyse data on health care services across the NHS. NHSBN have made their mental health data available to the Centre to provide an independent commentary on what the data suggests about secondary NHS mental health provision in England and Wales.

The data shows a sustained decrease in the number of adult acute inpatient beds for all but the last year that data was collected. This is continuing a trend over a number of decades.

While bed numbers have fallen in recent years, the number of admissions and lengths of stay in hospital have not. And the proportion of people admitted under the Mental Health Act has risen year on year.

This has put greater pressure on inpatient units, resulting in higher bed occupancy rates, consistently

above the levels recommended by the Royal College of Psychiatrists.

Overall community mental health team provision in secondary care reduced slightly between 2012/13 and 2015/16. However towards the end of the period, early intervention and crisis services grew again in response to national policy developments.

The last five years have witnessed a shift in care provision for people with common mental health problems with over 900,000 people in England now supported through new primary care services such as the Improving Access to Psychological Therapies initiative.

The data we analysed covers the five years prior to the introduction of the *Five Year Forward View for Mental Health* in England and offers a snapshot of the development of community and inpatient services up to that point.



Executive Summary

The NHS Benchmarking Network has been collecting data on adult mental health services in England and Wales every year since 2012/13. This data has been analysed by Centre for Mental Health to identify trends and patterns over that time and to compare it with wider evidence about mental health services.

The data shows a sustained decrease in the number of adult acute inpatient beds for all but the last year that data was collected. This is continuing a trend over a number of decades.

While bed numbers have fallen in recent years, the number of admissions and lengths of stay in hospital have not. And the proportion of people admitted under the Mental Health Act has risen year on year.

This has put greater pressure on inpatient units, resulting in higher bed occupancy rates, consistently above the levels recommended by the Royal College of Psychiatrists.

There has been no consequent increase in the provision of community mental health services to offset the reduction in bed availability in the last five years. Generic community mental health team provision fell slightly during this period.

There have, however, been changes in the types of community service available. Early Intervention in Psychosis (EIP) and Crisis Resolution and Home Treatment (CRHT) teams both reduced early in the period and then increased towards the end following the introduction of access and waiting time standards for first episode psychosis and the Crisis Care Concordat. Assertive Outreach teams have diminished in many parts of the country. Assessment and Brief Intervention teams, meanwhile, have grown significantly in recent years.

Most specialist mental health services are not subject to specific waiting times targets for non-urgent care. Most recent data from NHSBN

suggests around 90% of service users receive treatment within 18 weeks of referral and 50% receive treatment within 4 weeks of referral.

The predominant focus of government investment in mental health care during the period was the Improving Access to Psychological Therapies programme, mostly for people with common mental health problems. Through this programme, some 900,000 people received psychological therapy through the NHS in 2015/16.

Some areas are investing in primary care mental health provision for people who fall below the thresholds for secondary services or who no longer require such intensive support. There is as yet little or no national data about the size, scope or outcomes achieved by these services.

Significant changes are also happening in older adult mental health services, with a marked shift away from inpatient and community mental health service provision towards greater provision of memory services for those with dementia.

Without a clear national blueprint for community mental health care, a current lack of robust and comparable data about the types of support available is making it increasingly difficult to assess the state of secondary mental health services and the growing number of primary care based alternatives. NHS England is undertaking a review of community mental health services at the time of writing, which may provide further evidence on the changing shape of services and a clear direction for further development.

NHS England and NHS Wales have both published recent strategies for improving mental health services. The successful delivery of NHS England's *Five Year Forward View for Mental Health* and NHS Wales' *Together for Mental Health Delivery Plan 2016-19* will be essential to providing increased resilience in mental health services across the two nations.

Introduction

The NHS Benchmarking Network (NHSBN) is a membership organisation, which undertakes benchmarking review and analysis of health care metrics in the UK. All NHS mental health service providers in England and all Health Boards in Wales are current members of the Network. The Network has been collecting data on adult mental health services annually since 2012/13, providing a unique time series from the past five years of activity, staffing and quality.

Centre for Mental Health has worked with the Network to analyse the data from the last five years in order to build up a picture of how mental health services have been changing during that time, alongside what we know from other reports on service and policy developments.

This briefing aims to support future policy and practice development in adult mental health services by giving an evidence-based ‘from the ground’ report on how they are evolving across England and Wales. Central to this briefing is access to the data collected by the NHSBN which provides a strong empirical foundation to the work. Centre for Mental Health have provided an independent interpretation of the NHSBN’s data. The work has also benefited from an independent clinical review provided by Dr Parashar Ramanuj, an NHS Consultant Psychiatrist and health services researcher.

The briefing focuses mainly on acute inpatient care and community mental health services for working age adults. These make up the largest part of the activity of secondary mental health services for adults in England and Wales. It does not focus in detail on specialised services (such as secure care), on Improving Access to Psychological Therapies (IAPT) services or on primary care mental health provision.

Policy context

In an ongoing effort to ‘deinstitutionalise’ mental health care in England and Wales, policy initiatives have for decades consistently encouraged the development of

multidisciplinary community mental health teams (CMHTs). The intention was that this would reduce the number of inpatient beds required and enable people with severe and enduring mental health problems to live more independently with only occasional use of hospital services. The 1999 National Service Framework (NSF) introduced a number of additional ‘functional’ community teams, including crisis resolution and home treatment (CRHT), early intervention in psychosis (EIP) and assertive outreach (AO) (Department of Health, 1999) to meet specific needs, based on models developed in the US and Australia. These were backed up with significant extra funding following the 2000 NHS Plan, which also set targets for the creation of the new teams across England. The NSF ended in 2009 which has led to a growing diversity in the types of community provision. The move away from fidelity to the models outlined in the NSF has been most evident with Assertive Outreach teams. Recent national initiatives in England including the Crisis Care Concordat and first episode psychosis access target have helped to reinforce functional teams for crisis care and early intervention.

After the NSF period, the focus of policy shifted from secondary mental health services to meeting the needs of adults with common mental health problems. This resulted in the creation of the Improving Access to Psychological Therapies (IAPT) programme in 2008, which continued to expand throughout the period covered by this briefing (between 2012 and 2016) and which is now being extended further. The IAPT programme is the largest of its kind and now provides psychological therapy to 900,000 people a year in England, with plans to increase that number to 1.5 million annually by 2020/21.

Since 2010, mental health policy has had an increasingly high profile and spawned a wide range of government initiatives. The Coalition Government’s strategy *No health without mental health* (Department of Health, 2011) called for parity of esteem between mental and

physical health for the first time and set out a range of ambitions but with less detail about implementation than the NSF (Bell, 2016). Subsequently, *Preventing suicide in England: A cross-government outcomes strategy to save lives* (Department of Health, 2012) set out a new national strategy for preventing loss of life through suicide; the Crisis Care Concordat was developed in 2014 to lead the improvement of crisis care (Department of Health, 2014); and in the same year an action plan was published to establish the first of a planned series of access and waiting time standards for mental health services.

More recently, NHS England established an independent Taskforce to draw up a *Five Year Forward View for Mental Health*. The report of the Mental Health Taskforce (2016) was accepted by the Government and a detailed implementation plan was developed (NHS England, 2016) which outlined the actions required to deliver the strategy. The implementation plan contains objective targets against which achievement of the strategy can be measured.

Central to this plan are specific targets for enhancing the mental health workforce. The NHS's plans for achieving these were later published in a workforce strategy (Health Education England, 2017). Data from NHSBN from 2013 onwards confirms a mental health workforce that has not grown in recent years (with the exception of the IAPT programme) and identifies the degree of challenge in delivering the workforce targets in the *Five Year Forward View for Mental Health*.

In Wales, the publication of *Together for Mental Health* in 2012 announced a 10-year strategy for improving mental health and wellbeing, and improving the care and treatment of mental health service users and their families. The Social Services and Wellbeing (Wales) Act of 2014 establishes the legal framework for the mental health strategy in Wales, which provides an additional entitlement to a mental health assessment through the Welsh *Mental Health Measure*.

Throughout this time, there has also been a growing focus on meeting the needs of people

with mental health problems in the criminal justice system (following the 2009 Bradley Report), those in general hospitals being treated for physical illness and injury (through the development of liaison psychiatry services) and, more recently, a greater focus has been placed on children and young people's mental health. The latter is the subject of separate data collection by the Network.

Scope of the data analysed

The focus of this report is adult acute inpatient services and community mental health teams in secondary mental health services, as these are the main areas of activity and spend in secondary care.

Inpatient mental health provision within the NHS can be categorised as "acute" or "specialist". Acute admission beds are typically split by age, serving either working age adults (adult acute beds) or adults aged 65 years and older (older adult acute beds). A small number of providers operate ageless services where condition, rather than age, is the deciding factor for ward of admission, however this is not the norm.

On average, 35% of an NHS mental health provider's beds are general acute inpatient beds for working age adults, 21% are for older people and 44% cover a range of specialist services (including Psychiatric Intensive Care, Eating Disorder, Perinatal, Forensic, Rehabilitation and Continuing Care). The specialist bed complement of an individual provider will vary depending on historic commissioning decisions and local demand and supply. As a result of that variation, specialist inpatient services have not been included in this analysis.

Across England and Wales, the Benchmarking Network's data shows that around 780,000 adults are supported by specialist community mental health services at any one time. By comparison, in March 2016 there were 21,573 NHS mental health inpatient beds. At any one time, therefore, approximately 97% of secondary care mental health service users are supported in a community setting.

The term “community mental health services” can be interpreted in different ways. For our purpose, community mental health services are defined as those that support people with severe and enduring mental illness outside of a hospital. These services are organised in the form of teams, the most common of which are ‘generic’ community mental health teams but with a range of others including the three ‘functional’ team types introduced following the 1999 National Service Framework. The team types recorded by the Network include:

- Community Mental Health Teams (generic CMHTs);
- Crisis Resolution and Home Treatment (CRHT);
- Assertive Outreach;
- Early Intervention (including early onset psychosis);
- Assessment and Brief Intervention (including Primary Mental Health Teams);
- Rehabilitation and Recovery;
- Older People CMHT;
- Memory services;
- Other adult community mental health teams.

Data collection

The NHSBN’s data collection is undertaken on an annual basis during later spring and early summer, and collects a financial year end position. Metrics cover both inpatient and community services, and include activity, workforce, finance and quality measures. Core items remain consistent from year to year, and new questions are introduced to collect data relating to emerging national priorities.

Each year, data is collected directly from participant NHS Trusts and Health Boards which provide inpatient and community mental health care. Clear definitions of data items are supplied, and a helpline runs during the collection period to support organisations and encourage consistency in interpretation. During a validation process, participants review their data and revise their submission if required. Following this, results are finalised and published at a national level.

Adult acute inpatient services (16-64)

Beds

Data for adult acute beds shows that from 2012/13 to 2015/16 there was a 15% reduction in bed numbers, from a median of 23 beds per 100,000 population to 19.6.

Year	Adult Acute beds per 100,000 population	Reduction from 2012/13
2012/13	23	
2015/16	19.6	-15%

In contrast to reductions in beds, admissions only reduced by 4% during this time. Lengths of stay also remained at similar levels, rising slightly from 32.0 days on average to 33.4. It therefore appears that the substantial fall in bed numbers has been offset predominantly by increasing bed occupancy levels. Bed occupancy for adult acute beds has continued to rise with a median figure of 94% (excluding leave) reported for 2015/16. This is beyond the 85% that is deemed appropriate by the Royal College of Psychiatrists (2011). Average bed occupancy including people on leave is routinely above 100% and in some cases well beyond it. This suggests that acute wards are running at full capacity and managing beds through the use of leave. It is worth noting that in 2015/16 there was a small increase in the number of beds after previous years saw consistent reductions.

The Royal College of Psychiatrists (2011) advises “A bed occupancy rate of 85% is optimal. This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person’s illness to worsen and may be detrimental to their long-term health.”

Staffing

During this same period, there was a 20% reduction in inpatient staff numbers. While the reduction in staff numbers is largely in line with the reduction in beds, this is a matter for concern given the higher levels of acuity observed on wards.

Drawing on a recent report by Centre for Mental Health and the Mental Health Network NHS Confederation (Durcan *et al.*, 2017) using statistics from NHS Digital, these staff reductions in inpatient settings are more likely to have been in nursing than other staff groups as some increase was seen in all other staff groups including psychiatry and psychology.

Data from NHS Digital (quoted in Durcan *et al.*, 2017) shows that the number of mental health nurses working in the NHS has reduced significantly overall in recent years. It shows that while there was a slight increase in community nursing between 2009 and 2016, a significant reduction was found in ‘other’ (predominantly inpatient) nursing from 25,387 FTE in 2009 to 19,582 FTE in 2016.

The report also found that numbers of nursing support staff had remained largely stable since 2009 but there was much variation within this staff group. Data for nursing assistant, support worker and healthcare assistant posts (Durcan *et al.*, 2017) reveal a marginal (2%) reduction in the number of nursing support staff although the designations of staff within this group have been subject to considerable change during that period.

During the same period, the IAPT programme has almost doubled the NHS psychological therapy workforce, creating more than 7,000 posts across England.

Use of the Mental Health Act

While the total number of acute admissions has seen a small decrease, both the number and the proportion that are detained under the

Mental Health Act (involuntary admissions or “sections”) have increased. The proportion of patients admitted to adult acute beds under the Mental Health Act increased to 35% in 2015/16, from 25% in 2012/13. Patients who are admitted under the Mental Health Act typically have a longer length of stay than those whose admission is voluntary. In addition to the 35% of adults who are detained when admitted to an acute bed, a further 15% are detained at some point during their admission, providing an overall position of 50% of adult acute inpatients being subject to detention at some point during their stay in hospital. There is however much variation among providers, from just 5% to 67%.

Figures released by NHS Digital (2016) also demonstrate large rises in the use of detention over this period. In the 10 years since 2006 there has been a 47% rise. The largest year on year increase was between 2013/14 and 2014/15 at 10%, and last year it rose again by 9%. The Care Quality Commission (2016) has expressed concern about this growing use of the Mental Health Act.

“The reasons why increasing numbers of mental health patients are being detained are likely to be complex and may differ from area to area. Focused work is needed to investigate this. For example, data on community-based services for the same period show a decline in patient contact. This could suggest that reductions in the support that would keep patients out of acute crisis and reduce hospital admissions are a factor in the rising numbers of detentions. It may also be that rising detention rates are related to repeated admissions of the same patient on a rapid cycle, or that the threshold for accessing one of the reduced number of beds is now that a patient meets the criteria for detention under the MHA.”

Care Quality Commission, 2016

Since the introduction of the Crisis Care Concordat (Department of Health, 2014) there has been a marked reduction in the use of police cells as a ‘Place of Safety’ for people detained under section 136 of the Mental Health Act. But the total number of uses of this section has actually risen during the period.

Safety

Reported use of restraint has risen in recent years (from 781 incidents per 100,000 occupied bed days in 2013/14 to 954 in 2015/16). However, during this period the use of prone (face or chest down) restraint has demonstrated a reduction (from 231 incidents per 100,000 occupied bed days in 2013/14 to 160 in 2015/16).

Ligature incidents (recorded as any incident in which an item that could be used as a ligature and cause asphyxiation is discovered in an inpatient ward) averaged at 168 in 2015/16 (per 100,000 occupied bed days, excluding leave). This has risen consistently over the last four years (in 2012/13 it was 82 per 100,000 occupied bed days).

This represents a mixed picture for overall safety on the wards using these measures.

Out of area placements

The NHS Benchmarking Network does not currently collect data on out of area placements. More information on the negative impact of out of area placements and what can be done to reduce them can be found in a recent Centre for Mental Health briefing paper (Trewin, 2017). NHS England recently introduced a commitment to end out of area placements for adult acute care by 2020.

Community mental health services

Further analysis of the community services data was undertaken to ensure a robust understanding of available evidence. Community services are an area where more diversity exists in the terminology used to describe teams. Community care data can also be less complete in some trusts than inpatient data. For this reason the methodology used to analyse the data has been adjusted to use the absolute figures obtained from 2012/13 to 2015/16 (rather than population based benchmarks for this period). When using absolute figures, only areas that had submitted complete data for each year have been included to ensure a reliable basis for assessing changes. The comparisons that have been analysed in this way include caseload, staffing and contacts in community services. ('Contacts' refers to any face to face or indirect interaction with service users.)

The data for all working age adult community services in secondary mental health care since 2012/13 shows a caseload reduction of 7%. Following a similar pattern over the same period, staffing levels across all community services also reduced by 4% while the number of contacts with service users reduced by 6%.

The structure and typology of community mental health teams is complex and not all services are available in all areas but it is apparent from the data that there has been a reduction in the level of specialist community mental health care across England. In explaining the reduction in community team caseloads and contact levels, anecdotal comments from some Trusts and Health Boards suggest that some caseload management initiatives may have removed inappropriately placed patients from caseloads during this period, equally some patients with common mental health problems may now receive care from alternative services including IAPT.

It might be expected that a decrease in bed availability would be offset by an increase in community care provision. In the context of fewer beds and greater use of the Mental Health Act (including through community treatment orders, CTOs), it would be expected that people using community services would have more acute needs and thus require more intensive support, leading to a growth in both caseloads and contacts. The data analysed for this report, however, suggests that this has not been the case.

The growth of the IAPT programme provides important context for the reductions observed in specialist mental health services. IAPT is not designed to support people with severe mental illness and the competencies and capacity of IAPT services focus on people with common mental health problems. The IAPT programme in England began in 2008 and by 2016, some 972,000 people were using IAPT services annually (NHS England, 2017). It is unclear how far the growth in IAPT provision has offset demand for community mental health care. Most IAPT services do not accept people with complex mental health needs, many of whom have been noted to fall below the threshold for acceptance onto a CMHT caseload (Durcan *et al.*, 2017), leaving a gap between the two services.

In some areas, new primary care mental health teams have also been established to support people who have been in contact with CMHTs but no longer need the same intensity of support, or to provide alternatives for people who do not meet the threshold for secondary care. The nature and impact of these new services, and how far they offset reductions in other areas, is as yet not clear. The growth of IAPT in England has significantly improved access to services for people with common mental health problems, but complicates the overall interpretation of data on the overall capacity of specialist services for people with severe mental illness.

Observations on data by types of community team: Figures first available from 2013/14

Community Mental Health Teams (CMHTs) are by far the most common type of community mental health service and are responsible for more than half of all care provided in the community. CMHTs over the period saw a reduction in caseloads of 7%, a reduction in staffing of 3%, and a reduction in contacts of 3%. This implies that generic CMHTs have reduced in size, but not as much as some other types of community team. The fact that caseloads reduced more than staffing and contacts may be due to people who had little contact with CMHTs being ‘stepped down’ to primary care services, and more intensive support being available to those who remain.

The second most common type of community team is now **Assessment and Brief Intervention Teams (ABTs)**. ABTs are a more recent form of community care triage. Unlike other community team models such as EIP or CRHT, they are not a service model that has been extensively studied through empirical research or mandated through policy interventions, and yet have seen a recent proliferation in provision. ABTs gate-keep access to other services. They provide signposting and, for some, short-term intervention. There is variation among providers but referrals come mainly from GPs.

It is likely that the increase in caseload for these teams reflects the volume of referrals to secondary mental health services. It is unclear what impact this has had on the quality of care offered to service users. Assessment and Brief Intervention Team (ABT) services have substantially grown, with an increase in caseload from 188 per 100,000 population in 2013/14, to 282 in 2015/16.

Rehabilitation and Recovery Teams currently comprise the third biggest community mental health service type. They focus on the needs of people with long-term severe mental illness.

Referrals typically come from ABT and other CMHTs, reflecting the fact that they work with people who need longer term support than other community services are able to offer. These services have also seen a decrease in staffing but a slight increase in caseload and a significant increase in contacts. These figures may suggest either that the efficiency of these teams has improved or that each contact is shorter. Recent research from Centre for Mental Health points to a worrying growth in the number of people placed out of their local areas in ‘locked rehabilitation’ beds, in some cases for a number of years (Wright, 2017), instead of being supported by community services.

Early Intervention in Psychosis teams initially reduced in size and capacity but then grew as a response to new policy and investment (caseload per 100,000 population was 58 in 2013/14, then dipped, and rose to 61.6 in 2015/16). This reflects a renewed interest and need in this area after the introduction of an access and waiting time standard for first episode psychosis in 2015.

Crisis Resolution and Home Treatment (CRHT) teams show a mixed picture with no consistent increase or decrease. CRHTs were introduced throughout England to gate-keep hospital admissions and offer intensive home treatment as an alternative to inpatient care. A key organisational characteristic of CRHTs is that they can offer intensive home treatment to prevent inpatient admission or facilitate discharge to the community (Johnson, 2013).

NHS Benchmarking data shows that from 2013/14 to 2015/16 these teams experienced a slight increase in caseload and an even slighter increase in staff numbers but a decrease in contacts. In 2013, 4,392 contacts were reported per 100,000 population. This fell to 4,122 in 2016. In *Implementing the Five Year Forward View for Mental Health*, NHS England (2016) acknowledges that “The majority of CRHTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels

that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission”. Expanding CRHT coverage in England is a major objective of *The Five Year Forward View for Mental Health*.

Assertive Outreach shows a consistent and significant decline in caseloads and contacts, but staffing was found to be broadly similar. The majority of these teams have been dismantled or some functions integrated into CMHTs (Finn *et al.*, 2013). Some, however, remain and there are concerns that the loss of Assertive Outreach teams has left many vulnerable people without the support they require (Dissanayaka, 2017).

Waiting Times for non-urgent treatments by adult community mental health teams are not subject to specific waiting times targets. Data

for 2015/16 suggests around 90% of service users receive treatment within 18 weeks of referral and 50% receive treatment within 4 weeks of referral. Waiting times are shortest for Early Intervention in Psychosis services where around two thirds of patients are seen within 2 weeks of referral.

Post-discharge follow up for people discharged from inpatient care in 2015/16 is an explicit strategy within England and Wales which has ensured 94% of service users receive a follow-up contact from a community mental health worker within 7 days of discharge. This is a key strategy for ensuring joined up care and helps mitigate one of the major risk factors identified by the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness.

Older adult mental health services (65+)

The main focus of this briefing is on services for working age adults. But the Network also collects data on mental health services for older adults (aged 65+) and this is a brief summary of older adult acute inpatient and community mental health care.

Older adult inpatient care

The number of older adult acute beds has fallen consistently and at a higher rate than for working age adults: from 66 per 100,000 population to 44.5 (a total reduction of 32.6% over three years).

Year	Older Adult Acute beds per 100,000 population	Total reduction from 2012/13
2012/13	66	
2015/16	44.5	-32.6%

Unlike adult acute inpatient beds, older adult inpatient admissions fell proportionately with the reduction in bed numbers (at 30.7% over the period). Consequently, bed occupancy for 2015/16 was 85%, within the recommended rate by the Royal College of Psychiatrists to maintain a ward that can operate safely and ensure appropriate patient flow.

Year	Admissions to Older Adult Acute beds per 100,000 population	Total reduction from 2013/14
2012/13	256	
2015/16	177.3	-30.7%

Older adult community care

The majority of community care for this age group is provided by Older Adult CMHTs and memory services. Community care for older adults shows a complex picture with reduced levels of traditional CMHT provision in the context of the parallel steep decrease in beds available. However, memory services have increased at an extraordinary rate over this period and perhaps represent the emergence of a more agile service for older people. The transition from traditional old age CMHTs to memory services has increased the total number of older people on any community caseload by 13% over the period 2012/13 to 2015/16, whilst contact rates for older people increased by 21% over this period.

Older adult CMHT caseload per 100,000 population reduced by 4% from 2012/13. Over the same period, staffing levels reduced at a significantly sharper rate of 24%, while contacts (both face to face and non-face to face) fell by 15%. The overall growth in old age community services thus appears to be directly related to a transition away from traditional old age CMHT services to memory services.

Waiting times for non-urgent treatments by older adult community mental health teams for 2015/16 suggest around 85% of service users receive treatment within 18 weeks of referral. 52% of people waiting for treatment by Old Age CMHTs receive treatment within 4 weeks of referral, this falls to 28% of people waiting for memory services receiving treatment within 4 weeks.

Policy implications

The findings of this report have significant implications for the development of mental health policy and practice in England and Wales. This section explores some of the key themes and what they might mean for policy and practice.

The balance between inpatient and community services

The Benchmarking Network's data points to a growing gap in adult mental health services as beds close but community services do not expand at an equivalent rate to meet people's needs. This requires urgent attention from both national and local policymakers. Bed numbers for adult acute services increased marginally in 2015/16 following several years of bed reductions. It will be interesting to monitor this position, to ascertain whether the position reached in March 2015 represents a floor for mental health bed numbers that will gradually increase in line with the need for beds with adequate occupancy capacity to ensure good patient flow. NHS England's commitment to end the use of out of area placements in adult acute care and to reduce delayed transfers of care will require whole system investment to increase capacity where it is needed, including a wider emphasis on integration with social care.

One conclusion that can be drawn is that many people who would previously have been looked after by specialist mental health services are now having their needs met in primary care and by intermediate services such as IAPT. General practice is also noted to be overburdened and experiencing problems in providing appropriate access to core primary health care services, raising questions over its ability to cope with complexity within existing resources. Studies have supported anecdotal evidence of revolving door admissions and discharges between primary and specialist mental health care (Ramanuj *et al.*, 2015). New service models to improve primary mental health care are emerging, but this is not universal and there is no blueprint to work from. This raises the question of how to support primary care in

meeting these needs effectively in the context of significant pressure on general practice.

An absence of specific policy direction on the configuration of inpatient and community services has led to a wide range of approaches emerging across the country. This makes previously familiar distinctions between types of team less clear and therefore harder both to achieve and to measure fidelity to models, where these exist. The lack of specific policy guidance on community services has also prompted the development of new types of community team, most notably Assessment and Brief Intervention, for which evidence of effective approaches will be important to guide commissioners and providers. It is hoped that the implementation of the *Five Year Forward View for Mental Health* will fill this gap in England and bring about a more consistent approach.

Sustainability and Transformation Partnerships (STPs) and emergent Accountable Care Systems are likely to bring about further changes to the balance between mental health inpatient, community and primary care. It is imperative that these are led by evidence of need and accurate data about current provision and gaps in available care and support. As few of the Vanguard sites implementing New Models of Care included a significant element of mental health support (Naylor *et al.*, 2017) there is little experience to draw upon as yet to embed mental health within STPs and accountable care arrangements.

Crisis care

Few aspects of mental health care have received as much attention since 2013 as the support people get in a crisis. Fuelled by public, media and political concern about the use of police cells for mental health emergencies, and broader concern about pressures on A&E, the Crisis Care Concordat programme has brought about a lot of national and local activity to improve urgent care for people with mental health problems.

An investigation carried out by the Care Quality Commission (2015) found wide variation in the quality and effectiveness of crisis care among providers and concluded that too many people were not receiving timely and good quality responses at their most vulnerable. They found that just 14% of people experiencing a crisis received the right response.

Following 20 years of research, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) examined aspects of mental health care to determine if there is an association with patient suicide rates. They found lower suicide rates were linked with there being specialised community teams such as assertive outreach and crisis resolution and home treatment (CRHT).

However, there are now approximately three times more suicide deaths among people being treated under CRHT than in inpatient settings. A third of CRHT patients who died by suicide had been under the service for less than one week. A third had recently been discharged from hospital and 43% lived alone.

The National Confidential Inquiry (2016) concludes that these features suggest that CRHT may not have been a suitable setting for their care, and raises concerns that CRHT has become the default option for acute mental health care because of pressure on other services.

Our data over the last five years, however, shows no increase in the number of people being supported by crisis teams but does show a decrease in the number of contacts.

The provision of crisis houses, cafes and other alternatives to admission is frequently put forward as a way of reducing the need for hospital beds. However, relatively few NHS Benchmarking Network participants report providing crisis houses and the number of places reported is equivalent to less than 1% of total mental health bed capacity.

Mental Health Act

The rise in Mental Health Act use was identified as a major political issue during the 2017 General Election campaign and it is now due to be revised. It remains to be seen whether

any new legislation will be able to tackle the current trend in rising use of (or need for) the Act, given that it is unclear what is driving the increase. A number of explanations have been put forward for this, including reductions in bed numbers, pressures on community services, changes to the 1983 Act in 2007 (which introduced Community Treatment Orders for example), external pressures (i.e. housing/benefit changes) or a combination of these factors. There is no current evidence that there are significantly more people with mental health problems. However, the reduction in community service capacity and high levels of bed occupancy may mean there are fewer alternatives to use of the Act.

The Government's recent pledge to review the Mental Health Act is an important opportunity to develop a greater understanding of why more people are being detained year on year. This would need to look not just at the legislation but at the wider context in which the Act is being used and the range of factors that influence its use in practice. Gaining a greater understanding of this trend is a vital precursor to any changes to the legislation.

Spending on mental health care

The data collected by the Benchmarking Network relates to a period of time during which reliable data about spending on mental health services in England has been difficult to ascertain.

Between 2000/01 and 2011/12, funding figures show that money allocated for adult mental health services increased year on year in England, albeit not evenly over time (Mental Health Strategies, 2012). The National Survey also provided detailed information about the types of service that were receiving funding in each of these years, giving a clear picture of where investment was going.

From 2011/12, however, official data on mental health service funding is unavailable. Figures gathered through freedom of information requests, however, point to the conclusion that funding for mental health services fell by 8% in real terms between 2010 and 2015, while referrals went up by 20% (Community Care and

BBC, 2015). More recently, Planning Guidance for the NHS (NHS England & NHS Improvement, 2016) has stipulated that all CCGs in England should fund real terms increases in mental health care spending. It is as yet unclear how many CCGs have followed this standard in the context of growing financial pressures across the NHS. The *Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016) sets out an expectation that reliable spending data on mental health services will be collected and published regularly from this year onwards. The Mental Health Dashboard aims to report on CCG level investment in mental health services across England (NHS England, 2017).

Data on services

An analysis published by The King's Fund states that: "An absence of robust data makes it difficult to provide a definitive assessment of the state of mental health services" (Gilbert, 2015).

The independent Commission on Adult Acute Psychiatric Care (2016) likewise described a 'data and information crisis', and suggested that inconsistent definitions and processes

and a lack of agreed outcomes make it difficult to understand what is happening throughout the system, to measure variation and to bring about improvements. The Commission's report recommended that "the collection, quality and use of data is radically improved so it can be used to improve services and efficiency, ensure evidence based care is being delivered and improve accountability".

It is clear from this analysis that data on mental health service delivery and performance is currently limited. This should be addressed in the implementation of the Five Year Forward View for Mental Health (NHS England 2016 and 2017).

Older people's mental health care

Older people's mental health services have received little policy attention in recent years. Yet during that time a major transition has taken place, with ongoing reductions in bed numbers and a shift away from traditional community teams towards more short-term memory services. This change has been driven by the provider sector and reflects further moves away from traditional models of care.

Conclusions

The NHSBN data we have analysed for this report points to an urgent need to review the capacity of community mental health services to meet people's needs. While a fall in acute inpatient bed numbers represents a continuation of a long-term trend reflecting changing service patterns, it is a matter of great concern that admissions have not fallen to anything like the same degree while nursing staff numbers have fallen by 20% in just four years. With bed occupancy levels rising year-on-year, and a growing reliance on leave to manage bed capacity, pressure on acute inpatient services can no longer be ignored. But it is the combination of reductions in inpatient care capacity and a fall in community care provision that is the greatest cause for concern from the data we have reviewed.

Both nationally and locally, policymakers and commissioners need to address this situation as a priority. Improving community mental health care is one of the key pledges of the *Five Year Forward View for Mental Health in England*. With capacity falling and a growing diversity of approaches to community care evident across the country, there is a clear and pressing need to rebuild community services and identify good practice models. With a welcome increase in both early intervention and crisis services evident towards the end of the period we have reviewed, it is now vital that commissioners sustain those gains and extend their focus to the full range of support required by people living with mental health conditions.

The long-term impact of IAPT services on England's mental health system remains to be determined. With almost a million people accessing care through IAPT, it remains to be seen whether this creates a permanent shift in care, with fewer people requiring support from specialist community mental health teams. IAPT is the largest initiative of its kind in the world and provides alternative access choices to referrers for people with non-complex needs.

With a growing focus on primary care in supporting people who do not meet thresholds for secondary mental health services, we need to identify what services are being provided to whom, and over time to develop an evidence base to ensure that the right help is on offer. Extending the scope and reach of primary care mental health support has the potential to meet the needs of people who currently fall between IAPT and secondary care. And like other health services, it needs to be informed by good evidence and subject to scrutiny for the quality and outcomes of the care it provides.

The NHS in both England and Wales has set out bold plans to improve access to mental health services and the quality of support they offer. The data we have reviewed for this report shows the scale of the challenge the NHS faces in bringing about better access to high quality care and support. Reducing bed numbers without expanding community support is not sustainable long-term. Investing in high quality community and primary care is now imperative to bring about the changes outlined in national strategies that will be vital to put mental health on an equal footing to physical health across the country.

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Briefing 52: Adult and older adult mental health services 2012-2016

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52: Adult and older adult mental health services 2012-2016

An analysis of Mental Health NHS Benchmarking Network data for England and Wales

Summary

This report summarises the results of a collaboration between Centre for Mental Health and the NHS Benchmarking Network. The NHS Benchmarking Network (NHSBN) is a member-based organisation of NHS commissioners and providers who collect and analyse data on health care services across the NHS. NHSBN have made their mental health data available to the Centre to provide an independent commentary on what the data suggests about secondary NHS mental health provision in England and Wales.

The data shows a sustained decrease in the number of adult acute inpatient beds for all but the last year that data was collected. This is continuing a trend over a number of decades.

While bed numbers have fallen in recent years, the number of admissions and lengths of stay in hospital have not. And the proportion of people admitted under the Mental Health Act has risen year on year.

This has put greater pressure on inpatient units, resulting in higher bed occupancy rates, consistently

above the levels recommended by the Royal College of Psychiatrists.

Overall community mental health team provision in secondary care reduced slightly between 2012/13 and 2015/16. However towards the end of the period, early intervention and crisis services grew again in response to national policy developments.

The last five years have witnessed a shift in care provision for people with common mental health problems with over 900,000 people in England now supported through new primary care services such as the Improving Access to Psychological Therapies initiative.

The data we analysed covers the five years prior to the introduction of the Five Year Forward View for Mental Health in England and offers a snapshot of the development of community and inpatient services up to that point.

Centre for
Mental Health



Centre for Mental Health
Office 2D21, South Bank Technopark,
90 London Road, London SE1 6LN
Tel 020 7717 1558
www.centreformentalhealth.org.uk

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