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Mental Health Services Monthly Statistics, provisional January 2016, experimental

This first report from the Mental Health Services Dataset presents experimental statistics about Access and Waiting Times for people with suspected first episode psychosis (FEP).

New referrals

802 people

were referred with suspected first episode psychosis in January

Gender ratio of caseload

More males than females with suspected first episode psychosis in contact with services

Starting treatment

80 of them

were both referred and entered treatment in January, 93% having waited no more than 2 weeks*

Age range

30%

of these people were aged 18-35

Read the full report to find out more:
www.hscic.gov.uk/pubs/mhsjan16prov

*In this first release waiting times are only calculated for referrals received since 1 January 2016, the date information started to be collected in the Mental Health Services Dataset (MHSDS). These waiting times figures therefore exclude referrals received prior to 1 January 2016, which would be included in the official waiting time standard. Future reports will be more complete .

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Executive summary

This release presents experimental statistics from the Mental Health Services Data Set (MHSDS), using provisional submissions for January 2016. Included are a small set of statistics produced to support the introduction of waiting time standards for mental health and data quality measures in line with our previous release from provisional monthly data.

A fuller report, including many of the measures previously produced from final monthly data in the Monthly Mental Health and Learning Disabilities Dataset (MHLDS) Reports series, which this replaces, will be published in April 2016 from January final data.

Information provided in this release covers mental health and learning disability services for all ages ('services').

Definitions for key measures included in this report are available in the accompanying data tables.

Key Facts

All services

- Provisional submissions for January 2016 were received from 78 service providers
- 246,428 new referrals into services took place during January 2016
- Within these services 1,462,057 referrals were open on 31 January 2016
    - Of these 1,458,279 had a recorded gender, from which 706,914 (48.5%) were male and 751,365 (51.5%) were female
    - 1,461,014 of these referrals had a recorded age. 208,602 (14.3%) were under the age of 18 and 920,667 (63.0%) were aged 35 or over

Services for people with a suspected first episode of psychosis

- Of the 246,428 new referrals into services 33,569 (13.6%) had a primary reason for the referral recorded
- Referrals with a primary reason for referral of a suspected first episode of psychosis were received from 25 service providers
- 802 new referrals for a suspected first episode of psychosis were received into these services during January 2016
    - 80 of these referrals entered treatment during January 2016. Of which 74 (92.5%) entered treatment within two weeks of referral and six (7.5%) waited more than two weeks to enter treatment
    - 329 of these referrals were waiting to enter treatment on 31 January 2016. Of these 122 had been waiting more than two weeks to enter treatment from the date they were originally referred. The remaining 207 were waiting two weeks or less on 31 January and so it is too early to determine if the access and waiting time standard has been exceeded

Introduction

This release presents the first statistics from the Mental Health Services Data Set (MHSDS), using provisional submissions for January 2016. It comprises a small set of experimental analysis in support of the introduction of waiting time standards for mental health. It also includes data quality measures in line with our previous release from provisional monthly data.

A fuller report, including many of the measures previously produced from final monthly data in the Monthly Mental Health and Learning Disabilities Statistics (MHLDS) Report series, which this replaces, will be published in April 2016 from January final data. It will also include some initial analysis of information about children's and young people's services. The publication is likely to evolve as new analysis is produced from the dataset.

The MHSDS not only supersedes and replaces the Mental Health and Learning Disabilities Dataset (MHLDDS) but also the following standards:

- ISB 1072 Child and Adolescent Mental Health Services (CAMHS) data set
- ISB 1509 Mental Health Care Cluster
- ISB 1078 Mental Health Clustering Tool

The changes incorporate requirements in support of Children and Young People's Improving Access to Psychological Therapies (CYP IAPT), elements of the Learning Disabilities Census (LDC) and elements of the Assuring Transformation (AT) Information Standard.

One of the reasons for changing the MHLDDS was to enable the dataset to support the monitoring of waiting times in mental health. Due to the extensive nature of the changes required to the underlying dataset it will take some time to re-create all the measures previously included in our monthly reports and some elements will change. Further details are provided in a Methodological Change paper[1].

We will release the reports as experimental statistics until the characteristics of data flowed using the new data standard are understood.

The classification of experimental statistics is in keeping with the UK Statistics Authority's Code of Practice. Experimental statistics are new official statistics that are undergoing evaluation. They are published in order to involve users and stakeholders in their development, and as a means to build quality at an early stage. The UK Statistics Code of Practice states that *"effective user engagement is fundamental to both trust in statistics and securing maximum public value…"* and that as suppliers of information, it is important that we involve users in the evaluation of experimental statistics.

The UK Statistics Code of Practice can be accessed via the following web-link: http://www.statisticsauthority.gov.uk/assessment/code-of-practice/code-of-practice-for-official-statistics.pdf

Further information on this can be found in the data quality section of this publication.

[1] http://www.hscic.gov.uk/media/19380/Monthly-MHLDS-Reports/pdf/MethChange20160119_MHSDS.pdf

Access and waiting times

Early intervention in psychosis

Ensuring that people with mental health problems have an equivalent level of access to timely, evidence-based care as people with a physical health condition is part of the plan set out by the Department of Health in 2014[2].

More recently the Mental Health Taskforce report[3] sets a priority action for the NHS that by April 2016 more than 50 per cent of people experiencing a first episode of psychosis have access to access to a NICE-approved care package within two weeks of referral. The MHSDS supports monitoring of this standard.

The new access and waiting time standard is 'two-pronged' and both conditions must be met for the standard to be deemed to have been achieved, i.e.

1. A maximum wait of two weeks from referral to treatment; and
2. Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia - either in children and young people CG155 (2013) or in adults CG178 (2014)[4].

Further guidance regarding the introduction of access and waiting times standards in mental health services can be found at https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf

These statistics relate to the first measure included within this standard showing the number of people with a suspected first episode of psychosis entering treatment broken down by whether the two week standard was met. Other statistics related to this measure are included to provide context.

In this first release waiting times are only calculated for referrals received since 1 January 2016. A primary reason for changes implemented in the MHSDS was to enable the dataset to support the monitoring of waiting times in mental health. As the MHSDS was mandated for collection from 1 January 2016 waiting time information is not available before this date. Future reports will include a more complete picture of the access and waiting time standard.

78 organisations provided a provisional submission of information for January 2016. Of these 25 provided information on referrals with a primary reason for referral of a suspected first episode of psychosis. Across all new referrals beginning in January 2016 submitted by all organisations, 13.6% had a primary reason for referral recorded. Data quality improvements in future collections are expected to result in an increase in the number of organisations providing information on referrals with a primary reason for referral recorded. As these statistics are based on provisional submissions these are subject to change.

Background

As this report provides a partial picture of the early intervention in psychosis (EIP) access and waiting time standard, this report includes contextual measures in order to give an indication of what the wider EIP caseload may look like.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[4] https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf

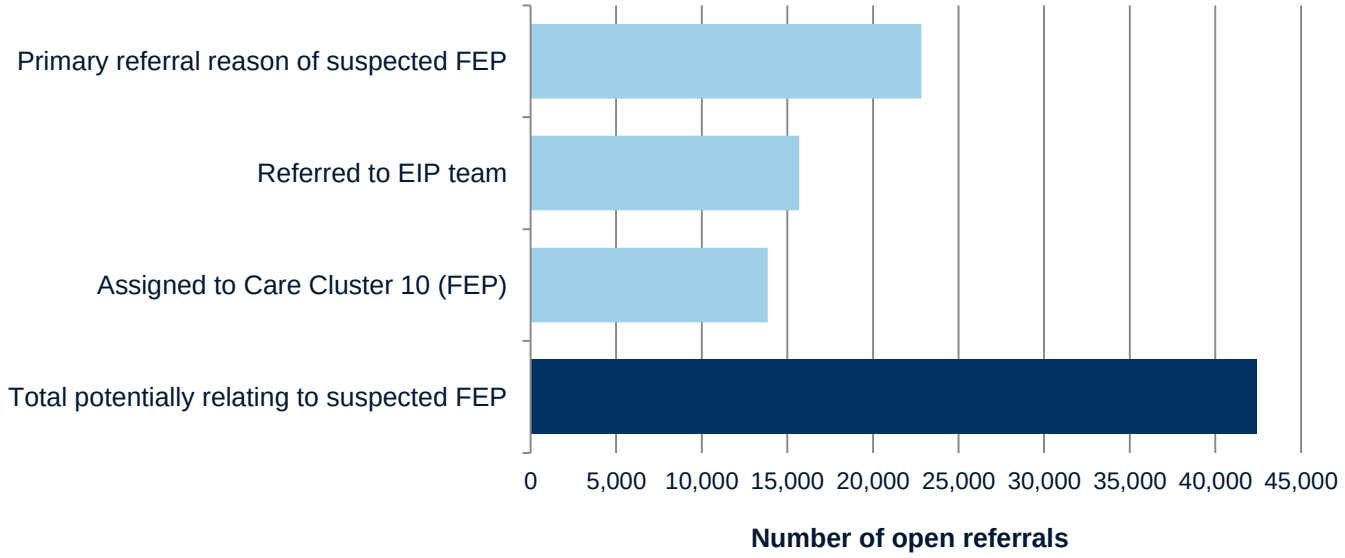
In order to be included in these initial statistics on EIP access and waiting times a person must have a referral recorded which:

1. Began on or after the 1 January 2016
2. Has a primary reason for that referral recorded as a suspected first episode of psychosis
3. Be assigned to an EIP team.

In order to provide a picture of what the caseload may look like once more referrals are available to be included, here are some measures which show the number of referrals open as at 31 January 2016 which do not have the restriction of beginning after 1 January 2016 applied. Also included are measures which show the number of referrals for people who have either a primary reason for that referral recorded as a suspected first episode of psychosis **or** assigned to an EIP team **or** are assigned to the related Mental Health Care Cluster 10 (FEP)[5] as at 31 January 2016. Measures for all open referrals as at 31 January 2016 are included to provide an early indication of how characteristics may compare to those of service users more generally.

The following summary statistics are expanded on in the associated access and waiting times data tables accompanying this report.

Fig 1: Open referrals potentially relating to a suspected First Episode of Psychosis (FEP), England, as at 31 January 2016

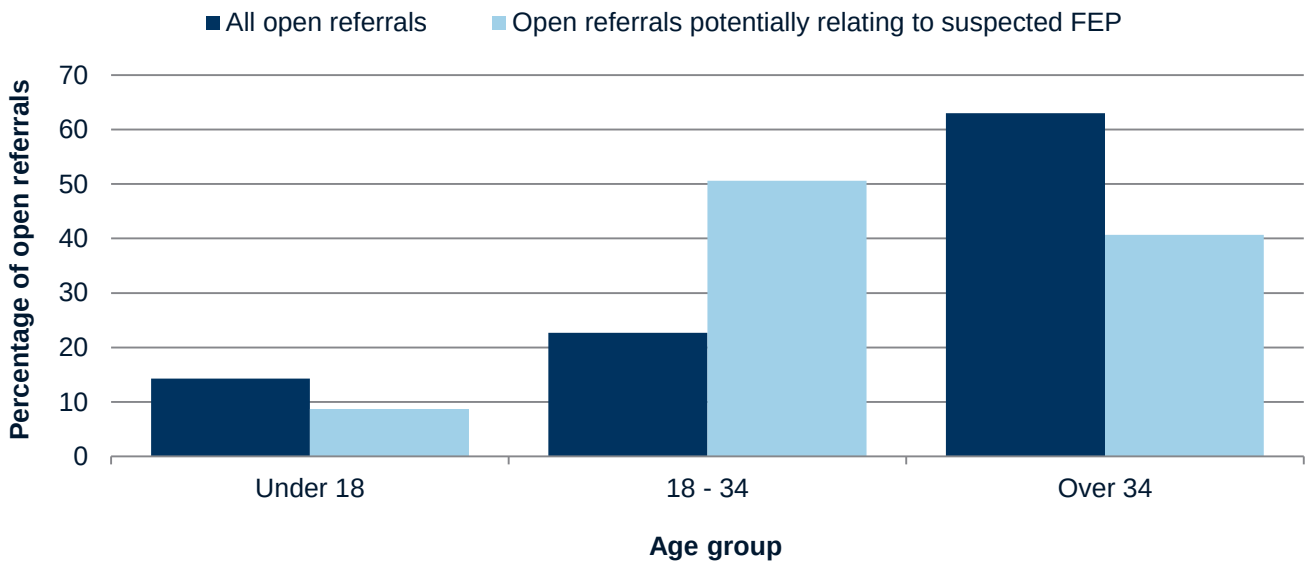


Of the 1,462,057 referrals open on 31 January 2016, 42,422 (2.9%) had at least one of the three indicators associated with a potential suspected FEP recorded. 22,840 referrals had a primary reason for referral of a suspected FEP recorded, 15,685 where recorded as being assigned to an EIP team, and 13,860 where recorded as assigned to Care Cluster 10 (FEP).

[5] Mental health care clusters (or care clusters) are the nationally mandated currency model for mental health. The model covers most mental health services for working age adults and older people but does not cover learning disability services. Further information can be found in the Monitor and NHS England guidance, here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300864/Guidance_to_mental_health_currencies_and_payment.pdf

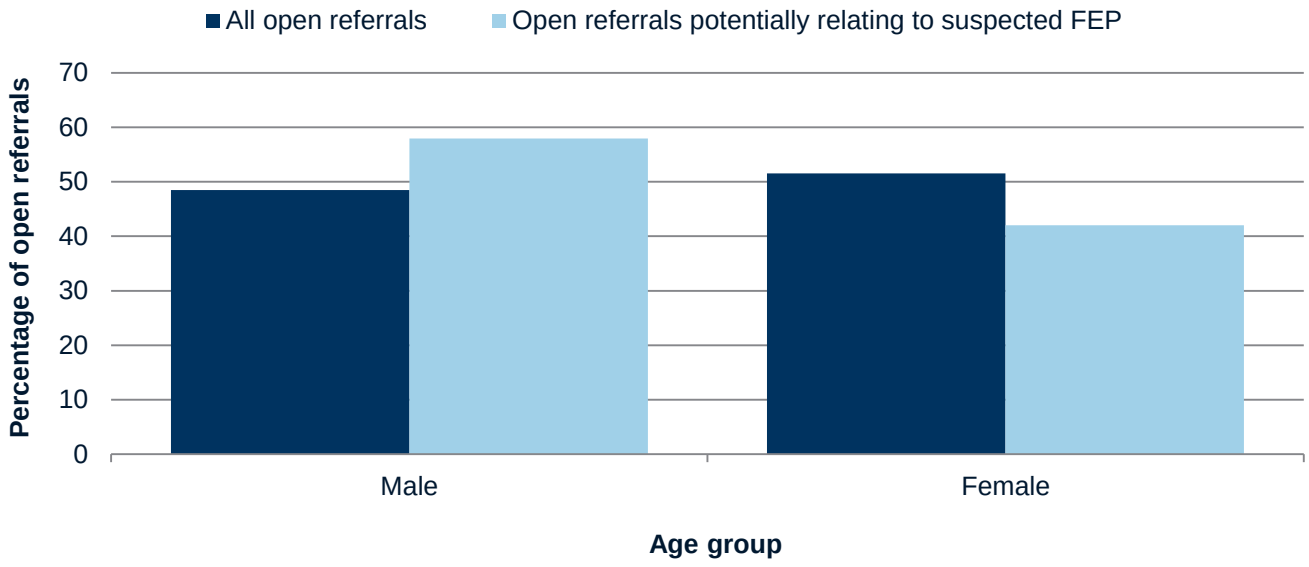
Of the 1,462,057 referrals open on 31 January 2016, 1,461,014 (99.9%) had a recorded age and 1,458,279 (99.7%) had a recorded gender. Of the 42,422 referrals with an indicator of a potential suspected FEP recorded, 42,418 (>99.9%) had a recorded age and 42,419 (>99.9%) had a recorded gender. The below Figures 2 and 3 summarise the proportion of referrals by age group and gender. These figures are different to those in other parts of this report which show referrals by age group and gender for the narrower single indicator of a primary reason for referral being a suspected FEP. Further information, including a breakdown of open referrals by ethnicity, is available in the associated access and waiting times data tables accompanying this report.

Fig 2: Open referrals by age group, England, as at 31 January 2016



[1] Percentages are calculated from referrals where age of person referred is known.

Fig 3: Open referrals by gender, England, as at 31 January 2016



[1] Percentages are calculated from referrals where gender of person referred is known.

EIP access and waiting times

New referrals to treatment

Of the 246,428 new referrals to treatment in January 2016, 802 referrals were made for people with a suspected FEP. Across all new referrals beginning in January 2016 13.6% had a primary reason for referral recorded. 2.4% of new referrals in January 2016 which had a primary reason of referral recorded were for people with a suspected FEP.

Referrals entering treatment

80 referrals for people on a first episode of psychosis (FEP) pathway entered treatment during January 2016. Referrals are considered to be on a FEP pathway when they have been referred into a service with a primary referral reason of a suspected first episode of psychosis and have been assigned to an Early Intervention in Psychosis (EIP) team.

Of these referrals entering treatment, 74 (92.5%) waited two weeks or less from the date they were originally referred. Referrals are considered to have entered treatment when the person referred has had a first contact with an EIP team and has been assigned to a care coordinator. Six (7.5%) waited more than two weeks before entering treatment.

Open referrals waiting for treatment

329 referrals for people on a FEP pathway where waiting to enter treatment on 31 January 2016. Of these 122 had been waiting more than two weeks to enter treatment from the date they were originally referred. The remaining 207 were waiting two weeks or less on 31 January and so it is too early to determine if the waiting time standard has been exceeded.

In order to be considered to have entered treatment a person referred has to have had both a first contact with an EIP team and have been assigned to a care coordinator. Including both those who have entered treatment during January 2016 and those still waiting to enter treatment on 31 January 2016, 203 referrals for people on a FEP pathway received a first contact with an EIP team during January, and 130 referrals for people on a FEP pathway were assigned a care co-ordinator.

Data quality

Background

The MHSDS is a regular return of data generated by providers of Community and Mental Health services in the course of delivering mental health and learning disability services to people of all ages in England. The original version of the dataset was first mandated in April 2003 and is acknowledged as the national source of administrative data about NHS funded secondary mental health services for secondary uses. Submission of the dataset is a requirement of the NHS Contract for mental health services.

The dataset has gone through a number of version changes since April 2003 in response to changes to legislation, service models and payment mechanisms. The scope has also been expanded to include independent sector providers of NHS funded mental health services (from April 2010) learning disabilities services (September 2015) and now, with the current set of changes, mental health services for children and young people. The current changes were approved by Standardisation Committee for Care Information (SCCI) in July 2015 for implementation from 1 January 2016[6]. Further information on the MHSDS can be found at www.hscic.gov.uk/mhsds

This section aims to provide users with an evidence based assessment of the quality of the statistical output of the MHSDS Monthly Reports publication by reporting against those of the nine European Statistical System (ESS) quality dimensions and principles[7] appropriate to this output.

In doing so, this meets our obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics[8], particularly Principle 4, Practice 2 which states:

> *"Ensure that official statistics are produced to a level of quality that meets users' needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors and other aspects of the European Statistical System definition of quality".*

For each dimension this section briefly describes how this applies to the publication. We will continue to provide clear and comprehensive information about the methods used in our analysis and the quality of the data to assist users in interpreting our reports. This publication of provisional January data includes data quality measures and a brief summary of major data quality considerations. More detailed background information will be presented once the quality of the data has been investigated.

Some data quality considerations relating to specific measures can be found in the report. General considerations are included here.

[6] SCCI0011 Information Standard - http://www.hscic.gov.uk/isce/publication/SCCI0011

[7] The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.

[8] UKSA Code of Practice for Statistics: http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html

Relevance

This dimension covers the degree to which the statistical product meets user need in both coverage and content.

This publication comprises a report which has been produced from mental health and learning disability service providers' MHSDS provisional submissions for January 2016. It provides the timeliest information from the MHSDS.

This report includes an initial analysis of the access and waiting time standard for early intervention in psychosis. Included alongside this are additional statistics produced in order to provide users with context in which access and waiting time statistics can be understood.

The MHSDS is the key source of national information about the use of NHS funded mental health and learning disability services. The recent changes of the dataset have been designed to ensure that the dataset can be used to monitor access and waiting times for different pathways into services. However, guidance on recording waiting times for early intervention in psychosis was only made available on 1 March 2016 and could not be used to inform the submission of January provisional data, for which the submission deadline was 23 February 2016. This means that many providers have not recorded data in the way required to support a consistent measurement of waiting times. Now that guidance has been published we expect greater compliance.

The statistics in this publication are marked as **experimental** and may be subject to further change as we develop our statistics. Feedback is very welcome via enquiries@hscic.gov.uk (please quote 'MHSDS Monthly' in the subject line).

Accuracy and reliability

This dimension covers, with respect to the statistics, their proximity between an estimate and the unknown true value.

The MHSDS is a rich, referral level dataset that records packages of care received by individuals as part of referrals into treatment within NHS funded specialist mental health and learning disability services and these packages of care vary widely. This means that each record contains different elements of the dataset. Therefore, no single approach can measure the completeness and accuracy of the data collected and reported nationally. However the HSCIC provides a number of different reports at different stages in the data flow to ensure that the submitted data reflect the services that have been provided.

For data suppliers only

At the point of submission:

- Providers receive immediate feedback on the quality of their submission, including detailed Data Summary Reports about coverage, volume, code validity and data consistency. Providers have the opportunity to re-submit data up to the deadline and to send a refresh submission one month later.

On receipt of processed data by HSCIC:

- Where there are concerns about data quality we contact providers directly so that any issues with local data extraction processes can be addressed for a future submission. These checks are currently limited to key elements of the dataset. Additional checks will be developed as part of future submissions to the extent were they offer the same level of coverage as those previously available for MHLDDS submissions, along with previously available reports for data suppliers highlighting key data quality issues.

For all users

As part of this publication national and organisation level data quality measures are shown that validate a selection of key data items by provider. These show the proportion of records as counts and percentages which have 'valid', 'other', 'default', 'invalid' and 'missing' values for key elements of the dataset, such as Team Type and Primary Reason for Referral. These elements will be expanded upon in future submissions. It has not been possible to monitor waiting times where these items were not recorded.

All providers of NHS funded specialist mental health and learning disability services should submit the MHSDS. However, at present only a small number of independent sector providers are making submissions. When an organisation starts or ceases to submit data this can affect overall record numbers.

Timeliness and punctuality

Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

The deadline for submitting January provisional data was 23 February 2016. These reports have been produced within two months of the end of January and five weeks of the submission deadline. This is the most timely information that has ever been produced for adult mental health and learning disability services at a national level.

The submission deadlines for MHSDS are published here: www.hscic.gov.uk/mhsds

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

Alongside this report data tables providing a greater level of detail for the analysis presented here have been included in this publication. Data quality measures applied to this initial submission of MHSDS have been provided in both human readable (MS Excel) and machine readable (Comma Separated Values - CSV) form.

Re-use of our data is subject to conditions outlined here:

http://www.hscic.gov.uk/data-protection/terms-and-conditions

Definitions for those measures included in this report are available in the accompanying data tables available as a MS Excel file. Terminology is defined where appropriate. Further details including the data items used in the analysis and constructions, and current or intended uses, will be developed and provided in future editions of this publication series.

Full details of the way that MHSDS returns are processed, which will be of use to analysts and other users of these data, are provided in the MHSDS v1.0 User Guidance, available on the HSCIC website:

http://www.hscic.gov.uk/mhsds

In order to prevent disclosure of identities or information about service users, all figures (except national totals) are rounded to the nearest five. All figures between 0 and 4 are suppressed (shown as '*').

Coherence and comparability

Coherence is the degree to which data which have been derived from different sources or methods but refer to the same topic are similar. Comparability is the degree to which data can be compared over time and domain.

The number of providers of adult mental health services submitting January data was consistent with the volume previously making a primary submission of MHLDDS monthly data.

There is currently no other national reports on waiting times for first episode psychosis, however some comparisons can be made with related information published in the following:

Monthly MHLDS Reports produced from a previous version of the dataset[9]:

- The experimental data file that formed part of this release included counts of first contacts with EIP teams (see Table 2 of the Data Tables in this publication).
- The currency and payment file included a count of people assigned to Care Cluster 10 at the end of the month (see Tables 3a and 3b of the data tables in this publication)

Mental Health Community Teams Activity published by NHS England[10].

- Number of new cases served by EIP Teams (year to date)

In this first release waiting times are only calculated for referrals received since 1 January 2016. As the MHSDS was mandated for collection from 1 January 2016 waiting time information is not available before this date. Waiting time statistics produced in this report will not be fully comparable with statistics produced using other sources that include referrals before this date. Future reports will develop a more complete picture of the access and waiting time standard.

Trade-offs between output quality components

This dimension describes the extent to which different aspects of quality are balanced against each other.

Because this analysis is produced from provisional submissions for January and this was the first submission of the MHSDS, some providers experienced issues making a comprehensive submission within the permitted timescales. We expect a more complete and accurate picture to be available from final January data, which will be published in April. This analysis presents an early view and is subject to caveats both in terms of the completeness of the submission and the limits of the data that could be provided about pathways into services for a suspected first episode of psychosis.

The format of this publication has been determined to enable timelier reporting of key initial measures while adjusting the scope of analysis to be achievable within HSCIC resources and production time. The scope of analysis will be expanded in future editions of the publication series to increase the usefulness and usability of these statistics for different users. By publishing an increasing range of clearly defined measures in a timely fashion we hope to support discussions between providers and commissioners about caseload and activity and promote a virtuous cycle of improving data quality through use.

[9] http://www.hscic.gov.uk/mhldsreports
[10] https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/

Assessment of user needs and perceptions

This dimension covers the processes for finding out about users and uses and their views on the statistical products.

The purpose of the MHSDS monthly reports is to provide mental health and learning disabilities service providers, commissioners and other stakeholders with timely information about caseload and activity. This is intended to support changes in commissioning arrangements as services move from block commissioning to commissioning based on activity, caseload and outcomes for patients. The purpose of this initial report in the publication series is to give all users a timely early understanding of measures relating to the access and waiting times standard alongside contextual information.

We undertook a consultation on our adult mental health statistics during 2015 and published the results in November 2015[11]. Changes to the MHLDS Monthly Reports that were previously published from MHLDDS are described in a Methodological Change Paper[12]. The introduction of statistics to support the monitoring of waiting times is in line with the ambitions set out in the governments Five Year Forward Plan for Mental Health[13] and we will introduce further waiting time measurements in line with priorities identified with interested parties.

Performance, cost and respondent burden

This dimension describes the effectiveness, efficiency and economy of the statistical output.

The dataset preceding MHSDS (MHLDDS) was identified as the data source to replace others in the Fundamental Review of Returns programme designed to reduce burden on the NHS. The current changes, which include a change to the name of the dataset, were approved by Standardisation Committee for Care Information (SCCI) in July 2015 for implementation from 1 January 2016. As a secondary uses data set it intends to re-use clinical and operational data from administrative sources, reducing the burden on data providers of having to submit information through other primary collections.

[11] http://www.hscic.gov.uk/article/6545/Consultation-on-Adult-Mental-Health-Statistics
[12] http://www.hscic.gov.uk/media/19380/Monthly-MHLDS-Reports/pdf/MethChange20160119_MHSDS.pdf
[13] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

Submissions have been processed in line with the rules described in the Technical Output Specification for the dataset[14] using a fully assured system that pseudonymises individual identifiers. As for all HSCIC publications the risk of disclosing an individual's identity in this publication series has been assessed and the data are published in line with a Disclosure Control Method for the dataset approved by the HSCIC's Disclosure Control Panel.

Please see links below to relevant HSCIC policies:

Statistical Governance Policy (see link in 'user documents' on right hand side of page)

http://www.hscic.gov.uk/pubs/calendar

Freedom of Information Process

http://www.hscic.gov.uk/foi

A Guide to Confidentiality in Health and Social Care

http://www.hscic.gov.uk/confguideorg

Privacy and Data Protection

http://www.hscic.gov.uk/privacy

[14] http://www.hscic.gov.uk/mhsds

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