Agenda Item No: 17

MENTAL HEALTH NATIONAL MINIMUM DATASET ANALYSIS: ADDITIONAL INFORMATION FOR THE ADULT AND OLDER PEOPLE'S MENTAL HEALTH JSNA

To: Health and Wellbeing Board

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1.0 PURPOSE

1.1 This report is for information and summarises the findings of the analysis of the mental health minimum dataset for the adult and older people's mental health Joint Strategic Needs Assessment (JSNA).

2.0 BACKGROUND

2.1 An analysis of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)service activity from the Mental Health Minimum Dataset (MHMDS) was not possible for the Adult and Older People's Mental Health JSNAs as the data was not available in time.

2.2 The public health team committed to undertake an analysis of the available data to provide additional service information for these JSNAs. Since April 2014 CPFT have provided an anonymised (non-sensitive) version of the mental health national minimum dataset to the public health team at the same time as the data is returned monthly to the Health and Social Care Information Centre (HSCIC). The attached analysis of the MHMDS has been undertaken jointly with CPFT.

3.0 SUPPORTING PARAGRAPHS

What is the Mental Health Minimum Dataset?

3.1 TheMHMDScontains record-level data (individual level data) about the care of adults and older people using secondary mental health services.Children and adolescents under the age of 18 are included where they are in receipt of care from adult services.

3.2 The MHMDSis designed to deliver information on people in contact with specialist secondary mental health services that is:

- robust
- comprehensive
- nationally consistent
- comparable

3.3 The MHMDS is unique in its coverage, because it covers not only services provided in hospitals, but also in outpatient clinics and in the community,

where the majority of people in contact with mental health services are treated. It brings together key information from the mental health care pathway that has been captured on clinical systems as part of patient care. During processing, this information is compiled into a single patient record, so that activity can be considered by patient.

3.4 The MHMDS also carries data on mental health clusters, the currency for Payment by Results for mental health. There is more detail on mental health clusters within the full document.

3.5 Submission of MHMDS data is mandatory for NHS funded care, including independent sector providers. Organisations make regular MHMDS submissions to the Health and Social Care information Centre (HSCIC) who process and analyse the data.

3.6 The data set also supports a wide variety of secondary use functions such as commissioning, clinical audit, research, service planning, local and national comparative analysis and monitoring government policies and legislation. Notably the dataset provides the basis for much of the analysis of mental health provided by the 'Fingertips' profiles and other benchmarking work.

4.0 WHAT IS THIS ANALYSIS CONSIDERING?

4.1 This analysis uses non-sensitive MHMDS information for CPFT provided to the HSCIC for the months of April 2014 to August 2014. A significant amount of work has been done to improve the data since April 2014. This work therefore focuses on the first 5 months of data submitted for the 2014/15 year. The data presented here is all CPFT activity, not just the CPFT activity for those people resident in Cambridgeshire and Peterborough. The commissioning source table in the MHMDS suggests that approximately 90% of the activity here is for the population of Cambridgeshire and Peterborough. This report is presented in four sections.

A. Referrals and contacts
B. Inpatient activity
C. Clusters &HoNOS
D. Other information including mental health act episode, accommodation and employment.

4.2 The MHMDS does not include all mental health treatment activity, and critically the MHMDS did not at the time of this analysis, include treatment for those under the age of 18, learning disabilities and any GP activity.

5.0 LIMITATIONS AND DATA QUALITY ISSUES

5.1 Data quality is a national issue with Mental Health Trusts finding they have considerable work to do to improve data quality and recording to produce an accurate MHMDS. CPFT are working to address data quality issues and this work is reflected in the commentary on the data. As a result any interpretation of the data for service planning is limited, and instead it illustrates the need for a continued focus on data quality. Appendix A to the report sets out some areas for the annual CCG Data Quality Improvement plan (DQIP) to focus on, many of which are already reflected in planned CPFT data quality work.

5.2 There are some elements of the data, such as diagnosis, which currently remain largely incomplete and therefore analysis is limited. In particular this means that although the output from the analysis of the data will be useful and informative it does not currently provide specific information by condition. This report is therefore much broader than the three conditions focused on in the Adult Mental Health JSNA (autism spectrum conditions, dual diagnosis and personality disorder), and the Older people's Mental Health JSNA.

5.3 The most complete and robust data is inpatient data which has been collected for some time through hospital data systems, and referral data and the analysis focuses on these areas.

6.0 SUMMARY OF KEY FACTS FROM THE ANALYSIS

6.1 Between April and August 2014, five months of data, there were:

- 9,766 referrals to CPFT, with the majority aged 18 to 44 years. Referrals are higher in females than males. Three-quarters of referrals are from GPs.

- Almost 40% of people admitted to an inpatient bed at CPFT were admitted as an emergency, with a quarter of these being admitted via A&E.The diagnostic coding shows that 97 patients (37%) had 'disorders of adult personality and behaviour, 63 (24%) had schizophrenia, schizotypal and delusional disorders and 55 (21%) had mood affective disorders. 19 patients were admitted three or more times over the five month period.

- Over half of primary diagnoses for inpatients were for schizophrenia (15%), specific personality disorders (13%), depressive episodes (12%) and bipolar affective disorder (11%) combined.

- There were just over 72,000 health care professional contacts over this time period, where the patient attended. Over 6,600 did not attend their appointment (6.9% did not attend). Around two-thirds of people were seen up to 5 times. Where recorded, the majority of contacts took place at the patient's home. Most appointments lasted between 20 minutes and an hour.

- At 31st October 2014 the largest proportion of patients were within Care cluster 3 (Non-psychotic (moderate severity)), Care cluster 4 (non-psychotic (severe)), and Care clusters 18 (Cognitive Impairment (low need)) and 19 (Cognitive impairment or Dementia (Moderate need))**.**

- In general 90% of CPFT activity is commissioned by Cambridgeshire and Peterborough CCG.

- At the end of August 64% of individuals in secondary care mental health services with CPFT were in settled accommodation. The latest data from the HSCIC on those in settled accommodation, found that at the end of July 2014 58.4% of people aged 18-69, were recorded as being in settled accommodation nationally.

- The latest data from the HSCIC found that at the end of July 2014, 6.6% per cent of patients were recorded as being employed. CPFT data for the end of August found that 7.4% employed.

7.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

7.1 The JSNA supports the implementation of priority 4 of the Health and Wellbeing Strategy (HWBS).

8.0 IMPLICATIONS

8.1 The analysis has a number of key findings with implications for future work. In particular:

a) CPFT, along with all other mental health trusts, have been and are working to improve the data quality of the MDS. To progress this further Appendix A suggests the focus of the annual Data Quality Improvement Programme (DQIP) between the CCG and CPFT. Many of the suggested areas of focus are already areas of CPFT data quality work.

b) To ensure that data quality is improved the MHMDS extract needs to be routinely triangulated with the internal CPFT dataset (Rio). Through doing this the quality of the dataset can be checked and the differences between the internal data and the MHMDS understood.

c) Once numbers a & b are completed further analysis of the data should be considered. This could include:
    a. An audit of referrals. For example this might try and answer questions such as why and where are there repeat referrals.
    b. An investigation of activity patterns by cluster including changes in HoNOS ratings over time.

9.0 RECOMMENDATION/DECISION REQUIRED

9.1 The Health and Wellbeing Board is asked to note the findings of this supplement to the adult and older people's mental health JSNAs, which will be made available at:
http://www.cambridgeshireinsight.org.uk/older-peoples-mental-health-2014

SOURCE DOCUMENTS

Mental Health Minimum Dataset v4.1 Dataset Specification. Health and Social Care Information Centre.
Monthly MHMDS Report: July 2014 final data. Health and Social Care Information Centre.