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Mental Health Bulletin:

Annual report from MHMDS returns - England 2011-12, initial national figures

Published 19 February 2013

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Version:	**V1.0**
Date of publication	**19 February 2013**

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Executive Summary

The figures in this annual report provide a more comprehensive picture of people using adult specialist mental health services than has been published before. The new version of the dataset (MHMDS v4) that underpins this annual report was introduced in April 2011/12, with changes to the way some data was collected and processed and these have contributed to a significant increase in overall numbers. The report also uses the latest population figures from the 2011 census.

This report therefore contains a reduced set of time series analyses and effectively presents a new baseline for some established measures, particularly those relating to people only in contact with community services.

Key findings include:

- Over 1.5 million people were in contact with specialist mental health services in 2011/12 and the rate of access to services is 3,032 per 100,000 population (approximately one person in 32 in England).
- A third (33.8%) of people who use specialist mental health services are aged 65 or over (530,833). This is double the proportion who are aged 65 or over in the general population (16.3% of people).
- The number of people spending time in an NHS hospital during the year was the lowest ever recorded in MHMDS (99,098) and this appears consistent with a fall in the average number of occupied beds from 21,076 in 2010/11 to 18,924 in 2011/12.
- 7.6% of male service users spent time in hospital compared with 5.4% of female service users. 17.2% of all service users who spent time in hospital during the year were men in the 18-35 age group.
- Of those people who spent time in hospital over 42% were subject to the Mental Health Act ('the Act') at some point in the year.
- There are big differences in the profile(s) of men and women experiencing detention during the year. For example 42.7% more women than men were subject to civil detentions in the 65 and over age group (4,412 women compared with 3,092), whilst men outnumbered women by 69.6% in the 18-35 age group (6,938 men compared with 4,092 women).
- Experimental analysis of data about people assigned to the care clusters being used for Payment by Results ('PbR') provides more comprehensive information than has been available previously about the kinds of problems that bring people into contact with services (although they do not provide a clinical diagnosis). The care clusters are grouped into super clusters which provide a broad grouping for patients according to clinically assessed need. The figures suggest that over 69% of people aged 65 or over who were assigned to a cluster on 31 March 2012 (128,873) had needs consistent with the allocation to cognitive impairment or dementia super cluster.
- Up to date 2011 census data on the ethnicity of the population suggests that rates of access to mental health services for BME groups are lower than previously thought. However, once in contact with mental health services, rates of access to hospital care for all minority groups (except the Any other ethnic group) are higher than for the White British group; for example the highest rates of access to inpatient care were for the Caribbean , African, and any other Black background groups (at 13.8, 12.9 and 13.4 per 100 service users, respectively) compared to 6.9 for the White British group.

A special feature in this year's report uses a linked dataset (based on MHMDS and ONS mortality data) to compare mortality rates of those in contact with mental health services with the general population in 2010/11. It also provides information about cause of death. This is the first time that it has been possible to use routinely collected administrative data at a national level for this purpose. The analysis shows that:

- People in contact with specialist mental health services have a mortality rate that is 3.6 times as high as the general population at 4007.8 per 100,000 (83,393 deaths in total) compared to 1,121.8 per 100,000 in the general population
- By age, the difference in mortality rates was largest among people aged 30-39, where the mortality rate for people in contact with services was nearly five times as high as the general population at 300.4 per 100,000 (524 deaths in total) compared with 63.2 per 100,000 in the general population.
- Rate of death was higher for people aged 19 and over using services than for the general population across all underlying causes (using ICD10 Chapters), but particularly for mental and behavioural disorders and diseases of the nervous system, such as Alzheimer's disease. The difference in underlying cause of death was greatest for mental and behavioural disorders (where the leading cause of death was unspecified dementia); at 12.2 times that of the general population at 556.1 per 100,000 (or 11,571 deaths in total) compared to 45.6 per 100,000.
- It is also noticeable that rates were at least twice as high in the under 75 age group for lifestyle-related diseases including:
    - Nearly four times the general population rate of deaths from diseases of the respiratory system (at 142.2 per 100,000 service users, compared with 37.3 per 100,000 in the general population).
    - Just over four times the general population rate of deaths from diseases of the digestive system (at 126.1 per 100,000, compared with 28.5 per 100,000 in the general population).
    - 2.5 times the general population rate of deaths from diseases of the circulatory system (at 254.0 per 100,000 compared with 101.1 per 100,000 in the general population).
- These causes accounted for over 45.1% of deaths in this age group (8,555 out of 18,979 deaths for people aged under 75).
- Within these disease areas specific conditions accounted for a high proportion of deaths among service users (under the age of 75):
    - Diseases of the liver; at 7.6 per cent of deaths (1,434 in total).
    - Ischaemic heart disease; at 9.9 per cent of all deaths (1.879 in total).

Foreword

A new version of the Mental Health Minimum Dataset (version 4) was mandated for collection from April 2012 and new arrangements for processing the data were implemented to coincide with these changes. During 2012 the Health and Social Care Information Centre (HSCIC) also undertook a consultation on the statistics produced from MHMDS with the aim of ensuring that the information produced from the new version of MHMDS continues to meet users' needs. Both these events have an impact on this latest annual publication.

The responses to this consultation - and less formal feedback gathered in the course of dealing with stakeholders, showed that the analysis in the Mental Health Bulletin is widely valued. The counts and profiles of people using mental health services, which we introduced in our first publication in 2008, are now established and being used in a variety of ways and they remain the core of this publication.

This analysis of the service user population was devised to exploit the strengths of the original dataset (full, rich demographic information with plenty of detail about the kinds of interaction the patient has had with services) and to minimise the impact of its weaknesses (a lack of clarity about the patient pathway, including what happened, when and for how long).

Changes to the way the data is processed means that it is now received in a more granular and transparent format than previously. We have had to develop new ways to assure the quality of this torrent of data – complex relational data for around 3/4 million patients in each submission, many of whom have spells of care lasting months or years –and all our existing analysis has had to be re-designed from scratch.

So the focus of this year's publication is to provide some continuity over the period 2010/11 to 2011/12. We have kept changes to a minimum and the content of this release is essentially the same as last year. The only changes are those necessary to accommodate the changes to the dataset and the way it is received by HSCIC, or are changes where we felt we could quickly respond to feedback and make improvements.

Two features are worthy of note: we have used the new 2011 Census data to provide the most up to date information on rates of access to services by ethnic group. We have also included a special feature on analysis of a linked dataset including selected information from the ONS mortality data and MHMDS. This was developed during 2012 as the data source for the new excess mortality indicator (number 1.5) in the NHS Outcomes Framework.

The MHMDS consultation revealed an appetite for much more information to be produced from MHMDS and for wider engagement with stakeholders in developing this. The design, frequency and dissemination method for such analysis is yet to be determined but we shall continue to work closely with providers, commissioners, policy leads and other stakeholders to ensure that it meets users' needs.

Jo Simpson

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Introduction

Content of this publication

This is the sixth annual report from MHMDS and covers the financial year 2011/12. Previous reports were produced from an annual MHMDS submission, but in 2011/12 the changes to processing of submissions introduced to support MHMDS v4 included the retirement of an annual refresh submission. The analysis in this report has been produced from a single file compiled by the HSCIC from 4 quarters 2011/12 data, making use of the new centrally derived unique Spell ID to link patient spells across quarters. The associated data quality measures for the 4 quarters data have already been produced and are available on the HSCIC website.

Quarterly analysis for 2011/12 has already been released in a quarterly publication, which includes different measures to this annual report.

For operational reasons this publication is being released in two parts. The first includes national analysis and the second will provide organisation level analysis.

The content of this first release is:

- This report on the analysis
- National reference data tables
- A background data quality report

And can be found at: http://www.ic.nhs.uk/pubs/mhb1112

The second release, due for publication later in spring 2013, will include:

- Organisation level reference tables
- A machine readable file of aggregate mental health service activity data

Each annual release has included a special feature on a related topic of interest. This year's feature provides analysis of the linked dataset initially created to support the development of the new indicator in the NHS Outcomes Framework: Excess mortality for people with severe mental illness. We know there is a lot of interest in this linked dataset and our special feature provides some basic analysis of the data with an accompanying narrative.

The release also includes rates of access to services by ethnic group, based on the latest available 2011 census data. When further age and gender breakdowns are available we plan to provide standardised as well as crude rates, but only the data that could support the calculation of crude rates of access was available in time for this release.

Changes to this publication

As well as the change to a quarterly data source, we have had to redesign some analyses to take account, as far as possible, of known differences between methods of data submission processing (some derivations which were previously part of the processing (assembly) of MHMDS submissions are now constructed by HSCIC as part of receipt and load of data). Some derivations have also been changed to improve accuracy and details are shown in the 'constructions' and 'derivations' worksheets of the reference data tables.

We have also included some additional statistical breakdowns to take account of user needs identified during our consultation (see below). Time series have been maintained at high level within our reference data tables but we cannot be confident that at more detailed breakdowns (eg age and gender) we can make like-for-like comparisons with statistics from the previous data source. Data are shown for the current year only and will be extended as a new time series going forward.

We have also had to omit some tables; the method previously used for average length of stay could not measure length of stay across submissions and so the maximum length of stay that could be reported was a year. Version 4 will support a more accurate measure but further engagement with key stakeholders, such as commissioners, is required to understand how this should be defined. We have also omitted tables showing statistics on new users on CPA with recent HoNOS assessment, since we now publish similar analyses as part of our routine quarterly reports throughout the year. For this year only, this Bulletin will be published in two parts. The second release, due for publication in April, will include organisational level analysis and an underlying machine readable data file. The machine readable file of underlying activity data will include mental health service activity by CCG and provider combinations, similar to last year but with slight amendments to information about contacts, drawing on the new, richer data source. An update of Table 1.5 (Rates of access to NHS funded adult specialist mental health services per 100,000 population by ethnic group, 2011/12) containing standardised rates calculations will be issued once the appropriate population breakdowns are available from the Office for National Statistics (ONS).

Please see the Health and Social Care Information Centre's methodological changes page for further details[1].

Consultation on MHMDS statistics

In view of the data source change to MHMDS version 4, we held a public consultation[2] in 2012 to determine user needs and requirements of national MHMDS data reporting at service and provider level. A number of recommendations were made as a result (including a demand for much more information, particularly population based analysis and information at a more granular geographic level) which informed the new design of this bulletin. We will regularly review our MHMDS statistics to ensure that they remain relevant and a useful source of MHMDS information and continue to welcome feedback on this publication at any time via:

enquiries@ic.nhs.uk

The consultation on statistics produced from the MHMDS aimed:

1. To ensure that information produced nationally, at service level and commissioner level meets the needs and requirements of all of our users;
2. To assess whether the statistics in our MHMDS publications are up to date and are appropriate;
3. To assess how the change of data source could add value to these statistics;
4. To find out which statistics are most important in supporting PbR;
5. To assist in designing new products required under the Transparency Agenda;
6. To form part of our preparation for future assessment of these statistics by the United Kingdom Statistics Authority (UKSA) against National Statistics standards.

Further details can be found in the full consultation report[2].

[1] Methodological changes (see Mental Health section)
http://www.ic.nhs.uk/pubs/methchanges
[2] Consultation on statistics produced from the mental health minimum data set (MHMDS):
http://www.ic.nhs.uk/mhmdsconsultation

People using services

Definitions, changes in methodology, data quality, time series and rounding conventions

Where reference is made to 'mental health services' or 'services' in this report, this means NHS funded specialist mental health services for adults, including people over the age of 65, including NHS funded services delivered by independent sector providers. Where reference is made to NHS services, this is only services provided by NHS providers. Where reference is made to 'hospitals' this means specialist mental health inpatient services.

A methodological change paper (http://www.ic.nhs.uk/pubs/methchanges) was published prior to this release providing detail of changes, but where relevant, aspects of these changes are mentioned in the text as well.

This report is accompanied by a background data quality report but some further explanation of data quality issues is included in the commentary, where it is considered important for interpretation.

Where time series analysis is presented it is for NHS providers only, as prior to 2010/11 no independent sector providers submitted MHMDS, unless otherwise stated, all analysis of 2011/12 data refers to figures for all providers.

Whole numbers are stated precisely and percentages are presented to one decimal point accuracy.

Number of people using services in the year

Change: people are categorised as 'admitted' or 'other', whereas previously they were categorised as 'admitted', 'non admitted' or 'no care'. The admitted category remains the same but 'other' incorporates both the 'non admitted and 'no care'.

Analysis of quarterly data for 2011/12 shows that 1,607,153 people used NHS funded mental health services during the year. These latest figures suggest a rate of access to services for England of 3,032 per 100,000 population (using the latest 2011 census figures), compared with 2,789 per 100,000 in 2010/11. This increase can be attributed to the rise in the number of people recorded as being in contact with mental health services. It should also be noted that these rates use the most up to date England population data from the Office for National Statistics 2011 Census ('2011 Census').

The increase in the overall number of service users may be partly due to changes in the way the data is processed, that more accurately capture providers' caseload. However, it is also possible that a delay in updating local systems for submitting data in MHMDS v4 format has resulted in some inactive cases that should have been closed, being included in submissions. There is further information about how we have investigated this issue in the Service Activity section and in the Background Quality Report that accompanies this release.

Counting and categorising people

Each person is counted once in the year and in only one category, regardless of the number of times they were in contact with services and whether or not they were in contact with more than one provider.

Individual patient spells (the basic MHMDS record) are categorised, ranked and flagged so that only one patient spell per person is used in each measure. The category of the flagged record is the one shown in the analysis and each person appears in only one category.

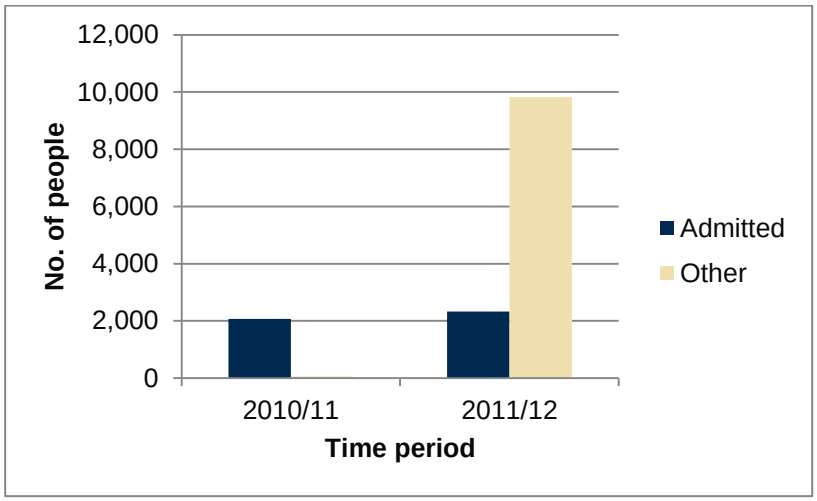
For example, people counted in the 'admitted' category spent at least one night in hospital during the year, but will also probably have had contact with services delivered in the community. However a spell that includes time as an inpatient is ranked over spells that did not include time spent in hospital, for this analysis. People in the 'other' category did not spend any time in hospital during the year.

Where people are categorised as being in an independent sector provider, they could also have received services from an NHS provider, but this spell will have received a lower rank and not been flagged for the particular analysis.

Due to the large increase in the overall number of people using services only limited high level time series are included in this report and this first report from MHMDS version 4 effectively re-baselines many of established analyses in this report.

This years' total also includes a much larger number of people for whom the most intensive level of care they received was in an independent sector provider (ISP). This is partly due to more ISPs submitting MHMDS (six ISPs returned data in 2011/12 compared with two in 2010/11) and noticeably due to the increase in the number of people in the 'other' category of care within ISP returns – that is people who had access to services delivered outside hospital who did not also spend time as an inpatient. This increased from 62 to 9,923 between 2010/11 and 2011/12, as shown in the chart below and is due to two of the new providers sending data providing community based services as well as hospital care As so few ISPs are submitting MHMDS the data the data may not be representative of the sector.

Figure 1: Number of people accessing NHS funded independent sector services by highest level of care, by year



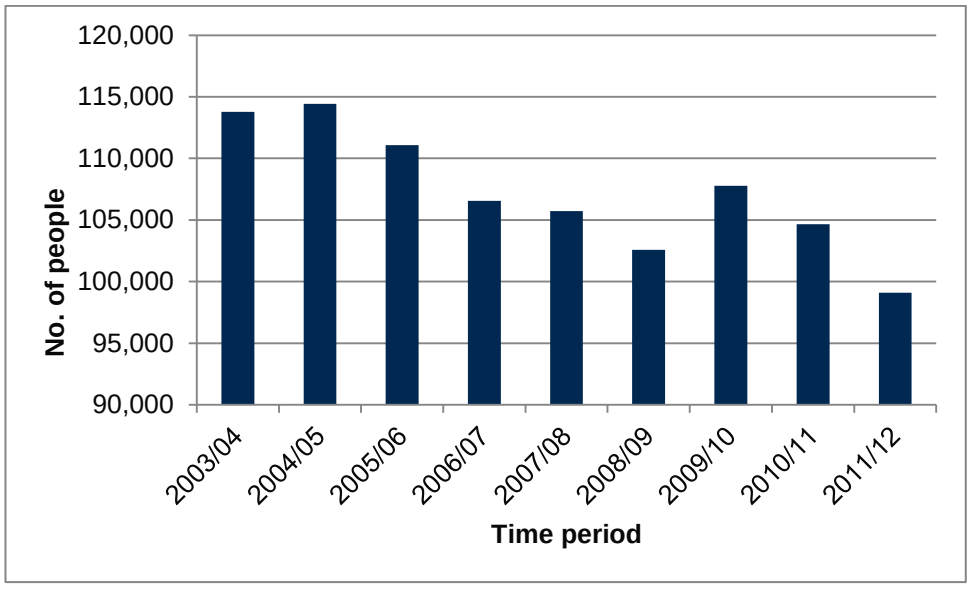
Data source: Table 1.1 from the supporting national reference data tables

Hospital and community care

101,424 of the people who accessed services in 2011/12 spent some time in hospital at some point during the year. Not only is the number of people who spent time in hospital (categorised in these reports as 'admitted') smaller than the number reported in 2010/11, when it was 106,719, but it is also a smaller proportion of the total number of people in contact with mental health services (6.3%, compared with 8.1% in 2010/11). In 2010/11 and 2011/12 these figures included a small number of patients in NHS funded independent sector services.

Figure 2 below, which presents a time series for NHS providers only, shows that the lower number of patients receiving care as an inpatient in 2011/12 continues a broadly downward trend since 2004/05 and is the lowest number recorded since MHMDS started to be submitted in 2003/04.

Figure 2: Number of people spending time in NHS provider inpatient services, by year



Data source: Table 1.1 from the supporting national reference data tables

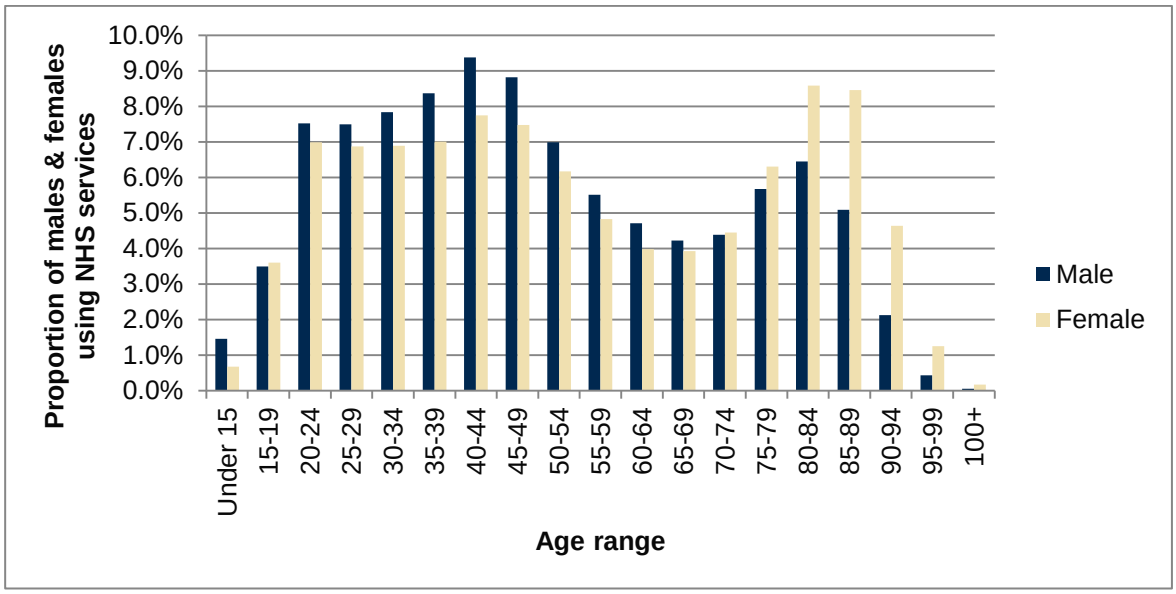
This would be consistent with a reduction in the number of beds available in NHS providers, as suggested by the reduction in the number of beds available each day (described later in this report) and as a result of service re-organisation and ward closures.

Age and gender

The age and gender profile of people who use adult specialist mental health services is distinctive and differs from the general population where numbers decline steadily after the age of 65 for both men and women. 33.8% of people using services are aged 65 or over (530,833), compared with 16.3% in the latest population data. There are further comparisons of these two populations in the special feature (page 36).

When service users are broken down by gender and 5 year age band, the largest proportion of men are in the 40-44 year age group (9.4% compared with 7.7% for women), whereas for women the age group with the largest proportion of service users is the 80-84 year age group (8.6% compared with 6.4% for men).

Figure 3: Percentage of males and females using NHS funded services by age group, 2011/12



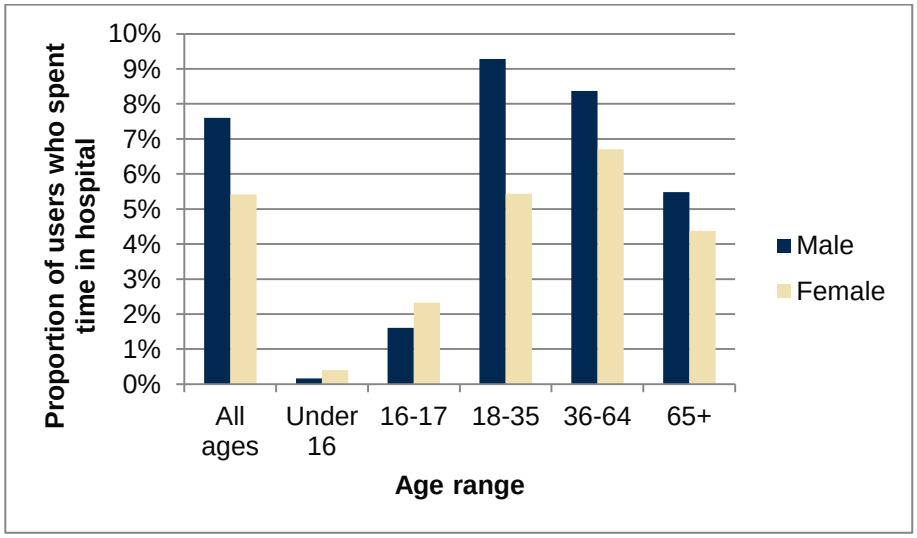
Data source: Table 1.3 from the supporting national reference data tables

The largest percentage difference between men and women was in the 85-89 age group, which included 8.5% of women compared with 5.1% of men.

In the 20-69 age group, the proportion of men using services is larger than the proportion of women. Over the age of 69 the proportion of women using services becomes much larger than the proportion of men.

The proportion of people who were in the 'admitted' category of service users and spent at least one day in the hospital during the year, also varies by age and between males and females. 7.6% of men spent time in hospital compared with 5.4% of women. Figure 4 shows that a larger proportion of men than women spent time in hospital across all age groups, except in the 16-17 age group. The difference between men and women was greatest in the 18-35 age group where 9.3% of men were in the 'admitted' category compared with 5.4% of women.

Figure 4: Proportion of service users in each age group who spent time in hospital during the year, by gender, 2011/12



Data source: Table 1.2 from the supporting national reference data tables

Legal status of people who spent time in hospital

Two consultations relating to statistics about uses of the Mental Health Act in health services

During 2012 the Health and Social Care Information Centre undertook a consultation on the annual National Statistics publication: Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment. As well as ensuring the continued usefulness of the statistics by consulting with users on their needs, the aims of the consultation included assessing how a potential change of data source from the Admissions, Changes in Status and Detentions under the Mental Health Act Collection (KP90) online collection to administrative data from MHMDS could add value to these statistics.
Responses indicated that stakeholders welcomed the potential in MHMDS to provide a wider range of analysis about patients subject to the Mental Health Act, particularly the greater demographic detail and information about what happens prior to and after detention. However, the existing publication is established and respected and users were cautious about a change of data source until concerns about data quality in MHMDS could be addressed.

Overall findings confirmed that the measures reported in the National Statistics ('NS') publication that count uses of the Act, in all its detail, are important for monitoring purposes and should be retained.

The counts of whole year populations provided in this annual Bulletin, however, were seen as complementary to the NS and should be continued.

A working group of experts convened as part of the consultation also recommended small changes to some definitions used in the NS, for clarity and consistency. Detentions under the Act are now grouped into the following categories:

- Detentions on admission to hospital
- Detentions subsequent to admission
- Detentions following use of sections 135 and 136
- Detentions following revocation of a CTO

The use of short term holding powers under sections 4, 5(2) and 5(4) together with the use of sections 135 and 136 are no longer included in the measure of total detentions (although detentions following uses of these powers, for example, section 2 following section 5(4) are).

To be consistent with these slight changes we have amended the grouping of mental health care spells by the most restrictive legal status that applied during the year to include a new category of 'holding powers'.

Before the KP90 collections could be retired? we would therefore ideally wish to demonstrate data quality and coverage are adequate by providing some parallel running of some of the NS measures. To this end, HSCIC has started to release counts of detentions on admission to hospital (see above) in its routine MHMDS release, together with new data quality measures highlighting inconsistencies in the data about uses of the Mental Health Act.

The latest Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment published in October 2012 also included some parallel analysis (badged as experimental analysis) at provider level and these showed that there is wide variation in comparability of the data sources between providers. Taking into account that MHMDS does not include services for children and young people or learning disability services, the counts are expected to be lower from MHMDS. However, for some providers they were significantly lower and one NHS provider returned no Mental Health Act data in MHMDS. Coverage of the independent sector in MHMDS is also still very low.

It is expected that the recommendations in the report on responses to the Secretary of State's Fundamental Review of Returns, due for publication in spring 2013, will propose the retirement of the KP90 collection once equivalent analysis can be produced from MHMDS. At this point it is expected that the KP90 will need to be continued at least in 2012/13 and possibly longer for organisations that do not complete the MHMDS.

Change: inpatients are categorised as 'informal', 'subject to holding powers', 'civil detentions' or 'court and prison disposals'. 'Subject to holding powers' and 'civil detentions' are new categories replacing 'place of safety orders' and 'part 11 detentions'. This is to provide consistency with revised definitions in the NS on uses of the Mental Health Act, implemented as a result of a national consultation in 2012. The total of inpatients 'subject to the Act' is equivalent to the 'total detained' category used previously, except it includes people on Community Treatment Order who are voluntary inpatients. These people as a distinct group could not be identified previously and so it is not known if they were included before.

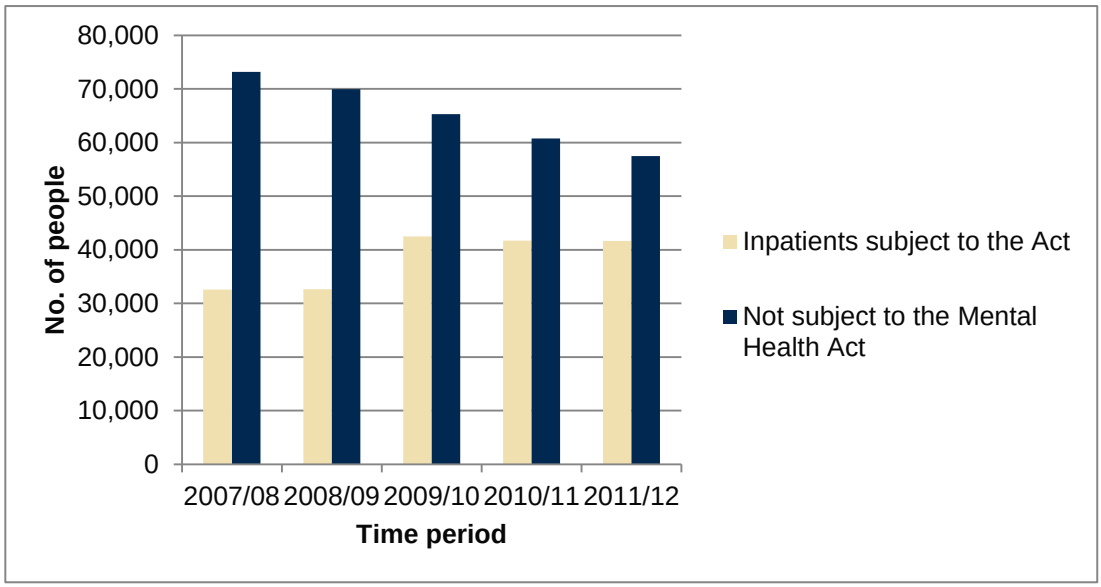
The data for 2011/12 show that 42.4% per cent of people (43,051 out of 101,424) who spent time in hospital during the year were also subject to the Mental Health Act at some point during the year.

Although high secure services were eligible to submit MHMDS for the first time in 2011/12, there is no evidence that the providers who run these services included data for high secure hospitals in their returns and so people who spent time detained in high secure hospitals are probably not included.

The figures should be treated with caution, because of methodology changes to produce this analysis from version 4 MHMDS and also because of evidence that some providers did not provide comprehensive information about uses of the Mental Health Act in their returns (see previous page). The figures probably slightly undercount the proportion of inpatients who spent time subject to the Mental Health Act.

Within NHS providers, the data show a slight fall in the number of inpatients being subject to the Mental Health Act during the year the (41,628 compared with 42,818 in 2010/11) but they represented a larger proportion of all inpatients than in 2010/11 (42.0% compared with 40.9%). These figures suggest a continuing trend for psychiatric beds to be increasingly occupied by people subject to some form of legal restriction.

Figure 5: Number of inpatients in NHS providers by most restrictive legal status, by year



Data source: Table 2.1 from the supporting national reference data tables

The number of men who spent time in hospital and were subject to the Mental Health Act at some time in the year ('subject to the Act') was larger than the number of women and was a higher proportion of all inpatients (44.7% of men compared with 39.9% of women). But while the proportion of male inpatients who were informal patients was smaller than the proportion of females, the actual number of men and women who were informal inpatients were similar, as shown in figure 6 below (29,419 men compared with 28,624 women).

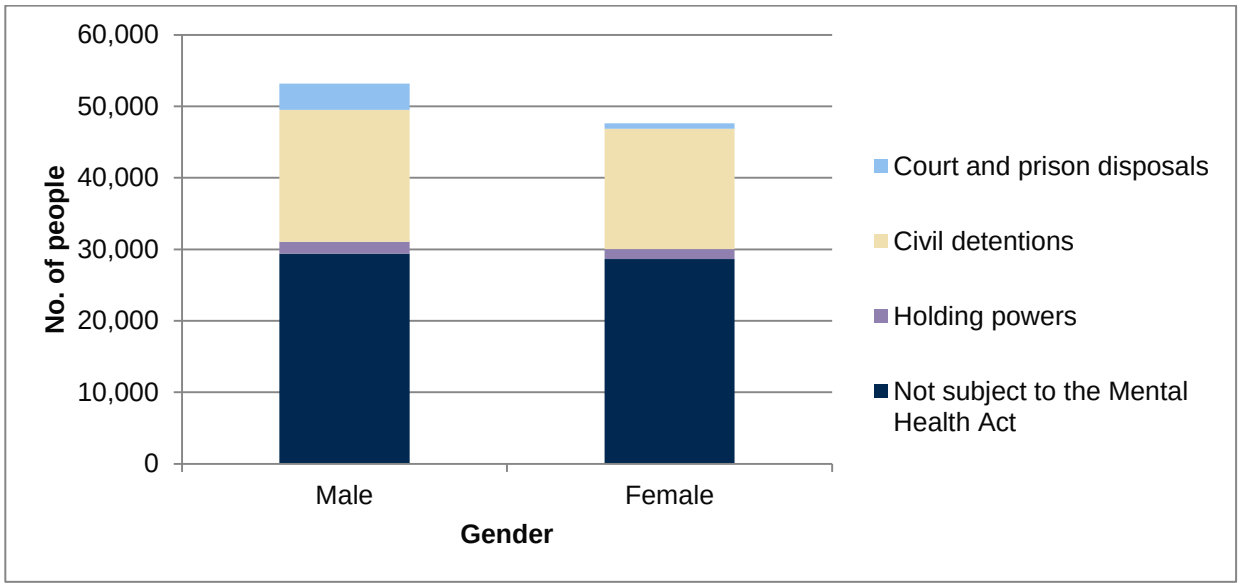
More detailed breakdown of these figures categorises each person by the most restrictive legal status that applied to them during the year and counts them once in this category. Table 1 below shows how different sections of the Mental Health Act were grouped into broader categories for reporting purposes and the text box on page 19 explains the concept of legal status restrictiveness which was introduced into MHMDS in 2003/04 and continues to be used in this analysis. All people categorised in the holding powers, civil detentions and court and prison disposals categories were 'subject to the Mental Health Act' during the year, even though the people categorised under 'holding powers' were liable to be detained for a short period of time, but not actually detained in hospital.

Table 1: Grouping of legal status into categories, according to legal status restrictiveness score

Most restrictive legal status category	Restrictiveness score	Legal Status
Informal		
	0	Informal
Holding powers		
	1	Formally detained under MHA Section 5(4)
	2	Formally detained under MHA Section 5(2)
	3	Formally detained under MHA Section 135
	4	Formally detained under MHA Section 136
Civil detentions		
	5	Formally detained under MHA Section 4
	6	Formally detained under MHA Section 2
	6.5	Subject to guardianship under MHA Section 7
	7	Supervised Discharge (Mental Health (Patients in the Community) Act 1995; Mental Health Act Section 25(a)
	8	Formally detained under MHA Section 3
Court & prison disposals		
	15	Formally detained under other acts
	20	Formally detained under MHA Section 35
	21	Formally detained under MHA Section 36
	21.5	Subject to guardianship under MHA Section 37
	22	Formally detained under MHA Section 38
	23	Formally detained under Section 37 or under Criminal Procedure Act
	24	Formally detained under MHA Section 48
	25	Formally detained under MHA Section 47
	26	Formally detained under MHA Section 44
	27	Formally detained under MHA Section 46
	28	Formally detained under MHA Section 37 with section 41 restrictions
	29	Formally detained under MHA Section 48 with section 49 restrictions
	30	Formally detained under MHA Section 47 with section 49 restrictions
	31	Formally detained under MHA Section 45A

Date Source: MHMDS Specification v4.0

Figure 6: Number of male and female inpatients by most restrictive legal status in the year, 2011/12



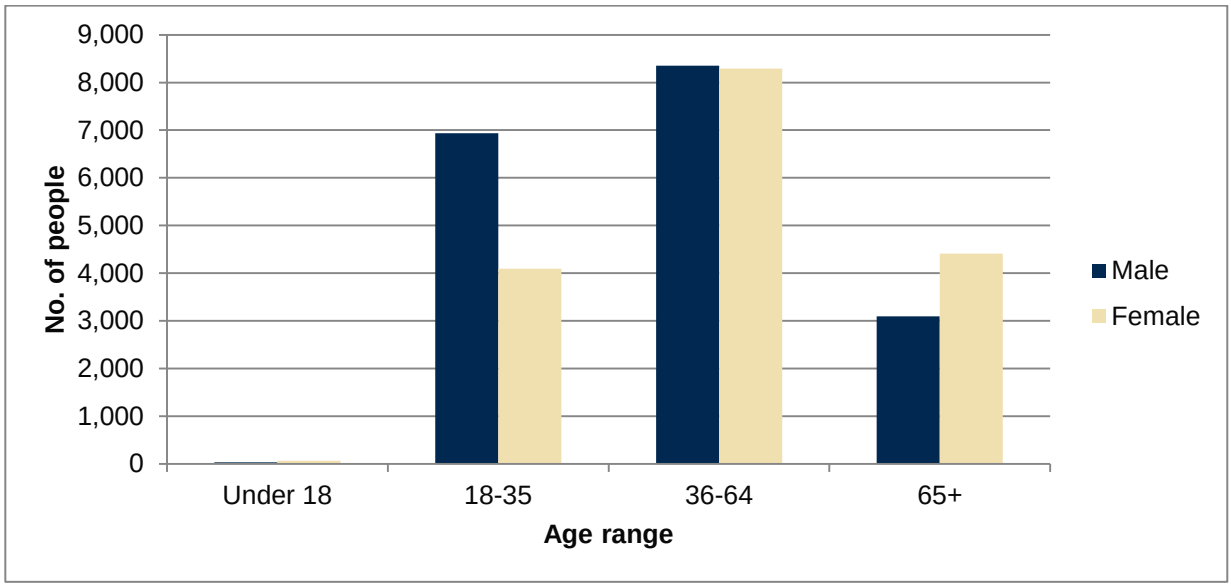
Data source: Table 2.2 from the supporting national reference data tables

The number of men detained in hospital under the most restrictive sections of the Mental Health Act (court and prison disposals) was nearly five times higher than the number of women (3,665 compared with 759) and the difference in these numbers accounted for the larger part of the difference between overall numbers of male and female inpatients.

For 77.6% of men and 88.7% of women who were subject to some form of restriction under the Mental Health Act a civil detention was the most restrictive part of the Mental Health Act that applied to them in the year.

Unlike the KP90, the data source for NS about uses of the Mental Health Act, the MHMDS supports analysis by age as well as gender and this shows significant differences in the use of civil detentions for men and women in different age groups, as shown in figure 7.

Figure 7: Number of inpatients for whom a civil detention under the Mental Health Act was the most restrictive legal status that applied in the year, by age and gender, 2011/12



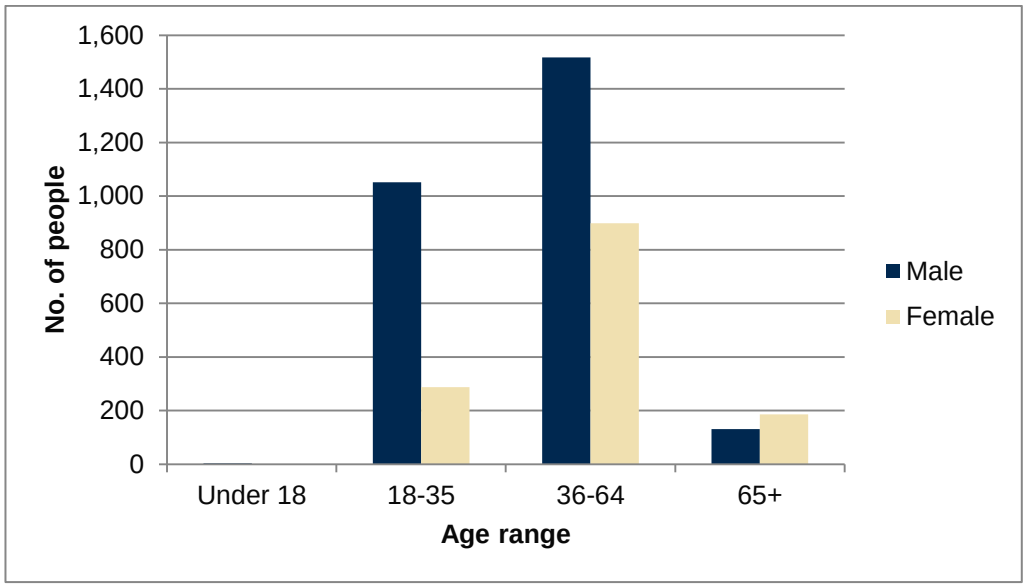
Data source: Table 2.2 from the supporting national reference data tables

42.7% more women than men were subject to civil detentions in the 65 and over age group (4,412 women compared with 3,092), roughly equal numbers of men and women were in the 36-64 age group (8,356 men compared with 8,293 women) and men outnumbered women by 69.6% in the 18-35 age group (6,938 men compared with 4,092 women). Although there were only 95 people under 18 in this category (they would be expected to be in CAMHS services, not adult services), the number of young females who had been subject to a civil detention was larger than the number of young males.

Community Treatment Orders

Some comparison figures with the count of people on Community Treatment Orders (CTO) published in the National Statistics publication: Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment are included in Table 2.4 of the accompanying national reference data tables. These give a breakdown by gender and age and by ethnic group of the figures that appear in the National Statistics publication (which only includes a breakdown by gender).

Figure 8: Number of people on a CTO on 31 March 2012, by age and gender



Data source: Table 2.4 from the supporting national reference data tables

Whilst the MHMDS sourced figure (4,076) is lower than the national statistic (4,764), the MHMDS figure does not include learning disability or CAMH services or all independent sector hospitals. The MHMDS figures show that the majority of people on CTO are of working age, and suggest that in the 65 and over age group more women than men are on CTO.

Categorising people by highest legal status restrictiveness score

The concept of a 'legal status restrictiveness score' was introduced with the original Mental Health Minimum Dataset in 2003 and was derived for each mental health care spell record during assembly of data submissions. The data now flows with the full detail of individual episodes where the Mental Health Act has been applied, but a derivation for categorising spells of care according to the most restrictive use of the Act applied to the person during that spell remains useful and has been retained. The derivation is now calculated by the HSCIC as part of our database load routine. The scoring assigned to each legal status code is specified in the MHMDS v 4 Data Specification. The concept enables us to assign patient records to discrete categories and report accordingly.

For example, a person who was subject to the Mental Health Act on a number of occasions, first being brought to a section 136 suite at the hospital, perhaps on more than one occasion and eventually being formally detained under section 3, will be categorised under section 3, as it is more restrictive both in the nature and duration of the restraint, than a section 136. Table 1 above shows the restrictiveness score assigned to different sections of the Act and how they are grouped for presentation of the data.

The holding powers category includes people who were subject to a section 135 or 136 order during the year and people subject to doctors' or nurses' holding powers (ss 5(2) and 5(4)) *and* who were not subsequently or at any other point during the year, formally detained. It is not the same as a count of people subject to s135 or 136 during the year because some of these are subsequently detained, for example under a s2 or s3. The people categorised here in the holding powers category are a small proportion of the total number of inpatients subject to the Mental Health Act, as most are formally detained at some point.

Most inpatients subject to the Mental Health Act were detained under other sections in Part 11 of the Act and these are grouped under 'civil detentions'. The civil detentions category created for this analysis also includes the very small number of people subject to Guardianship under s7 of the Act as well as the small number of people on Community Treatment Orders who were voluntary inpatients – or had been temporarily recalled to hospital – but were not detained during the year. These figures are given in the notes to Table 2.1. However, for the majority of inpatients in the civil detentions category the most restrictive section, they were subject to during the year was a section 2 or a section 3 detention.

Complexity of care

Ways of describing complexity of care

Previous versions of this annual report have presented analysis of the population of people using NHS funded adult mental health services ('services') by age and gender and ethnic group. In order to provide more information about the severity of their illness and complexity of their needs, service users have been categorised according to whether or not they spent time in hospital during the year or were on the Care Programme Approach, CPA. (Care for patients with more complex needs is co-ordinated using CPA, although a small number of complex and high risk individuals may be receiving care in eating disorder or psychotherapy services where CPA may not be used).

Previous reports have shown, however, that the majority of people in contact with services do not spend time in hospital or on the CPA and that these people are also less likely to have a clinical diagnosis recorded. It has therefore been difficult to provide detail about why most people are in contact with services.

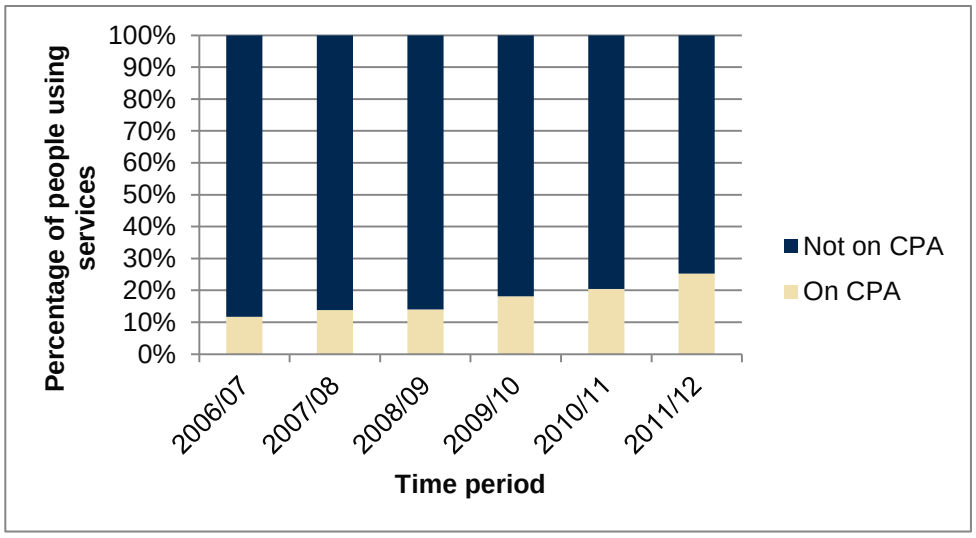
However, mental health care clusters (the proposed currency for delivering payment by results in mental health services) are designed to categorise groups of patients according to need. Clusters were introduced to MHMDS in 2010/11 and the quarterly reports produced this year show that the proportion of people assigned to a cluster has increased significantly over the year. In response to a demand for more information about clusters and to complement the existing tables, we have therefore included experimental analysis showing the profile of people on different clusters at the end of the year 2011/12, alongside the established reports about the number of people on CPA.

Number of people on CPA

In 2011/12 the data show that the proportion of people on CPA in NHS services increased from 20.5% to 25.3% since the previous year. Not only were people on CPA a larger proportion of all people in contact with services, there were many more of them (403,615 on CPA in 2011/12 compared to 263,203 in 2010/11).

There are a number of explanations for this and we do not believe the data should be interpreted as showing that a much larger proportion of patients required complex care in 2011/12, although this could be part of the reason.

Figure 9: Number of people using services by CPA status, by year



Data source: Table 3.1 from the supporting national reference data tables

In MHMDS v4 the way that CPA information is collected was amended (in line with the change in policy in 2008, which removed the two levels of CPA – 'Standard' and 'Enhanced' so that a person is either on CPA or not). However, we have heard that in some cases local systems have not been updated and providers have had difficulties collecting the data in the required format. Some of the people recorded as being on CPA are probably not but are on the old 'standard CPA'. The rise in the proportion of people on CPA is partly driven by improved data collection but may be inflated by difficulties providers have had in submitting data in the required format. HSCIC has published indicators where the denominator is people on CPA throughout 2011/12 and some adjustments to volumes in each quarter, occurred over this period, which might reflect improvements in the quality of submissions.

These figures should also be interpreted in the light of the discussion on the overall rise in the number of people recorded as being in contact with services.

Number of people assigned to a mental health care cluster on 31 March 2012

Mental health care clusters are the currency developed to support Payment by Results (PbR) for mental health services. The care cluster approach involves clinicians assessing the clinical need of patients and allocating them into one of 22 clusters depending on their care needs. As their clinical needs will be related to diagnosis and the severity of their condition, the cluster provides another way of analysing people using specialist adult mental health services. As the majority of these people do not spend time in hospital and traditionally diagnosis is not recorded by professional staff groups treating people in the community, the cluster has potential to help us categorise most people in contact with services according to their clinical need and likely condition. As the clusters are relatively new, there may still be issues with the consistency of allocating patients to clusters across the country.

It's estimated that around 61% of the total caseload reported in MHMDS at the end of the year were considered 'in scope' for assignment to a cluster, as shown in table 2 below (patients who have not yet been assessed or who are in the care of some specific teams are currently not in scope). Approximately 64% of people on the case load at the end of the year who were 'in scope' for clustering (744,675 people) at the end of the year had been assigned to a cluster. A one day count has been used to avoid the complications presented by people being on several clusters during the year and also because the number of people assigned to a cluster has increased over the course of 2011/12 as the new arrangements become established.

Table 2: Number of patients with an open spell of care on 31 March 2012 by cluster status

Total patients	1,218,389	100%
of which:		
in scope for clustering	744,675	61%
of which:		
assigned to cluster	474,321	
not assigned to cluster	270,354	
not in scope	473,714	39%

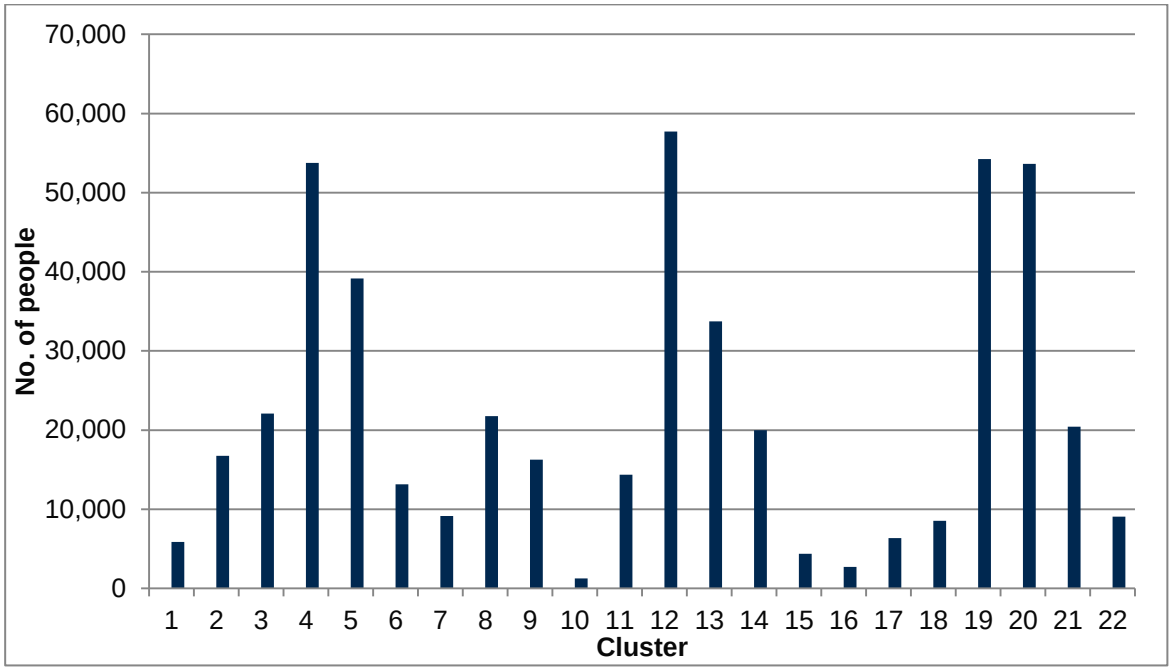
Data Source: Q4 2011/12 MHMDS returns

During 2011/12, HSCIC started to produce some experimental analysis in the quarterly MHMDS releases showing the proportion of people assigned to a cluster and the experimental analysis in this report builds on this work, but adds the dimension of the allocated cluster, age, gender and ethnic group.

The analysis can start to help us understand why different groups of people are accessing services and their level of need.

The benefit of this information is that although it is not complete it is much more comprehensively recorded now than any other data item that suggests what a patient's needs might be.

Figure 10: Number of people assigned to a cluster on 31 March 2012, by cluster

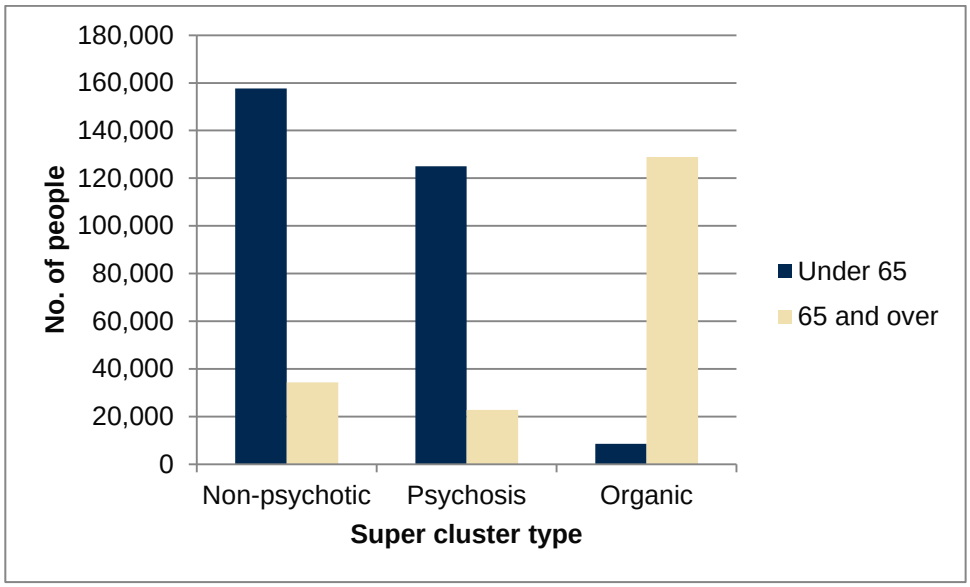


Data source: Table 3.5 from the supporting national reference data tables

At the end of the year, out of patients who had been assigned to clusters, the largest number (57,706 people) had been assigned to cluster 11 for 'on-going recurrent psychosis, low symptoms' (13.8%). The next largest group (54,256 people) was for cluster 18 'cognitive impairment, low need', followed by cluster 3 (53,769 people) for 'non psychotic - moderate severity' and cluster 19 (53,637 people) for 'cognitive impairment or dementia complicated, moderate need'. A description of all the clusters can be found in the Appendix of the supporting national reference data tables. The 22 clusters (excluding clusters 0 and 9, –variance and blank clusters) can be grouped up to three super clusters: non psychotic (clusters 1-8), psychosis (clusters 10-17) and organic (clusters 18-21). These provide a useful way to look assess the overall mix of patients and to group them for comparisons by age and gender.

Figure 11 shows that the age profile of the three super clusters is very different. 93.8% of people in the organic super cluster (which covers cognitive impairment and dementia), were in the 65 and over age group. These 128,873 people represented 27.2% of the total number of people assigned to a cluster at 31 March 2013 and 69.5% of those who were aged 65 or over. This does not mean that all these people had a particular diagnosis but the clustering does suggest the extent to which the active caseload for older people is dealing with problems of cognitive impairment and dementia.

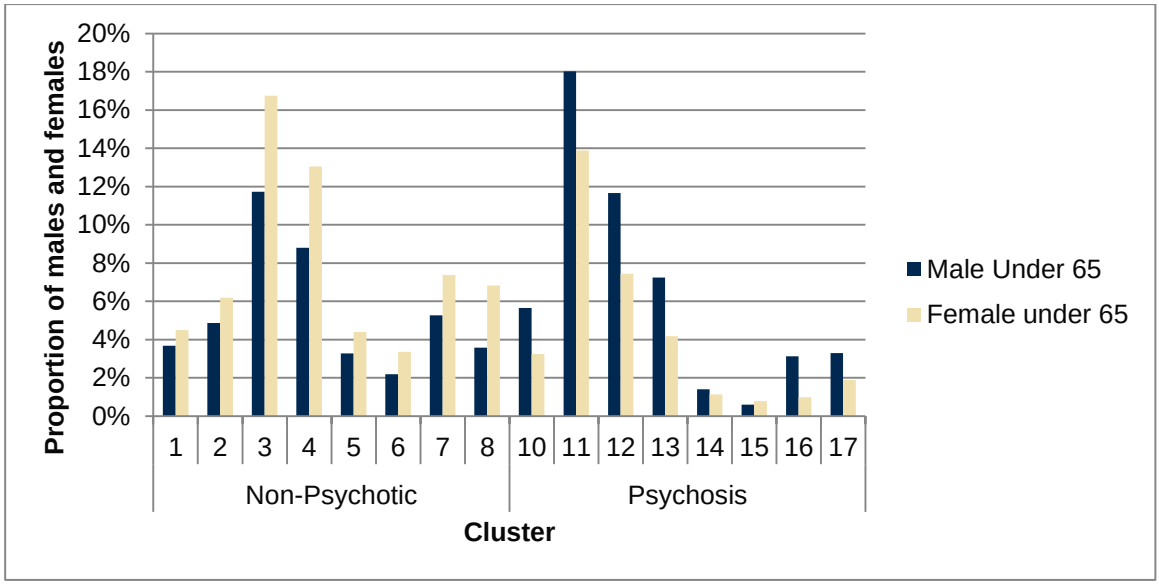
Figure 11: Number of people assigned to super cluster at 31 March 2012, by age group



Data source: Table 3.4 from the supporting national reference data tables

Figure 12 shows that in the under 65 age group a larger proportion of women than men were in the non-psychotic clusters (clusters 1 to 8), whilst a larger proportion of men than women were in the psychosis clusters (10 to 17), with the exception of cluster 15 for severe psychotic depression.

Figure 12: Proportion of males and females under 65 assigned to clusters in the non-psychotic and psychosis super clusters, at 31 March 2012



Data source: Table 3.4 from the supporting national reference data tables

The HSCIC undertook some work on behalf of the Department of Health in 2012 analysing MHMDS by cluster to support the development of outcomes indicators for PbR. Details of these will be in the PbR Guidance due to be published by the Department of Health in spring 2013.

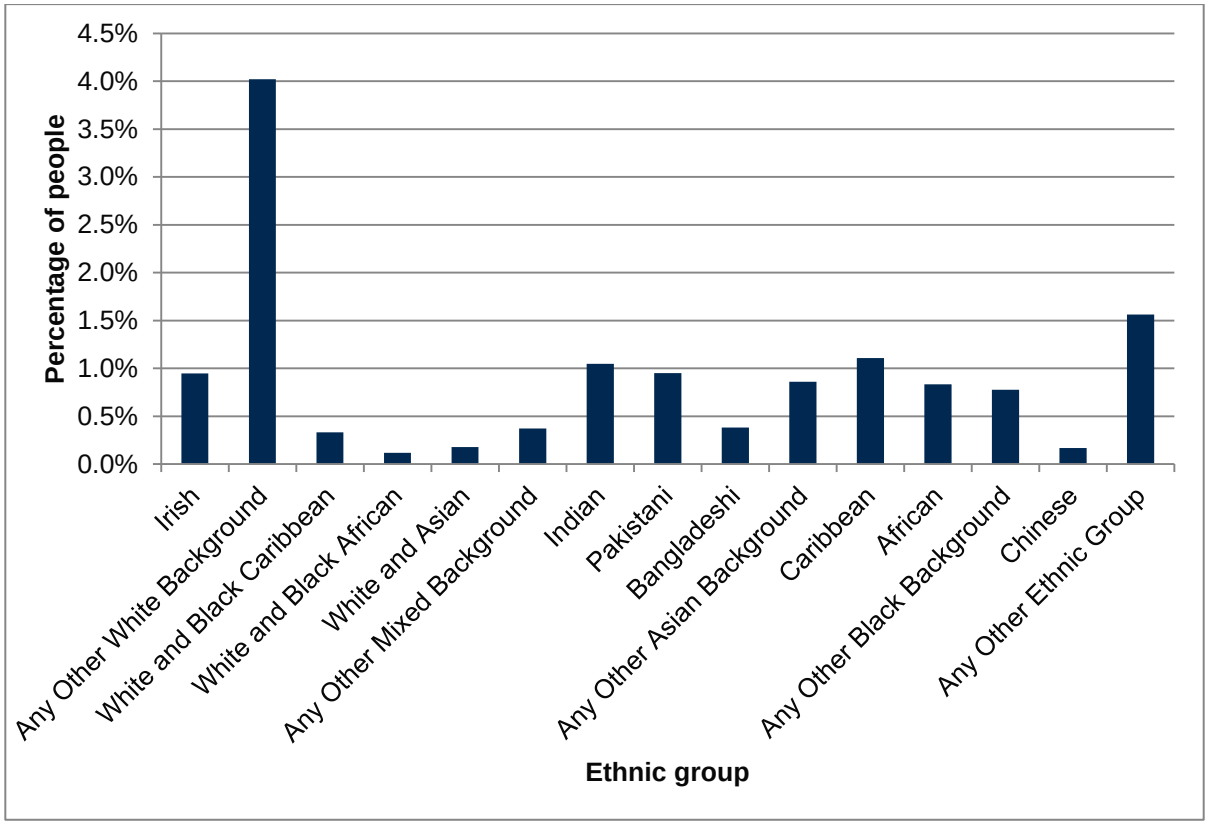
Table 3.4 and 3.5 in the supporting national reference data tables are presented as experimental analysis and it would be helpful to know whether producing reports where people are categorised by cluster would complement the existing analyses future reports.

Analysis by ethnic group

High quality recording of the self-assigned ethnic group of service users has been a feature of MHMDS for a number of years. Data Quality Measures for Q4 2011/12 (www.ic.nhs.uk/pubs/mhmds1112q4) showed that 89.9% of all MHMDS records had a valid ethnic code (excluding, 'not stated' or 'unknown'). For this reason the MHMDS supports detailed analysis by ethnic group.

In 2011/12 73.3% of people using services were categorised as British and they were the majority group. The next largest defined category (using the ONS 2001 census categories, approved for use by the NHS Data Dictionary) were the Caribbean (1.1%) and the Indian (1.0%) groups, as shown below.

Figure 13: Ethnic category of people using services, who did not categorise themselves as British, 2011/12



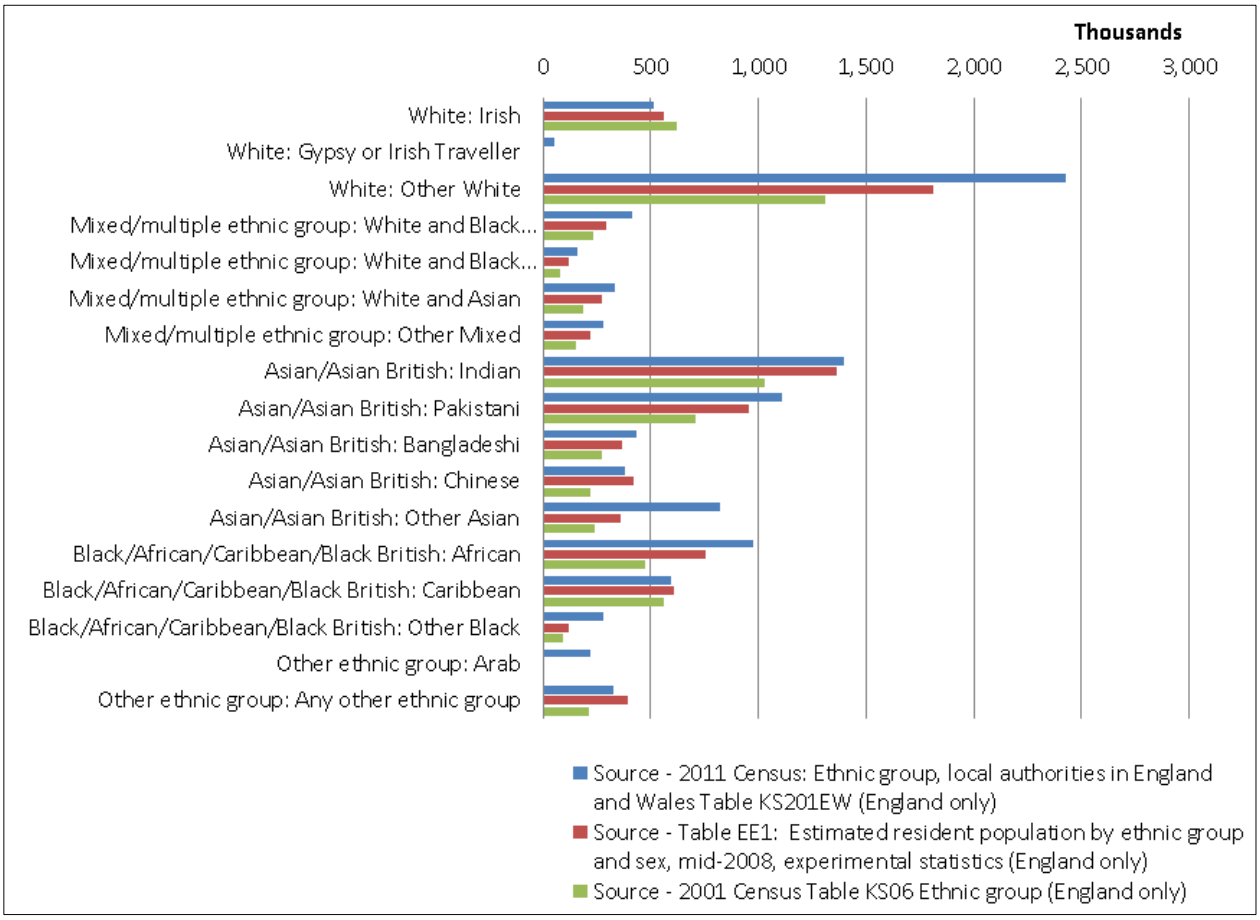
Data source: Table 1.5 from the supporting national reference data tables

However any analysis based on the England population figures in previous years has been limited by the fact that ethnic breakdowns of the England population had to be based on estimates; the last 'actual' figures were from the 2001 ONS population census. Nevertheless we have previously published population based rates of access by ethnic group to help to understand where there are differences in access to services.

We therefore welcome the publication of figures from the 2011 census to support up to date population based analysis, although an exact mapping to NHS categories of the two new categories in the 2011 census (Arab and Gypsy or Irish traveller) and of the way these are now organised by ONS into broad groupings is not possible. (Caveats are included on the relevant national reference data tables.)

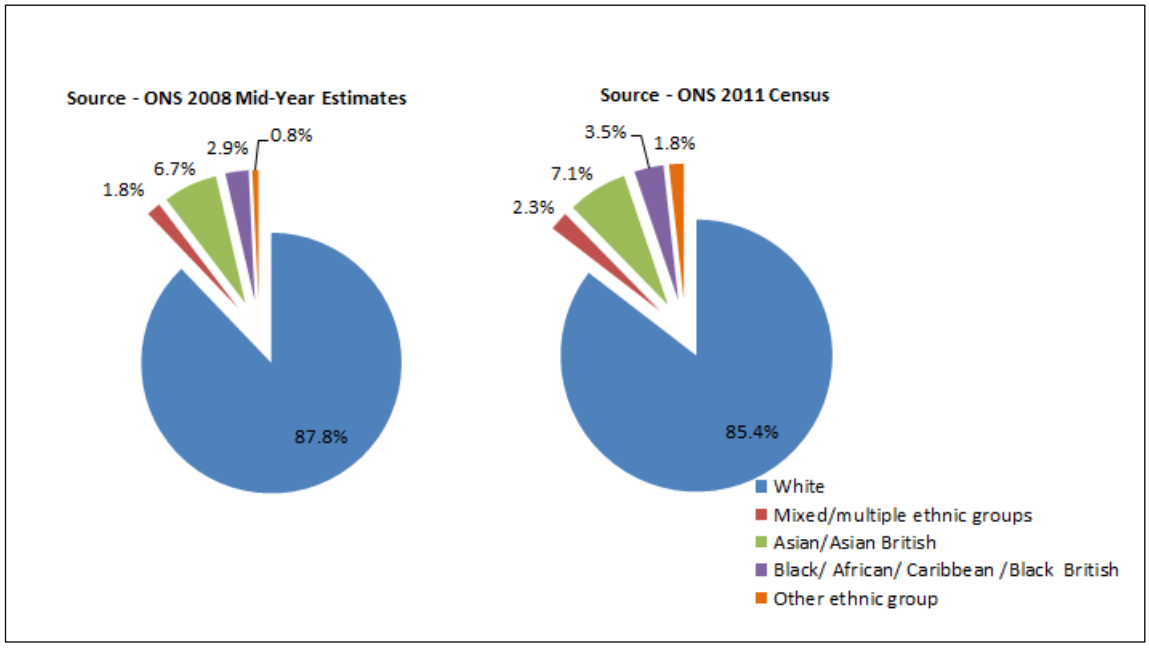
The latest census shows increases since 2001 across all non-British groups and for most of these when compared with the 2008 ethnicity estimates that we have used in some previous analysis. The Caribbean and Chinese groups were the only defined groups where the 2008 estimates appear to have been a slight over estimate, as shown in figure 14 below. The fall in the number assigned to Any Other ethnic group could be linked to the introduction of an Arab category in the 2011 census.

Figure 14: England Population figures by Ethnic Group, 2001, 2008, 2011



These increases mean that the Asian/Asian British and Black/African/Caribbean/Black British broad groups now make up an increased proportion of the population (for example they were estimated to be 2.9% of the population in 2008 and were 3.5% in the 2011 census), whilst the broad White group has reduced from an estimated 87.8% in 2008 to 85.4% in 2011. (Some of the increase for the Asian/Asian British group shown in figure 15 below is due to 2011 census moving Chinese from Any Other ethnic group to the Asian/Asian British group).

Figure 15: England Population by Broad Ethnic Group 2008, 2011



These changes are likely to have an impact on the rates of access within these broad ethnic groups as the populations are larger than estimated. The rates will also be affected by the greater number of people reported as being in contact with services.

The age and gender breakdowns required for the calculation of age and gender standardised rates are not yet available by ethnic group from the 2011 census but table 3 below shows how crude rates compare with those published last year.

Whilst the overall rate of access has increased from 2789 to 3032 per 100,000 population, crude rates of access for all defined groups have reduced since the rates were calculated last year, except for the Irish and Chinese groups.

Rates of access are lower than the overall rate of 3,032 per 100,000 for all groups except for Any Other Black Background and Any other ethnic group.

Table 3: Crude rate of access per 100,000 population to adult specialist mental health services by ethnic group, 2010/11 – 2011/12

Ethnic category	Crude Rate		Difference in rates
	2010/11	2011/12	
All groups	2789	3032	243
			0
British	2786	2785	-1
Irish	2678	2940	262
Any Other White Background	3427	2660	-767
White and Black Caribbean	3466	1279	-2187
White and Black African	2414	1183	-1231
White and Asian	1575	851	-724
Any Other Mixed Background	3781	2113	-1668
Indian	1430	1208	-222
Pakistani	2080	1371	-709
Bangladeshi	2055	1408	-647
Any Other Asian Background	4131	1687	-2444
Caribbean	3470	3013	-457
African	1970	1370	-600
Any Other Black Background	14386	4495	-9891
Chinese	580	713	133
Any Other Ethnic Group	5648	7675	2027

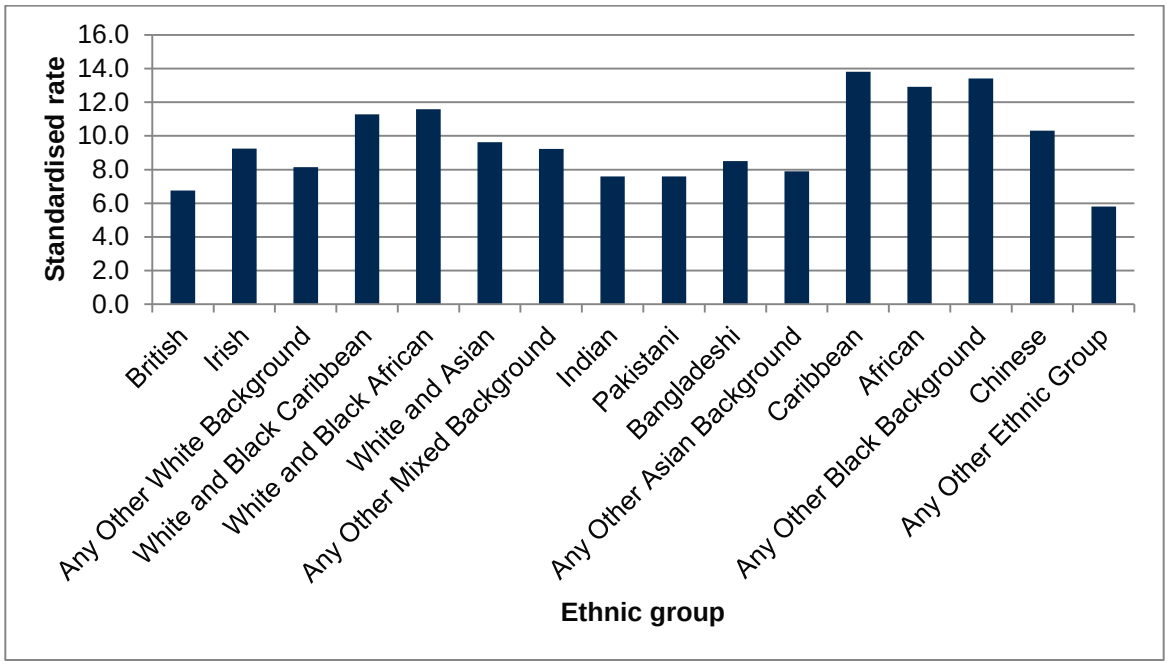
Data source: Table 1.5 from the supporting national reference data tables and Table 1.6 from the supporting national reference data tables accompanying the Mental Health Bulletin, 2010/11

Previous reports showed that standardising for age and gender had a significant effect on crude rates and we will provide age and gender standardised rates when the relevant 2011 census figures are available. Having new, up to date population figures for England will make a difference to any population based analysis by ethnic group.

Using MHMDS data, it's possible to calculate the proportion of service users in each ethnic category who spent time in hospital and to standardise these figures by age and gender.

Figure 16 below shows that the ethnic groups with the highest rate of access to hospital services per 100 service users (compared to a rate of 6.8 for the majority British group) were those in the broad Black or Black British group. The Caribbean, African and Any Other Black group categories had rates of 13.8, 12.9 and 13.4per 100 service users, respectively.

Figure 16: Standardised rates of access to NHS funded hospital inpatient care, per 100 service users, by ethnic group, 2011/12



Data source: Table 1.6 from the supporting national reference data tables

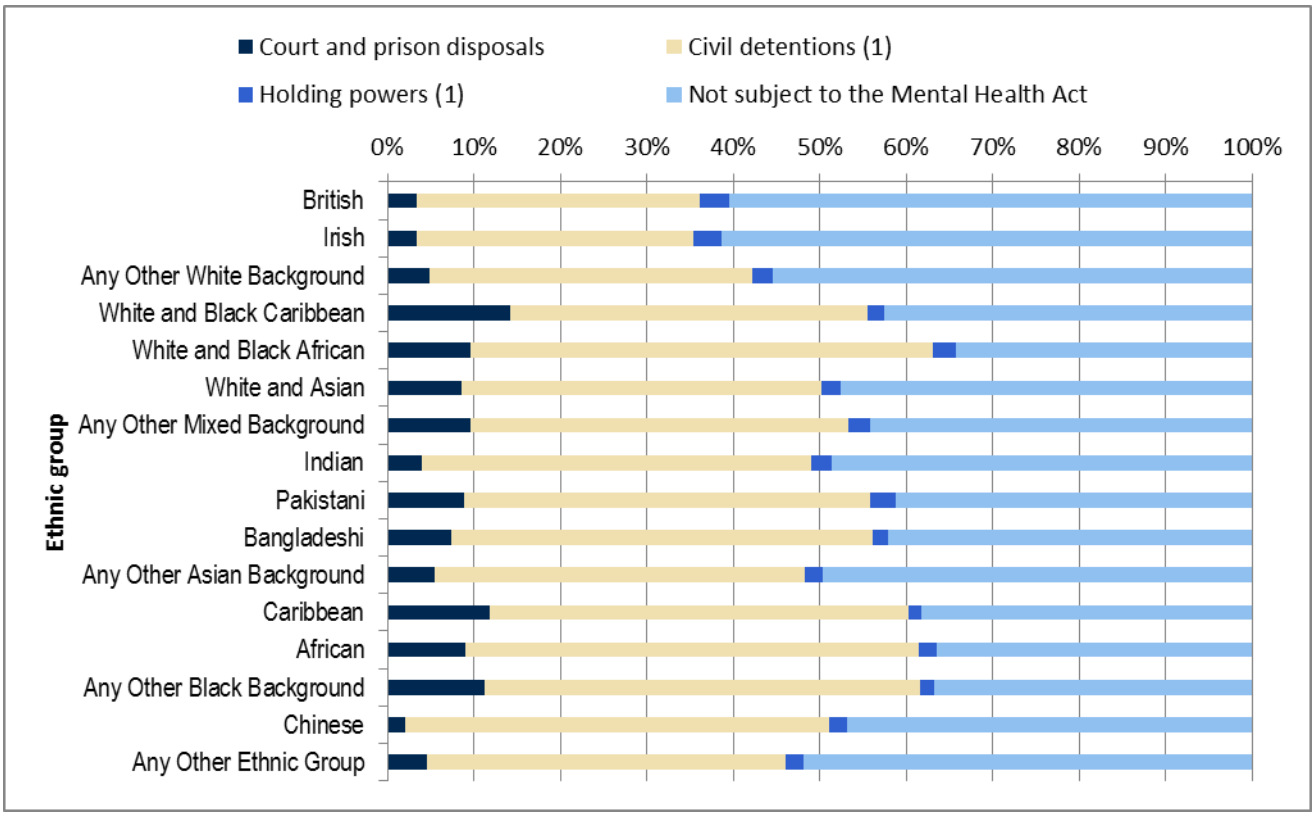
Although these rates are approximately double those for the British and Any Other ethnic groups, they would be higher if the differences that are attributable to age and gender had not been removed by standardisation. For example, the crude rate of access to hospital services per 100 service users for the African group was 17.6, but standardisation reduces this to 12.9. This demonstrates that some of the differences observed between ethnic groups are due to the age and gender profile of the different populations.

Most restrictive legal status, by ethnic group

There is wide variation in the proportion of people in each ethnic group who spent time in hospital that were subject to the Mental Health Act during the year. Whilst less than 40% of inpatients in the British and Irish groups were subject to some form of restriction under the Mental Health Act, figure 17 shows that for all the other ethnic minority groups the proportion was higher. Over 60% of the White and Black African, Caribbean, African, and Any Other Black background groups were subject to compulsory detention during the year, (even when the small numbers subject to holding powers but not actually detained are not included).

The group with the largest proportion of inpatients who were in hospital during the year, as a result of a detention via the court and criminal justice system, was the White and Black Caribbean group; the Caribbean and Any Other Black background groups also had more than 10% of inpatients in this category.

Figure 17: Proportion of inpatients subject to the Mental Health Act, by most restrictive legal status, by ethnic group, 2011/12



Data source: Table 2.3 from the supporting national reference data tables

The figures for the number of people on CTO on 31 March 2012 show that 13.4% of people on CTO were from the Black or Black British group, which suggests they are over-represented amongst people on CTO. This ethnic group was only 2.7% of the service user population in 2011/12 and only 3.5% of the England population, according to the 2011 Census.

Table 4: Proportion of people on CTO on 31 March 2012 in each broad ethnic group,

White		74.5%
Mixed		3.0%
Asian or Asian British		6.6%
Black or Black British		13.4%
Other Ethnic Groups		1.7%

Data source: Table 2.4 from the supporting national reference data tables

Service activity

Improvements in information about service activity

The move away from block contracts for mental health services to a payment system that reimburses providers according to the needs of their service users and the outcomes of care, is focussing attention on the need for accurate information about services delivered to patients. Although the MHMDS does not currently include information about clinical interventions (although this is planned to be included in a future release), it includes much information about hospital stays and contact with healthcare professionals.

Changes to the way version 4 MHMDS is submitted and processed mean that the sequence, duration and concurrency of events in the patient journey are now accessible within the patient record, although further work is needed to make the data coherent enough to support accurate pathway analysis. Duplication and inconsistency in the data that is provided between one submission and the next are current problems. It is not fully understood how the previous 'assembly' of MHMDS submissions handled these scenarios but this is certainly the reason for some of the inconsistencies observed in the data (for example, patients with more than 365 bed days in a year).

In this release we have retained most of the simple activity measures included in previous releases, with some refinements:

- The calculation of the number of bed days within each mental health care spell during the year has been amended to exclude overlaps in Ward Stays (ie where a patient appears to be in two beds at once). Previous data cleansing routines were only able to cap the maximum number of bed days in any spell but could not make further adjustments for duplicate or inconsistent data.
- The old system for 'assembling' MHMDS submissions failed to flow contacts where the staff group of the healthcare professional was recorded as 'other'. As the list of valid staff groups was restricted this resulted in contacts not being flowed. Where these contacts were not flowed, it's possible that no MHMDS record was generated for the patient. 'Missing Patients' has been a theme in some discussions with providers in the past. In MHMDS version 4, all contacts are flowed and they are categorised by team type, so that there is more information about which services are in contact with patients. Version 4 not only includes a much more comprehensive list of team types but it also includes an attendance code so contacts can be categorised according to whether the patient was seen or not.

The machine readable file to be published in the second part of the Mental Health Bulletin in April 2013 will include a breakdown of bed days, contacts and attendances by CCG, commissioner and provider.

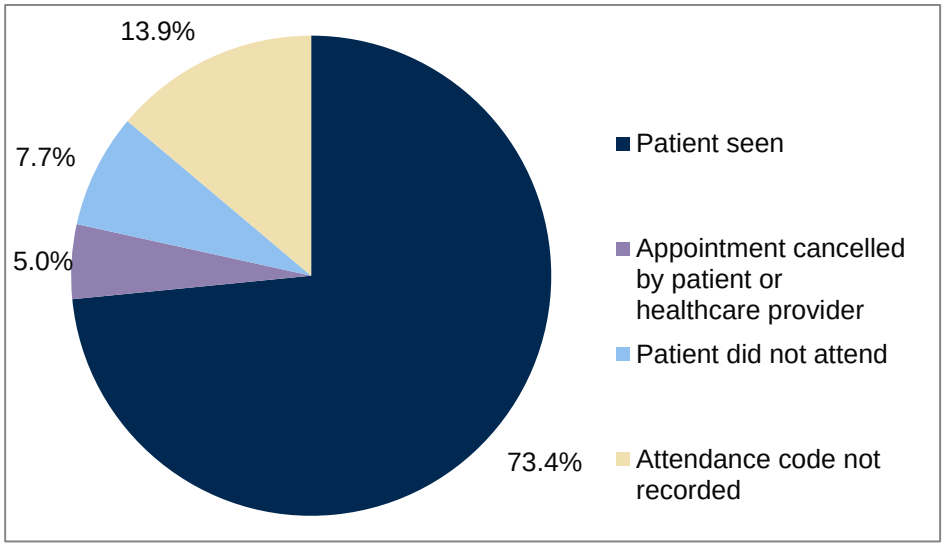
Contacts with healthcare professionals and day care attendances

A new report describing contacts by team type and attendance code replaces previous reports on contacts and caseload by team type.

This shows a total of nearly 22 million contacts in 2011/12 compared with nearly 13 million in 2010/11. For the reasons described above, these figures are not considered comparable but they provide some evidence that the new version of the dataset and the new systems for processing it are providing better coverage of services.

The majority of contacts were recorded against a team type of Adult mental health community team or older people community mental health team, or the team type was not recorded. However, the new value list for team types was only mandated for submission from April 2012 and was optional in 2011/12, so we expect recording of team type to improve. A full list of contacts by team type is in Table 6 of the accompanying reference table file and indicates how this data can be used to track activity in specialist teams, such as Memory services (204,969 contacts), Criminal Justice Liaison and Diversion Service (19,113 contacts) and Assertive Outreach Services (688,234 contacts). NHS re-organisation is leading to some service reconfiguration and we have heard that some teams are no longer able to categorise themselves by a single team type. The inclusion of attendance code shows that patients were recorded as having been seen for 73.4% of contacts and attendances; a patient DNA was recorded for 7.7%. No valid attendance code was recorded for 13.4% of contacts and attendances.

Figure 18: Contacts and day care attendances by attendance code, %, 2011/12



Data source: Table 6.1 from the supporting national reference data tables

Out of all the contacts for which an attendance code was recorded, Young Onset Dementia services had the lowest recorded proportion of DNAs (1.4%) and Psychological Therapy services had the highest (16.8%).

Inpatient activity

Change: the counts of bed days, admissions and discharges that underpin this analysis used to be performed as part of the assembly of submissions. In MHMDS version 4 the start and end dates of Ward Stays and Hospital Provider Spells are flowed in the data and the HSCIC has used this information to derive counts of bed days, admissions and discharges as part of our database load routine. Although we believe this has been done in a similar way to the previous assembly of the data, we cannot evidence this as there was no reliable documentation about assembler derivations. In particular, we do not know how the assembler handled the duplicates that occur in the data. We have also introduced a new derivation to eliminate the inaccuracies in the calculation of bed days caused by duplicate submissions and the provision of start and end dates in the source data support a more accurate count of 'cleansed' bed days than was possible before. For this reason time series analysis should be treated with caution. There is further information about derivations in the supporting national reference data tables.

In year bed days, admissions and discharges

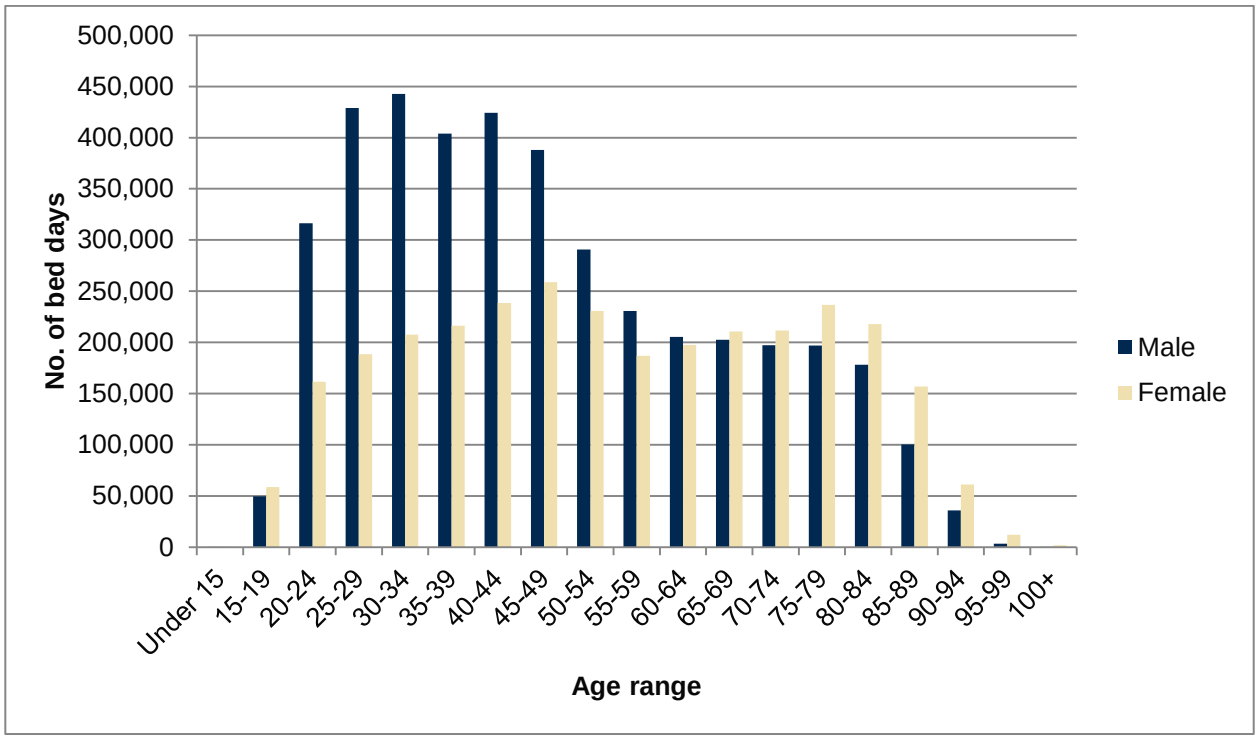
In 2011/12 the data shows that people in contact with NHS funded adult specialist mental health services spent over 7 million (7,172,391) days in hospital. Over 95.1% of these days were in NHS hospitals; as not all independent sector providers return MHMDS the figure for this sector (350,747) is not complete.

The average number of daily occupied beds (a rough proxy for the number of beds available, if you assume 100% occupancy) in the NHS was 18,924. This figure probably excludes high secure hospitals as none of the Ward Stay data from the 3 NHS providers that provide high secure services was categorised as 'high secure'. This is a lower figure than in 2010/11 (210,756) and this appears to be consistent with a lower number of admissions (112,749 admissions in 2011/12 compared with 124,558 in 2010/11) and a lower number of people spending time in NHS hospitals (99,098 in 2011/12 compared with 104,645 in 2010/11).

Bed days by age and gender

Figure 18 below shows that in every 5 year age group from 15-64 men spent more days in hospital during the year than women. The difference was greatest in the 25--35 age group and almost equal in the 60-74 age group. From age 75 upwards, women spent more days in hospital than men.

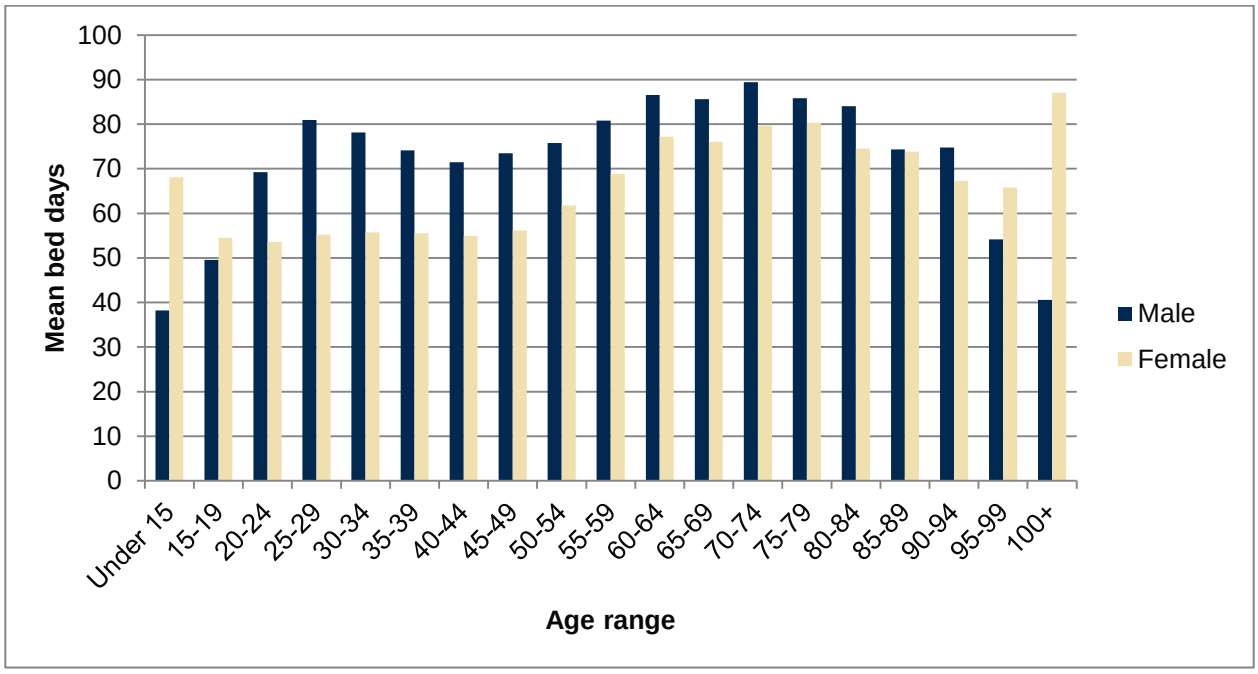
Figure 19: In year bed days, NHS funded services, by gender, 2011/12



Data source: Table 4.1 from the supporting national reference data tables

However, these differences are partly due to the numbers of men and women and women spending time in hospital (e.g. more younger men and more older women). The calculated mean figures below show proportionately smaller differences between these groups. The mean number of bed days spent in hospital during the year by women was 64 days; for men the number was 77.

Figure 20: Mean in year bed days, NHS funded services, by gender, 2011/12



Data source: Table 4.2 from the supporting national reference data tables

Special Feature: A linked dataset to investigate mortality of people with severe mental illness

Analysis of linked data from the Primary Care Mortality database (PCMD), 2010/11 and MHMDS annual submissions, 2008/09-2010/11

Background

During 2011/2012 the Health and Social Care Information Centre (HSCIC) collaborated with the Systems and Service Delivery Team at Connecting for Health and the ONS on behalf of the Department of Health to link MHMDS to ONS mortality data in the Primary Care Mortality database (PCMD[3]).

This linkage was required to support the creation of a linked dataset to be the data source for a new indicator in Domain One: Preventing People from Dying Prematurely, in the new NHS Outcomes Framework. The indicator falls within the Improvement Area: Reducing premature death in people with serious mental illness and measures excess mortality in people with severe mental illness.

The new indicator was published in June 2012 for deaths occurring in the financial year 2010/11 and a further release followed in September 2012. The indicator is available at England level for different age and gender groupings and at local authority level.

We are aware of interest in this linked dataset, which is not based on a survey or sample but provides comprehensive data from administrative sources about the deaths of people who were in contact with NHS funded adult mental health services. We also observed that there was value in the information about deaths for people aged 75 and over, although these were not included in the indicator construction.

The purpose of this special feature is therefore to provide some further descriptive analysis of this MHMDS and PCMD linked dataset for 2010/11, to which we have added 'Underlying Cause of Death' from PCMD for purposes of this short report.

Full information about the methods used for linkage and the quality of the linked data can be found in the mental health and mortality data linkage specification which forms part of the Indicator 1.5 release at this web address:

https://indicators.ic.nhs.uk/webview/index.jsp?v=2&submode=ddi&study=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfStudy%2FP01446&mode=documentation&top=yes

Data analysis

This analysis covers deaths of people aged 19 and over in England for the financial year 2010/11 only. The data is taken from the Mental Health Minimum Data Set (MHMDS) and the population includes patients who were in contact with services in either 2010/11 or the previous two financial years (i.e. 2009/10 and 2008/09). Mortality data comes from the Office for National Statistics (ONS)

[3] The Primary Care Mortality database (PCMD) is updated with monthly data from ONS about 1-2 weeks after month end to provide timely data to the NHS. Final annual validated mortality data is published by ONS about 10 months after the year end. Consequently there will be some small differences between annual data that has been aggregated from monthly data from PCMD and annual data published by ONS.

2010 Annual Mortality Statistics. Population data for the general population comes from ONS 2010 population estimates based on the 2001 census. The analysis presented in this report builds on Indicator 1.5: Excess under 75 mortality rate in adults with serious mental illness as described above. It should be noted that this analysis looks at all deaths aged 19 and over, whereas indicator 1.5 uses only those aged 18 to 74. The analysis does, at certain points, break into two sections to analyses those aged 19 to 74 and those aged 75 and over.

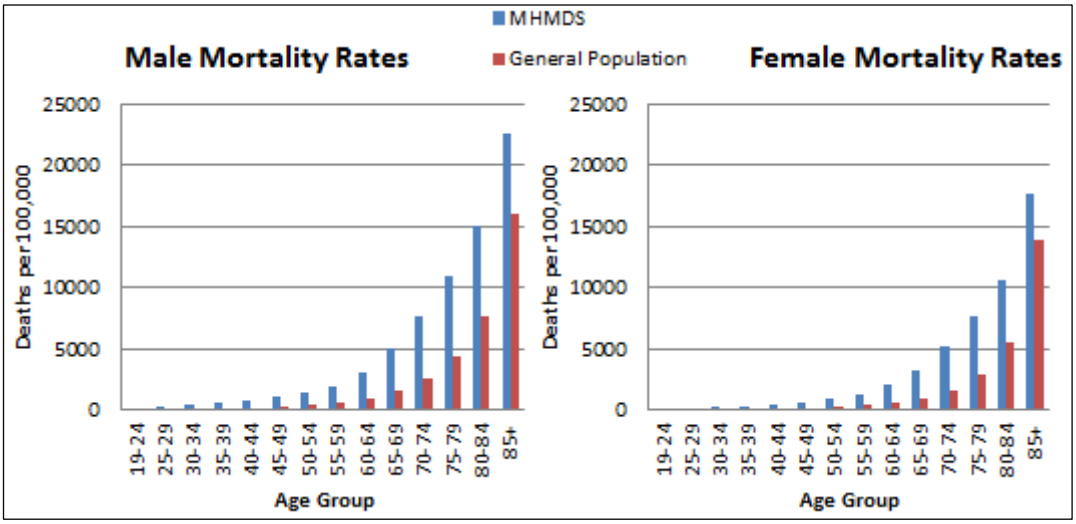
Mortality rate differences

The number of people in contact with Mental Health services in the three years from 2008/09 to 2010/11 is 2,080,770 and the number of deaths in 2010/11 was 83,393. It should be noted that for the analysis presented in this report not everyone had a recorded gender or a valid age. (Further information about the quality of the linked dataset can be found in the data linkage specification referenced above). The date used was the registration date of death, which will be later than the date the death occurred.

The mortality rate for service users in MHMDS for 2010/11 was 4,008 deaths per 100,000 service users compared to 1,122 deaths per 100,000 in the general population. This shows that the MHMDS mortality rate is 3.6 times as high as the mortality rate in the general population.

The mortality rates show a similar pattern for gender with mortality rates of 3,892 per 100,000 service users for males and 4,103 per 100,000 service users for females and consistently higher rates across all age groups (Table 1). Figure 1 displays the mortality rates (presented as the number of deaths per 100,000) for both the MHMDS population and the general population, for males and females respectively across five year age bands.

Chart A: Male and female mortality rates across five year age bands for the MHMDS population and the general population.



Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Table A presents the differences in the rates as a ratio of the MHMDS rate to the general population rate. The difference in rates is highest for those aged 30-39 and then generally decreases with age.

Table A: MHMDS population and general population mortality presented as 1) rates per 100,000, and 2) the ratio of MHMDS rate to the general population rate. Data is displayed separately for 5 year age bands and gender.

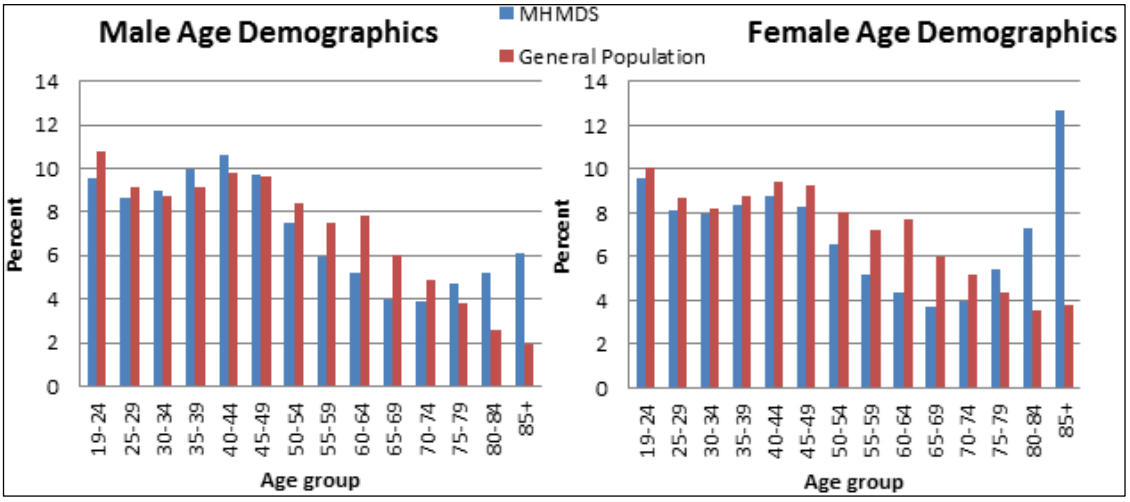
	Males					Females					All				
	MHMDS		General Population			MHMDS		General Population			MHMDS		General Population		
Age	Number of deaths	Rate per 100,000	Number of deaths	Rate per 100,000	Ratio	Number of deaths	Rate per 100,000	Number of deaths	Rate per 100,000	Ratio	Number of deaths	Rate per 100,000	Number of deaths	Rate per 100,000	Ratio
Total	**35602**	**3891.5**	**219769**	**1112.4**	**3.5**	**47720**	**4102.6**	**236586**	**1130.6**	**3.6**	**83390**	**4008.4**	**456355**	**1121.8**	**3.5**
19-24	153	174.8	1147	54.0	3.2	74	66.7	441	21.0	3.2	227	114.2	1588	37.6	3.0
25-29	218	275.1	1136	63.0	4.4	121	128.8	521	28.6	4.5	341	196.5	1657	45.7	4.3
30-34	336	409.0	1458	84.7	4.8	187	203.2	717	41.8	4.9	524	300.4	2175	63.2	4.7
35-39	519	571.2	2170	120.2	4.8	321	330.5	1292	70.7	4.7	841	446.8	3462	95.3	4.7
40-44	777	801.5	3432	177.2	4.5	418	409.0	2132	108.3	3.8	1196	599.8	5564	142.5	4.2
45-49	948	1065.9	4774	251.1	4.2	553	577.9	3116	161.0	3.6	1510	816.8	7890	205.6	4.0
50-54	989	1437.5	6448	389.9	3.7	690	905.7	4479	267.8	3.4	1682	1158.8	10927	328.5	3.5
55-59	1079	1996.8	9340	633.6	3.2	744	1246.5	6294	417.2	3.0	1825	1602.8	15634	524.2	3.1
60-64	1469	3106.0	15252	985.5	3.2	1052	2068.0	10043	626.1	3.3	2521	2565.4	25295	802.6	3.2
65-69	1817	4966.9	18573	1567.1	3.2	1369	3205.9	12396	985.9	3.3	3187	4016.6	30969	1267.9	3.2
70-74	2739	7654.7	25015	2580.4	3.0	2386	5152.8	17986	1667.7	3.1	5127	6242.6	43001	2099.8	3.0
75-79	4711	10910.9	32523	4339.0	2.5	4815	7647.5	27052	2955.9	2.6	9534	8978.2	59575	3578.6	2.5
80-84	7161	15087.2	38663	7582.7	2.0	8923	10538.8	40212	5482.5	1.9	16090	12170.6	78875	6343.7	1.9
85+	12686	22634.2	59838	15988.5	1.4	26067	17643.0	109905	13898.1	1.3	38785	19016.0	169743	14569.6	1.3

Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Demographics – Age and Gender

As can be seen in Chart B, the general population numbers are the highest in the youngest age group for both genders (Male 10.7%, Female = 10%), peak again at the 40-44 year age group for both genders (Male = 9.8%, Female = 9.4%), and then the numbers decline steadily with age. In contrast the MHMDS population, while similarly showing a rise in numbers up to the 40-44 age group (Male = 10.6%, Female = 8.8%), differs from the general population for those aged 50 and over. For these ages, the MHMDS is proportionally smaller then general population before becoming proportionally larger at the 75 and over population with the proportion for females being markedly different especially noticeable in the 85 and over age group: 12.7% for the MHMDS population compared to 3.8% of general population in the 85+ years category; for males the proportion of people in the MHMDS population and the general population for the 85+ years age group is 6.1% and 1.9% respectively.

Chart B: Number of males and females in each age group belonging to the MHMDS population and the general population expressed as a percentage of the corresponding population.



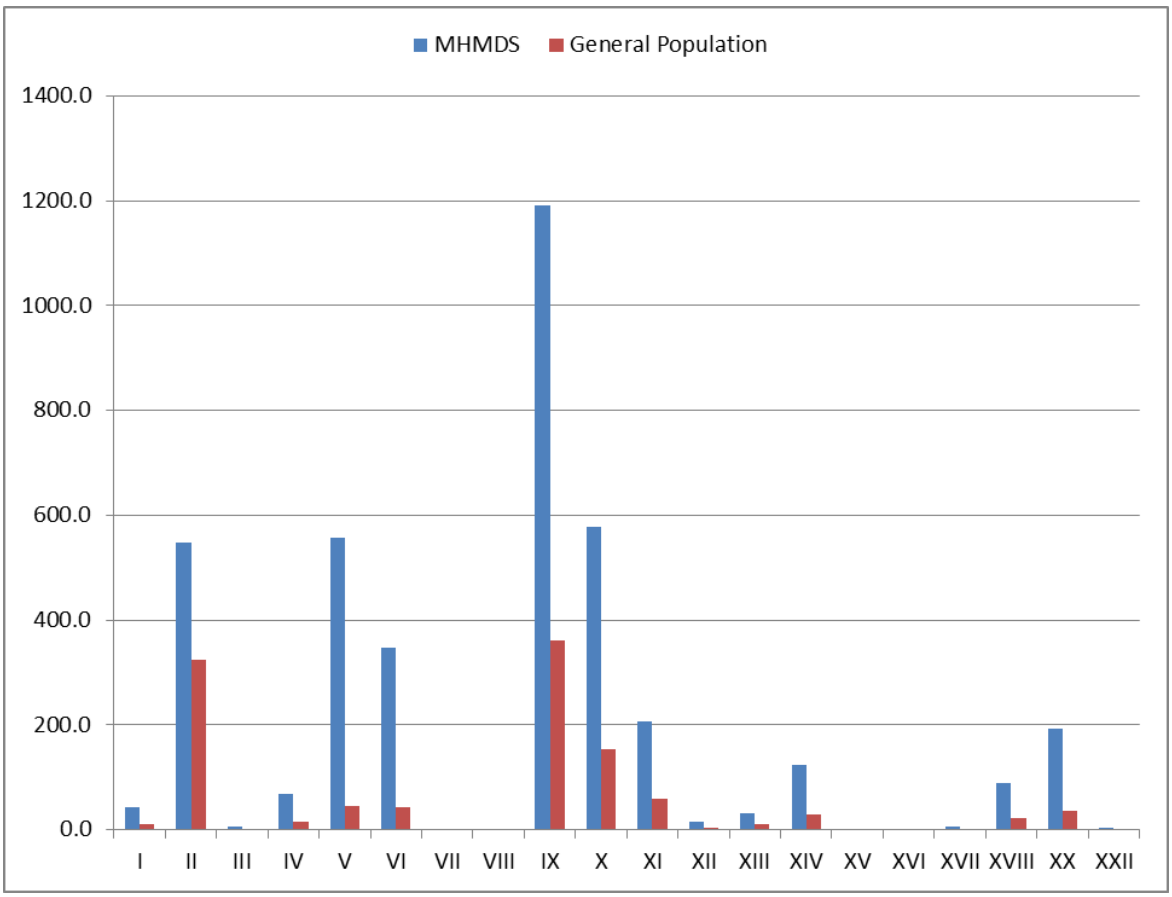
Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Underlying causes of death

An important aspect of this analysis is exploring the underlying cause of death, as defined by an ICD-10 code. The ICD-10 (the 10th revision of the International Statistical Classification of Diseases and Related Health Problems) is a code set used internationally to classify diseases and health problems. When assigning a cause of death to an ICD-10 code, a single code is selected from a reported selection of codes and this single cause is called the underlying cause of death.

The ICD-10 classification is first divided into chapters of which there are 22. Each chapter is usually associated with a particular system in the body or a special disease. In the following analysis, the codes for underlying causes of death are broken down at this broad level into ICD-10 chapters. The key to each chapter code title is presented in Table B.

Chart C: Age 19 and over mortality rates per 100,000 by ICD-10 chapter given for underlying causes of death for the MHMDS population and the general population.



Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Chart C shows that the mortality rates for the MHMDS population are higher than those for the general population across nearly all the ICD-10 chapter codes. Table b has the mapping of ICD-10 codes to the chapter names.

These figures can be used to assess what the underlying causes of death are where the MHMDS mortality rate is much higher than the general population. For instance, where chapter V (mental and behavioural disorders) is given as the underlying cause of death, the MHMDS mortality rate is 12.2 times the general population rate as can be seen in table B.

Table B Aged 19 and over mortality rates for the MHMDS and general population and the ration of the MHMDS rate to the general population rate

		MHMDS		General Population		
ICD-10 chapter	Condition	Deaths	Rate	Deaths	Rate	Ratio
I	Certain infectious and parasitic diseases	886	42.6	4439	10.9	3.9
II	Neoplasms	11381	547.0	132181	324.9	1.7
III	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	139	6.7	893	2.2	3.0
IV	Endocrine, nutritional and metabolic diseases	1429	68.7	6619	16.3	4.2
V	Mental and behavioural disorders	11571	556.1	18559	45.6	12.2
VI	Diseases of the nervous system	7216	346.8	17154	42.2	8.2
VII	Diseases of the eye and adnexa	2	0.1	10	0.0	3.9
VIII	Diseases of the ear and mastoid process	1	0.0	18	0.0	1.1
IX	Diseases of the circulatory system	24796	1191.7	147183	361.8	3.3
X	Diseases of the respiratory system	12041	578.7	62685	154.1	3.8
XI	Diseases of the digestive system	4320	207.6	23913	58.8	3.5
XII	Diseases of the skin and subcutaneous tissue	297	14.3	1768	4.3	3.3
XIII	Diseases of the musculoskeletal system and connective tissue	673	32.3	3939	9.7	3.3
XIV	Diseases of the genitourinary system	2587	124.3	11604	28.5	4.4
XV	Pregnancy, childbirth and the puerperium	5	0.2	31	0.1	3.2
XVI	Certain conditions originating in the perinatal period	0	0.0	3	0.0	0.0
XVII	Congenital malformations, deformations and chromosomal abnormalities	122	5.9	775	1.9	3.1
XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1861	89.4	9205	22.6	4.0
XX	External causes of morbidity and mortality	3992	191.9	14801	36.4	5.3
XXII	Codes for special purposes	71	3.4	575	1.4	2.4

Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Given the prominent difference in demographic profile between those aged under 75 and those aged 75 and over, the remainder of the analysis, where appropriate, will look at these two age groups (19-74 and the 75 and over) separately.

An alternative way to view the mortality data is to present the proportion of deaths by ICD-10 chapter for the MHMDS population and the general population. Table C presents the difference in proportions between the MHMDS population and the general population for each age group (19-74 and those aged 75 and over respectively.

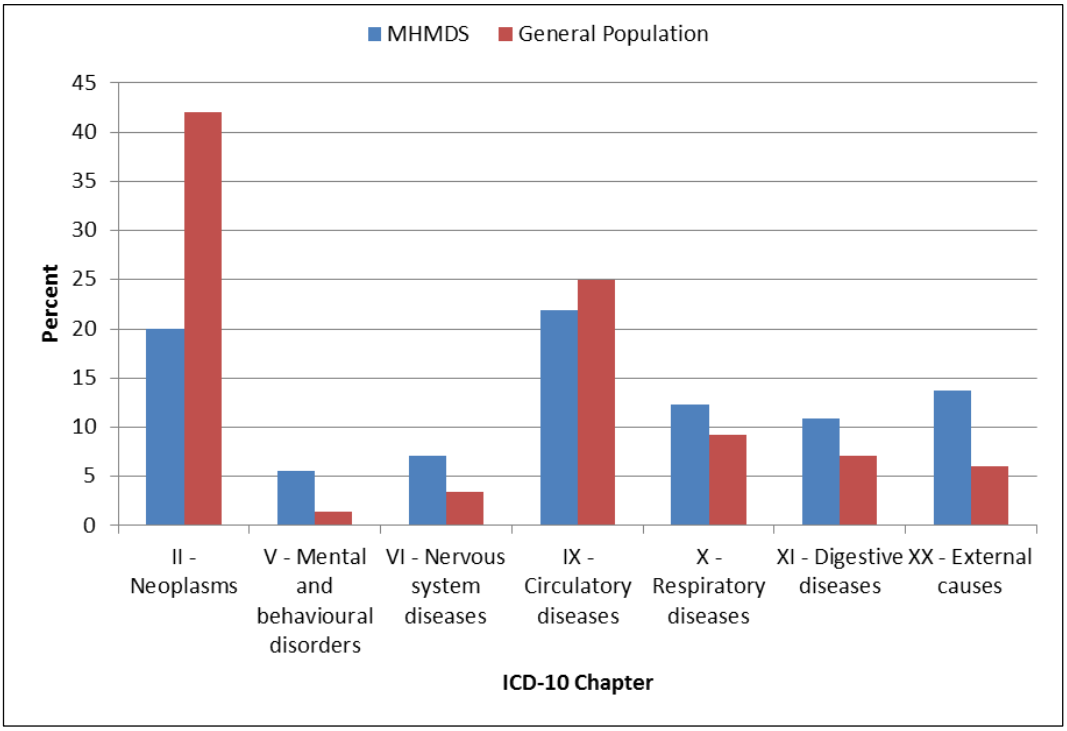
Table C: Proportion of underlying causes of deaths by ICD-10 chapter, separately for the MHMDS population and the general population, for those aged between 19 and 74 and those aged 75 and over. The key to the chapter names can be found in Table B.

	19-74							75 and over						
	MHMDS			General Population				MHMDS			General Population			
ICD-10 Chapter	Number of deaths	Rate per 100,000	Proportion	Number of deaths	Rate per 100,000	Proportion	Ratio	Number of deaths	Rate per 100,000	Proportion	Number of deaths	Rate per 100,000	Proportion	Ratio
I	282	17.2	1.5	1532	4.2	1.0	4.1	604	136.5	0.9	2907	71.4	0.9	1.9
II	3805	232.3	20.0	62307	170.2	42.1	1.4	7576	1712.7	11.8	69874	1715.5	22.7	1.0
III	42	2.6	0.2	370	1.0	0.2	2.5	97	21.9	0.2	523	12.8	0.2	1.7
IV	392	23.9	2.1	2107	5.8	1.4	4.2	1037	234.4	1.6	4512	110.8	1.5	2.1
V	1047	63.9	5.5	1998	5.5	1.3	11.7	10524	2379.1	16.3	16561	406.6	5.4	5.9
VI	1356	82.8	7.1	4994	13.6	3.4	6.1	5860	1324.7	9.1	12160	298.5	3.9	4.4
VII	0	0.0	0.0	2	0.0	0.0	0.0	2	0.5	0.0	8	0.2	0.0	2.3
VIII	0	0.0	0.0	7	0.0	0.0	0.0	1	0.2	0.0	11	0.3	0.0	0.8
IX	4160	254.0	21.9	37017	101.1	25.0	2.5	20635	4664.8	32.0	110166	2704.7	35.7	1.7
X	2330	142.2	12.3	13657	37.3	9.2	3.8	9709	2194.8	15.1	49028	1203.7	15.9	1.8
XI	2065	126.1	10.9	10428	28.5	7.0	4.4	2255	509.8	3.5	13485	331.1	4.4	1.5
XII	52	3.2	0.3	363	1.0	0.2	3.2	245	55.4	0.4	1405	34.5	0.5	1.6
XIII	123	7.5	0.6	903	2.5	0.6	3.0	550	124.3	0.9	3036	74.5	1.0	1.7
XIV	284	17.3	1.5	1496	4.1	1.0	4.2	2303	520.6	3.6	10108	248.2	3.3	2.1
XV	5	0.3	0.0	31	0.1	0.0	3.6	0	0.0	0.0	0	0.0	0.0	-
XVI	0	0.0	0.0	3	0.0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	-
XVII	104	6.3	0.5	625	1.7	0.4	3.7	18	4.1	0.0	150	3.7	0.0	1.1
XVIII	254	15.5	1.3	927	2.5	0.6	6.1	1607	363.3	2.5	8278	203.2	2.7	1.8
XX	2611	159.4	13.8	8858	24.2	6.0	6.6	1381	312.2	2.1	5943	145.9	1.9	2.1
XXII	67	4.1	0.4	537	1.5	0.4	2.8	4	0.9	0.0	38	0.9	0.0	1.0

Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

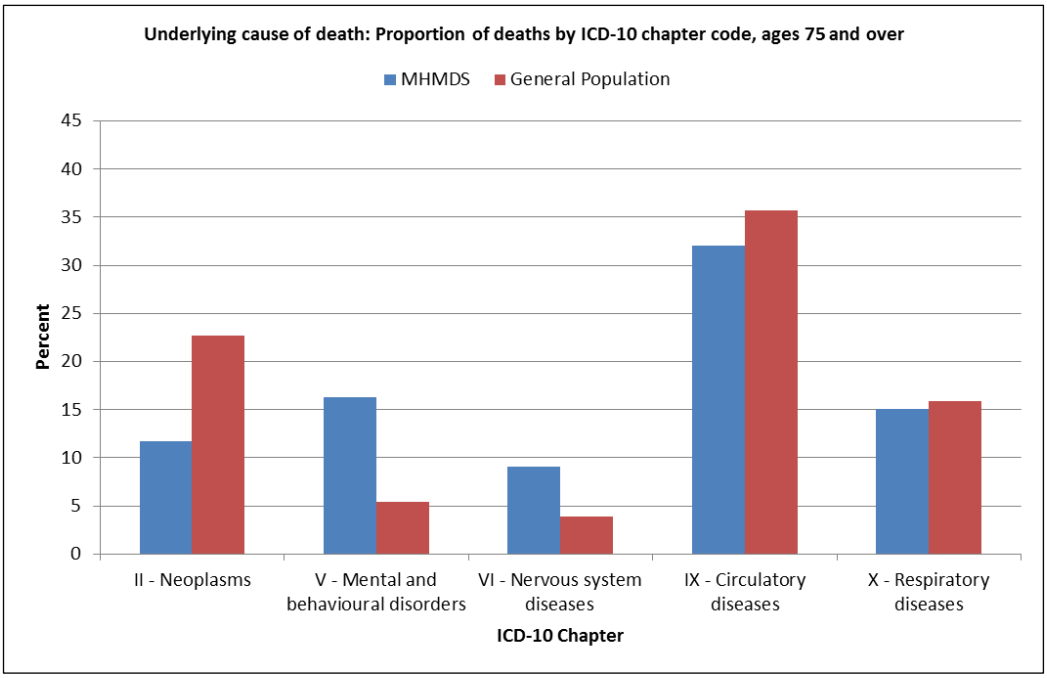
The remainder of this analysis will only look at those ICD-10 Chapters in Table C that accounted for more than 5% of the total deaths in MHMDS for those aged 19 to 74 and 75 and over respectively. To highlight the differences between the two populations for each age group, charts D and E show the proportions of deaths for the ICD-10 chapters that are most different.

Chart D: Proportion of underlying causes of deaths by ICD-10 chapter, separately for the MHMDS population and the general population, for the 19-74 age group.



Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

Chart E: Proportion of underlying causes of deaths by ICD-10 chapter, separately for the MHMDS population and the general population, for the 75 and over age group.



Data Source: MHMDS and PCMD linked dataset for 2010/11, ONS 2010 Annual Mortality Statistics and ONS 2010 population estimates based on the 2001 census

As shown in charts D and E, the underlying cause of death for neoplasms and diseases of the circulatory system are greater in the general population for both 19 to 74 and those aged 75 and

over. Furthermore, both age groups show greater deaths in the MHMDS population due to mental and behavioural disorders and diseases of the nervous system than the general population. Additionally, those in the 19 to 74 age group show greater deaths in the MHMDS population when compared to the general population for diseases of the respiratory system, diseases of the digestive system and external causes of morbidity and mortality.

Underlying causes of death for the MHMDS population in greater detail

Grouping the underlying causes of deaths by ICD-10 chapter is very broad, thus the next stage of the analysis looks at underlying causes of deaths in more specific detail. ICD-10 chapters can be further divided into sub-chapters, known as blocks. Blocks contain ICD-10 codes of related conditions. Within each block are three and four character codes which describe a disease/health problem at a finer level of detail. For example, the categorisation for someone with cancer of the lip at the three levels, from broad to specific, might be: Chapter II (Neoplasms, C00-D48), malignant neoplasms (C00-C97) and malignant neoplasm of lip (C00).

The following analysis identified the block for each ICD-10 chapter that accounts for the most MHMDS patient deaths for that particular chapter (again, including only those ICD-10 chapters that account for 5% or more of MHMDS patient deaths; see Table C). Furthermore, for that block, the three digit code with the highest number of deaths was identified. This was conducted for each age group separately (19 to 74, and 75 and over). See Table D for a summary of this analysis.

Table D presents the ICD-10 blocks that are the leading underlying causes of MHMDS deaths for each ICD-10 chapter, separately for each age group. Column (a) displays the name of the block within the ICD-10 chapter that was accounted for the most deaths. Column (b) shows the percentage of deaths that the block in column (a) accounted for out of the ICD-10 chapter as a whole. Column (c) shows the percentage of deaths that the block in column (a) accounted for out of the total number of deaths for each age group (18,979 for 19 to 74 age group and 64,408 for the 75 and over age group). Column (d) presents the name of the 3 digit ICD-10 code and name that was accountable for the highest number of deaths within the block named in column (a). No figures are provided for this ICD-10 3 digit code. Note that this 3 digit code may not be the leading cause of death for a chapter as a whole as it relates only to the block listed in column (a).

Table D: Deaths by age group, ICD-10 chapter, ICD-10 block and ICD-10 3 digit code.

	19-74				Ages 75 and over			
ICD-10 Chapter	Leading cause of death block (a)	Proportion of ICD-10 Chapter that the block accounted for (b)	Proportion of total 19-74 MHMDS deaths that the block accounted for (c)	Leading cause of death within the block at the 3 digit code level (d)	Leading cause of death block (a)	Proportion of ICD-10 Chapter that the block accounted for (b)	Proportion of total 75 and over MHMDS deaths that the block accounted for (c)	Leading cause of death within the block at the 3 digit code level (d)
II - Neoplasms	Malignant neoplasms	97.2%	19.5% (3,699 deaths)	C34 – Malignant neoplasm of bronchus and lung	Malignant neoplasms	95.9%	11.3% (7,269 deaths)	C34 – Malignant neoplasm of bronchus and lung
V – Mental and behavioural disorders	Organic, including symptomatic, mental disorders	64.8%	3.6% (678 deaths)	F03 – Unspecified dementia	Organic, including symptomatic, mental disorders	98.9%	16.2% (10,410 deaths)	F03 – Unspecified dementia
VI – Diseases of the nervous system	Other degenerative diseases of the nervous system	35.2%	2.5% (477 deaths)	G30 – Alzheimer's disease	Other degenerative diseases of the nervous system	70.2%	6.4% (4,113 deaths)	G30 – Alzheimer's disease
IX – Diseases of the circulatory system	Ischaemic heart diseases	45.2%	9.9% (1,879 deaths)	I25 – Chronic ischaemic heart disease	Cerebrovascular diseases	41.3%	13.2% (8,159 deaths)	I64 - Stroke, not specified as haemorrhage or infarction
X – Diseases of the respiratory system	Chronic lower respiratory diseases	47.5%	5.8% (1,170 deaths)	J44 – Other chronic obstructive pulmonary disease	Influenza and pneumonia	41.8%	6.3% (4,056 deaths)	J18 – Pneumonia, organism unspecified
XI – Diseases of the digestive	Diseases of liver	69.4%	7.6% (1,434 deaths)	K70 – Alcoholic liver disease	Other diseases of intestines	42.4%	1.5% (956 deaths)	K55 – Vascular disorders of intestine
XX – External causes of morbidity and mortality	Intentional self-harm	43.0%	5.9% (1,122 deaths)	X70 – Intent self-harm by hanging strangulation and suffocation	Accidents	91.4%	2% (1,262 deaths)	X59 – Exposure to unspecified factor

Data Source: MHMDS and PCMD linked dataset for 2010/11

There is potential for further analysis of this linked dataset to further understand mortality of people with severe mental health problems.

Appendices

National reference data tables

Table	Title
Table 1.1	Number of people using adult and elderly NHS funded secondary mental health services by highest level of care and provider type, 2003/04 - 2011/12
Table 1.2	Number of people using NHS funded adult and elderly secondary mental health services by gender, age and provider type, 2011/12
Table 1.3	Number of people using NHS funded adult and elderly secondary mental health services by gender and 5 year age band, 2011/12
Table 1.4	Number of people using NHS funded adult and elderly secondary mental health services by ethnic group and provider type, 2011/12
Table 1.5	Rates of access to NHS funded adult specialist mental health services per 100,000 population by ethnic group, 2011/12
Table 1.6	Rates of access to NHS funded hospital inpatient care per 100 mental health service users by ethnic group, 2011/12
Table 2.1	Most restrictive legal status of people who were inpatients during the year(a) by provider type, 2007/08-2011/12
Table 2.2	Number of inpatients subject to detention in an NHS funded hospital under the Mental Health Act 1983 by most restrictive legal status, gender and age, 2011/12
Table 2.3	Number of inpatients subject to detention in an NHS funded hospital under the Mental Health Act 1983 by most restrictive legal status and ethnic group, 2011/12
Table 2.4	Number of people subject to Community Treatment Orders (CTOs) at 31st March 2012 by gender, age and ethnic group
Table 3.1	Number of people accessing services and those on CPA, 2007/08-2011/12
Table 3.2	The number of people on CPA by gender, age and provider type, 2011/12
Table 3.3	The number of people on CPA by ethnic group and provider type, 2011/12
Table 3.4	Experimental statistics: Number of people assigned to Cluster at the end of the year by age, gender and cluster, 2011/12
Table 3.5	Experimental statistics: Number of people assigned to Cluster at the end of the year by broad ethnic group and cluster, 2011/12
Table 4.1	In year bed days by age, gender and provider type
Table 4.2	Mean in year bed days by age, gender and provider type
Table 5.1	Inpatient activity by year, 2007/08 - 2011/12 (NHS providers only)
Table 5.2	Admissions and discharges by gender and age, 2011/12
Table 6.1	Outpatient and community contacts by team type and attendance, 2011/12
Constructions	Construction used to generate the analysis in these reports

IC Derivations	Data items derived by the Health and Social Care Information Centre for analysis of 2011/12 version 4 data
Appendix	Meta data and definitions

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

Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment - England, 2011-2012, Annual figures
http://www.ic.nhs.uk/catalogue/PUB08085

Mental Health Bulletin, Fifth report from Mental Health Minimum Data Set (MHMDS) annual returns: 2011
http://www.ic.nhs.uk/pubs/mhbmhmds1112

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 NHS Information Centre web site:
http://www.ic.nhs.uk/mentalhealth

MHMDS Specifications:
Mental Health Minimum Data Set specifications and guidance
http://www.ic.nhs.uk/mhmds/spec

Routine Quarterly MHMDS Reports:
http://www.ic.nhs.uk/mhmdsquarterly

Mental Health Information from other UK countries

Admission of Patients to Mental Health Facilities, 2011 - 2012
http://wales.gov.uk/topics/statistics/headlines/health2012/121024/?lang=en
Produced by the Welsh Government, this publication provides the latest available statistics to mental health facilities in Wales.

Mental Health (Psychiatric) Hospital Activity Statistics, 2011 - 2012
http://www.isdscotland.org/Health-Topics//Mental-Health/Publications/index.asp#746
Produced by the Information Services Division (ISD) for Scotland, this publication provides statistics on psychiatric hospital activity including admissions, discharges, age and sex characteristics and geographical information.

Mental Health and Learning Disability Activity Statistics, 2011 - 2012
http://www.dhsspsni.gov.uk/mental_health_learning_disability
Produced by the Department of Health, Social Service and Public Safety (Northern Ireland), this publication presents information on activity in mental health and learning disability hospitals in Northern Ireland. It details information on inpatient and day case activity, outpatient activity, and compulsory admissions under the Mental Health (NI) Order 1986.

Glossary of terms and abbreviations

BME	Black and Minority Ethnic
CAMHS	Child & Adolescent Mental Health Service
Clusters	Mental Health Care Clusters
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
CTO	Community Treatment Order
HoNOS	Health of the Nation Outcomes Scale
HSCIC	Health & Social Care Information Centre
ICD10	World Health Organisation – International Classification of Diseases
ISP	Independent sector providers of specialist mental health services for working age adults and people aged 65 and over.
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.*
Mental Health Act 1983 (The Act)	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
Mental health services (services)	Mental Health Services for working age adults and people aged 65 and over with severe and enduring mental health problems.
NHS services	NHS only organisations which provide specialist mental health services for working age adults and people aged 65 and over who should submit the MHMDS
NHS funded services	NHS funded organisations (this may include independent sector providers) which provide specialist mental health services for working age adults and people aged 65 and over who should submit the MHMDS
NS	National Statistics Publication
ONS	Office of National Statistics
PbR	Payment By Results
Spell ID	Details and definition on the MHMDS Spell ID and its creation can be found at: http://www.ic.nhs.uk/mhmds/spec
SCT	Supervised Community Treatment
UKSA	United Kingdom Statistics Authority

Related links

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

- Office for National Statistics 2011 Census
  http://www.ons.gov.uk/ons/guide-method/census/2011/index.html

- Department of Health NHS Reference Costs
  http://www.dh.gov.uk/health/2011/11/reference-costs/

- 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/training/honos.aspx
  HoNOS is the most widely used routine clinical outcome measure used by English mental health services.

- 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.

- 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 2011/12, Care Quality Commission
  http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf

- National Statistics Code of Practice
  http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html
  Code of Practice for Statistics that sets out the professional standards which official statistics are expected to meet

- Office for National Statistics to 2010 Population Estimates
  http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm:77-22371

- Patterns of Specialist Mental Health Service Usage in England
  http://www.neighbourhood.statistics.gov.uk/HTMLDocs/images/Mental-Health-Service-usage-small-analysis1_tcm97-97434.pdf

Published by the Health and Social Care Information Centre
Part of the Government Statistical Service

Responsible Statistician
Claire Thompson, Principal Information Analysts

ISBN 978-1-84636-834-9

This publication may be requested in large print or other formats.

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