



# briefing

June 2010

## FTN Benchmarking

Driving performance improvement in **psychological therapies**

### Key points

- 11 mental health trusts took part in the FTN's second psychological therapies benchmarking project between June and November 2009.
- Progress has been made on defining indicators for use in mental health.
- Issues with data capture and reporting remain significant challenges to benchmarking mental health trusts.

Following the success of a pilot study exploring data availability in 2008, a group of 11 Foundation Trust Network (FTN) member trusts took part in a benchmarking project to identify how they could improve their psychological therapies services by analysing costs and comparing performance.

### Background

The FTN Benchmarking team has successfully run projects benchmarking a range of specialty services within acute trusts since 2006. These projects compare data on cost and productivity, set against quality measures, to help participants identify the underlying reasons for performance differences. Acute trusts have been collecting and submitting mandatory data for many years and mature IT systems are now in place in the majority of trusts.

In comparison, information systems are more basic in mental health trusts, along with a lack of widely used coding for interventions and diagnosis. In addition, there is a wide variation in the delivery of care as opposed to the more defined pathways commonly seen in acute care.

In 2008 a group of eight trusts piloted our first project for mental health trusts. There was high interest in a repeat, with certain modifications. Changes were made and there has been agreement that progress has been made in defining a useful set of common indicators.

### The benchmarking process

Each participant trust established a project team with a clinical, data, and operational lead, and a board-level sponsor to oversee the project.

During the initial scoping phase the data collection tool used in the 2008 pilot study was developed with input from the current participating trusts. Data collection was restricted to psychological therapies provided to service users over 18 years old,

between 1 April 2009 and 30 June 2009, in the primary (where responsibility of care remains with the GP) or secondary (where responsibility moves to a specialist mental healthcare coordinator) care setting.

Data collection excluded inpatient care, learning disabilities services and forensic mental healthcare. Data was collected, analysed and reported on separately for primary and secondary care. Data for two trusts was submitted and reported separately across their different sites.

During the data collection period and subsequent data validation stage, support was provided by the FTN Benchmarking team, with regular contact to ensure trusts were collecting comparable data.

A workshop provided an opportunity to discuss data findings as a group, share learning resulting from different practices and identify improvement opportunities. Trusts presented on aspects of their services that the benchmarking study identified as high performing. Individual trusts developed their own improvement action plans during the findings workshop.

The final analyses, separated into care delivered in primary and secondary settings, focused on activity and productivity, quality and staffing. A comparison of the participating trusts showed that they were diverse organisations as was their provision of psychological therapy services.

## Primary care

### Benchmarking results: Activity and productivity

The average direct staffing cost per contact hour in primary care was calculated at £236 across all trusts. However, the range was between £94 and £552, with two trusts reporting high costs in training needs and a low number of contact hours due to the setting up of new services (see Figure 1).

For service users discharged between April and July 2009, the duration of therapy intervention was less than five weeks for the majority of service users in most trusts. This suggests that a lot of time is being spent on first referrals and assessments without engaging service users in long-term treatment.

The 'did not attend' (DNA) rate for psychological therapy services in primary care was 11 per cent across data providers.

The average waiting time from referral to assessment was 5.9 weeks across trusts able to provide this data and 2.6 weeks' average waiting time between assessment and first treatment.

### Quality

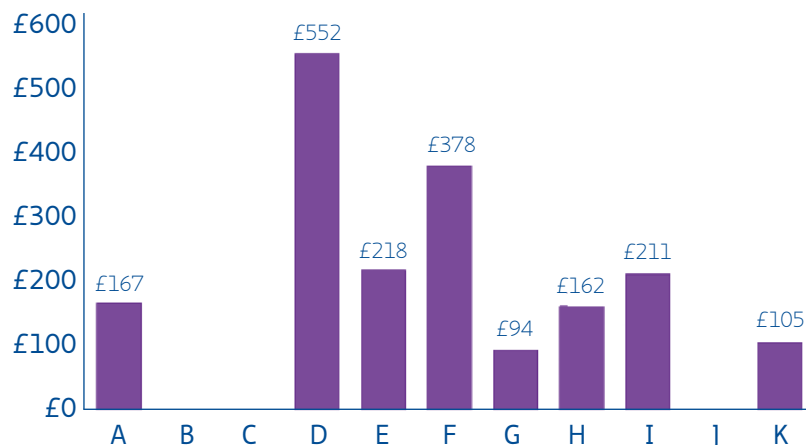
Outcome measures were collected by participating trusts at assessment for 90–100 per cent of service users and at discharge for 50–100 per cent of service users.

Termination of care or treatment was mostly with professional advice (74 per cent of service users on average), with 18 per cent finishing due to non-attendance, 4 per cent ending treatment against professional advice and 4 per cent because care was permanently transferred to another healthcare provider.

### Staffing

In primary care the majority of staff are skilled professionals;

**Figure 1. Direct staffing costs per contract hour – primary care**



Calculated as: Primary care direct staffing costs/Total number of hours of contact

(Gaps indicate trusts that could not provide the necessary data)

in most trusts over 70 per cent of staff are Agenda for Change (AfC) Band 6 or above. The largest groups of staff types were counsellors (45 per cent average for trusts with this staff group) and low-intensity cognitive behavioural therapy (CBT) practitioners (38 per cent average for trusts with this staff type).

Across all staff bands, participating trusts reported a high proportion of other non-clinical activities that included, for example, meetings and client administration. However, this time was not regarded as avoidable or wasted as some of these activities are central to the care provided.

For trusts able to collect activity data by service user diagnosis<sup>1</sup>, mood (affective) disorders (F30–F39) and neurotic, stress-related and somatoform disorders (F40–F48) accounted for over 90 per cent of staff activity time across all band levels.

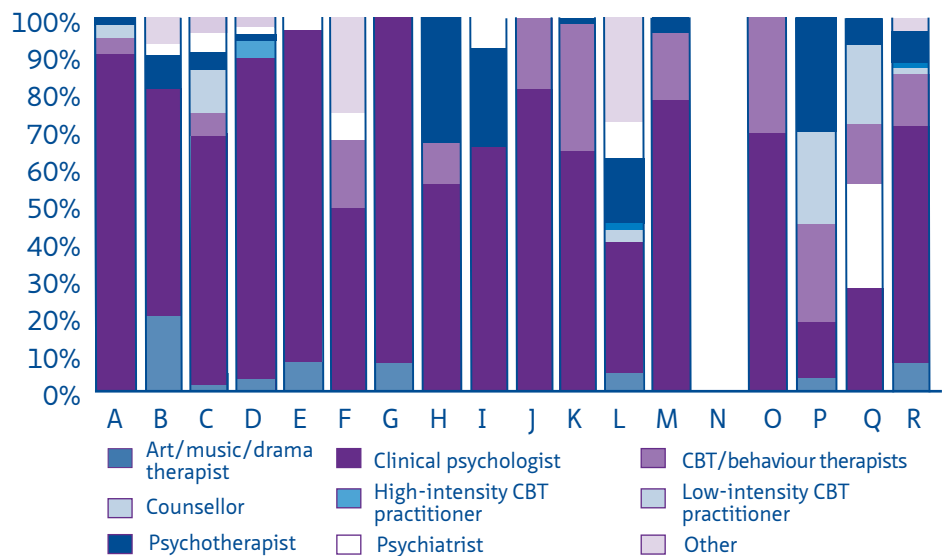
## Secondary care

### Benchmarking results: Activity and productivity

The average direct staffing cost per contact hour was calculated at £283. However, the range was from £44 to £1,310, with two trusts reporting far higher costs than the others. With these two outlying trusts excluded, the average direct staffing cost per contact hour was £119.

The average number of hours of contact per service user discharged between April and July 2009 was 27 hours. However, there was a wide variation between trusts

**Figure 2. Staffing level by type – secondary care**



(Gaps indicate trusts that could not provide the necessary data)

providing data, from three to 79 hours per service user.

The average waiting time from referral to assessment was 7.8 weeks across data providers and 4.6 weeks between assessment and first treatment.

The DNA rate for psychological therapy services in secondary care was 14 per cent across data providers.

### Quality

Outcome measures are assessed for 31–100 per cent of service users during assessment and 10–95 per cent of service users on discharge.

Termination of care or treatment was with professional advice for 69 per cent of service users on average, whilst 20 per cent of service users ended treatment due to non-attendance, 7 per cent finished against professional

advice and 3 per cent because care was permanently transferred to another healthcare provider.

### Staffing

The majority of trusts reported 80 per cent of staff at AfC Band 7 or above, clinical psychologists (64 per cent on average for trusts reporting this staff type), making up the most common and largest group (see Figure 2).

As in primary care, participating trusts reported across all staff bands a high proportion of 'other non-clinical' activity that included, for example, meetings and client administration.

The case mix in secondary care was diverse, with members of staff on higher bands (Band 7 and above) treating service users with schizophrenia, schizotypal and delusional disorders (F20–F29) and disorders of adult personality and behaviour (F60–F69) for 40–50 per cent of activity time.

<sup>1</sup> using the 10<sup>th</sup> edition of International Classification of Diseases coding (ICD-10)

## Actions to improve performance

The trusts involved in the project used the findings and the shared learning at the workshop to focus on areas for development. The following actions were noted during discussions as being key to future progress:

- Embed a culture of accurate data collection and reporting – it was agreed that ensuring all staff are engaged and aware of the importance of setting and collecting relevant metrics was essential to assessing and monitoring performance.
- Ensure there are no areas with gaps in data collection of key metrics – this would require reviewing the systems used. Additionally, the diverse ways of working within psychological therapy increases the challenge to ensure accuracy and completeness.
- Consider the refocusing of data collection based on service user care clusters, thus ensuring that metrics are consistent and relevant to the activity delivered.

Feedback from participating trusts was that the opportunity to network, discuss individual experiences and share concrete learning was highly valued by all participants.

## Future development

It was recognised by the group that performance management and benchmarking needs development within mental health trusts. Despite difficulties for some with data collection, trusts found the exercise very useful and were keen to see the project developed.

Looking forward, the following key refinements were discussed:

- collect and analyse data by care clusters in addition to, or instead of, presenting diagnosis
- collect different data for primary and secondary care where applicable (for example, stepped care level data for primary care only, presenting diagnosis (and/or care cluster) data for secondary care only)
- include definitions of roles for data on staff type

- give advance notice of the data to be collected so that IT systems can be adjusted.

## The Foundation Trust Network

The Foundation Trust Network (FTN) was established as part of the NHS Confederation to provide a distinct voice for NHS foundation trusts. We aim to improve the system for the public, patients and staff by raising the profile of the issues facing existing and aspirant foundation trusts and strengthening the influence of FTN members.

The FTN runs a series of benchmarking projects on different topics. For more information, visit [www.nhsconfed.org/FTNBenchmarking](http://www.nhsconfed.org/FTNBenchmarking) or contact Liz Smith, Benchmarking Manager, at [liz.smith@nhsconfed.org](mailto:liz.smith@nhsconfed.org)

