Shaping the Future of Mental Health Care: Insights, Innovation & Benchmarking

NHS Benchmarking Network

11th November 2025

Housekeeping

Mute

- You will have joined the session on mute and off camera. If you want to speak at any point please raise your hand and we can enable your camera and mic.

Interact

- We encourage you to interact in the chat, ask questions to our speakers or to other attendees – please introduce yourself!
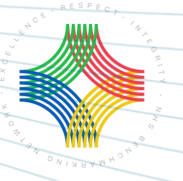
Recording

- We will be recording and transcribing this session and the recording will be available on the NHSBN Members' Area after the event.

Timings

- There will be plenty of breaks throughout the day.
- We hope you can stay for all the sessions, but if you need to leave and come back, that is no problem.

Time	Session	Speaker
10:00	Welcome and introduction	**Emma Bamber** – Associate Director, NHS Benchmarking Network
10:15	Keynote speaker: Centre for Mental Health	**Kadra Abdinasir** – Associate Director for Policy, Centre for Mental Health
11:00	Adult & older people's mental health 2024/25 benchmarking findings	**Daniel Iyoha** – Project Manager, NHS Benchmarking Network
11:45	Overview of the NHS Benchmarking Network's workforce programme	**Janet Heaton** – Senior Project Manager, NHS Benchmarking Network
12:00 – 12:30 Break for lunch		
12:30	International mental health benchmarking	**Sean Russell** – COO and European Lead, Global Leadership Exchange (GLE)
13:00	Children and young people's mental health 2024/25 benchmarking findings	**Alison Worden** – Project Manager, NHS Benchmarking Network
13:45	National Audit of Care at the End of Life (NACEL) – mental health spotlight audit	**Joylin Brockett** – Senior Project Manager, NHS Benchmarking Network
14:00	Stepped care system transformation in Wales	**Sarah Harte** – Implementation and Service Delivery Manager, Stepped Care Solutions
14:30 – 14:40 Comfort break		
14:40	Mental health pharmacy 2024/25 benchmarking findings	**Stanley Fleming** – Project Manager, NHS Benchmarking Network
15:00	MHLDA indicators benchmarking project	**Daniel Iyoha** – Project Manager, NHS Benchmarking Network
15:30	Spotlight on neurodiversity services	**Alison Worden** – Project Manager, NHS Benchmarking Network

NHS Benchmarking Network: Who are we?

We are a **UK-wide**, **impartial**, **member-led** community of health and social care organisations.

We believe in the importance of **harnessing the power of data** to drive meaningful change.

Network Vision and Values

Our vision

To enable members to **improve patient outcomes**, **raise health standards**, and deliver **sustainable**, **quality** health and care services through **data excellence**, **benchmarking**, and the **sharing of innovation**.

Our values

Excellence

Respect

Integrity

Harnessing the power of data to drive meaningful change

NHS Benchmarking Network: What do we do?

Source Data
- Extract
- Collect
- Store

Curate Data
- Cleanse
- Pseudonymise
- Validate

Analyse Data
- Benchmark
- Describe
- Model

Visualise Data
- Dashboards
- Charts
- Reports

Collaborative Insights
- Engagement
- Improvement
- 'So what?'

Harnessing the power of data to drive meaningful change

NHS Benchmarking Network: What do we do?

Membership Programme

Why the Network originally formed, offering a programme of benchmarking opportunities and insights to inform decision making within NHS and healthcare organisations.

Healthcare organisations are welcome to join.

Products and Services

We specialise in unlocking the value of data to support driving improvements across services. With over 25 years of experience, our expert team delivers bespoke analytical solutions, helping organisations translate data into meaningful insights that inform strategic and operational decision-making.

Workforce Programme

Ensuring a workforce of the right size, in the right place, with the right skills is essential to meeting current population need and underpins the ambitious transformation plans set out in key healthcare policy documents.

Currently benchmarking for the mental health workforce nationally across NHS, VCSE, LAs and offering a benchmark of workforce data in tailored solutions for NHSE WT&E.

National Clinical Audits

National Clinical Audits currently delivered by the NHS Benchmarking Network:

CVDPREVENT

National Audit of Care at the End of Life
Auditing last days of life in hospitals

Learning Disability Improvement Standards

NHS Benchmarking Network

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What we do: Member Programme

All employees of a member organisation gain access to the online members' area which provides access to:

Data and insight from various areas of healthcare

Online data explorers

Member participant reports

Shared learning compendiums

Project event recordings

Data collection projects and publicly-sourced datasets

Opportunities to participate

National Indicators tool

Publicly available data presented in easy to use formats

A network of information and support

Virtual webinars and in-person events

Reference groups and user groups

NHS Futures forum

Our Support Team

NHS
Benchmarking Network

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What outputs do members get access to?

- Data Explorers
- Reports
- Shared learning compendiums
- Insight and networking events

Keynote speaker: Centre for Mental Health

Kadra Abdinasir

Associate Director for Policy – Centre for Mental Health

WHO WE ARE

Centre for Mental Health is an independent charity.

We take the lead in challenging injustices in policies, systems and society, so that everyone can have better mental health.

By building research evidence to create fairer mental health policy, we are pursuing equality, social justice and good mental health for all.

CENTRE FOR MENTAL HEALTH

The state of the nation's mental health

ABOUT THE BIG MENTAL HEALTH REPORT

◎ In partnership with Mind, we publish an annual report on the state of the nation's mental health and the support available across England and Wales.

It brings together data, policy developments and new insights from:

◎ Mind's Big Mental Health Survey: exploring adults' experiences of accessing mental health support.

◎ The 2024 Attitudes to Mental Illness Survey: examining public attitudes towards mental health and stigma.

Together, these findings provide a comprehensive picture of the mental health landscape across England and Wales.

Supported by
CENTRE FOR MENTAL HEALTH

mind

The Big Mental Health Report
2025

THE CURRENT STATE OF MENTAL HEALTH

Common mental health problems are on the rise across all age groups.

Prevalence among adults (NHS Digital, 2025)
- Around 1 in 5 adults in England live with a common mental health problem such as anxiety or depression, with rates higher among women (24.2%) than men (15.4%).
- Young adults aged 16-24 are particularly affected, with prevalence increasing from 17.5% in 2007 to 25.8% in 2023-24.

Prevalence among children and young people (NHS Digital, 2023)
- In 2023, 1 in 5 children and young people (aged 8-25) were identified as having a probable mental health problem, up from 1 in 9 in 2017.

MENTAL HEALTH INEQUALITIES

The Big Mental Health Report also highlights the inequalities around mental health:

◎ Around 1 in 3 adults (32.9%) in England with a physical health condition also have a common mental health problem

◎ In England, adults in the most deprived areas have higher rates of mental health problems (26.2%) than those in the least deprived areas (16.0%)

◎ People in problem debt were more than twice as likely to experience a mental health problem (39.0%) than those without (18.4%)

◎ Children from the least well-off 20% of households are 4 times more likely to experience serious mental health difficulties by age of 11, compared to those growing up in the wealthiest homes.

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EXPERIENCES OF SUPPORT

- In 2023-24, about **2.8 million referrals** were made to adult community mental health services in England and Wales.
- Over 1 in 3 people waiting for appointments with a GP or VCSE organisation said their mental health deteriorated while waiting.
- About 33% of those seeing a GP for mental health support said their needs were not met, up from 27% in 2019.
- Approximately 34% reported unfair treatment when they received support from a GP.
- The system is under strain: long waits, unmet needs, and people being passed between services or turning to crisis support.

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STIGMA AND DISCRIMINATION

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◎ Stigma remains widespread, and understanding of mental health is slipping. In 2024, knowledge scores fell below 2009 levels for the first time.

◎ Negative stereotypes about severe mental illness persist. For example, agreement with "people with schizophrenia are a danger to others" rose from 27% in 2023 to **32%** in 2024.

◎ Fewer people feel comfortable working with or living near someone receiving mental health care.

◎ Mental health service providers and commissioners can play a role in tackling stigma and embedding inclusive, equitable services, this is a local leadership opportunity.

THE COST OF MENTAL ILL-HEALTH

MENTAL ILL HEALTH COSTS THE UK £300 BILLION A YEAR

THAT'S DOUBLE THE NHS BUDGET
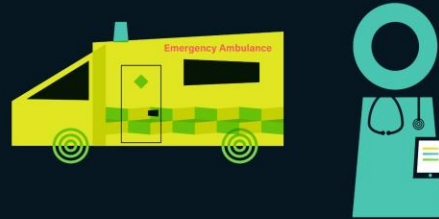
In 2022 the NHS budget was £153 billion

Breaking this down:
- ⊙ £110bn economic costs
- ⊙ £130bn human costs
- ⊙ £60bn health and care

YOUNG PEOPLE, MENTAL HEALTH AND WORK

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- ◎ Youth economic inactivity is rising: The number of young people not in work or education has reached an 11 year high.

- ◎ Sharp increase in health-related benefit claims: Over 4 million working-age adults now claim disability benefits, more than half due to 'mental health or behavioural difficulties'.

- ◎ Mental health driving claims among young people: The proportion of 25-year-olds on health-related benefits rose from 4.9% in 2019 to **7% in 2023-24** - the steepest rise of any age group.

- ◎ Economic exclusion and mental health are deeply connected: Young people with mental health problems are nearly five times more likely to be economically inactive than their peers.

- ◎ The relationship is cyclical: Poor mental health can drive unemployment, while insecure, low-quality work worsens mental health.

FUTURE
M I N D S

Why investing in children's mental
health will unlock economic growth

WHAT'S DRIVING THE RISE IN MENTAL HEALTH PROBLEMS?

◎ Inequality, poverty and poor housing remain major drivers of poor mental health.

◎ Covid-19 and ongoing cost-of-living pressures have deepened levels of distress.

◎ The real-terms value of benefits has fallen, leaving more people struggling in an increasingly restrictive system.

◎ Social media, school pressures and poor sleep are taking a toll on children and young people.

◎ Cuts to community and youth services have weakened local safety nets and early support.

◎ Addressing these drivers requires a whole system response, while the NHS plays a vital role, local government, education, housing and community partners all hold key levers for change.

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The policy landscape: progress, gaps and challenges

MENTAL HEALTH BILL

Progress:
- ◎ Advance decision-making and advocacy
- ◎ Care and Treatment Plans
- ◎ Time limits on Community Treatment Orders (CTOs)
- ◎ Limit on prison to hospital transfers (28 days)

Ongoing gaps and challenges:
- ◎ Making the reforms work for children and young people
- ◎ Race equity

THE 10 YEAR PLAN FOR HEALTH

Key measures:
- 'Neighbourhood' health care at the centre
- A Modern Service Framework for mental health
- Mental health emergency departments
- Expansion of Individual Placement and Support (IPS) services
- For CYP: roll out of Mental Health Support Teams and Young Futures Hubs

Gaps:
- Measures to advance parity of esteem, i.e. around waiting times, fair share of funding, growing mental health workforce
- Mental health in later life
- Lacks commitment to the Patient and Carer Race Equality Framework
- Primary prevention and working with councils, third sector partners & others

OTHER KEY DEVELOPMENTS

◉ **Neighbourhood Mental Health Hub pilots** are being developed in six areas across England to bring care closer to home - offering walk-in access, 24/7 local support and short-stay beds to provide earlier, more joined-up help and reduce hospital admissions.

NHS Medium Term Planning Guidance

◎ Expansion of Mental Health Support Teams, NHS Talking Therapies and Individual Placement and Support (IPS) are welcome

◎ Investment in 'mental health emergency departments' – despite lack of evidence

Gaps and concerns:

◎ Mental Health Investment Standard redefined and diluted

◎ Access and waiting times standards

◎ Access targets for children and young people

◎ Youth Futures Hubs

◎ Annual physical health checks for people with severe mental illness

◎ Patient and Carer Race Equality Framework

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Centre for Mental Health

What's on the horizon?

WHAT'S ON THE HORIZON?

- 10 Year Workforce Plan

- Local and regional reforms: ICBs and councils

- Review announcement expected of the 'prevalence of mental illness and neurodivergence, with a particular focus on whether some conditions are being overdiagnosed'

- Mental Health, work and social security: Timms and Mayfield reviews

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Where do we go from here?

WHERE DO WE GO FROM HERE?

◎ Embed a 'Mental Health in All Policies' approach through a cross-government strategy.

◎ Guarantee fair funding for mental health across all parts of the system.

◎ Invest in the workforce: boosting capacity, skills, and diversity.

◎ Shift the focus to prevention and promotion, tackling stigma and supporting wellbeing across the life course.

◎ Maintain a sustained focus on equality: using PCREF to drive systemic change and addressing hidden inequities, including those affecting older adults and LGBT+ communities.

A MENTALLY HEALTHIER NATION

◎ A national mental health plan

◎ Mental health (test) in all policies
  - Social security
  - Education
  - Justice
  - Race equality
  - Housing & workers' rights

◎ A Mental Health Commissioner

◎ https://www.centreformentalhealth.org.uk/publications/mentally-healthier-nation

HOW CAN WE HELP YOU?

◉ Local strategic support: needs assessments, complex system mapping, creating future vision for services, eg: https://www.centreformentalhealth.org.uk/how-we-work/needs-assessments/

◉ Mentally Healthier System Leaders Network : https://www.centreformentalhealth.org.uk/mentally-healthier-system-leaders-network/

◉ Equally Well UK: www.equallywell.co.uk

◉ Anything else? Let us know... kadra.Abdinasir@centreformentalhealth.org.uk

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THANK YOU
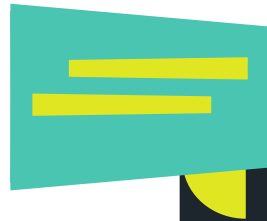
Kadra Abdinasir

Kadra.abdinasir@centreformentalhealth.org.uk

Adult & older people's mental health 2024/25 benchmarking findings

Daniel Iyoha

Project Manager - NHSBN

NHS
Benchmarking Network

Project context

History

- This is the **14th year** that the NHS Benchmarking Network has delivered the benchmarking collection on adult and older people's mental health services

The project

- Comparison across adult and older people's community and inpatient mental health services
- The data shown is for the 1st April 2024 to 31st March 2025 period
- Bespoke reports were issued at the end of October

Participation

- **75** submissions were received from **63** organisations
  - ➢ **90%** of Mental Health Trusts in England
  - ➢ **71%** of Health Boards in Wales
  - ➢ **80%** of Health Boards in Scotland (4th year of comprehensive participation)
  - ➢ One Health and Social Care Trust in Northern Ireland
  - ➢ States of Jersey & Independent Sector

The sample

The data shown represents:

- **2,575,173** referrals received
- **813,330** service users on the caseload at 31st March 2025
- **15,242,952** contacts delivered
- **93,558** admissions to inpatient care
- **21,522** total beds at 31st March 2025

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Balance of care

Total inpatient expenditure vs total community expenditure

Legend: ■ Community Services ■ Inpatient Services
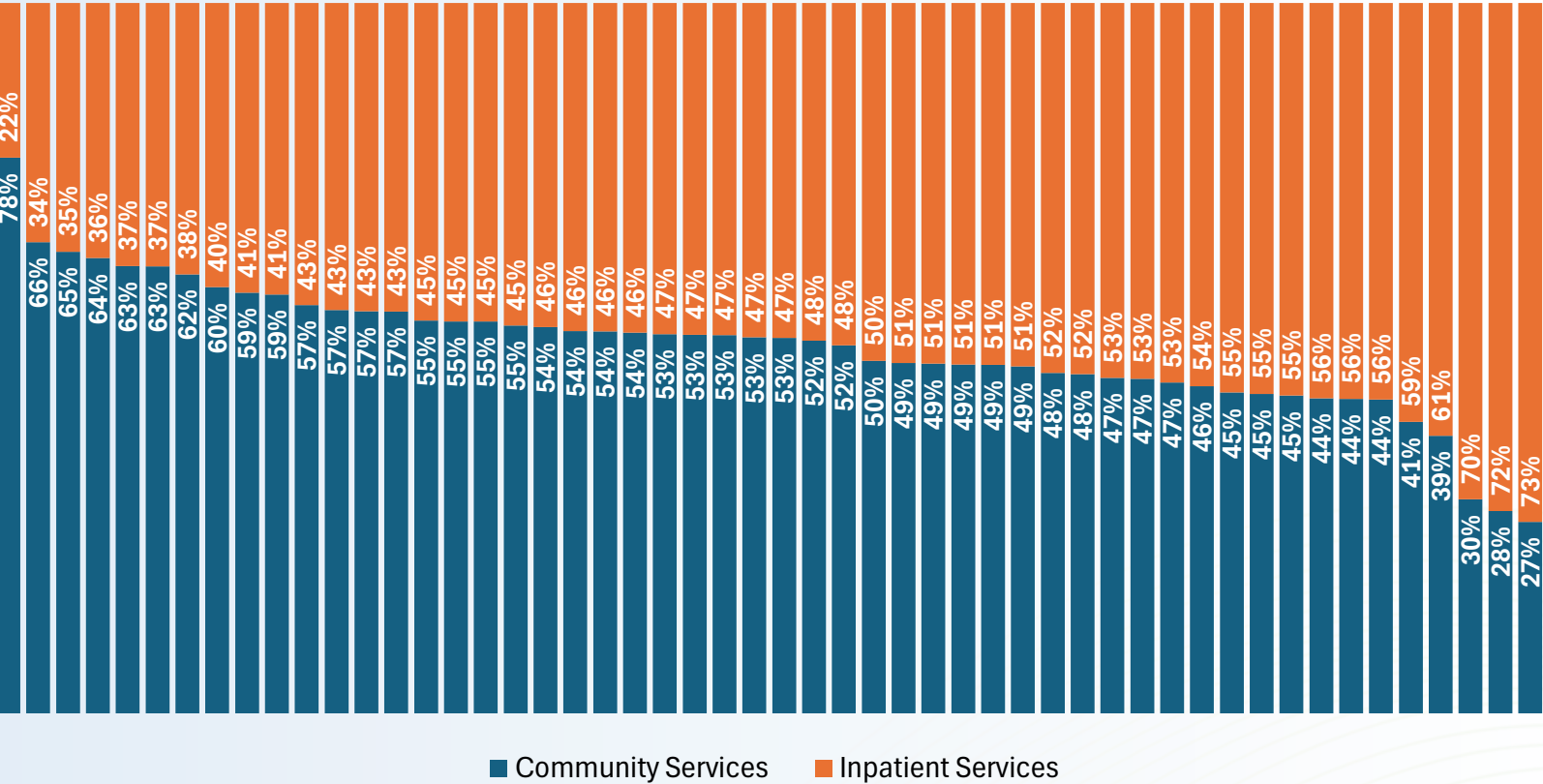
Includes specialist services and represents all organisations that submitted to both inpatient and community services
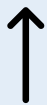
↑ Median proportion of expenditure on community services: **53%**

↓ Median proportion of expenditure on inpatient services: **47%**

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Clinical contacts

Contacts delivered per clinical WTE per day (generic CMHT)

Mean	2.4
Median	**2.0**
N	61
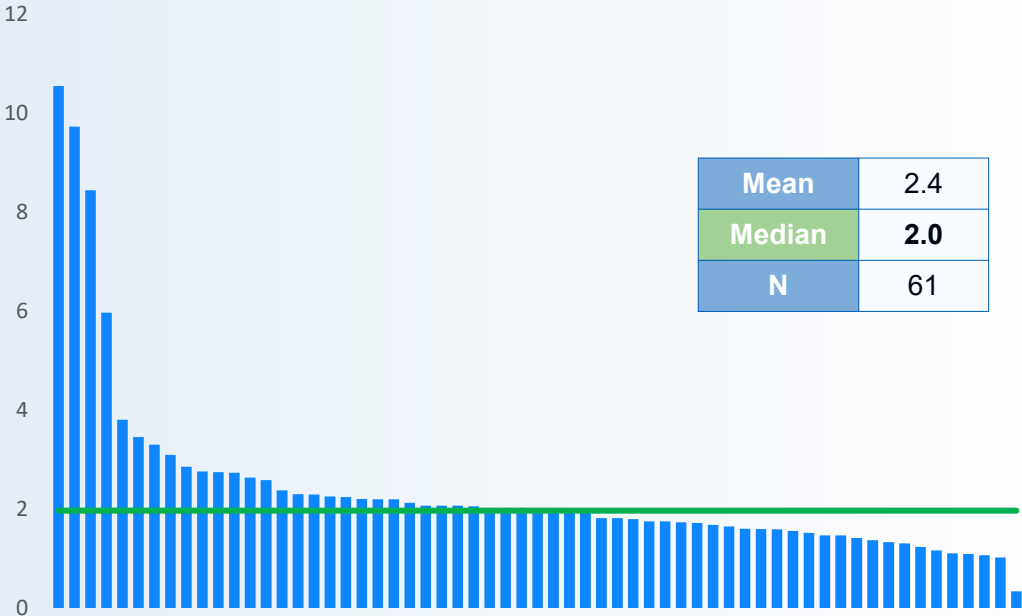
Cost per contact (generic CMHT)

Mean	£254
Median	**£241**
N	52

£222 — 2021/22
£250 — 2022/23
£265 — 2023/24
£241 — 2024/25

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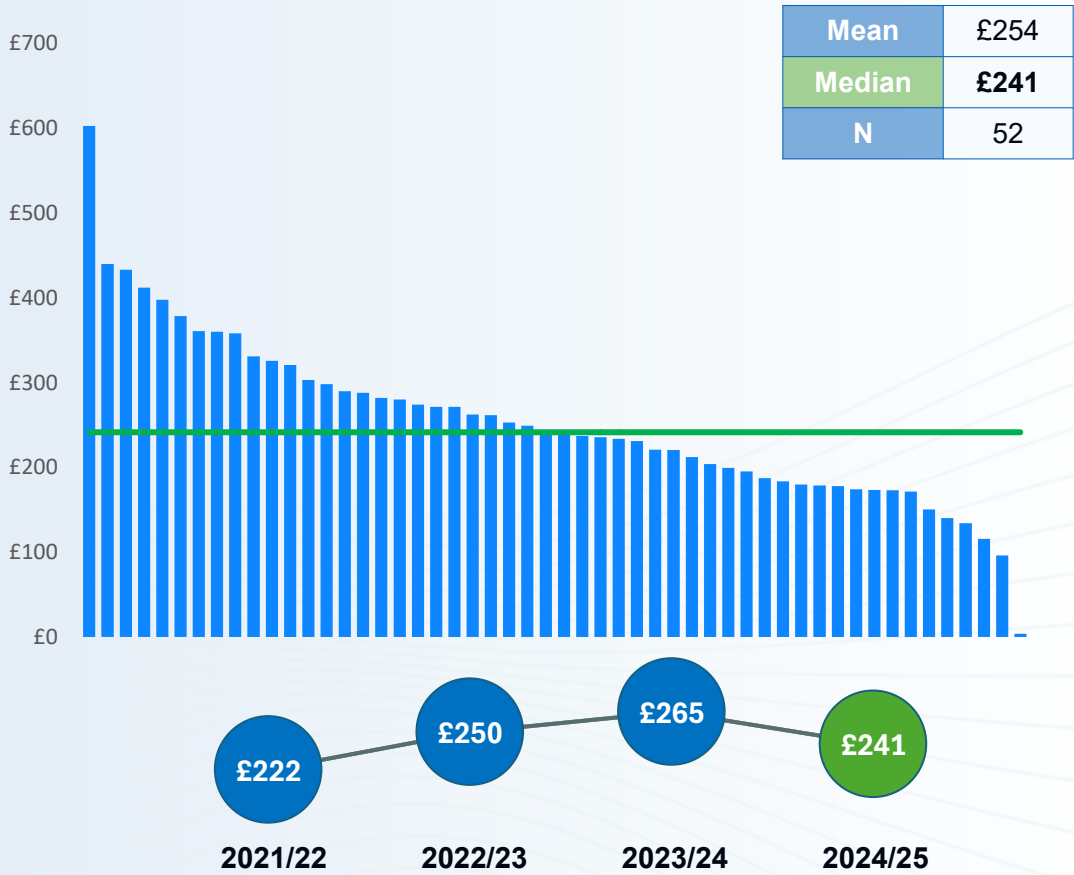
Clinical contacts

Contacts delivered per clinical WTE per day (older people)

Mean	1.9
Median	**1.6**
N	53
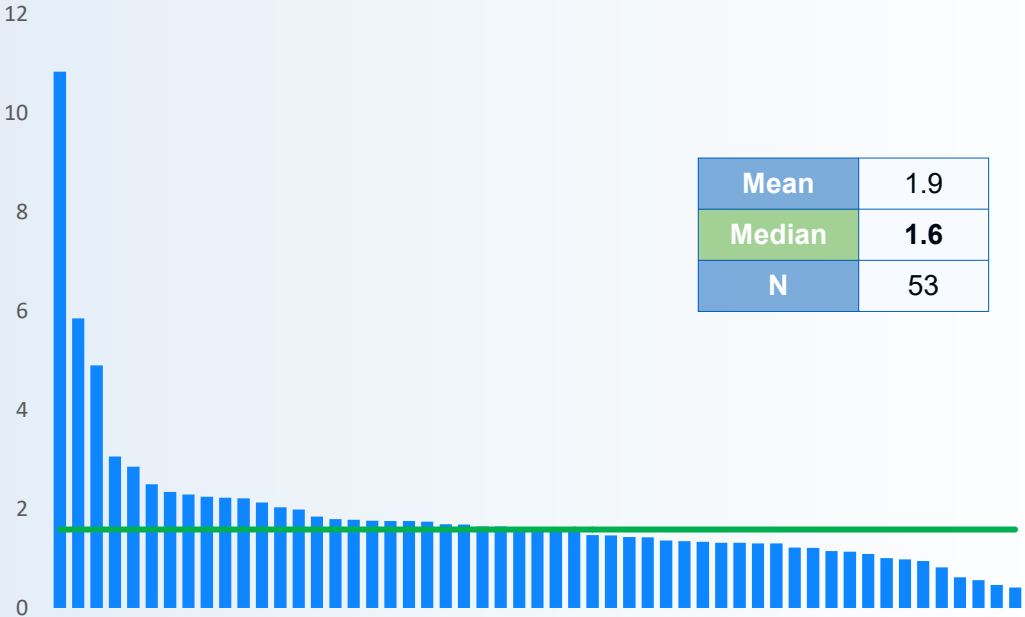
Cost per contact (older people)

Mean	£336
Median	**£311**
N	46

- 2021/22: £227
- 2022/23: £270
- 2023/24: £273
- 2024/25: £311

Harnessing the power of data to drive meaningful change

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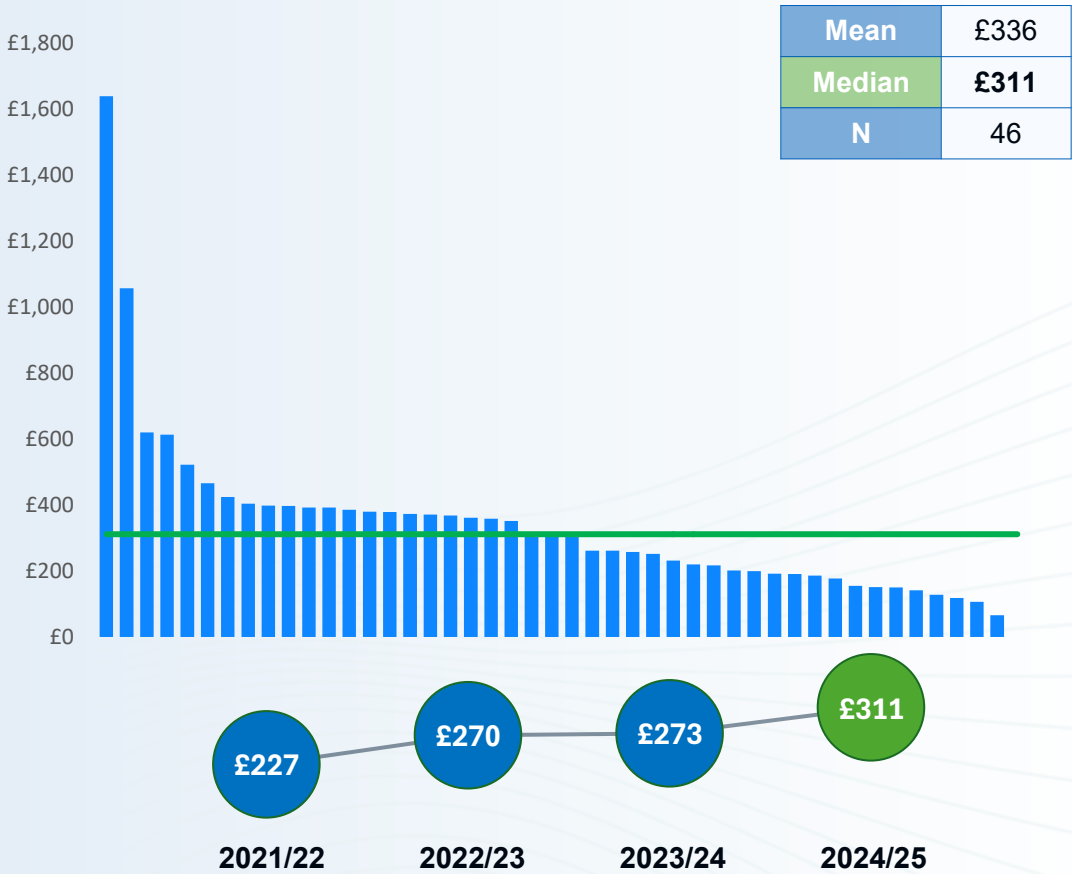
Contact method

Generic CMHTs

- Face-to-face contacts **down 1%**
- Digital (video) contacts up **1%**

65%	27%	4%	4%

- ■ Face-to-face
- ■ Non-face-to-face: telephone
- ■ Non-face-to-face: digital (video link)
- ■ Non-face-to-face: other (incl. text/instant messaging)

Older people

- Face-to-face contacts **up 2%**
- Telephone contacts down **1%**

66%	29%	4%

- ■ Face-to-face
- ■ Non-face-to-face: telephone
- ■ Non-face-to-face: digital (video link)
- ■ Non-face-to-face: other (incl. text/instant messaging)

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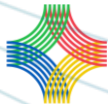
Time on caseload

Forensic: **42 weeks**
EIP: **44 weeks**

Average time spent on caseload (weeks) (generic CMHT)

Mean	49
Median	**40**
N	50
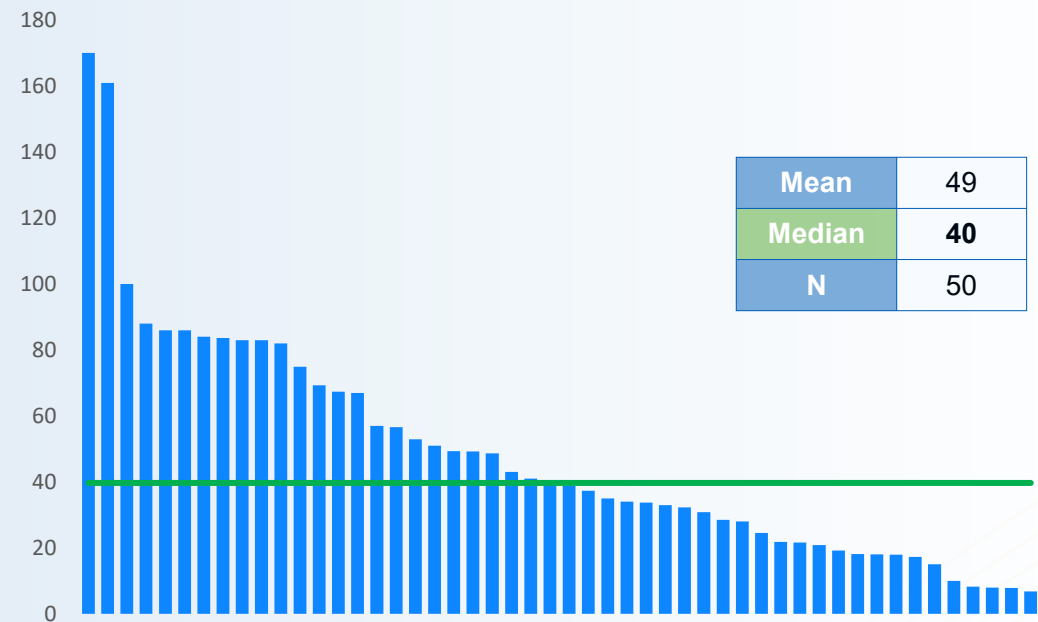
Average time spent on caseload (weeks) (older people)

Mean	41
Median	**30**
N	48

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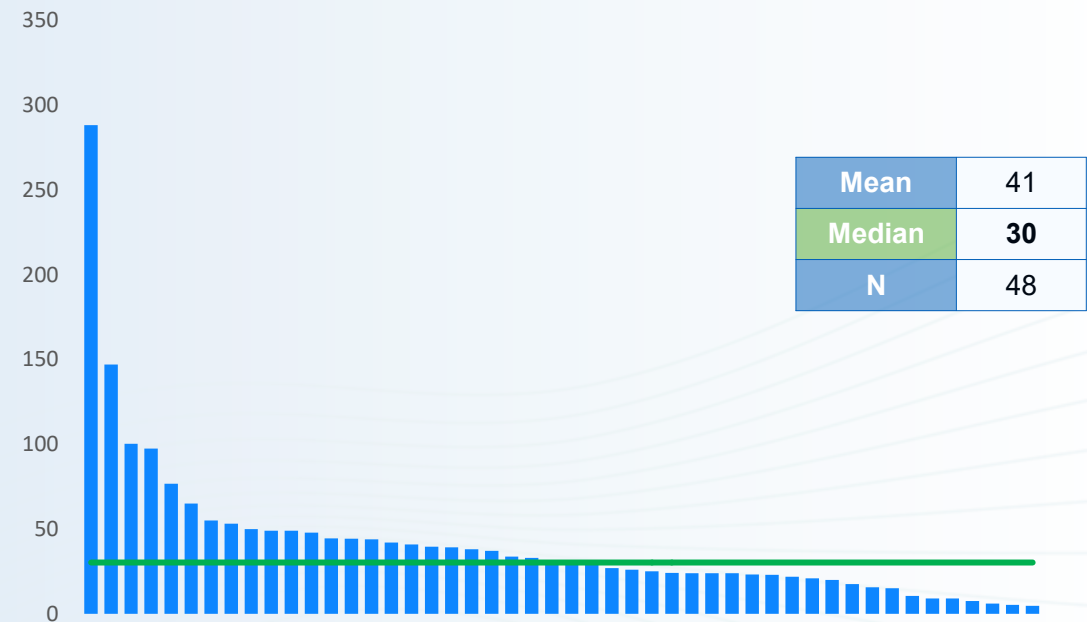
Re-referrals

Re-referral rate % (generic CMHT)

Mean	24%
Median	**21%**
N	40

2023/24: 23% → 2024/25: 21%
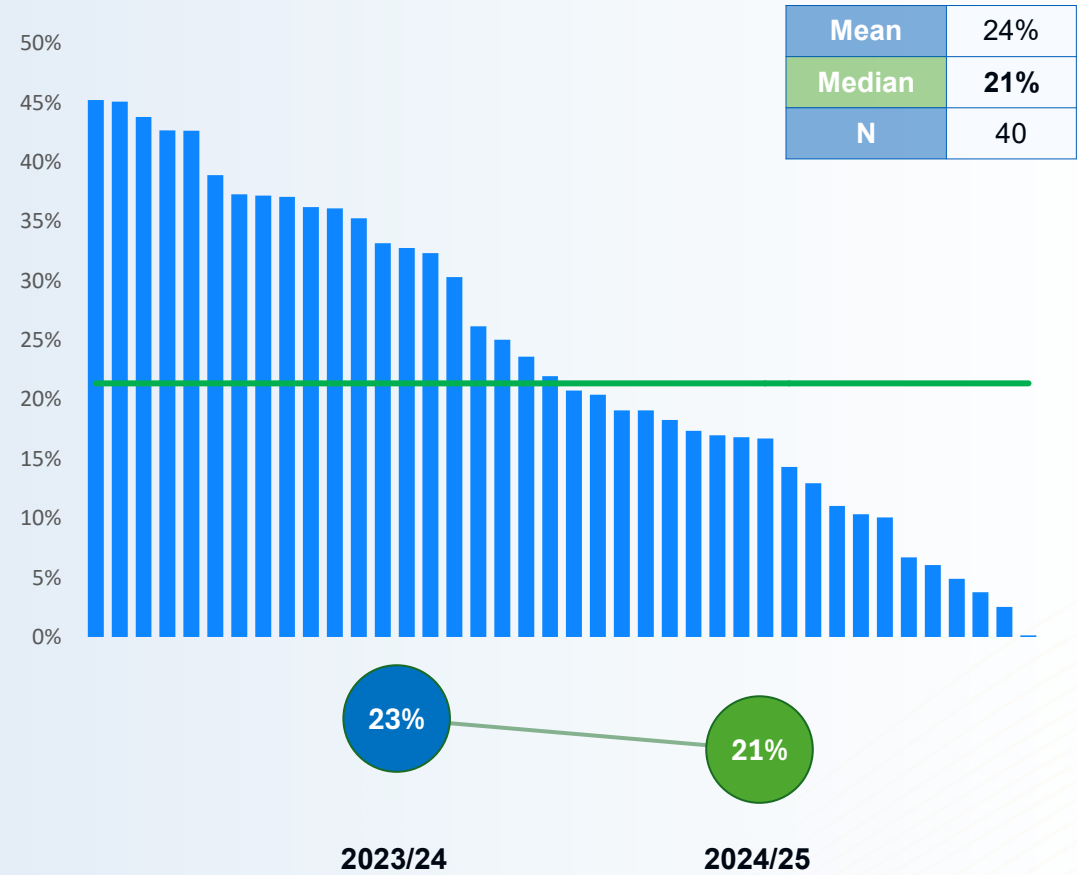
Re-referral rate % (older people)

Mean	20%
Median	**15%**
N	37

2023/24: 23% → 2024/25: 15%

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Did-not-attends (DNAs)
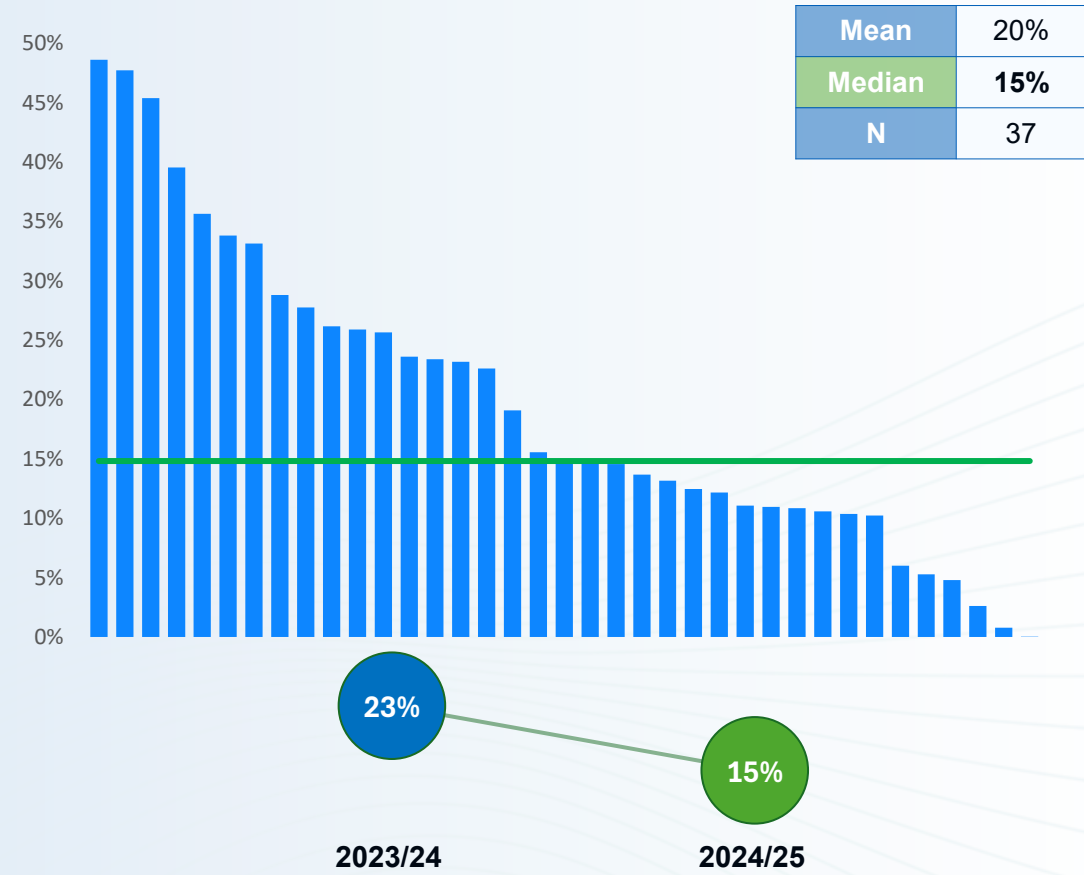
Median overall cost of DNAs: **£2.5M**

DNA rate % (generic CMHT)

Mean	10%
Median	**10%**
N	59
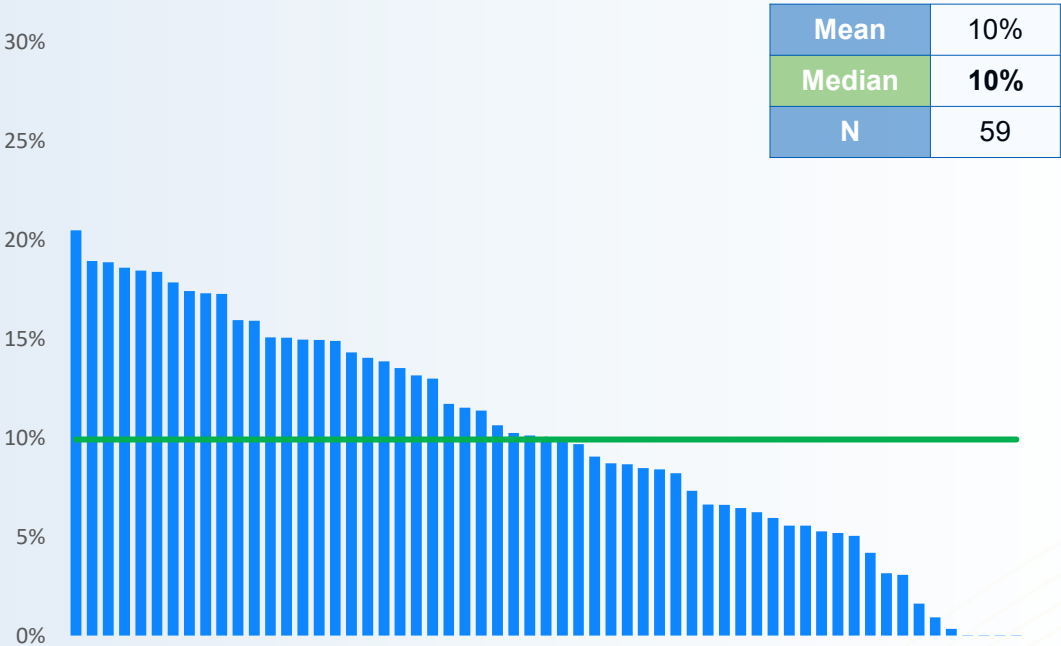
Cost per DNA (generic CMHT)

Mean	£231
Median	**£223**
N	52

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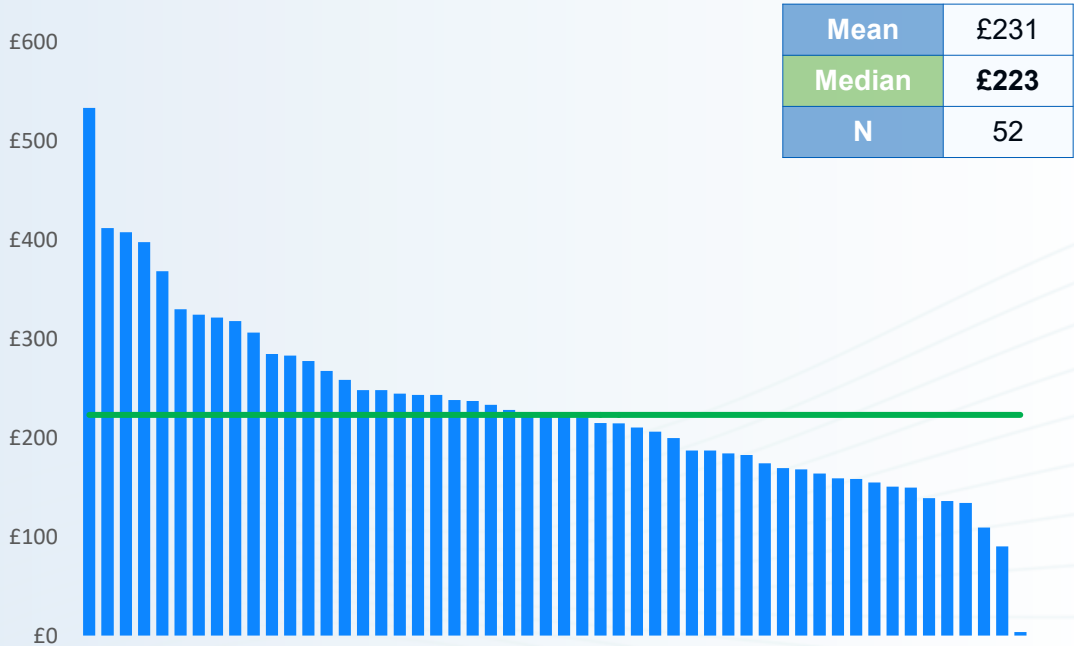
Did-not-attends (DNAs)

Median overall cost of DNAs: **£0.2M**

DNA rate % (older people)

Mean	3.5%
Median	**2.3%**
N	54
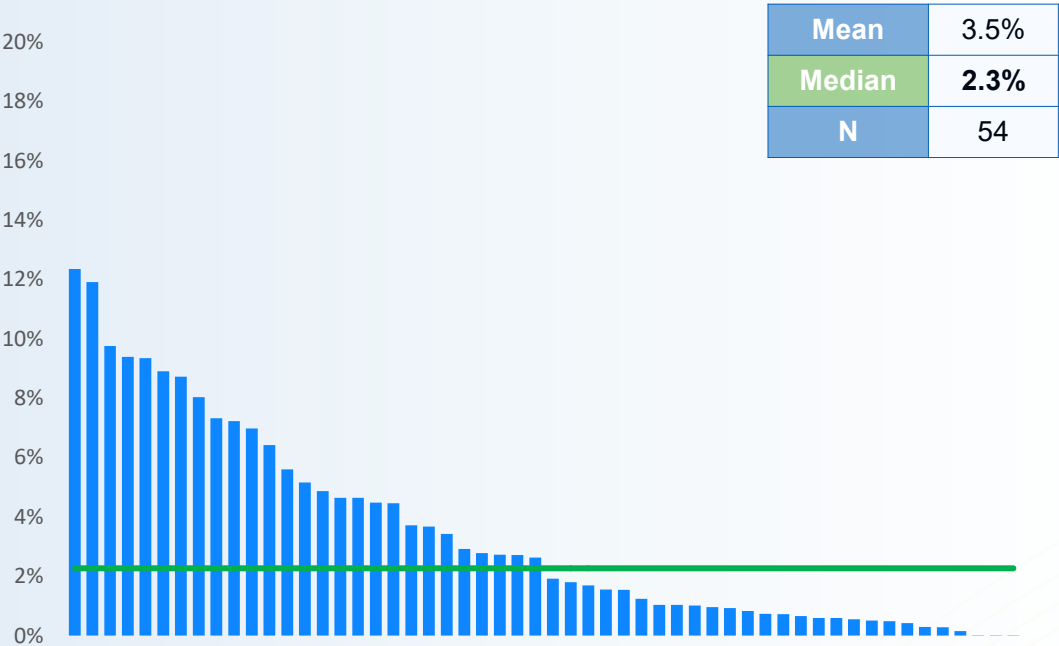
Cost per DNA (older people)

Mean	£325
Median	**£284**
N	46

Health Inequalities

Ethnicity at national and service level

	White/white British	Mixed	Asian/Asian British	Black/black British	Other	Not stated/known
UK population	84%		8%	4%	3%	
Community caseload	69%	3%	6%	4%	3%	16%
Inpatient admissions	70%	3%	6%	7%	3%	11%
Inpatient detentions (at the point of admission)	64%	4%	8%	10%	4%	9%

Harnessing the power of data to drive meaningful change
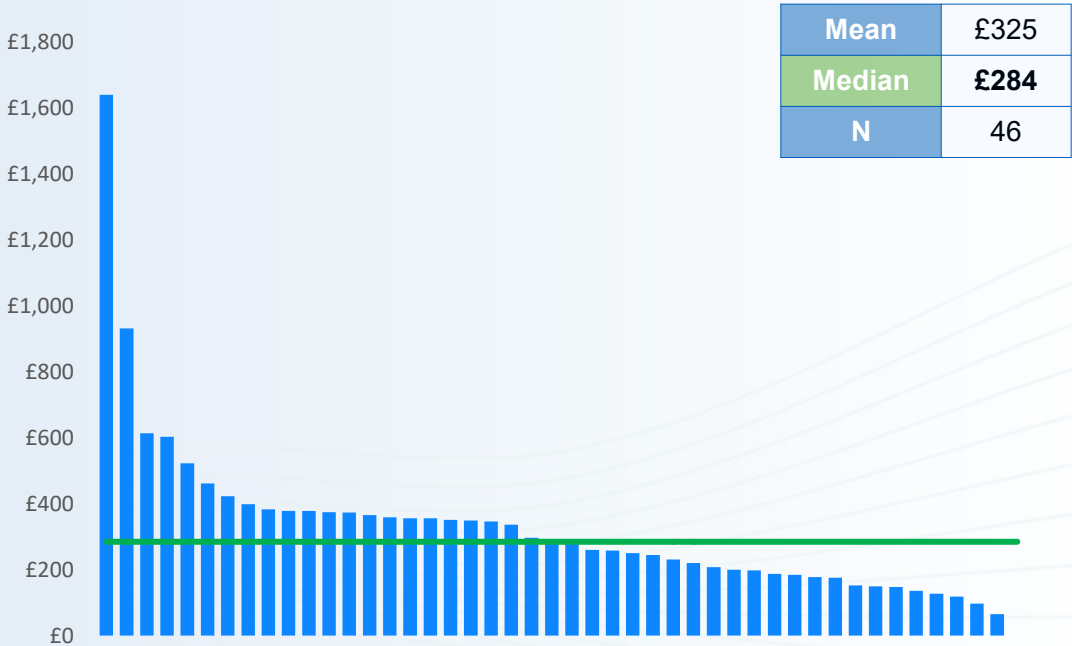
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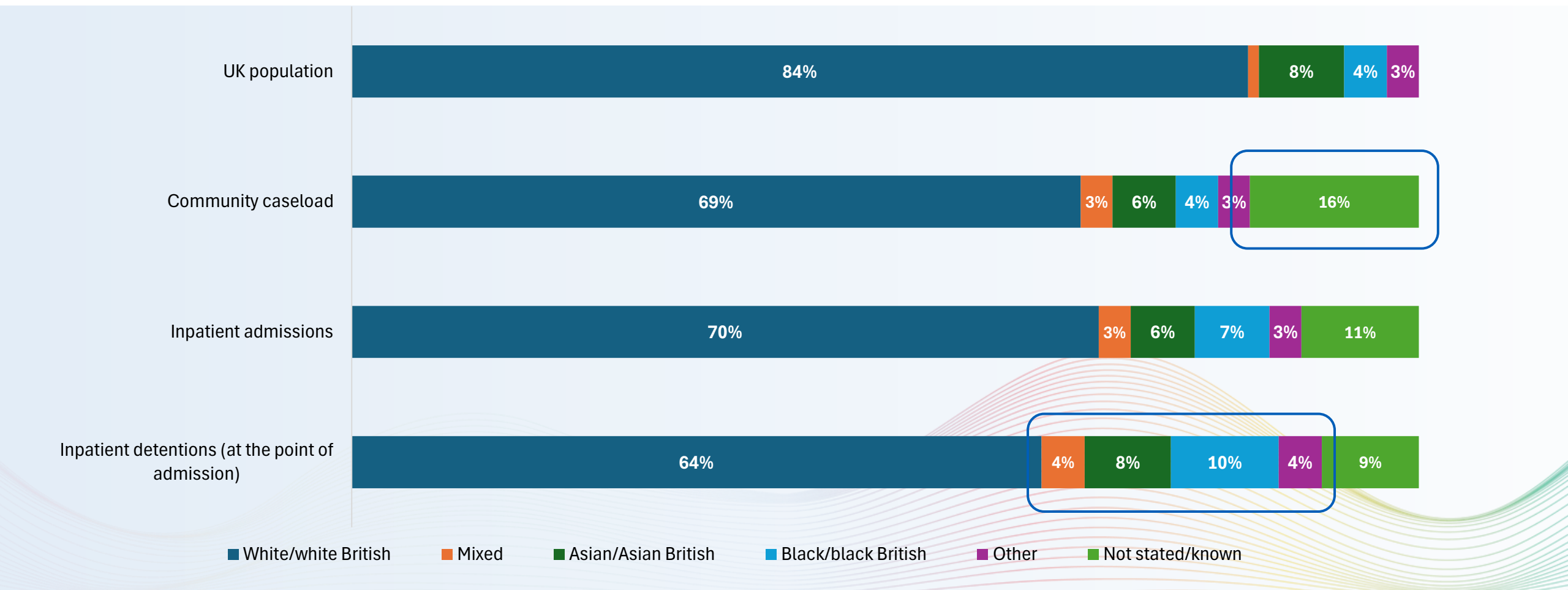
Ethnicity in community mental health teams
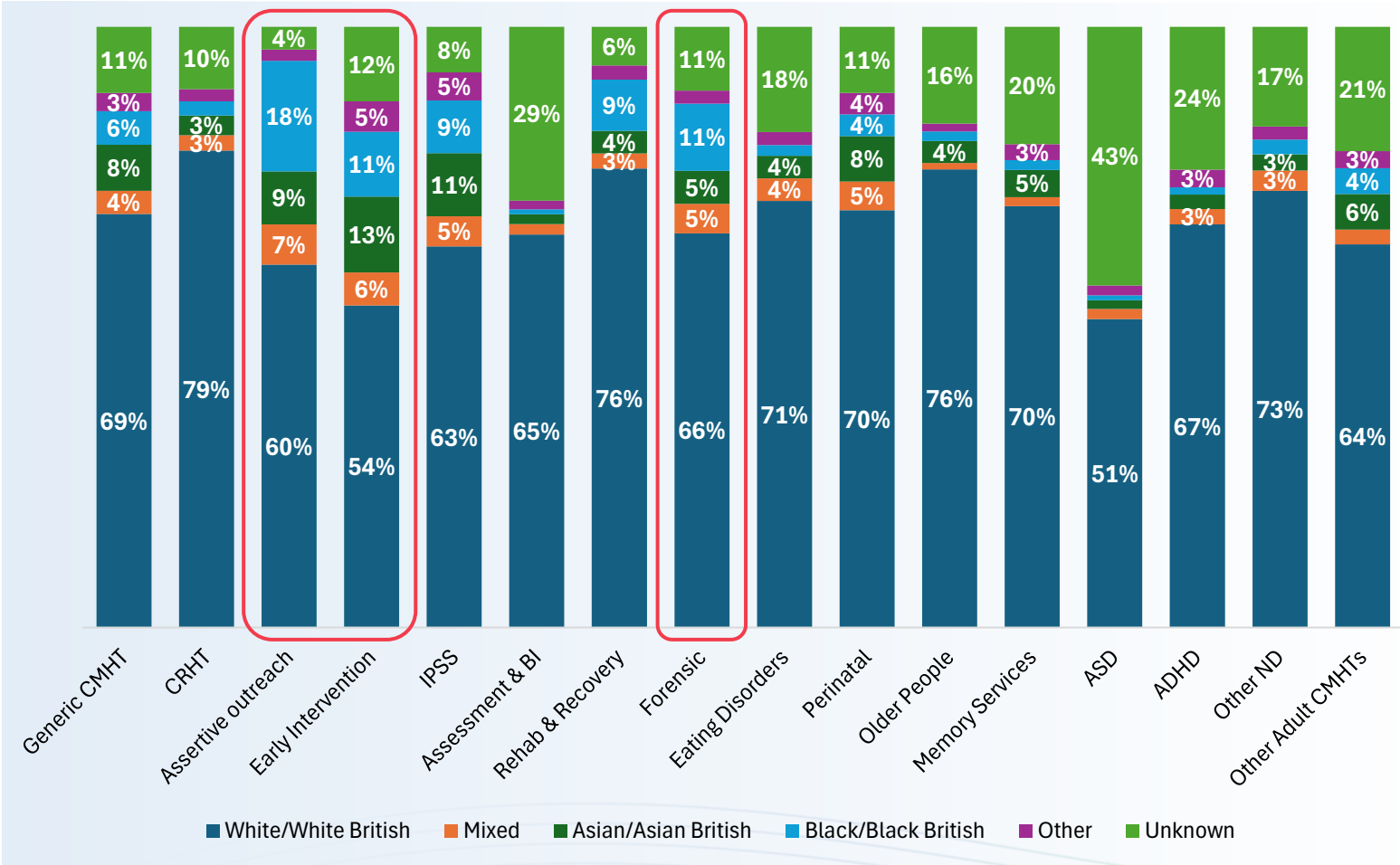
Over-representation of individuals from an ethnic minority background in areas of highest acuity

Under-representation in assessment and brief intervention, older people's and neurodiversity services

Legend: White/White British, Mixed, Asian/Asian British, Black/Black British, Other, Unknown

Ethnicity in inpatient mental health teams
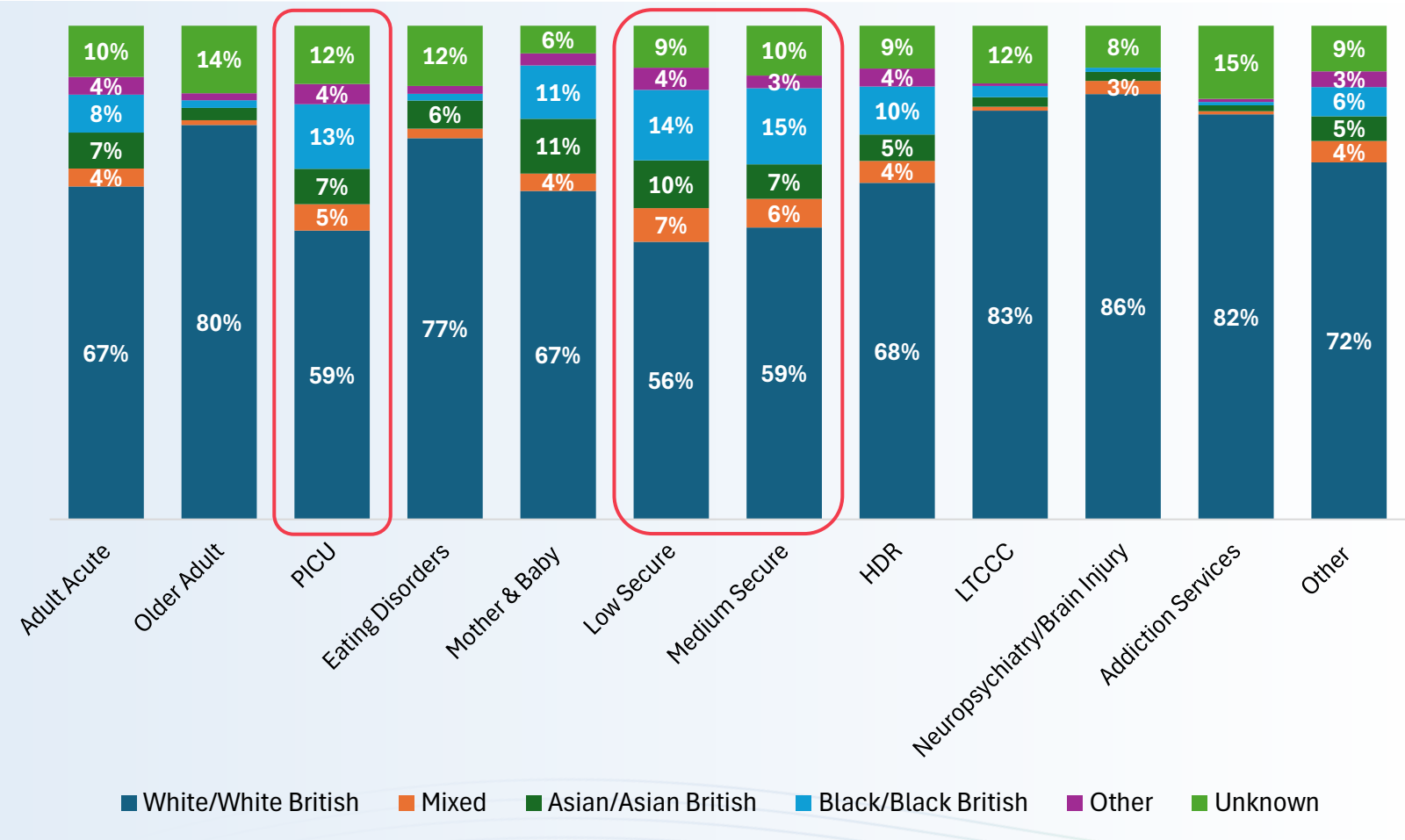
Over-representation of individuals from an ethnic minority background in PICU and secure services

Under-representation in older adult, longer-term, neuropsychiatry and addiction services

Legend: White/White British | Mixed | Asian/Asian British | Black/Black British | Other | Unknown

Harnessing the power of data to drive meaningful change

Gender in community mental health teams

Community: Male 45%, Female 55%
Inpatient: Male 53%, Female 47%

Legend: Male, Female, Non-binary, Not stated/known

Generic CMHT: Male 46%, Female 53%
CRHT: Male 50%, Female 50%
Assertive Outreach: Male 67%, Female 33%
Early Intervention: Male 56%, Female 43%
IPSS: Male 49%, Female 51%
Assessment & BI: Male 40%, Female 60%
Rehab & Recovery: Male 55%, Female 45%
Forensic: Male 81%, Female 19%
Eating Disorders: Male 13%, Female 87%
Older People: Male 40%, Female 59%
Memory Services: Male 43%, Female 56%
ASD: Male 45%, Female 55%
ADHD: Male 49%, Female 51%
Other ND: Male 51%, Female 48%
Other Adult CMHTs: Male 48%, Female 52%

Legend: Male, Female, Non-binary, Not stated/known

Harnessing the power of data to drive meaningful change

Gender in inpatient mental health teams
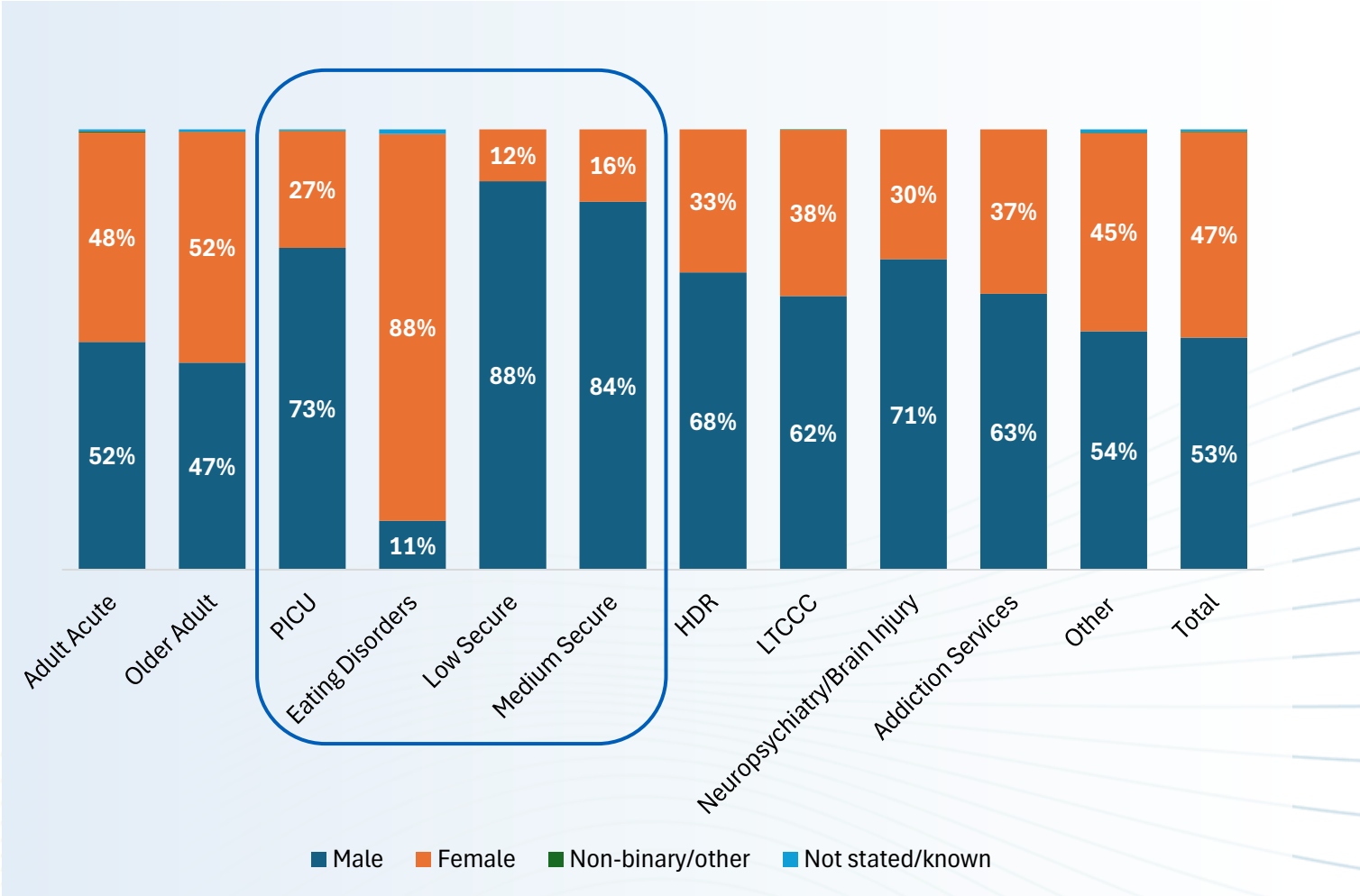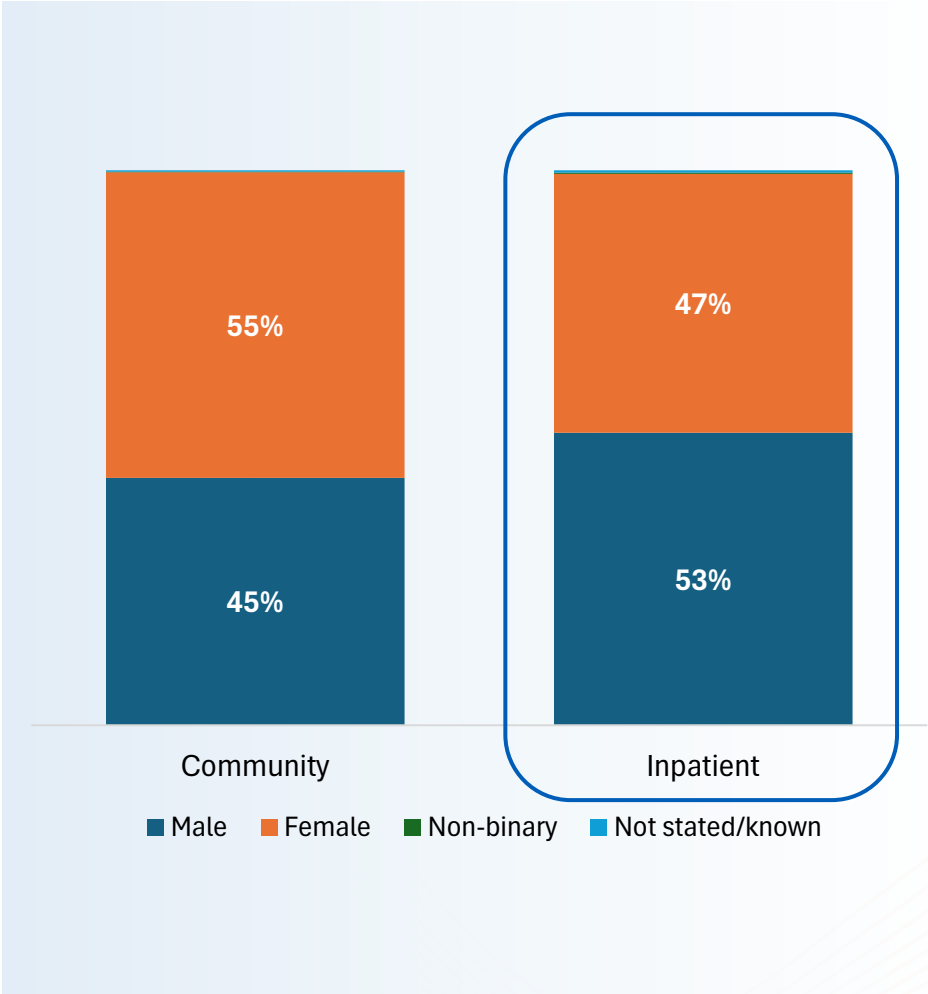
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Community Services

Demand – referral profile
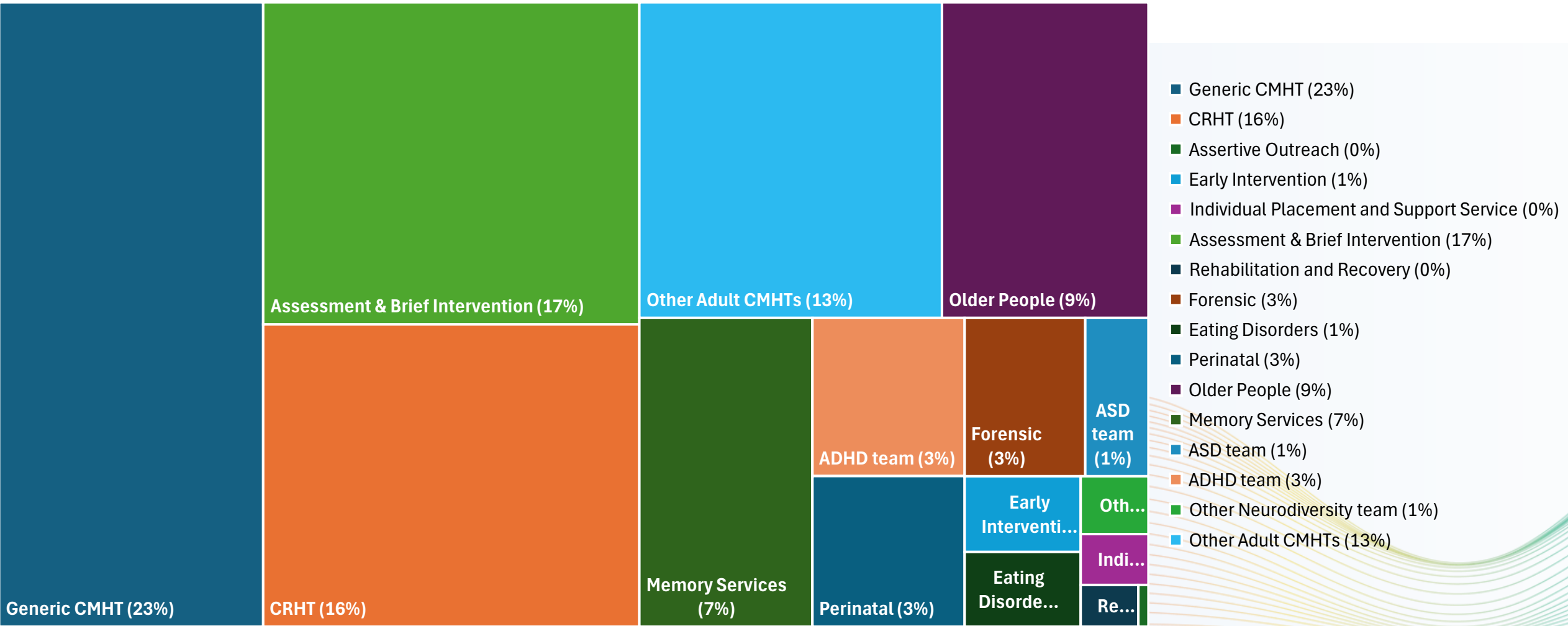
Waiting times

Median waiting time (weeks) by community team 2024/25

Team	Referral to 1st appointment (weeks)	1st to 2nd appointment (weeks)
Generic CMHT	3.0	4.1
CRHT		
Assertive Outreach	3.0	
Early Intervention		
IPSS		
Assessment & BI		
Rehab and Recovery		
Forensic	3.0	3.0
Eating Disorders	3.9	3.8
Perinatal	3.0	
Older People		3.0
Memory Services	6.9	5.7
ASD team	76.5	15.4
ADHD team	60.7	30.3
Other ND	12.0	5.7
Other Adult CMHTs		3.0

■ Referral to 1st appointment (weeks)   ■ 1st to 2nd appointment (weeks)

Referral to 2nd appt. waits (wks)

Team	2023/24	2024/25	Change
Generic CMHT	8.0	7.1	-0.9
CRHT	0.1	0.2	+0.1
Assertive Outreach	5.0	4.5	-0.5
EIP	2.1	2.0	-0.1
IPS	4.9	3.9	-1.0
A&BI	4.0	4.1	+0.1
Rehab & Recovery	5.0	4.9	-0.1
Forensic	6.4	6.0	-0.4
ED	7.1	7.7	+0.6
Perinatal	6.0	5.4	-0.6
Older People	6.0	5.0	-1.0
Memory Services	14.0	12.6	-1.4
ASD Team	53.0	91.9	+38.9
ADHD Team	61.0	91.0	+30.0
Other ND	56.4	17.7	-38.7
Other CMHT	7.2	5.1	-2.1

NHS Benchmarking Network

Referrals

Total referrals received per 100,000 population (generic CMHT)

Mean	2,000
Median	**1,801**
N	65

- 1,405 — 2021/22
- 1,524 — 2022/23
- 1,568 — 2023/24
- 1,801 — 2024/25
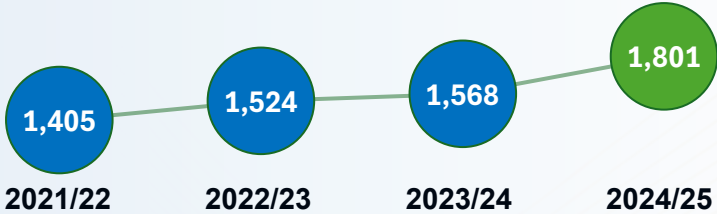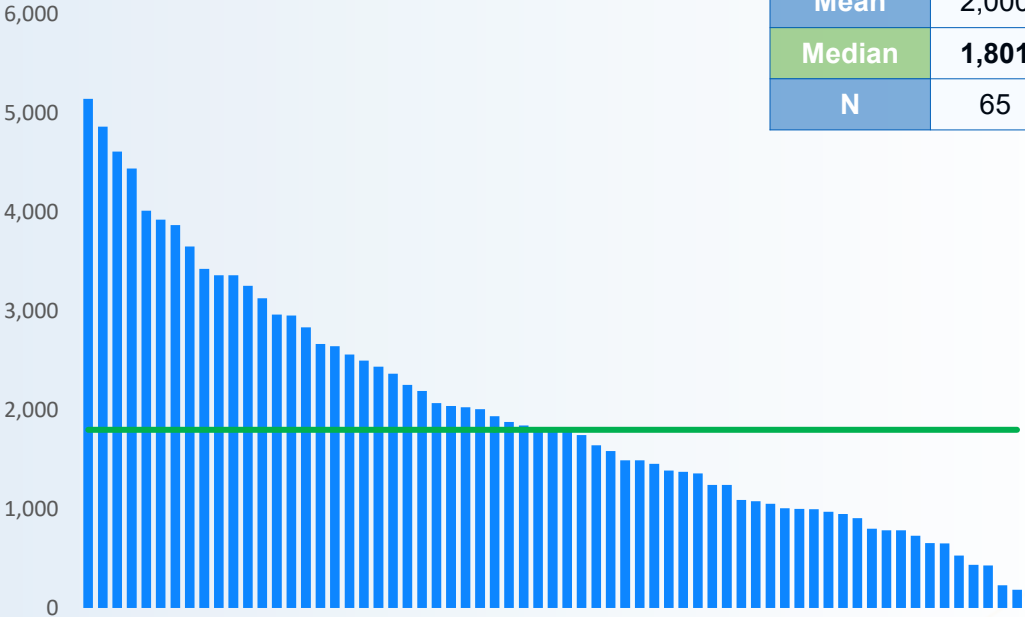
Referral acceptance rate % (generic CMHT)

Mean	80%
Median	**86%**
N	64

- 85% — 2021/22
- 85% — 2022/23
- 86% — 2023/24
- 86% — 2024/25

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change
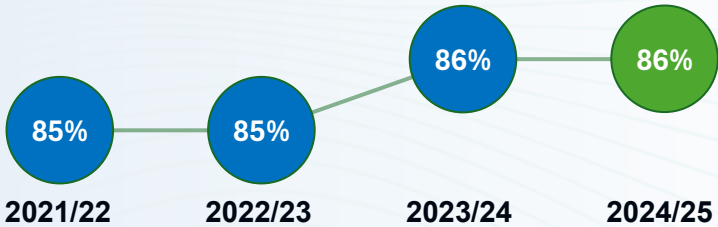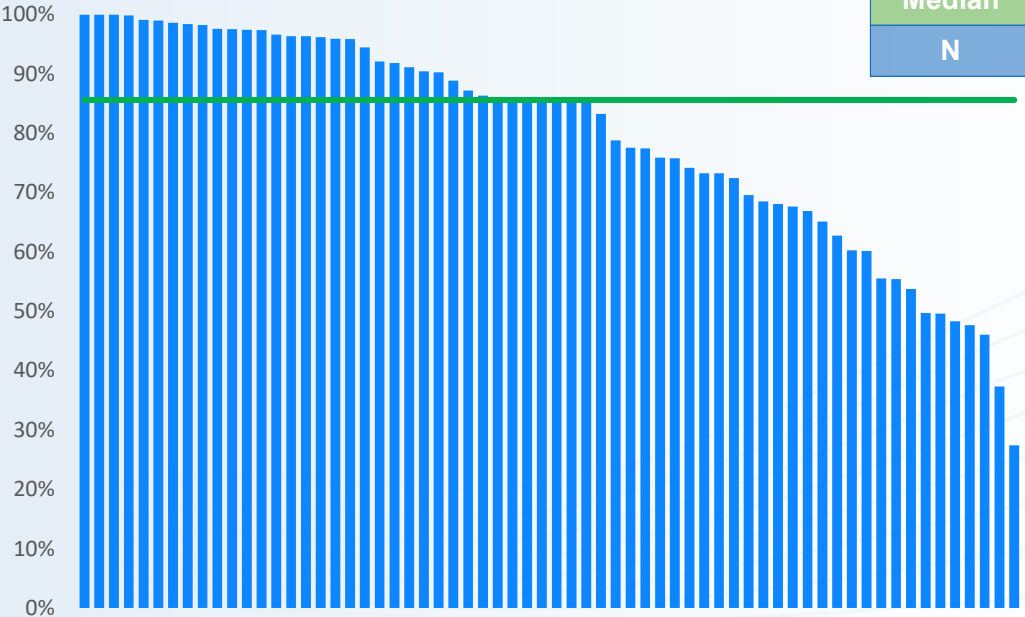
Caseload & activity

Caseload at 31st March 2025 per 100,000 population (generic CMHT)

Mean	1,215
Median	**1,028**
N	65

- 2021/22: 824
- 2022/23: 911
- 2023/24: 900
- 2024/25: 1,028
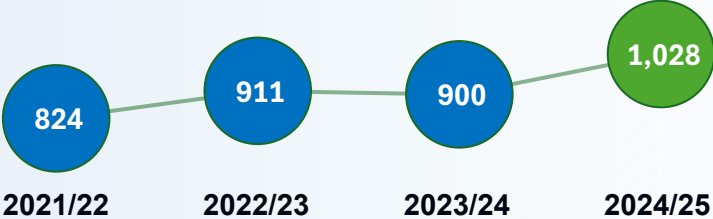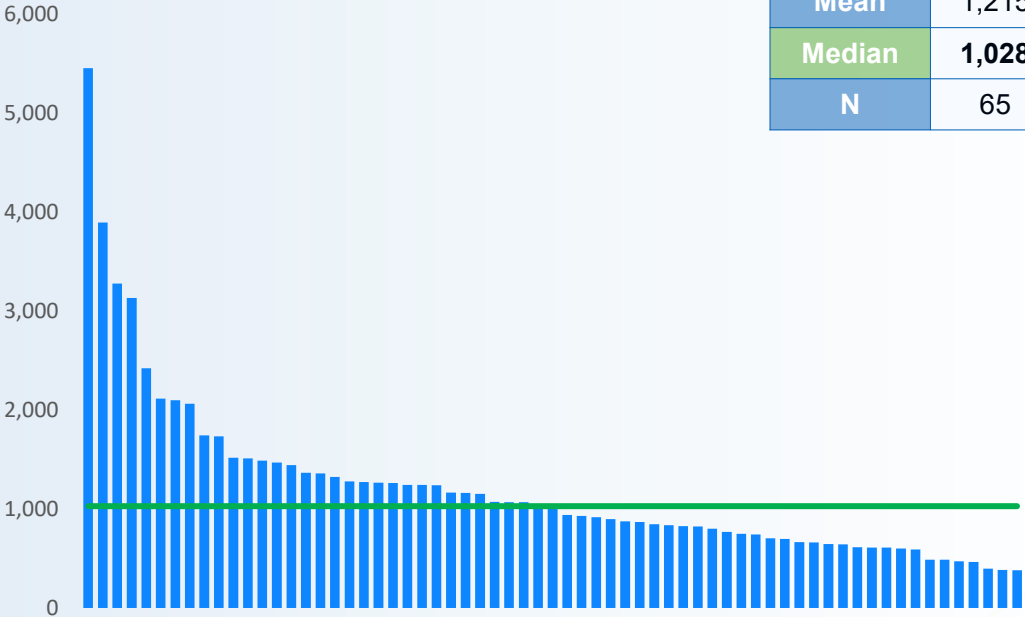
Contacts per 100,000 population (generic CMHT)

Mean	18,165
Median	**17,279**
N	64

- 2021/22: 15,061
- 2022/23: 14,647
- 2023/24: 15,046
- 2024/25: 17,279
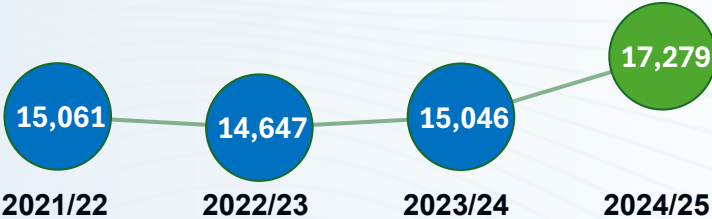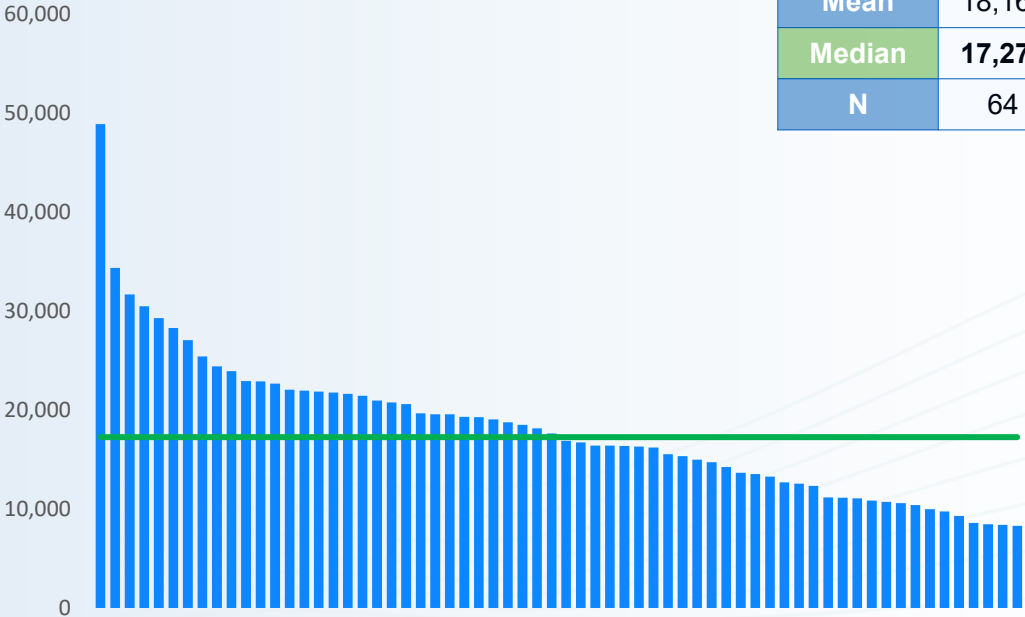
Skill mix & staffing levels

👤 = 5%

Nursing & Clinical Support	👤👤👤👤👤👤👤👤👤👤	50%
Allied Health Professionals	👤	6%
Medical Staff	👤👤	7%
Psychological Professions	👤👤👤	17%
Social Care & Community Roles	👤	5%
Administrative & Management	👤👤👤	14%
Other	👤	1%

Staff (WTE) per 100 patients on caseload (generic CMHT)
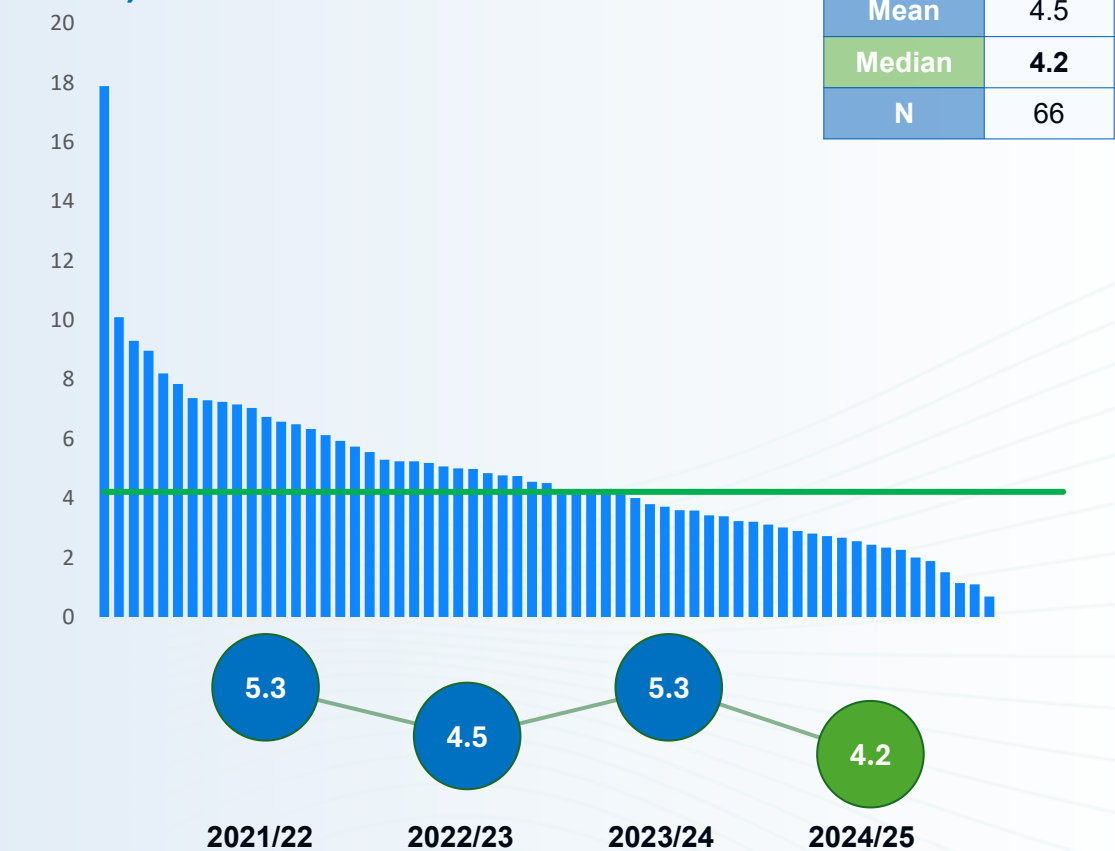
Mean	4.5
Median	**4.2**
N	66

2021/22 — 5.3
2022/23 — 4.5
2023/24 — 5.3
2024/25 — 4.2
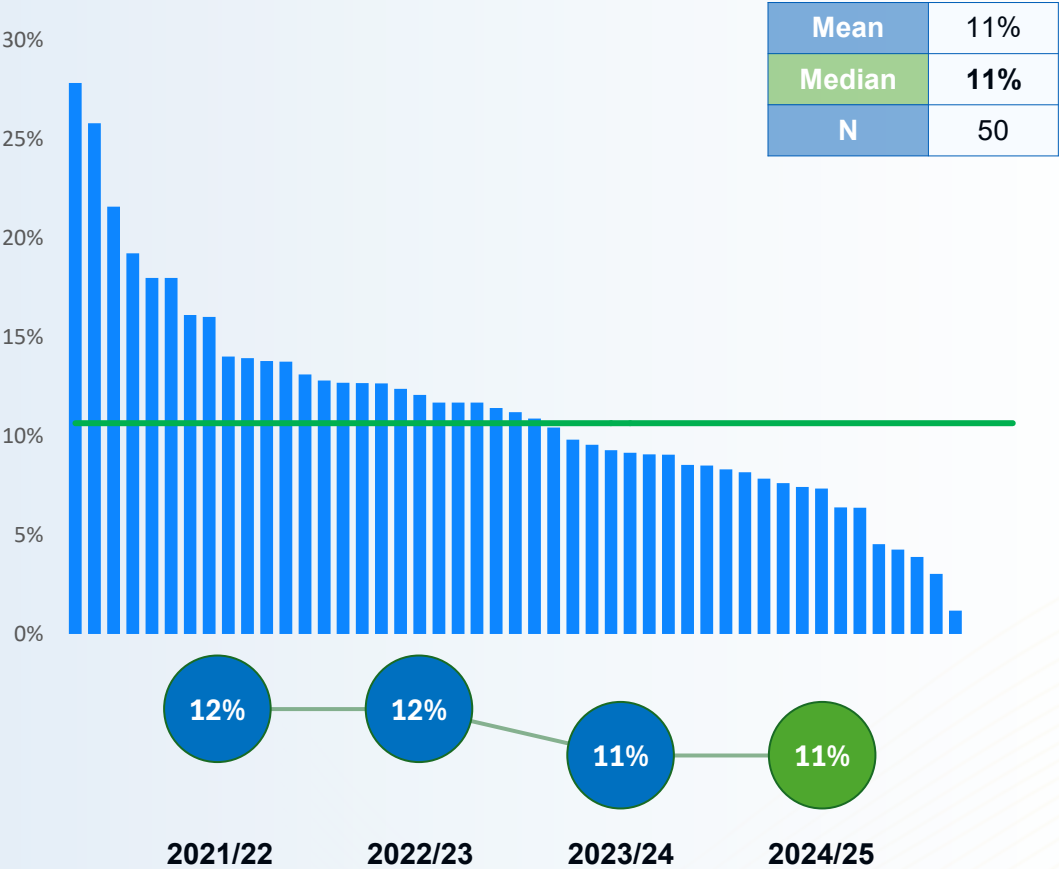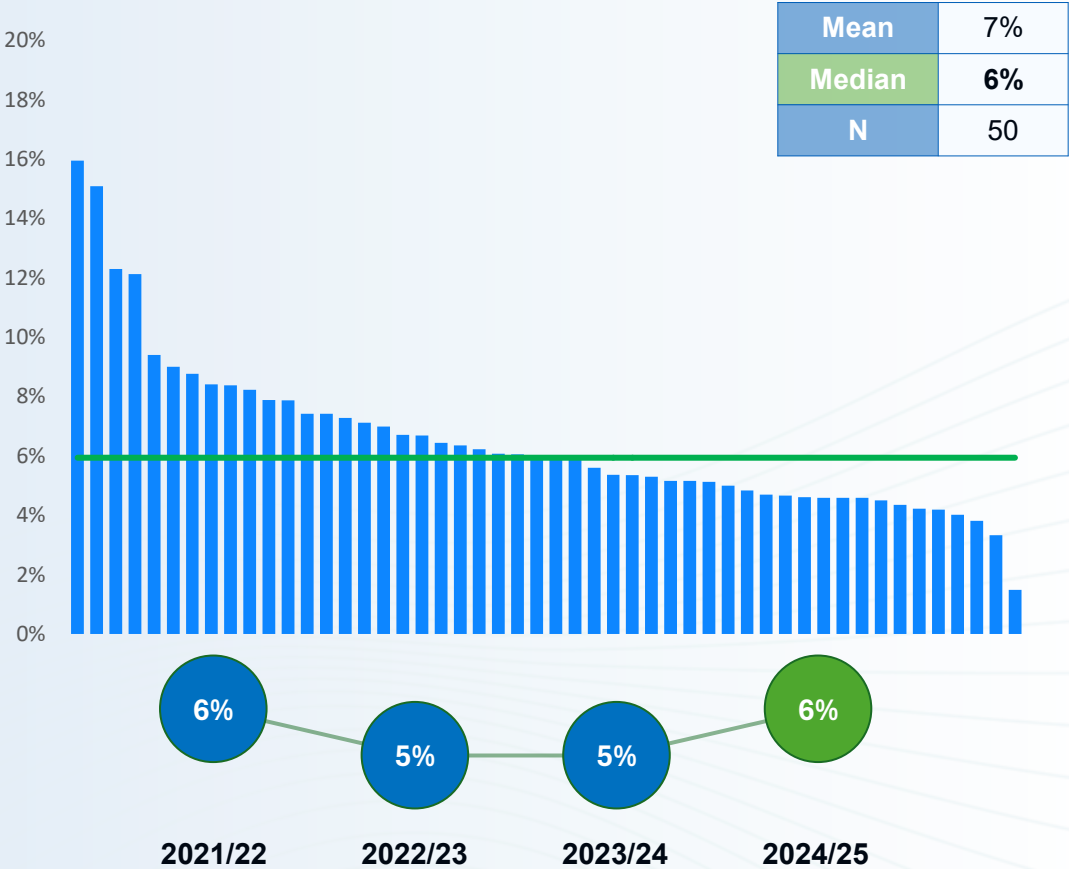
Bank & agency spend, patient costs

Bank & agency spend as a % of total pay costs (generic CMHT)

Mean	11%
Median	**8%**
N	57

2021/22: 10%
2022/23: 12%
2023/24: 11%
2024/25: 8%
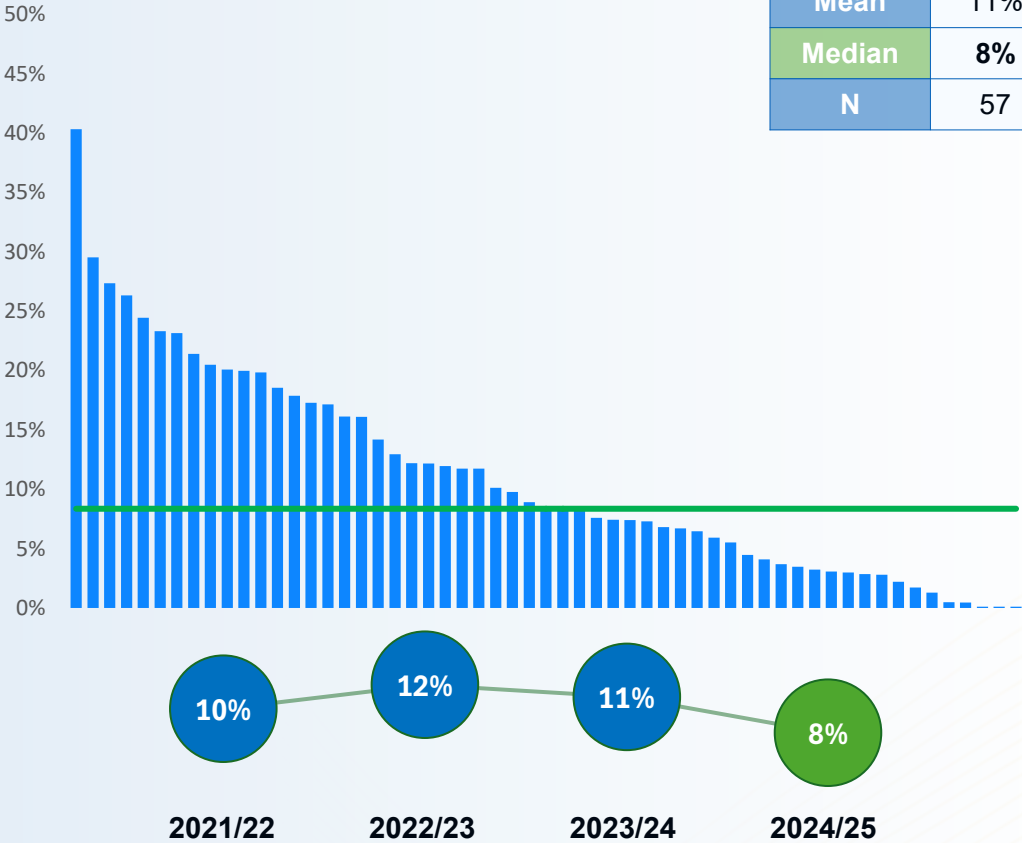
Total cost of service per patient on caseload (generic CMHT)

Mean	£4.9k
Median	**£4.5k**
N	54

2021/22: £4,244
2022/23: £4,690
2023/24: £4,276
2024/25: £4,511

NHS Benchmarking Network
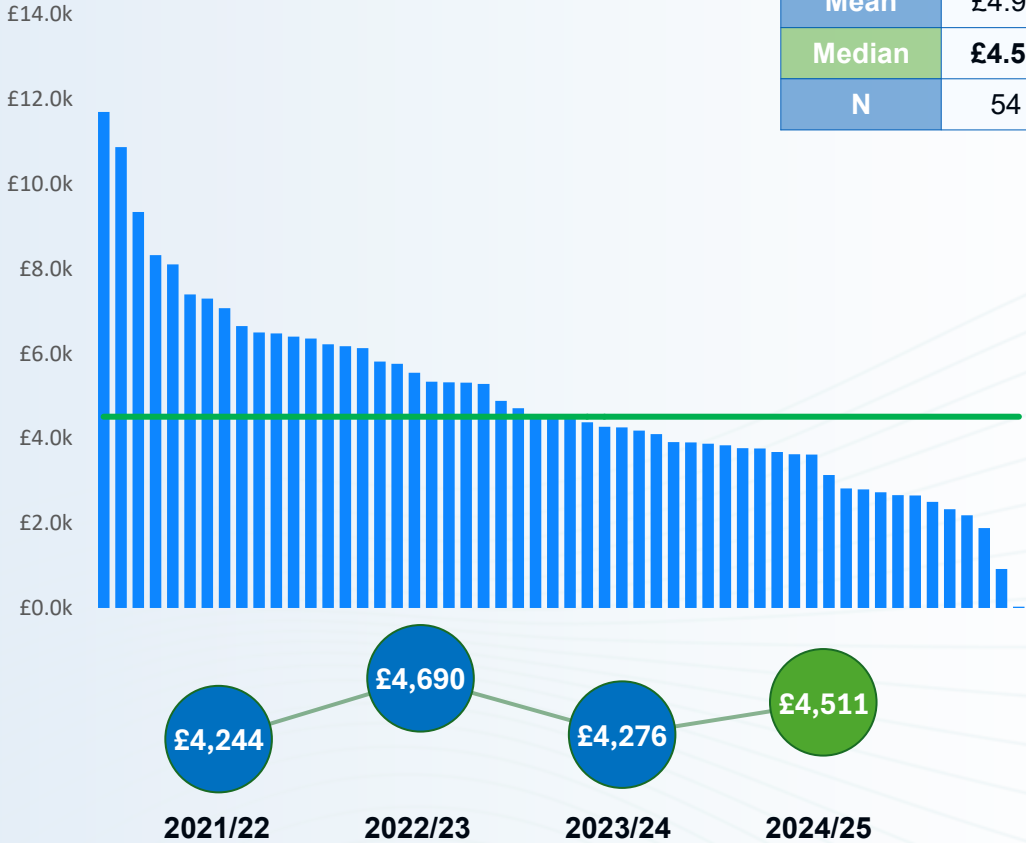
Inpatient Services

Bed profile

Adult Acute (38%) | Older Adult (21%) | Medium Secure (11%) | Low Secure (9%) | LTCCC (5%) | PICU (5%) | HDR (5%) | Other (3%) | Neuropsychiatry/Brain Injury… | Eating Disorders (1%) | Addiction Services… | Mother & Ba…

Legend:
- Adult Acute (38%)
- Older Adult (21%)
- PICU (5%)
- Eating Disorders (1%)
- Mother & Baby (1%)
- Low Secure (9%)
- Medium Secure (11%)
- HDR (5%)
- LTCCC (5%)
- Neuropsychiatry/Brain Injury (1%)
- Addiction Services (1%)
- Other (3%)

Bed occupancy

Category	Occupancy	Change from 2023/24
Adult Acute	95% / 5%	-1%
HDR	93% / 7%	+4%
Older Adult	91% / 9%	+1%
PICU	91% / 9%	-2%
Low Secure	87% / 13%	-4%
Medium Secure	86% / 14%	0%
Other	85% / 15%	+2%
LTCCC	83% / 17%	-5%
Eating Disorders	74% / 26%	-3%
Neuropsychiatry/Brain Injury	73% / 27%	-3%
Addiction Services	67% / 33%	-3%
Mother & Baby	63% / 37%	+1%

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Length of stay

Median Length of Stay (days)

Bed Type	Median Length of Stay (days)
Adult Acute	42
Older Adult	84
PICU	56
Eating Disorders	96
Mother & Baby	36
Low Secure	742
Medium Secure	755
HDR	360
LTCCC	263
Neuropsychiatry/Brain Injury	139
Addiction Services	
Other	268
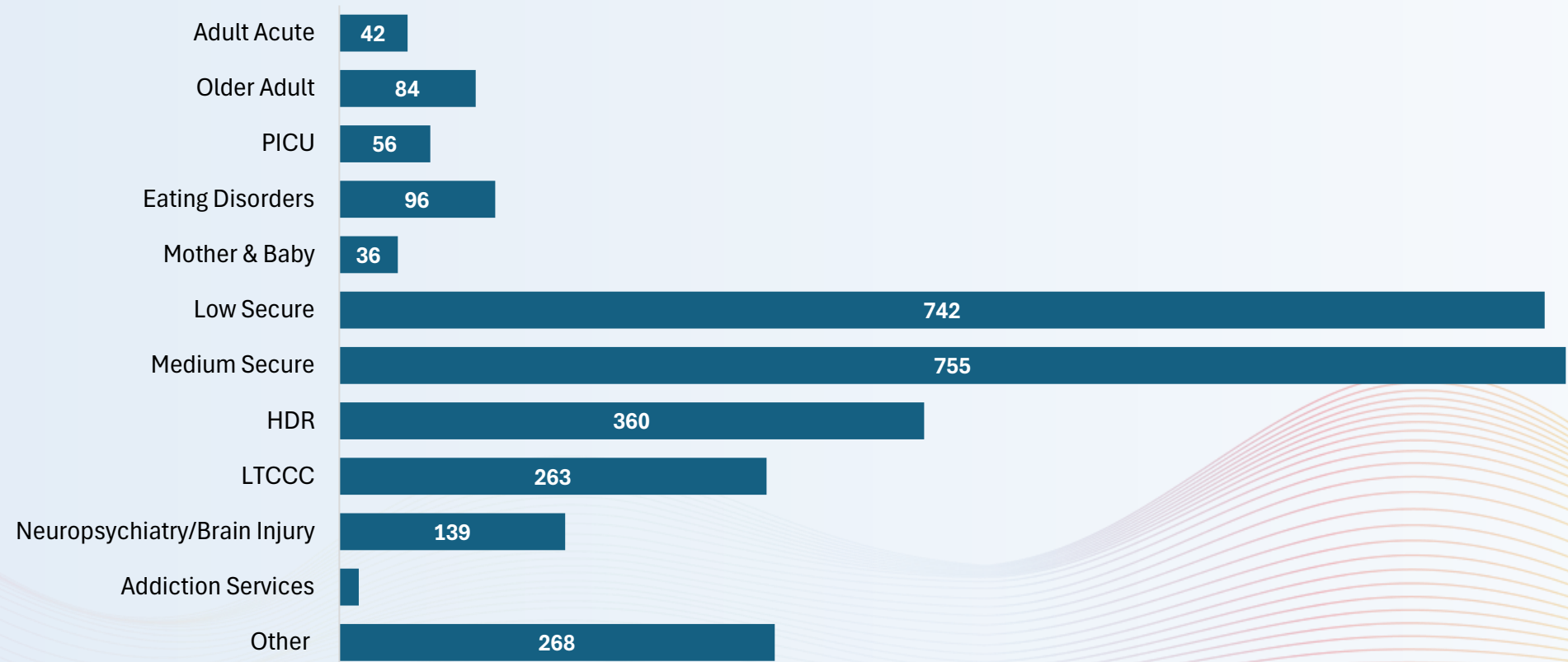
Bed Type	Change (days) from 2023/24
Adult Acute	+3
Older Adult	-6
PICU	+5
Eating Disorders	-9
Mother & Baby	-2
Low Secure	-58
Medium Secure	+93
HDR	+26
LTCCC	-57
Neuropsychiatry/Brain Injury	+14
Addiction Services	0
Other	+53

Harnessing the power of data to drive meaningful change

Adult acute beds

Beds at 31st March 2025 per 100,000 population

Mean	23
Median	**22**
N	65

2021/22 — **20**
2022/23 — **22**
2023/24 — **22**
2024/25 — **22**
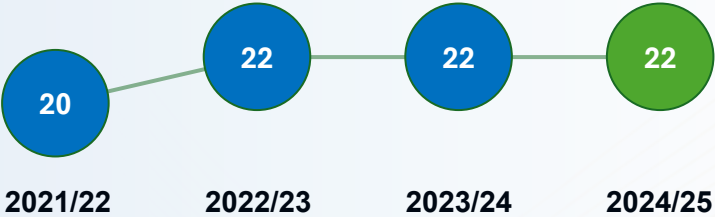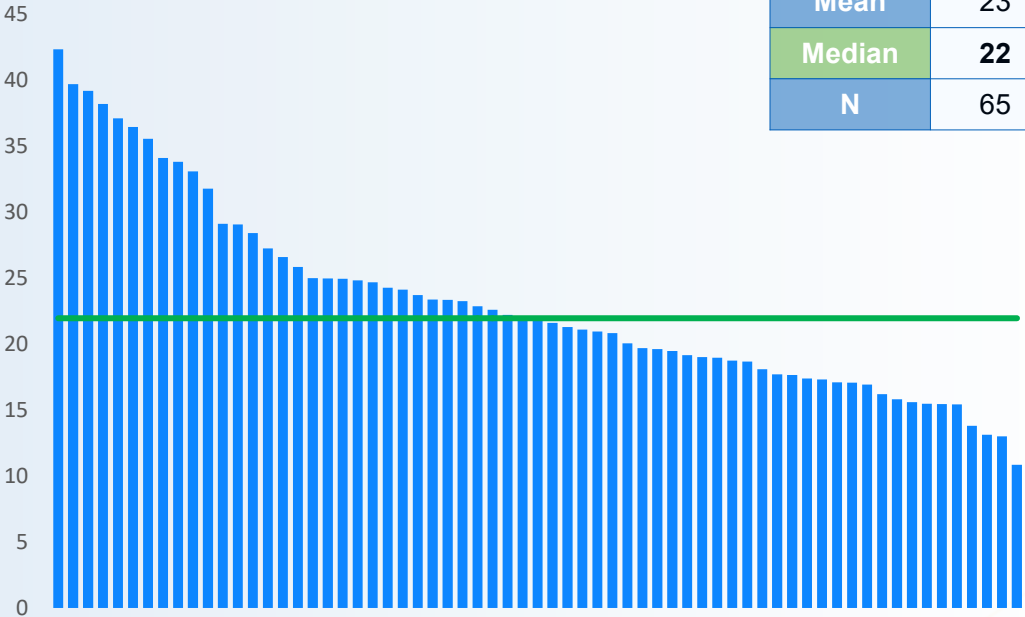
Bed occupancy rate %

Mean	91%
Median	**95%**
N	63

2021/22 — **93%**
2022/23 — **94%**
2023/24 — **96%**
2024/25 — **95%**

NHS
Benchmarking Network
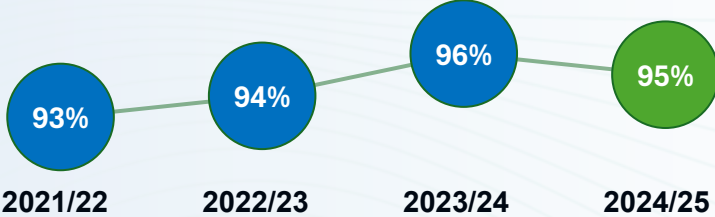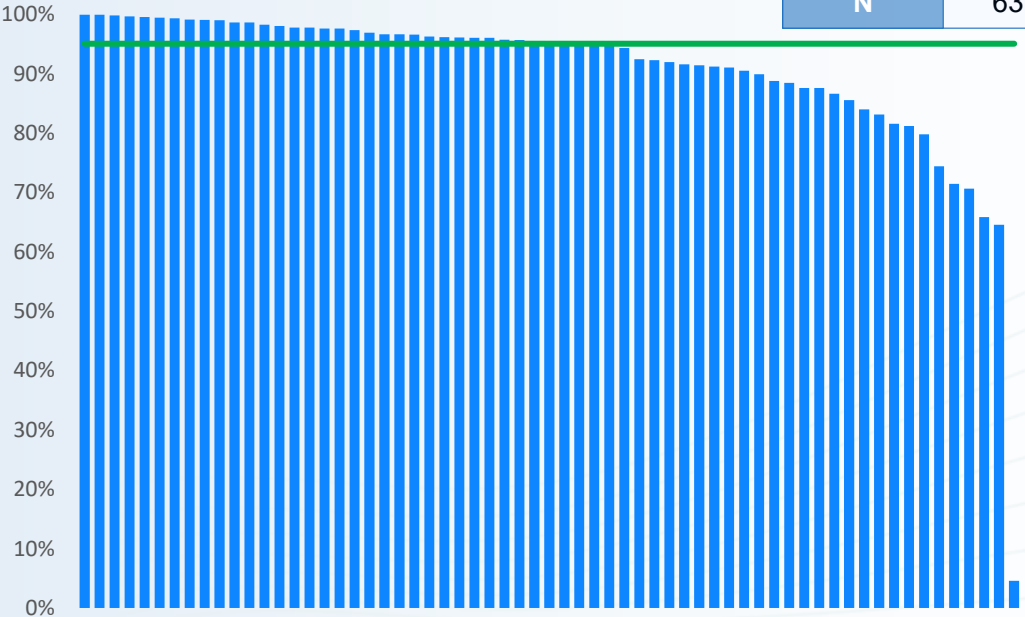
Adult acute admissions

Admissions per 100,000 population

Mean	206
Median	**185**
N	66

- 202 — 2021/22
- 215 — 2022/23
- 195 — 2023/24
- 185 — 2024/25

% admissions under the Mental Health Act

Mean	54%
Median	**55%**
N	66

- 47% — 2021/22
- 52% — 2022/23
- 49% — 2023/24
- 55% — 2024/25

Harnessing the power of data to drive meaningful change
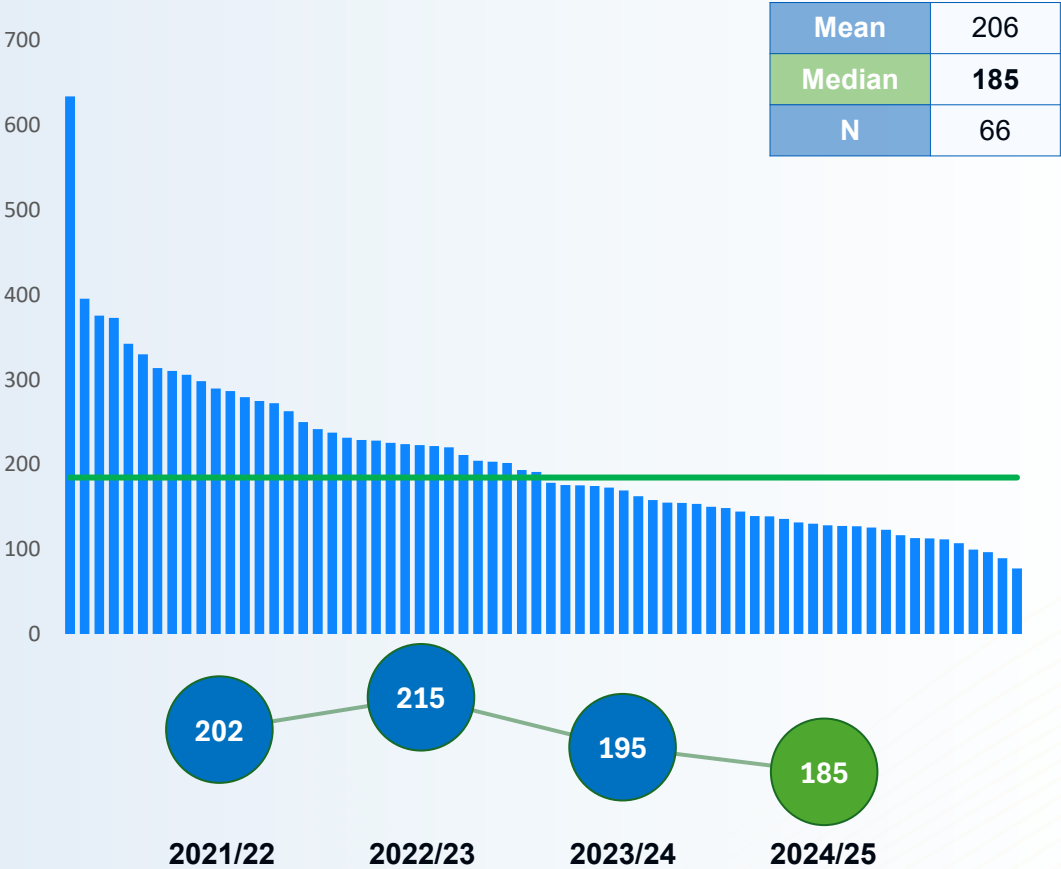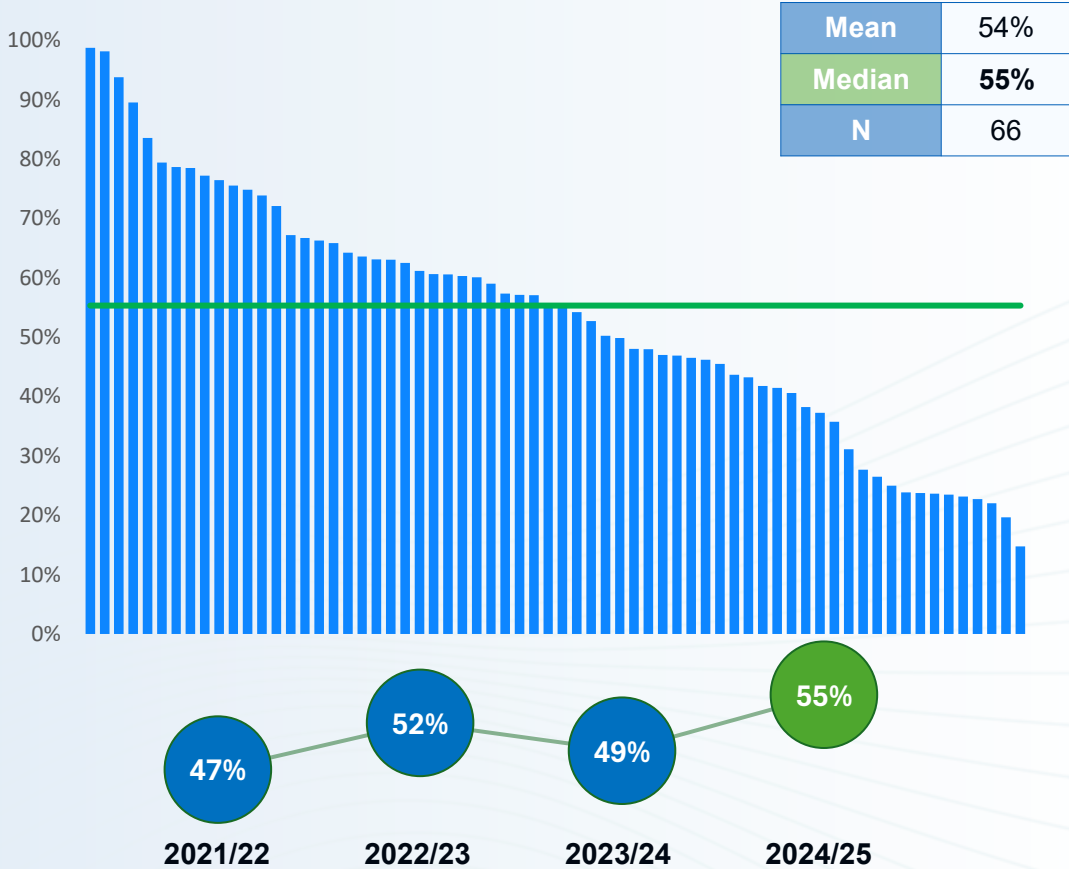
Adult acute patient status

% patients admitted not previously known to service

Mean	12%
Median	**6%**
N	47

2021/22: 9%
2022/23: 8%
2023/24: 7%
2024/25: 6%
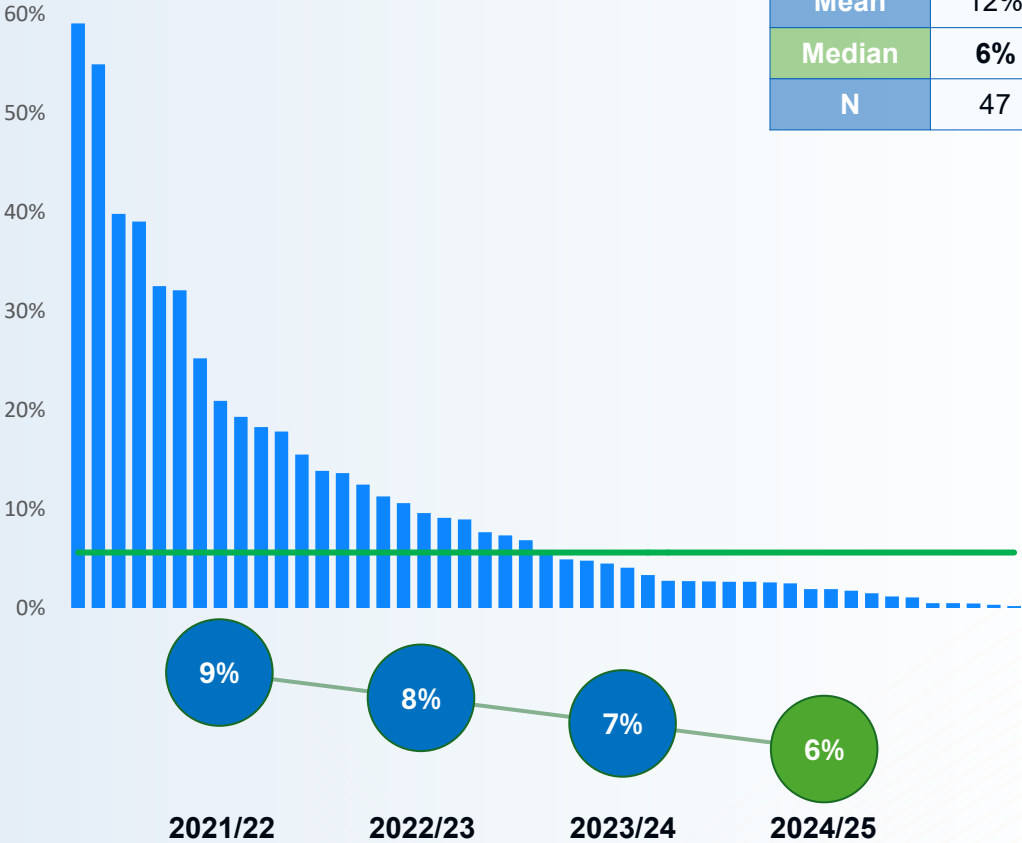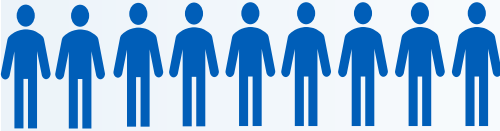
% patients admitted who were of no fixed abode

Mean	3.0%
Median	**2.4%**
N	57

2021/22: 1.8%
2022/23: 2.2%
2023/24: 2.3%
2024/25: 2.4%

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

67
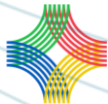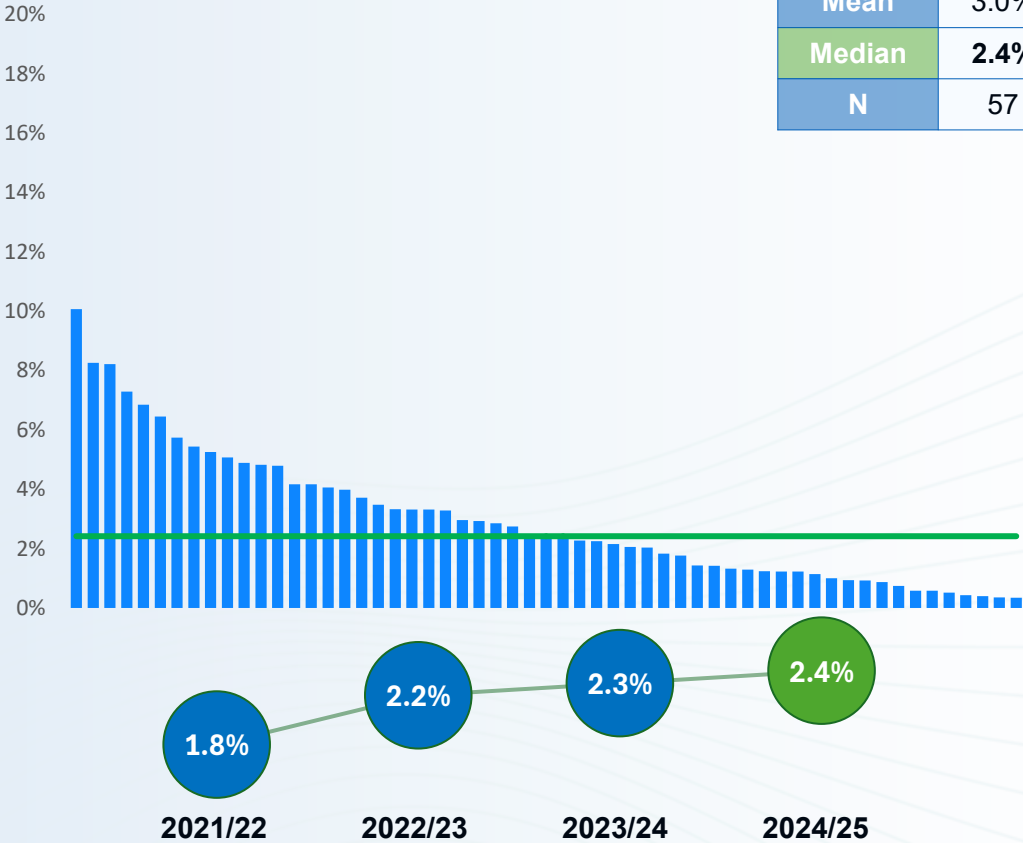
Adult acute skill mix and staffing levels

 = 5%

Nursing		38%
Clinical Support		45%
Allied Health Professionals		3%
Medical Staff		5%
Psychological Professions		2%
Administrative & Management		5%
Other		1%

Staff (WTE) per 10 beds

Mean	20
Median	**20**
N	67

2021/22: 22
2022/23: 22
2023/24: 21
2024/25: 20

Harnessing the power of data to drive meaningful change

NHS Benchmarking Network
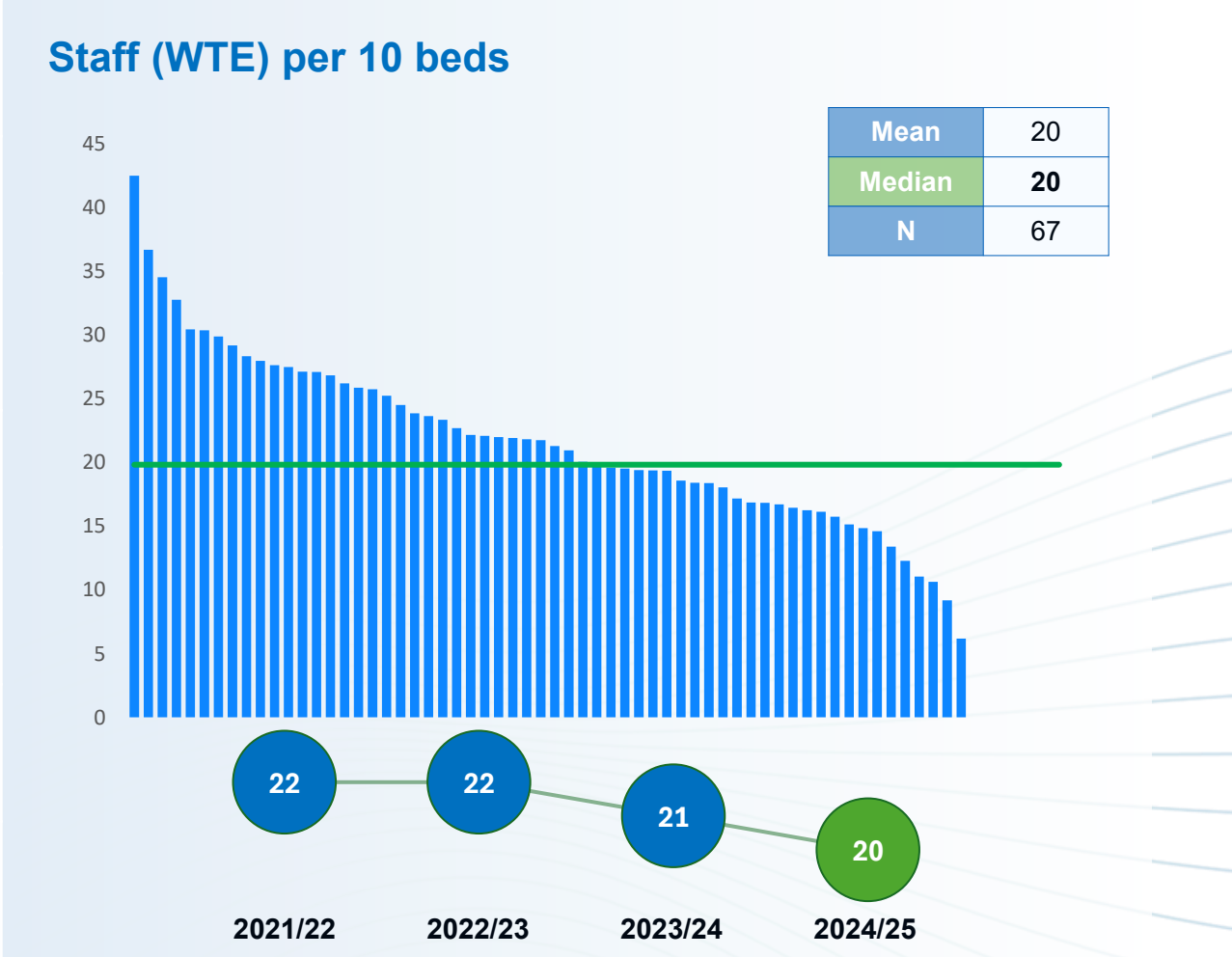
Adult acute staff vacancies & sickness/absence

Staff vacancy rate %

Mean	14%
Median	**14%**
N	48

2021/22: 18%
2022/23: 16%
2023/24: 13%
2024/25: 14%

Staff sickness/absence rate %

Mean	7%
Median	**7%**
N	51

2021/22: 8%
2022/23: 7%
2023/24: 7%
2024/25: 7%

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

69
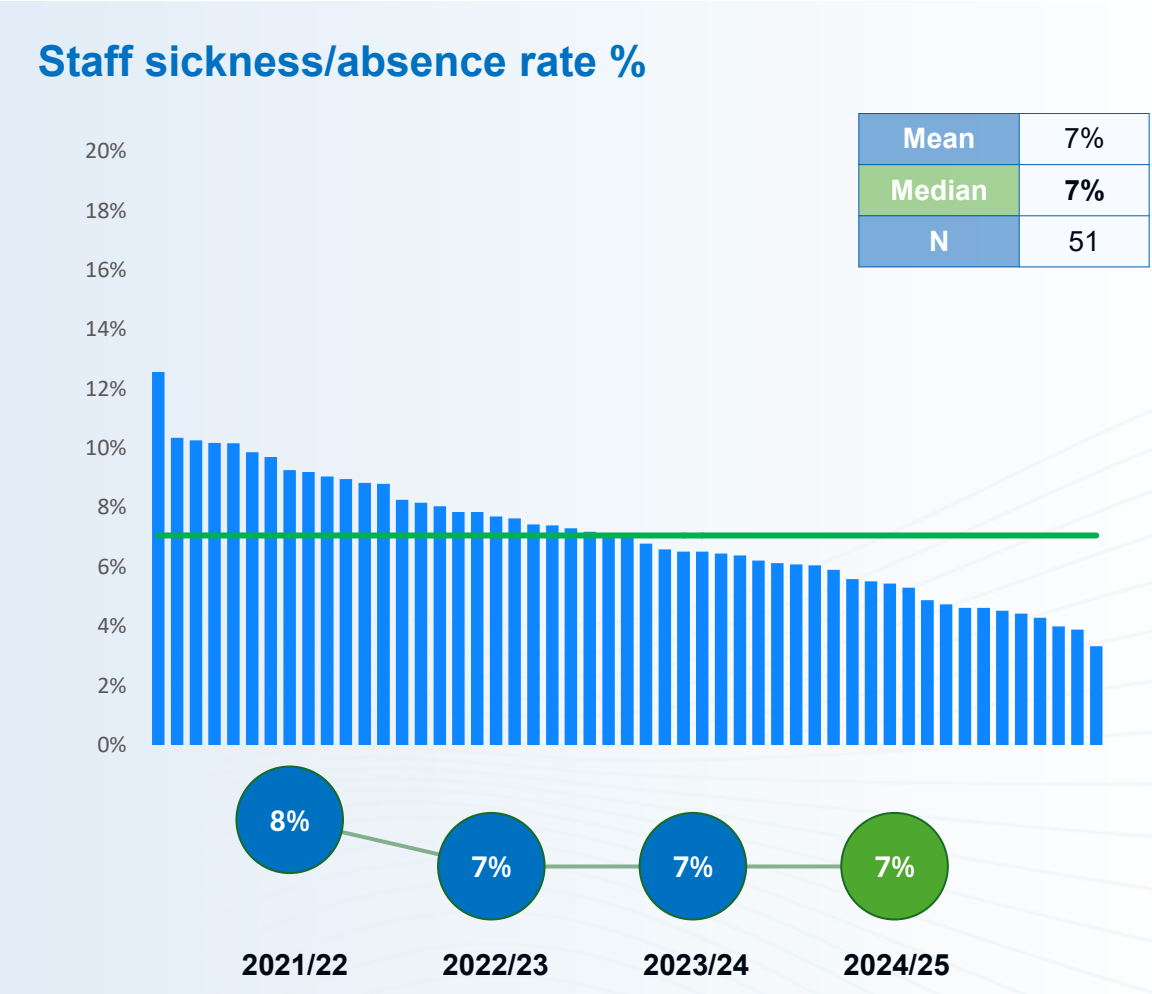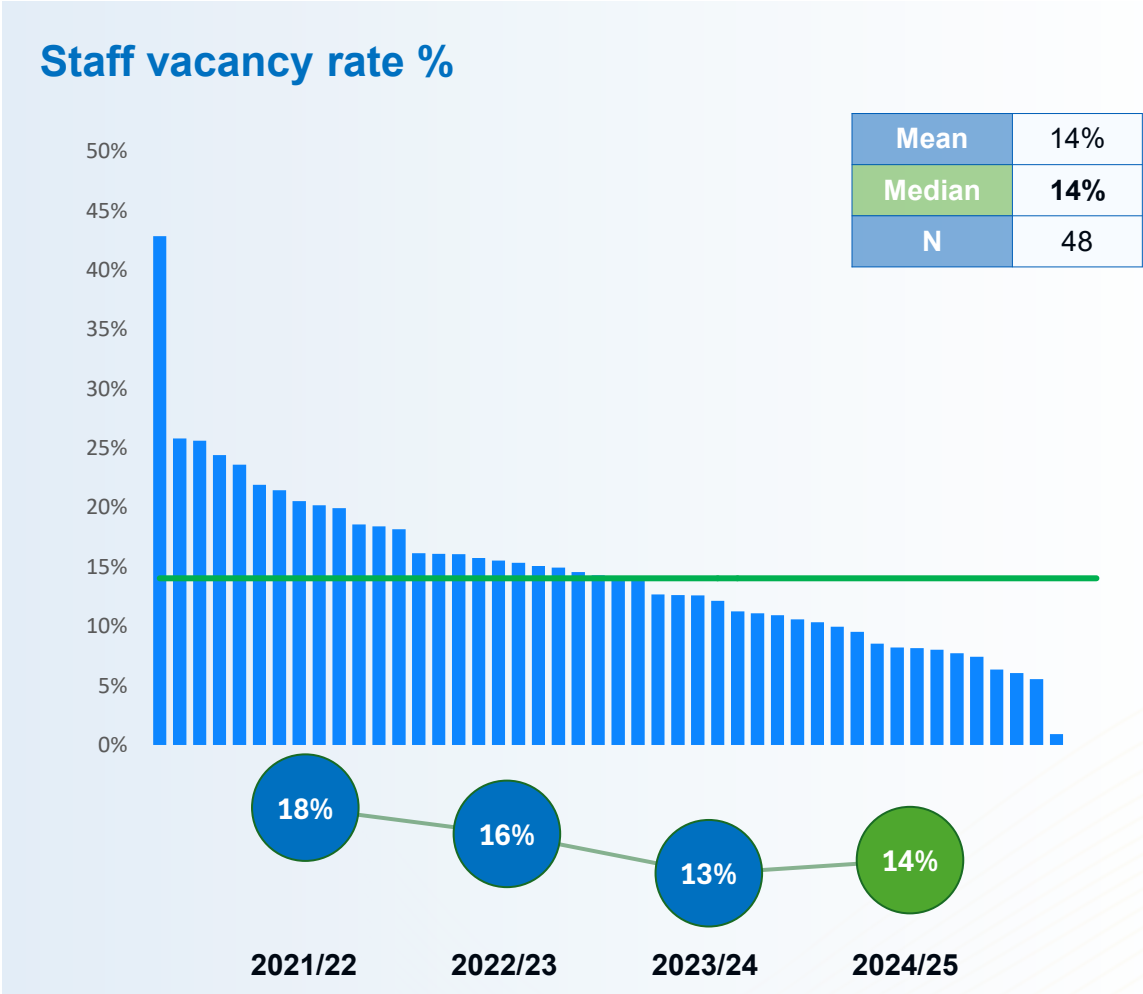
Adult acute bank & agency spend, bed costs

Bank & agency spend as a % of total pay costs

Mean	29%
Median	**28%**
N	55

2021/22: 29%
2022/23: 30%
2023/24: 33%
2024/25: 28%

Cost of service per 10 beds

Mean	£2.4M
Median	**£2.3M**
N	52

2021/22: £1.9M
2022/23: £2.1M
2023/24: £2.2M
2024/25: £2.3M

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change
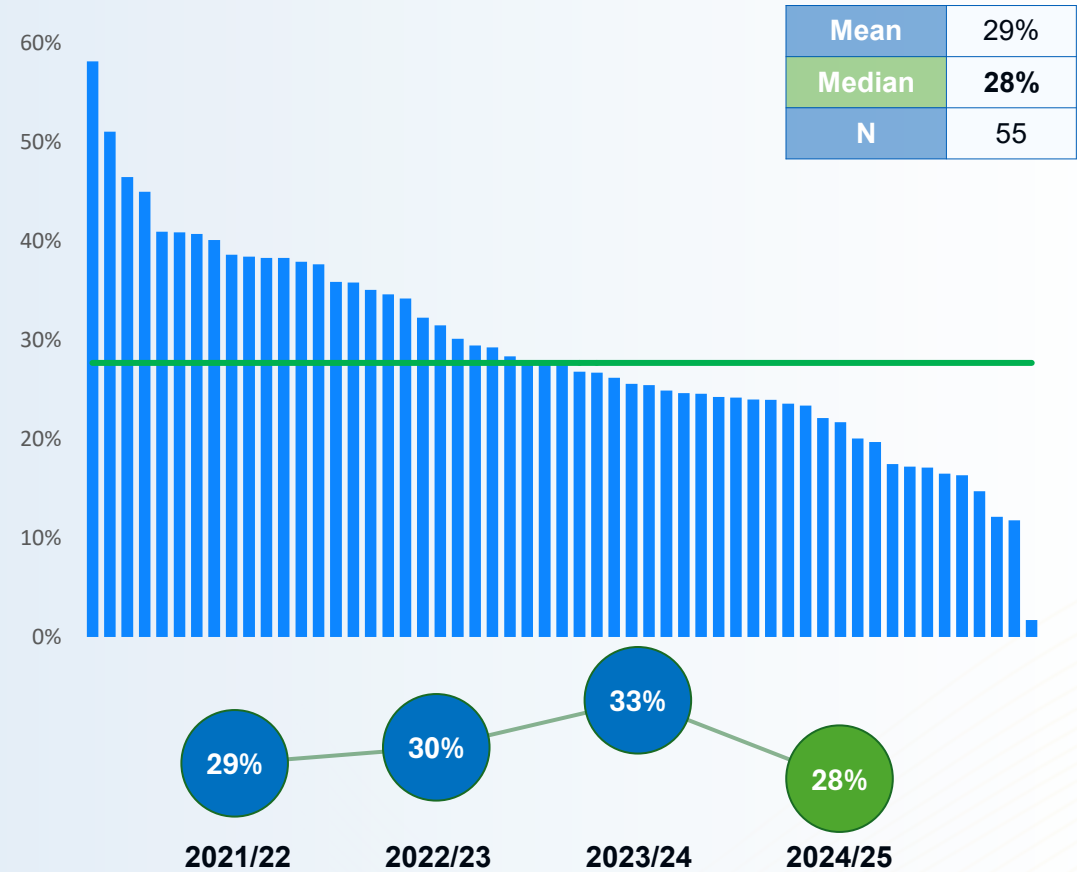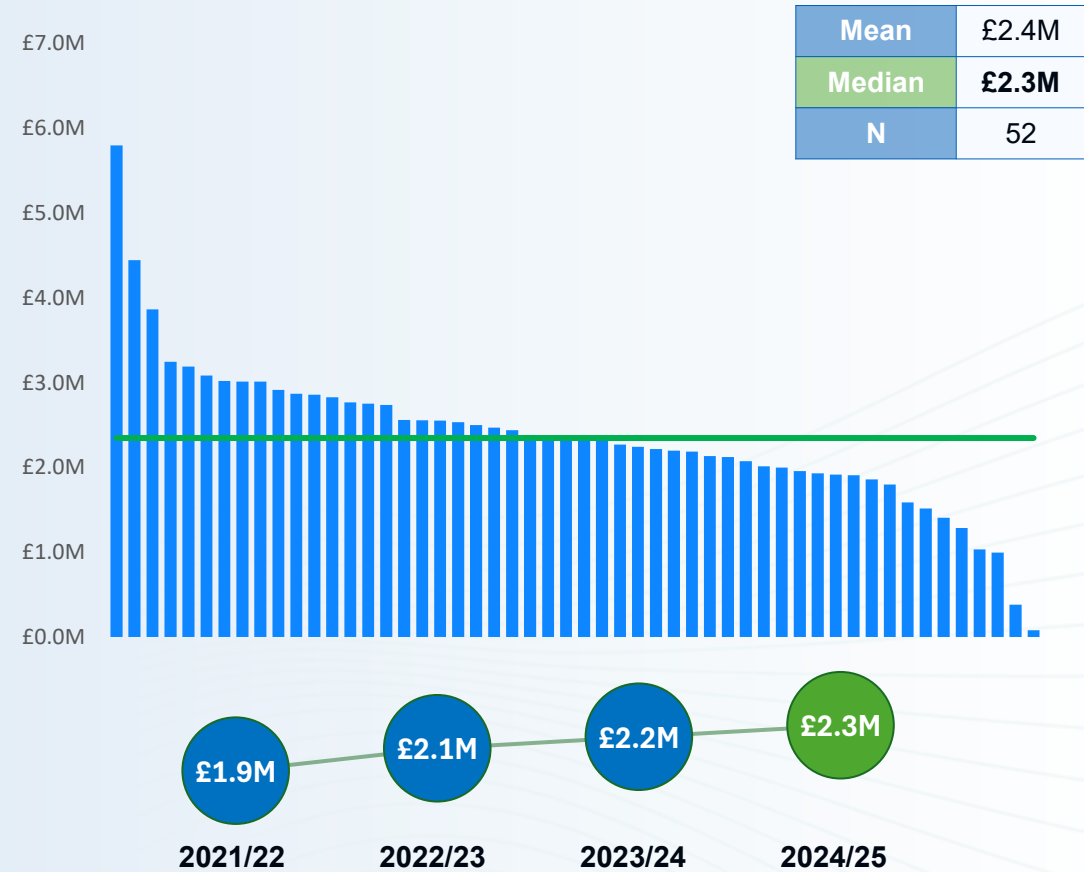
Older adult beds

Beds at 31st March 2025 per 100,000 population

Mean	42
Median	**35**
N	63

- 2021/22: 36
- 2022/23: 37
- 2023/24: 35
- 2024/25: 35

Bed occupancy rate %

Mean	88%
Median	**91%**
N	59

- 2021/22: 87%
- 2022/23: 89%
- 2023/24: 90%
- 2024/25: 91%
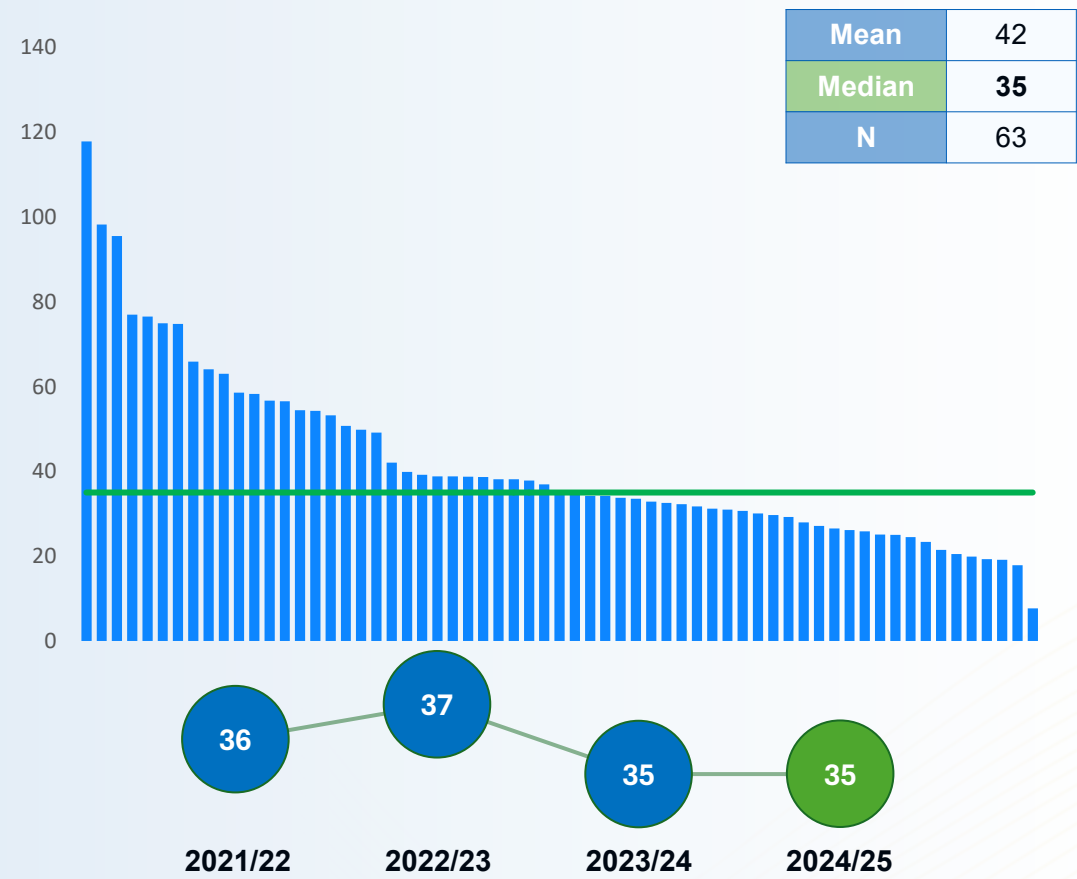
Harnessing the power of data to drive meaningful change
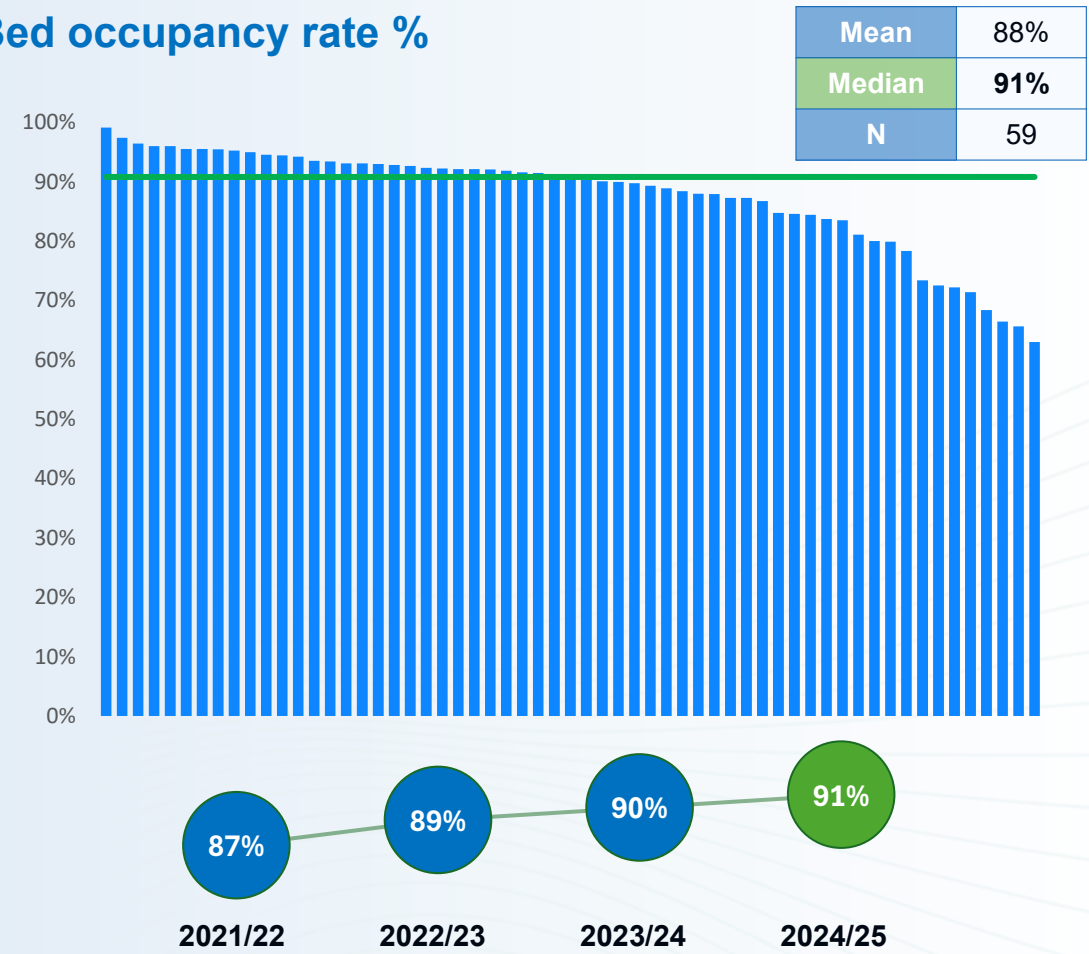
Older adult admissions

Admissions per 100,000 population

Mean	162
Median	**135**
N	64

- 135 — 2021/22
- 129 — 2022/23
- 128 — 2023/24
- 135 — 2024/25

% admissions under the Mental Health Act

Mean	59%
Median	**67%**
N	64

- 58% — 2021/22
- 63% — 2022/23
- 60% — 2023/24
- 67% — 2024/25

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change
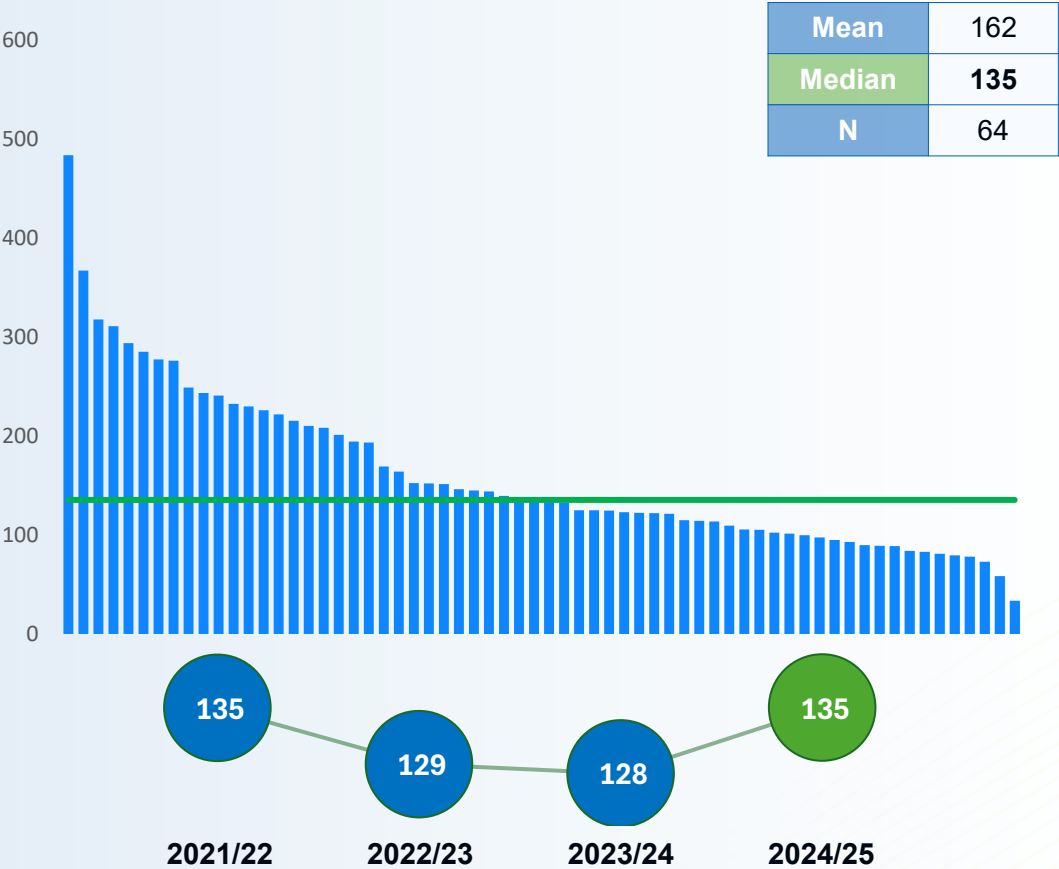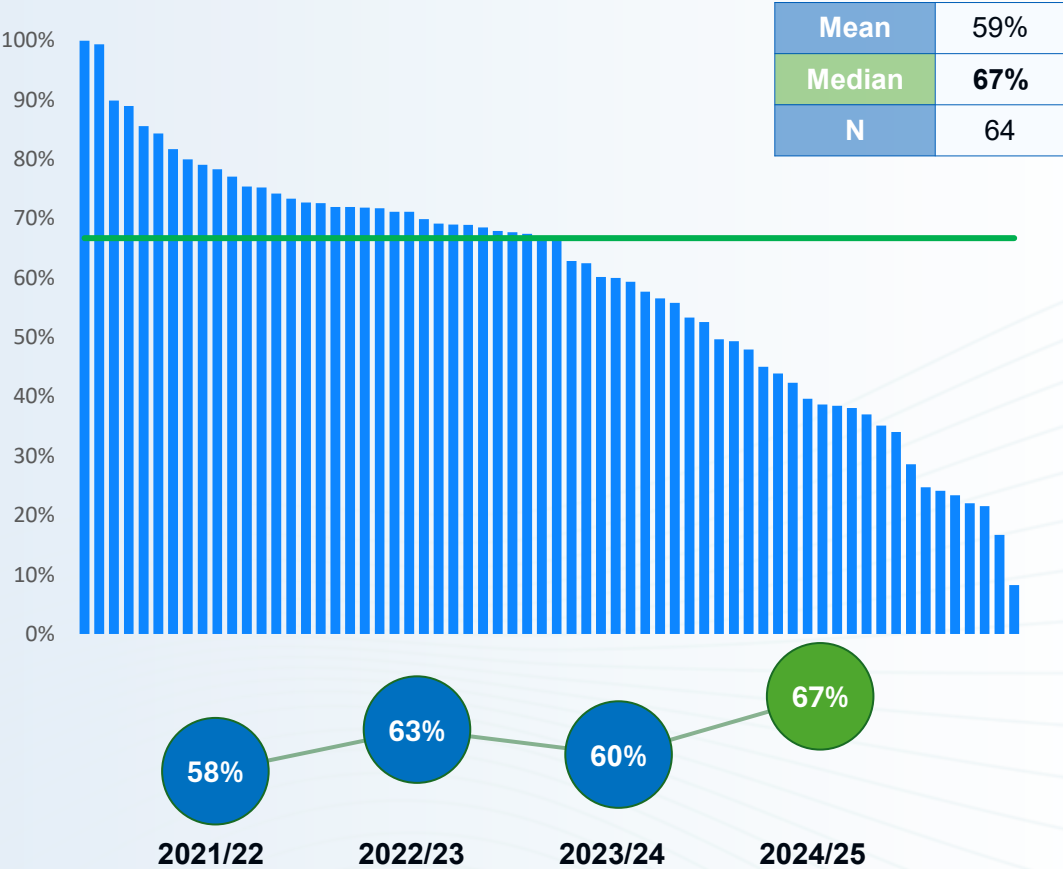
Older adult patient status

% patients admitted not previously known to service

Mean	18%
Median	**8%**
N	40

- 2021/22: 10%
- 2022/23: 7%
- 2023/24: 7%
- 2024/25: 8%

% patients admitted who were of no fixed abode

Mean	0.8%
Median	**0.7%**
N	26

- 2021/22: 0.9%
- 2022/23: 0.8%
- 2023/24: 0.9%
- 2024/25: 0.7%

NHS Benchmarking Network
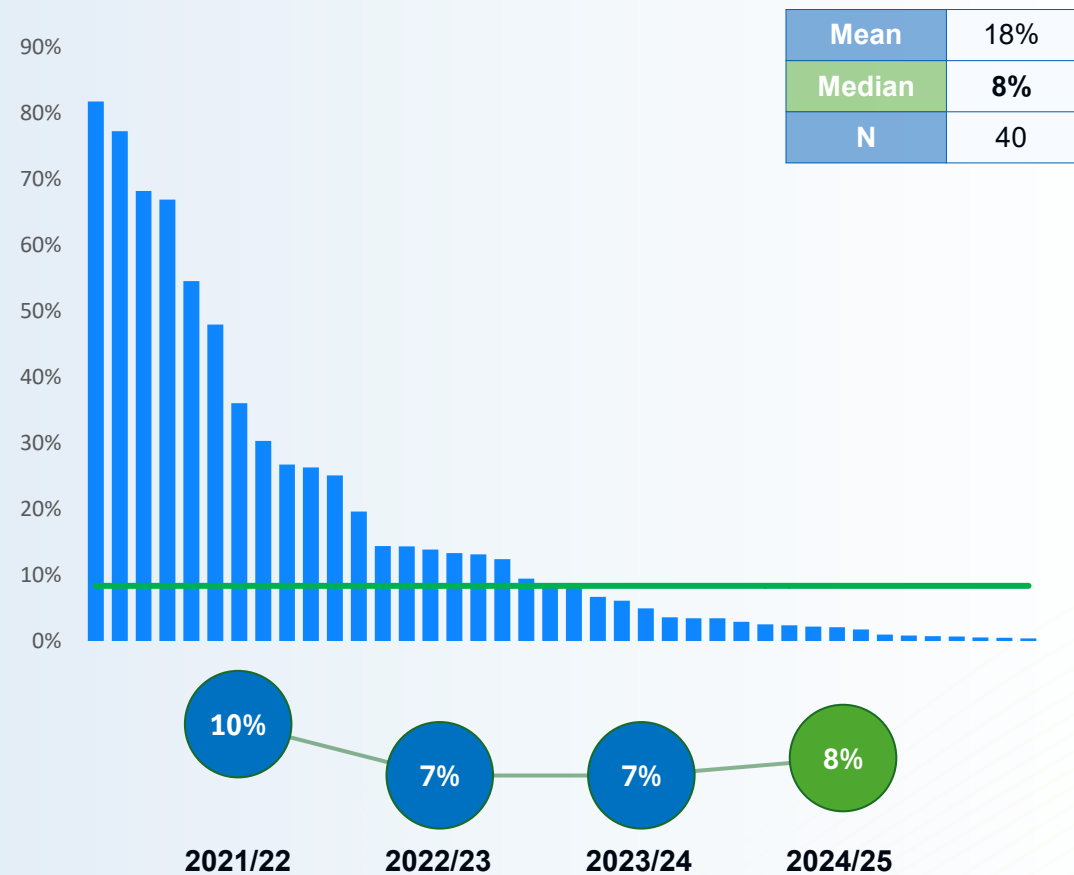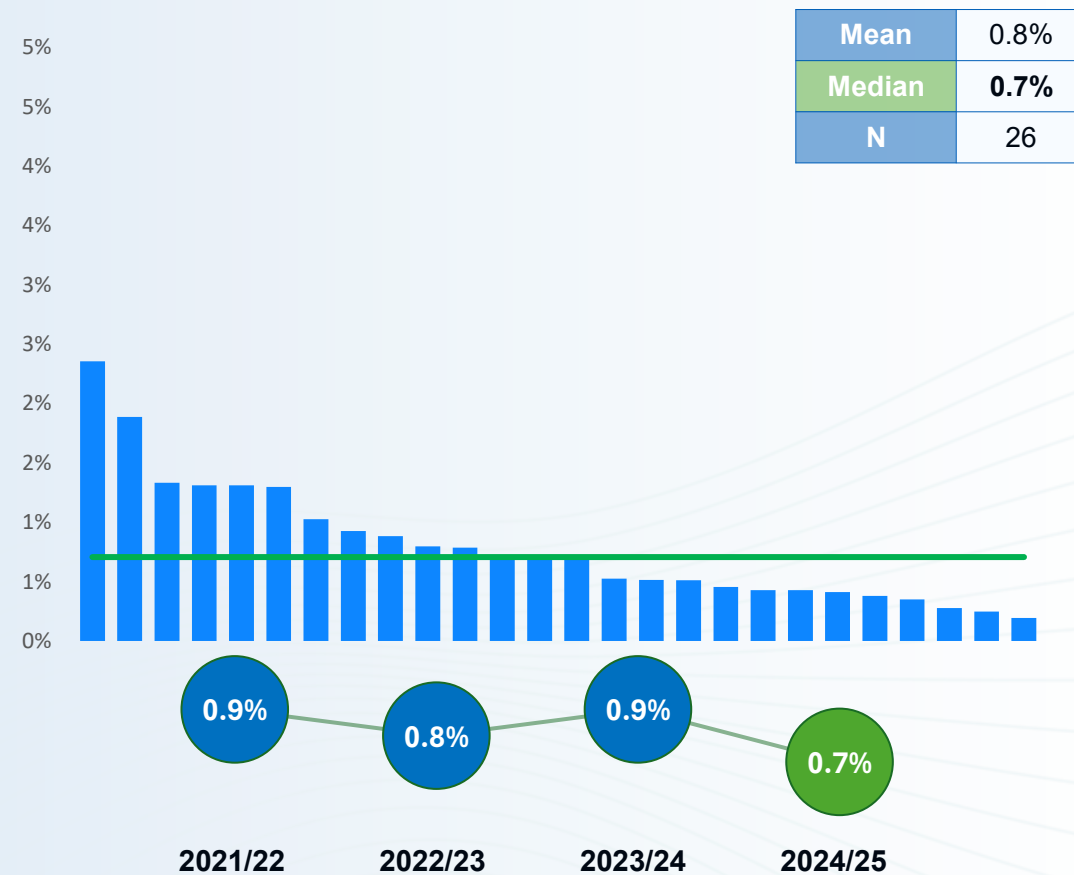
Older adult skill mix and staffing levels

= 5%

Nursing		35%
Clinical Support		52%
Allied Health Professionals		3%
Medical Staff		5%
Psychological Professions		2%
Administrative & Management		4%
Other		1%

Staff (WTE) per 10 beds

Mean	22
Median	**24**
N	64

2021/22	2022/23	2023/24	2024/25
24	25	24	24

Harnessing the power of data to drive meaningful change
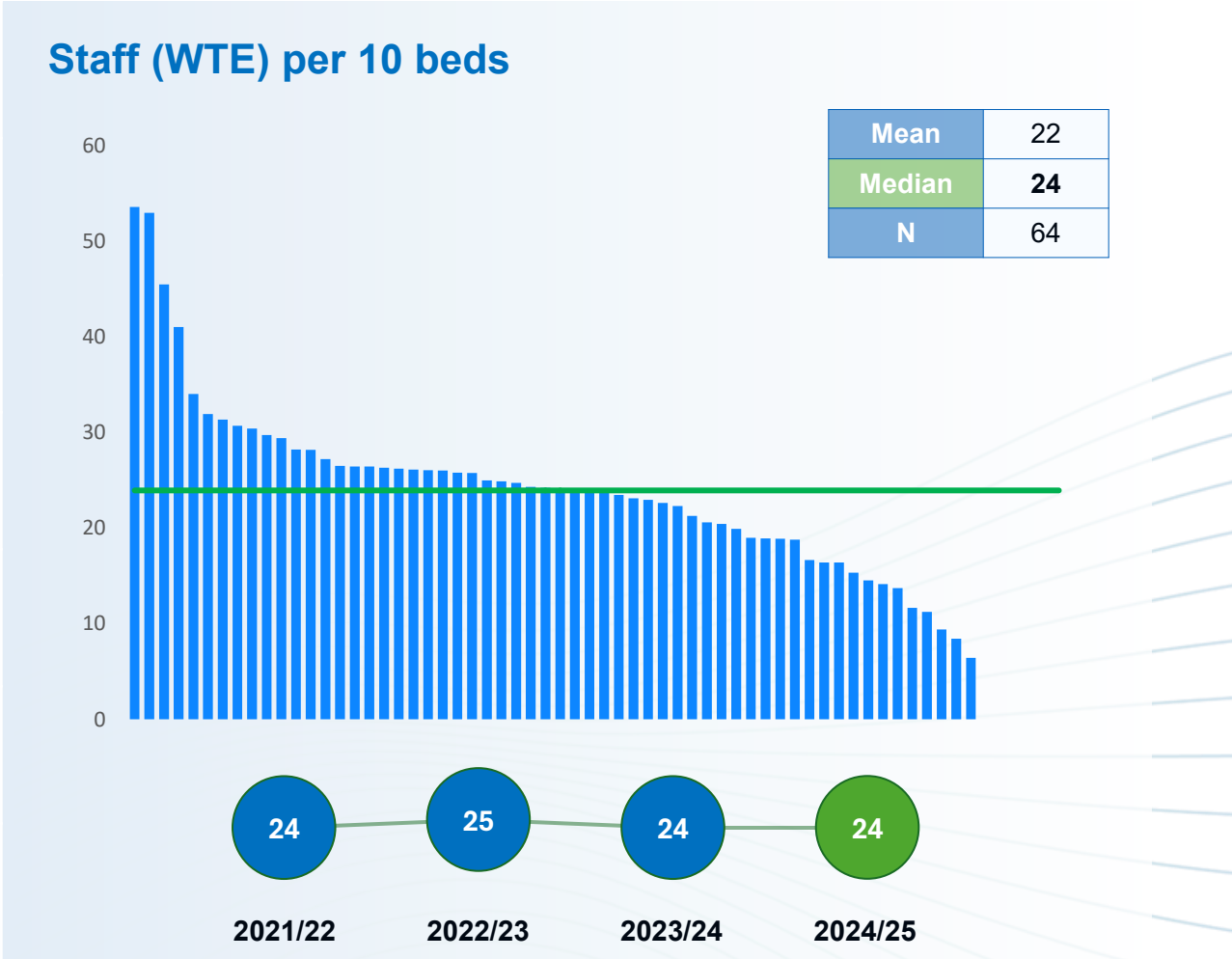
Older adult staff vacancies & sickness/absence

Staff vacancy rate %

Mean	11%
Median	**9%**
N	47

- 14% (2021/22)
- 15% (2022/23)
- 13% (2023/24)
- 9% (2024/25)

Staff sickness/absence rate %

Mean	8%
Median	**8%**
N	50

- 8% (2021/22)
- 8% (2022/23)
- 7% (2023/24)
- 8% (2024/25)

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change
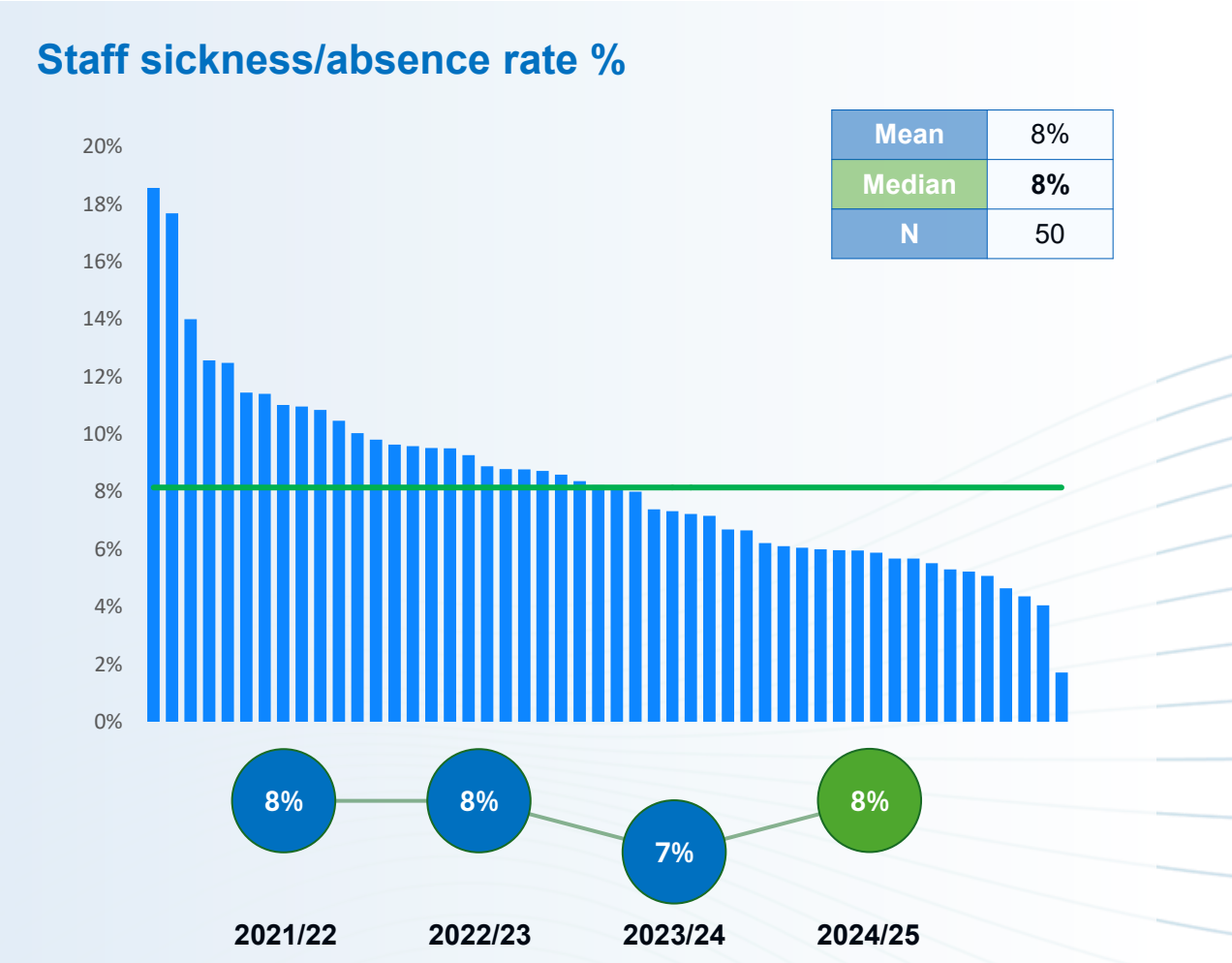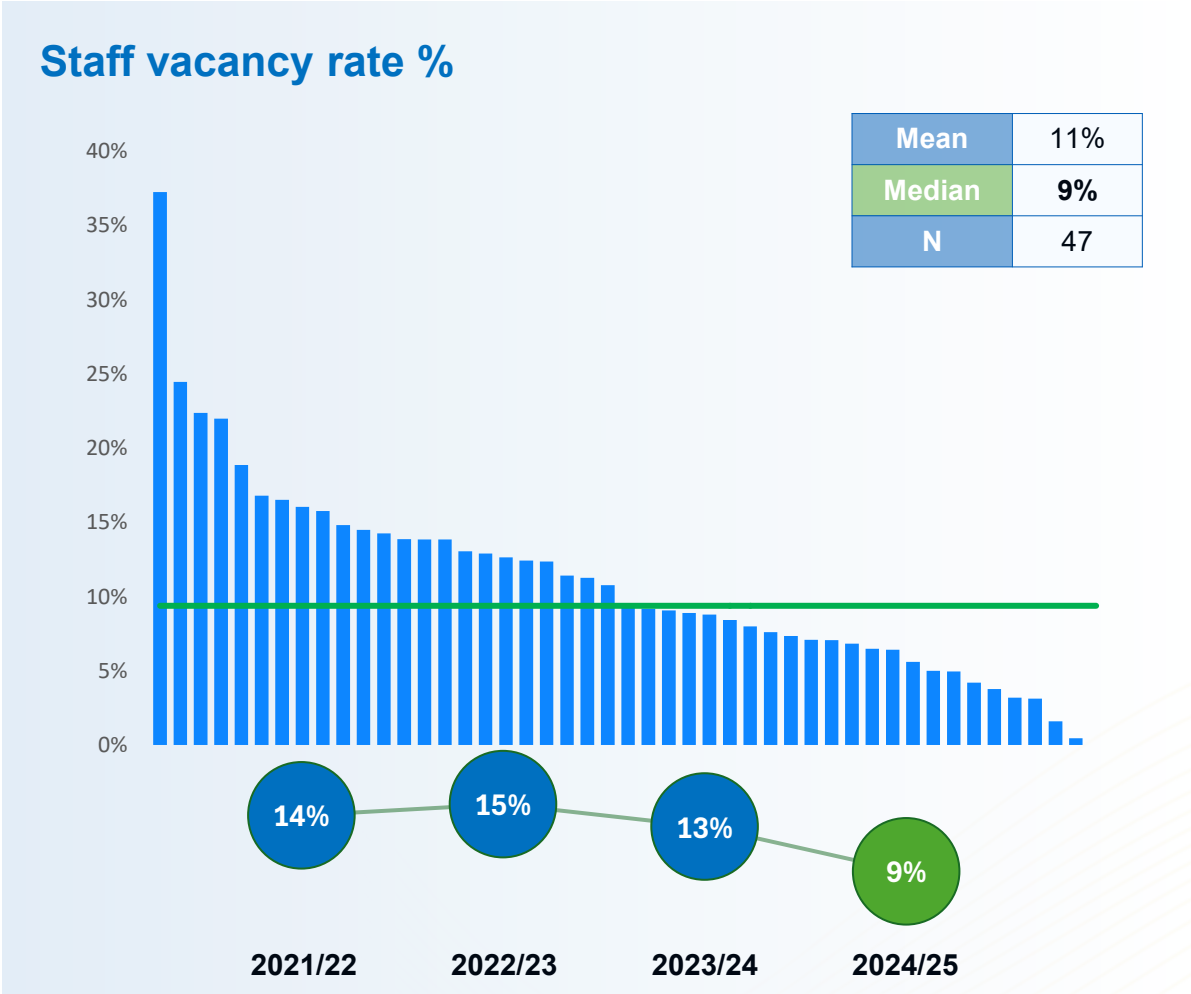
Older adult bank & agency spend, bed costs

Bank & agency spend as a % of total pay costs

Mean	24%
Median	**23%**
N	54

(Bar chart showing values descending from ~58% to ~2%, with a green median line at ~23%)

- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

2021/22	2022/23	2023/24	2024/25
23%	26%	27%	23%

Cost of service per 10 beds

Mean	£2.2M
Median	**£2.3M**
N	51

(Bar chart showing values descending from ~£4.9M to ~£0.3M, with a green median line at ~£2.3M)

- £6.0M
- £5.0M
- £4.0M
- £3.0M
- £2.0M
- £1.0M
- £0.0M

2021/22	2022/23	2023/24	2024/25
£1.8M	£2.0M	£2.1M	£2.3M

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change
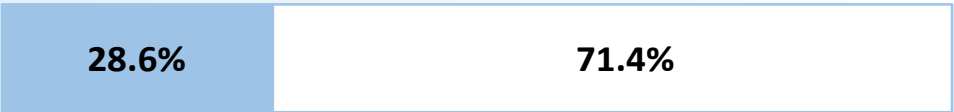
76
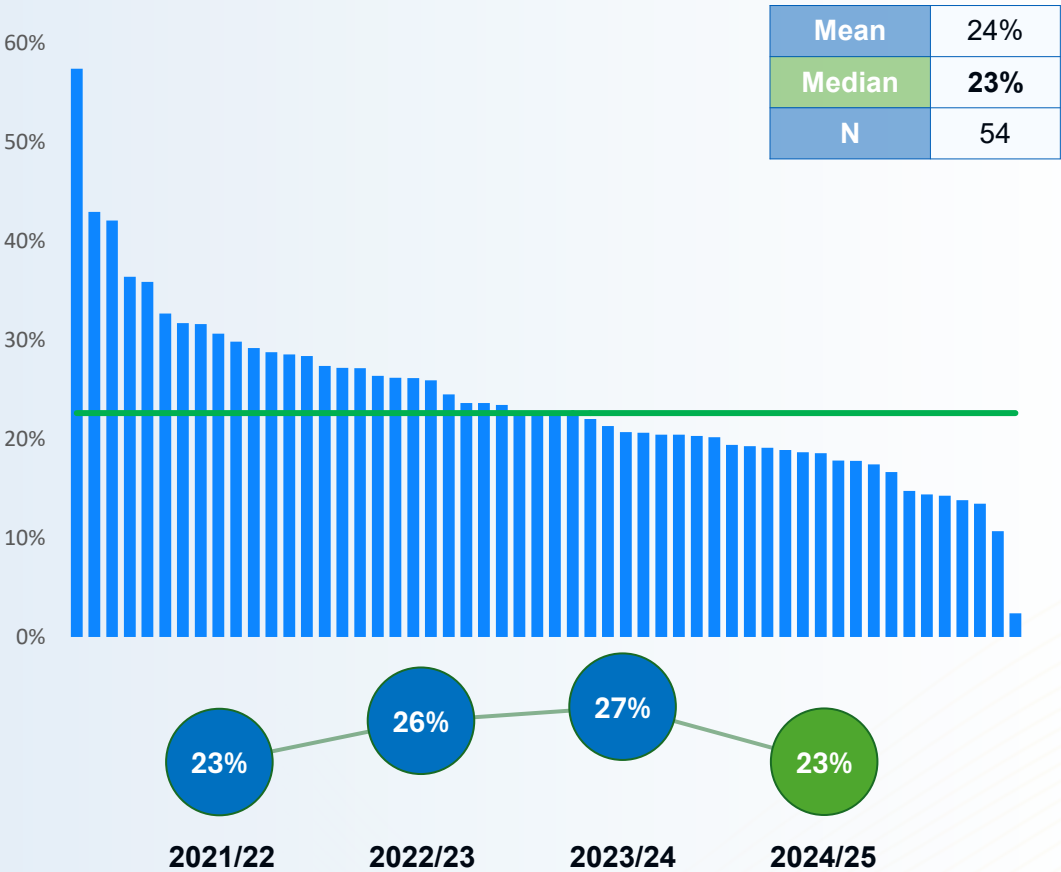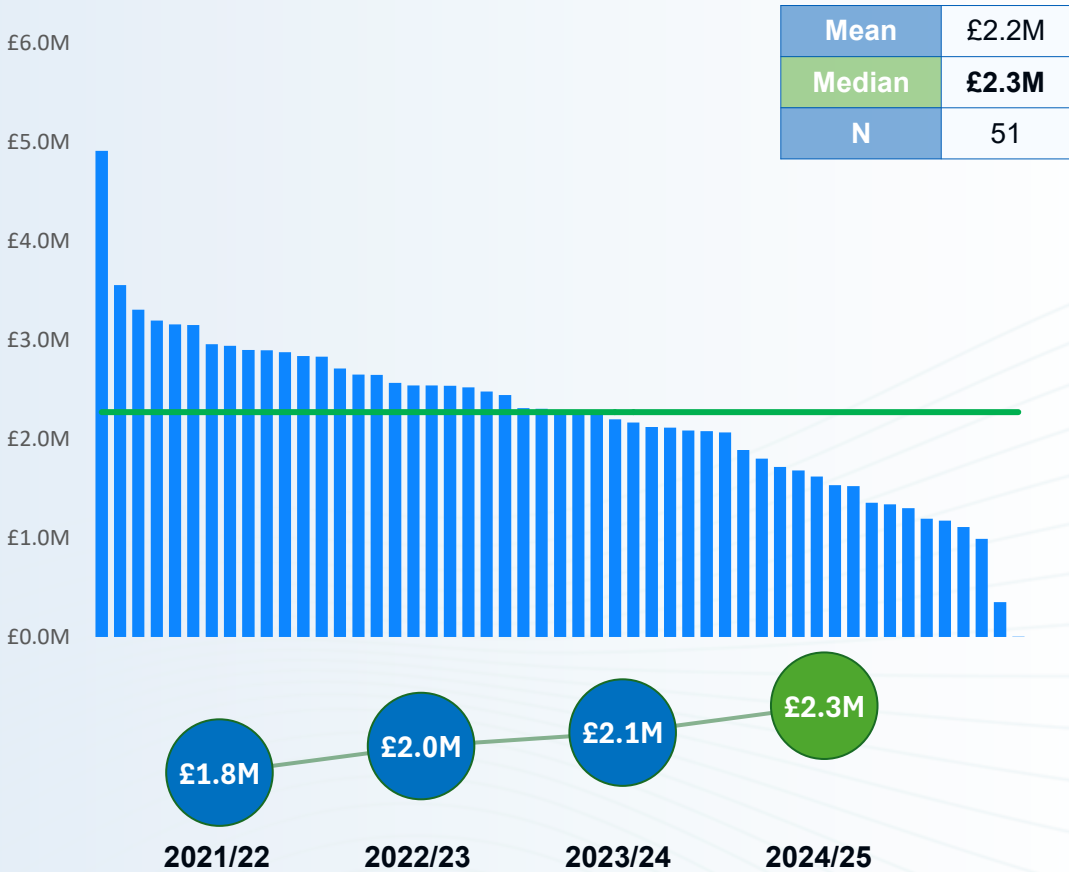
Equally Well Pledge & use of outcome measures

Is your organisation signed up to the Equally Well UK Pledge?

| 28.6% | 71.4% |

■ Yes □ No

Do you use outcome measures?

| 93.2% | 6.8% |

■ Yes □ No

Common PROMs/PREMs:

ReQoL

DIALOG scale

CORE

Harnessing the power of data to drive meaningful change
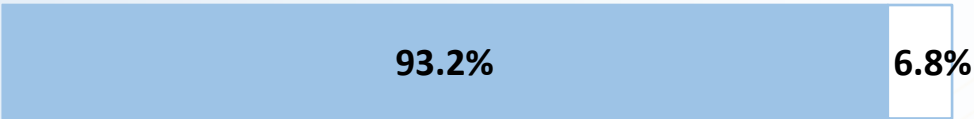
Thank you

Any questions?

For any further information, please get in touch:

Daniel Iyoha
Project Manager
d.iyoha@nhs.net

NHS
Benchmarking Network

Overview of the NHS Benchmarking Network's workforce programme

Janet Heaton

Senior Project Manager - NHSBN

Workforce Benchmarking for Health and Care

Transformation through benchmarking

Ensuring a workforce of the right size, in the right place, with the right skills is essential to meet current population need and underpins the ambitious transformation plans set out in key healthcare policy documents.

Commissioned by NHS England Workforce, Training and Education Directorate

Workforce Benchmarking
Supporting Workforce Planning with Data

How can workforce benchmarking data support you?

Workforce planning & retention
Identify trends in staffing levels and retention to inform decision making.

Workforce productivity
Compare staff skill mix, roles, and activity levels to enhance efficiency.

Safe staffing & service delivery
Benchmark against peers to ensure safe and effective workforce models.

Workforce pressure & absence
Analyse sickness rates, absences, and workforce challenges.

Future workforce modelling & recruitment
Plan for future staffing needs, recruitment and funding allocations based on evidence.

What we delivered in 2024

Workforce Programme in Numbers

936,800 Data points collected in 2024

NHS Talking Therapies for anxiety and depression
55,657 data points
6 drop-in sessions
1 launch event

Psychological Professions
263,297 data points
6 drop-in sessions
1 launch event

Drug and Alcohol Treatment and Recovery Services
70,251 data points
8 drop-in sessions
1 launch event, 3 OHID events

Specialist Perinatal Mental Health
115,383 data points
6 drop-in sessions
1 launch event

Children and Young People's Mental Health
251,813 data points
6 drop-in sessions
1 launch event

Adult's and Older People's Mental Health
150,101 data points
5 drop-in sessions
1 launch event

Peer Support Workers
5,515 data points
4 interviews conducted

Social Workers and Social Care
24,783 data points
5 drop-in sessions
1 launch event

Outputs include:

A national report per collection

Participant reports*

ICS reports*

*These will be integrated as part of our exciting technological solution

How are we supporting safer staffing in 2025?

We have been re-commissioned in 2025 by NHS England to collect workforce census for the following service areas:

- Psychological Professions
- Talking Therapies for Anxiety and Depression
- Peer Support Workers
- Children and Young People's Mental Health
- Adult and Older People's Mental Health
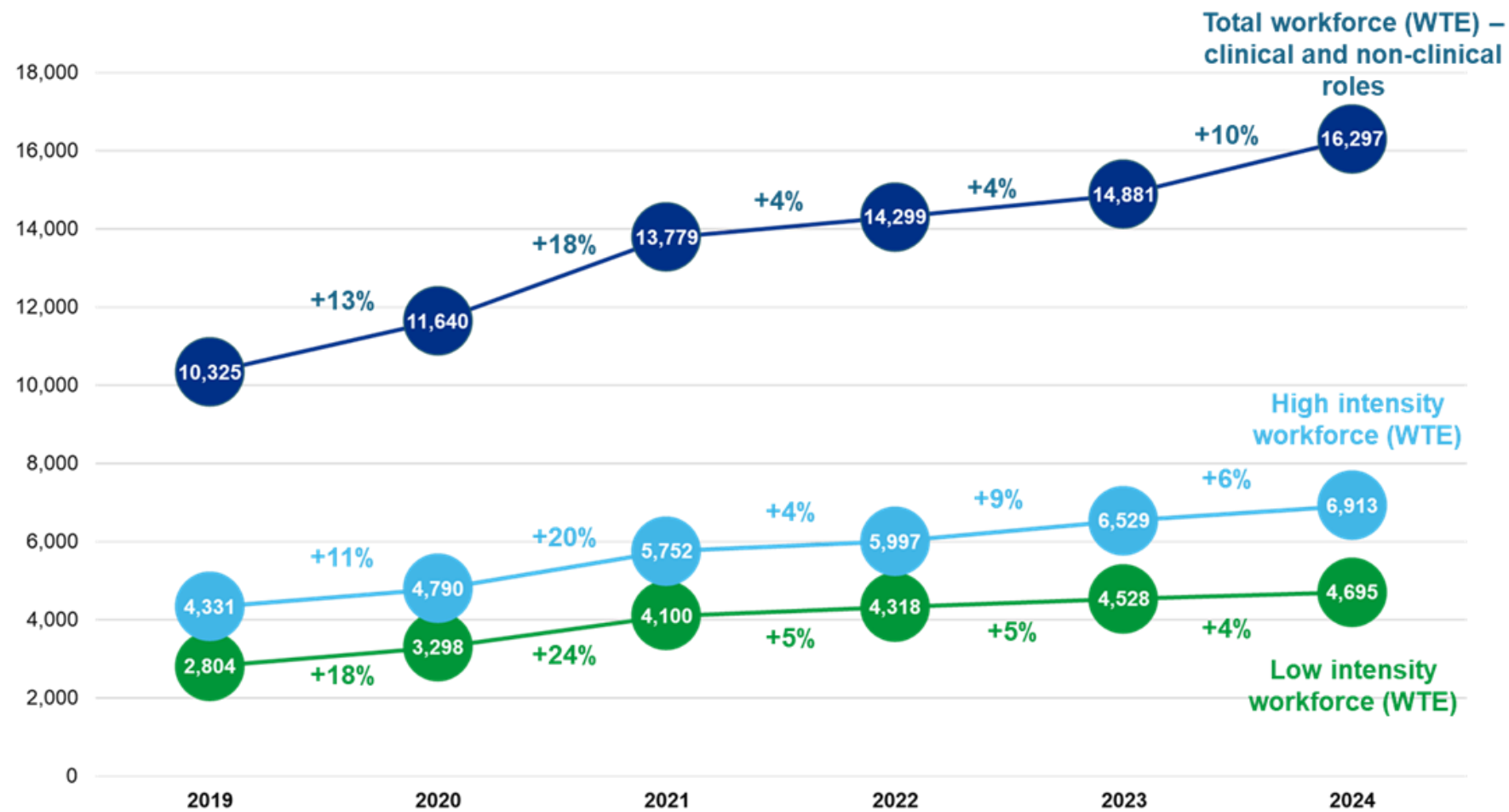- Learning Disabilities and Autism

Our workforce benchmarking services are available for commissioning!

- Focused deep dives into your service workforce
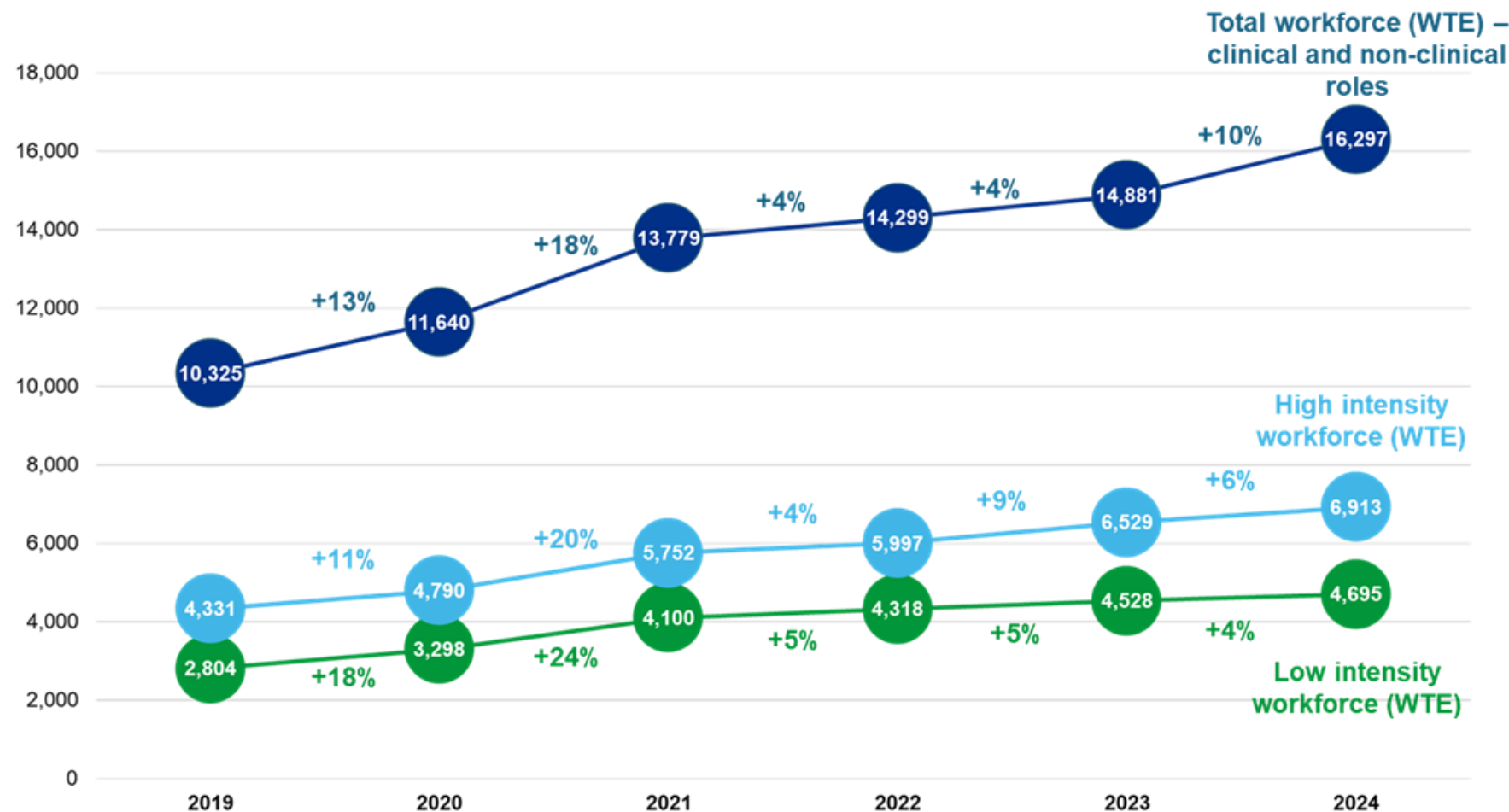- Tailored data collections to help you understand your workforce

Workforce planning & retention

Total workforce (WTE) – clinical and non-clinical roles

- 2019: 10,325
- 2020: 11,640 (+13%)
- 2021: 13,779 (+18%)
- 2022: 14,299 (+4%)
- 2023: 14,881 (+4%)
- 2024: 16,297 (+10%)

High intensity workforce (WTE)

- 2019: 4,331
- 2020: 4,790 (+11%)
- 2021: 5,752 (+20%)
- 2022: 5,997 (+4%)
- 2023: 6,529 (+9%)
- 2024: 6,913 (+6%)

Low intensity workforce (WTE)

- 2019: 2,804
- 2020: 3,298 (+18%)
- 2021: 4,100 (+24%)
- 2022: 4,318 (+5%)
- 2023: 4,528 (+5%)
- 2024: 4,695 (+4%)

NHS Talking Therapies for Anxiety and Depression Workforce Census in England at 31st March 2024, NHS Benchmarking Network.
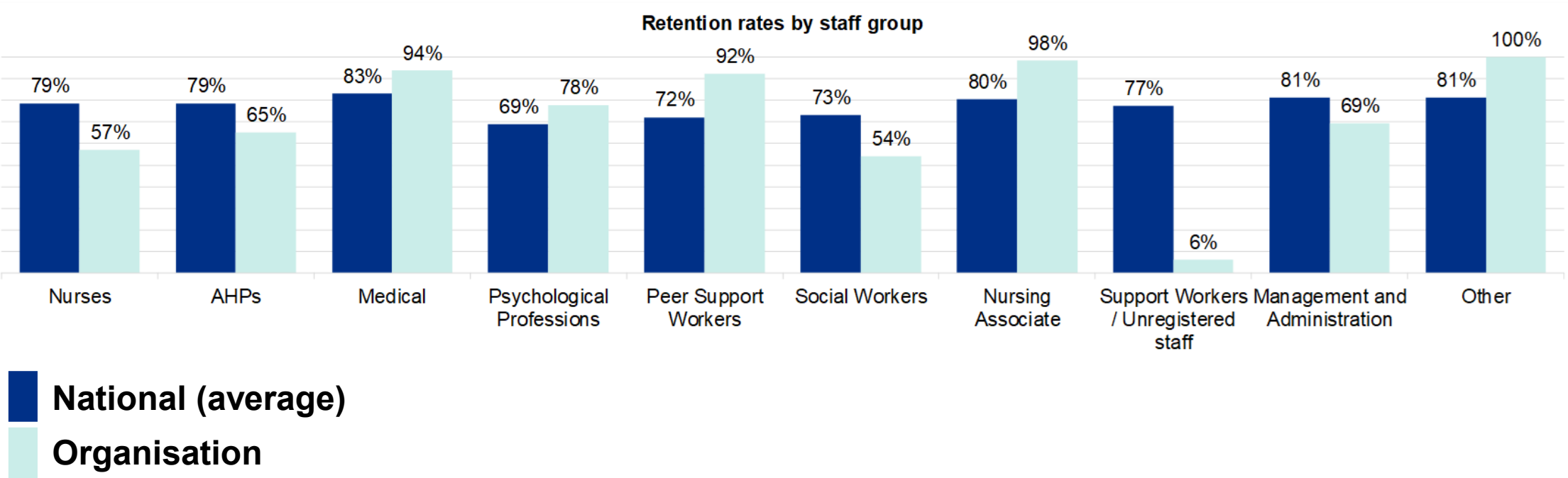
Workforce planning & retention

Total workforce (WTE) – clinical and non-clinical roles

- 2019: 10,325
- 2020: 11,640 (+13%)
- 2021: 13,779 (+18%)
- 2022: 14,299 (+4%)
- 2023: 14,881 (+4%)
- 2024: 16,297 (+10%)

High intensity workforce (WTE)

- 2019: 4,331
- 2020: 4,790 (+11%)
- 2021: 5,752 (+20%)
- 2022: 5,997 (+4%)
- 2023: 6,529 (+9%)
- 2024: 6,913 (+6%)

Low intensity workforce (WTE)

- 2019: 2,804
- 2020: 3,298 (+18%)
- 2021: 4,100 (+24%)
- 2022: 4,318 (+5%)
- 2023: 4,528 (+5%)
- 2024: 4,695 (+4%)

Is the workforce changing in line with current policy guidance and targets?

Are the workforce levels rising in line with population need?

Is change being observed in the expected workforce areas?

NHS Talking Therapies for Anxiety and Depression Workforce Census in England at 31st March 2024, NHS Benchmarking Network.

Workforce planning & retention

"The data ensures we have equitable provision across the Trust, and to notice where we may have areas of difficulty for recruitment/retention etc"

Dr Celia Lesquerre, CPsychol AFBPsS, Consultant Clinical Psychologist
Interim Director Psychological Professions
Sussex Partnership NHS Foundation Trust

Retention rates by staff group

Staff group	National (average)	Organisation
Nurses	79%	57%
AHPs	79%	65%
Medical	83%	94%
Psychological Professions	69%	78%
Peer Support Workers	72%	92%
Social Workers	73%	54%
Nursing Associate	80%	98%
Support Workers / Unregistered staff	77%	6%
Management and Administration	81%	69%
Other	81%	100%

■ **National (average)**
■ **Organisation**

Future workforce modelling and recruitment

HR
- Vacancy rates by staff group
- Joiner rates by staff group
- Leavers by staff group
- Leaver destination

What else?

Demographic
- Gender; by pay band, by sector
- Ethnicity; by pay band, by sector
- Age; by pay band, by sector
- Disability status; by pay band, by sector

Service model/skills/training
- Skills and training by staff group
- Service model comparison
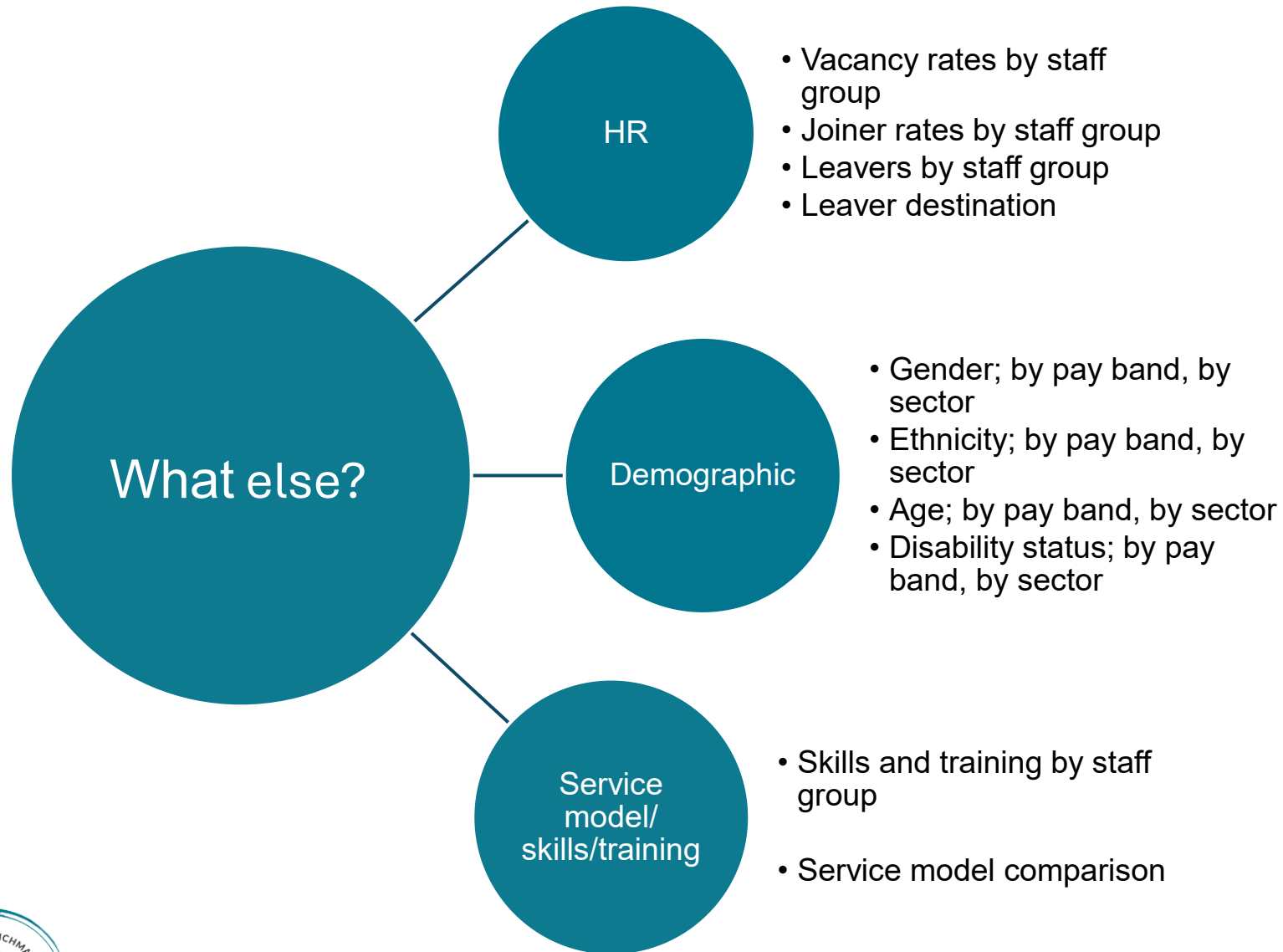
*"[The reports] serve a crucial role in ensuring quality and accountability, providing the necessary insights to **assess progress**, **identify challenges**, and **guide future decision-making**"*

Carol Benson
Head of Operations for community and wellbeing services
Coventry, Warwickshire and Worcestershire Mind

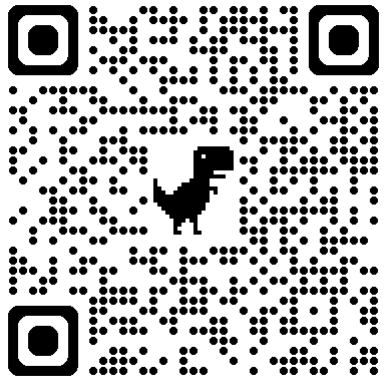# Data Explorer online solution

Introducing our new and exciting **interactive data explorer tool**!

Workforce Benchmarking for Health and Care

Transformation through benchmarking

Scan the QR code to visit our website for more information

Contact us at:

enquiry@nhsbenchmarking.nhs.uk

"Benchmarking data is absolutely valuable to service improvement, but it's only the beginning of the story.
You're going to learn a hell of a lot more by actually looking sideways at what similar services are doing and how they've improved their own services"

Dr Steve Jones
National Clinical Advisor for Children and Young People's Mental Health (CYPMH) at Specialised Commissioning, NHS England.

Break for lunch –
see you back here at 12.30

Time	Session	Speaker
12:30	International mental health benchmarking	**Sean Russell** – COO and European Lead, Global Leadership Exchange (GLE)
13:00	Children and young people's mental health 2024/25 benchmarking findings	**Alison Worden** – Project Manager, NHS Benchmarking Network
13:45	National Audit of Care at the End of Life (NACEL) – mental health spotlight audit	**Joylin Brockett** – Senior Project Manager, NHS Benchmarking Network
14:00	Stepped care system transformation in Wales	**Sarah Harte** – Implementation and Service Delivery Manager, Stepped Care Solutions
14:30 – 14:40 Comfort break		
14:40	Mental health pharmacy 2024/25 benchmarking findings	**Stanley Fleming** – Project Manager, NHS Benchmarking Network
15:00	MHLDA indicators benchmarking project	**Daniel Iyoha** – Project Manager, NHS Benchmarking Network
15:30	Spotlight on neurodiversity services	**Alison Worden** – Project Manager, NHS Benchmarking Network

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

International mental health benchmarking

Sean Russell

COO & European Lead – Global Leadership Exchange

About us...

Global Leadership Exchange **connects leaders** in mental health, disability, and addiction. We create space for sharing **ideas, knowledge**, and **best practice** to help spread innovation, improve services and **change lives**.

GLE members

Our members come from all over the world and are committed to leading change and to learning about new or different ways of working to improve the lives of people with mental health, disability or addiction needs.

Some have many years of experience, and some are just starting out, and we believe we can all learn from each other.

Our global community is vast and wide-ranging consisting of organizational, policy, government, service, experts by experience, academic and faith leaders.
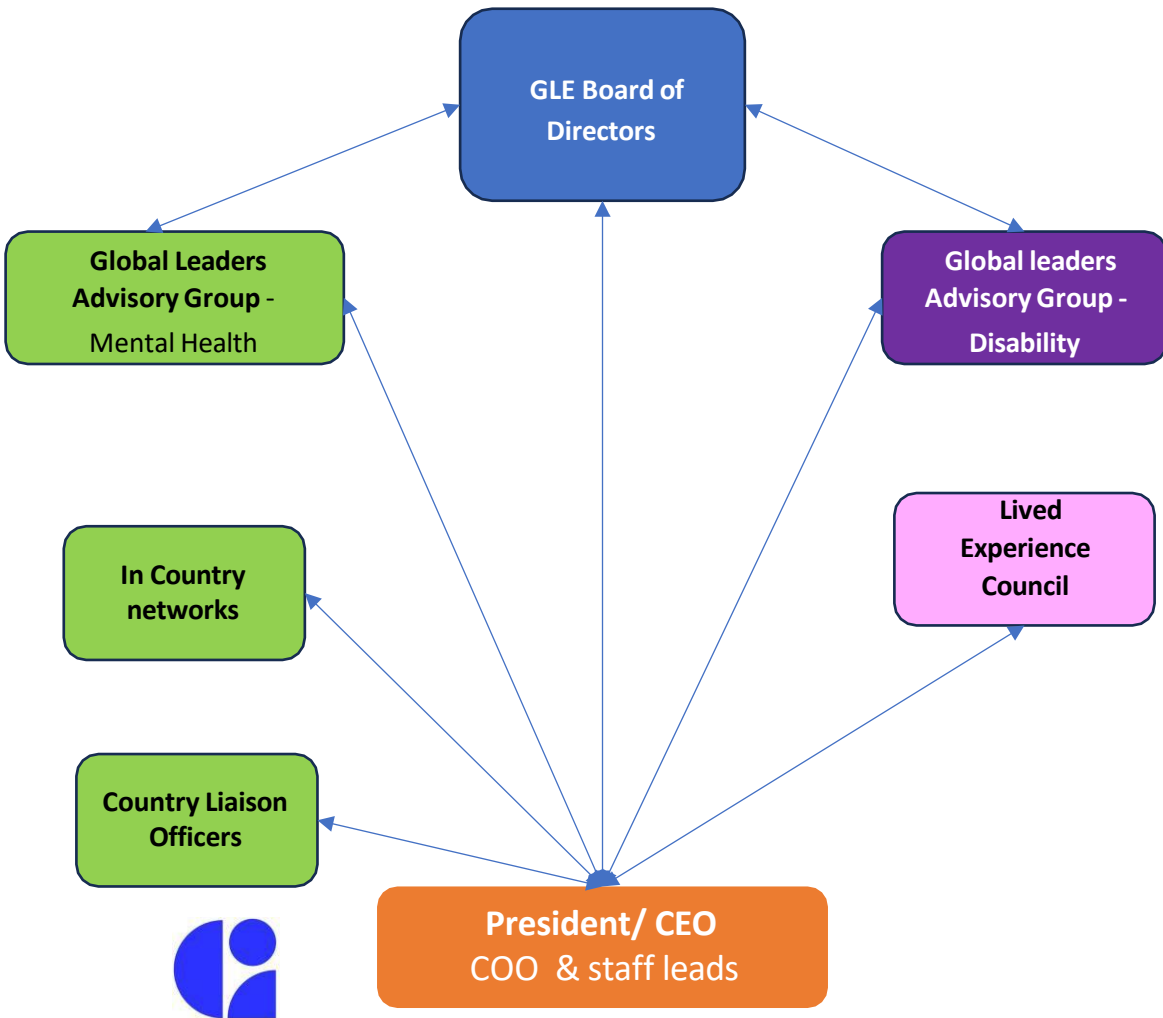
Leadership Principles underpin our work

We ask all members and subscribers to GLE to sign-up to our principles. We regularly revisit these and seek input from members to ensure they are relevant and reflect the everchanging and expanding environments we find ourselves in.

Benefits of being a member of GLE

Attendance at
Leadership Exchange, webinars & access to
resources and presentations

International Leaders
Network

GLE Monthly Exchange
(newsletter)

Online membership portal launching soon

Reports &
Publications

Exposure to emerging
innovations and
knowledge exchange

Knowledge Exchange
Collaborations – usually
member–led

Global Leadership Exchange Operating Model

GLE Board of Directors

Global Leaders Advisory Group - Mental Health

Global leaders Advisory Group - Disability

In Country networks

Lived Experience Council

Country Liaison Officers

President/ CEO COO & staff leads

Collaboratives and networks focused on Thematic Priorities

- Council of Clinical Leaders
- Council of Public Health Leaders
- Rural Behavioural Health Collaborative
- ICiRCLE Cities and Urban regions Collaborative
- Children Young People and Families Collaborative
- Military and Veterans Collaborative
- Benchmarking Collaborative
- Peer Leadership Collaborative
- Wharerãtã Network
- Women's Leadership Network
- 2SLGBTQAI+ Network
- Knowledge Exhange Hub Network
- Suicide Prevention and Reduction Network
- Crisis Now – Network
- Emerging Leaders Network

The way we work
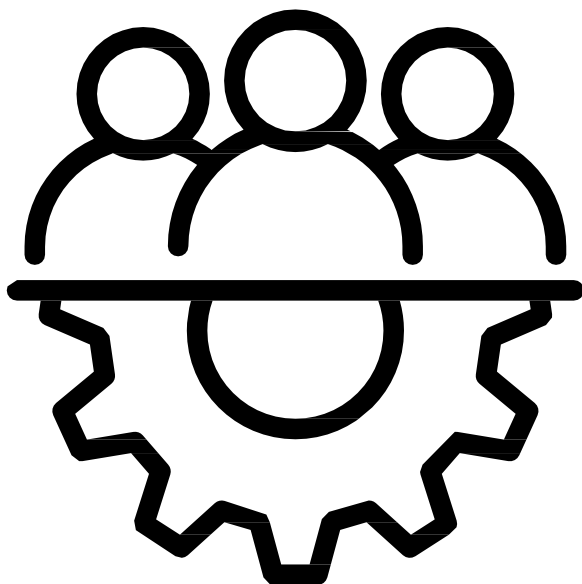
We are a global collaboration

• A virtual international office is led by Steve Appleton, President/CEO.

• A small global team works flexibly across multiple time-zones providing a wide range of expertise, network facilitation, membership coordination, communication and administrative support.

• We are funded by departments/ organizations in Australia, Canada, England, Italy, Northern Ireland, the Netherlands, New Zealand, Republic of Ireland, Scotland, Slovakia, Sweden, USA and Wales

• We currently have **almost 5,000 members** subscribed
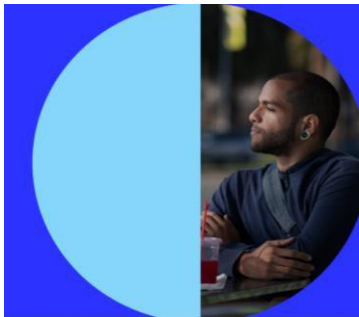
Snapshot of GLE activity

International Mental Health Benchmarking

Membership Programme

Why the Network originally formed, offering a programme of benchmarking opportunities and insights to inform decision making within NHS and healthcare organisations. Healthcare organisations are welcome to join.

Find out more.

The *International Mental Health Benchmarking Project: Where are we now?*

Since 2016, 15 countries have taken part in *one or more* of the international benchmarking project cycles as part of the bi-annual leadership exchange.

Participating countries in the NHS Benchmarking International Mental Health Project (2016-2022)

Australia	England	Northern Ireland	Sweden
Belgium	Japan	Norway	Switzerland
Canada	Netherlands	Republic of Ireland	United States of America
Czech Republic	New Zealand	Scotland	Wales

In 2024, the NHS Benchmarking Network and GLE agreed to pause the international mental health project. This was an opportunity to reassess interest, review the focus and impact of the project, and create a sustainable model of delivery.

A session on data and benchmarking was held at the 2024 Leadership Exchange in Utrecht, Netherlands which resulted in two broad outcomes:
- confirmed interest in continuing an international mental health benchmarking project, and
- establishing a Data and Benchmarking Collective.

Global Leadership Exchange

June 2026, Canada

https://www.youtube.com/watch?v=j4JoCPdrJzE

NHS Benchmarking Network
Harnessing the power of data to drive meaningful change.

2022 - International Mental Health Benchmarking Report

- **Purpose:** Summarises international collaboration (IIMHL, NHS Benchmarking Network and partners) to compare mental health service provision and inform policy, practice and professional dialogue.

- **Significance:** First international comparison report since the Covid-19 pandemic; platform for discussion with policymakers, providers and professional bodies.

- **Pandemic impact:** Country timelines show different Covid trajectories; pandemic changed how services are delivered and increased demand, acuity and complexity for many countries.

- **Role of benchmarking:** Helps identify cross-country service pressures and unmet needs in an international context.

Findings, limits and next steps

- **Comparisons included:** Health and mental-health spending; inpatient and community services for adults and children/young people.

- **Key patterns:** Some coherence across countries in areas of care, suggesting similar needs or delivery approaches; where variation exists it reflects data quality, differing service models and population differences.

- **Shared international interests:** Specialist community services, restrictive inpatient practices, and outcome measurement.

- **Data gaps and priorities:** Robust, comparable data is not yet available for all areas; these are priorities for future iterations.

Length of stay – int'l benchmarking project 2019, 2022

Mean average lengths of stay (2019)

A 12-fold variation is evident in child & adolescent bed length of stay.

37 days (42 days in 2017/18), although this included substantial variation from 9 days (Australia) to 119 days (Wales).

Length of stay in children and young people's beds (days, excluding leave)

Mean = 46   Median = 37
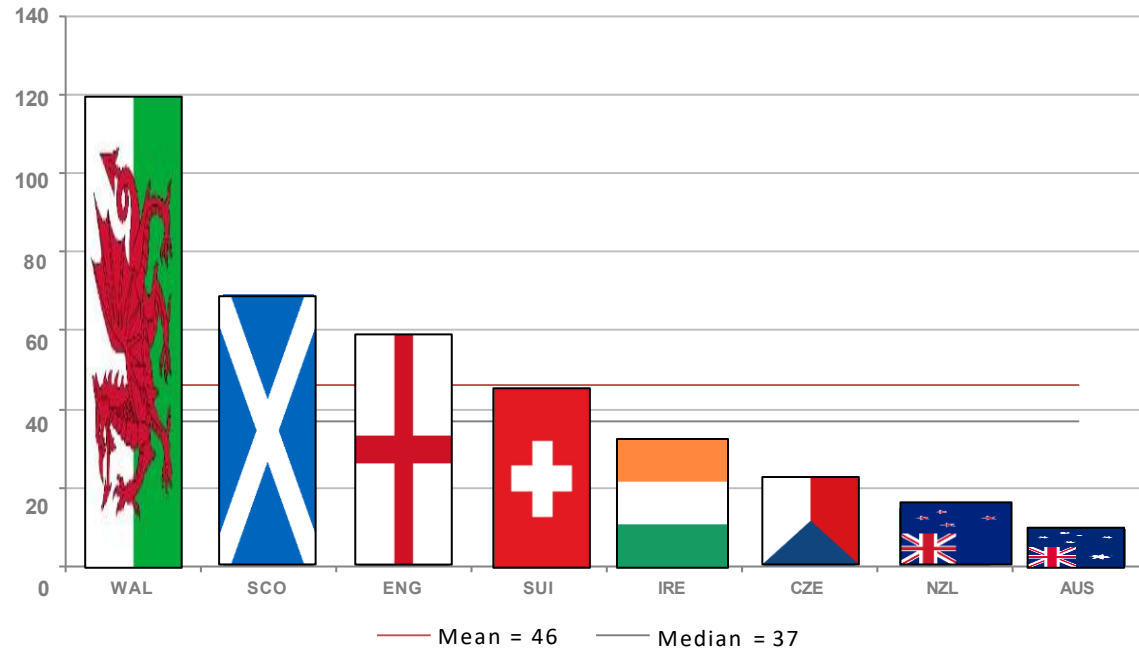
Mean average lengths of stay (2022)

36 days, ranging from 9 days in Australia and Sweden to 125 days in England.*

* data for England includes forensic and specialist eating disorder beds for children and young people which inflate the overall length of stay. At 105 days, the length of stay for general admission (GA) beds for children and young people in England is still notably higher than reported for the other 6 countries.

Children and young people psychiatry: Mean average length of stay

Mean = 36   Median = 24

General adult Psychiatry Beds

General adult psychiatry beds per 100,000 population

Mean = 37   Median = 31

Length of stay and bed occupancy

General adult psychiatry: Mean average length of stay
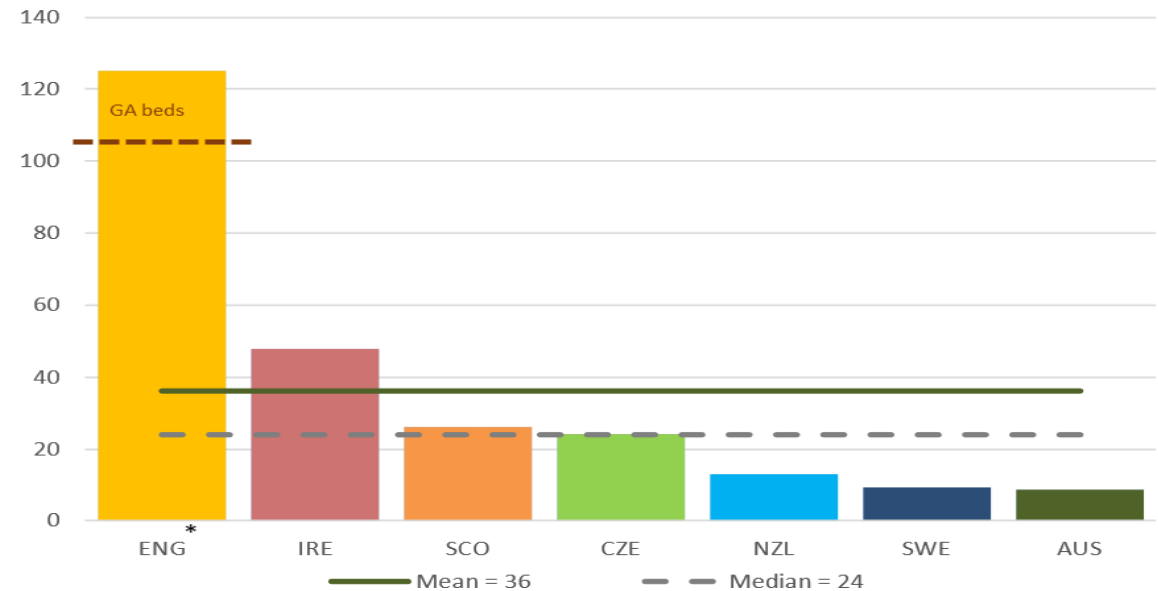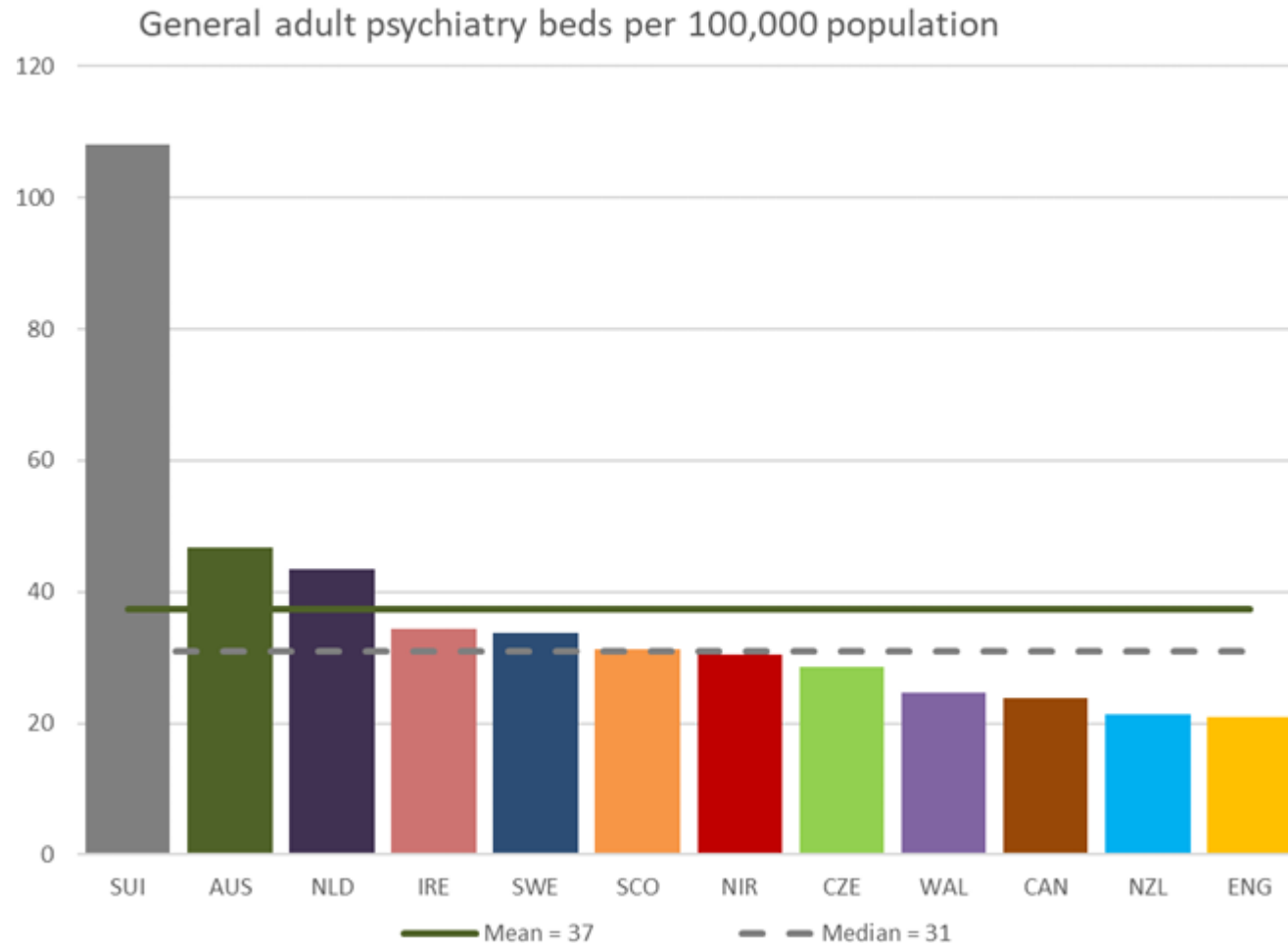
General adult psychiatry: Bed occupancy
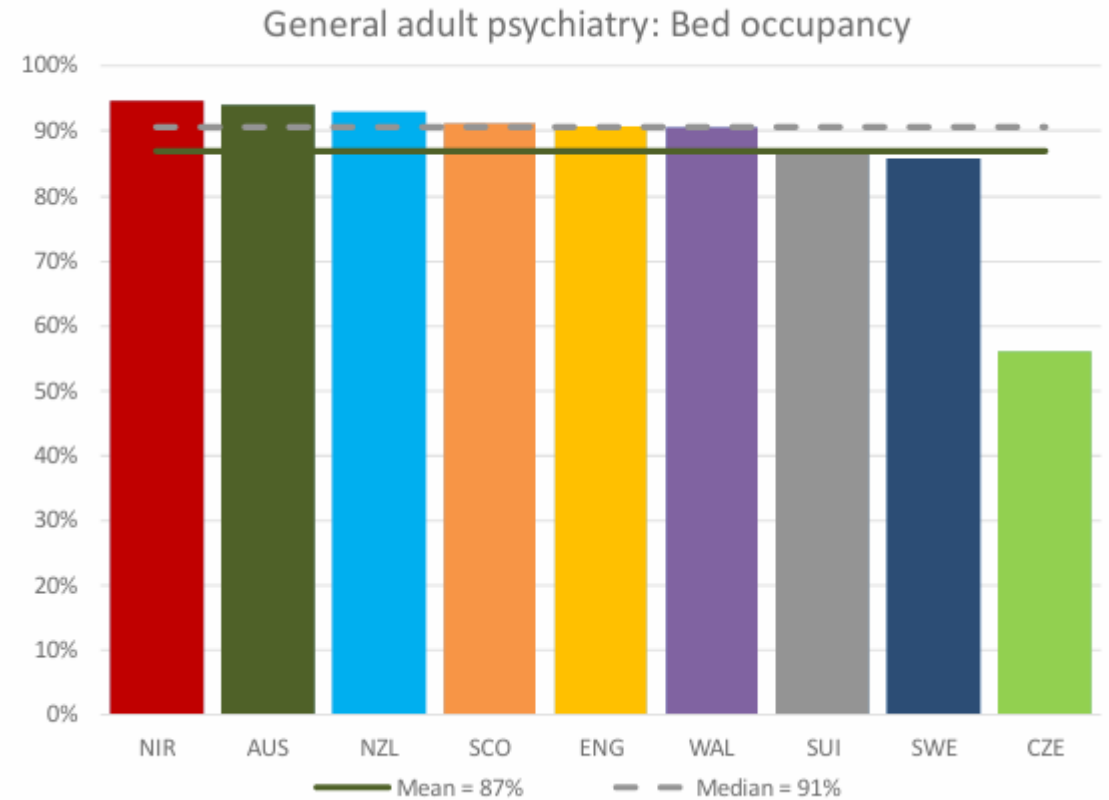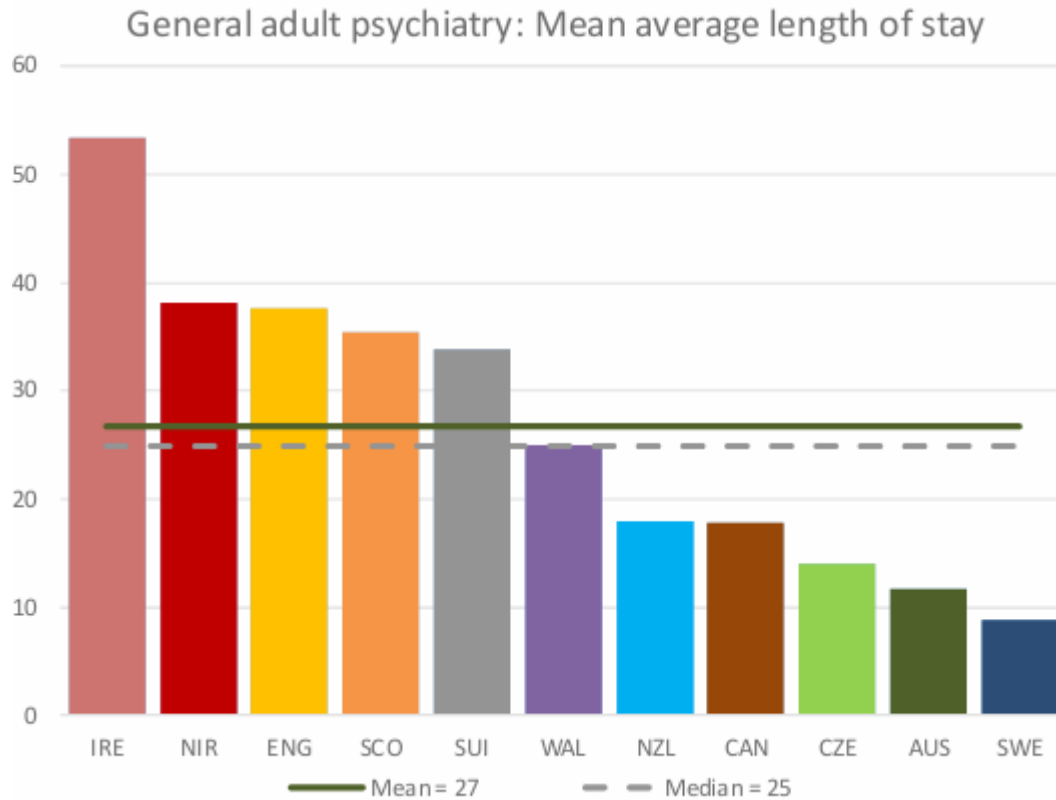
Detention rates and Emergency readmission

Forensic Beds

Forensic beds per 100,000 population
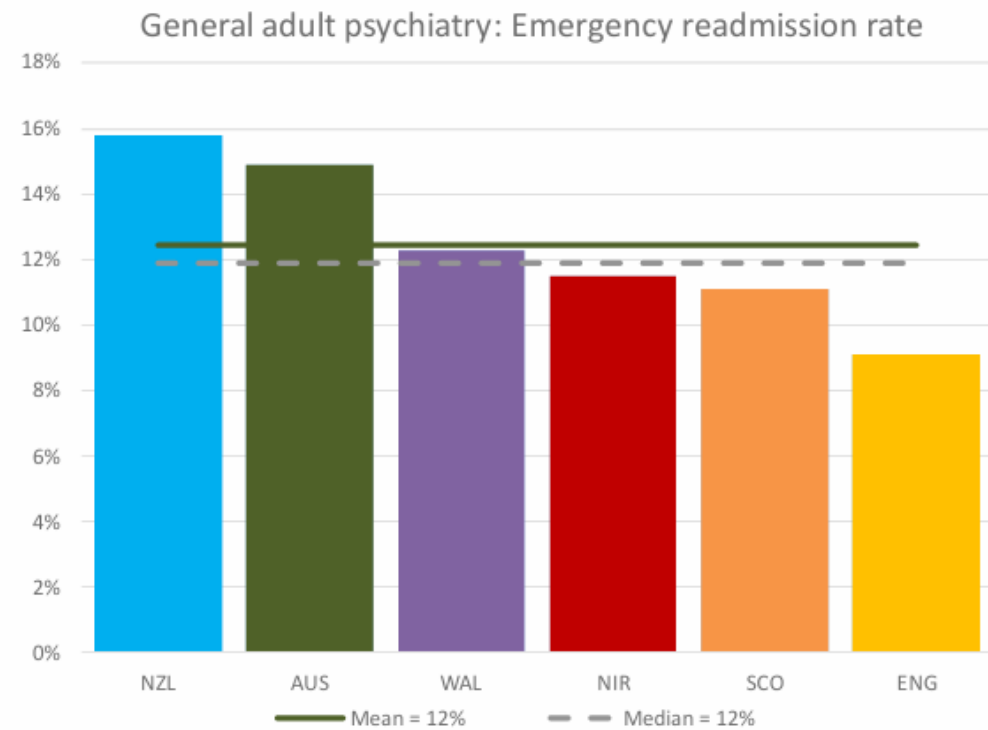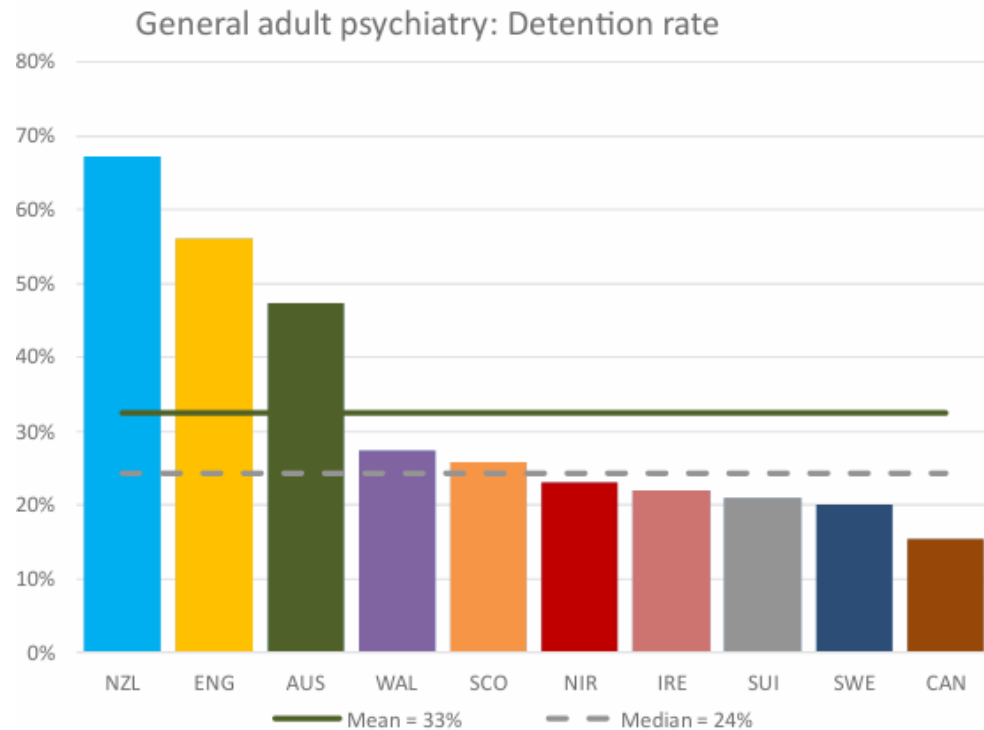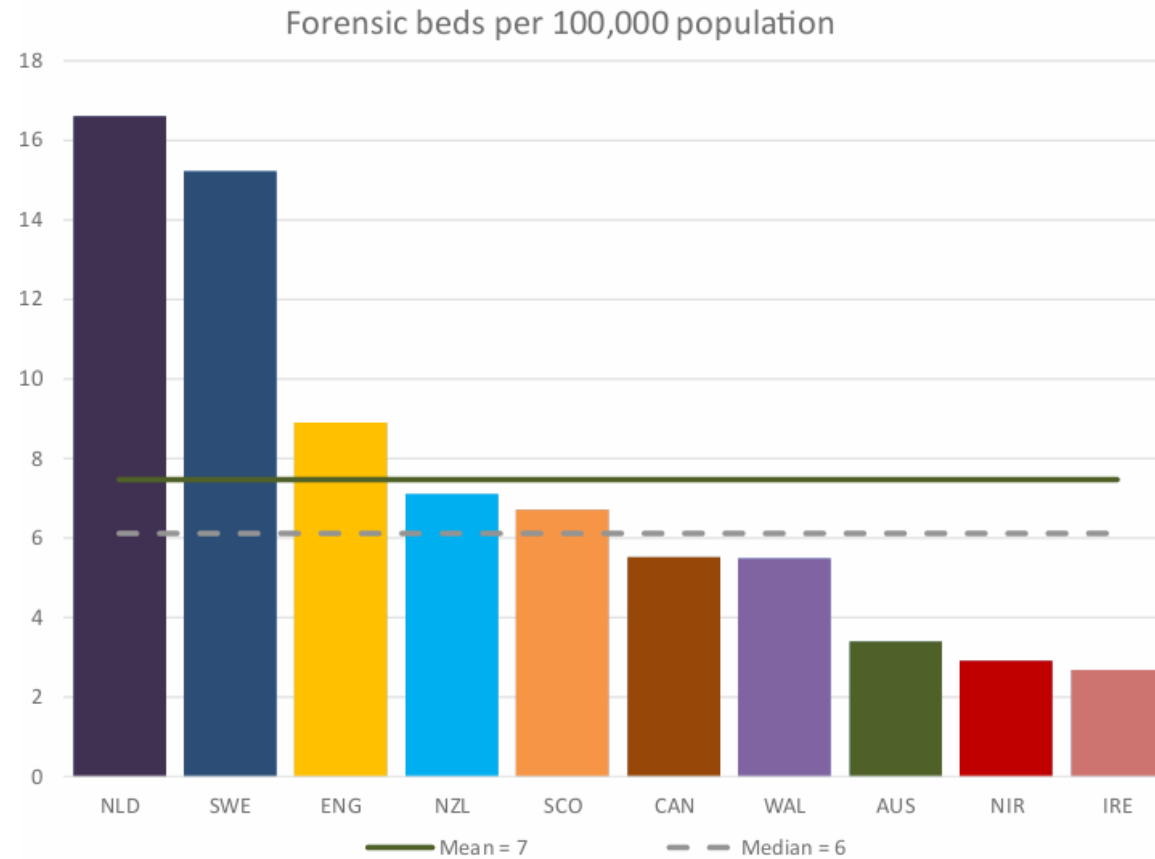
Children and young peoples psychiatry beds
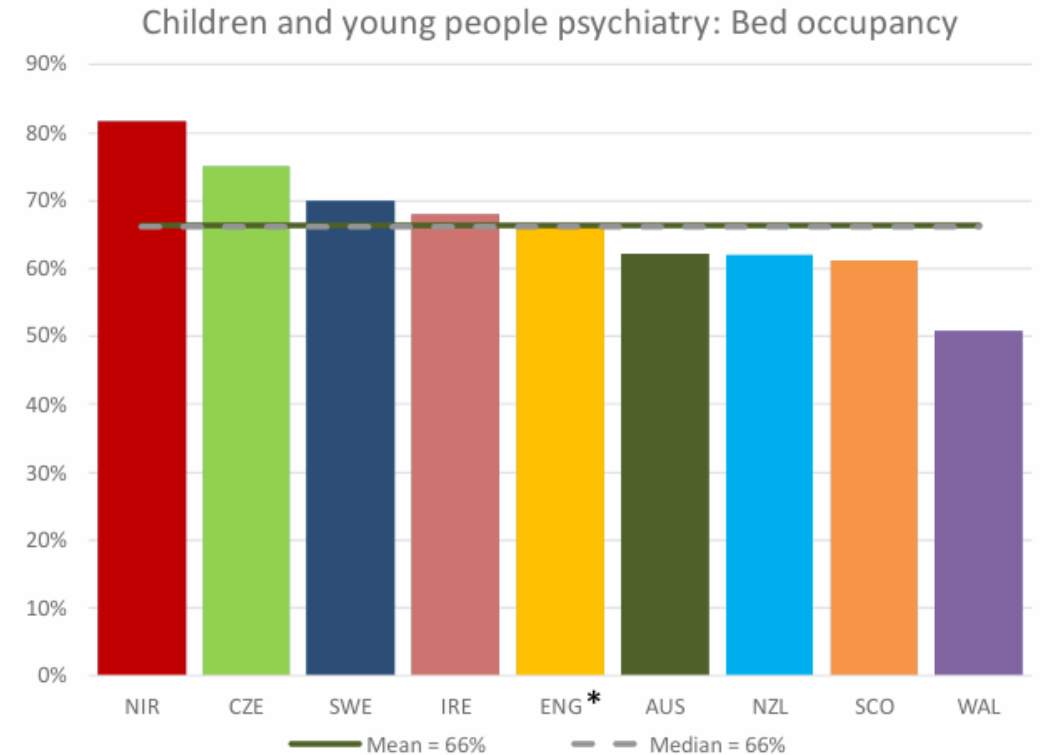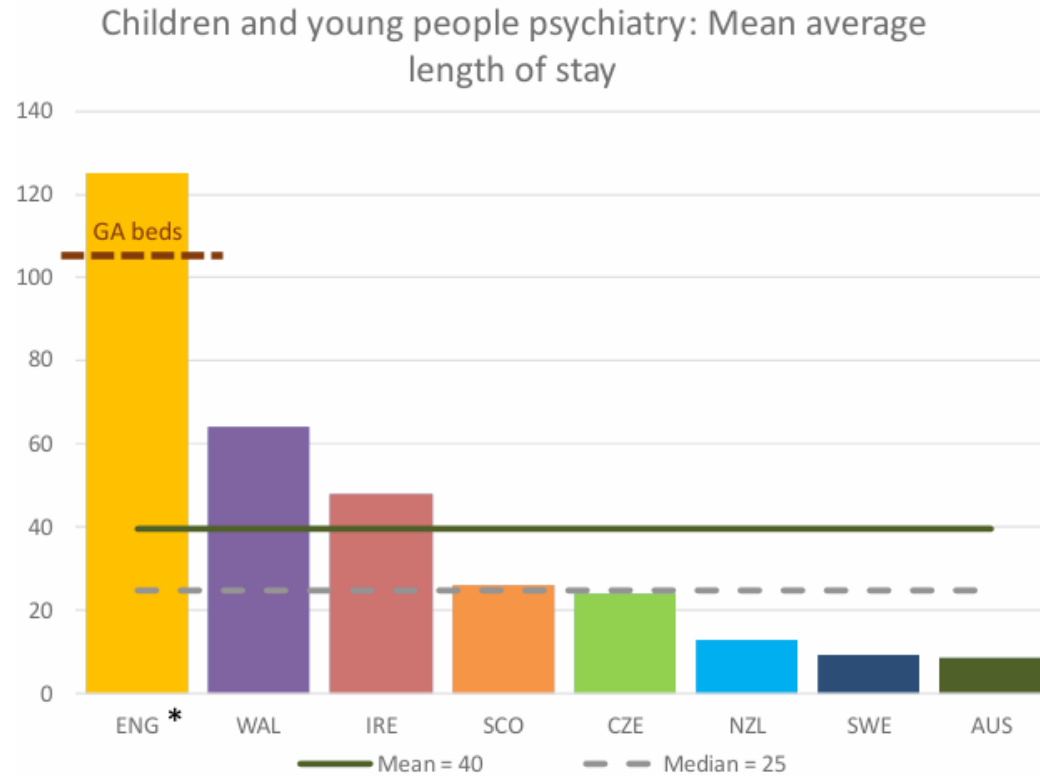
Children and young people psychiatry beds per 100,000 population

Length of stay and bed occupancy

Use of restraint
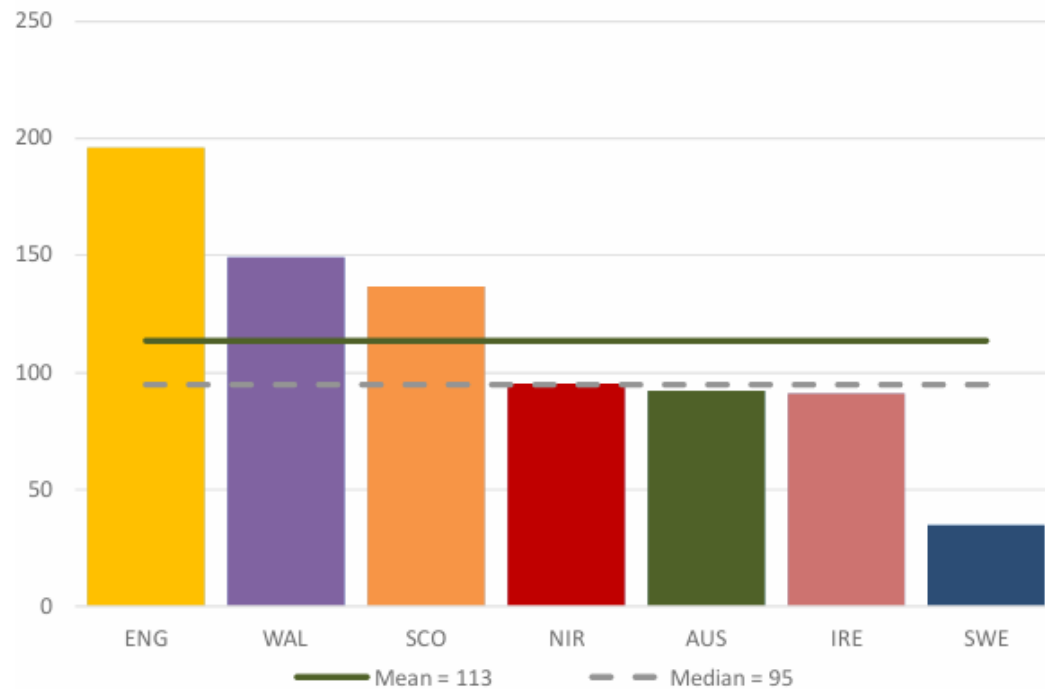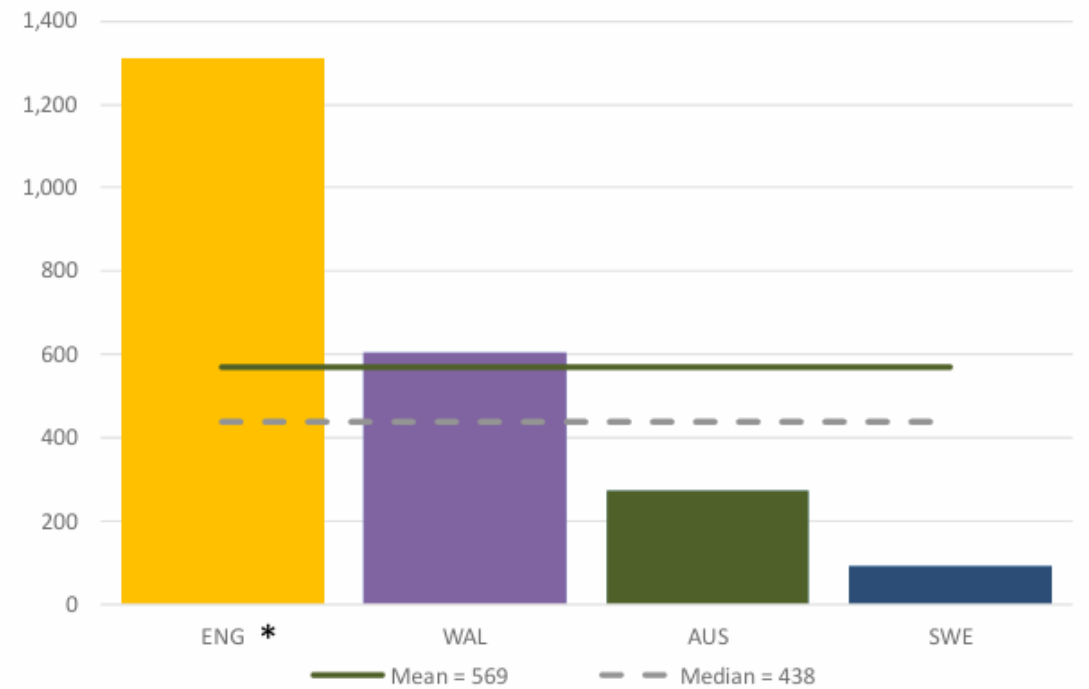
NHS Benchmarking and GLE Reports for download:

2022

- International Mental Health Benchmarking Report

- Benchmarking Dashboard

2019

- International Mental Health Comparisons

2018

- International CAMHS Benchmarking Report

- International Adult Mental Health Benchmarking Report

About our Leadership Exchange

- Our main event is our Leadership Exchange which happens every two years and is mainly an in-person event, hosted within one of our funding countries and attended by up to 600 of our members.

- We host a series of matches (similar to innovation labs or workshops) in the lead up to the event, and outcomes and learning is played back to all attendees where more discussions take place, and leaders plan the next level of activity or engagement to keep the conversation going and ensure learning continues in between the Leadership Exchange event.

- Our last Leadership Exchange was held in Utrecht, Netherlands, June 2024
  - **In-Person Workshops** (Matches): June 24 and 25
  - **Welcome Reception**: June 26
  - **In-Person Network Meeting**: June 27 and 28

- Visitors came from all over the world,
  primarily from our 13 investing countries/regions

- Leadership Exchange 2024 - Global Leadership Exchange (gle.world)

Our Leadership Exchange in pictures
Link : GLE 2024 photo gallery (youtube.com)

Coming soon

GLE is now starting to plan for the next Leadership Exchange in June 2026 in Canada.

We have a strong international mental health, disability and addictions leadership network and we are committed to strengthening relationships with existing and new members.

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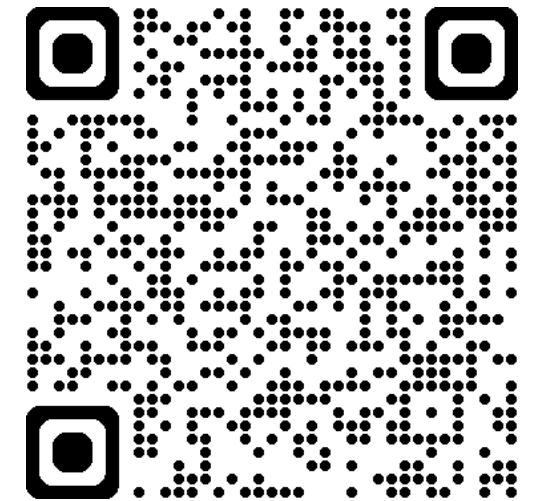
Scan the QR code to find out more about becoming a member

Conclusion

Our members come from all over the world, show immense goodwill and are committed to leading change and to learning about new or different ways of working.

Some have many years of experience, and some are just starting out, and we believe we can all learn from each other.

"For me, this network introduced me to international mental health care. It connects world-wide knowledge and expertise."

- Sabien Raams, Netherlands

Global
Leadership
Exchange

Children and young people's mental health 2024/25 benchmarking findings

Alison Worden

Project Manager - NHSBN

Acknowledgements

Thank you to all who contributed to the 2025 CYPMHS project data collection and validation!

- Provider organisations

- Executive teams, BI teams, and clinical staff

- Mental Health Reference & Steering Groups

- All attendees to in person & online events

- Everyone behind the scenes in the NHSBN team!

Project context

Background

- This is the 14th year that the NHS Benchmarking Network has delivered the benchmarking project for children and young people's mental health services.

- The data presented relates to the 2024/25 financial year.

Participation

- **98 submissions from 64 organisations**

- 81 Mental Health Trusts in England

- 4 Health Boards in Wales

- 12 Scottish Health Boards

- States of Jersey

Community CYPMH statistics

- 659k referrals received

- 508k referrals accepted

- 227k patients on caseload

- 3.7m contacts delivered

- 17k total WTE

Inpatient CYPMH statistics

- 1.5k admissions

- 913 MHA detentions

- 514 beds

- 123k occupied bed days

- 2.5k total WTE

Outgoing

Community CYPMHS Key Metrics

Community service model

Do you have this team type?

Team	Yes	No
General	98.8%	1.2%
MHST	84.5%	15.5%
Eating Disorders	85.7%	14.3%
Crisis	87.3%	12.7%
Forensic	20.0%	80.0%
Other specialist teams	79.4%	20.6%
ASD team	50.0%	50.0%
ADHD team	41.8%	58.2%
Other neurodiversity team	51.9%	48.1%

■ Yes ■ No
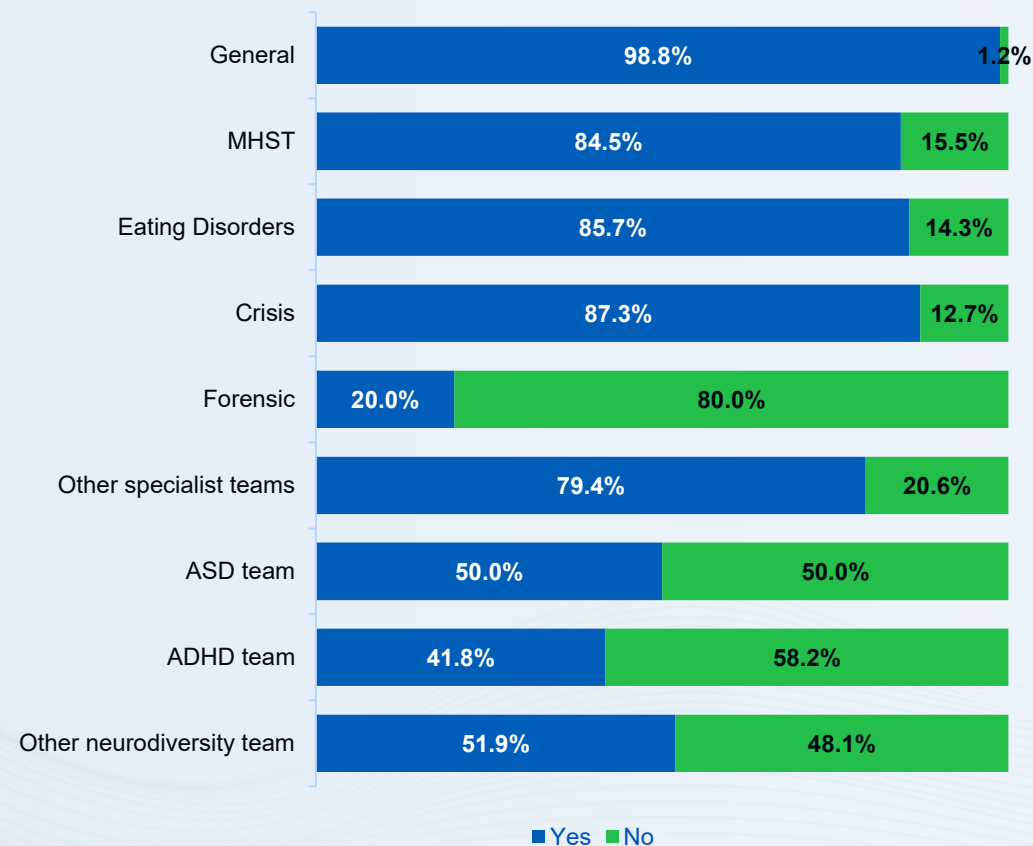
Do you have a single point of access in this service?

Team	Yes	No
General	94.4%	5.6%
MHST	60.0%	40.0%
Eating Disorders	80.6%	19.4%
Crisis	80.6%	19.4%
Forensic	42.9%	57.1%
Other specialist teams	81.5%	18.5%
ASD team	48.8%	51.2%
ADHD team	41.2%	58.8%
Other neurodiversity team	83.3%	16.7%

■ Yes ■ No

Harnessing the power of data to drive meaningful change
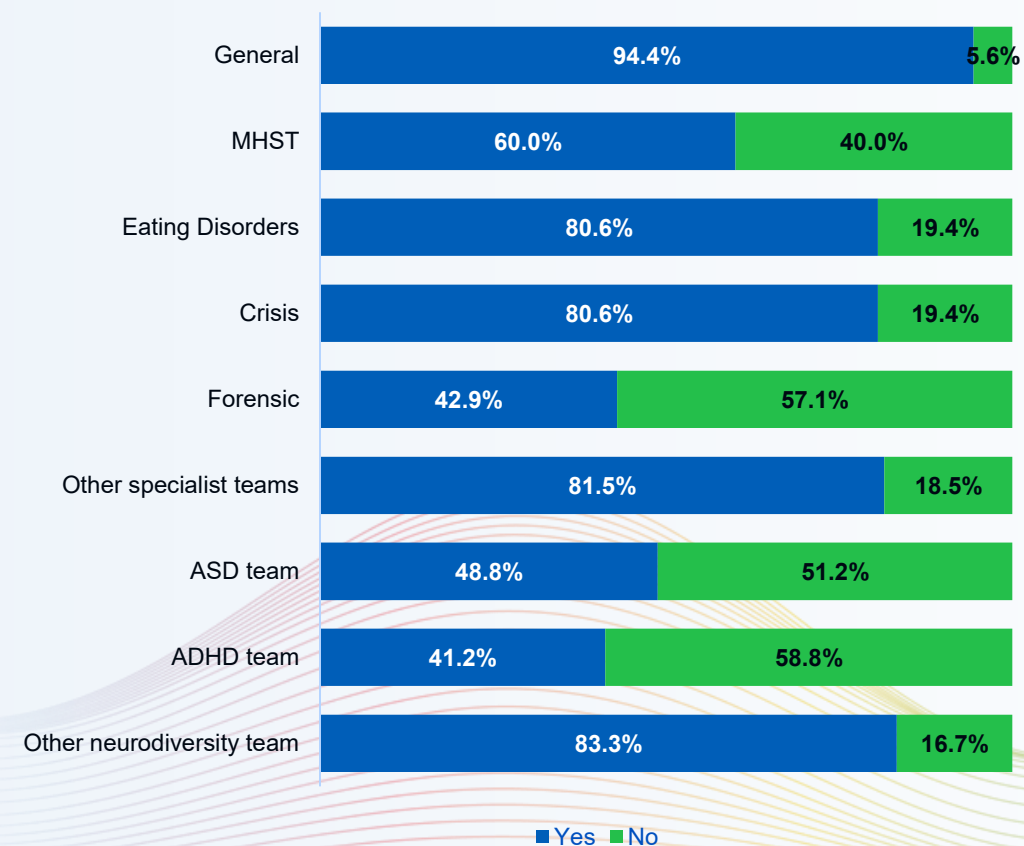
Patient outcomes

How compliant are you with the personalised care and support planning guidance?

- Fully compliant
- Partially compliant
- Planning to move to personalised care and support planning within financial year 2024/25
- No formal plans as yet

Pie chart values: 41%, 39%, 2%, 18%
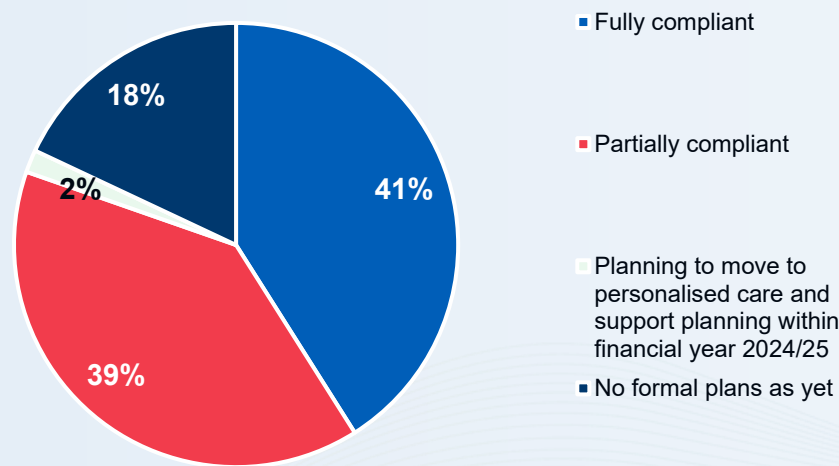
Do you use your collected outcome measures to inform care? — 99%
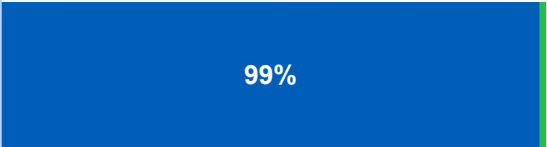
Do you use outcome measures for CYP? — 99%
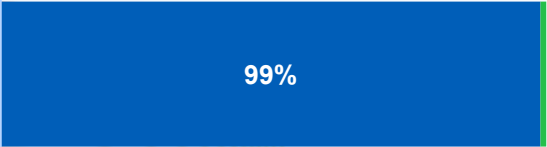
Yes (%)   No (%)

Toolkit link - Outcome measures

Referrals by team type

General, 53.6%

MHST, 10.8%

Crisis, 9.2%

Other neurodiversity team, 8.5%

ASD team, 6.5%

Other specialist teams, 4.7%

ADHD team, 3.8%

Eating Disorders, 2.4%

F or e

Harnessing the power of data to drive meaningful change
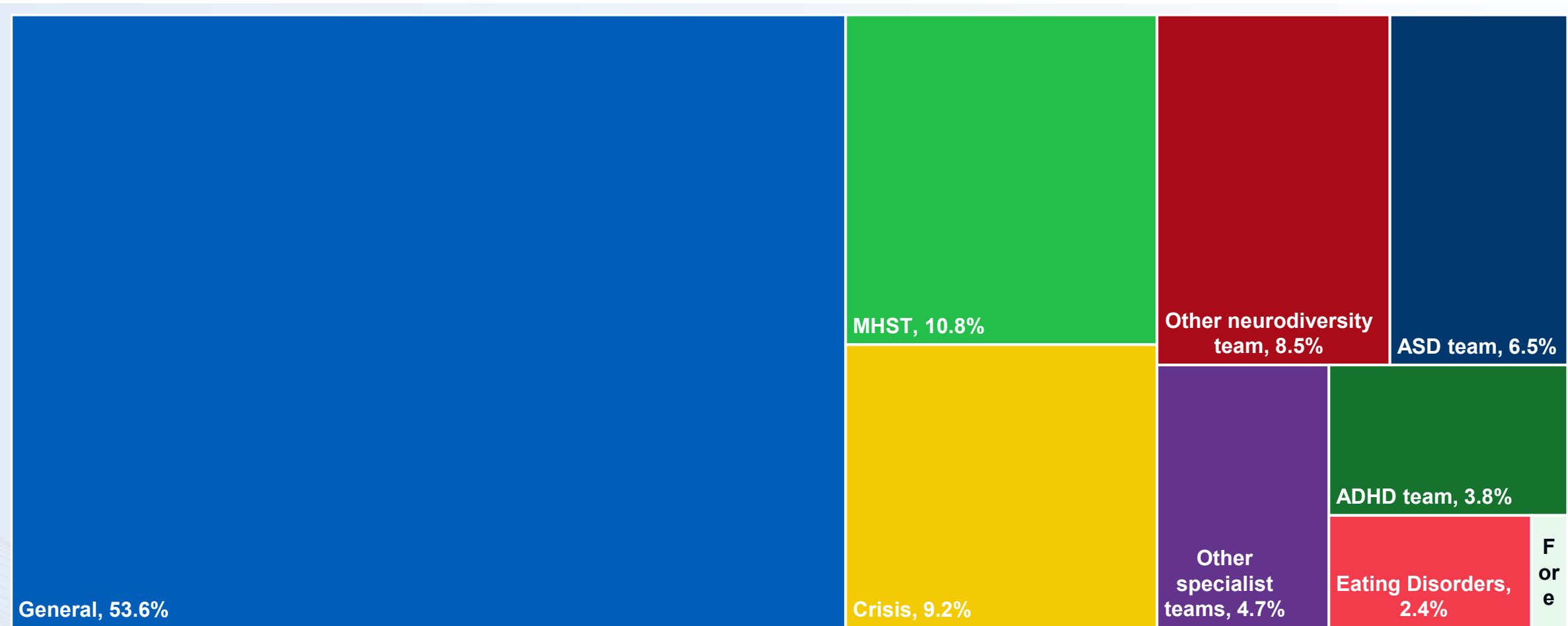
RTT pathway – General CYPMHS

| 30% | 31% | 9% | 27% | **2024/25** |

- ■ % of patients whose RTT was less than 4 weeks
- ■ % of patients whose RTT was 4-12 weeks
- ■ % of patients whose RTT was 13-18 weeks
- ■ % of patients whose RTT was 18+ weeks

| 28% | 32% | 12% | 28% | **2023/24** |

- ■ % of patients whose RTT was less than 4 weeks
- ■ % of patients whose RTT was 4-12 weeks
- ■ % of patients whose RTT was 13-18 weeks
- ■ % of patients whose RTT was 18+ weeks
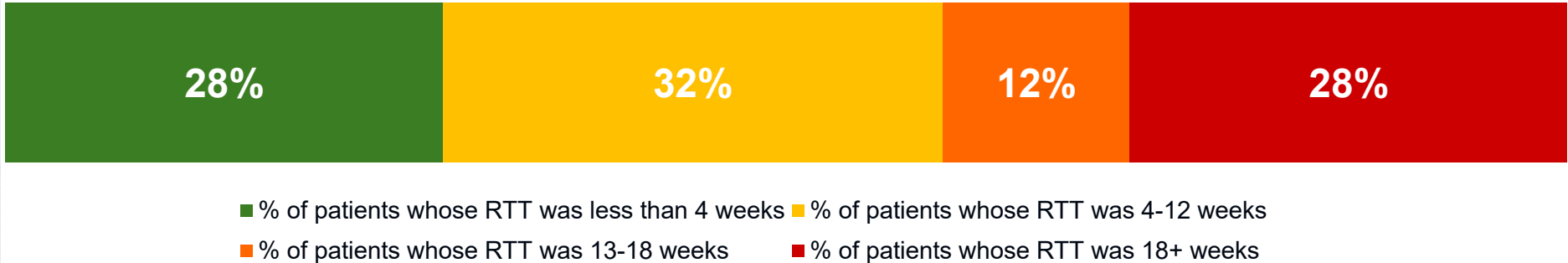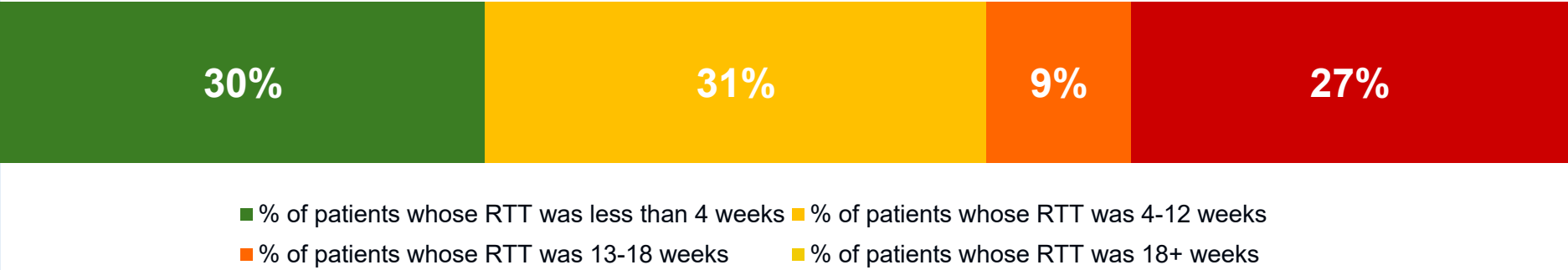
Waiting lists – General CYPMHS

31 March 2025

175,000 CYP at this stage

80,000 CYP at this stage

Total CYP on waiting lists = 255,000

Referral received → Awaiting 1st appointment → Assessment → Awaiting 2nd appointment → Added to caseload

31 March 2024

165,000 CYP at this stage

86,000 CYP at this stage

Total CYP on waiting lists = 251,000

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Caseloads and contacts timeseries – General CYPMHS

Caseload per 100k population

- 2020/21: 1,450
- 2021/22: 1,639
- 2022/23: 1,211
- 2023/24: 1,165
- 2024/25: 1,093
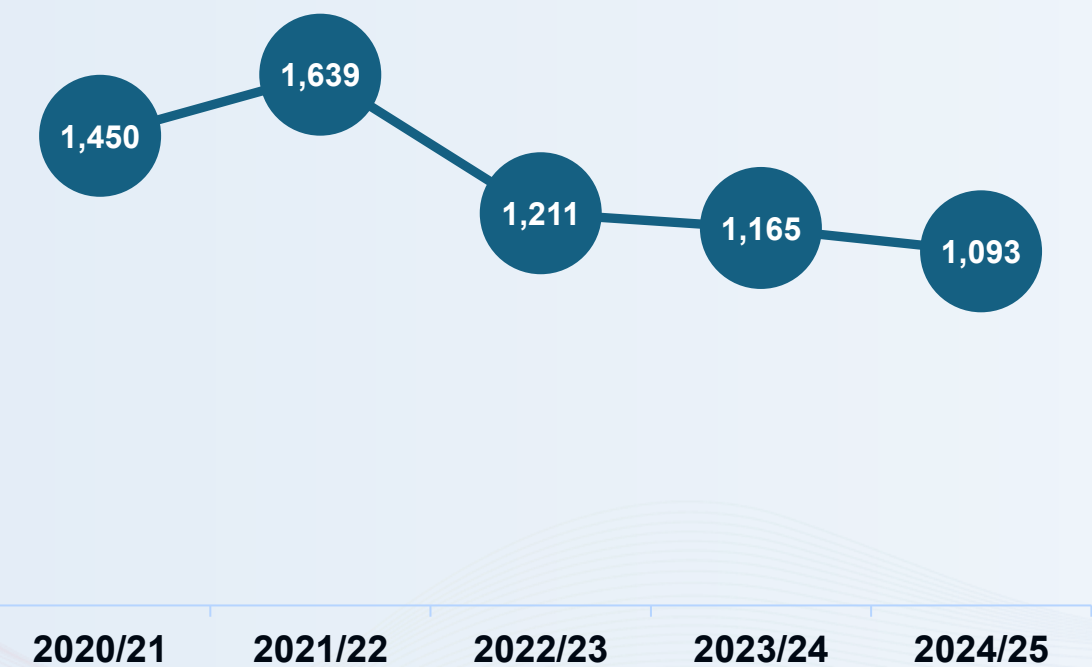
Contacts per 100k population

- 2020/21: 22,786
- 2021/22: 22,110
- 2022/23: 18,012
- 2023/24: 19,221
- 2024/25: 19,801

Harnessing the power of data to drive meaningful change
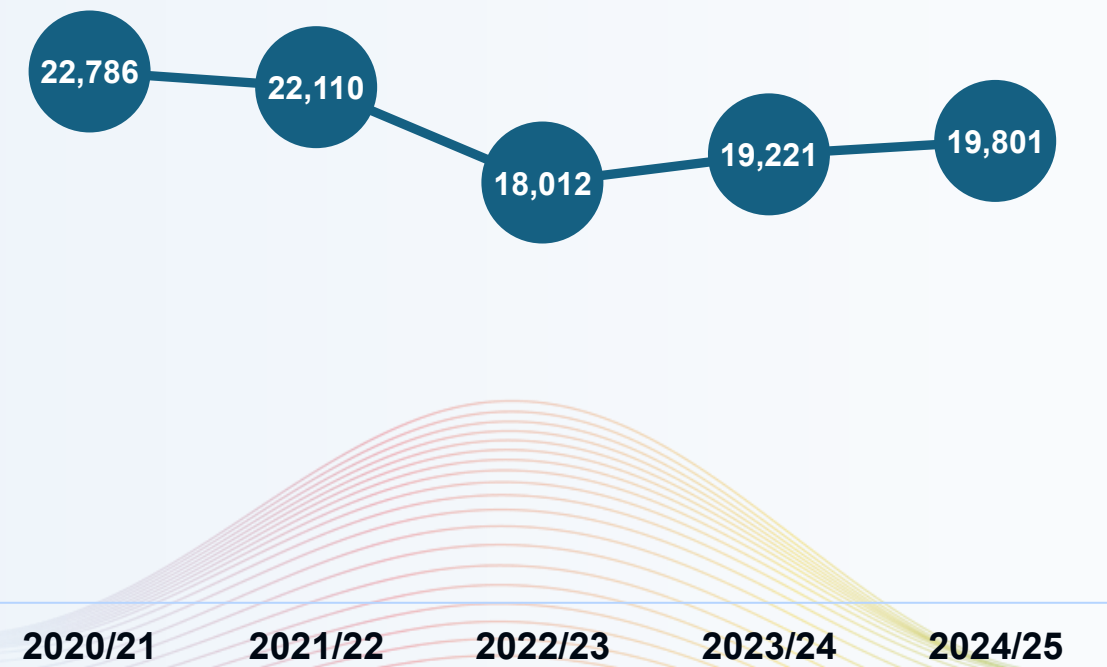
Contact mediums – General CYPMHS

2024/25

24%	9%	6%	60%

■ Non F2F - Telephone ■ Non F2F - Digital ■ Non F2F - Other Medium ■ Face to Face

2023/24

25%	10%	6%	59%

■ Non F2F - Telephone ■ Non F2F - Digital ■ Non F2F - Other Medium ■ Face to Face

Harnessing the power of data to drive meaningful change
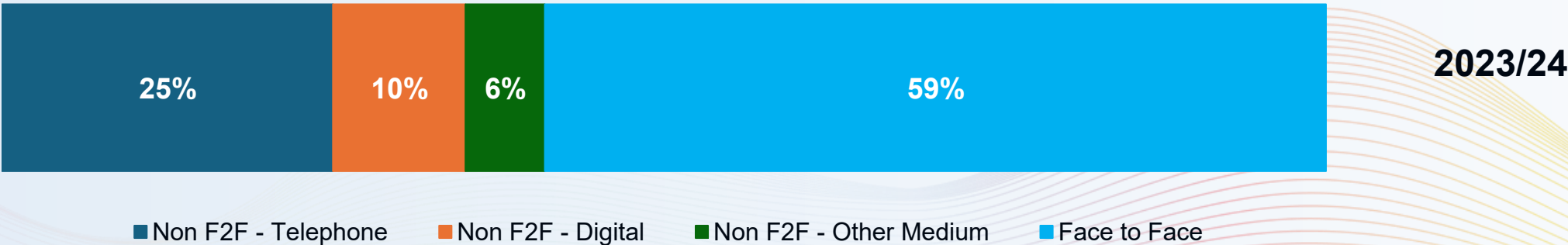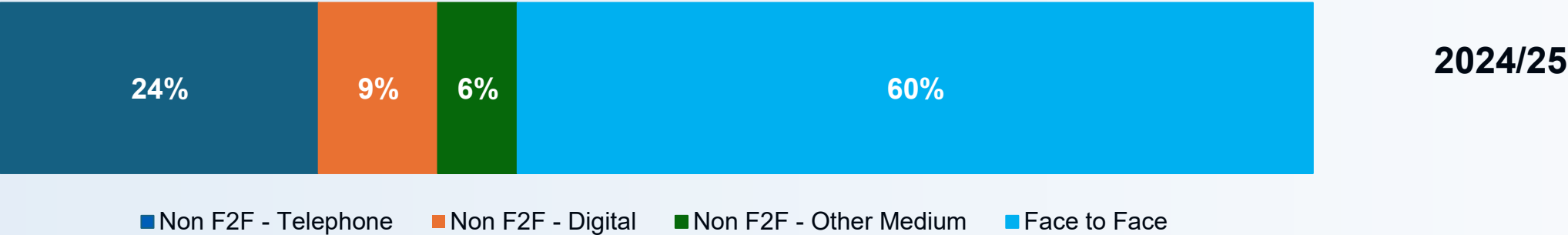
CYP Services by Team Type: Key Metrics

	General	MHST	Eating Disorder	Crisis	Forensic
0-17 Median referrals received per 100,000 pop.	3,385	814	148	677	78
Waiting times – 1st appt (weeks)	4.0	2.0	2.0	0.9	5.7
Waiting times – 2nd appt (weeks)	10	4.2	3.0	1.0	7.8
Median RTT percentage less than 4 weeks	22%	46%	72%	98%	30%
Median 0-17 caseload per 100,000 pop.	1,093	211	69	18	10

Harnessing the power of data to drive meaningful change

CYP Services: Treatment Intensity

General	2024/25
Average no. of weeks on caseload	35
Mean number of contacts before discharge	10
Approx contacts per week	**0.3**

MHST	2024/25
Average no. of weeks on caseload	16
Mean number of contacts before discharge	9
Approx contacts per week	**0.6**

Eating disorders	2024/25
Average no. of weeks on caseload	36
Mean number of contacts before discharge	22
Approx contacts per week	**0.6**

Crisis	2024/25
Average no. of weeks on caseload	3
Mean number of contacts before discharge	5
Approx contacts per week	**1.7**

Workforce – General CYPMHS

Workforce per 100k population

- 87.66 — 2020/21
- 93.93 — 2021/22
- 74.65 — 2022/23
- 83 — 2023/24
- 78.9 — 2024/25

Vacancy rate %

Median = 14%

Harnessing the power of data to drive meaningful change
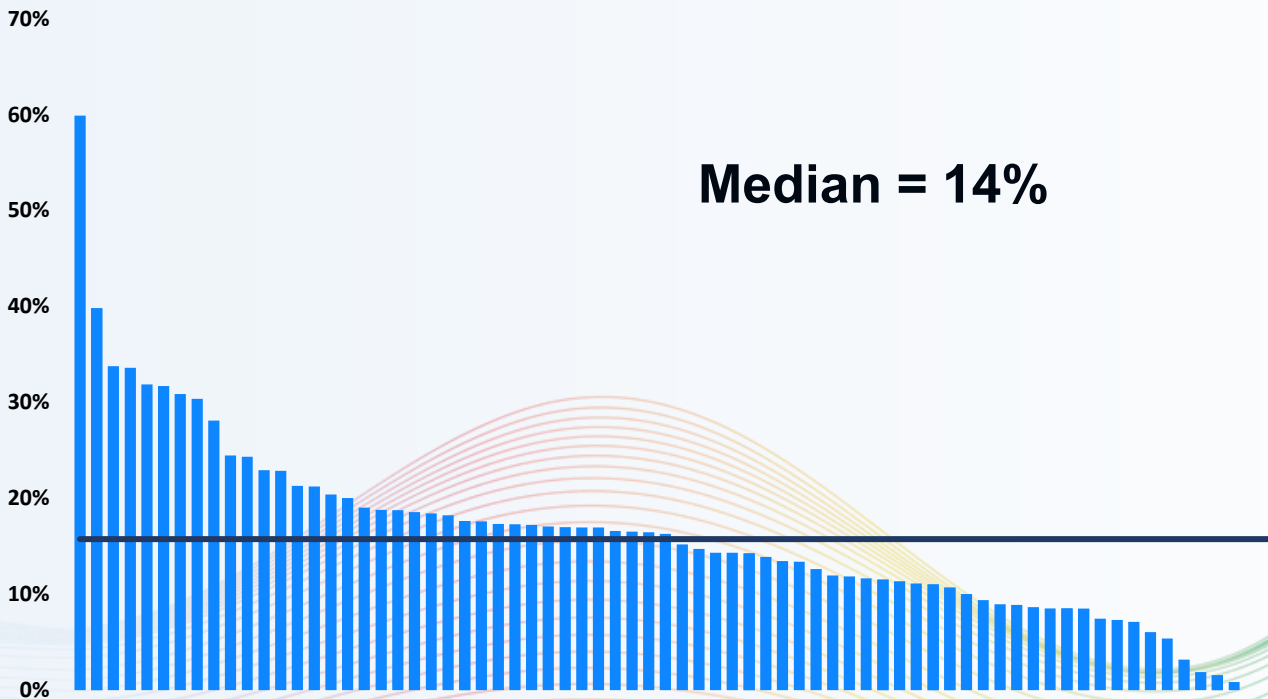
Discipline mix – General CYPMHS

 = 5%

Nursing & Clinical Support		27%
Allied Health Professionals		3%
Medical Staff		7%
Psychological Professions		32%
Social Care & Community Roles		7%
Administrative & Management		21%
Other		3%

Harnessing the power of data to drive meaningful change
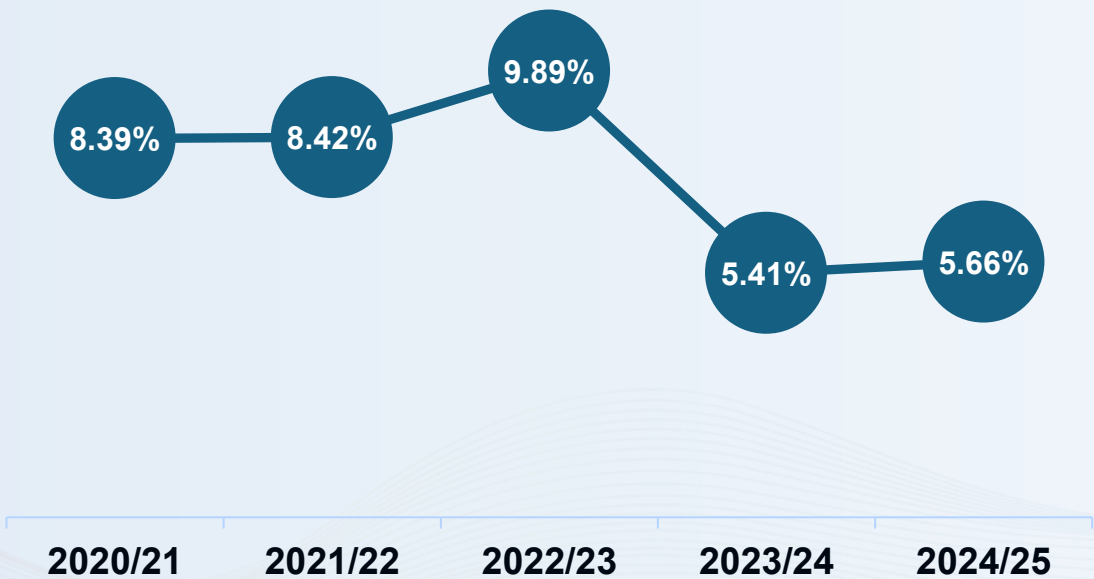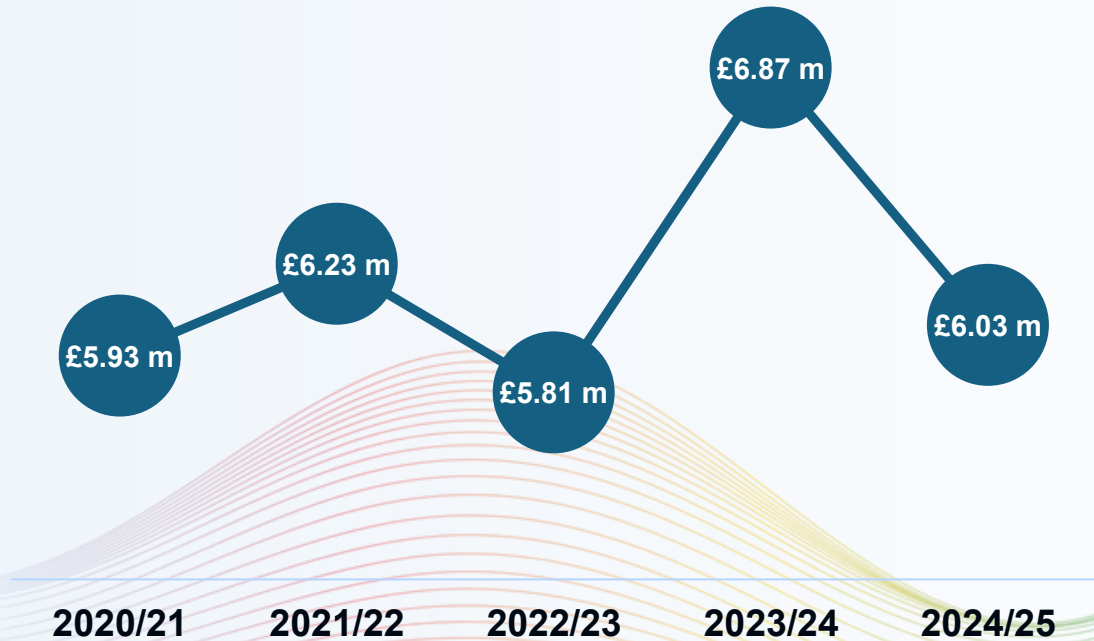
NHS Benchmarking Network

Productivity in focus

Contacts per clinical WTE per day

General CYPMHS

1.47 — 1.47 — 1.42 — 1.28 — 1.40

2020/21   2021/22   2022/23   2023/24   2024/25

2025 median by team type

General 1.4 | MHST 1.0 | Eating Disorder 1.1 | Crisis 0.9 | Forensic 0.6

NHS Benchmarking Network
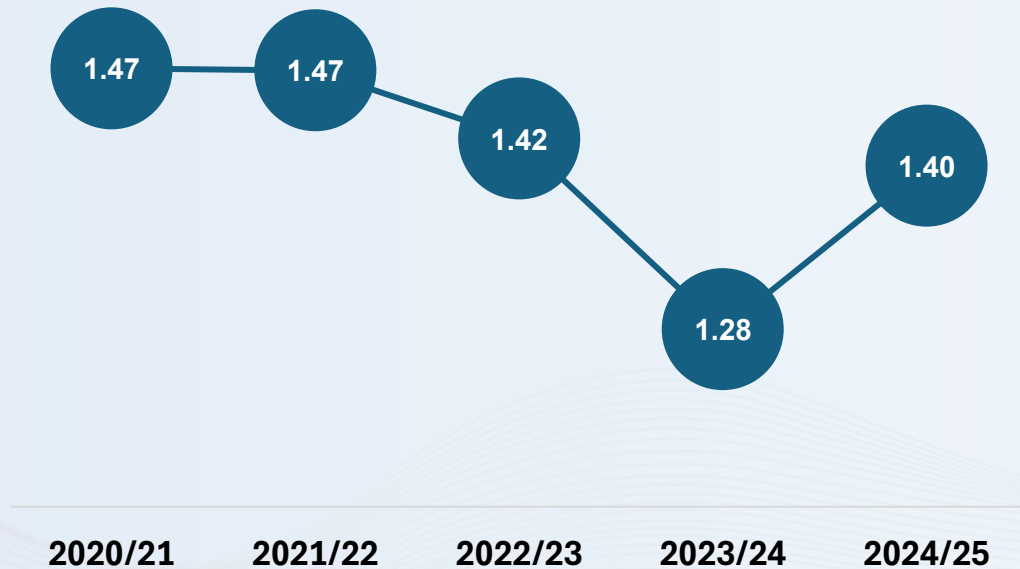
Harnessing the power of data to drive meaningful change
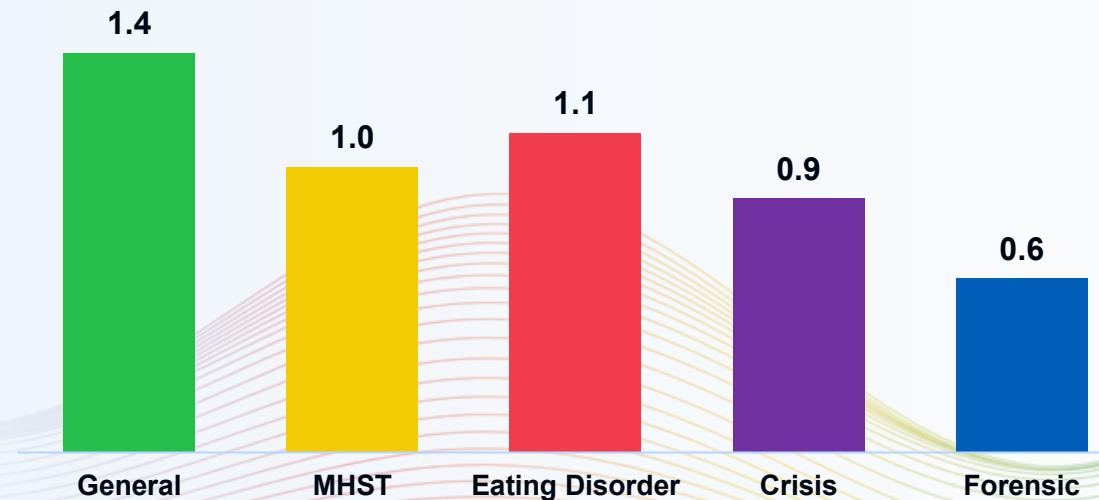
DNA rate

Median DNA % - General CYPMHS

- 2020/21: 8.1%
- 2021/22: 8.78%
- 2022/23: 9.08%
- 2023/24: 8.3%
- 2024/25: 8.09%

2025 median by team type

- General: 8.09%
- MHST: 6.27%
- Eating Disorder: 5.57%
- Crisis: 2.83%
- Forensic: 2.22%
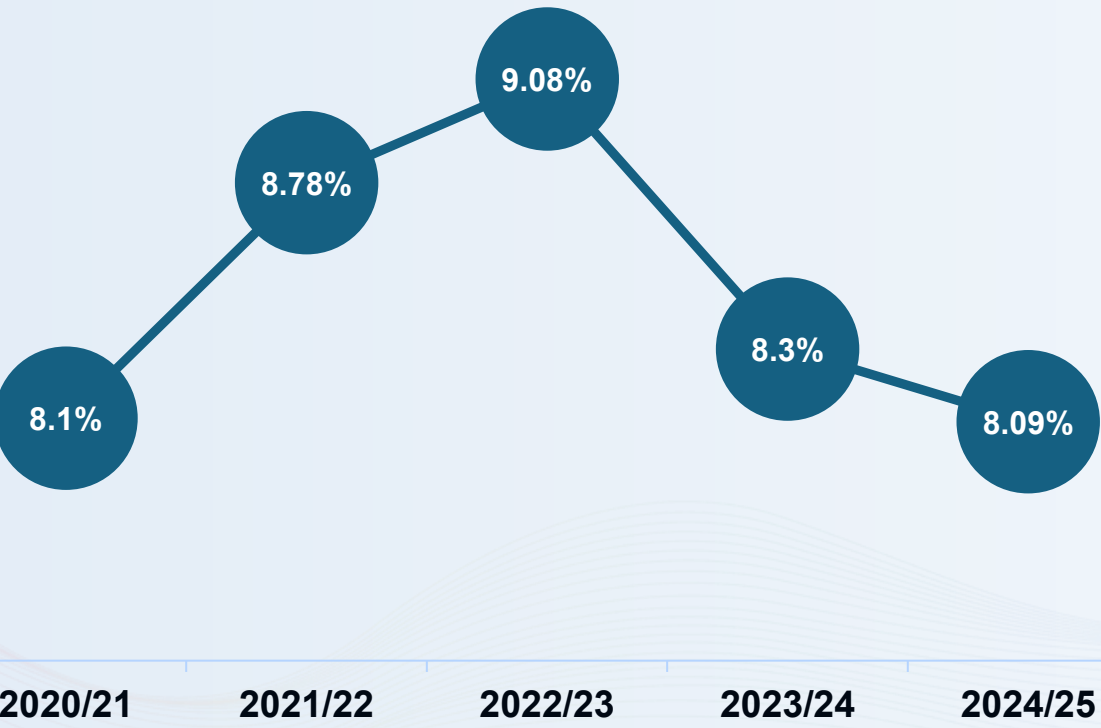
Harnessing the power of data to drive meaningful change
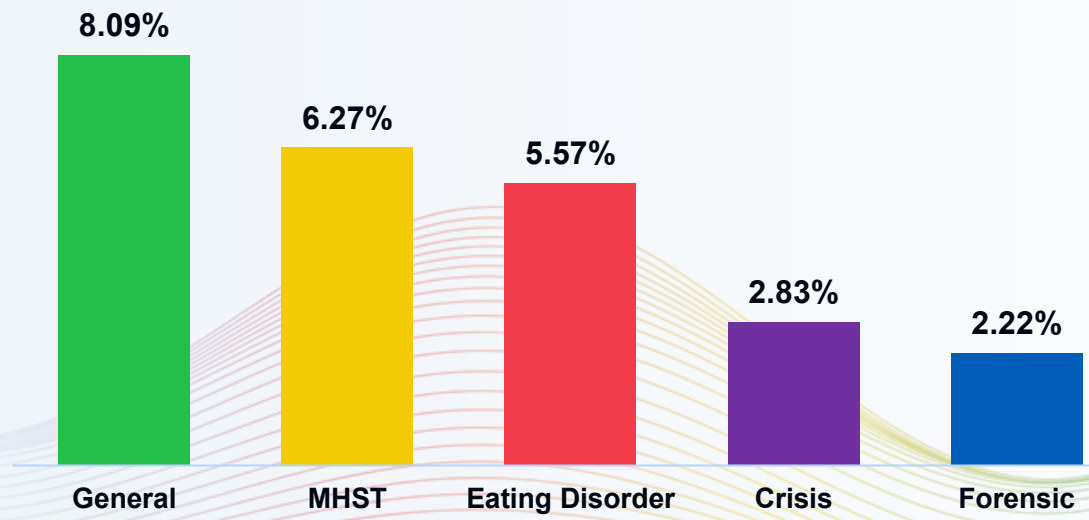
Cost per DNA/Overall costs of DNAs

Cost per DNA
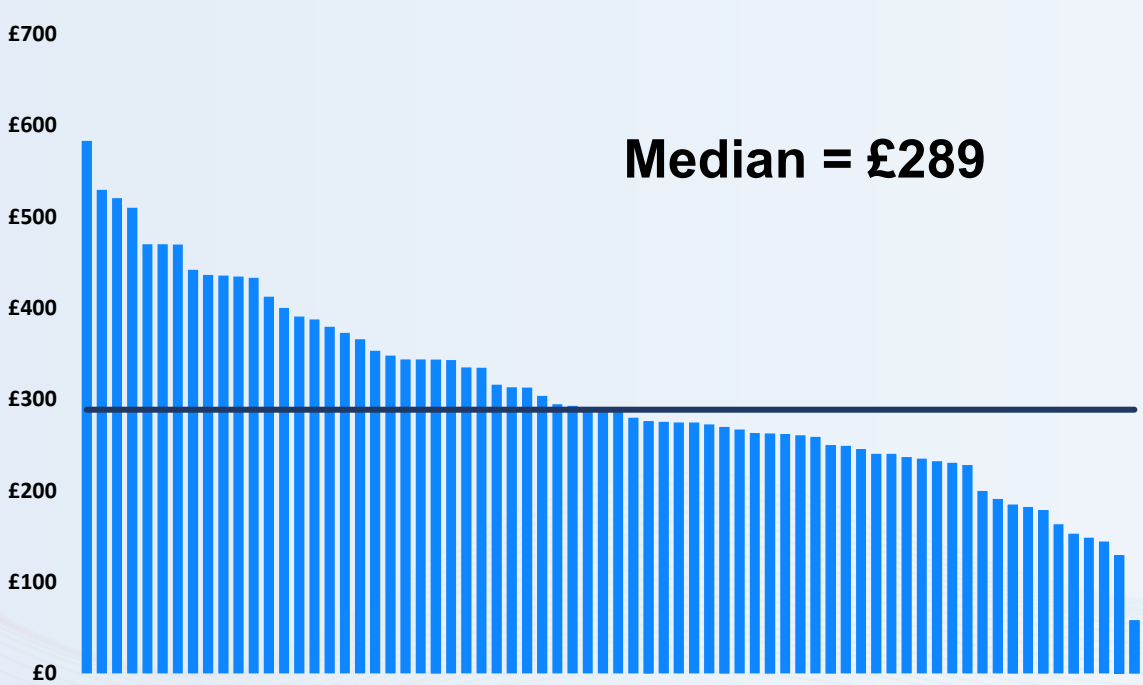
Median = £289

Overall costs of DNAs

Median = £493k

NHS
Benchmarking Network

Contacts per clinical WTE per day

General CYPMHS

1.47 — 2020/21
1.47 — 2021/22
1.42 — 2022/23
1.28 — 2023/24
1.40 — 2024/25

2025 median by team type

General	MHST	Eating Disorder	Crisis	Forensic
1.4	1.0	1.1	0.9	0.6
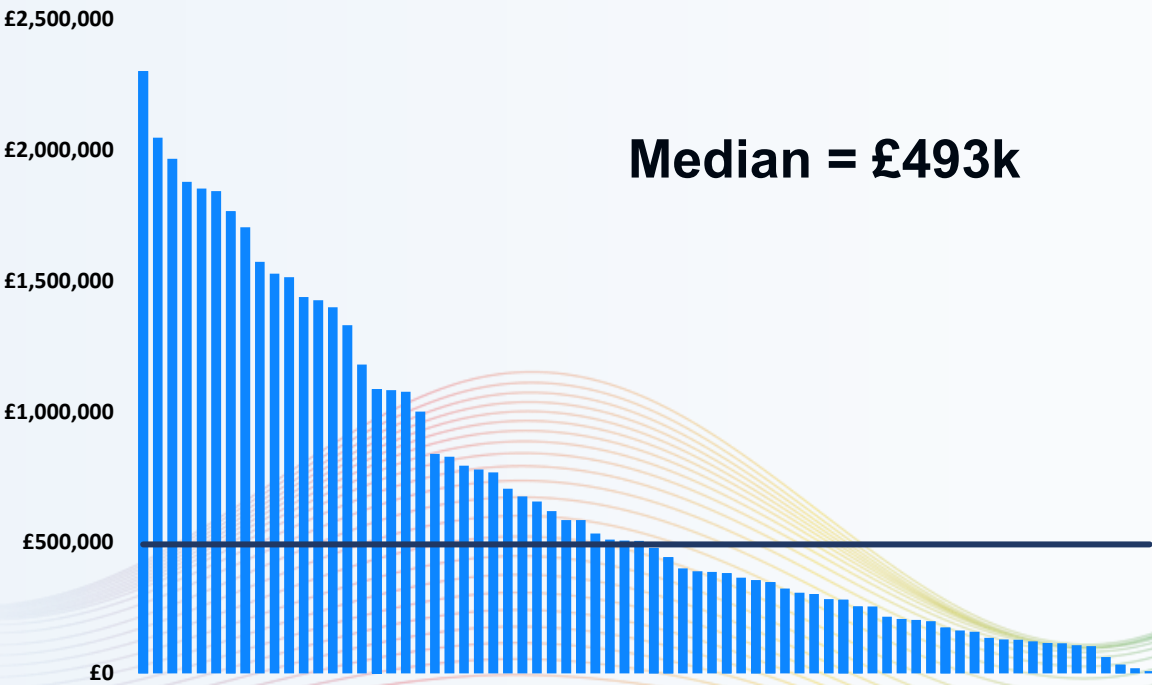
NHS Benchmarking Network
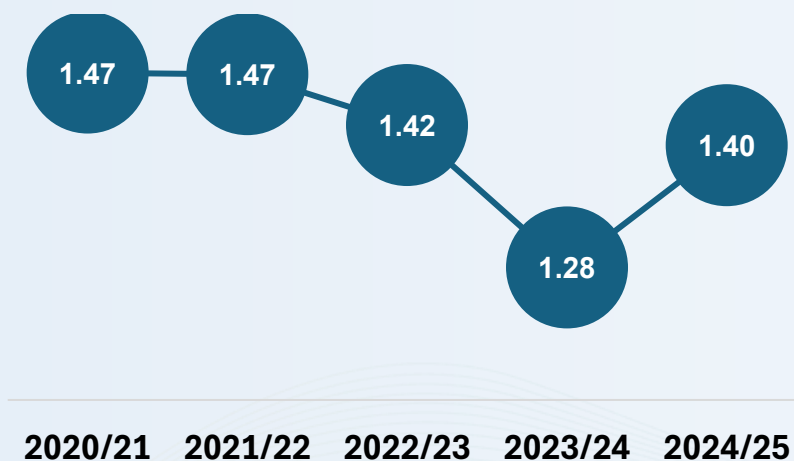
Harnessing the power of data to drive meaningful change
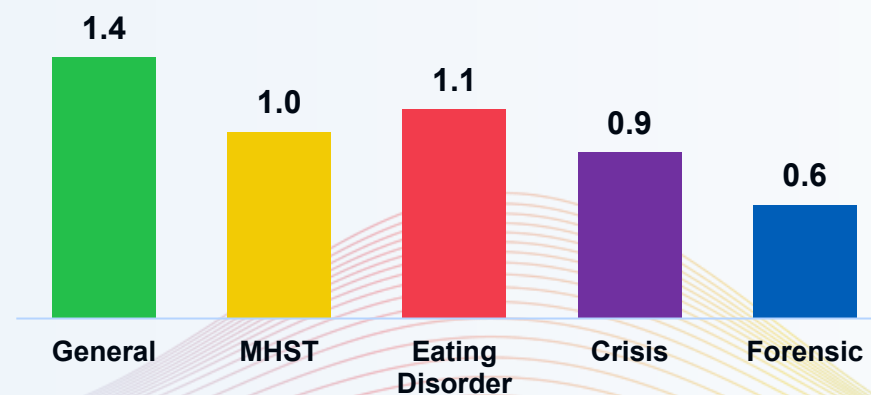
Average time on caseload before discharge (weeks)

General CYPMHS

| 36 | 36 | 37 | 36 |
| 2021/22 | 2022/23 | 2023/24 | 2024/25 |

2025 median by team type

| General | MHST | Eating Disorder | Crisis | Forensic |
| 36 | 16 | 36 | 3 | 37 |

Harnessing the power of data to drive meaningful change
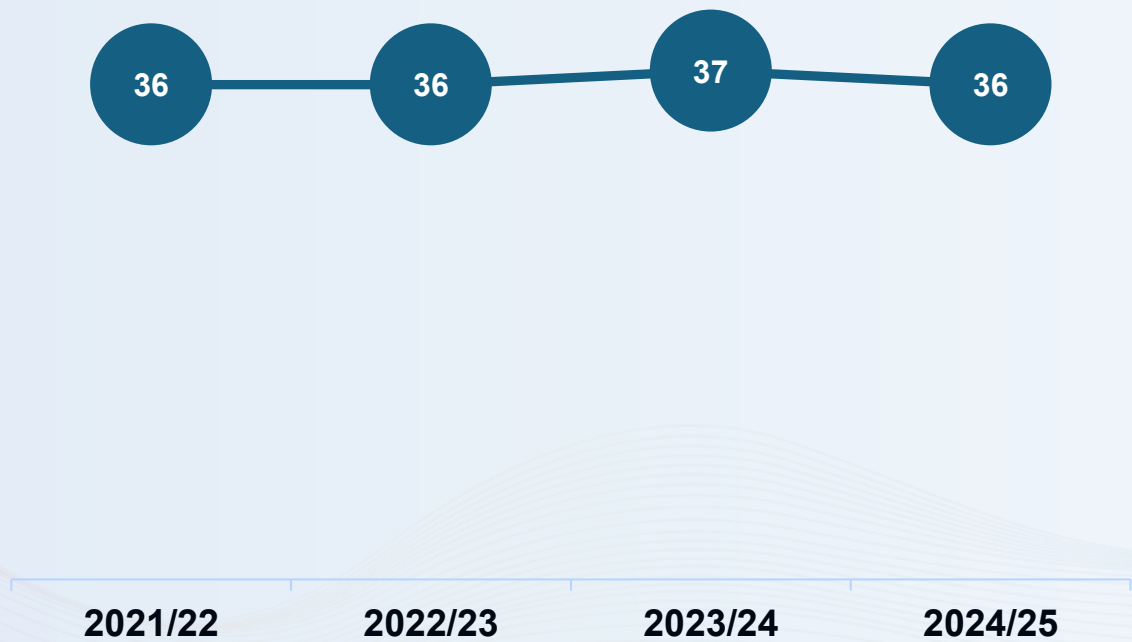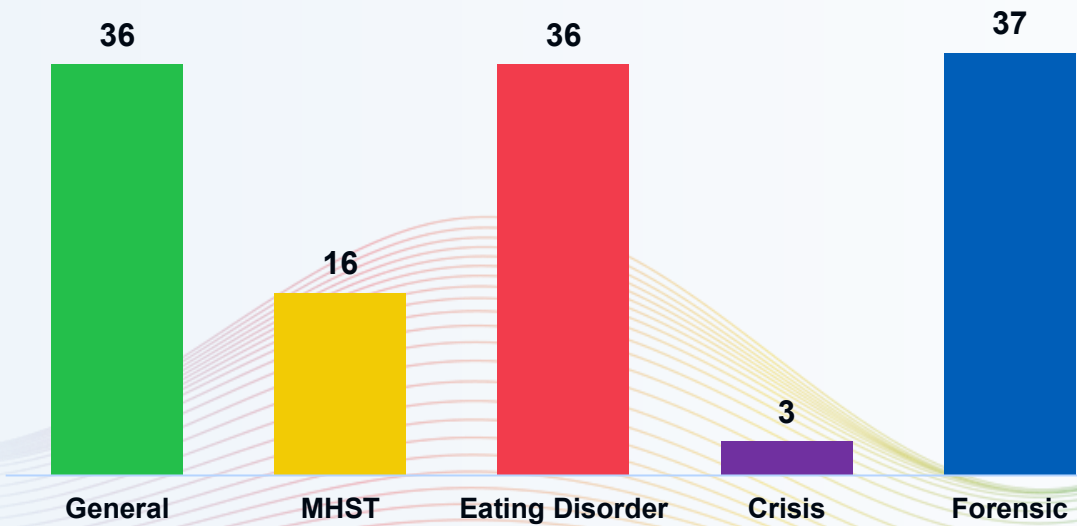
Inpatient CYPMHS Key Metrics

Bed type profile

Admissions – General admission adolescent

Admissions per 10 beds

2022/23	2023/24	2024/25
32	30	30

% of inpatient episodes where patient was detained under Mental Health Act at point of admission

2022/23	2023/24	2024/25
49%	60%	65%

Harnessing the power of data to drive meaningful change
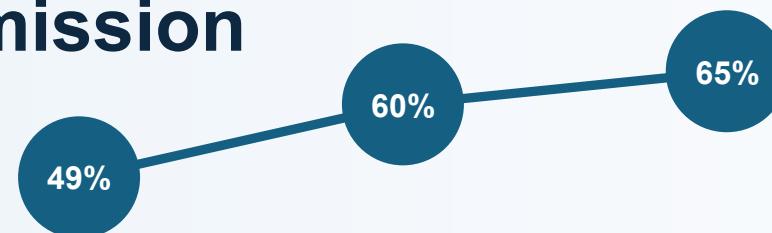
Length of stay and occupancy by bed type

Average length of stay excluding leave (days)

Bed type	Days
GA - Children	148
GA - Adolescent	78
Eating Disorders	122
PICU	77
Low Secure	729
Medium Secure	561

Bed occupancy rate excluding leave

Bed type	Rate
GA - Children	69%
GA - Adolescent	63%
Eating Disorders	60%
PICU	66%
Low Secure	62%
Medium Secure	46%

Harnessing the power of data to drive meaningful change
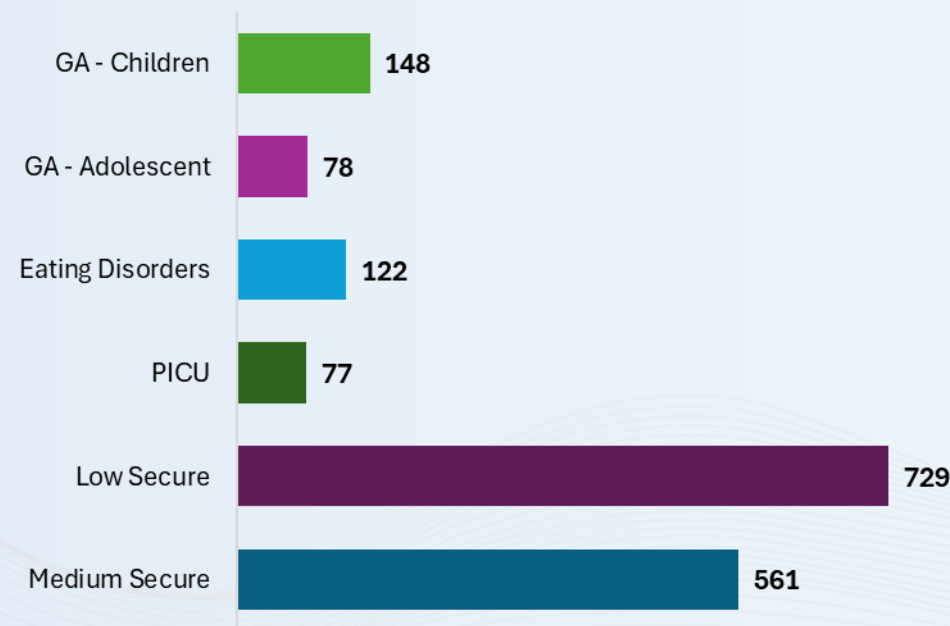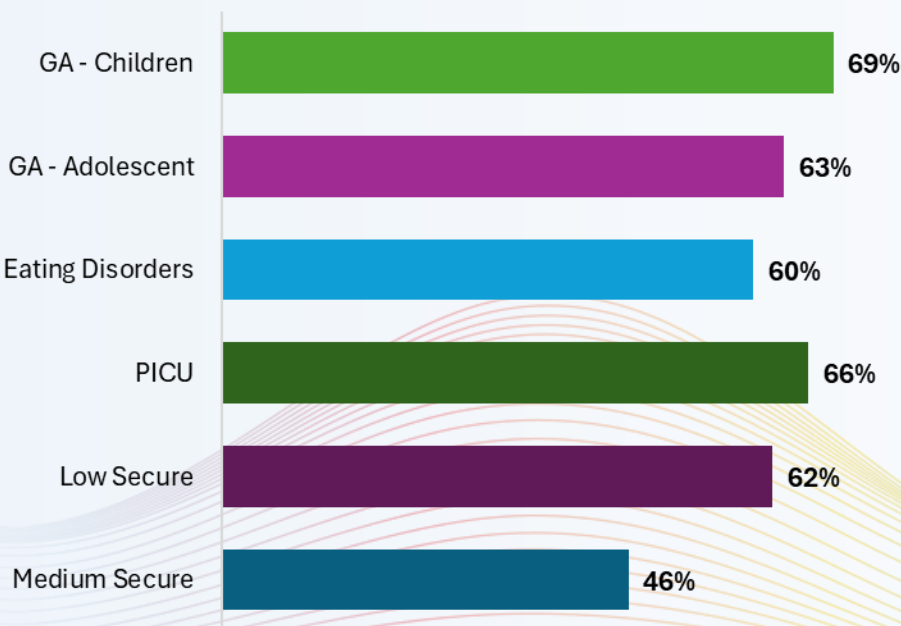
Length of stay and occupancy – General admission adolescent

Average length of stay (days)
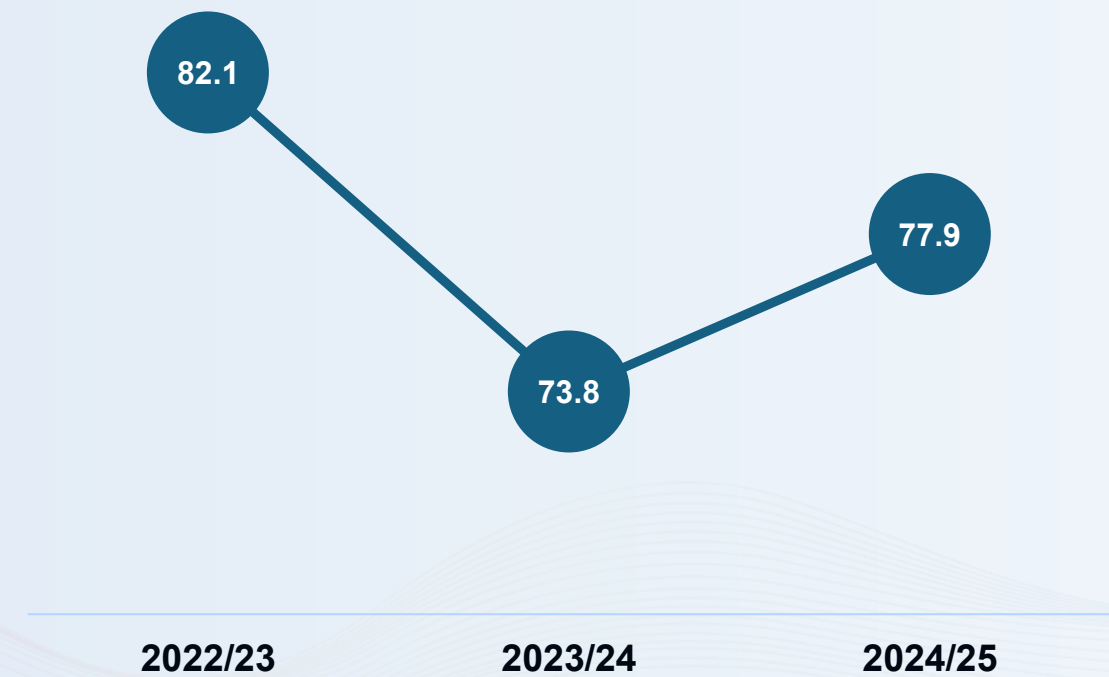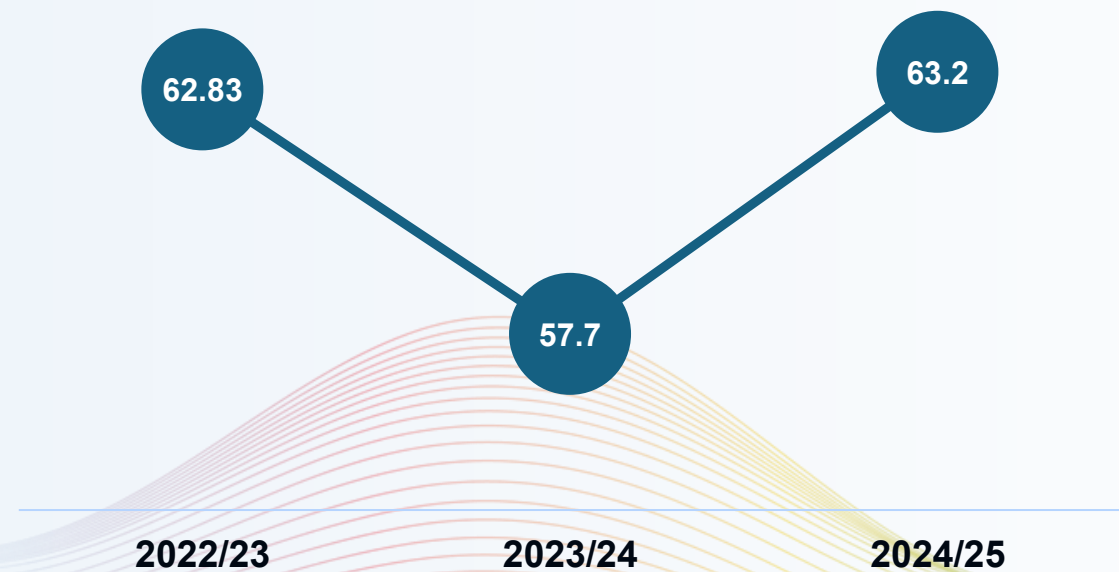
82.1 — 2022/23

73.8 — 2023/24

77.9 — 2024/25

Bed occupancy rate excluding leave

62.83 — 2022/23

57.7 — 2023/24

63.2 — 2024/25
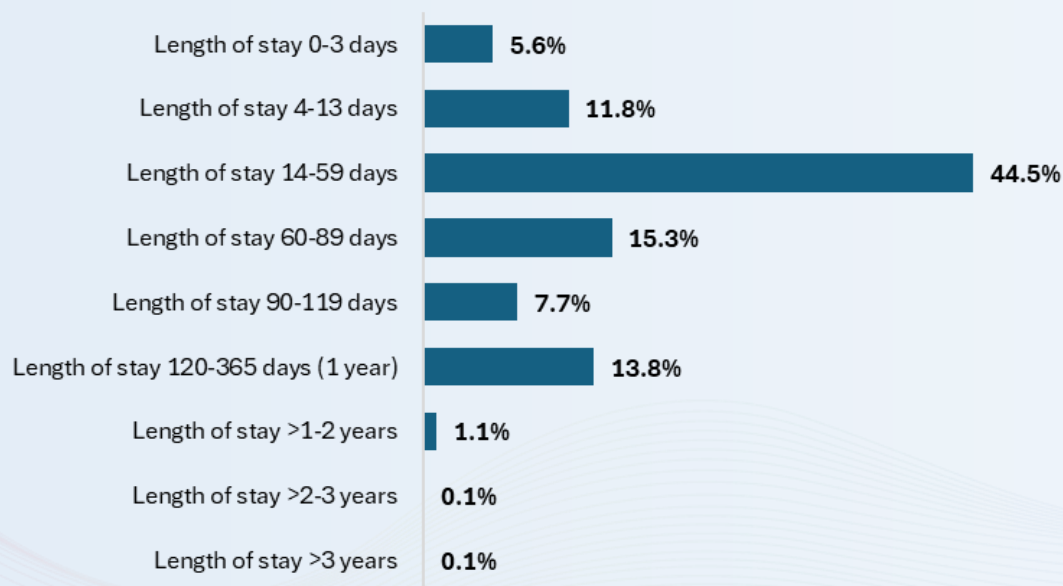
Harnessing the power of data to drive meaningful change
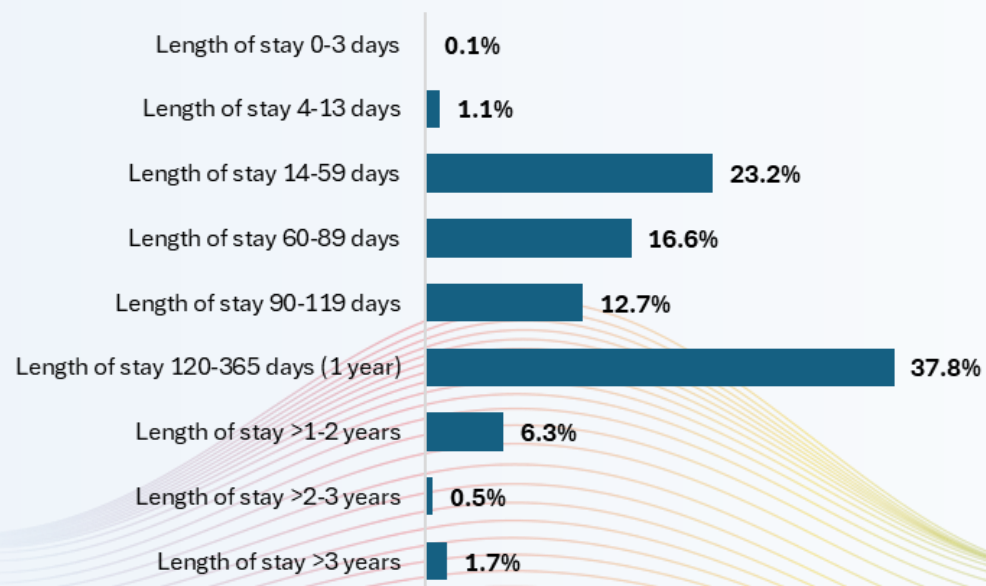
Use of restraint – median incidences per 10,000 occupied bed days

General Admission Children

- 2022/23: 1,247
- 2023/24: 1,182
- 2024/25: 554

General Admission Adolescents

- 2022/23: 784
- 2023/24: 919
- 2024/25: 802

Harnessing the power of data to drive meaningful change
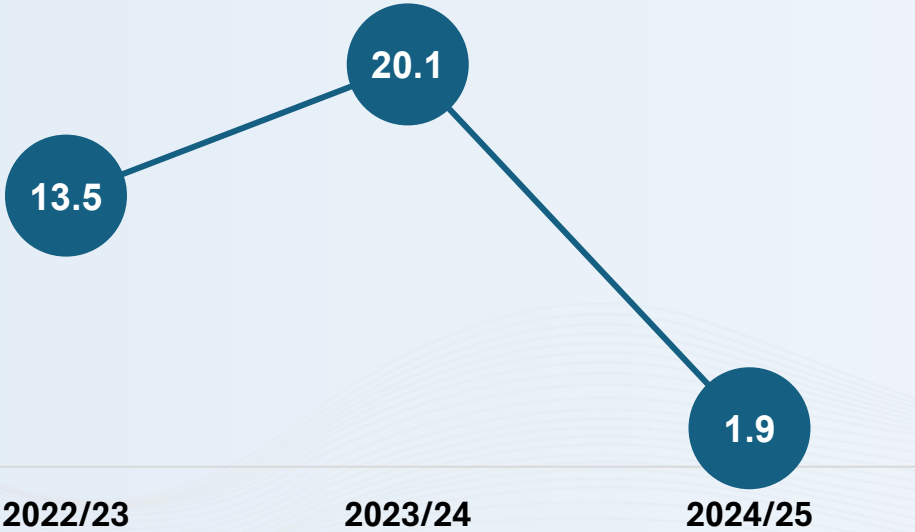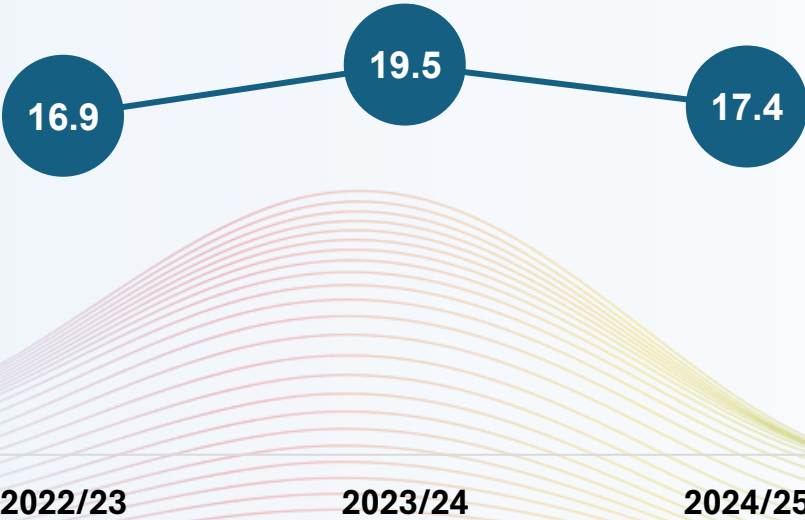
Workforce – General admission adolescent

Workforce per 10 beds

| 2022/23 | 2023/24 | 2024/25 |

38.2 — 38 — 35.3
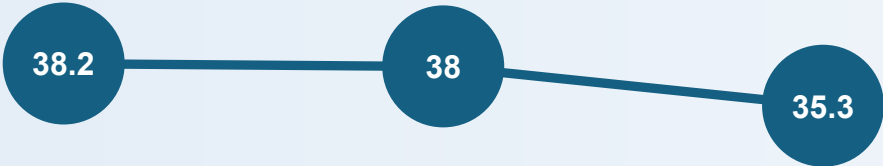
Vacancy rate %
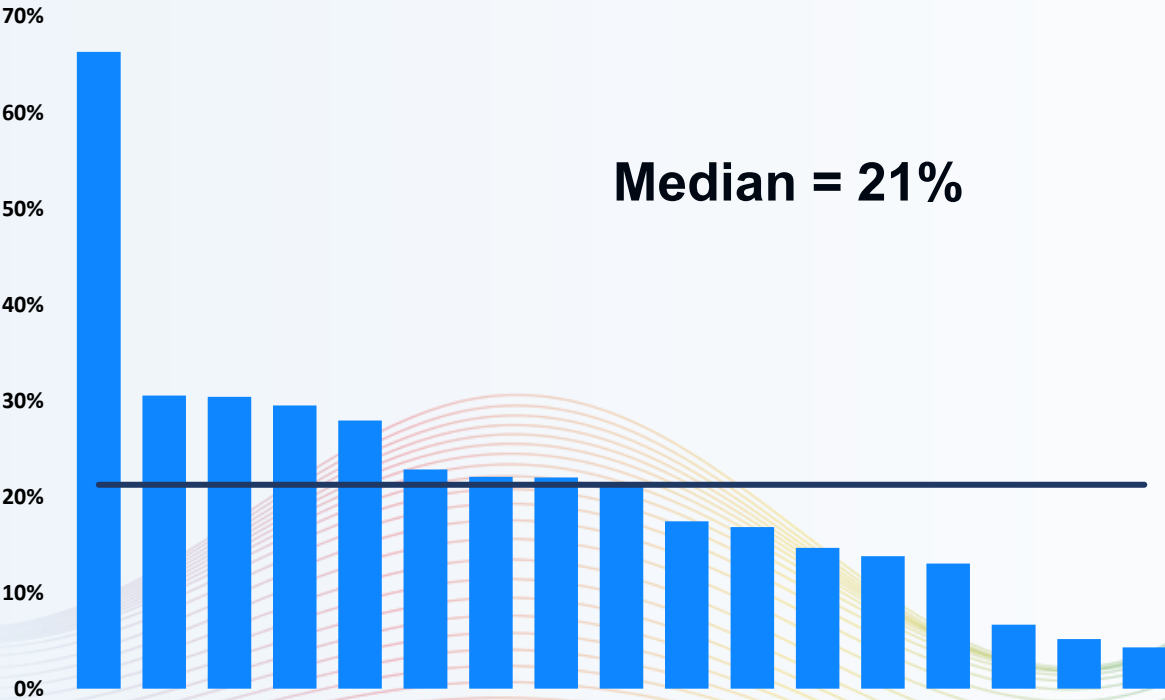
Median = 21%

Discipline mix – General admission adolescent

👤 = 5%

Nursing & Clinical Support	👤👤👤👤👤👤👤👤👤👤👤👤👤👤👤	73%
Allied Health Professionals	👤	4%
Medical Staff	👤	5%
Psychological Professions	👤	5%
Social Care & Community Roles	👤	1%
Administrative & Management	👤👤	9%
Other	👤	2%

Harnessing the power of data to drive meaningful change
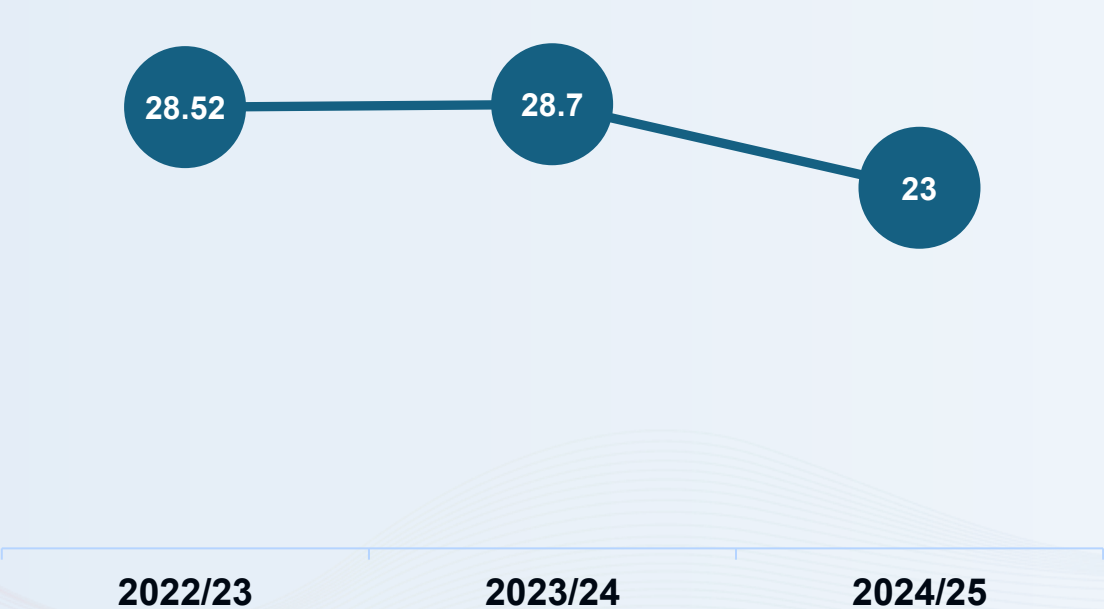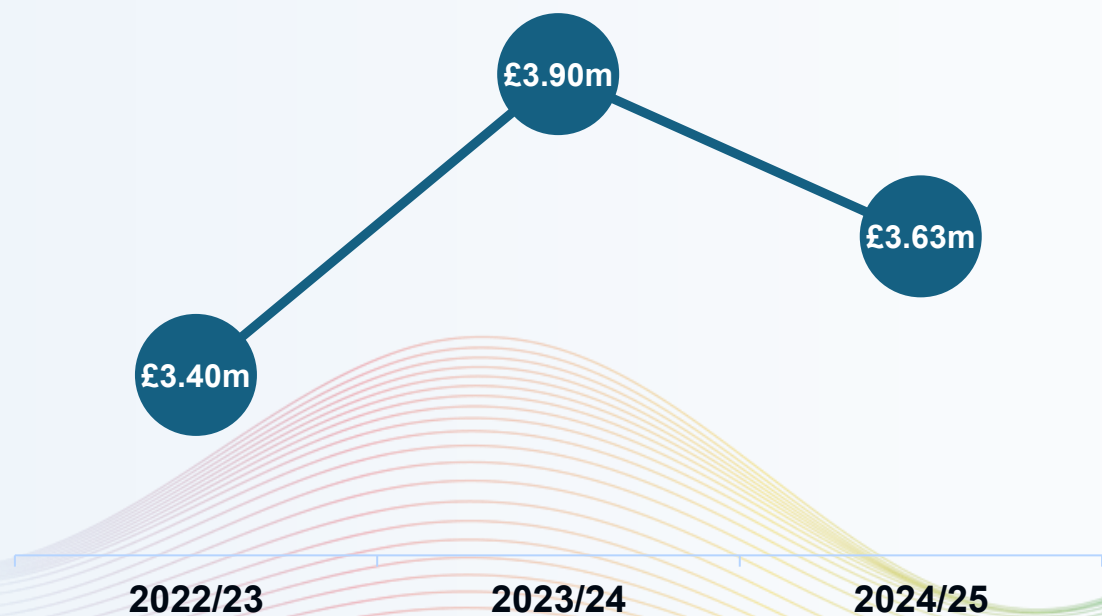
Health Inequalities in focus

Population ethnicity (outer ring) compared to totality of community and inpatient services' patients (inner ring)

Community
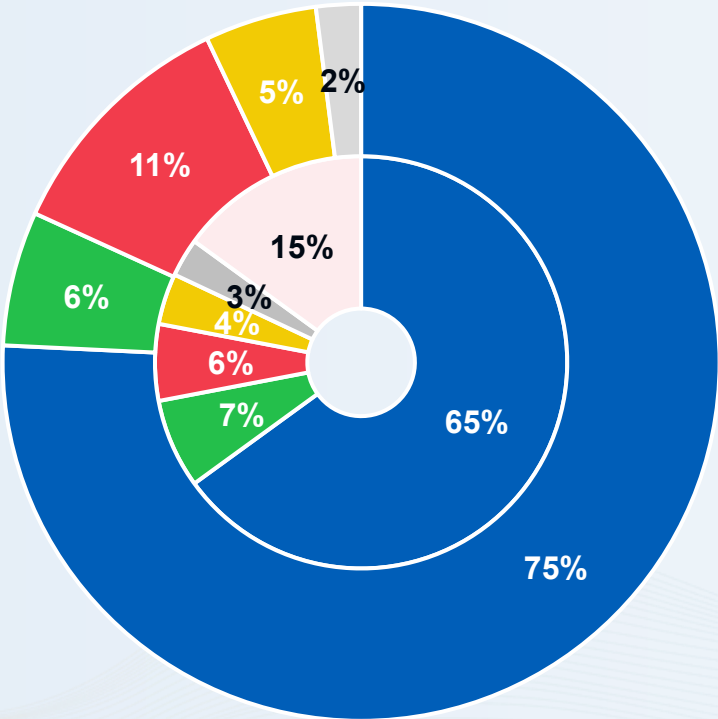
Inner ring: 65%, Outer ring: 75%, 7%, 6%, 4%, 3%, 15%, 6%, 11%, 5%, 2%

Inpatient

Inner ring: 57%, Outer ring: 75%, 4%, 7%, 8%, 4%, 19%, 6%, 11%, 5%, 2%

Legend:
- White/White British
- Mixed
- Asian/Asian British
- Black/Black British
- Other
- Not known/Not stated
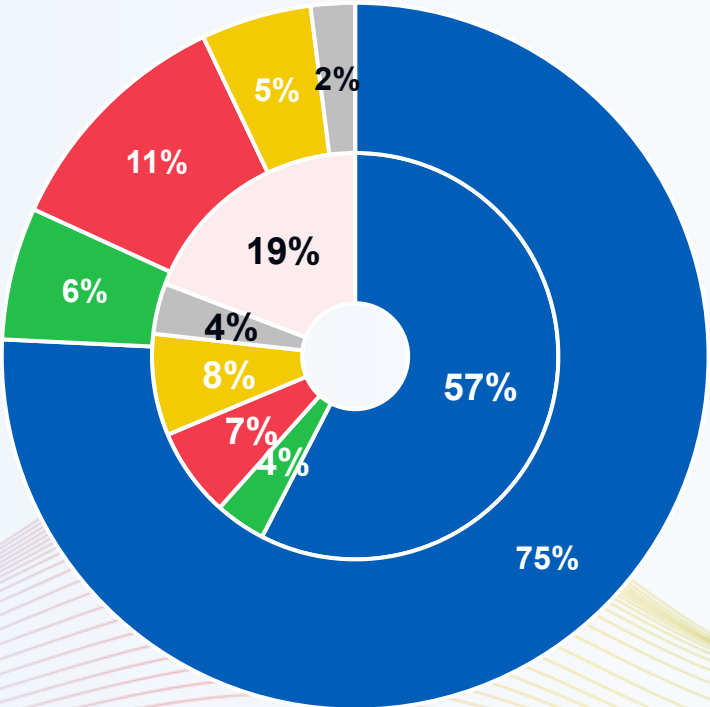
Ethnicity of patients on caseload by community team type

Team type	White/White British	Mixed	Asian/Asian British	Black/Black British	Other	Not known/Not stated
UK 0-17 population	75%	6%	11%	5%	2%	0%
General	65%	7%	5%	4%	4%	15%
MHST	73%	6%	6%	3%	3%	10%
Eating Disorders	70%	5%	5%	1%	2%	17%
Crisis	63%	5%	5%	3%	4%	20%
Forensic	68%	8%	2%	6%	1%	15%
Other specialist teams	64%	6%	8%	4%	2%	15%
ASD	51%	9%	16%	8%	5%	12%
ADHD	66%	7%	7%	3%	2%	16%
Other neurodiversity team	69%	6%	4%	1%	1%	19%

Harnessing the power of data to drive meaningful change

Ethnicity of patients admitted by inpatient bed type

Bed type	White/White British	Mixed	Asian/Asian British	Black/Black British	Other	Not known/Not stated
UK 0-17 population	75%	6%	11%	5%	2%	
General Admission (Children)	76%	5%		3%		17%
General Admission (Adolescents)	56%	4%	7%	8%	5%	21%
Eating Disorders	92%	2%	0%	6%		
PICU	45%	6%	12%	20%	6%	13%
Low Secure	100%					
Medium Secure	50%	14%	7%	14%	7%	7%

Legend: White/White British, Mixed, Asian/Asian British, Black/Black British, Other, Not known/Not stated

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Totality of community and inpatient services' patients by gender

Community

0%

48%

52%

- Male
- Female
- Non-Binary/Other

Inpatient

1%

36%

63%

- Male
- Female
- Non-Binary/Other

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Ethnicity of patients admitted by inpatient bed type

	Male	Female	Non-Binary/Other
General Admission (Children)	37%	61%	2%
General Admission (Adolescents)	34%	65%	1%
Eating Disorders	2%	98%	
PICU	57%	42%	1%
Low Secure		100%	
Medium Secure	93%	7%	

Male **Female** **Non-Binary/Other**

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

Does your system use flags for patients with a neurodevelopmental profile or diagnosed learning disability?

	Yes	No
General	36%	64%
MHST	40%	60%
Eating Disorders	37%	63%
Crisis	32%	68%
Forensic	40%	60%
Other specialist teams	35%	65%
ASD	29%	71%
ADHD	40%	60%
Other neurodiversity team	28%	72%

■ Yes ■ No

Harnessing the power of data to drive meaningful change
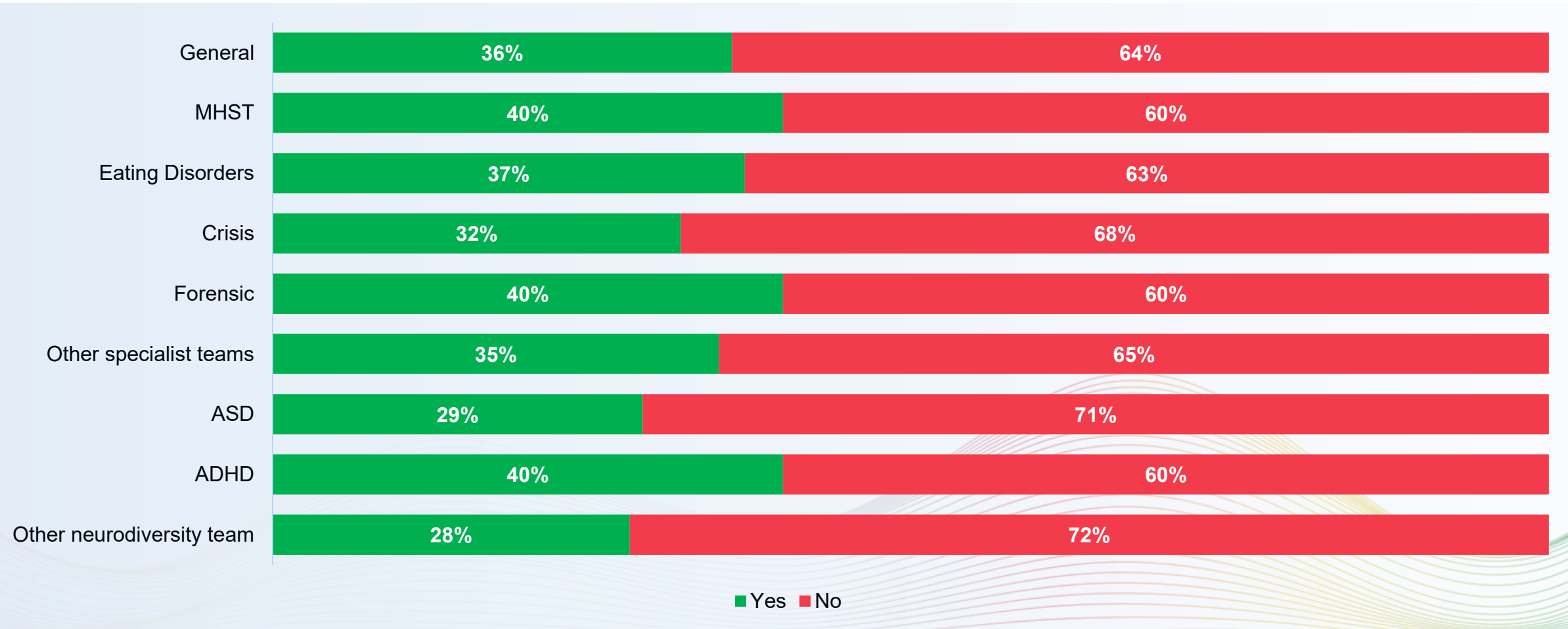
Median % of staff with up-to-date Oliver McGowan training
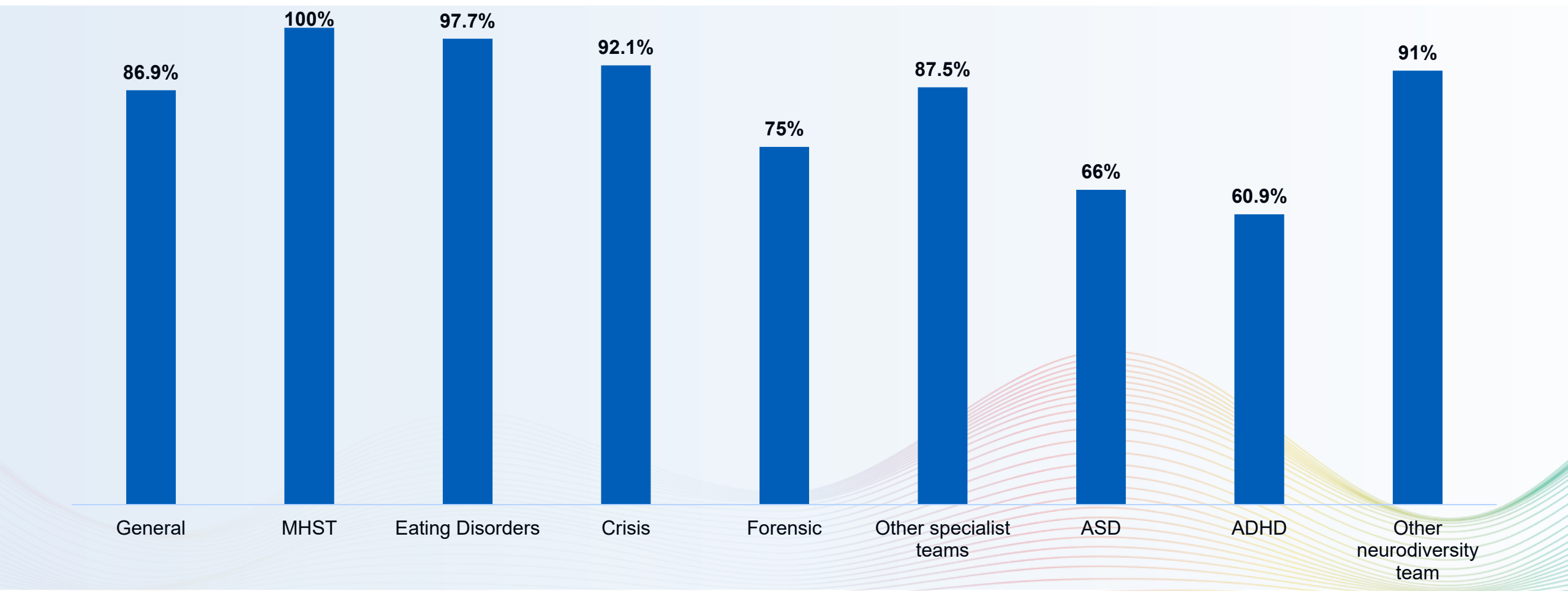
General	MHST	Eating Disorders	Crisis	Forensic	Other specialist teams	ASD	ADHD	Other neurodiversity team
86.9%	100%	97.7%	92.1%	75%	87.5%	66%	60.9%	91%

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

NACEL mental health spotlight audit

Joylin Brockett

Senior Project Manager - NHSBN

About NACEL

- An annual, national comparative audit of the **quality and outcomes of care** experienced by the dying person (18+) and those important to them.

- The overall goal is to improve the quality of care of the dying person and those important to them during the **last admission** leading to death.

- During 2025, NACEL is conducting a spotlight audit into the quality of care delivered in **mental health** inpatient facilities (previous was in 2021).

- The audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Governments of Wales and Jersey.

Audit aims:

- To improve quality of end-of-life care by identifying areas for action

- Reduce unwarranted variation

- Understand and reduce health inequalities

- Share and adopt best practice

About NACEL
Mental Health Spotlight Audit 2021

3. Recommendations

The findings from this first Mental Health Spotlight Audit (2021/22) have been reviewed by the NACEL Mental Health Reference Group who have formulated the following recommendations.

Integrated Care Systems/Health Boards, working with providers, should:

1. **Review local arrangements for integrated care for mental health patients with complex physical co-morbidities to ensure access to the right care in the right environment at the right time when they reach the end of life.** Mental health providers should work with their ICS and Health Boards to jointly develop pathways of care for those who are in mental health inpatient beds to ensure equity of access to specialist palliative care services.

Trust/Health Boards should:

2. **Ensure policies and guidelines are in place to support care planning for the** *Five Priorities for Care of the Dying Person*. Processes should be put in place to link policies and guidelines to frontline practice. In particular, staff should feel able to raise a concern about end of life care within their Trust/Health Board.

Chief Executives should:

3. **Ensure health and care staff, on wards more likely to care for patients at the end of life, have the appropriate training, managerial and emotional support to develop the competence and confidence to; recognise imminent death, communicate with the dying person and people important to them as early and sensitively as possible, and deliver end of life care.**

National Audit of Care at the End of Life
Mental Health Spotlight Audit
Summary Report
England and Wales
(2021/22)
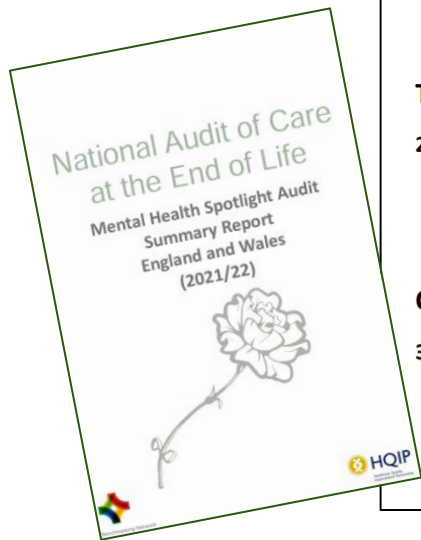
National Audit of Care at the End of Life 2025
Auditing last days of life in hospitals

www.nacel.nhs.uk/outputs

National Audit of Care at the End of Life 2021
Mental Health Spotlight Audit
Key findings at a glance

46 Trust/Health Board overviews (T/HB)
54 Hospital/site overview (H/S)
75 Case Note Reviews (CNR)
481 Staff Reported Measures (SRM)

(CNR – Cat 1₂) 75% — Case notes recorded that the patient might die within hours or days

(CNR – Cat 1) 98% — Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care

(CNR – Cat 1) 98% — Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die

82% — Case notes recorded an individualised plan of care

38% — Case notes recorded a preferred place of death as indicated by the patient

(CNR – Cat 1) 85% — Patient's hydration status was assessed daily once the dying phase was recognised

(CNR – Cat 1) 95% — Case notes recorded extent patient wished to be involved in care decisions, or a reason why not recorded

(T/HB) 100% — Trusts/HBs have guidelines for how to respond to/learn from, deaths of patients

(H/S) 44% — Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week

61% — Staff feel confident they can recognise when a patient might be dying imminently

48% — Staff felt supported by their specialist palliative care team

(SRM) 74% — Staff feel they work in a culture that prioritises care, compassion, respect and dignity

2. Category 1. It was recognised that the patient may die

About NACEL

National Audit of Care at the End of Life 2025
Auditing last days of life in hospitals
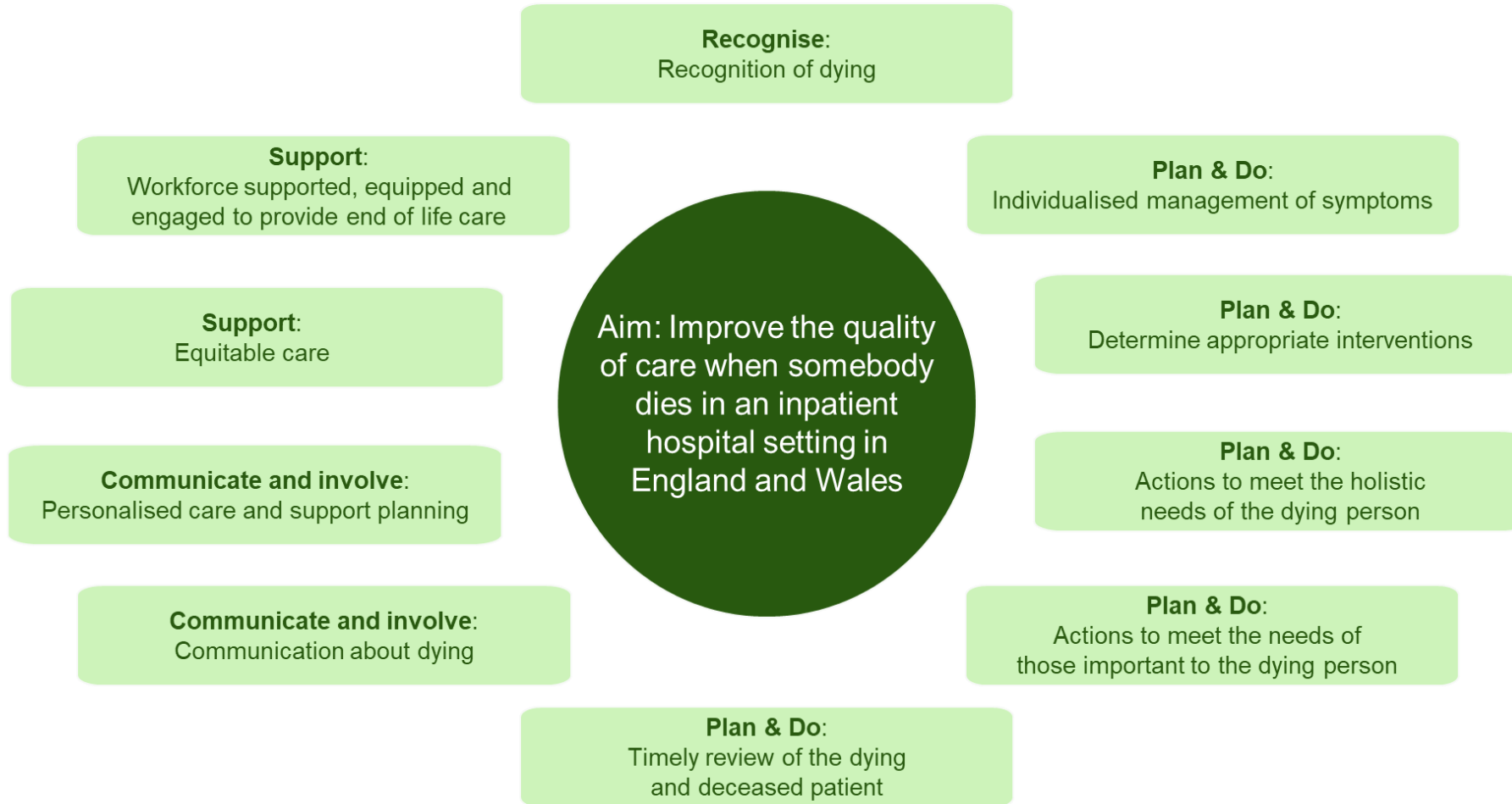
About NACEL

Support quality improvement

- **A State of the Nations Report,** with a summary of the key national findings and national recommendations.

- Findings at a local, regional, system and national level reported in an online, interactive **Data and Improvement Tool.**

- A series of **webinars** held to share quality improvement ideas and celebrate success, as well as sharing QI resources on the website

- **A Good Practice Compendium** published to share local examples of improvement initiatives in end of life care, and more…

- **Dataset** will be available for public benefit e.g research via HQIP's Data Access Request Group (DARG).

National Audit of Care
at the End of Life 2025
Auditing last days of life in hospitals

Measurement without improvement wastes time and money
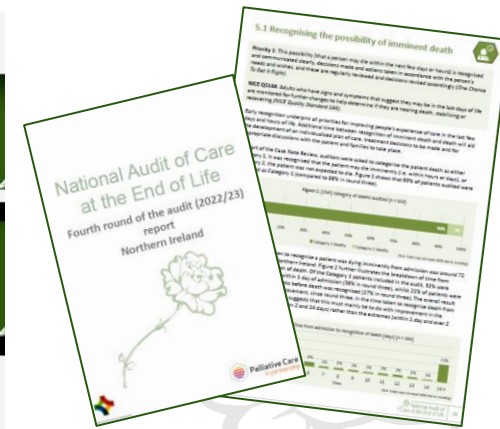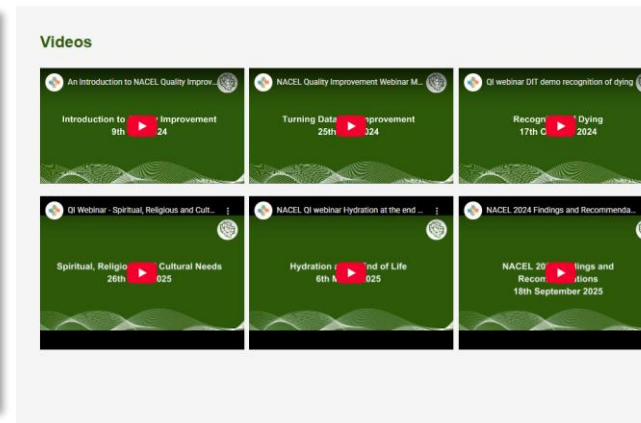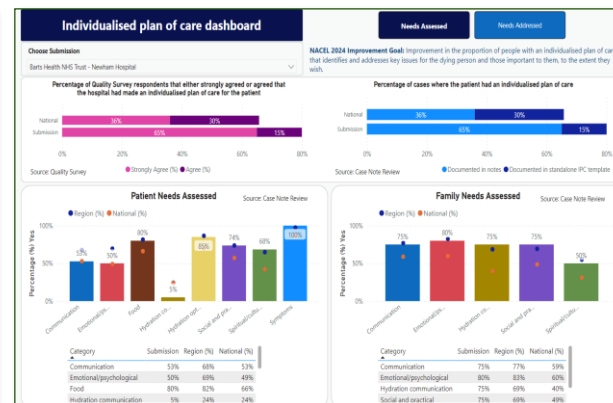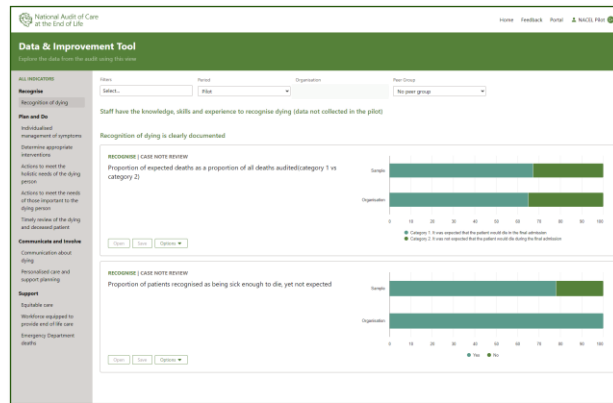
Spotlight Audit

Audit elements

Case Note Review: A review of patient notes
(DC: 20th January 2025 – 16th January 2026)

Staff Reported Measure: Online survey for those most likely to interact with dying patients
(DC: 20th January 2025 – 31st December 2025)

Trust/Health Board Overview: Specific questions pertaining to the Trust/Health Board
(DC: 1st July – 30th September 2025)

Annual death data collection: Specific questions pertaining to the number of deaths in the year
(DC: 1st January 2026 – 28th February 2026)

Data submitted via NHS Benchmarking Network Members' area

National Audit of Care at the End of Life 2025
Auditing last days of life in hospitals

Where are we in the audit cycle?

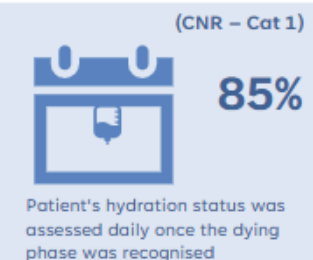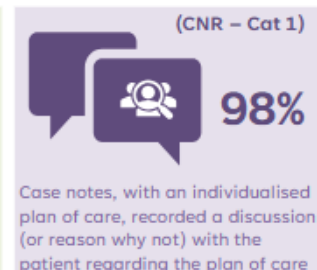|		2025												2026							
		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Case Note Review		Data collection													Local Outputs						SoN Report & GPC
Staff Reported Measure		Data collection																			
Trust/ Health Board Overview							Data collection													
Annual Death Data Collection														■							
Task and Finish Group meeting						■						■			■						
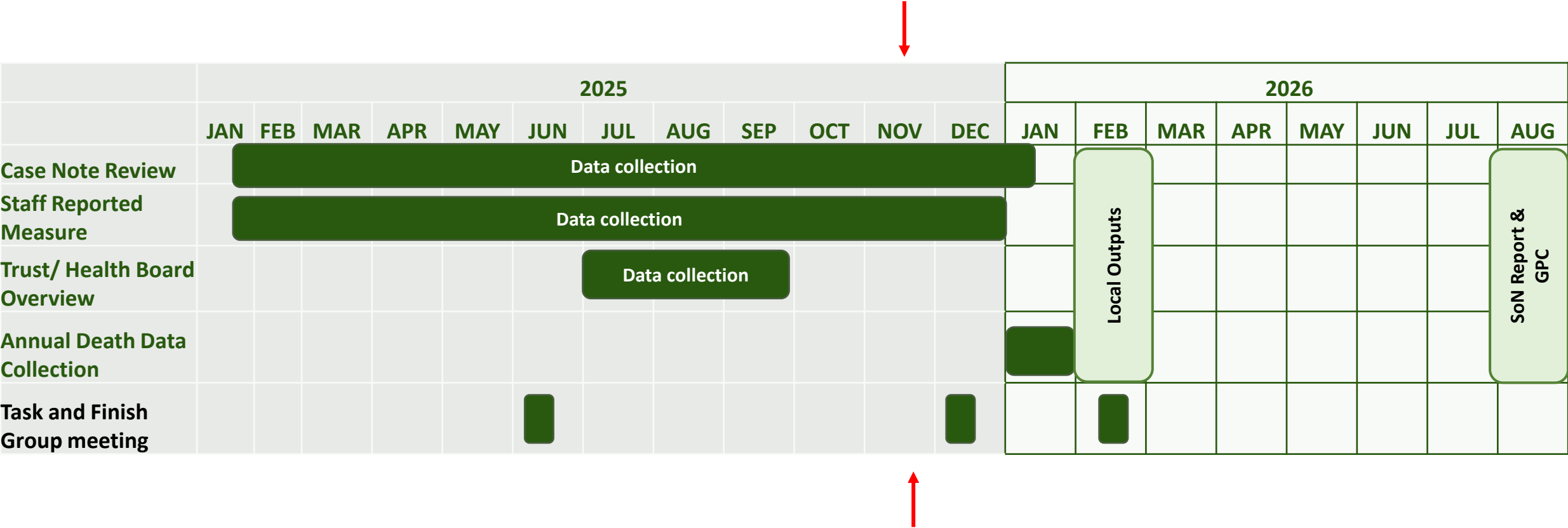
Full timescales available [here](#)

National Audit of Care
at the End of Life 2025
Auditing last days of life in hospitals

Participation in the 2025 Spotlight Audit

58 Mental Health Trusts across England and Wales are registered to participate.

53 Trust/Health Board Overviews (HSO) — *Closed*

429 Staff Reported Measure (SRM) — *Open until 31st December 2025*

80 Case Note Review (CNR) — *Open until 16th January 2026*

- Annual death data collection — *Opens 1st Jan – 28th Feb 3036*

There's still time to take part

National Audit of Care at the End of Life 2025
*Auditing last days of life in hospitals*

Next steps

How to get involved?

1. Check whether your Trust is actively participating in NACEL and are on track to submit by:
   - Staff Survey - 31st December 2025
   - Case Note Review – 16th January 2026
   - Annual death data collection – 28th February 2026

2. Look out for the release of local outputs in February 2026 and the State lof the Nation Report in August 2026

3. Review the NACEL Portal, sign up to our events, use the QI resources

National Audit of Care
at the End of Life 2025
Auditing last days of life in hospitals

Welcome to the NACEL Portal
England, Wales and Jersey

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Jersey.

Go to NACEL Northern Ireland →

About NACEL

NACEL is the National Audit of Care at the End of Life, supporting improvements by collecting and analysing data to highlight good practice, address gaps, and promote compassionate, evidence-based care.

About the Audit

Jump to: Frequently Asked Questions

For Professionals

Resources, guidance and tools to support health and care professionals taking part in NACEL. Access methodology documents, timelines, and support materials to engage confidently and contribute effectively to improving end-of-life care.

Participate in the Audit

Jump to: Audit Guidance

For Patients & Carers

Information for patients and carers about NACEL. Learn how the audit works, how feedback from families helps shape services, and how your experiences contribute to improving end-of-life care nationwide.

Learn more

Jump to: Patient and Carer Voice

Northern Ireland

NACEL Northern Ireland is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals and community hospitals in Northern Ireland.

Go to NACEL Northern Ireland

Mental Health Spotlight

The Spotlight Audit will review the quality and outcomes of care experienced by the dying person (18+) and those important to them during the last admission to a mental health inpatient facility in England, Wales and Jersey.

Learn more about the Spotlight

www.nacel.nhs.uk

National Audit of Care at the End of Life

About   For Professionals   For Patients and Carers   Results and Reports   News   Northern Ireland

For Professionals

📅 Key Dates   🖥 Events

Data Collection

Patient demographics

1 There are two categories of deaths for patients included in the audit. Indicate whether for this patient:

* Please answer the above question, ensuring the response is accurate. This measure will be analysed in Outliers policy.

2 For Category 2 deaths only: Was it recognised that the patient was sick enough to die during the final admission?

3 Age (at the time of death)

4 Ethnicity

Data collection guidance for all acute and community organisations in England, Wales and Jersey looking to take part in the audit.

[Data Collection Guidance](#)

Data Collection Login ↗

Data & Improvement Tool

Sample (%) is average of all data for the Acute site type

Peer group (%) is average of the data in the Acute site type in London

Bereaved people who strongly agreed or agreed that the person who died had these aspects are undertaken

1. Support to drink or receive fluid if they wished
2. Support to eat or receive nutrition if they wished
3. Enough pain relief
4. Enough relief of symptoms other than pain

Source: Bereavement Survey

The Data & Improvement Tool (DIT) is a new platform has been developed to display results of the audit, in a user-friendly, interactive tool.

[Data and Improvement Tool Guidance](#)

Data & Improvement Tool Login ↗

Quality Improvement

1 Identification of a quality issue

Stakeholder identification
Consider sustainability evaluation here

2 Understanding the current situation/problem

Stakeholder Analysis / Fishbone Diagram
Driver Diagram / Process Map

Stage 1: Identificat...
Tools:
Stakeholder mappin...
NHS Sustainability r...
Alternative sustainab...

Stage 2: Understan...
Tools:
Stakeholder mappin...
Fishbone diagram (S...
Driver Diagrams (Sc...
Process mapping (S...

There have been many fantastic Quality Improvement (QI) efforts from participating organisations and NACEL is keen to support these.

[Good Practice Compendium](#)

Learn more about QI

www.nacel.nhs.uk

Contact the NACEL team

You can get in contact with the NACEL team at:

✉ nhsbn.nacelsupport@nhs.net

☎ 0161 521 8274

Visit the website at www.nacel.nhs.uk

Visit the mental health spotlight audit pages at: https://www.nacel.nhs.uk/mental-health-spotlight

National Audit of Care at the End of Life 2025

Auditing last days of life in hospitals

Stepped care system transformation in Wales

Sarah Harte

Implementation & Service Delivery Manager – Stepped Care Solutions

About Stepped Care Solutions

We are a mission-driven not-for-profit, committed to principles that support the **transformation** of mental health and substance use health systems for **better access and outcomes**.

We are the creators of Stepped Care 2.0® (SC2.0)

SCS exists to help organizations and communities **reframe**, **rethink**, and **redesign** the delivery of mental health care services.

We are a global team across a range of disciplines.

OUR VISION

WELLBEING EVERYWHERE

Stepped Care
Solutions

What we do: Mental health system transformation for better access and outcomes

System design and strategic planning

Implementation and change management support

Coaching and Training

Co-design and engagement

Digital innovation

Evaluation and data-informed decision making

We are recognized for our:

- Clinical expertise
- Implementation success
- Digital innovation experience
- Leadership in transforming mental health and substance use health systems

Our approach:

- Building from existing strengths, expertise and capacity
- Collaborative, flexible, and tailored planning
- Data-informed, iterative process

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The Case for Change in Wales

- More people seeking mental health support means more people are using services, and the **demand for services is exceeding what is available.**
- Experiences and outcomes for people in Wales **vary considerably.**
- Workforce issues such as **recruitment, retention and development,** remain a challenge.
- There are extremely **limited funding opportunities** available in the current financial climate – impacting the quality of elements such as estates and digital offers.

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Wales is Not Alone!

Long waitlists	Quick and easy access to different resources and services
Barriers to care	A care-first approach that puts people's needs first and recognizes their strengths and capacities
Services are often disconnected and hard to navigate	A framework for organizing services in a way that promotes collaboration and easier navigation
Limited data at all levels	Data is collected and used to make decisions, leading to more flexible, person-centric services and improved outcomes
Workforce shortage and burnout	An expanded and diverse workforce with a community-wide approach

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In Spring 2025, Welsh Government published the **Mental Health and Wellbeing Strategy 2025-35**.

Vision statement 4 of the strategy sets out ambitions where **"there are seamless mental health services – person centred, needs led, and guided to the right support first time, without delay."**

All Age Mental Health and Wellbeing Strategy 2024-34, Vision 4

Seamless mental health services

Person-centred and needs led

Guided to the right support first time and without delay

SC2.0®: A framework to underpin flexible, open access care

- **Provides rapid access** to a range of mental health resources and supports across a full continuum of care

- **Responsive and adaptive**; is designed to enable service provision that best meets the diverse needs of individuals and communities

- **Recovery and resilience approach**; recognizes that individuals can take ownership of their mental health, and their mental health journey is unique

- **Incorporates technology-based programs** that are efficient and effective

- **Proven outcomes and benefits** for both service users, service providers and at the system level

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Stepped care models

Stratified Models

People are assigned to a level of care based on symptom severity and functioning (e.g. low symptom severity = low intensity intervention).

(National Institute for Health and Clinical Excellence, 2011).

Progressive Models

People start with lowest level of intervention and progress to higher levels of intensity as required.

(National Institute for Health and Clinical Excellence, 2011).

Stepped Care 2.0® Model

Decision making about service is based on the person's readiness, preferred level of autonomy and preference.

(Cornish, P., 2020)

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Components that support system design

➔ Co-designed with people holding diverse perspectives

➔ A range of diverse services are included

➔ Distributed management of risk

➔ Continuous improvement

➔ Recovery-oriented

Components that support client experience

➔ Care is person-centric and collaborative (not a one-size fits all approach)

➔ Services are flexible, and data-informed

➔ Access to same-day support

➔ A one-at-a-time approach, ensuring a helpful intervention at each interaction

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180

SC2.0 system planning framework
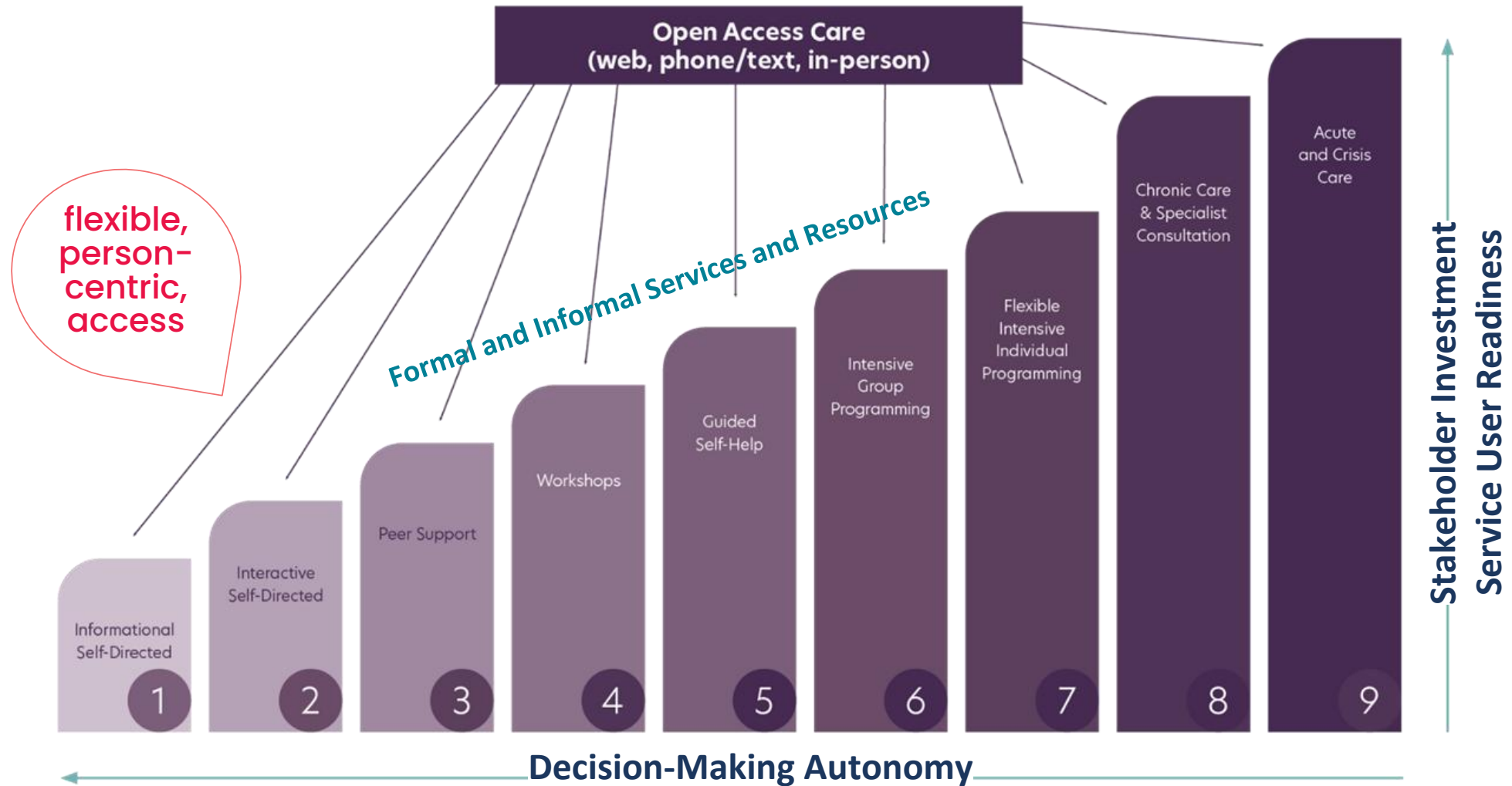
Examples of SC2.0 models

Examples of SC2.0 models

Wellness Together Canada

SC 2.0 Implementation roadmap

Non-linear phases that support practical starting points and ongoing improvement

Building Readiness

Establishing a solid foundation for ongoing changes

Ongoing Implementation and Improvement

What felt new is now integrated into usual practice
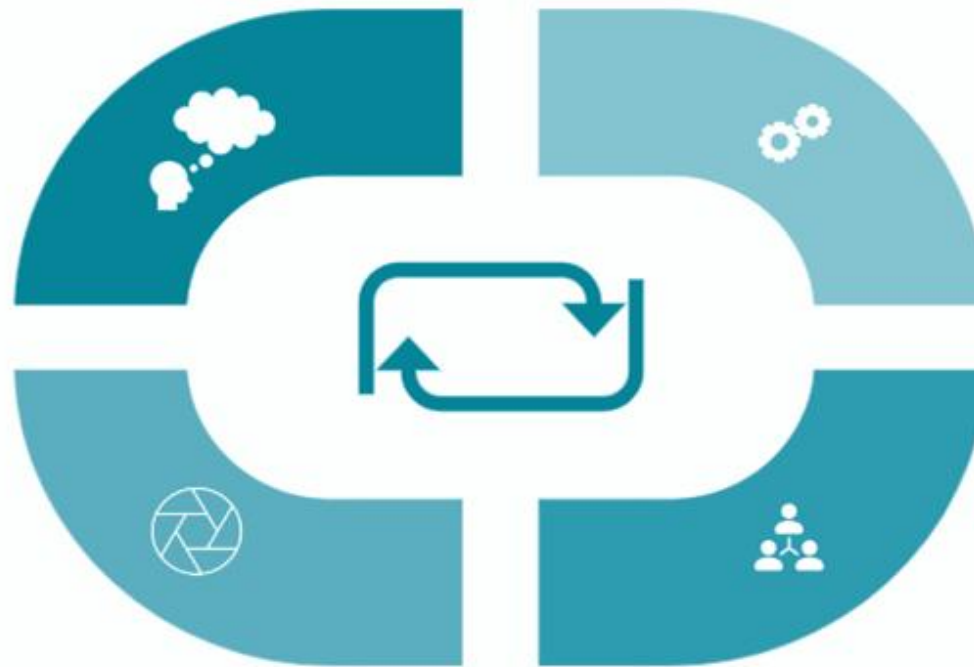
Preparing for Success

Defining and planning the system of care, and assembling the necessary resources and infrastructure

Starting to Implement

Starting small, collecting data and improving

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Evaluation Framework

Data-informed decisions at the **client**, **agency** and **system** level enable the execution of a system wide evaluation.

Plans for a national evaluation of the system transformation in Wales are in development.
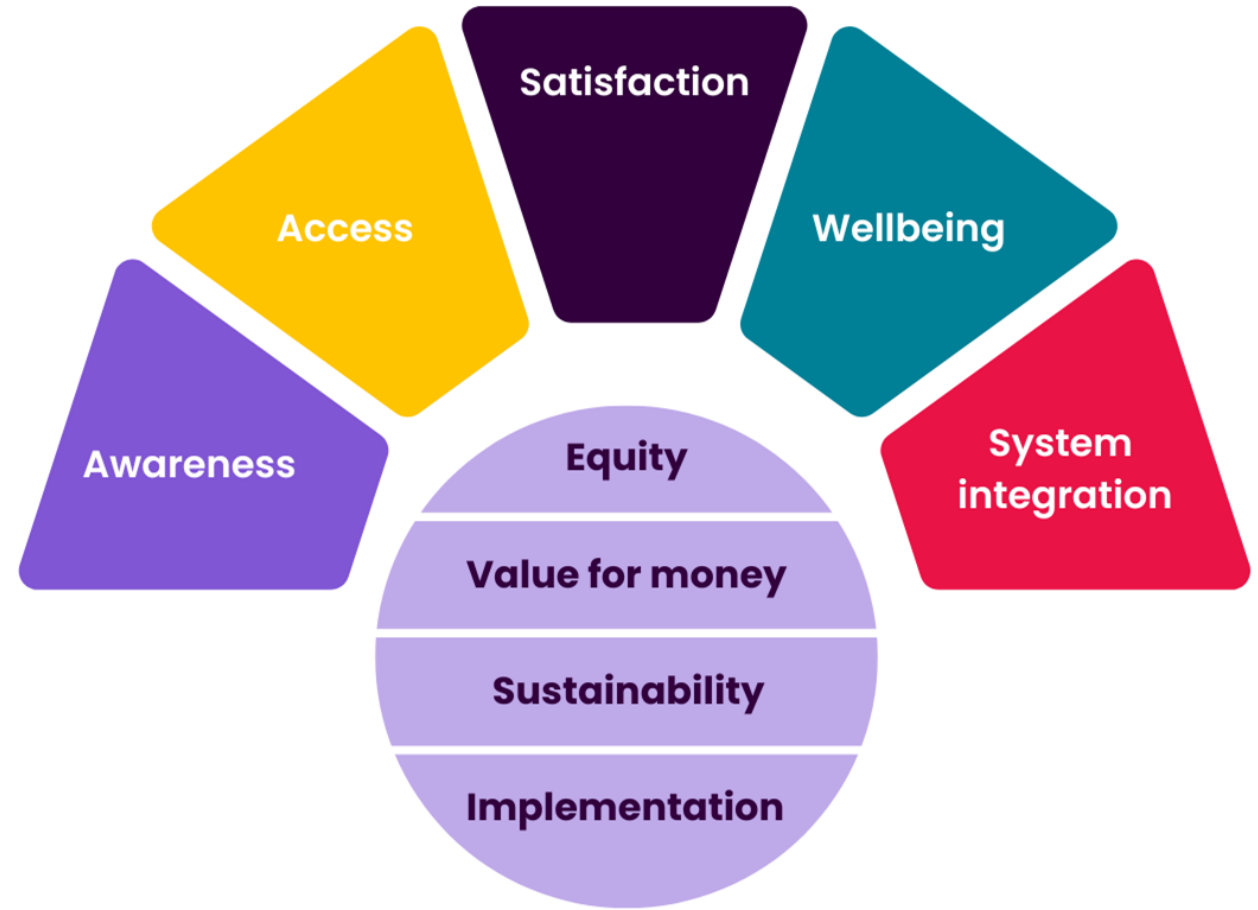
Data-Informed Decision Making in the Context of SC2.0

- **DIDM Definition: The use of routinely collected data for self-monitoring and to inform individual and collaborative care decisions, as well as system level development and improvement.**

- **DIDM and SC2.0 principles:**
  - Increases mental health literacy
  - Empowers people to manage and take action on their mental health
  - Supports client-centric and collaborative care
  - Enables trial and error and adaptation at individual and system level
  - Present a pathway towards social justice and health equity

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Data-informed Decision Making:
Five essential elements

Routine

Person Centered

Across the Continuum

Facilitated by technology
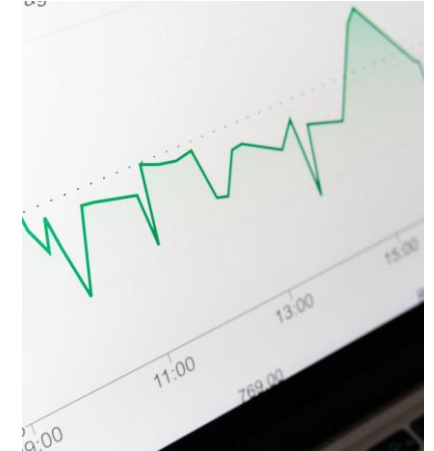
Includes multiple types of data

"It's given me the push I need to get help with my mental health, after being able to see trends in the self-assessment and working on those areas." (Sky*, age 20, Ontario)

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Process in Wales Thus Far

1. Two years of extensive community engagement.

2. Development of a new 10 year Mental Health Strategy, supported by a 3 year implementation plan.

3. Continued community engagement and co-design of their model.

4. Development of a national implementation roadmap.

5. Beginning implementation with demonstrator projects, focusing on a flexible and person-centric front door to services.

System Impacts of SC2.0

Wait Times
Reduced by 68-79%, sometimes eliminated
(MHCC, 2019; MHCC.,2023; Harris-Lane et al. 2022)

Access
Improved immediate support
(SCS, 2022; Cornish et al, 2017)

Cultural Sensitivity
Adaptive and sensitive to cultural differences
(Goodman, 2021; MHCC, 2023)

Attendance
Increased appointment attendance
(Cornish et al., 2017)

Reduced crises
Decreased incidence of hospitalization and crisis sessions (University of Northern Iowa, 2024; San Jose State University, 2024)

Satisfaction
High rates among service users (65-92%)
(Goodman, 2021; Harris-Lane et al, 2022; MHCC, 2023)

Implementation
Increased number of OAAT sessions year over year (Brieba et al, 2023)

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System Impacts of SC2.0

"Most impactful change to the organization in more than a decade."
(UC Berkeley Manager)

"One of the greatest benefits of this system is the capacity for flexibility and responsivity"
(Executive Director, University of Toronto Health & Wellness)

"It's given me a sense of pride to work in a system that allows me to help in an efficient and effective manner. We are here when you need us, not several months from now."

(Provider, New Brunswick)

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System Impacts of SC2.0

"Much more satisfaction and feel like I am making a difference today"

(Provider, New Brunswick)

"They are coming in, we're helping them, they're leaving feeling better. That's the whole point of what we're doing"

(Provider, New Brunswick)

"One of the greatest benefits of this system is the capacity for flexibility and responsivity"

(Executive Director, University of Toronto Health & Wellness)

"Everyone gets priority now... not just clients in crisis"

(Social Worker, Newfoundland)

Stepped Care Solutions

Thank you!

Learn more about SCS and SC2.0®:

🌐 SteppedCareSolutions.com

💼 linkedin.com/company/sc2-0-stepped-care-solutions-inc

▶️ @steppedcaresolutions

Stepped Care Solutions

Comfort break –
see you back here at 14:40

Time	Session	Speaker
14:40	Mental health pharmacy 2024/25 benchmarking findings	**Stanley Fleming** – Project Manager, NHS Benchmarking Network
15:00	MHLDA indicators benchmarking project	**Daniel Iyoha** – Project Manager, NHS Benchmarking Network
15:30	Spotlight on neurodiversity services	**Alison Worden** – Project Manager, NHS Benchmarking Network

NHS
Benchmarking Network

Harnessing the power of data to drive meaningful change

Mental health pharmacy 2024/25 benchmarking findings

Stanley Fleming

Project Manager - NHSBN

Project context

History
- Previously benchmarked in 2014 – 2016 as part of Pharmacy & Medicines Optimisation
- Interest from providers of MH Pharmacy in the South of England
- Scoping completed between Nov 2024 and March 2025

The project
- Focus on pharmacy workforce supporting community and inpatient mental health services
- The data shown is for the 1st April 2024 to 31st March 2025 period
- Bespoke reports were issued at the end of October

Participation
- Submissions received from 40 providers across England and Wales
- Interest from other devolved nations and crown dependencies

The sample
The data shown represents:
- Total of **1,863** WTE pharmacy staff in post as at 31st March 2025
- **757.8** WTE dedicated to supporting inpatient services
- **319.5** WTE dedicated to supporting community services

Harnessing the power of data to drive meaningful change

Background

1	**2014**
2	2018
3	2018 - Present
4	2024 - Present

Pharmacy & Medicines Optimisation:

- First iteration

- Acute, Community and Mental Health

- High level data specification

Harnessing the power of data to drive meaningful change

Background

1	**2014**	**Pharmacy & Medicines Optimisation:**
2	**2018**	
3	**2018 - Present**	• Project re-design
4	**2024 - Present**	• Removal of Community and Mental Health
		• Targeted data specification

NHS Benchmarking Network

Background

1	2014	**Acute Pharmacy & Medicines Optimisation:**
2	2018	
3	**2018 - Present**	• Long standing
4	2024 - Present	• High levels of engagement
		• Targeted and iterative data specification

NHS Benchmarking Network

Background

1   **2014**

2   **2018**

3   **2018 - Present**

4   **2024 - Present**

Mental Health Pharmacy & Medicines Optimisation:

- Pilot exercise
- Workforce focus
- Collaborative process

NHS Benchmarking Network

Workforce planning

Does the organisation carry out capacity planning for clinical services?
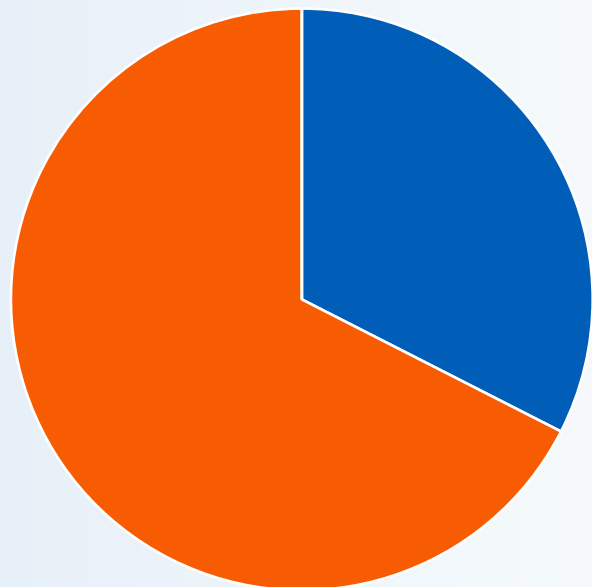
Yes %	33%
No %	67%
N	40

Does the organisation use e-rostering for pharmacy staff?

Yes %	65%
No %	35%
N	40

NHS
Benchmarking Network
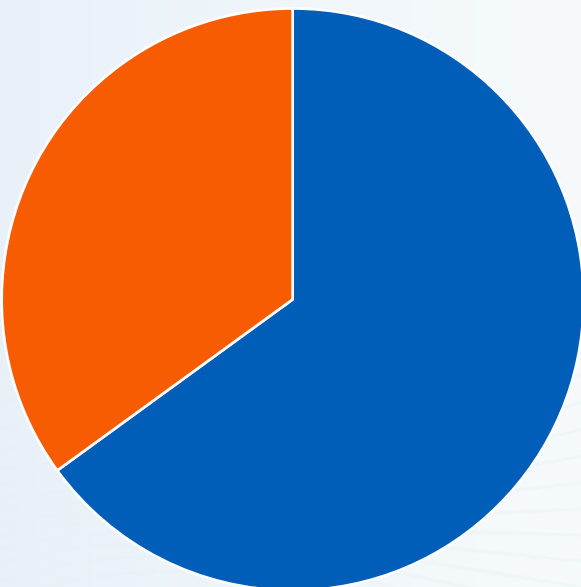
Community services

Total WTE pharmacists supporting CMHTs per 100,000 population

Mean	0.49
Median	0.50
N	35

Total WTE pharmacy staff supporting CMHTs per 100,000 population

Mean	0.66
Median	0.68
N	35

Harnessing the power of data to drive meaningful change

NHS
Benchmarking Network
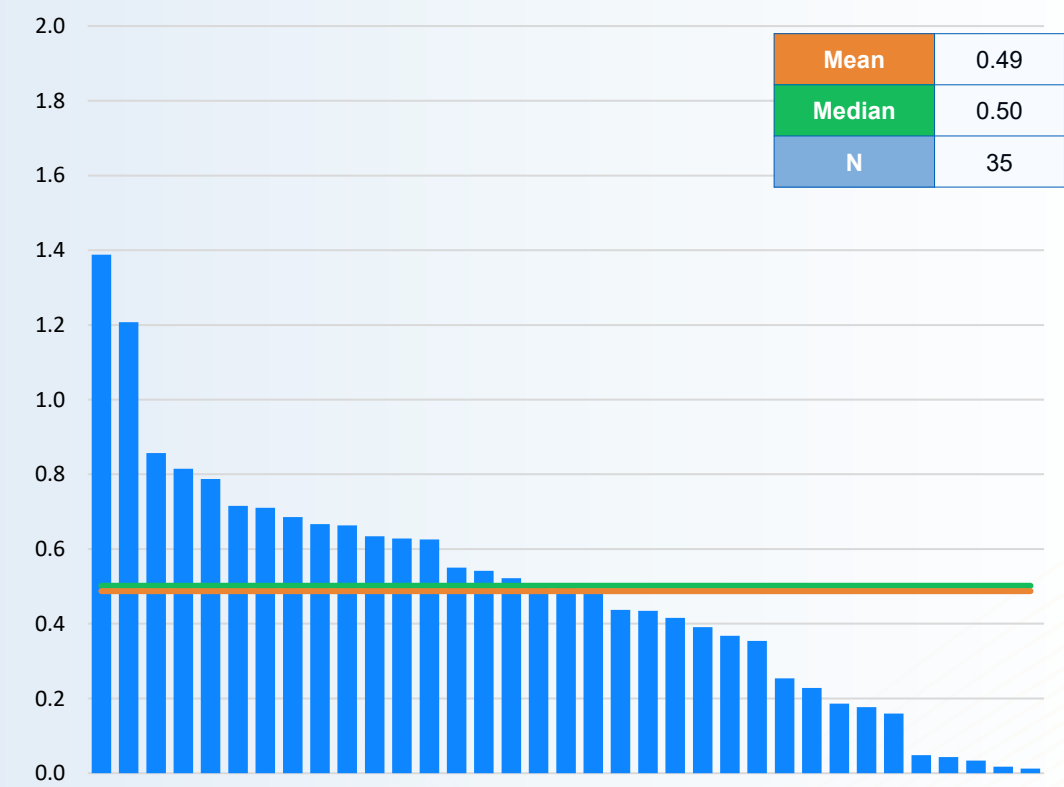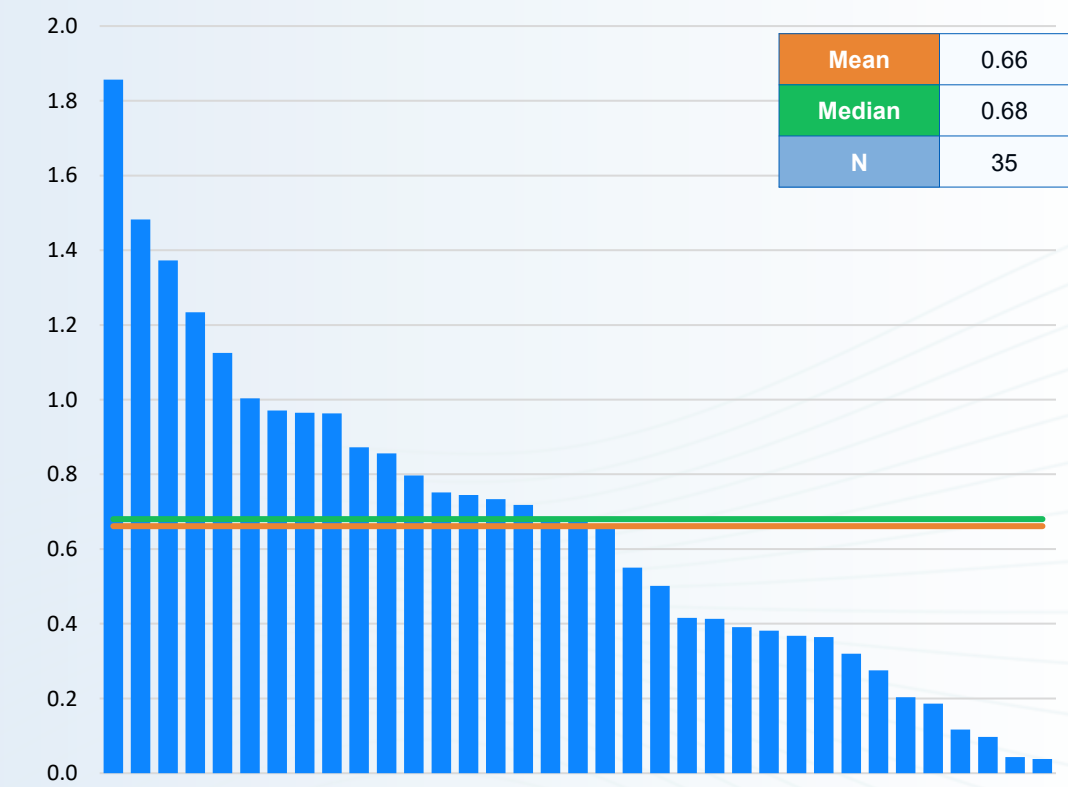
Inpatient services

Total WTE pharmacists supporting all bed based services per 100 total mental health beds
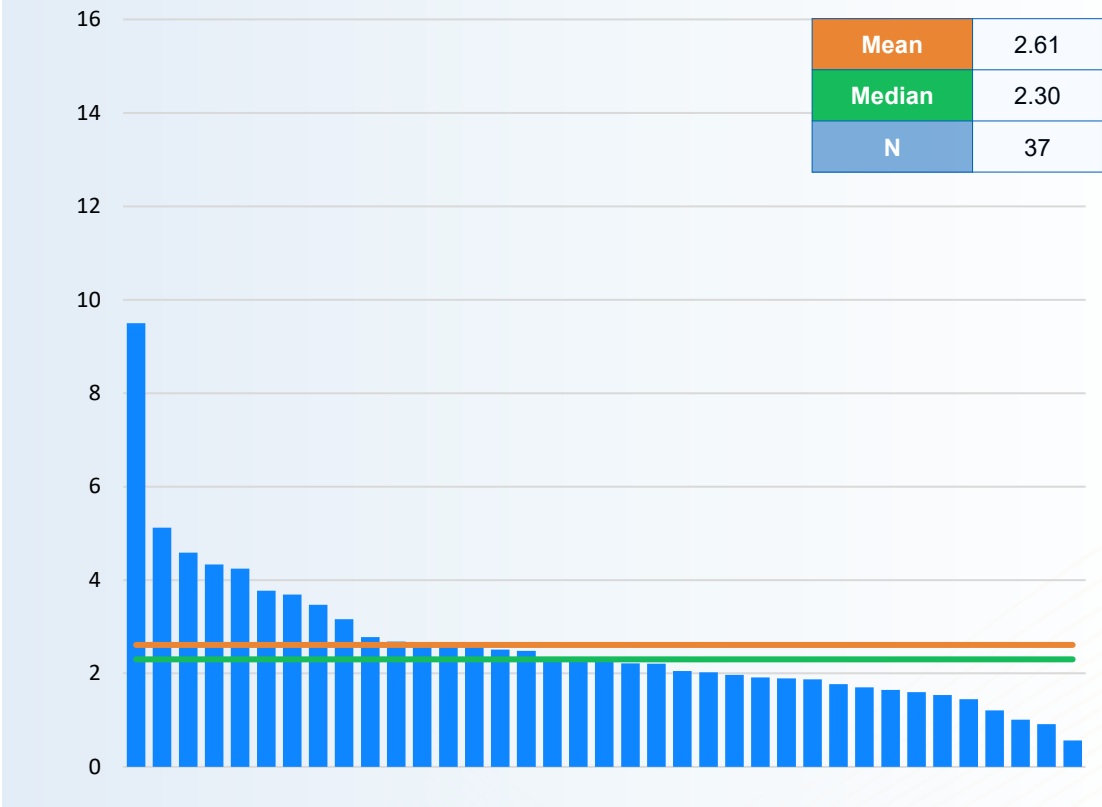
Mean	2.61
Median	2.30
N	37

Total WTE pharmacy staff supporting all bed based services per 100 total mental health beds

Mean	4.56
Median	4.26
N	37

NHS Benchmarking Network
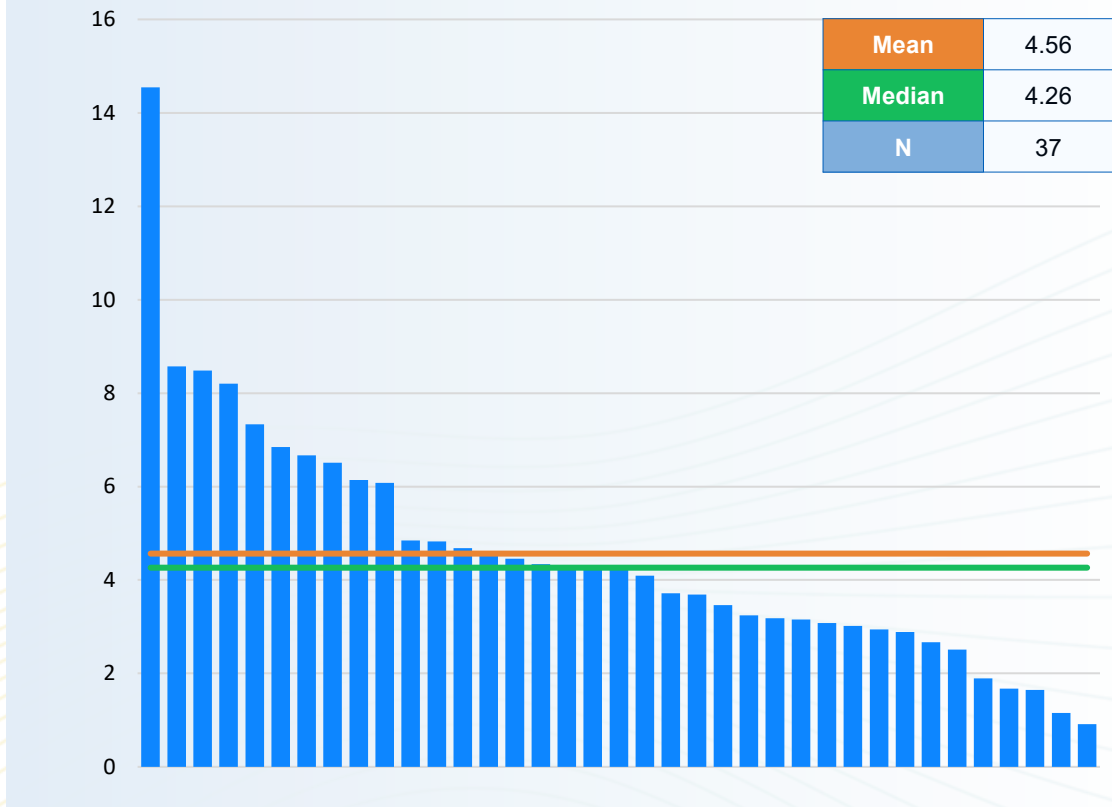
Vacancy and Turnover

Vacancy rate (%)

Mean	6.4%
Median	6.0%
N	38

Turnover rate (%)

Mean	9.5%
Median	9.4%
N	33

Harnessing the power of data to drive meaningful change
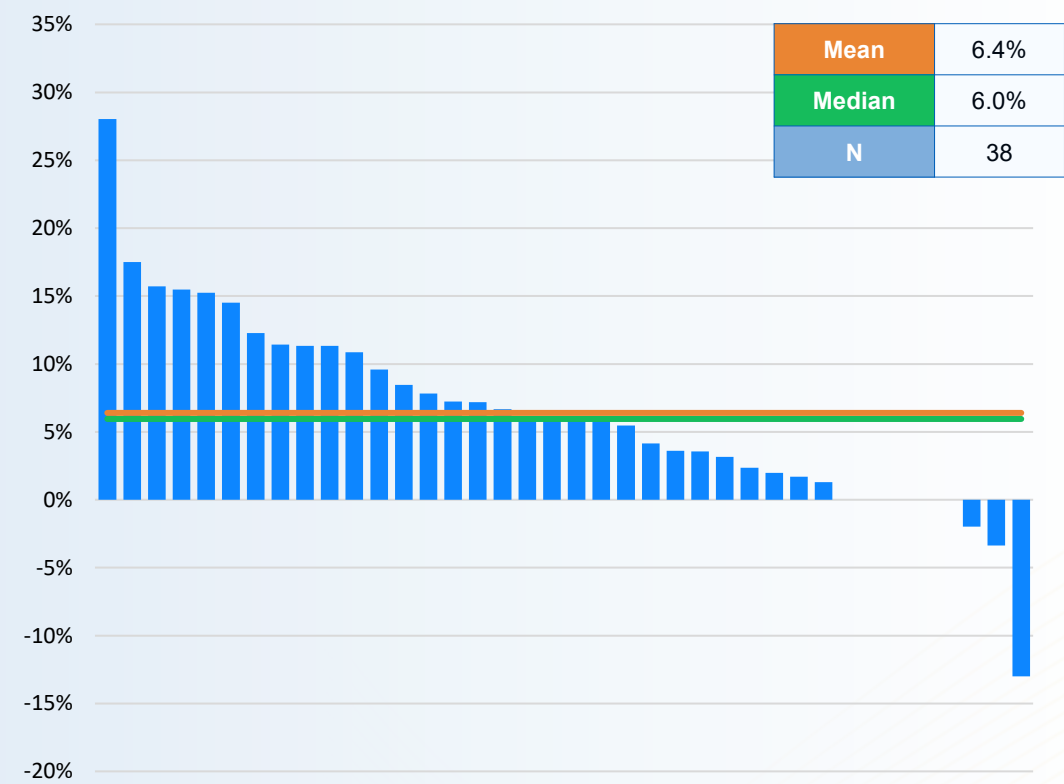
NHS Benchmarking Network
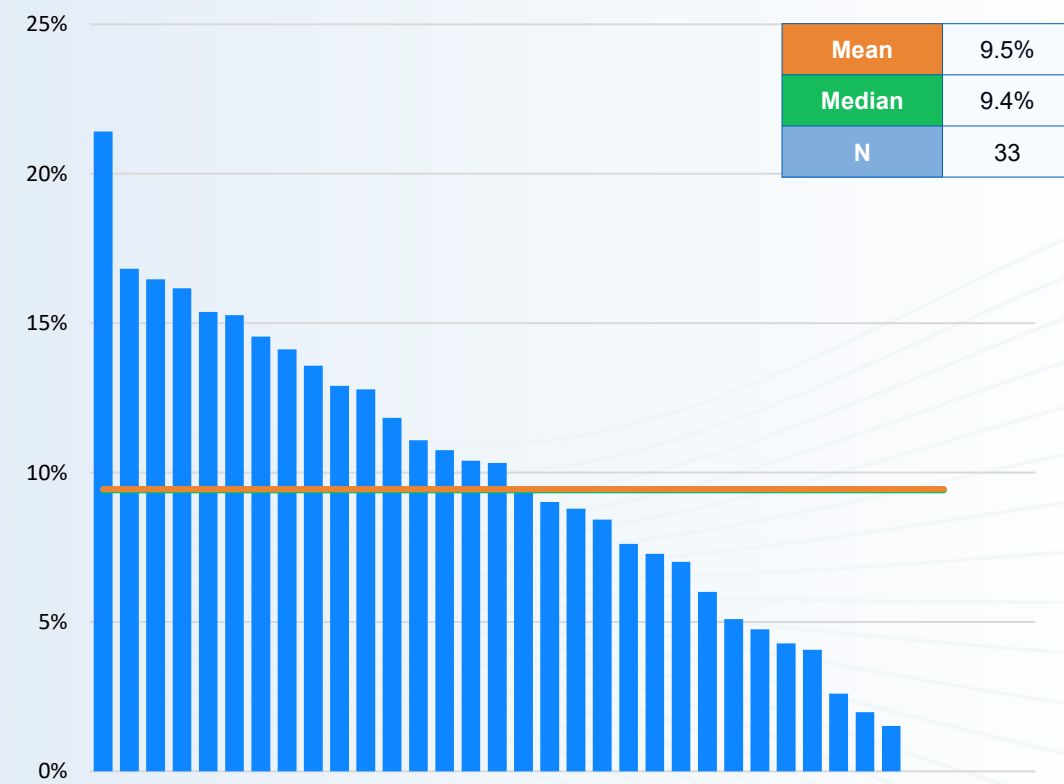
Next steps

Dedicated Lunch & Learn

Tuesday 25th November: 12:00 – 12:45

Outputs available

Project feedback and review
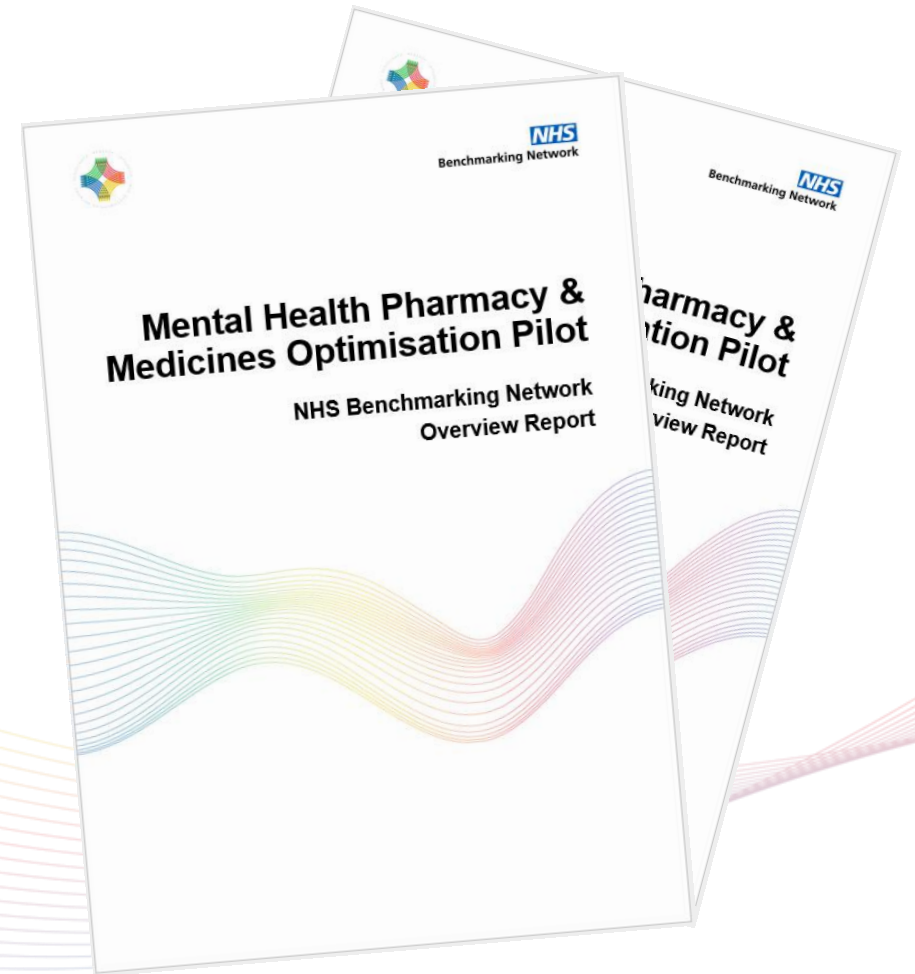
Harnessing the power of data to drive meaningful change

MHLDA indicators benchmarking project

Daniel Iyoha

Project Manager - NHSBN

NHS
Benchmarking Network

Overview

- **Data is collected quarterly, comparing key metrics including productivity, activity, talking therapies, patient safety**

- **Available for Adult Inpatient & Community, CYP Inpatient & Community, Community Adult and Child LD Services**

- **Data can be uploaded once per quarter or monthly**

- **Reports published within 6 weeks after the end of every quarter**

- **No upload required – data processed straight away!**

Reports available:
- **Q1 – August**
- **Q2 – November**
- **Q3 – February**
- **Q4 – May**

Mental Health, Learning Disabilities and Autism Indicators Apr - Jun25 Report
COV119

NHS Benchmarking Network
Raising standards through sharing excellence

Online outputs

Full online toolkit – data back to start of project in April 2020

Bars to show your benchmarked position against national position

Dashboard to view key metrics, grouped by service (CYP, AOP, LD, inpatient/community etc.)

6-month historic data - national mean & your value
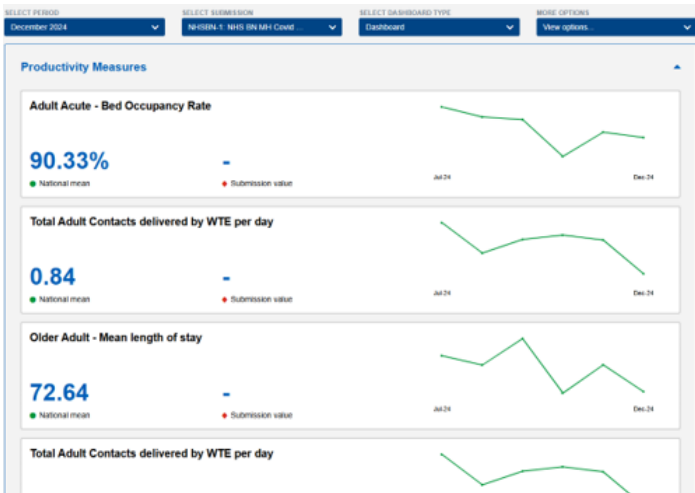
Data extract service release planned for the coming weeks to extract this data

NHS Benchmarking Network

Project process

Revisions can be made to metrics and reporting as priorities change

Collect feedback when possible regarding data collection, metrics, toolkit, reporting

Implement technical changes, new metrics, remove unnecessary/unhelpful metrics for next iteration

Utilise outputs e.g. quarter-on-quarter reporting

Members provide feedback on metrics, formats, etc

Feedback implemented in toolkit, data collector

Data entered by members, trends captured

Reports sent out – data can also be used in bespoke work

Harnessing the power of data to drive meaningful change
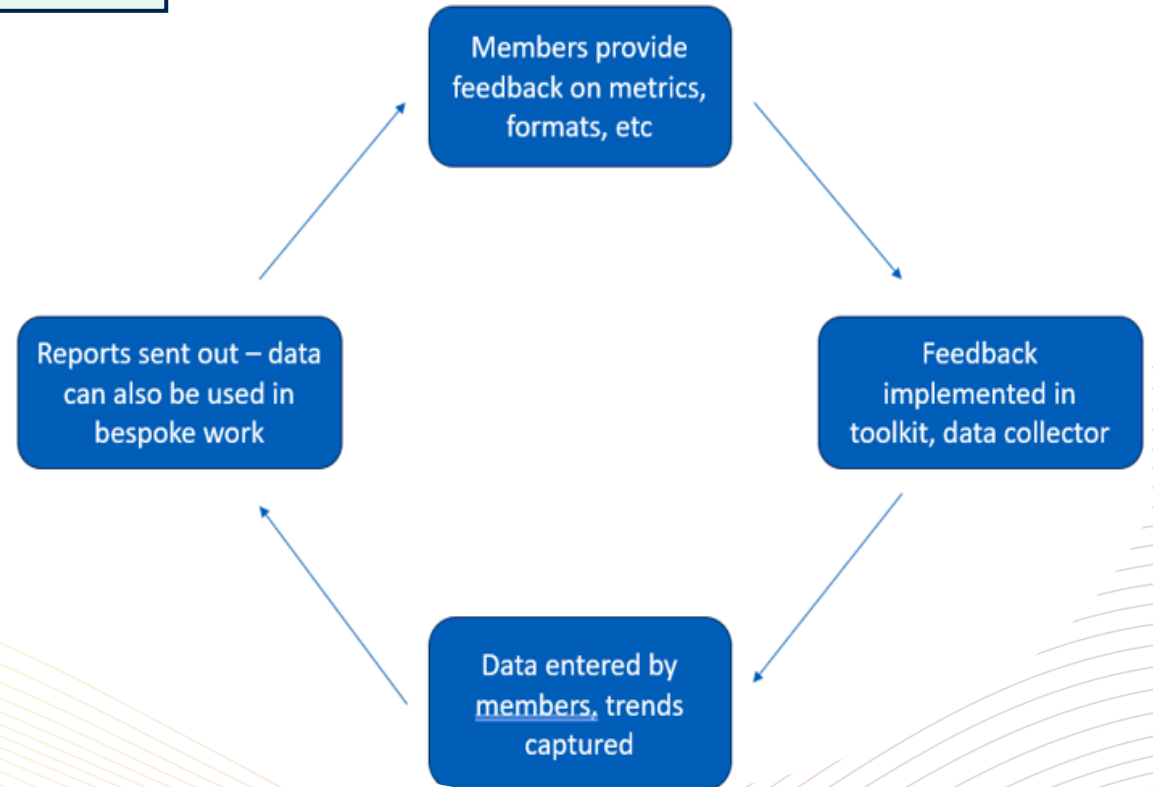
Spotlight on Neurodiversity Services

Data from within CYP and AOP Project Findings 2024/25

11th November 2025

Alison Worden

Project Manager

a.worden@nhs.net

Spotlight on Neurodiversity Services

For Children and Young People

Provision of services

ASD

50%
Reported an ASD service

England: 53% (26)
Scotland: 17% (1)
Wales: 67% (2)

The % = the number of submissions that responded affirmatively (in brackets), as a % of the total responses to the question

ADHD

42%
Reported an ADHD service

England: 43% (20)
Scotland: 17% (1)
Wales: 100% (2)

Other Neurodiversity

52%
Reported an 'other' neurodiversity service

England: 56% (25)
Scotland: 29% (2)
Wales: 50% (2)

Does this team offer diagnosis only, post diagnostic support only, or both?

ASD (n=15)
- 47% Diagnosis only
- 53% Both diagnosis and post diagnostic support
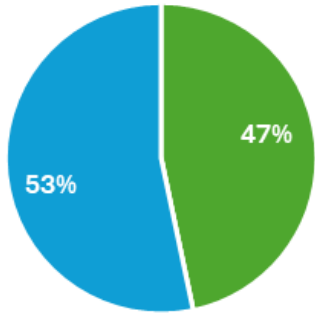
Legend:
- Diagnosis only
- Post diagnostic support only
- Both diagnosis and post diagnostic support

ADHD (n=14)
- 14% Post diagnostic support only
- 86% Both diagnosis and post diagnostic support
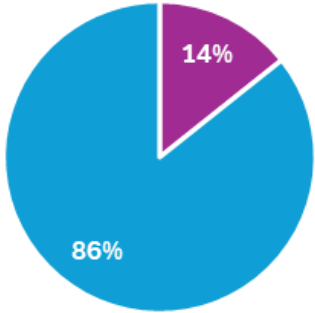
Legend:
- Diagnosis only
- Post diagnostic support only
- Both diagnosis and post diagnostic support

Other Neurodiversity (n=13)
- 15% Diagnosis only
- 8% Post diagnostic support only
- 77% Both diagnosis and post diagnostic support

Legend:
- Diagnosis only
- Post diagnostic support only
- Both diagnosis and post diagnostic support

Harnessing the power of data to drive meaningful change
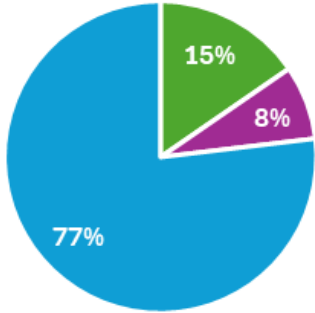
If post diagnostic support is offered, is this medication only, or other interventions?
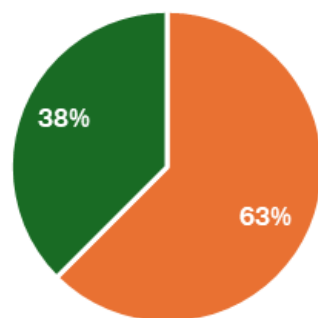
ASD (n=8)
- 38%
- 63%
- Medication only
- Other interventions
- Medication and other interventions
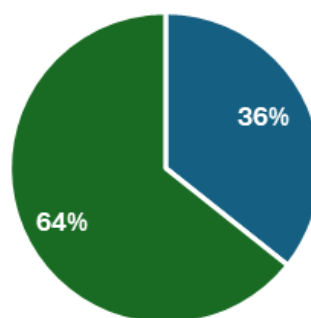
ADHD (n=14)
- 36%
- 64%
- Medication only
- Other interventions
- Medication and other interventions

Other Neurodiversity (n=10)
- 10%
- 20%
- 70%
- Medication only
- Other interventions
- Medication and other interventions
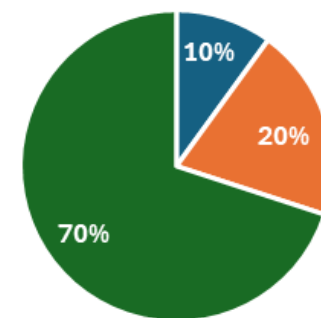
Patient profiling – ethnicity and gender

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

ASD teams activity summary

830 median referrals received per 100k population

→

82% referral acceptance rate

↓

43.2k CYP waiting for 1st appointment

←

69% conversion rate

↓

18.4k CYP waiting for 2nd appointment

→

193 median caseload per 100k population

ASD Median waiting times (weeks)

Median referral to 1st = 42 weeks
Median referral to 2nd = 43 weeks

- Median waiting time from 1st appointment to 2nd appointment
- Median waiting time from referral to 1st appointment

ADHD teams activity summary

881 median referrals received per 100k population

→

94% referral acceptance rate

↓

31.1k CYP waiting for 1st appointment

←

65% conversion rate

↓

11.2k CYP waiting for 2nd appointment

→

449 median caseload per 100k population

ADHD Median waiting times (weeks)

Median referral to 1st = 23 weeks
Median referral to 2nd = 38 weeks

Legend:
- Median waiting time from 1st appointment to 2nd appointment
- Median waiting time from referral to 1st appointment

Other neurodiversity teams activity summary

1,249 median referrals received per 100k population

→

83% referral acceptance rate

↓

60k CYP waiting for 1st appointment

←

63% conversion rate

↓

20k CYP waiting for 2nd appointment

→

579 median caseload per 100k population

Other neurodiversity median waiting times (weeks)

Median referral to 1st = 52 weeks
Median referral to 2nd = 58 weeks

■ Median waiting time from 1st appointment to 2nd appointment
■ Median waiting time from referral to 1st appointment

Harnessing the power of data to drive meaningful change

Treatment Intensity

ASD	2024/25
Average no. of weeks on caseload	81
Mean number of contacts before discharge	6
Approx contacts per week	**0.07**

ADHD	2024/25
Average no. of weeks on caseload	109
Mean number of contacts before discharge	7.5
Approx contacts per week	**0.07**

Other Neurodiversity	2024/25
Average no. of weeks on caseload	93
Mean number of contacts before discharge	5
Approx contacts per week	**0.05**

Provision of services

ASD

63%
Reported an ASD
service

England: 64% (23)
Scotland: 43% (3)
Wales: 80% (4)

The % = the number of submissions that responded affirmatively (in brackets), as a % of the total responses to the question

ADHD

65%
Reported an ADHD
service

England: 72% (28)
Scotland: 43% (3)
Wales: 40% (2)

Other Neurodiversity

15%
Reported an 'other'
neurodiversity service

England: 19% (6)
Scotland: 0%
Wales: 0%

Patient profiling – ethnicity and gender

	ASD	ADHD	Other neurodiversity team
Unknown	43%	24%	17%
Other	2%	3%	2%
Black/Black British			2%
Asian/Asian British		2%	3%
Mixed	2%	3%	3%
White/White British	51%	67%	73%

Legend: White/White British, Mixed, Asian/Asian British, Black/Black British, Other, Unknown

	ASD	ADHD	Other neurodiversity team
Female	55%	51%	48%
Male	45%	49%	51%

Legend: Male, Female, Non binary/other

NHS Benchmarking Network

Harnessing the power of data to drive meaningful change

ASD teams activity summary

180 median referrals received per 100k population

→

80% referral acceptance rate

↓

16.5k waiting for 2nd appointment

←

40.2k waiting for 1st appointment

↓

45 weeks on caseload on average

→

193 median caseload per 100k population

ASD Median waiting times (weeks)

Median referral to 1st = 77 weeks
Median referral to 2nd = 92 weeks

Legend:
- Median waiting time from 1st appointment to 2nd appointment
- Median waiting time from referral to 1st appointment

Harnessing the power of data to drive meaningful change

ADHD teams activity summary

377 median referrals received per 100k population

→

86% referral acceptance rate

↓

139.4k waiting for 1st appointment

←

56.3k waiting for 2nd appointment

↓

88 weeks on caseload on average

→

449 median caseload per 100k population

ADHD Median waiting times (weeks)

Median referral to 1st = 61 weeks
Median referral to 2nd = 91 weeks

- Median waiting time from 1st appointment to 2nd appointment
- Median waiting time from referral to 1st appointment

Other neurodiversity teams activity summary

203 median referrals received per 100k population

→

69% referral acceptance rate

↓

20.6k waiting for 1st appointment

←

5k waiting for 2nd appointment

↓

47 weeks on caseload on average

→

579 median caseload per 100k population

Other neurodiversity median waiting times (weeks)

Median referral to 1st = 12 weeks
Median referral to 2nd = 18 weeks

■ Median waiting time from 1st appointment to 2nd appointment

■ Median waiting time from referral to 1st appointment

Harnessing the power of data to drive meaningful change

Keep Learning, Keep Connecting:

Explore more Member Programme events at:

www.nhsbenchmarking.nhs.uk/events

Stay connected, see what events NACEL have planned at:

www.nacel.nhs.uk/events

For more information on anything you've heard today or for general enquiries contact us: enquiry@nhsbenchmarking.nhs.uk

www.nhsbenchmarking.nhs.uk