

Title: 'ACCESS AND WAITING TIME STANDARDS FOR 2015-16 IN MENTAL HEALTH SERVICES' Impact Assessment IA No: 7088 Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)		
	Date: 25/09/2014		
	Stage: Development/Options		
	Source of intervention: Domestic		
	Type of measure: Other		
Contact for enquiries: Amy.Edens@dh.gsi.gov.uk Panos.Zerdevas@dh.gsi.gov.uk			
Summary: Intervention and Options			RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Two-Out? Measure qualifies as
-£293m	£0m	£0m	No NA

What is the problem under consideration? Why is government intervention necessary?

Access to services for people with mental health problems is more restricted and waiting times are longer than for other services, with no robust system of measurement in place to quantify the scale of the problem. This disparity can lead to poor outcomes for patients and the system, such as mental health patients presenting as emergencies rather than via elective pathways. Particularly, early identification and access to specialist treatment is critical to improve the immediate and longer-term personal, clinical and economic outcomes, and to reduce healthcare utilisation. Government through setting appropriate waiting and access standards, as they already exist for physical health, can help incentivise the system to reduce this disparity.

What are the policy objectives and the intended effects?

To see an introduction of access and waiting time standards in 2015/16 in the key areas of mental health services. This would set the pace for the continuous staged roll out of these new standards across the whole of mental health services in England, bringing the reality of parity of esteem between services for mental illness and physical illness closer. The detail of what might be achieved following 2015/16 will be subject to the next Spending Review and the next Government, and therefore all details for years beyond 2015/16 in this Impact Assessment, including trajectories, represent aspirations only and are discussed purely for illustrative purposes and do not represent policy.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

DH and NHS England policy and analytical colleagues, have considered a longlist of options. Stakeholder priorities were used alongside initial evidence gathering, and consideration of services for people with the range of different mental health conditions (see detail at paragraph 13.) From this, a shortlist of proposals have been developed for mental health access and waiting times standards for the 2015/16 NHS Mandate in the areas of Improving Access in Psychological Therapies, Early Intervention in Psychosis and Crisis Care Liaison Psychiatry (paragraphs 14 onwards).

Will the policy be reviewed? It will/will not be reviewed. If applicable, set review date: Month/Year					
Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro No	< 20 No	Small No	Medium No	Large No
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded: N/A		Non-traded: N/A

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY:

Date:

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	-	£450m	£4,951m

Description and scale of key monetised costs by 'main affected groups'

Costs are expected to fall on the NHS. The estimated costs for 2015/16 wait and access standards broken down to policy area are: Data changes: £1.6m, IAPT: £3.3m, Early Intervention Psychosis: £41.0m, Liaison Psychiatry: £29.0m; giving a total cost of £74m in 2015/16 (in 2014/15 prices).

Other key non-monetised costs by 'main affected groups'

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BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	-	£423m	£4,658m

Description and scale of key monetised benefits by 'main affected groups'

For 2015/16, we estimate the following cost savings to be realised by the NHS: IAPT: £0.2m, Liaison Psychiatry: £96.6m; giving a total cost saving of £96.8m in 2015/16 (in 2014/15 prices) for the NHS (please note that cost savings of approximately £33.1m is expected to be realised by the NHS in 2016/17 as the outcome of the 2015/16 investment. For 2015/16, we estimate a monetised health gain and employment benefits accruing to IAPT patients worth £7.0m.

Other key non-monetised benefits by 'main affected groups'

We could not monetise health benefit for patients as a result of standards implemented in Early Intervention Psychosis and and Liaison Psychosis services, which are expected to be considerable. We could not monetise cost savings as an outcome of these interventions for the social care sector, either.

Key assumptions/sensitivities/risks	Discount rate (%)	3.5%
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1.5% for monetised health benefits.

The detail of what might be achieved following 2015/16 will be subject to the next Spending Review and the next Government, and therefore all details for years beyond 2015/16 in this Impact Assessment, including trajectories, represent assumptions on how the aspirations might be implemented and are discussed purely for illustrative purposes and do not represent policy.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:	In scope of OITO?	Measure qualifies as
Costs: -	No	NA
Benefits: -		
Net: -		

Evidence Base (for summary sheets)

Problem under consideration

Introduction

The policy context

1. The Health and Social Care Act 2012 secured explicit recognition of the Secretary of State for Health's duty towards both physical and mental health. In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these place an obligation on the Secretary of State to address the current disparity between physical and mental health.
2. Parity of esteem for mental health means that people with a mental health condition should have the same level of access to timely, effective, safe and user-responsive care as they would for a physical health condition. Improving access and waiting time standards for mental health is only a partial response to the issue of parity. The Royal College of Psychiatrists report '*Whole-Person Care: From Rhetoric to Reality*' goes on to explain parity more fully - "parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by:
 - equal access to the most effective and safest care and treatment
 - equal efforts to improve the quality of care
 - the allocation of time, effort and resources on a basis commensurate with need
 - equal status within healthcare education and practice
 - equally high aspirations for service users; and
 - equal status in the measurement of health outcomes"
3. The NHS Mandate states that "Too often, access to services for people with mental health problems is more restricted and waiting times are longer than for other services, with no robust system of measurement in place even to quantify the scale of the problem. The Department of Health and NHS England are committed to ending this and believe that implementing new access and/or waiting time standards is vital in order to have true parity of esteem. We expect NHS England to work with the Department of Health and other stakeholders to develop a range of costed options in order to implement these standards starting from April 2015, with a phased approach depending on affordability" (paragraph 3.8).
4. The Mandate objective focuses on both improving **access** to services and shortening **waiting times** for services. Access is defined as the availability of service, ensuring that someone with a specific condition has access to a service from which they may benefit. Waiting times are defined as the time an individual waits to receive the service from the time of referral to the first appointment.

The issue

5. Each year about one in four people (23%) in the United Kingdom will have mental health problems (APMS, 2007). One in ten children need support or treatment for mental health problems. These can range from short spells of quite mild depression or anxiety through to severe and persistent

conditions that are massively disruptive, frightening and life threatening for those who experience them.

6. Mental health problems can also have a debilitating impact on people's physical health, for example, people with mental illness are almost twice as likely to die from heart disease as the general population and four times more likely to die of lung disease¹. For young people, mental illness is strongly associated with behaviours that pose a risk to their health, such as drug and alcohol abuse and risky sexual behaviour.
7. The impact of these conditions on individuals of all ages, their friends and families can be very high. The impact on society and the economy is massive:
 - A recent study estimated that mental illness costs the United Kingdom economy as much as £105 billion per year (2009/10 figures), about 4.5% of gross domestic product². Around 20% of this is through health and social care costs, and 30% through lost output in the economy, with the remainder (half) due to human suffering.
 - Mental illness results in 70 million sick days per year, making it the leading cause of sickness absence in the United Kingdom³.
 - 43% of the 2.6 million people on long term health-related benefits have a mental health problem as their primary condition⁴.
 - The lifetime costs of a one-year group of children with conduct disorders are estimated to be as much as £5.2 billion and those affected by these disorders cost services about ten times the amount as children without these conditions⁵.
 - More than 75% of adults who access mental health services had a diagnosable condition before the age of 18⁶. Mental health is the biggest cause of illness in children and young people, with only 25% being treated over a three year period.
8. While most people with physical illness are in treatment, fewer than one in three people with mental illness are in treatment⁷. Despite the high costs to individuals, society and the economy of mental ill health and although psychology and psychiatry have a range of effective interventions at their disposal, we know that for decades there has been a persistent failure to reach all the people who need care and to provide them with timely treatment. It is estimated that as few as a quarter of adults with depression or anxiety receive treatment. For children and young people with a mental health problem, only a quarter receive treatment. Only 65% of people with psychotic

¹ <http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf>

² http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

³ <https://www.gov.uk/government/news/employers-urged-to-take-3-steps-to-improve-mental-health>

⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf

⁶ More than 75% of adults who access mental health services had a diagnosable condition before the age of 18

⁷ <http://cep.lse.ac.uk/layard/thriveannex.pdf>

disorders are receiving treatment⁸. With more people coming forward to seek treatment each year – the result, partly due to greater awareness and reducing stigma – the long history of underinvestment in mental health means that services are not currently able to cope and offer the timely treatment that people with physical health problems would rightly expect to receive.

8. Disparity of access and waiting times for mental health can lead to poor outcomes for patients and the system, such as mental health patients presenting as emergencies rather than via elective pathways⁹. Particularly, early identification and access to specialist treatment teams is critical to improve the immediate and longer-term personal, clinical and economic outcomes, and to reduce healthcare utilisation.
9. Some people with mental health problems wait a long time, either from the point of exhibiting symptoms or once diagnosis has been made, from external referral to appropriate treatment¹⁰. There is evidence that people with mental illness can experience long waits for services, for example, for Early Intervention Psychosis services where the current average waiting times are between 10 and 17 weeks¹¹. This produces poor outcomes for patients and imposes additional unnecessary and/or avoidable costs on mental health services and the wider health and care system (particularly urgent care).
10. The referral, assessment and treatment pathway for mental health services is not as straightforward as a referral to an acute hospital consultant, therefore access and waiting time standards for mental health does not easily map to the 18 weeks waiting time target for physical healthcare, and non-consultant led mental health services are exempt from the 18 weeks target.

The case for change / government intervention

- The level of unmet need is high. Only 25% of adults experiencing depression and anxiety related problems receive treatment, and only 65% of people with psychotic disorder are thought to access treatment¹².
- Referrals to mental health services continue to increase. Monthly referrals to community mental health teams were up 13% in 2013, and up 16% for crisis services¹³.
- There are potentially significant impacts of long waits including exacerbation of the condition, relationship breakdown, unemployment, isolation, and in extreme cases, suicide attempts.
- Poor mental health carries an economic and social cost of £105 billion a year in England. The business cost of mental ill health among the UK workforce is £26 billion¹⁴. Between 10% and 16% of working age people with a mental health condition, excluding depression, are in employment¹⁵. However, the vast majority of people with mental health problems want to work.

⁸ <http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf>

⁹ http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

¹⁰ http://www.hscic.gov.uk/media/15035/Time-to-first-contact-in-adult-and-older-peoples-secondary-mental-health-services-by-provider/xls/Time_to_first_contact_in_adult_secondary_mental_health_services_by_provider.xlsx

¹¹ NHS Benchmarking Network, Data Intelligence Report, 2014

¹² <http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf>

¹³ <http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf>

¹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

¹⁵ <http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf>

Improving access and waiting time standards – options for consideration

11. The NHS Mandate 2013/14 sets out a requirement for NHS England to work with DH and other stakeholders to develop costed options for new mental health access and/or waiting times standards, for implementation from April 2015. A workshop was held in April 2014, with DH and NHS England policy and analytical colleagues, to consider all options, with a view to producing a shortlist of options for further development. This work was undertaken jointly between NHS England and DH colleagues, as part of NHS England's Parity of Esteem Programme, and the DH Closing the Gap Delivery Programme.
12. Stakeholder engagement has also been carried out with clinicians; providers; people who use services; and third sector stakeholders, to build a picture of what is important for people who provide and use mental health services.
13. To determine a list of options for consideration, stakeholder priorities were used alongside initial evidence gathering, and consideration of services for people with the range of different mental health conditions. The options considered are shown below:
 - time to access early intervention in psychosis;
 - time to access to psychological therapies: standard IAPT;
 - access to psychological therapies (either time or absolute access): severe and enduring mental illness;
 - time to care in a crisis;
 - time from referral to treatment;
 - time to care in a crisis for prisoners;
 - time to be stepped down from more restrictive settings, once assessed as suitable
 - eating disorders;
 - self-harm;
 - personality disorders;
 - perinatal mental health;
 - obsessive compulsive disorder; and
 - post-traumatic stress disorders.
14. From an initial long-list of options, 4 options were shortlisted for further work:
 - IAPT (waiting times);
 - IAPT for people with severe and enduring mental illness (access to services);
 - Access to early intervention in psychosis (access and waiting times); and
 - Crisis care (three variants involving access and waiting times).
15. Work on the shortlist involved:

- Reviewing the existing evidence base. This includes analysing nationally available access and waiting times information, published literature and other unpublished material, much of which is set out in this assessment;
 - Identifying and clarifying options, the groups of patients affected, mapping patient pathways, and identifying and estimating likely costs and benefits;
 - Engaging with stakeholders – clinicians, providers, academic experts, people who use mental health services and other key stakeholders, including Rethink and Mind, to test the options and build a picture of what is important for people who provide and use mental health services;
 - Modelling to generate cost/benefit analyses, as far as the data allow; and
 - Identifying the range of further work that would be required to improve the evidence base and implement any of the options.
- 16.** Developing an access or waiting times standard for mental health services is considerably more complex than for some physical health services. Pathways are less well defined and are less episodic, service models vary significantly, and data availability is poorer.
- 17.** Work has continued from April 2014 to present to develop proposals on mental health access and waiting times standards for the 2015/16 NHS Mandate. A number of stakeholder events have been held during 2014 to capture views from providers, commissioners, the voluntary sector, service users, clinicians and other experts on some initial thoughts on access standards and waiting times. These events include specific consultations with the Policy Group of organisations (including Mind, Rethink, Centre for Mental Health, Royal College of Psychiatrists and Mental Health Foundation) and Voluntary and Independent Providers and the Equalities Working Group.
- 18.** The following areas have been prioritised for particular focus in the 2015/16 NHS Mandate, on the basis that improved access and waiting times in these areas will deliver significant impact on patient outcomes and effective use of NHS resources:

2015/2016 Standard

- Improving Access to Psychological Therapies
95% of patients referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral, and 75% will be treated within six weeks.
- Early Intervention in Psychosis
More than 50% of patients needing early intervention in psychosis will be treated with a NICE approved care package within two weeks of referral.
- Crisis Care – Liaison Psychiatry
A further £30 million annual recurrent investment will be made available to support acute hospitals with A&E departments to achieve clinically appropriate liaison psychiatry standards.

Improving Access to Psychological Treatments

19. Depression and anxiety disorders are serious and debilitating conditions affecting an estimated 6.6 million adults in England (APMS, 2007¹⁶). About half these patients will seek assistance from their GP in a given year¹⁷. NICE Guidelines state that people diagnosed with these conditions should be offered talking therapies as an effective treatment to speed recovery in those who would otherwise naturally recover; and as an adjunct or alternative to drug therapies for those with more enduring conditions. However, according to the Adult Psychiatric Morbidity Survey (2007), only a small proportion of those who score above the clinical threshold CIS-R score for IAPT (CIS-R 12) currently receive treatment, and only 33% of those with the highest scores (most severe mental health problems, CIS-R 36+) are currently receiving treatment.
20. The first stage of the Increasing Access to Psychological Treatments (IAPT) programme was introduced in 2008 to increase the availability of psychological treatments for depression and all anxiety disorders by training a large number of psychological therapists, and deploying them in specialized, local services for depression and anxiety disorders. *Talking therapies: A four-year plan of action*¹⁸ set out in 2011 the aim to further develop talking therapies for all ages. It aimed to ensure that by the end of March 2015, the nationwide roll-out of IAPT services for adults of all ages who have depression or anxiety disorders would be complete. The Government has demonstrated the importance it attaches to talking therapies by including them in *'The Coalition: our programme for government'*, the Spending Review; and by making them the subject of a ministerial keynote speech.
21. The Increasing Access to Psychological Treatments programme has expanded over the last three years to increase the number of people treated, with the ambition to treat 15% of the population with depression and anxiety disorders per year by quarter 4 of 2014/15, and aims for a 50% recovery rate¹⁹. The fact that 3.23% of the estimated number of people with common mental health problems received IAPT treatments in quarter 4 of 2013/14 suggests that it may be possible for the quarterly rate to reach the planned 3.75% (15%/4) by the end of 2014/15.
22. On the other hand, in some parts of the country patients wait unacceptably long periods between their referral and first treatment appointment. In these areas drop-out rates between referral and initial assessment are also exceptionally high.
23. The national average waiting time from referral to treatment is around 5 weeks, with approximately 11% of patients waiting more than 12 weeks. There is also considerable variation behind these figures nationally with some CCGs having median waits of 3 months or longer from referral to the first treatment appointment²⁰. Long waiting times can result in increased drop-outs before treatment, and reduced numbers of GP referrals.

¹⁶ <http://www.hscic.gov.uk/pubs/psychiatricmorbidity07>

¹⁷ London School of Economics. Mental Health policy group (2006) The Depression report: anew deal for depression and anxiety disorders. <http://eprints.lse.ac.uk/818/>

¹⁸ *Talking therapies: A four-year plan of action*, <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf>

¹⁹ <http://www.iapt.nhs.uk/silo/files/iapt-programme-review-december.pdf>

²⁰ <http://www.hscic.gov.uk/searchcatalogue?productid=13995&q=IAPT+annual&sort=Relevance&size=10&page=1#top>

24. Delays in accessing talking therapies not only increase the time period patients spend untreated, but analysis carried out by the Department of Health on the IAPT dataset (for Quarters 2 & 3, 2013/14) suggests that delays can also lead to a reduction in the effectiveness of the service due to lower treatment participation rates and worse employment outcomes.
25. Offering patients access to psychological treatments more quickly is not only expected to improve outcomes, but is also likely to lead to an increase in the number of people who receive treatment which in turn should deliver further net cost savings to the wider public sector. Broadening access to these services and decreasing waiting times will ultimately deliver important benefits to individuals, the NHS, and the wider economy. These include: health and wellbeing gains for those who recover from common mental health problems; NHS savings through reductions in healthcare usage by those who recover; exchequer savings through helping people attain, regain or retain employment and move off welfare benefits; and economic gains to employers through reduced sickness absences.

Early Intervention Psychosis (EIP)

26. Psychosis costs the NHS around £2bn per year²¹. If patients are not getting treatment sufficiently quickly or not getting the appropriate interventions, their long term care could be especially costly.
27. Clinical evidence is unequivocal in suggesting that minimising the Duration of Untreated Psychosis (DUP) is absolutely vital in treating psychosis (see Norman et al 2002²² for an overview of the literature). Prompt treatment of psychosis benefits the individual, the health services, wider public services and society.
28. The NICE-recommended intervention for people who exhibit early symptoms of psychosis is a structured set of treatment provided by Early Intervention for Psychosis Services²³. EIP services are provided for people aged 14-35 experiencing their first episode of psychosis. They are a specialist intensive form of treatment, which, when implemented well, provides improved outcomes over standard mental health care^{24,25,26}. Early intervention services are also highly valued by service users and their carers²⁷. Length of untreated psychosis is related to effectiveness of treatment, highlighting the importance of early intervention²⁸. The acknowledged optimal window for EIP services to begin treatment, based on clinical advice, is 2 weeks.²⁹

²¹ NHS programme budget data suggests that treatment of Psychosis cost the NHS around £2.0bn in 2012/13. Reference cost data suggests a similar figure in the same year of £1.9bn across the Mental Health reference cost clusters.

²² Ross M.G. Norman, Shon W. Lewis and Max Marshall (2002), 'Duration of untreated psychosis and its relationship to clinical outcome' *BJP* 2005, 187:s19-s23; <http://bjp.rcpsych.org/content/187/48/s19.full.pdf>

²³ NICE: "Psychosis and schizophrenia in adults: treatment and management. Mar 2014. [Guidance.nice.org.uk/cg178](http://guidance.nice.org.uk/cg178)

²⁴ Marshall M, Rathbone J Early intervention for Psychosis (Review)

²⁵ Singh "Early intervention in Psychosis". *British Journal of Psychiatry*. 2010

²⁶ Birchwood et al. "Reducing duration of untreated Psychosis: care pathways to early intervention in Psychosis services". *British Journal of Psychiatry*. 2010

²⁷ Birchwood et al. "Reducing duration of untreated Psychosis: care pathways to early intervention in Psychosis services". *British Journal of Psychiatry*. 2010

²⁸ <http://bjp.rcpsych.org/content/187/48/s19.full.pdf>

²⁹ Clinical advice sought from a number of practitioners/clinicians.

29. The EIP model requires higher up-front investment (in order to identify symptoms at an earlier stage) but a recent Cochrane Review found that EIP services can work more effectively than ‘standard care’, and this investment can pay off in terms of improved outcomes and reduced costs over time. Indeed, an overall reduction in costs per patient with EIP rather than standard care is approximately £9,900³⁰, mainly due to reduced need for inpatient care.
30. Evidence suggests that there are access issues with EIP services, and while anecdotal evidence suggests serious waiting time issues, the available data (discussed below) does not seem to support this claim, although it suggests a substantial variation across services.
31. There are currently 152 established EIP services, with coverage around the country³¹. Each year, between 16,000^{32,33} and 30,000³⁴ people exhibit first **early prodromal** symptoms of psychosis. Of these, 7,500³⁵ and 15,000³⁶ people develop first episode psychosis, and although the rest do not develop psychosis those people still have serious underlying mental illnesses and would require a course (between 12 – 16 sessions³⁷) of cognitive behavioural therapy from EIP services. EIP services diagnose and provide services to around 3,000³⁸ **new** patients each quarter – potentially leaving between 4,000 and 18,000 first episode psychosis patients undiagnosed, which means that these people cannot access the most appropriate treatment in a timely fashion.
32. In addition, there have been cuts in service provision recently³⁹. This specifically includes:
- Merging of EIP services into general community mental health services;
 - Significant losses of staff/funding for existing EIP services; and
 - Reduction of provided services from the optimal characteristics, which are:
 - Raising awareness of psychotic illness, symptoms and early detection;
 - Comprehensive assessment, care planning, sustained engagement, regular review;
 - A robust medication strategy, and treatment of co-morbidities;
 - Use of psychological therapies as appropriate, including family and carers;
 - Addressing daily living requirements and a pathway to education and employment;
 - A relapse prevention plan and crisis plan;
 - Avoidance and appropriate use of hospital and respite care;
 - A robust discharge plan from EIP services.
33. We do not have fully accurate data on waits for EIP services – however we have several sources of partial information:

³⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf

³¹ <http://www.nepft.nhs.uk/eip/nationwide/>

³² Martin Knapp et al (2011) ‘Mental health promotion and mental illness prevention: The economic case’; (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf)

³³ Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

³⁴ Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

³⁵ Early intervention in psychosis services (NHS CONFED);

http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/early_interventionbriefing180511.pdf?dl=1

³⁶ Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM and Jones PB, (2012) Systematic Review of the Incidence and Prevalence of Schizophrenia and Other Psychoses in England; Department of Health Policy Research Programme; <http://www.psychiatry.cam.ac.uk/files/2014/05/Final-report-v1.05-Jan-12.pdf>

³⁷ Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

³⁸ Mental Health Community Teams Activity; <http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/>

³⁹ Rethink: “Lost generation: why young people with Psychosis are being left behind, and what needs to change”

- a. A 2009 study found particularly long waits for treatment in some areas⁴⁰.
- b. A waiting time data extract showing waiting times from external referrals to the first face-to-face contact with the first team from the Mental Health Minimum Dataset⁴¹ (MHMDS - Health and Social Care Information Centre) for the 12 month period to March 2014 shows average waiting times for EIP services to be around 8.4 weeks. It also appears that there is potentially a significant problem with very long waits, as around 21% of people seem to be waiting more than 9 weeks and 12.5% waiting more than 18 weeks for their first face-to-face contact.
- c. Waiting times information from 22 Trusts in 2013/14 as part of the NHS Benchmarking club initiative show the average waiting time for early intervention services varied between 8 weeks and less than one week, with a median of two weeks across trusts, however, some patients wait up to 60 weeks for a routine appointment⁴²

34. The NHS Plan (2000)⁴³ set the objective of “reducing the duration of untreated psychosis to a service median of less than three months”. This waiting time objective seems to be achieved at least on average, but the data clearly suggests that some services have unacceptably high waiting times.

Crisis Care - Liaison psychiatry

35. It is estimated that co-existing mental health problems including mental illness-caused ‘medically unexplained symptoms’ cost the NHS around £13.5 billion⁴⁴ ***extra spending on physical health services*** each year – nearly half of which falling on general and acute hospitals.

36. Mental illness is estimated to be the ***primary*** cause of about 5% of all A&E attendances⁴⁵, including significant numbers with acute psychosis, and it is estimated that around 30% of all acute and A&E hospital patients suffer from some kinds of mental health problems such as depression, delirium^{46,47} or dementia⁴⁸. Furthermore, people with underlying mental health problems are believed to account for 150,000 – 170,000 A&E admissions for self-harm each year⁴⁹, and untreated mental health problems are thought to be the primary reason for frequent re-admissions to hospital.

37. For many of these patients, contact with a liaison psychiatry practitioner in the emergency department will be their first experience of mental health services. Liaison psychiatry has an

⁴⁰ Birchwood et al. “Reducing duration of untreated Psychosis: care pathways to early intervention in Psychosis services”. British Journal of Psychiatry. 2010

⁴¹ The MHMDS extract should be treated with caution for three primary reasons: 1.) It is developmental, unpublished data. It has not been formally assured. Initial checking suggests significant data quality issues; 2.) It includes ‘external’ referrals only (eg from GPs and others), i.e. it excludes ‘internal’ referrals from other mental health services; and 3.) It represents the time from initial contact with the service (eg a GP referral) to first face to face contact. However, we cannot be certain that the initial referral was for suspected psychosis, or that the receiving team is definitely an EIP team, because community mental health teams are often multifunctional.

⁴² NHS Benchmarking Club data, 2012/13 collection

⁴³ <http://www.nhshistory.net/nhsplan.pdf>

⁴⁴ Parsonage, M, Fossey, M and Tutty, C (2012) Liaison psychiatry in the modern NHS. London: Centre for Mental Health; http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

⁴⁵ Royal College of Psychiatrists (2013) Liaison psychiatry for every acute hospital – Integrated mental and physical healthcare; <http://www.rcpsych.ac.uk/files/pdfversion/CR183.pdf>

⁴⁶ Royal College of Psychiatrists (2013) Liaison psychiatry for every acute hospital – Integrated mental and physical healthcare; <http://www.rcpsych.ac.uk/files/pdfversion/CR183.pdf>

⁴⁷ Parsonage, M, Fossey, M and Tutty, C (2012) Liaison psychiatry in the modern NHS. London: Centre for Mental Health; http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

⁴⁸ Aitken et al, 2014, “An Evidence Base for Liaison Psychiatry – Guidance <http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/2-evidence-base-for-liaison-psychiatry-services.pdf>

⁴⁹ Aitken et al, 2014, “An Evidence Base for Liaison Psychiatry – Guidance <http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/2-evidence-base-for-liaison-psychiatry-services.pdf>

important role to play in the identification of severe mental illness in this setting and to arrange engagement with mainstream community-based services, including crisis and early intervention teams. This is particularly important among young people experiencing a first episode of psychosis, as there is now a strong evidence base to demonstrate the effectiveness and cost-effectiveness of early intervention services for this group⁵⁰.

38. Liaison Psychiatry services are specially trained teams which can provide timely diagnosis for co-morbid mental health conditions for people who are admitted to hospital and can enable patients to receive appropriate treatment quicker. The patient groups who most likely to benefit from these services include:

- frail elderly people with dementia, depression or delirium;
- people who self-harm, and need medical or surgical treatment;
- people with drug and/or alcohol induced problems;
- people with known severe mental illness; and
- others with 'medically unexplained symptoms', or people with anxiety or depression due to a Long Term Condition (LTC).

39. In most hospitals, liaison psychiatry provision is inadequate. A recent survey by The Royal College of Psychiatrists⁵¹ found that 62% of A&E departments do not have adequate⁵² level of liaison psychiatry provision, and only 1/3 of those who do, provide a true 24/7 service. In addition, there is a striking variability in levels of provision and models of psychiatric liaison service delivery including patient age-groups and conditions treated, nature of service, size, composition and skill mix of team, and hours of operation⁵³. The observed "*postcode lottery*"⁵⁴ in liaison psychiatry provision is the outcome of the commissioning split between physical and mental health.

40. On the other hand, the available data suggests that, where the service exists, waiting times are acceptable. A waiting time data extract showing waiting times from external referrals to the first face-to-face contact with the first team from the Mental Health Minimum Dataset (MHMDS - Health and Social Care Information Centre) for the 12 month period to March 2014 shows median waiting times for Liaison Psychiatry services to be around 1 day.

41. As an outcome of inadequate liaison psychiatry provision, people with mental health problems often face longer waits than patients with physical conditions for assessment, for acute inpatient admission or for discharge^{55,56}.

42. The Joint Commissioning Panel for Mental Health⁵⁷ suggests that the following types of benefits can be attributed to liaison psychiatry services:

⁵⁰ McCrone, P., Park, A. & Knapp, M. (2011) Early intervention for psychosis. In Knapp, M., McDaid, D. & Parsonage, M. (editors) Mental health promotion and mental illness prevention: the economic case. London: Department of Health.

⁵¹ Aitken, P and Lee, W. (2014): 'Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a Census Survey', London: Royal College of Psychiatrists. – page 6.

⁵² Hospitals are judged inadequate in the report if served by a 'consultant in-reach', by external crisis response and home treatment teams, by social services duty teams, or where the liaison team is led by a nurse, a trainee psychiatrist or a GP, or if it is single point of access.

⁵³ Parsonage, M., Fossey, M and Tutty, C. (2012): Liaison Psychiatry in the Modern NHS', Centre for Mental Health, page 15; http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_nhs_2012.pdf

⁵⁴ Foley, T (2013): 'Bridging the Gap: The financial case for a reasonable rebalancing of health and care resources', London: Royal College of Psychiatrists and Centre for Mental Health, page 4; http://www.centreformentalhealth.org.uk/pdfs/bridgingthegap_fullreport.pdf

⁵⁵ Evidence Base for Urgent & Emergency Care Review, NHS England, 2013 <http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf>

⁵⁶ Fielden, J and Stanton, E. (2014): 'Not all liaison services are equal', Health Service Journal, 11th April 2014, 26-27

⁵⁷ JCPMH (2012): 'Guidance for commissioners of liaison mental health services to acute hospitals', <http://www.jcpmh.info/wp-content/uploads/jcpmh-liaison-guide.pdf>

- Improved service user experience;
- Improved care outcomes;
- Ensuring patients with co-morbid long term conditions receive better treatment while using fewer health care resources;
- Treating and reducing costs for patients with medically unexplained symptoms;
- Reducing A&E waiting times;
- Reduced admission, re-admissions and lengths of stay, including among frequent A&E re-attenders;
- Reduced risk of adverse events;
- Improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005);
- Reducing psychological distress following self-harm and reducing suicide; and
- Improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST).
- On average, reducing length of stay in hospital by between 1.3 and 3.2 days^{58,59}

43. An LSE evaluation of the Rapid Assessment Interface and Discharge (RAID) liaison psychiatry service in Birmingham has provided compelling evidence of the cost effectiveness of the programme⁶⁰. Even though the only monetised benefits in this study come from the earlier discharge of patients with comorbid mental health conditions (attributable to RAID), the paper estimates a 4:1 benefit:cost ratio for the RAID model. As there are potential additional benefits from a comprehensive, RAID-type liaison psychiatry provision, this is likely to be an underestimate. These un-monetised benefits include savings from avoided re-admissions, avoided admissions to acute wards, fewer delayed transfers of care, reduction in social service and care home use and reduced psychological distress.

44. The paper finds that among all elderly inpatients seen by the RAID service, 67% were discharged to their own homes compared with only 34% in the retrospective control group (that is, before the implementation of RAID). This large reduction in post-discharge care demonstrates the scale of further, as yet un-monetised benefits.

45. The Centre for Mental Health recently estimated that a **comprehensive** roll-out of Liaison Psychiatry services could save £5 million per year in an average 500 bed general hospital or £1.2 billion per year nationally⁶¹.

46. Two US pilots suggest even higher incremental benefits due to Liaison Psychiatry services from reduced bed days. Strain et al⁶² calculate a benefit:cost ratio of 5:1 and 8:1 in two US hospitals by reducing length of stay from 15.5 to 13.8 days and from 20.7 to 18.5, respectively.

⁵⁸ <http://www.hsj.co.uk/resource-centre/best-practice/qipp-resources/liaison-psychiatry-can-bridge-the-gap/5051771.article#.VBwz3qHTXct>

⁵⁹ Parsonage, M. and Fossey, M. (2011): 'Economic evaluation of a liaison psychiatry service', London: Centre for Mental Health.

⁶⁰ Parsonage, M. and Fossey, M. (2011): 'Economic evaluation of a liaison psychiatry service', London: Centre for Mental Health.

⁶¹ Foley, T (2013): 'Bridging the Gap: The financial case for a reasonable rebalancing of health and care resources', London, Royal College of Psychiatrists / Centre for Mental Health, page 4; http://www.centreformentalhealth.org.uk/pdfs/bridgingthegap_fullreport.pdf

⁶² Strain JJ, Lyons JS, Hammer JS, Fahs M, Lebovits A, Paddison PL, Snyder S, Strauss E, Burton R, Nuber G, et al. (1991) "Cost offset from a psychiatric consultation-liaison intervention with elderly hip fracture patients." Am J Psychiatry. 1991 Aug;148(8):1044-9.

47. Also, a recent pilot in Central and North West London NHS Trusts suggests that the implemented liaison psychiatry service was able to reduce length of stay by 1.3 days for patients with comorbid mental health conditions. Patients' re-admissions rates have also dropped considerably while user experience improved⁶³.

Description of options considered (including do nothing):

Option 1. – Do Nothing

Option 2. – Implement Access and Waiting Times Standards as follows

48. The 'Mental Health 2020 – the Path to Parity' document sets out the commitments which form part of the updated objective on mental health in the NHS Mandate for 2015/16 and a set of ambitions for NHS to work towards achieving further parity between physical and mental health.

49. The following table summarises the actions and ambitions as set out in the "Mental Health 2020-the Path to Parity" document. Please note that the detail of what might be achieved following 2015/16 will be subject to the next Spending Review and the next Government, and therefore all details for years beyond 2015/16 are *aspirations* only and do not represent policy.

2014/15

Building up the capacity to enable the NHS to meet access standards from 2015/16 and beyond and to develop the information and data systems needed to support this.

2015/16

Introducing waiting time and access standards as set out below:

- 95% of patients referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral, and 75% will be treated within six weeks
- More than 50% of patients needing early intervention in psychosis will be treated with a NICE approved care package within two weeks of referral
- £30m targeted investment on effective models of liaison psychiatry in more acute hospitals. The CQC will inspect against this standard and this will therefore contribute to CQC ratings.

Continue planning for countrywide service transformation of children and young people's Improving Access to Psychological Therapies.

The Department of Health and NHS England will work together to set out how and when access and waiting time standards and the relevant commissioning and payment models and reporting infrastructure could be introduced over subsequent years.

⁶³ Aitken et al, 2014, "An Evidence Base for Liaison Psychiatry – Guidance <http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/2-evidence-base-for-liaison-psychiatry-services.pdf>

Ambition for years beyond 2015/16

The priorities for years beyond 2015/16 will be determined by the next government and its spending plans, and will be based on the next spending review. The document sets out some *aspirations* including:

- 95% of patients referred to the Improved Access to Psychological Therapies programme should be treated within six weeks of referral.
- 95% of patients experiencing a first episode of psychosis should be treated with a NICE approved care package within two weeks of referral.
- All acute trusts should have a liaison psychiatry service for all ages appropriate to the size, acuity and specialty of the hospital, with rigorous CQC inspection against this standard.

Continuing to work towards matching waiting standards for mental health to treatment in physical health will take place

50. This Impact Assessment provides costings (and benefits) calculation for the access and waiting time standards. **Cost and benefit estimates (including trajectories) for the aspirations for years beyond 2015/16 are discussed purely for illustrative purposes and do not represent policy. Should specific actions be agreed and plans for how these ambitions would be achieved be formulated, further analyses would be required to update the estimated costs and benefits of the aspirations for years beyond 2015/16.**

Monetised and non-monetised costs and benefits of each option

Developing a Referral-To-Treatment style data collection in all mental health services

Costs

51. These are the costs resulting from the development of the required data collection mechanism. The HSCIC has suggested that necessary changes to the MHLDDS, IAPT and CAMHS dataset would require a one-off investment of £1.25 million. In addition, collecting and analysing the extra data is expected to cost £0.7 million each year.
52. There will also be transitional plus ongoing costs to the NHS of collecting and submitting this information, which would require new practice to be implemented by all commissioners and providers across the country. This could include IT costs in the data collection plus manpower costs for ongoing collection, checking etc. It is hard to estimate the likely scale of these costs. As an initial estimate, if each of the 211 CCGs and 57 Mental Health Trusts are required a day of effort from an administrator each month, plus some IT investment, this could cost around £1 million per year⁶⁴, recurrent.

Table 1.

(£m)	For illustrative purposes only											Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
One-off cost of changing datasets	£1.25											
Recurrent costs of HSCIC data collection		£0.7	£0.7	£0.7	£0.7	£0.7	£0.7	£0.7	£0.7	£0.7	£0.7	
Recurrent costs of data input by CCGs		£1.0	£1.0	£1.0	£1.0	£1.0	£1.0	£1.0	£1.0	£1.0	£1.0	
Present discounted value (2014/15 prices)	£1.25	£1.6	£1.6	£1.5	£1.5	£1.4	£1.4	£1.3	£1.3	£1.2	£1.2	£15.4

Improving Access to Psychological Therapies

- **In 2015/16: 95% of patients referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral, and 70% will be treated within six weeks**

Costs

53. Based on quarter 4 2013/14 IAPT data, 74.2% of IAPT patients already receive treatment within 6 weeks⁶⁵ while 94.0% of patients receive treatment within 18 weeks⁶⁶, therefore the policy would require 1.8% of patients to be treated more quickly.
54. Based on a recent NHS England simulation exercise⁶⁷, we estimate that implementing a maximum waiting time standard of 18 weeks applied to 95% of patients (i.e. to treat 1% of patients more quickly),

⁶⁴ We assumed an annual £2,000 IT investment, plus an average annual salary of £25,000 for the administrator who inputs the data.

⁶⁵ Data source: Improving Access to Psychological Therapies (IAPT) Dataset, Health and Social Care Information Centre.

⁶⁶ Data source: Health and Social Care Information Centre.

while assuming constant demand for IAPT services, would require a 0.4% increase⁶⁸ in recurrent investment. Assuming a proportional resource requirement to increase the number of patients who are treated within six weeks, to achieve both tiers of the policy, a 0.72% increase in recurrent investment would be needed. Given that £320 million is spent on IAPT services, this would correspond to an extra £2.3 million recurrent annual expenditure in 2014/15 prices. Although the waiting time standard is expected to be achieved by the end of 2015/16, we assume that the increased resources will need to be in place throughout the year to ensure that the waiting time standard is achieved by the end of the year.

55. However, we know that reduced waiting times could lead to an increase in referrals and a decreased drop-out rate. DH analysis of published IAPT data⁶⁹ for Q3 of 2013/14 suggests that the implementation of an 18 weeks maximum waiting time standard applying to 95% of patients would lead to an increase of approximately 0.28% in the number of referred patients over a year – around 3,500 more patients. On the other hand, we did not predict a statistically significant reduction in drop-out rates for the 18-week standard (but we did for more ambitious standards – starting from a 10 week waiting time standard applying to 95% of patients). By assuming current (31%) drop-out rates between referral and first treatment to remain constant, of the 3,500 extra patients we expect approximately 2,400 to access treatment at an additional cost of £1 million⁷⁰ per year.
56. Increasing demand for services also introduces a non-recurrent workforce cost. Every 100,000 new patients entering IAPT treatment requires an additional 550 new High Intensity Therapists (costing £10,000 to train), and 375 new Psychological Wellbeing Practitioners (costing £5,000 to train). The 0.4% increased resource requirement would imply training 19 new High Intensity Therapists and 13 new Psychological Wellbeing Practitioners⁷¹. To deal with the 2,400 extra patients due to the introduction of the waiting time standard would require training 13 new High Intensity Therapists and 9 new Psychological Wellbeing Practitioners. These suggest an overall one-off investment of £0.4 million in therapist training incurring in year zero.
57. As IAPT services has been rolled-out nationally, and as the proposed policy only requires marginal changes in the service delivery, no further implementation costs are considered.
58. We **assume** that the transition towards the 6 weeks maximum waiting time standard (applying to 95% of patients) will be completed by 2020 and will take place gradually as shown by Table 2. The increased

⁶⁷ A discrete event simulation model (using Simul8) has been built by NHS Analytical Services to test the resource requirements to reduce the queuing time for a typical IAPT service.

⁶⁸ The NHS England analysis estimated that implementing a 12 week maximum waiting time standard applied to 95% of patients would require a 0.8% increase in resources. Please note that this original calculation assumed that providers will achieve the waiting time standard in the most cost-effective way, in particular by moving the required number of people who would be waiting more the 12 weeks (but would be closest to 12 week mark), to exactly 12 weeks. Quarter 4 2013/14 IAPT data suggests that approximately 11.9% of patients wait more than 12 weeks. This is based on the assumption that the waiting time distribution among those who wait between 57 and 90 days is uniform. Therefore, a 12 week maximum waiting time standard applying to 95% of patients would require treating 6.9% of patients more quickly. We assume a linear relation between the required resource requirement for the 12 weeks and 18 weeks waiting time standard. Correspondingly, as 3.3% of patients would need to be treated more quickly under the 18 week standard, we estimate that implementing the standard would require a $(3.3\%/6.9\%)*0.8\% = 0.4\%$ increase in resources.

⁶⁹ Longitudinal regression analysis on the relationship between waiting time and referral rates *over time* in CCGs in Quarter 3 of 2013/14.

⁷⁰ Current unit costs per patients who receive at least one treatment appointment is £376 (£320 million annual spend divided by the 850,000 patients who are expected to receive at least one treatment in 2014/15). The unit cost is estimated to become £378 when uprated for the 0.4% required increase in resources to implement the waiting time standard.

⁷¹ This is based on the estimate that currently 4675 High Intensity Therapists and 3188 new Psychological Wellbeing Practitioners work in IAPT services.

resource requirements (based on the NHS England simulation exercise) to achieve these waiting time standards in each year (assumed to be needed to be in place throughout each year) are set out in Table 2.

Table 2.

Year	For illustrative purposes only										
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Maximum waiting time applying to 95% of patients (weeks)	-	18	16	14	10	6	6	6	6	6	6
Increased resource requirement compared to the 2014/15 baseline (assuming constant demand)	-	0.7%	1.1%	1.3%	2.7%	8.9%	8.9%	8.9%	8.9%	8.9%	8.9%
Expenditure to achieve waiting time standard (assuming constant demand) (2014/15 prices - £m)	-	£2.3	£3.5	£4.0	£8.7	£28.6	£28.6	£28.6	£28.6	£28.6	£28.6

59. Table 3 shows the estimated increases in demand for IAPT services both due to increased referrals and due to decreased drop-outs (where applicable) as the outcome of the waiting time standards.

Table 3.

Year	For illustrative purposes only										
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Maximum waiting time applying to 95% of patients (weeks)	-	18	16	14	10	6	6	6	6	6	6
Increased demand for services due to higher referral rates and lower drop-out rates where applicable (number of treated patients)	-	2,360	4,719	9,438	29,443	85,249	85,249	85,249	85,249	85,249	85,249
Cost of treating additional patients (2014/15 prices - £m)	-	£0.9	£1.8	£3.6	£11.4	£34.9	£34.9	£34.9	£34.9	£34.9	£34.9

60. Finally, Table 4 presents the one-off training requirements and the corresponding one-off costs each year to achieve these standards. It is assumed that training will have to take place in the year before the increase in patient numbers are expected.

Table 4.

Year	For illustrative purposes only										
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Maximum waiting time applying to 95% of patients (weeks)	-	18	16	14	10	6	6	6	6	6	6
Increased demand for services due to higher referral rates (number of treated patients)	-	2,360	4,719	9,438	29,443	85,249	85,249	85,249	85,249	85,249	85,249
Additional training requirement given increased resources and increased demand - High Intensity Therapists	13	13	26	110	309	-	-	-	-	-	-
Additional training requirement given increased resources - Psychological Wellbeing Practitioners	9	9	18	75	210	-	-	-	-	-	-
Training cost of extra therapists (2014/15 prices - £m)	£0.2	£0.2	£0.4	£1.5	£4.1	-	-	-	-	-	-

61. The cost profile is shown in Table 5. Costs in the future are discounted by 3.5%.

Table 5.

Year	For illustrative purposes only											Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	

Maximum waiting time applying to 95% of patients (weeks)	-	18	16	14	10	6	6	6	6	6	6	
Expenditure to achieve waiting time standard (assuming constant demand) (2014/15 prices - £m)	-	£2.3	£3.5	£4.0	£8.7	£28.6	£28.6	£28.6	£28.6	£28.6	£28.6	
Cost of treating additional patients (2014/15 prices - £m)	-	£0.9	£1.8	£3.6	£11.4	£34.9	£34.9	£34.9	£34.9	£34.9	£34.9	
Training cost of extra therapists (2014/15 prices - £m)	£0.2	£0.2	£0.4	£1.5	£4.1	£0.2	-	-	-	-	-	
Total discounted present value of costs (2014/15 prices - £m)	£0.2	£3.3	£5.3	£8.2	£21.1	£53.5	£51.7	£49.9	£48.2	£46.6	£45.0	£333.0

Benefits

62. Taking into account both that there is a subset of IAPT patients who would have recovered naturally (ie without any intervention), and a subset who would relapse following successful IAPT treatment, Layard et al⁷² estimates that the average patient will spend 13.1 *extra* months being well following Cognitive Behavioural Therapy (the therapy type most commonly offered by IAPT providers). The paper also estimates a 0.2 Quality Adjustment Life Year (QALY) gain for the period spent without the mental health problem.
63. In estimating benefits, we have assumed that they only accrue from patients who ‘recover’ - as defined by IAPT services. For recovery to be considered a patient had to have received at least two treatment sessions. For this reason, this is a conservative assumption as recovery is not assumed for people who receive one treatment session only (approximately half of all treated patients).
64. Our analysis suggests that although reducing waiting times decreases the period that people live with untreated symptoms, it does not necessarily increase the proportion of people who recover⁷³, therefore this source of potential benefits will also be ignored.
65. The IAPT dataset suggest that only 21% of those who access treatment will recover. Given the estimated extra patient numbers, we expect around 500 extra people to recover in 2015/16 as the outcome of the 18 weeks maximum waiting time standard (applying to 95% of patients).
66. Therefore, the monetised health benefit of introducing a 18 week maximum waiting time standard for 95% of patients accruing to the extra patients is £6.3 million per year. This figure uses £60,000*0.2 = £12,000 monetised QALY gain for the extra 13.1 months gained through treatment for 21% of the additional patients treated as the outcome of the policy.
67. Recovery from common mental health problems is also estimated to lead to reductions in healthcare usage per person⁷⁴ in GP consultations, outpatient procedures and inpatient bed nights. It has been

⁷² Layard, Richard, Clark, David, Knapp, Martin and Mayraz, Guy (2007) Cost-benefit analysis of psychological therapy, CEPDP, 829. Centre for Economic Performance, London School of Economics and Political Science, London, UK. (http://eprints.lse.ac.uk/19673/1/Cost-Benefit_Analysis_of_Psychological_Therapy.pdf)

⁷³ Longitudinal analysis on Quarter 1-3 2013/14 IAPT data suggest that, holding other things constant, lower waits do not increase the proportion of treated patients who recover, thereby this section only concentrates on extra recovery given the extra access.

⁷⁴ A multinomial logistic regression was estimated on waves 17 and 18 (2007/08 – 2008/09) of the British Household Panel Survey. In the different iterations of the model, the dependent variable was GP consultations, Outpatient procedures, and Inpatient bed nights, respectively, explained by possible mental health conditions, gender, age and dummies for various long term (physical) health conditions. This model was used to predict the difference in the outcomes for people who have and who do not have mental health conditions while holding all other influences constant.

estimated that people who are free from common mental health problems use 1.59 fewer GP consultations, 0.36 fewer outpatient procedures, and 0.73 fewer inpatient bed nights each year compared to people with common mental health problems. These differences in healthcare utilisation were monetised for the estimated number of people who recover as the outcome of the waiting time standard – using unit costs of £47 per GP consultation⁷⁵, £115 per outpatient procedures and £363 per inpatient bed nights⁷⁶, and by assuming that this additional decrease (on top of the baseline) will last for an average 13.1 months following IAPT treatment. This gives savings of £0.2 million per year for the 18 week maximum waiting time standard (applying to 95% of patients).

68. Results of a regression analysis⁷⁷ that compared similar individuals (in terms of education, age, ethnicity, physical conditions etc.) suggested that people with moderate/severe mental health problems are 11.4% less likely to be employed; and those with mild mental health problems are 4.3% less likely to be in employment. Applying these figures to 13.1 months extra time spent free of the mental health condition we estimate that the 18 week maximum waiting time standard (applying for 95% of patients) will result in a £0.3 million per year extra tax revenue⁷⁸.

69. The benefits of the policy are similarly evaluated for the period 2015/16 – 2024/25 as a function of the estimated number of extra recovered patients as the outcome of the waiting time standard as set out in Table 6.

Table 6.

Year	For illustrative purposes only											Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Maximum waiting time applying to 95% of patients (weeks)	-	18	16	14	10	6	6	6	6	6	6	
Extra number of patients expected to recover each year (assumed 21% of patients who access services)	-	496	991	1,982	6,183	17,902	17,902	17,902	17,902	17,902	17,902	
Cost savings from reduction in healthcare expenditure (2014/15 prices - £m)	-	£0.2	£0.4	£0.8	£2.4	£6.8	£6.8	£6.8	£6.8	£6.8	£6.8	
Increase labour force participation (2014/15 prices - £m)	-	£0.8	£1.5	£3.1	£9.6	£27.7	£27.7	£27.7	£27.7	£27.7	£27.7	
Monetised health gain for the cohort (2014/15 prices - £m)	-	£6.3	£12.5	£25.0	£78.0	£226.0	£226.0	£226.0	£226.0	£226.0	£226.0	
Total discounted present value⁷⁹ of benefits (2014/15 prices - £m)	-	£7.2	£13.9	£27.4	£83.9	£238.8	£234.8	£230.7	£226.8	£223.0	£219.2	£1,505.8

Early Intervention Psychosis

- **In 2015/16: More than 50% of patients needing early intervention in psychosis will be treated with a NICE approved care package within two weeks of referral**

⁷⁵ Unit Costs of Health and Social Care, 2013 (PSSRU)

⁷⁶ Reference Costs, 2012/13

⁷⁷ Binomial multinomial logistic regression was estimated on the sample of Adult Psychiatric Morbidity Survey (2007) on the probability of a person being employed as explained by educational qualification, ethnicity, and the presence of various specific longstanding physical illnesses, age, marital status, and the severity of the mental health condition.

⁷⁸ Including income tax, employees' national insurance contribution and employers' national insurance contribution.

⁷⁹ Following cross-government guidelines, cash savings are discounted at a 3.5% rate, while health benefits are discounted at a 1.5% rate.

Costs

70. Each year, between 16,000^{80,81} and 30,000⁸² people exhibit first **early prodromal** symptoms of psychosis. Of these, 7,500⁸³ and 15,000⁸⁴ people develop first episode psychosis, and although the rest do not develop psychosis those people still have serious underlying mental illnesses and would require a course (between 12 – 16 sessions⁸⁵) of cognitive behavioural therapy from EIP services. As the 15,000 incidence is based on a meta-evaluation of a large number of studies, and is likely to be used in upcoming NICE publications, we decided to base our calculations on the 15,000 incidence figure.
71. Based on clinical advice⁸⁶, we assume that, with full service-coverage, approximately 45,000 people will seek help from Early Intervention Psychosis Services each year. Of these, approximately 15,000 would be found not to have psychosis at the first appointment, 15,000 would require a short course (usually 12-16 sessions) of Cognitive Behavioural Therapy over a 3-month period, whereas the remaining 15,000 would require a 3-year course of treatment.
72. To remain conservative in our assumptions, we assume that those people, who are found not to have psychosis at the first appointment, would cost Early Intervention services the equivalent of providing one month of full service (i.e. the service provided to people with psychosis). These assumptions, when incorporated in a stock-flow model suggest that, with full coverage, in any one month Early Intervention Psychosis services would be in contact with approximately 50,000 people, provide treatment to approximately 48,750 people, of whom 2,500 would be new patients having entered treatment that month. This also implies that the annual cost of providing services to all those who need these services would be equivalent to providing a one-year treatment for 50,000 people each year.
73. The latest Mental Health Minimum Dataset suggests that in March 2014⁸⁷, 16,462 people received treatment from Early Intervention Psychosis services – suggesting that only approximately 1/3 of patients who need these services access treatment by Early Intervention Psychosis teams (although this figure depends on the validity of the assumptions set out above).
74. It has been estimated that Early Intervention Psychosis services spend around £2,589⁸⁸ (in 2014/15 prices) per patient per year including both wage and non-wage costs. This would suggest a total annual cost of £66.3 million⁸⁹ for providing full access to Early Intervention Psychosis services with current

⁸⁰ Martin Knapp et al (2011) 'Mental health promotion and mental illness prevention: The economic case'; (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf)

⁸¹ Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

⁸² Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

⁸³ Early intervention in psychosis services (NHS CONFED); http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/early_interventionbriefing180511.pdf?dl=1

⁸⁴ Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, Murray RM and Jones PB, (2012) Systematic Review of the Incidence and Prevalence of Schizophrenia and Other Psychoses in England; Department of Health Policy Research Programme; <http://www.psychiatry.cam.ac.uk/files/2014/05/Final-report-v1.05-Jan-12.pdf>

⁸⁵ Clinical advice from Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

⁸⁶ From Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

⁸⁷ Monthly Mental Health Minimum Data Set (MHMDS) Reports, England - March 2014 summary statistics and related information; <http://www.hscic.gov.uk/searchcatalogue?productid=14884&q=MHMDS&sort=Relevance&size=10&page=1#top>

⁸⁸ Martin Knapp et al (2011) 'Mental health promotion and mental illness prevention: The economic case'; (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf) gives a cost estimate of £2,282 in 2008/09 prices for a year of treatment. Using GDP deflators (<https://www.gov.uk/government/publications/gdp-deflators-at-market-prices-and-money-gdp-march-2014-quarterly-national-accounts>) 2.74%, 2.61%, 2.26%, 1.15%, 1.8% and 2.2% for 2009/10 - 2014/15, respectively, this figure can be uprated to

⁸⁹ £25,625 x £2,589 = £66.3 million

waiting times. However, we were advised by a clinical expert⁹⁰ that it would cost up to £6,000 per person per year to provide NICE-accordant treatment (for which an expanded workforce with increased numbers of therapists and vocational workers – i.e. compared to the workforce of a typical Early Intervention Psychosis team – would be required). This would put the total annual cost of providing full access to NICE-recommended Early Intervention Psychosis services with current waiting times to £300 million⁹¹.

75. We do not know what the current spend is on Early Intervention Psychosis services. The Department of Health’s 2011/12 National Survey of Investment in Adult Mental Health Services found that £109 million⁹² was spent on Early Intervention Psychosis services in 2011/12 (which would be £115 million in 2014/15 pounds⁹³). On the other hand, based on voluntary submissions by 39 Mental Health Trusts to the NHS Benchmarking Network, NHS England analysts estimated that approximately £275 million would be spend on EIP services in 2014/15. Correspondingly, the NHS Benchmarking Network data suggests that an extra £25 million recurrent annual investment would be needed to provide full access to NICE-recommended Early Intervention Psychosis services (with current waiting times).

76. A recent NHS England modelling exercise (assuming a baseline of 10 weeks average waiting time from referral to treatment and full access) has estimated that, to achieve a 2 week **average** waiting time⁹⁴ in Early Intervention Psychosis services from referral to the first treatment appointment, a 5.8% increase in resources would be required. Using the £300 million overall spend baseline (corresponding to full access), this would be equivalent to an extra £17.4 million recurrent annual expenditure. By assuming a symmetric waiting time distribution, we believe that the average 2 week waiting time standard is largely equivalent to the standard where 50% of patients are treated within 2 weeks of referral.

77. Given that treatment for people who are diagnosed with psychosis lasts for three years, if we were to **assume** that 95% of patients will receive EIP services within 2 weeks from referral by 2020, additional extra recurrent investment will be required to be in place from 2019/20 the latest. The same NHS England modelling exercise has estimated that it would require a 8.0% increase in resources to achieve a 1 week **average** waiting time in Early Intervention Psychosis services from referral to the first treatment appointment. Using the £300 million overall spend baseline (corresponding to full access), this would be equivalent to a £24 million recurrent annual expenditure. By assuming a symmetric waiting time distribution, we believe that the average 1 week waiting time standard is largely equivalent to the standard where 95% of patients are treated within 2 weeks of referral. Table 7 summarises the costs and presents the discounted present value of these figures.

Table 7.

For illustrative purposes only

⁹⁰ Stephen McGowan, South West Yorkshire Partnership NHS Foundation Trust.

⁹¹ 50,000 x £6,000 = £300 million

⁹² Department of Health’s 2011/12 National Survey of Investment in Adult Mental Health Services, page 37;

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf

⁹³ Using GDP deflators (<https://www.gov.uk/government/publications/gdp-deflators-at-market-prices-and-money-gdp-march-2014-quarterly-national-accounts>) 1.15%, 1.8% and 2.2% for 2012/13 - 2014/15, respectively.

⁹⁴ The costs are calculated by using a simulation model to calculate the extra resource required in percentage terms to move the system from the current state to a new, lower steady state, and applying those percentages to the baseline costs. It excludes any costs for training, and also assumes that the extra resource is all ‘front-loaded’ into initial assessments to reduce the waiting times. It does not include any extra resource required to treat the patients for the subsequent Year 2 and 3 EIP services, as it is not clear at this stage that there is a capacity issue for those stages of the service.

Year	50% of patients receive treatment within 2 weeks				95% of patients receive treatment within 2 weeks							Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Extra spend to provide full access (2014/15 prices - £m)	-	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0	£25.0
Costs to achieve the waiting time targets (2014/15 prices - £m)	-	£17.4	£17.4	£17.4	£17.4	£24.0	£24.0	£24.0	£24.0	£24.0	£24.0	£24.0
Discounted present value of costs (2014/15 prices - £m)	-	£41.0	£39.6	£38.2	£36.9	£41.3	£39.9	£38.5	£37.2	£36.0	£34.7	£383.3

Benefits

78. The benefits result from earlier diagnosis of psychosis, helping to reduce the Duration of Untreated Psychosis (DUP)⁹⁵. There is evidence that reducing DUP can lead to better patient experience, health outcome and cost benefits to the NHS, to the wider public sector and to the society⁹⁶. However, only the ‘cash’ benefits to the NHS are included in this benefit calculation, as there are lots of unknowns with respect to wider benefits.
79. To calculate the benefits, we estimate the gain that would have been made by EIP services had they had earlier access to the patient, i.e. we are comparing the whole NHS costs of a patient under EIP care with costs of patients not receiving EIP services.
80. Literature evidence⁹⁷ suggests that the whole NHS costs per year to patients who receive **timely** EIP treatment (excluding the costs of receiving EIP treatment, which were accounted for in the costs section) are around £9,052 in 2014/15 prices⁹⁸. In contrast, the cost per patient on the longer run if the patient does not receive treatment from Early Intervention Psychosis services is estimated to be £18,950 in 2014/15 prices⁹⁹. To remain very conservative in our estimates, we only assume these cost-savings to accrue to the approximately 15,000 patients who are diagnosed with psychosis each year (i.e. not for those who receive a short course of cognitive behavioural therapy only). Correspondingly, we estimate a potential cost saving of $(£18,950 - £9,052) = £9,900$ per treated patient with psychosis, or a potential total cost saving of $15,000 \times 9,900 = £148.5$ million each year for the full roll-out of EIP services.
81. We do not know exactly what proportion of this cost-savings could be generated as the outcome of the £25 million incremental annual expenditure estimated for 2014/15 – 2015/16. Assuming that, as the outcome of the investment the number of **new** patients entering treatment by EIP services would increase by 50% (approximately 5,500), the extra spend would generate a £54.5 million recurrent annual cost saving. Because people with first episode psychosis are expected to receive treatment from Early Intervention Psychosis services for three years, we assume that none of these cost savings will accrue in the first year, 50% of these cost savings will accrue in the second year, and 100% of these cost savings will accrue from the third year onwards following the implementation of the waiting time standard.

⁹⁵ The time from referral to first assessment by EIP forms a significant part, but not the whole, of DUP. However, reducing referral to assessment time should help reduce DUP.

⁹⁶ See a summary in McGorry, P. D., Edwards, J., Mihalopoulos, C., et al (1996) EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin*, 22, 305– 326; <http://schizophreniabulletin.oxfordjournals.org/content/22/2/305>

⁹⁷ Knapp et al. “Mental Health promotion and mental illness prevention: the economic case” Apr 2011, LSE.

⁹⁸ The total figure is given as £10,927 (including the costs of EIP) in 2008/09 prices, using GDP deflators 1.15%, 1.8% and 2.2% for 2012/13 - 2014/15.

⁹⁹ The total figure is given as £16,704 in 2008/09 prices, using GDP deflators 1.15%, 1.8% and 2.2% for 2012/13 - 2014/15.

82. In addition to these cost-savings, the NHS England simulation exercise has also estimated that reducing average waiting times for EIP Services to 2 weeks (while holding access rates constant) is likely to generate additional annual benefits to the health service of £1,500 per treated patient with psychosis – or £22.5 million in total. Assuming symmetric waiting time distributions, this figure would correspond to the ‘50% of patients to receive treatment in 2 weeks’ waiting time standard.

83. The same NHS England simulation exercise has also estimated that reducing average waiting times for EIP Services to 1 week (while holding access rates constant) is likely to generate additional annual benefits to the health service of £1,700 per treated patient with psychosis – or £25.2 million in total. Assuming symmetric waiting time distributions, this figure would correspond to the ‘95% of patients to receive treatment in 1 weeks’ waiting time standard. Again, we assume that none of these cost savings will accrue in the first year, 50% of these cost savings will accrue in the second year, and 100% of these cost savings will accrue from the third year onwards following the implementation of the waiting time standard. Table 8 summarises these cost savings for the 2014/15 – 2024/25 period.

Table 8.

Year	For illustrative purposes only											
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	Total
Cost savings due to increased access (2014/15 prices - £m)	-	-	£27.25	£54.5	£54.5	£54.5	£54.5	£54.5	£54.5	£54.5	£54.5	
Cost savings due to quicker treatment (2014/15 prices - £m)	-	-	£8.3	£16.5	£16.5	£16.5	£16.5	£17.5	£18.5	£18.5	£18.5	
Discounted present value of benefits (2014/15 prices - £m)	-	-	£33.1	£64.0	£61.9	£59.8	£57.8	£56.6	£55.4	£53.6	£51.8	£493.9

84. Monetised benefits to patient experience and outcomes, and the benefits to the wider public sector and society, which are believed to be substantial¹⁰⁰ adding to the strength of the cost-benefit case, are not modelled here. Additionally, NHS benefits beyond the first year have not been modelled, these are estimated to be around 40% of the benefit from the first year in years 2-5.¹⁰¹

Liaison Psychiatry

- **In 2015/16: A further £30 million recurrent annual investment will be made available to support acute hospitals with A&E departments to achieve clinically effective liaison psychiatry standards**

Costs

85. A ‘Core’ standard liaison psychiatry service is defined by the Royal College of Psychiatrists (RCPsych) as “the minimum specification likely to offer the benefit suggested by the literature. Core will serve acute health care systems with or without minor injury or emergency department environments where there is variable demand across the week, including periods of no demand where a 24-hour staffed response would be uneconomical”¹⁰².

¹⁰⁰ See McGorry, P. D., Edwards, J., Mihalopoulos, C., et al (1996) EPPIC: An evolving system of early detection and optimal management. Schizophrenia Bulletin, 22, 305– 326; <http://schizophreniabulletin.oxfordjournals.org/content/22/2/305>

¹⁰¹ Knapp et al. “Mental Health promotion and mental illness prevention: the economic case” Apr 2011, LSE.

¹⁰² Aitken, P and Lee, W. (2014): ‘Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a Census Survey’, London: Royal College of Psychiatrists. See Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf> for further specification of the Core model.

86. A recent report by the RCPsych¹⁰³ estimates that operating a ‘Core’ standard¹⁰⁴ liaison psychiatry service in a typical 500-bed acute hospital with emergency department would cost approximately £0.7 million each year, with an additional 20% one-off expenditure¹⁰⁵ incurring in the first year to set up the model. This suggests, that a further £30 million annual recurrent investment would be sufficient to provide ‘Core’ standard liaison psychiatry in at least 35 hospitals with accident and emergency departments (assuming 35 x £0.7 million annual recurrent expenditure plus 20% allowance for one-off set-up costs, and also assuming that these hospitals do not currently invest in liaison psychiatry services).
87. For illustrative purposes only, we estimated the likely costs of providing liaison psychiatry in all acute trusts **assuming** that it will be implemented by 2020. Given that there are approximately 105,000 acute overnight hospital beds in England¹⁰⁶, we estimate that it would cost approximately £147 million each year to provide Core standard liaison psychiatry services in all acute trusts. However, the ‘Core’ model, which has been described as a minimum clinically appropriate provision, may be inadequate in hospitals with busy emergency departments – where a ‘Core 24’ model or even an ‘Enhanced 24’ provision would be more appropriate. A ‘Core 24’ model is defined as a ‘Core’ model operated on a 24/7 basis – recommended for hospitals “where there is sufficient demand across the 24-hour period to merit a full service”, whereas the ‘Enhanced 24’ model is defined by the RCPsych as a liaison psychiatry provision with “enhancements to the minimum specification to fit with gaps in existing pathways and services. Often they have additional expertise in addictions psychiatry and the psychiatry of intellectual disability. Demography and demand may suggest a need for additional expertise related to younger people, frail elderly people or offenders, crisis response or social care.”¹⁰⁷.
88. We do not know the number of hospitals where the ‘Core 24’ or ‘Enhanced 24’ models would be more appropriate than the ‘Core’ model, and clinical opinion varies on this matter widely. For this reason, we will assume that the ‘Core 24’ standard would be appropriate in 25% of hospitals with emergency departments (around 47 hospitals – given that the total number of emergency departments is 189¹⁰⁸), whereas the ‘Enhanced 24’ model would be adequate in 12.5% of hospitals with emergency departments (around 24 hospitals). The RCPsych¹⁰⁹ estimates that the operating costs of ‘Core 24’ and ‘Enhanced 24’ standard¹¹⁰ liaison psychiatry services in a typical 500-bed acute hospital with emergency department are approximately £1.1 million and £1.4 million each year, respectively, with an additional 20% one-off set-up cost¹¹¹ incurring in the first year. This suggests that providing appropriate liaison psychiatry in all acute trusts would cost approximately £182.6 million¹¹².

¹⁰³ Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf>

¹⁰⁴ See Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf> for the specification of the Core model.

¹⁰⁵ Aitken, P and W. Lee (2014) ‘Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a census survey’

¹⁰⁶ Bed Availability and Occupancy Data – Overnight, NHS England: Unify2 data collection - KH03, April to June 2014; http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Beds-Open-Overnight-Web_File-Final-Q1-2014-15-34655.xlsx

¹⁰⁷ See Aitken, P and Lee, W. (2014): ‘Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a Census Survey’, London: Royal College of Psychiatrists, and Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf> for further specification of these models.

¹⁰⁸ Accident and Emergency Attendances in England - 2012-13; <http://www.hscic.gov.uk/catalogue/PUB13464>

¹⁰⁹ Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf>

¹¹⁰ See Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf> for the specification of the Core model.

¹¹¹ Aitken, P and W. Lee (2014) ‘Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a census survey’

¹¹² Based on the assumption that for 47 hospitals the provision will cost £1.1 million instead of £0.7 million (difference of £18.8 million), and for 24 hospitals the provision will cost £1.4 million instead of £0.7 million (difference of £16.8 million), making the total £147.0m + £18.8m + £16.8m = £182.6m

89. The RCPsych estimates¹¹³ that current spend on liaison psychiatry provision is £68 million per annum. Given this, Table 9 shows the estimated incremental costs (recurrent and set-up costs) over the 2014/15 – 2024/25 period assuming linear transition from the 2015/16 standard to achieving appropriate liaison psychiatry provision in all acute trusts by 2020.

Table 9.

Year	For illustrative purposes only											Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Recurrent costs (2014/15 prices - £m)	-	£25.0	£47.4	£69.8	£92.2	£114.6	£114.6	£114.6	£114.6	£114.6	£114.6	
Set-up costs (2014/15 prices - £m)	-	£5.0	£4.5	£4.5	£4.5	£4.5	-	-	-	-	-	
Total discounted present value of costs (2014/15 prices - £m)	-	£29.0	£48.4	£67.0	£84.3	£100.3	£93.2	£90.1	£87.0	£84.1	£81.2	£764.6

90. There may be some un-quantified costs, too. A liaison psychiatry service is expected to increase the number of patients diagnosed with mental health problems. This may have some knock-on effect on the demand for secondary mental health services and for the social care sector. Further analysis would be needed to identify how this increased demand may be counterbalanced by the lower hospital stay and readmission rates of patients seen by the liaison psychiatry service as well as by the higher discharge rate to patients' own homes.

Benefits

91. A number of studies, as well clinical experts, have suggested that a clinically appropriate model of liaison psychiatry service in hospitals with emergency departments (i.e. one of 'Core', 'Core 24', 'Enhanced 24' or 'Comprehensive' models most suitable for the type of emergency department in question) could generate four times as much benefits in terms of reduced length of stay and lower readmission rates as the costs of the service^{114,115,116}. Liaison psychiatry, when rolled out to acute hospitals has still proven to generate at least 3 times as much cost savings as the cost of the service¹¹⁷. Correspondingly, the 2015/16 standard (providing a further £25 million recurrent annual investment) could generate recurrent cost savings of approximately £100 million each year.
92. Table 10 shows the benefit profile over the 2014/15 – 2024/25 period. These figures take into account the expected fall in the cost:benefit ratio as liaison psychiatry is rolled out to an increasing number of acute hospitals – assuming an average 1:3.5 cost:benefit ratio by 2019/20 and a linear transition towards this ratio.

Table 10.

Year	For illustrative purposes only											Total
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	
Recurrent benefits (2014/15 prices - £m)	-	£100.0	£183.7	£261.8	£334.2	£401.1	£401.1	£401.1	£401.1	£401.1	£401.1	

¹¹³ Aitken, P and W. Lee (2014) 'Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a census survey'

¹¹⁴ Parsonage, M. and Fossey, M. (2011): 'Economic evaluation of a liaison psychiatry service', London: Centre for Mental Health; http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf

¹¹⁵ See Aitken, P and Lee, W. (2014): 'Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department – findings from a Census Survey', London: Royal College of Psychiatrists, and Palmer et al (2014) Quality Standards for Liaison Psychiatry Services: Fourth Edition 2014; <http://www.rcpsych.ac.uk/PDF/PLAN%20standards-4th%20edition%202014.pdf> for further specification of these models.

¹¹⁶ Michael Parsonage (LSE) and Peter Aitken (University of Exeter)

¹¹⁷ Michael Parsonage (LSE) and Peter Aitken (University of Exeter)

Total discounted present value of benefits (2014/15 prices - £m)	-	£96.6	£171.5	£236.1	£291.3	£337.7	£326.3	£315.3	£304.6	£294.3	£284.3	£2,657.9
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Risks and assumptions

93. Due to the nature of available data, several assumptions were made during this impact assessment in order to estimate various outcomes.

General assumptions

94. Prevalence rates were assumed based on APMS (2007), as this is the most comprehensive report available. However, due to the small sample size used in this study, estimates or prevalence could be either higher or lower than reality, when applied to the whole population.

Improving Access to Psychological Therapies

95. The assumed unit cost reflects the fact that most IAPT patients are not offered NICE-recommended full course of treatment. If the average number of treatment appointments would change, this would have an effect on the unit cost and on all cost estimates.

96. It was assumed that there will be a constant demand for IAPT, at 15% of prevalence. However, if demand was to increase or decrease from this constant, estimates of future costs may not cover the reality

97. When estimating benefits of recovery from mental health problems, such as reduced numbers of GP appointments, due to data incompleteness we assumed IAPT recovery rates excluded those who recovered after only having one treatment session, meaning that actual recovery rates may be higher than estimated here, thereby increasing the estimated benefits.

Early Intervention for Psychosis

98. There are considerable uncertainties around the unit cost of Early Intervention Psychosis services. Academic evidence suggests that services spend below £3,000 per patient per year, while clinical experts suggest that it could cost up to £6,000 per year per patient to provide a NICE-compliant EIP service. To remain conservative, we used the £6,000 figure, but this may be an overestimate.

99. We assumed that each year around 30,000 patients would seek help from EIP services, of whom 7,500 would be found to have a non-psychotic but serious mental health problem resulting in a course of treatment over 3 months on average, and 7,500 would be found to have psychosis requiring a course of treatment over 3 years. This was based on advice by a clinical expert, and so may reflect a clinician's own experience rather than objective national statistics. The 7,500 incidence rate is widely cited in literature, although one paper suggests that it could be as high as 15,000 each year. If incidence rates were indeed 15,000, then costs would increase – albeit not by doubling, as the 15,000 would have a lower severity rate than the 7,500 on average.

100. Based on clinical advice, it was assumed that half of those who seek help from EIP service would not be found to have psychosis at first appointment.

101. When estimating the cost of imposing reduced waiting times on EIP services, it was assumed that the aim of a 1 week average waiting time would be equivalent to 95% of patients being treated within 2 weeks of referral, based on a symmetric waiting time distribution. This was in order to estimate maximum waiting times that could be expected, fitting with the average goal. However, this does not account for non-symmetric waiting time distributions which may occur in some areas, with a few people potentially waiting far longer than this. This may increase the costs.

102. When estimating the proportion of cost savings that would be generated as an incremental outcome of EIP expenditure with reduced waiting times, it was assumed that service redesign and therapist training would achieve full access to the services. This was in order to provide a best-case example of savings that could incur. However, it is possible that redesign would not achieve full access to these services, meaning the impact of this intervention on cost savings could be overestimated here.

Liaison Psychiatry

103. It was assumed that the annual cost of Liaison Psychiatry services providing 'core' standard service in all acute trusts would be around £147million. This was based on the number of acute overnight hospital beds in England. However, this does not account for extra internal costs which may occur in different localities.

104. Similarly, it was assumed that 'core-24' standard Liaison Psychiatry services would only be appropriate in 25% of hospitals with emergency departments, recognising that this provision would not be realistic for all hospitals. This was assumed in order to estimate the total costs of providing appropriate Liaison Psychiatry services in all trusts (where the highest level appropriate would be provided). However, the validity of this assumption affects the overall cost estimates.

105. An assumption of linear transition of costs from 2015/16 after implementation of more 'core' standard services was used to estimate incremental costs for Liaison Psychiatry services per annum until 2024/25, based on RCPsych estimates of current Liaison Psychiatry spend. This was in order to predict increases in future spend required based on the desired service provision increases. However, these figures would be subject to change dependent on factors such as successful implementation of estimated numbers of 'core' services.

106. To be conservative in estimations of benefits of increased Liaison Psychiatry provision, it was assumed that Liaison Psychiatry would only shorten length of hospital stay in 5% of admissions. However, this may underestimate the average reduction in hospital stay time, meaning the predicted benefits of Liaison Psychiatry services may be higher than indicated here.

Direct costs and benefits to business calculations (following OITO methodology)

N/A

Wider impacts

Summary and preferred option with description of implementation plan

107. The following table presents a summary of the total discounted present value costs and benefits presented in this IA. The table also shows the opportunity cost of funding these three policies. As a rule of thumb, the Impact Assessment guidance assumes that the opportunity cost is £4 for every £1 spent.

Year	For illustrative purposes only										
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25

Costs (£m)

<i>Data changes</i>	£1.25	£1.6	£1.6	£1.5	£1.5	£1.4	£1.4	£1.3	£1.3	£1.2	£1.2	£15.4
<i>IAPT</i>	£0.20	£3.30	£5.30	£8.20	£21.10	£53.50	£51.70	£49.90	£48.20	£46.60	£45.00	£333.00
<i>EIP</i>		£41.0	£39.6	£38.2	£36.9	£41.3	£39.9	£38.5	£37.2	£36.0	£34.7	£383.3
<i>Liaison Psychiatry</i>		£29.0	£48.4	£67.0	£84.3	£100.3	£93.2	£90.1	£87.0	£84.1	£81.2	£764.6
Total Costs	£1	£74	£64	£88	£107	£131	£167	£159	£154	£149	£144	£1,237
Opportunity cost value of real costs (x4)	£6	£300	£254	£352	£426	£522	£668	£637	£616	£595	£575	£4,951

Benefits

<i>IAPT</i>		£7.20	£13.90	£27.40	£83.90	£238.80	£234.80	£230.70	£226.80	£223.00	£219.20	£1,505.80
<i>EIP</i>			£33.1	£64.0	£61.9	£59.8	£57.8	£56.6	£55.4	£53.6	£51.8	£493.9
<i>Liaison Psychiatry</i>		£96.6	£171.5	£236.1	£291.3	£337.7	£326.3	£315.3	£304.6	£294.3	£284.3	£2,657.9
Total Benefits		£104	£219	£328	£437	£636	£619	£603	£587	£571	£555	£4,658

Net Benefit	-£1	£29	£155	£240	£331	£506	£452	£443	£433	£422	£412	£3,420
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Net Benefit vs opportunity cost	-£6	-£196	-£36	-£25	£11	£114	-£49	-£35	-£29	-£24	-£20	-£293
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