

**A Proposed New System for Health and Social  
Services**

**Adult Mental Health: Improving  
Access to Psychological Therapies**

**Scheme-level Outline Business Case (OBC)**

**Version 2.0**

**13 June 2012**

### **Purpose of the Outline Business Case**

The Green Paper, *'Caring for each other, caring for ourselves'*, was produced in May 2011. Following public consultation, eight service areas were selected for early service development in 2012 – 2015. Sustaining Acute Services was identified as being 'Business As Usual', and was removed from the OBC list, therefore, seven OBCs have been produced.

Each proposed service change has been developed robustly, with full involvement from stakeholders. Working groups have used an Outline Business Case (OBC) template when discussing and developing the service changes, in order to ensure that all relevant aspects have been considered. The template incorporates guidelines from the UK Government's website on Business Cases as well as the template on the Treasury & Resources website.

Once approved, each OBC will be progressed to Full Business Case (FBC) – this is anticipated to be by Autumn 2012. The FBC will provide detail on the service change, including detailed timescales and action plans for implementation. Service implementation commences once the FBC has been approved and fund secured from the Medium Term Financial Plan, which is due to be agreed in late Autumn 2012.

### **Structure of this document**

This Outline Business Case presents the elements of service change that must be considered in order for plans to be robust, stakeholders to be fully engaged, and risks to be managed effectively.

The case for change for Improving Access to Psychological Therapies is presented, building from the case for change in the Green Paper. The linkage with the HSSD strategic principles and with the relevant services' strategies is clearly identified. The outcome of the Green Paper consultation, and in particular the views of stakeholders received during the consultation period have been presented where applicable, in recognition of the importance of these views.

The OBC then outlines the proposed service change, and the elements thereof, for example, the impact on workforce, on costs and on service delivery / quality.

Indicative costs and benefits are outlined. Some rounding adjustments have been made. All costs are presented at prices relevant to the each year, to ensure that the full cost of the proposals is understood. Costs and benefits which are quantitative and qualitative, short and long term and relevant to patients / service users / carers / families, clinicians and the public have been considered.

Implementation considerations are then presented, including stakeholder engagement and communication, key risks and issues for both the implementation period and for the full service delivery.

**Revision history**

Version	Date	Author	Description
0.01		Tracy Wade	Second Draft minus financials
0.02	02.11.11	Tracy Wade	Revised OBC structure including financials
1.0	20.05.12	Rachel Williams	Final review and revision
1.1	11.06.12	Chris Dunne	Final review
2.0	13.06.12	Rachel Williams	Finalisation

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## Abbreviations and Definitions

Abbreviation	Definition
CBT	Cognitive behaviour therapy
FBC	Full Business Case
HSSD	Health And Social Services Department
IAPT	Improving Access To Psychological Therapies
MTFP	Medium Term Financial Plan
OBC	Outline Business Case

# 1 Executive Summary

## 1.1 Introduction and background

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. The KPMG technical document and the Green Paper, both published in May 2011, demonstrated that health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services in the near future, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 10 years.

In early 2011 the vision for health and social care in Jersey was agreed. This clearly stated that services must be safe, sustainable and affordable.

The public consultation on the future of health and social services in Jersey concluded on 22 August 2011. Since that time, a Working Group has been considering the service changes that are required urgently; this Outline Business Case is a result of that process.

## 1.2 Strategic Context

Mental health problems are common, and are a major source of suffering for individuals and their families<sup>1</sup>. This can lead to social exclusion and costs to the economy<sup>2</sup>. The World Health Organisation estimates that 154 million people worldwide suffer from depression<sup>3</sup>. The Jersey Annual Social Survey (2010)<sup>4</sup> found 18% of the adult population suffer with moderate depression and a further 2% revealed they were extremely anxious or depressed. In addition, increasing rates of death from suicide and undetermined injury was identified as a key concern.

Depression and anxiety make it much more difficult for a person to work and increase the likelihood of sickness absence<sup>5</sup>. The Stafford Report (2007)<sup>6</sup> highlighted the longer an individual is signed off sick from work the greater the likelihood of moving into permanent incapacity benefit and subsequent absenteeism.

Stigma associated with mental health issues are a common barrier which prevent people from accessing help. Long waiting lists for psychological interventions have a major impact on people who require support.

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<sup>1</sup> Marmot Review (2010) Fair Society Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post 2010. Available at: [www.ucl.ac.uk/marmotreview](http://www.ucl.ac.uk/marmotreview)

<sup>2</sup> World Health Organisation (2009) *Mental Health, Resilience and Inequalities*. Europe. WHO.

<sup>3</sup> World Health Organisation (2010) *Suicide Prevention (SUPRE)* Available at: <http://www.who.int/mentalhealth/prevention/suicide/suicideprevention/en/index.html>

<sup>4</sup> Jersey Annual Social Survey (2010) *JASS*, States of Jersey

<sup>5</sup> Black, C. (2008) *Working for a healthier tomorrow. Review of the health of Britain's working age population*. Crown Copyright.

Layard, R., Clark, D., Knapp, M. and Mayraz, G. (2007) *Cost-Benefit Analysis of Psychological Therapy*. National Institute Economic Review, No 202, October 2007

<sup>6</sup> Health & Social Services (2007) *The Stafford Report*. Social Security Department. States of Jersey.

Primary Care for mental health can reduce stigma and produce good outcomes<sup>7</sup>. The National Institute for Health and Clinical Excellence (NICE) guidelines recommend that cognitive behaviour therapy should be available as an option for people with mild or recent onset of depression<sup>8</sup> and anxiety<sup>9</sup>. Evidence from randomised controlled trials suggests psychological therapy is as effective as drug treatment for many common mental health issues and recommends a Stepped Care Model for diagnosing and treating anxiety and depression<sup>10</sup>.

In addition, the UK policy *No Health without Mental Health* (2011)<sup>11</sup> highlighted that access to Talking Therapies resulted in a reduction in the need for inpatient facilities and people taking their own life.

### 1.3 The Case for Change

The States of Jersey Strategic Plan 2009-2014<sup>12</sup> committed to enhance and improve health care provision and promote a healthy lifestyle. The States Business Plan 2010<sup>13</sup> aims to reduce mortality rates from suicide and injury, as highlighted in recent research conducted by the University of Southampton (2009)<sup>14</sup> and the Annual Report of the Medical Officer of Health (2009)<sup>15</sup>.

The need for low level mental health service provision is high - in the Jersey Annual Social Survey (2010), 18% of the adult population indicated that they were suffering moderately from anxiety or depression and another 2% were extremely anxious or depressed, 40% of repeat GP visits are individuals diagnosed with depression and anxiety.

Direct service provision costs for adult mental health total £10,222,60. Prescribing is high, particularly for benzodiazepines, hypnotics and antidepressants -this cost the States £450k in 2009.

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<sup>7</sup> World Health Organisation. (2008) *Now More Than Ever. Primary Health Care*. WHO  
Department of Health (2011) *Delivering better mental health outcomes for people of all ages*. Crown Copyright.

<sup>8</sup> National Institute for Health and Clinical Excellence (2010). *Depression: The NICE Guideline on the treatment and management of depression in adults*. Updated edition. National Collaborating Centre for Mental Health. Commissioned by NICE and the British Psychological Society and the Royal College of Psychiatrists. NICE Clinical Guideline 90. NICE. April 2010.

<sup>9</sup> National Institute for Health and Clinical Excellence (2011) *Generalised Anxiety Disorder and Panic Disorder (with or without agoraphobia) in adults: Management in Primary, Secondary and community care*. NICE Clinical Guideline 113. National Collaborating Centre for Mental Health and the Royal College of General Practitioners. NICE. April 2007.

<sup>10</sup> Department of Health (2008) *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit*. Care Services Improvement Partnership (CSIP) & National Institute for Mental Health in England. April 2008.

Department of Health (2011) *Talking Therapies: A four-year plan of action*. Crown Copyright.

<sup>11</sup> Department of Health (2011) *No Health without Mental Health. A cross government mental health outcomes strategy for people of all ages*. HM Government. UK

<sup>12</sup> Health and Social Services (2009) *Strategic Plan 2009-2014*. States of Jersey.

<sup>13</sup> Health and Social Services (2010) *Business Plan 2010*. States of Jersey.

<sup>14</sup> University of Southampton School of Medicine (2009). *Suicide in Jersey Between 2000 and 2009*. States of Jersey. August 2009-2010.

<sup>15</sup> Medical Officer of Health (2009) *Annual Report of the Medical Officer of Health. Our Island Our Health*. States of Jersey.

The wider economic cost of mental health is significant, 46.8% of all claims made for short-term and long-term incapacity allowance in Jersey in 2009<sup>16</sup> were for mental health problems. Over 2,600 claims on average were made by people on benefits due to depression, anxiety and other mental health issues,<sup>17</sup> and between 2006 and 2009 an estimated average of £4.9m p.a. was paid in short and long term Incapacity Benefit for people with all mental health issues.

The current Psychological Assessment and Therapy Service have a two month waiting list prior to assessment and over three months following assessment. Service Users cannot access Psychological Therapies directly, and there are no services for children or people over 65 years. The service levels are grossly under resourced, with the equivalent of six full time posts serving an adult population of 60,000.

The current lack of psychological therapies in community settings can deter individuals from seeking help, and there is no single point for health promotion information.

Primary Care information systems are variably developed, with a mixture of systems for recording, monitoring and sharing information. The ability to register with more than one practice increases the risk of data duplication and creates governance concerns such as 'doctor-shopping' linked to drug misuse.

### 1.4 Service Objectives for Improving Access to Psychological Therapies

The overall objective of Improving Access to Psychological Therapies (IAPT) is to provide quick, easy, equitable access to all adults over the age of 18 years for the treatment of common mental health issues. Specific objectives include:

- To reduce the impact of common mental health issues for individuals and thereby improve general wellbeing
- To improve access to psychological therapies through a single pathway
- To reduce exclusion from work through the provision of timely evidence based treatment provided by a number of specifically trained staff.
- To reduce inappropriate prescribing of benzodiazepines and antidepressants
- To enhance partnership working with GPs, professionals and other voluntary and Third Sector organisations

### 1.5 Improving Access to Psychological Therapies by 2015

Following NICE guidelines and Improving Access to Psychological Therapies (IAPT) guidelines a Stepped Care Model Service is proposed<sup>18</sup>.

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<sup>16</sup> Health and Social Services (2009) Social Security Department Data. States of Jersey.

<sup>17</sup> Health and Social Services (2009) Social Security Department Data. States of Jersey.

<sup>18</sup> Department of Health (2011) *The economic case for improving efficiency and quality in mental health*. Crown Copyright.

National Health Service (2011) IAPT. Available at [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

National Health Service (2011) Commissioning Talking Therapies for 2011/12. IAPT.

Department of Health (2008a) *NHS Next Stage Review. Our vision for primary and community care*. Crown Copyright.

Department of Health (2008) *Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery*. Care Services Improvement Partnership CISP, National Institute for Mental Health in England.

Department of Health (2008/09) *Improving Access to Psychological Therapies. Implementation Plan: National Guidelines for Regional Delivery*. Crown Copyright.



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Based on recommendations from the National Advisor of IAPT in the UK, a population of 90,000 would require 15 properly trained therapists (to include working with the over 65's) with a ratio of around six to four high-intensity to low-intensity therapists.

The expanded IAPT service will comprise cognitive behaviour therapy (CBT) therapists working at either high intensity or low intensity, depending on the needs of the Service User.

The enhanced services will build on the pilot undertaken in 2006 with two GP surgeries. This was positively received by Primary Care and sustained good outcomes including:

- Service Users seen in their own GP surgeries
- Waiting times for first appointment reduced from 2 weeks to 1 day
- Service User satisfaction with service provided
- Two GPs reported at that time that they were less likely to prescribe medication knowing that Service Users would be seen quickly.

Services will be supported by self care, with strengthened personal responsibility, and the role of Primary Care (and the public perception of this role) will be developed beyond simply those services provided by a GP, to encompass all care professionals working on the front line of service delivery in the community. This incorporates both the prevention and treatment of disease and the promotion of wellbeing and independence.

Services will be developed with Primary Care, based on new models of collaborative working, with clearly defined and safe care pathways and a distribution of responsibilities between primary, secondary, mental health, social care and the Third Sector– and the patient / service user and carer.

### **Benefits include:**

- Fast, equitable and evidence based interventions for common mental problems
- Reduced self reported anxiety and depression
- Early intervention services for common mental health difficulties
- Reduced absenteeism and sick certification amongst employed workers
- Increased chances of remaining in employment for those have common mental health difficulties
- Consistency in referrals and a reduction of referrals to Mental Health Services
- Improved seamless care pathway
- Increased use of self care
- Increased capacity for treatment of common mental health
- Reduced demand for secondary mental health services
- Early identification of common mental health issues
- Reduced inappropriate prescribing and increased change in prescribing practices working within NICE guidelines
- Reduced progression to more serious and enduring mental health problems
- Reduced need for inpatient beds in the future

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Department of Health (2007) *Mental Health: New Ways of Working for Everyone. Developing and sustaining a capable and flexible workforce.* Crown Copyright.

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### 1.5.1 The Financial Case

A recurring additional revenue investment of £344,000 in 2013, £736,000 in 2014 and £1,132,000 in 2015 is required.

Non-recurring implementation costs are estimated at £176,000.

The service will require an additional 14 FTE (8 High Intensity, 5 Psychological Wellbeing Practitioners and 1 Administrator).

The cost of overall investment is offset by an estimated annual cost containment of £1.2m (by 2015), which comprises (by Q2, 2015) from:

- Reduction in social security payments for visits to General Practitioners
- Reduction in benefits payments
- Reduction in medication costs
- Reduction in demand for both inpatient and outpatient mental health services.

### 1.5.2 Implementation Actions and Timescales

	2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Engage Stakeholders																
Formulate detailed requirement, including job descriptions		HI		LI												
Commissioning structures in place																
IT Scoping		HI			LI											
Accommodation scoping		HI			LI											
Tendering				HI	LI											
Prepare and plan marketing campaign; marketing		HI			LI											
Marketing and media campaigns																
Training providers scoping																
Reconfiguration of existing services to incorporate enhanced service																
Phase 1 - Service commencement 25% of HI workers (2 FTE)				HI												
Training																
Phase 2 - 25% HI workers (2 FTE)																
Phase 2 - 50% PWPs																
Training staff in brief interventions for alcohol																
Recruit administrators - 1 FTE																
Phase 3 - 25% HI plus 50% PWP																
6 month audit and evaluation																
Phase 4 - 25% remaining HI workers																

### **1.6 Stakeholders, risks, issues, dependencies and enablers**

#### **1.6.1 Stakeholders**

The OBC was produced by a Working Group comprising Mental Health Services, Jersey MIND, GP primary care body, Public Health, Human Resources, Social Security and Finance, Into the future it would be advisable to include representation from non statutory services for older persons.

Stakeholders to be engaged as the OBC develops into an FBC include Regulations and Inspections Team, Ministers, St John's Ambulance, General Practitioners, Private sector providers, Parishes and Acute services.

#### **1.6.2 Risks and Issues**

- Lack of funding availability
- Inability to recruit and / or retain staff
- Capacity pressures which limit the amount of clients and caseloads
- Interest from providers, including Third Sector, in delivering IAPT services
- Inflexible GP funding mechanisms
- Lack of flexibility in Social Security legislation (e.g. the 'fit for work' scheme in the UK)
- Lack of robust commissioning processes

#### **1.6.3 Dependencies**

The new IAPT service is dependent on:

- Existing services sharing the vision and participating in new ways of partnership working
- Public engagement and concordance with the new approach for accessing services for mental health issues
- Ongoing consultation and communication between Long Term Conditions and Healthy Lifestyles OBCs to prevent duplication and enhance partnership working
- Progress of Social Security changes in legislation

#### **1.6.4 Enablers**

The development of IAPT services will also require workforce development, as new ways of working will be required, both in terms of skills, locations and care delivery.

### **1.7 Next steps**

- Work with Primary Care Body to discuss IAPT
- Develop detailed service impacts, assuming future investment in early interventions, based on reductions in demand for Secondary care Mental Health services
- Scope potential venues for delivering the service
- Develop a commissioning framework
- Complete the Full Business Case, including developing detailed service design.

## 2 Introduction and background

### 2.1 A Global challenge

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand on all health and social care systems.
- Technological advances are allowing efficiency and quality improvements but also creating major new costs.
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically.
- Service ethos is shifting from treatment to prevention and promoting independence.

Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services aimed at managing demand, promoting health and wellbeing, ensuring equality of access and protecting / safeguarding vulnerable people. Our aspiration is to enable people to be cared for in the most appropriate place, living as productive and independent lives as possible.

### 2.2 The Challenge for Health and Social Care in Jersey

Jersey is experiencing many of the same challenges as all other health and social care systems internationally, but it also has some unique challenges.

#### A small island

In normal circumstances our population of just under 100,000 would be considered too small to support comprehensive acute hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

Accordingly, the unit cost of delivering hospital and social services in Jersey is higher compared with systems serving larger populations. This is because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation, which are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional funding “premium”, which increases unit costs. Secondly, it can produce vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

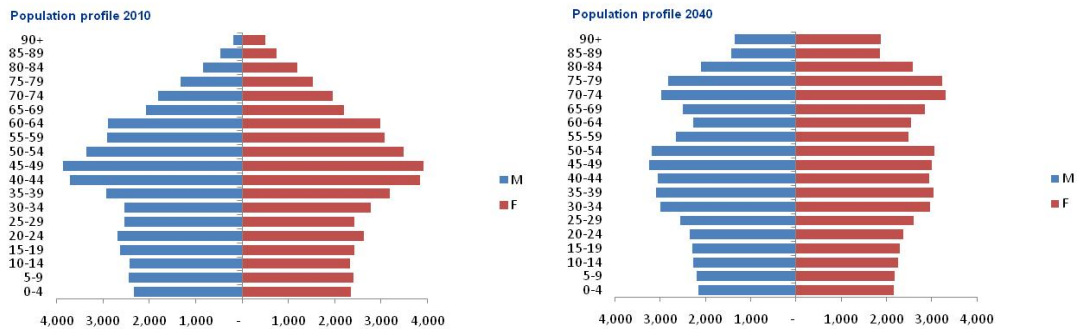
#### 2.2.1 Demography

Given immigration controls the population of Jersey is rising only slowly. But it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 is projected to rise by 95%; in the period to 2020 the increase is projected to be 35%.

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This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

**Fig 1. Demographic change in Jersey**



Within 5 years, the current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

### 2.3 Strategic Principles

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by Ministers:

- Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
- Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
- Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
- How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
- Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency
- Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities
- Clinical governance – sustaining a culture of safety, learning and transparency
- Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

#### 2.3.1 Service principles and assertions:

- Social care and health should be integrated as seamlessly as possible on a service user's/patient's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and

ensures that needs drive services and not the reverse, to improve emotional, social and health wellbeing.

- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven care will provide choice and empowerment. At present, complex services are provided by a multiplicity of providers, teams and professionals with different referral and access points, assessment frameworks, eligibility criteria and pathways. Simplifying and standardising the current range of approaches would improve co-ordination, providing a holistic, streamlined service which provides support, enablement and choice of care setting for older people and support for their carers.
- Services should be planned and delivered within partnerships bringing together all sectors of our Islands community and economy
- Where appropriate, service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and lead independent and productive lives as much as possible.

### 2.4 Stakeholders and public opinion

Between November 2010 and April 2011 a number of stakeholders were interviewed to ascertain their views on the future for health and social care. The key themes were:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist

Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

### 2.5 Results of the Green Paper consultation

Between May and August 2010 HSSD consulted on the Green Paper 'Caring for each other, Caring for ourselves'. More than 1,300 Islanders responded to the consultation. The response was overwhelmingly in favour of redesigning health and social services so that they continue to be safe and affordable for the future (86%), and many respondents included detailed comments and viewpoints.

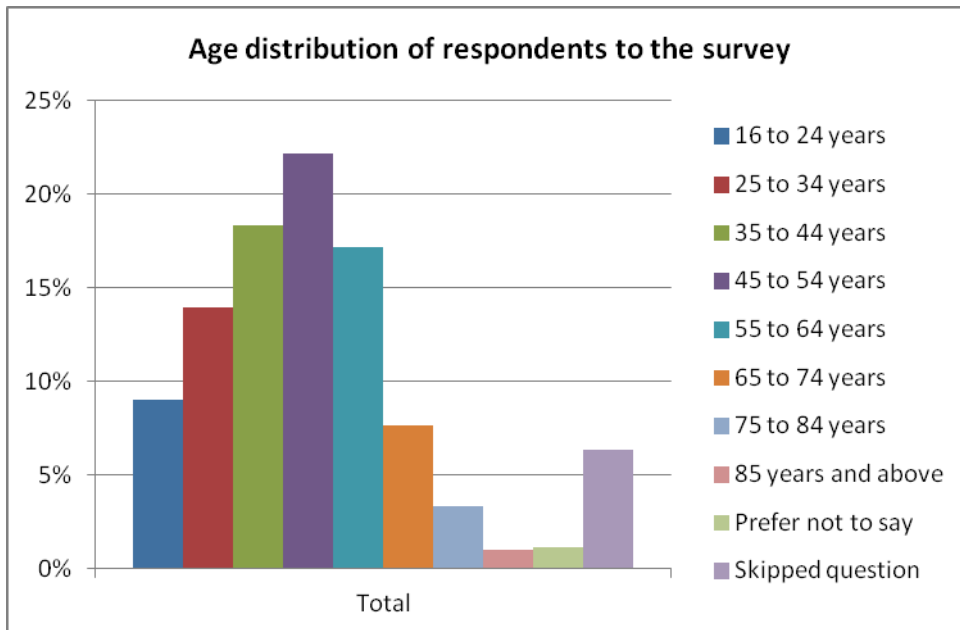
The Green Paper sought views on three scenarios for the future of health and social care:

- Scenario One: "Business as usual" – services continue to be provided in the same way and through the same structures as in 2010; spending increases to meet growing demand.
- Scenario Two: "A small increase in funding" – the funding allocation does not increase. Services have to be prioritised within this budget and many services will be subject to 'means testing' or will be stopped.

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- Scenario Three: “A new model for health and social care” – prioritised changes to service delivery, to ensure health and social services are safe, sustainable and affordable and are able to meet projected increases in demand.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and Mind Jersey. More women than men responded.



### Responses

The overwhelming message from the consultation was the positive views of Islanders about their health and social services. The majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island. The remaining questions elicited the following responses:

- The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.
- The vast majority of people (90%) agreed that “The States should ensure that preventing ill health is as important as curing ill health”. Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.
- Mixed views were received regarding having “responsibility for your own health” – whether this was for longer waiting times or increased charges for people who choose not to look after their own health. In particular, there were concerns about “self-inflicted” injuries or illnesses. Some respondents argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.
- Most respondents agreed that “People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and parishes.
- The vast majority of people (90%) agreed that “Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care

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professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes.”

- Most respondents said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some respondents commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of Primary Care to individual patients.
- Respondents also indicated that off-island travel was acceptable for some treatments. Some respondents would rather not have off island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.
- Professionals working together to deliver better integrated care was important, but some respondents noted that Jersey’s charities should receive more funding and support.
- The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.
- The need for affordable care was often stressed, and many respondents felt payment and funding needed to be explored in more depth.
- Most respondents said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with respondents expressing concern about the costs of care for people with long term illnesses and whether they would be able to pay.
- Some respondents commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.
- Some respondents felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.
- According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, while a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.
- Many respondents felt that there are opportunities to improve current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more third party and profit making organisations to provide care.

### 2.6 Development of the Outline Business Case

This Outline Business Case (OBC) presents the case for change for IAPT. It explains, within the context of current and future safety, sustainability and affordability and



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against the strategic principles agreed by Ministers in late 2010, the reasons why 'do nothing' is not an option.

The OBC was developed by a Working Group between August and November 2011. Between November 2011 and March 2012, significant work was undertaken with Treasury to ensure that financial projections are within an indicative cost envelope and sufficiently detailed and accurate for the Medium term Financial Plan submissions in summer 2012. It presents an outline cost/benefit analysis and outlines the features and timescales of the proposed service changes and assesses the potential impact against a range of factors, including workforce, cost and quality.

This OBC has been prepared by Tracy Wade as Senior Responsible Officer, after consultation with service providers, Third Sector organisations, service users and carers.

## 3 The IAPT Service

### 3.1 The Service Case

#### International evidence

Mental health is one of Britain's biggest social problems<sup>19</sup>. Depression and anxiety are serious conditions and have a major impact on how well an individual is able to function<sup>20</sup>. Currently only 30% of individuals with a diagnosable depression and less than a quarter with anxiety disorders are in treatment.

Mental health problems are common, and are a major source of suffering for individuals and their families. They can lead to social exclusion and costs to the economy<sup>21</sup>. The World Health Organisation estimates that 154 million people worldwide suffer from depression<sup>22</sup>.

Depression and anxiety make it much more difficult for a person to work and increase the likelihood of sickness absence<sup>23</sup>. The Stafford Report (2007)<sup>24</sup> highlighted that the longer an individual is signed off sick from work the greater the likelihood of moving into permanent incapacity benefit and subsequent absenteeism.

Stigma associated with mental health issues are a common barrier which prevent people from accessing help. Also, some individuals have physical health problems such as chronic pain that distracts them and the GP from recognising co-morbid mental health problems<sup>25</sup>. Long waiting lists for psychological interventions can further compound low level mental health problems - people who receive psychological treatment within 18 months of diagnosis are twice as likely to recover as people not receiving treatment<sup>26</sup>.

The prevalence of mental health issues in Primary Care settings has been researched extensively in a range of different countries. The principle disorders presenting in Primary Care settings are depression, generalised anxiety disorder (which account for

<sup>19</sup> Layard, R. (2006) 'The case for psychological treatment centres'. *British Medical Journal*, 332, pp 1030-1032. April 2006.

<sup>20</sup> Centre for Mental Health. Briefing 33 Mental Health and Employment. The Future of Mental Health: a vision for 2015. Policy Paper. Centre for Mental Health. Available at: <http://www.centreformentalhealth.org.uk/policyviewer.aspx?PWID=799>

<sup>21</sup> World Health Organisation (2009) *Mental Health, Resilience and Inequalities*. Europe. WHO. Kirkwood, T., Bond, J., May, C., McKeith, I., Min The, M. (2008) *Mental capital through life. Mental capital and wellbeing project. Mental Capital and Wellbeing: Making the most of ourselves in the 21<sup>st</sup> century*. Foresight.

<sup>22</sup> World Health Organisation (2010) *Suicide Prevention (SUPRE)*. WHO.

<sup>23</sup> Black, C. (2008) *Working for a healthier tomorrow. Review of the health of Britain's working age population*. Crown Copyright.

Layard, R., Clark., Knapp, M. and Mayraz, G. (2007) *Cost-Benefit Analysis of Psychological Therapy*. *National Institute Economic Review*, No 202.

<sup>24</sup> Health & Social Services (2007) *The Stafford Report, Social Security Department*. States of Jersey.

<sup>25</sup> Department of Health (2008) *IAPT-Improving Access to Psychological Therapies. Commissioning IAPT for the whole community*. NHS.

<sup>26</sup> Layard, R. (2006) 'The case for psychological treatment centres'. *British Medical Journal*, 332, pp 1030-1032.

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40% repeat visits to the General Practitioner in Jersey) harmful alcohol use and somatisation disorders<sup>27</sup>. Primary Care for mental health can reduce stigma and discrimination and can produce good outcomes<sup>28</sup>.

In 2007, IAPT services were introduced into the UK. Within 1 year an improvement in employment status was demonstrated, with pathfinders in England seeing 16% improvement in employment and 49% of patients stating they no longer had a mental health problem.<sup>29</sup> Further studies have confirmed the effectiveness of IAPT - a recent study demonstrated that Cognitive Behavioural Therapy (CBT) was as effective as antidepressants in treating recurrent depression, and that these therapies should be used as alternatives (where possible) to medication<sup>30</sup>. Recent research (Corporate Research Team Borough of Poole 2010)<sup>31</sup> has indicated that 52% of individuals who accessed IAPT in the UK were initially taking medication and 26% had stopped taking medication following a therapy intervention.

In addition, the UK policy *No Health without Mental Health*<sup>32</sup> highlighted that access to Talking Therapies resulted in a reduction in the need for inpatient facilities and people taking their own life.

The National Institute for Health and Clinical Excellence (NICE) guidelines recommend that CBT should be available as an option for people with mild or recent onset of depression<sup>33</sup> and anxiety<sup>34</sup>. NICE recommends a Stepped Care Model for diagnosing and treating anxiety and depression with access to high quality self-help facilities and a widely available choice of evidence based psychological interventions<sup>35</sup>.

Research by Lord Layard et al (2007) concluded that the benefits to the economy from psychological therapies should exceed the costs. Based on individuals receiving CBT

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<sup>27</sup> World Health Organisation (2008) *Integrating mental health into primary care. A global perspective*. Wonca. 2008.

<sup>28</sup> World Health Organisation (2008) *Now More Than Ever. Primary Health Care*. WHO. World Health Organisation (2008) *Integrating mental health into primary care. A global perspective*. Wonca.

<sup>29</sup> IAPT (2008) *Pathfinders achievements and challenges*, Department of Health, October 2008, p5.

<sup>30</sup> National Institute for Health and Clinical Excellence (2010). *Depression: The NICE Guideline on the treatment and management of depression in adults*. Updated edition. National Collaborating Centre for Mental Health. Commissioned by NICE and the British Psychological Society and the Royal College of Psychiatrists. NICE Clinical Guideline 90. NICE. April 2010.

Barclay (2010) *Mindfulness CBT as effective as antidepressants in preventing depression relapse*. Medscape: 14 December 2010.

<sup>31</sup> Borough of Poole (2010) *Improving Access to Psychological Therapies. IAPT*. Corporate Research Team, Borough of Poole.

<sup>32</sup> Department of Health (2011) *No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages*. Crown Copyright.

<sup>33</sup> National Institute for Health and Clinical Excellence (2007). *Depression: management of depression in primary and secondary care*. NICE Clinical Guideline 23. NICE. April 2007.

<sup>34</sup> National Institute for Health and Clinical Excellence (2007) *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. NICE. April 2007.

<sup>35</sup> Department of Health (2008) *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit. Care Services Improvement Partnership (CSIP) & National Institute for Mental Health in England*. DOH.

National Institute for Clinical Excellence (2006) *Depression and Anxiety-Computerised Cognitive Behavioural Therapy (CCBT) Review of Technology Appraisal 51. Technology Appraisal 97*. Available at: [www.nice.org.uk](http://www.nice.org.uk).

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for anxiety and depression, employment rates should be expected to increase by 4% and absenteeism reduce by three days per year per worker<sup>36</sup>. Additional local savings would be made by reducing the number of initiations for prescribed antidepressants and anxiolytic (benzodiazepine) medications<sup>37</sup>.

Enhancing Recovery Rates in IAPT Services: Lessons from year one.

The North East Public Health Observatory NEPHO reported key findings from IAPT services following the first year of the initiative (1st October 2008 to 30th September 2009). Their report particularly focuses on issues of equity of access, data completeness, methods of referral, the types of treatments that were offered and overall recovery rates. In the 32 (of 35) services that contributed data the average recovery rate among patients who had at least two sessions (including assessment) was 42%, however, there was considerable variability between sites (from 27% to 58%). In an attempt to understand this variability, and to learn lessons that services can draw on to further improve their effectiveness, the Department of Health commissioned the University of Reading to conduct a further analysis, particularly focusing on identifying the factors associated with enhanced recovery rates, which were<sup>38</sup>:

- *IAPT services appear to be beneficial to patients with clinical presentations that range from mild to severe.* Patients with higher initial depression (assessed by the PHQ-9) and anxiety (assessed by the GAD-7) scores were less likely to meet criteria for recovery at the end of treatment. However, the overall amount of symptomatic improvement observed in severe cases was larger than that observed in mild cases. It therefore appears that IAPT services are suitable for patients with a wide range of clinical presentations who require individual psychological treatment, sometimes augmented by medication management from their GP.
- *Self-referred patients were as severe as GP referred patients but recovered with fewer sessions of treatment.* This finding suggests that IAPT services should seek to expand self-referral in order to improve efficacy as well as promote better access for different sectors of the community. Self-referred patients may require less treatment sessions because they have considered whether they wish to have psychological therapy in more detail before they engage with an IAPT service and so have a „head start“. This process could be facilitated by the development of websites that describe in detail the clinical conditions covered by an IAPT service and the treatment options that are available.

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<sup>36</sup> Layard, R., Clark, D., Knapp, M. and Mayraz, G. (2007) *Cost-Benefit Analysis of Psychological Therapy*. *National Institute Economic Review*, No 202.

<sup>37</sup> Layard, R. (2006) 'The case for psychological treatment centres'. *British Medical Journal*, 332, pp 1030-1032.

<sup>38</sup> NHS (2011) *Improving Access to Psychological Therapies, Enhancing Recovery Rates in IAPT Services: Lessons from year one*. The IAPT National Team.

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- *Services that make good use of stepped care have higher overall recovery rates.* IAPT services offer low intensity interventions (such as guided self-help) supported by Psychological Well-being Practitioners and high intensity interventions (such as face-to-face CBT and other NICE approved therapies) delivered by suitably trained therapists. In order to ensure that a large number of people can be seen in IAPT services and individuals receive the least burdensome treatment that they require, it is recommended that most patients with mild to moderate clinical presentations are offered low intensity interventions first, but are promptly stepped up to high intensity interventions if they fail to recover. In support of this model, services that had a higher step-up rate among patients initially allocated to low intensity interventions had higher overall recovery rates. It was estimated that the average recovery rate for year one services could have risen from 42% to between 48% and 54% if step up had been more consistently offered.
- *Compliance with NICE treatment recommendations is associated with better clinical outcomes.* The NEPHO report showed that most treatments that were offered in the year one IAPT services were consistent with NICE recommendations. However, for some conditions, a significant minority of patients received a treatment not recommended by NICE. This created a „natural experiment“ in which it was possible to determine whether deviation from NICE recommendations is associated with reduced recovery rates. When considering high intensity treatments, NICE recommends both CBT and counselling for mild to moderate depression but only recommends CBT for any of the anxiety disorders. An analysis of the recovery rates amongst patients who had both pre and post treatment scores on the PHQ-9 and GAD-7 was broadly in line with NICE recommendations. In depression, there was no difference in recovery rates between CBT and counselling. However, in generalised anxiety disorder (GAD) and Mixed Anxiety and Depressive Disorder patients who received CBT were more likely to recover than those who received counselling. Turning to low intensity interventions, for depression NICE recommends guided self-help but not pure self-help. Consistent with this recommendation, guided self-help was associated with higher recovery rates. For GAD the latest (2010) NICE guideline recommends both guided self-help and pure self-help. The recovery rate data provided partial support for this recommendation as guided self-help and pure self-help had similar recovery rates among patients who provided a post-treatment score but significantly more people in pure self-help failed to do so. If people who fail to provide a post-treatment score are assumed to have not changed, guided self-help was more effective than pure self-help. In view of these findings, it is recommended that if IAPT services offer pure self-help to patients with GAD they should ensure that the patients are followed up by the service and offered a more intensive intervention, if subsequently needed.
- *Services that provided a larger average number of treatment sessions had higher overall recovery rates.* Prior to the advent of IAPT it was common for primary care psychological therapy services to offer a fixed number of therapy sessions (say up to 6). This is not consistent with NICE guidelines which recommend that patients should be offered *up to* the number of sessions provided in the RCTs that generated the relevant guidance (although some

patients may recover with fewer sessions). Some support for this position was provided by the finding that services that offered a larger average number of sessions at both low and high intensity had higher overall recovery rates. Interestingly, the average number of sessions in the services with the best recovery rates was still fairly modest (between 8 and 10, although some missing data makes it difficult to be completely precise).

- *A substantial number of people who do not meet recovery criteria in IAPT services still showed some benefit.* IAPT statistics have so far mainly focused on the percentage of patients who drop below the clinical/non-clinical cut-off at the end of treatment (“recovery”). However, it is possible to show reliable improvement (a reduction in symptom scores that exceeds the measurement error of the questionnaire) without fully recovering. Overall, 64% of patients in the year one IAPT services showed reliable improvement. Most of the remainder (29%) showed no reliable change and a small proportion (7%) showed reliable deterioration. It is thought that the latter figure is less than one might expect from the natural course of the relevant clinical conditions. It is recommended that in the future services calculate reliable improvement and deterioration rates as well as recovery rates, using the measures (including the anxiety disorder specific questionnaires) recommended in the IAPT Data Handbook.
- *Services that had a higher proportion of experienced therapists had higher overall recovery rates.* There was a significant correlation between the proportion of therapists at a site that were employed at AfC band 7 or above and the recovery rate of the site. In year one of the IAPT programme therapists who were employed at this level were generally experienced clinicians who were already trained in the relevant treatments. This finding would therefore appear to support the national recommendation that IAPT services should have a core of fully trained, experienced therapists to supervise, to model therapy, and to treat more complex cases.
- Provisional diagnoses are important to ensure that patients receive NICE recommended treatments and have their outcomes appropriately monitored. For 39% of patients in the year one services, there is no ICD-10 code for the problems that were treated. As NICE guidance is based on ICD-10 codes it was not possible to determine whether these people had NICE recommended treatment and it may also have been the case that their therapists failed to monitor their outcomes with the most appropriate measures (for example the Impact of Events scale in PTSD). To overcome this problem in the future, it is recommended that services aim to obtain provisional diagnoses using ICD-10 codes on everyone who receives treatment. The IAPT Data Handbook provides guidance on how to do this, including suggested screening questions (The IAPT National Team October 2011)

### 3.2 Current Services in Jersey

The Jersey Annual Social Survey (2010) reported that 18% of the adult population scored high levels of anxiety and depression, and a further 2% reported that they were extremely anxious or depressed. In addition, increasing rates of death from suicide and undetermined injury was identified as a key concern.

In 2009, the direct service provision costs for HSS Adult Mental Health Services was £10,222,60. In addition, costs of prescribed medicines funded by SSD (excluding December) were:

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Medication	
Hypnotics	£58,445.59
Antidepressants	£319,977.64
Anxiolytics	£58,711.92

The economic cost in providing mental health care in Jersey is significant. Suffering from mental health issues such as depression and anxiety make it much more difficult for a person to work and increase the likelihood of sickness absence<sup>i ii</sup>. In 2009, 46.8% of all claims made for short-term and long-term incapacity allowance were for mental health problems.<sup>iii</sup> Over 2,600 claims on average per year are made by people on benefits due to depression, anxiety and other mental health issues., equating to approximately 7,000 individuals<sup>iv</sup> Mental health and back pain are the top two benefit claims in the Island.

The Stafford Report (Health and Social Services 2007) highlighted the longer an individual is signed off sick from work the greater the likelihood of moving into permanent incapacity benefit and subsequent absenteeism.

Taking into account patients' Social Security co-payments, the cost of medicines and the cost of hospital and community care, it is estimated that the annual total economic cost of mental health issues could be up to £8m.

The average cost for Short Term Incapacity Allowance (STIA) is £170.24 per week. Between 2006 and 2009 an estimated £4.4m p.a. was paid in STIA related to mental health issues:

	Average claims per month	Average length of claim (days)	Estimated cost per annum (based on 2010-2011 rates)
<b>'One certificate claims'</b>	92	13	£370,017
<b>'Multiple certificate claims'</b>	129	105	£4,026,845
<b>Total</b>	<b>221</b>	<b>118</b>	<b>£4,396,862</b>

Source: States of Jersey Social Security Department (2010)

Department of Health (2008) *Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit. Care Services Improvement Partnership (CSIP) & National Institute for Mental Health in England.* DOH.

Health and Social Services (2009) *Social Security Department Data.* States of Jersey.

The above figures include new claims and repeat presentations. It is estimated that 30.6% of 'one certificate claimants' reported a mental health ailment, and 12.7% of 'one certificate claimants' returned at least three times within the four year period.

Once a claimant has been on STIA for a year, they are reviewed by a medical board. If they are deemed to still be incapacitated, they will then receive Long Term Incapacity Allowance (LTIA) at a rate that correlates to their level of incapacity (usually awarded in increments of 5%). The claimant can work whilst in receipt of this benefit.

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In 2009, 121 claimants moved from STIA to LTIA with a mental health ailment code. The average level of incapacity was 45%, and 27% of the new LTIA claims worked in some form and made contributions. At 2010-2011 rates, the cost of new LTIA's is estimated to be almost £510k p.a.

Services for mental health are fairly well provided once a service user becomes unwell. However, the level of service provision available for mild to moderate symptoms appears to be fairly low, as services are mainly provided within Primary Care and are not universally accessed by some individuals requiring intervention.. Common mental health issues specifically anxiety and depression result in 40% of repeat visits to the GP in Jersey<sup>39</sup> in contrast to 25% in the UK<sup>40</sup>.The level of prescribing of benzodiazepines, hypnotics and anti-depressants is particularly high compared to other areas. This generated a cost of £450,000 to the States in 2009.

Staff currently working in the HSSD Psychological Assessment and Therapy Service cover the whole spectrum of psychological difficulty for individuals below the age of 65. This covers the entire range of mental health issues, from common mental health problems such as anxiety and depression to the severe and complex end of the spectrum. Currently, face to face counselling and therapy capacity is based on the equivalent of six FTE staff. The Service is currently operating a two month waiting list prior to assessment, and a waiting list of over three months following assessment for individual one-to-one work.

Service principle	design	Challenges of the current services
Create a sustainable service model		<ul style="list-style-type: none"> <li>• 20% of individuals responding to the Jersey Annual Social Survey in 2010 reported anxiety and depression.</li> <li>• 40% of repeat GP visits are individuals diagnosed with depression and anxiety</li> <li>• Service levels are grossly under resourced - the equivalent of six full time posts serve a 60,000 working population in Jersey, whereas guidance from the UK IAPT Adviser indicates 15 full time posts are required</li> <li>• Limited capacity exists to provide self help information</li> <li>• Access to existing psychological therapies is limited, with a 3-month waiting list</li> <li>• Depression is the leading cause of disability as measured by Years Lost to Disability (YLDs). By 2020 depression is projected to be the second highest Disability Adjusted Life Years (DALYs) calculated for all ages, both sexes. It is already the second cause of DALYs in 15-44 year olds for both sexes combined (WHO 2012)</li> <li>• Levels of depression and anxiety set to rise according to World Health Organisation (2012)</li> </ul>

<sup>39</sup> Health & Social Services (2007) *Our Island Our Health* . Annual Report of the Medical Officer of Health. States of Jersey.

<sup>40</sup> Mental Health Foundation, Mind, Rethink, The Sainsbury Centre for Mental Health, Young Minds (2010) *We Need to Talk*. The case for psychological therapy on the NHS. Commissioned by five mental health charities.



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Service principle	design	Challenges of the current services
		<ul style="list-style-type: none"> <li>• Forthcoming staff retirements will further impact capacity</li> </ul>
Ensure Clinical/service viability		<ul style="list-style-type: none"> <li>• Primary Care receives limited support from HSS</li> <li>• The range of Psychological Therapy services are limited, and there are no facilities available for common mental health issues other than the existing secondary care services</li> <li>• Referrals for individuals with common mental health issues that can be managed effectively in Primary Care impact on secondary care mental health services (which were designed to manage complex mental health issues)</li> <li>• There is no register for individuals with low level mental health issues and limited coordination between the various tiers of service</li> <li>• Only a very limited range of low level mental health services are available. This can increase stigma, deter individuals from accessing help and impact longer term mental wellbeing and safety</li> <li>• Psychological Therapies are not available to under 18's or over 65's</li> <li>• The 'User Pays' model of Primary Care creates inequitable access to services and contributes to widening health inequalities in Jersey, with those in the lowest socioeconomic groups least likely to receive services for mental health issues. IAPT promotes equal access to services thus, reducing health inequalities.</li> </ul>
Ensure viability	financial	<ul style="list-style-type: none"> <li>• Levels of prescribing particularly for benzodiazepines, hypnotics and antidepressants are high</li> <li>• IAPT has been demonstrated as cost effective in other jurisdictions, particularly in terms of the full economic cost (including Social Security payments)</li> <li>• Early intervention is often effective at preventing the escalation of issues, and therefore is value for money in terms of reducing the need for Tier 2 and 3 mental health services</li> </ul>
Optimising utilisation	estate	<ul style="list-style-type: none"> <li>• There is a lack of accessible, non-stigmatising locations for service delivery</li> </ul>

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Service principle	design	Challenges of the current services
Workforce utilisation and development		<ul style="list-style-type: none"> <li>• Recruitment and retention remain a challenge</li> <li>• The IAPT workforce will be specifically developed to deliver NICE recommended low and high intensity interventions for people with mild, moderate and severe anxiety and depression within a Stepped Care model</li> <li>• IAPT has already been piloted in Jersey, so some staff are familiar with the concepts and ways of working. For others, however, redesign of delivery of care may present challenges</li> <li>• Providing outcome measures as well as output data may be challenging for practitioners/services to adjust to</li> <li>• Third Sector provision will be encouraged, and existing teams, including GPs, will need to adjust to new ways of working</li> <li>• Training, support, guidance and information for a wide range of staff is currently unavailable</li> </ul>
Clinical governance		<ul style="list-style-type: none"> <li>• There is currently no single point of access for health promotion information. Although some Third Sector groups provide good information, there are no quality assurance standards to control/approve the information that is available</li> <li>• Primary Care information systems are variably developed, with a mixture of systems for recording, monitoring and sharing information. The ability to register with more than one practice increases the risk of data duplication and creates governance concerns, particularly regarding 'doctor-shopping' linked to drug misuse</li> <li>• There is currently no clinical governance structure within Third Sector organisations</li> </ul>
Use of business intelligence		<ul style="list-style-type: none"> <li>• Data collection is extremely limited</li> <li>• Assessing value for money and outcomes is challenging</li> <li>• Robust commissioning (and decommissioning) is severely hampered by the lack of available, accurate, timely information</li> </ul>

In 2004 the HSSD Psychological Therapy and Assessment Service conducted a pilot for brief interventions based in GP surgeries. This demonstrated good outcomes and high satisfaction amongst Service Users and Professionals<sup>41</sup> Appropriate funding was not available at this time for this initiative to be sustained

The States of Jersey Strategic Plan 2009-2014<sup>42</sup> and recent white paper 'Caring for each other, Caring for ourselves'<sup>43</sup> committed services to enhance and improve health-

<sup>41</sup> Health & Social Services (2004) *Psychology past service user feedback*. Psychology Department. States of Jersey.

<sup>42</sup> Health & Social Services (2009) *Strategic Plan 2009-2014*. Achieving the Priorities: Priority 8 (support those in need and increase social inclusion by helping people to help themselves), Priority 9

care provision and promote a healthy lifestyle. In addition, The States Business Plan 2010<sup>44</sup> aims to reduce mortality rates from suicide and injury highlighted in recent research conducted by the University of Southampton (2009)<sup>45</sup> and the Annual Report of the Medical Officer of Health (2009)<sup>46</sup>.

IAPT is required in order to:

- Reduce the impact of common mental health issues for individuals and thereby improve the general well being of the Island's population
- Improve access to psychological therapies in Jersey through a single pathway
- To reduce exclusion from work through the provision of timely evidence based treatment provided by a number of specifically trained staff
- Reduce inappropriate prescribing of benzodiazepines and antidepressants
- Enhance partnership working with GP's, professionals and other voluntary and third sector organisations

### 3.3 Description of IAPT Service

The new model will significantly improve access to psychological therapies for individuals in the community by focusing on early intervention for all adults and older adults.

It will deliver person-centred services in safe, appropriate and flexible environments.

The market will be diversified, with standardised, high quality services available as part of a single care pathway, with easy access including self referral as an option.

Central to the new model is the focus on quality training, with enhanced clinical improvement and recovery which improves an individual's social and economic participation.

#### **Service principles and assertions:**

- Self care is a way of promoting healthier lifestyles and behaviours and creating an environment which makes healthy lifestyles easier. Supported by a strengthened personal responsibility, self care can ultimately delay in the progression of health and social care needs and improve the individual's health, wellbeing, independence and quality of life
- The perception of Islanders regarding Primary Care needs to be developed beyond simply those services provided by a GP, to encompass all care professionals working on the front line of service delivery in the community. This incorporates

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(Enhance support services to vulnerable children, families and others at risk) Priority 11 (Enhance and improve health care provision and promote a healthy lifestyle. States of Jersey.

<sup>43</sup> Health and Social Services (2012) *Caring for each other, Caring for ourselves*. Public consultation. States of Jersey.

<sup>44</sup> Health and Social Services (2010) *Business Plan 2010*. States of Jersey.

<sup>45</sup> University of Southampton School of Medicine (2010). *Suicide in Jersey between 2000 and 2009*. States of Jersey.

<sup>46</sup> Medical Officer of Health (2009) *Annual Report of the Medical Officer of Health. Our Island Our Health*. States of Jersey.

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both the prevention and treatment of disease and the promotion of wellbeing and independence

- Effective, enhanced Primary Care services are dependent on all professionals working collaboratively, with clearly defined and safe care pathways and a distribution of responsibilities between primary, secondary, mental health, social care and the Third Sector– and the patient, service user and carer
- Social care and health should be seamlessly integrated on a service user's life journey. Teams of social care, home care, medical, nursing, occupational therapy, psychology, Third Sector and private sector providers will work together
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and ensures that needs drive services in order to improve health and wellbeing
- Early intervention for adults who are displaying early signs of anxiety and depression is important in reducing the need for inpatient beds in the future

The IAPT pathway will comprise:

### Treatment

- Service Users will receive patient centred assessments (problem & goals, employment issues) plus a provisional diagnosis at intake. Provisional diagnoses are important to ensure that patients receive NICE recommended treatments and have their outcomes appropriately monitored
- Evidence based NICE recommended treatments will be offered
- In depression, guided self-help will be offered as opposed to pure self-help as this is associated with higher recovery rates
- Service Users will receive an appropriate length of therapy with regular reviews of their progress as outlined by IAPT (IAPT Commissioning Toolkit 2008)<sup>47</sup>

### Risk Management

- Individuals presenting with any issues around self-harm or suicide will be risk assessed in accordance with NICE National Clinical Guideline on self-harm (NICE 2011)<sup>48</sup> and local protocol

### Service Model

- The service will make rigorous use of stepped care to promote recovery rates
- There will be close links to employment advisors

### Staffing

Two types of psychological therapy practitioners are required:

- **High Intensity therapists** trained in cognitive behavioral therapy for people with moderate and severe depression and anxiety disorders
- **Psychological wellbeing practitioners** trained in cognitive behavioral approaches for people with mild to moderate anxiety and depression. Approaches include guided self help and delivering psycho-educational groups. IAPT Service will also have administrative staff. All staff will promote liaison with other services such as housing, drugs/alcohol advice and benefits

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<sup>47</sup> IAPT (2008) *IAPT Commissioning Toolkit*. Department of Health.

<sup>48</sup> National Institute for Health & Clinical Excellence (2011) *Self-harm: longer-term management National Clinical Guideline Number 133*. NICE.

### Psychological therapies competencies

- Delivering low- and high-intensity psychological therapies to an appropriate and coherent standard requires competent practitioners who are able to offer effective interventions. The British Association of Behavioural and Cognitive Psychotherapy will accredit staff and courses based on revised standards, linked to the CBT competencies.

### Supervision

Supervision will determine the success of the IAPT programme<sup>49</sup>. Training for IAPT supervisors is based on a competency framework developed specifically for the programme. Trainees and qualified staff delivering high or low intensity interventions through IAPT services should be supervised with:

- A minimum of one hour of individual supervision weekly with an experienced and trained supervisor working within the IAPT service
- Occasional group supervision with longer sessions

Clinical supervisors will have a working knowledge and experience of the interventions they are supervising. Supervision will be conducted in line with IAPT supervision Guidance (IAPT 2011)

### Choice

The service will provide multiple modes of delivery and a choice of treatments. It is important that people have a say in what kind of treatment they receive. This helps ensure the best health outcome for them. IAPT practitioners will explain which treatment they are recommending and why they think it is suitable for the patient.

### Access

- The service will ensure inclusion of marginalised groups. There will be regular analysis of care pathways and referral rates to identify and reduce inequalities affecting particular groups such as Portuguese and Polish residents
- The service will seek to expand self-referral in order to improve efficacy as well as promote better access for different sectors of the community. Clark et al (2009) found that self-referral produces a more equitable pattern of access to different ethnic groups. However, some people will be referred for therapy by their GP or a member of the practice team or other professionals. Internal and external teams and their patients will have clear information about local services and the treatment choices available

### Outcomes

- A key characteristic of an IAPT service is the effort individual therapists put into demonstrating the outcomes that are delivered. Routine outcomes measurement is central to improving service quality - and accountability. It ensures the person having therapy and the clinician offering it have up-to-date information on an individual's progress, which is of therapeutic value in itself. At an overview level, where individual patients are anonymised, service providers and commissioners can see a performance pattern for the service, which can be publicly reported. IAPT services will routinely measure people's health outcome.

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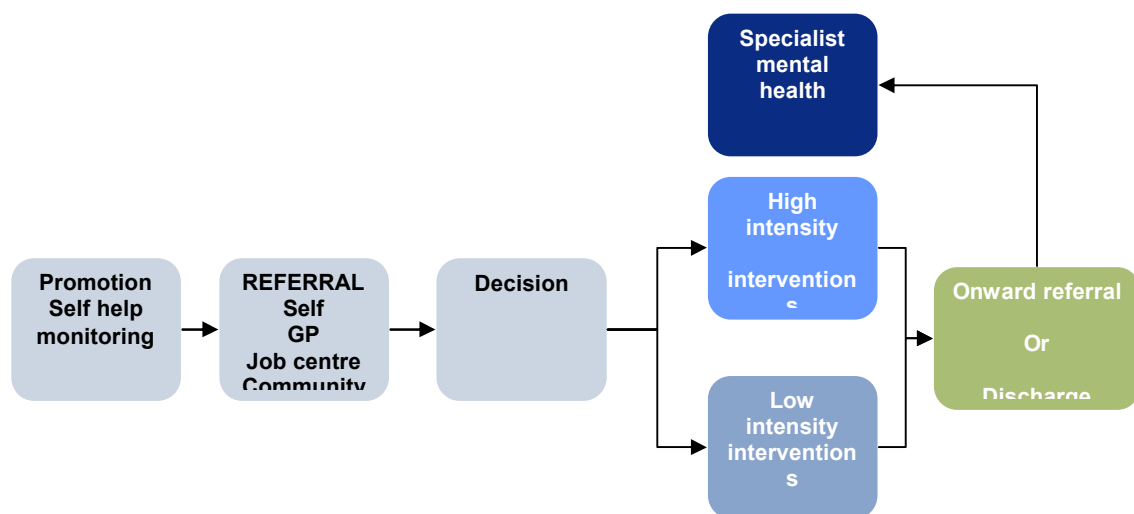
<sup>49</sup> IAPT (2011) IAPT Clinical Case Management Supervision. DOH

### IAPT Key Performance Indicators

- In order to provide robust health outcomes KPIs will be identified and agreed within the IAPT full business case in line with IAPT recommendations (IAPT Key Performance Indicator (KPI) Technical Guidance for 2011/12)

The overall objective of Improving Access to Psychological Therapies (IAPT) is to provide quick, easy, equitable access to all adults over the age of 18 years for the treatment of common mental health issues.

The service will be based on a Stepped Care Model, in accordance with NICE guidelines and best evidence based practice. The IAPT service will work closely with the existing Psychological Assessment and Therapy Service, providing personalised interventions which meet individual's clinical need:



The IAPT service will provide interventions for a number of common mental health problems such as:

- Generalised Anxiety Disorder
- Depression
- Panic Disorder
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Social Phobia.

Following an assessment, therapists will provide high intensity or low intensity interventions, depending on the needs of the individual. The therapist will be trained in cognitive behaviour therapy (CBT), which has a strong evidence base, and will be able to provide a service to a large number of individuals.

Low Intensity interventions will be delivered by trained Psychological Wellbeing Practitioners (or 'Psychological Wellbeing Practitioners'). This will include telephone and face to face contacts utilising:

- guided self help
- behavioural activation
- problem solving

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- a range of psycho education courses
- computerised CBT
- structured physical activity.

High Intensity interventions will be used when a person has not responded to low intensity interventions, or where a clinical assessment has indicated that a person is most appropriate for a High Intensity intervention. High Intensity interventions will be delivered by specifically trained therapists. This will comprise face to face therapy, up to a maximum of 20 sessions, utilising Cognitive Behaviour Therapy (CBT), Couple Therapy, Counselling, Brief Dynamic Interpersonal Therapy, Interpersonal Therapy (IPT), counselling for depression and Eye Movement Desensitisation Reprocessing (EMDR).

Service Users will be integral to decision-making about their treatment. This will be based on high quality and accessible information. The new service model will be flexible enough to offer effective and meaningful choices about where, who, how and what services are provided.

The citizens' portal will also enable service users to make informed decisions about their care and to determine their care plan. This is will not only improve service user experience, but will impact positively on their quality of life as they will be involved in the management of their condition.

The steps within the 'Stepped Care Model' are:

### **Step 1 – Awareness raising**

Working closely with GPs and other referrers, clarity will be provided on access criteria and the scope of the IAPT service.

Self help materials will be developed and made available.

Working across professions, 'at risk' individuals will be actively monitoring.

Service promotion will be undertaken within local communities to ensure all groups are aware of psychological services how to access them on an equal basis.

Marketing and advertising will raise awareness to individuals who may wish to self refer, providing clear guidance and instruction on how to access the service.

### **Step 2 - Single Point of Access.**

Following referral, the individual will be contacted by telephone within 48hrs. An assessment will be completed within 14 days, where the individual will be fully involved in decision-making relating to their care, and a choice of NICE indicated treatments will be offered.

The single care pathway will reduce duplication of assessment, elements of care delivery and review across health, social care and the Third Sector. The pathway will allow for improved access to services, hopefully at an earlier stage, thereby improving the service user's quality of life and outcomes.

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If the individual declines treatment, does not attend assessment or is not found suitable the next steps will be discussed with them and the referrer will be informed of the outcome.

### **Step 3 - Intervention**

Following assessment the individual will be assigned within 14 days to a high or low intensity intervention. Sessional outcome monitoring will indicate whether there is a need to step up the intervention, discharge or refer on to other voluntary or Third Sector services.

Following discharge the outcome of the intervention will be communicated to the referrer with the individuals consent, including requirements for ongoing monitoring and follow up.

Onward referral to step 4 will be activated if required.

At any point in the process an onward referral to a specialist mental health team or relevant service will be initiated, if risk is identified or the individual requires multi disciplinary input.

### **Step 4 – Onward Mental Health referral**

Ongoing mental health services will be provided by the Psychological Assessment and Therapy Service for those individuals who have not responded to a high intensity intervention or who require a different or more integrated approach utilising different therapy modalities. Individuals who are not suited to a high intensity intervention due to their complexity will also be referred on. These will include individuals who have problems that impact severely upon their day to day living, may have a significant history of early trauma or have long term interpersonal difficulties.

The National Advisor of IAPT in the UK recommended 15 properly trained therapists for a population of 90,000 (to include working with the over 65's). This will comprise nine high intensity and six low intensity therapists. An enhanced IAPT service will allow existing staff to focus on the complex spectrum of psychological difficulty and provide interventions for individuals who do not fit into the common mental health spectrum of difficulty.

The development of the IAPT service will require a strong clinical lead. It is proposed that the current Psychological Therapy and Assessment Service continue to lead on the operational detail, supported by Health Improvement Department and Social Security Department. However, the service will be robustly commissioned, and it is anticipated that Third Sector providers will work in partnership with HSSD to deliver the service.

Supervision and support for the new service will be provided by senior staff working with the Psychological Assessment and Therapy Service.



### 3.4 Activity Impacts

Service	Activity Impact
<b>High Intensity workers</b>	<ul style="list-style-type: none"> <li>• 22 face-to-face contacts per worker week, therefore 1,012 contacts per year per worker</li> <li>• 8,096 total contacts per year</li> </ul>
<b>Psychological Wellbeing Practitioners</b>	<ul style="list-style-type: none"> <li>• 42 contacts per worker per week, therefore 1,932 contacts per year per worker</li> <li>• 9,660 total contacts per year</li> </ul>

### 3.5 Workforce Impacts

Service	Workforce Impact	Number	Comment (e.g. timing)
<b>High Intensity workers -</b>	Training progression depending on experience	8 FTE	Recruitment phased in from 2013 – 2015
<b>Psychological Wellbeing Practitioners</b>	Training progression depending on experience	5 FTE	Recruitment phased in from 2013 – 2015
<b>Secretary</b>		1 FTE	2014

Training and CPD have been included in the initial budget for the IAPT Service. Training for a High Intensity worker costs £9,176 per person over two days per week for one year. Training for a Psychological Wellbeing Practitioner costs £4,588 over one day a week for one year. Additional costs include flights, accommodation and subsistence.

Figures have been based on 50% of High Intensity workers and 100% of Psychological Wellbeing Practitioners requiring additional training.

An ongoing training budget of £1,000 per person p.a (2011 prices) is required.

### 3.6 Infrastructure Impacts

Estates. The Psychological Assessment and Therapy Service is based at Overdale. The IAPT Service will require a base. Service users will have the ability to meet in GP surgeries or community facilities, in a non-stigmatising environment located away from the hospital.

Information Technology. The PCMIS or IAPTUS computer systems will be scoped. These systems have specifically adapted for IAPT. Staff will be provided with laptops loaded with appropriate software, to facilitate remote working and the delivery of services in local environments.

From 2015, health and social care professionals, children, parents and families will access information via a citizen's portal. The citizens' portal will enable care to be

designed by the individual and care professional, based on the individual's needs and, where appropriate, their choices. It will also enable care packages to be delivered and monitored in a coherent and co-ordinated manner.

The citizen's portal will provide real time information regarding service availability, self care, family support groups etc, to assist the child and family with feeling more in control of their situation. The citizen's portal is included within the IT cross cutting workstream.

### 3.7 Service delivery benefits

- Reduced levels of anxiety and depression, as measured by JASS from 18% to 13% in 2016./ This will have a significant impact upon individuals who experience these difficulties, their quality of life and will positively impact upon their families, their colleagues and employers
- Reduced levels of medication by 10% by 2016
- Reduced waiting lists. Individuals are contacted within 48 hours of a referral, assessed within 14 days will be able to access a high intensity worker or a Psychological Wellbeing Practitioner within another 14 days
- Improved access results in improved outcome, minimising the impact of an episode of depression or anxiety and potentially reducing the incidence of relapse or acute episodes
- Increased capacity – from 4,775 contacts in 2010 to almost 20,000 contacts p.a. by 2015
- Increased clinical standards and governance, through a uniformity approach to training, using standardised approaches and best evidence practice
- Improved outcome measurement, with Patient Reported Outcome Measures (PROMs) collected to monitor and review service user care at every intervention collecting data for each session, in order to identify progress or changes in needs. This further enhances clinical governance and provides constant feedback to the therapist
- Provision of data for audit on performance and outcomes which can be used to guide and improve services
- Benefit to society from the overall improvement in the mental health and wellbeing of those of working age
- Increased tax income as more individuals are able to work
- Reduced Short Term Incapacity Allowance claims by an estimated 120 per year by 2020
- Reduced duration of subsequent episodes by 40% (from 112 days to 63 days). These reductions equate to an estimated saving of almost £1.2 million in short term incapacity benefit payments.<sup>50</sup>
- Savings to individuals through reduced user-pays GP consultations for psychological therapies
- Improved recruitment and retention of staff by coordinating and prioritising resource to develop the workforce
- Support for a sustainable Third Sector
- Faster and less stigmatising access for low level mental health needs
- Increased capacity in secondary care Mental Health Services, as statutory services will be able to focus on clients with more complex needs
- Service reconfiguration may allow secondary care services greater capacity and flexibility in their core business

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<sup>50</sup> World Health Organisation (2010) Suicide Prevention (SUPRE). WHO 2010. Available at: <http://www.who.int/mentalhealth/prevention/suicide/suicideprevent/en/index.html>

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- Reduced absenteeism and sick certification amongst employed workers
- Increased chances of remaining in employment for those have common mental health difficulties
- Improved seamless care pathway
- Increased use of self care
- Reduction in demand of secondary mental health services
- Reduced inappropriate prescribing and change in prescribing practices working within NICE guidelines
- Increased empowerment, choice, control and confidence in service users
- Reduced duplication of assessment, elements of care delivery and review

### 3.8 Service delivery: risks

Anticipated risks include:

- Lack of funding
- Ongoing challenges with recruitment. This may include resistance to granting 'J' Category Licences for High Intensity workers.
- Staff retention
- Third sector ability to respond to opportunity, including available infrastructure, skilled staff and supervision / clinical governance
- GP funding
- Current Social Security legislation prevents new and flexible approaches for individuals when off sick for common mental health problems such as the 'fit for work' scheme in the UK
- Lack of a robust commissioning process
- Lack of data and information on which to base service needs and outcome metrics
- Unrealistic expectation from service users, communities and professionals
- Accommodation availability for enhanced team

### 3.9 Enablers

The focus of the IAPT service is to provide accessible, local low level mental health interventions in order to maximise mental health and wellbeing. Third Sector involvement is a key component, and Parishes and other community based organisations will have the opportunity to support the delivery of better services.

The IAPT OBC links with the Healthy Lifestyles and Long Term Conditions OBCs. The IAPT service will work with individuals who have an increased level of alcohol or drug intake as a result of a common mental health problem, providing brief and extended interventions for alcohol problems for those who have mild/moderate levels of drinking. Individuals living with a long term medical condition are seven times more likely to develop depression as a result of their illness. For the High Intensity workers to be able to provide the best possible interventions, an extra training module has been proposed which has yet to be rolled out in the UK.

IAPT for children will be developed in later years, as part of the Adult Mental Health Service Workstream.

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Interactions will also be required with:

- The entire range of services provided for individuals and their carers (including Primary Care). Existing services will need to share the vision and participate in new ways of partnership working
- Other States Departments
- Public engagement and concordance with the new approach to accessing services for mental health issues will also be important

### **Dependencies exist with:**

- HSSD Business Plan 2012
- States Strategic Plan
- Medium Term Financial Plan
- Health and Social Services White Paper
- Any Adults strategy? What about current operational plans, assessment processes, care planning etc?

### **Workforce:**

IAPT is dependent on recruiting 50% of High Intensity workers from off Island. This would require 'J' category permission. Recruiting trained and experienced IAPT professionals will help the implementation and delivery of early improvements and outcomes.

The development of IAPT will require workforce development, as new ways of working will be required, both in terms of skills, locations and care delivery.

Mechanisms will also be required to address the existing recruitment and retention challenges, both in terms of additional staff and changing skills and ways of working.

In particular, it is expected that IAPT will be delivered in partnership with the Third Sector and with Primary Care.

### **Estates:**

The Psychological Assessment and Treatment Service currently operates from a hospital setting. This increases stigma and can reduce accessibility. Alternative, easily accessible and less stigmatising venues will be required from which to deliver IAPT services.

### **Commissioning:**

The IAPT service will be robustly commissioned. Services will be provided transparently, with visibility on activity, outcomes and value for money. The provider market will be supported, in order to sustain Jersey's vibrant Third Sector, Primary Care and other providers.

Relationships with the voluntary sector will be prioritised, as they are crucial to the success of the new model of service. The connections that already exist in terms of referral pathways will be maintained – for example, onward referral to the Bereavement Service, RELATE, Victim Support or another voluntary service.

Metrics and outcome measures, including Patient Reported Outcomes, will be collected in order to assess the benefits provided by IAPT, to contribute to future commissioning and to demonstrate value for money.

### **Primary Care:**

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Primary Care services are integral to the delivery of IAPT. GPs often have the best relationship with an individual, understanding wider aspects such as their family situation, history and wellbeing.

IAPT services will be provided in accessible, local facilities. It is envisaged that this will include GP Practices, and that GPs and other Primary Care practitioners will work in partnership to deliver IAPT and to work within a seamless, personalised pathway.

### **IT:**

IT and informatics will be critical to the service's success, as these will support remote and provide visibility of outcomes, activity and benefits.

Awareness and information will require a range of media, including the citizen's portal.

### **Informatics:**

Data and information will need to be improved in order to monitor activity and to assess the benefits (both qualitative and quantitative, and in terms of outcomes).

### **Finance:**

Funding is required for a significant increase in capacity, for IT and for training.

### **Legislation:**

Social security legislation could further enable and support the IAPT service. Changes in legislation could include schemes such as the 'fit for work' scheme which has been very successful in the UK, whereby the GP can recommend a graded return to work rather than working on the premise that either a person is not fit for work or they are fit to return. These flexible schemes work well for individuals that experience common mental health difficulties.

## **3.10 The Financial Case**

### **3.10.1 Revenue costs**

The total additional recurrent revenue cost for IAPT increases to £1.13m by 2015.

The revenue cost is estimated to be:

2013 - £344,000

2014 - £736,000

2015 - £1,132,000

Non-recurring implementation costs are estimated at £176,000 over the period 2013 - 15. This includes £123,000 to stimulate and support the Third Sector, in order to enable the organisations to develop and work in partnership with statutory services. This diversity of provision will ensure a responsive service.

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Summary costs 2013 -2015	2013	2014	2015
	£'000	£'000	£'000
Implementation Costs	48	111	17
Recurrent revenue costs	344	736	1,132
Capital costs	-	-	-
<b>TOTAL</b>	<b>392</b>	<b>847</b>	<b>1,149</b>

The service will require an additional 14 FTE.

### 3.10.2 Revenue cost containment

Cost containment of £1.2m is anticipated by 2015. By year, revenue cost containments are projected to be:

2013 – £289,000

2014 – £593,000

2015 – £1,215,000

Clear evidence from the UK demonstrates that that improving access to early and appropriate psychological services both increases the chance of quicker recovery (reducing the need for longer term more expensive high level therapeutic services) and enables individuals to return to sustainable employment sooner.

The overall cost benefit of investing in to IAPT is in a range of prospective cost containment in other areas presently impacted by individuals experiencing depression and anxiety, including Social Security payments for visits to General Practitioners, benefits payments, medication costs, and the impact on both inpatient and outpatient services within Health & Social Services. The 'NHS Commissioning' document for IAPT, (Improving Access to Psychological Therapies, Commissioning IAPT for the whole community November 2008 returns on investment will be achieved from:

- **Cost containment on GP consultations:** An average reduction of 3.2 GP consultations per person per annum on average (over a 2 year period). The recovery rate due to IAPT is calculated at 32%. This has been calculated as the difference between the National standard of 50% recovery (IAPT Data Handbook 2011, V2) and the proportion that would make a natural sustained recovery without treatment (approximately 18%).
- **Cost containment due to a reduction in the number of inpatient bed days:** 1.5 fewer inpatient bed nights on average (over a 2 year period). The IAPT recovery rate is 32% and inpatient bed costs are approximately £500 per night.
- **Cost containment due to a reduction in the number of outpatient appointments:** 0.7 fewer outpatient appointments on average (over a 2 year period). The IAPT recovery rate is 32% and the approximate cost of an outpatient appointment is £200.

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- **Cost containment on the cost of medication.** Prescribing data for antidepressants, anxiolytics and hypnotics suggests that there is an over-reliance on prescribing as a first line of treatment for common mental health conditions which is not consistent with current NICE guidelines. Over use of antidepressants was similar in the UK prior to IAPT services. Social Security costs for these combined drugs in 2009 was £437k. According to research conducted by the Corporate Research Team, Borough of Poole (Improving Access to Psychological Therapies; Poole 2010), IAPT leads to a reduction in medication by 50%.
- **Cost containment in benefit payments.** Layard et al (CEP Discussion Paper No 829, October 2007, Cost-Benefit Analysis of Psychological Therapy) concluded that a person who is treated via IAPT will on average spend 1.17 fewer months on incapacity benefit. The annual cost containment of a reduction in benefit plus the extra taxation income would equate to £14,895 p.a. per person (SSD figures). In 2009, SSD paid £4,396,862 in benefit claims to those with mental health problems.
- Of the prospective areas for cost containment, areas where there is a confidence in achieving the prospective cost containment are:
  - GP consultations
  - Benefit cost containment
- Areas where there is less confidence in achieving the potential cost containment include:
  - Inpatient bed days
  - Outpatient appointments
  - Medication

### 3.10.3 Capital costs

Not applicable

### 3.10.4 Funding

**It is anticipated that IAPT will be free at the point of delivery.** It is possible to develop an option to establish a charging structure, however, this is likely to reduce demand.

Commissioning the IAPT service may require consideration of funding mechanisms, if the service is provided by GPs (specialist trained in psychological therapy).

### 3.10.5 Managing risk

Due to the nature of this scheme there is an inherent risk of increasing capacity and costs within psychological therapy while not achieving the level of intended cost deferments. To minimise the financial risk we intend to:

- Identify robust metrics for monitoring quantitative benefits

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- Monitor the IAPT service to ensure that maximum efficiency is achieved delivering a value for money service
- Monitor metrics to ascertain impacts in the hospital, Mental Health services and in Social Security payments
- Make staged investments to ensure the expected benefits are being realised.

### 3.10.6 Sensitivity analysis - scenarios

Cost deferment is based the reduction of revenue expenditure across other H&SS Departments, in regard to bed capacity and medication costs, and social security in regard to reduction in GP attendance and benefit cost containment. It is assumed that the opportunity for reductions in costs will offset the increase in expenditure within Community & Social Services, in delivering new services.

### 3.10.7 Assessment of affordability and value for money

The full revenue cost for the delivery of IAPT in 2015 is £1,132,000. Potential cost containment range from £289,000 to £1.2m p.a. by 2015.

Even though confidence in achieving reductions in inpatient bed days and outpatient visits is low, there is a strong body of evidence that people present commonly to the NHS in the UK with physical symptoms which are actually caused by psychological distress. It has been estimated that this costs the NHS some £3billion per year (at 2008/9 prices). Bermingham et al (2008)<sup>xiii</sup> state that the figures account for 1 in 5 new consultations in Primary Care, 25% of all outpatient care, 8% of all inpatient bed days.

In order to maximise the impact of delivering an IAPT service and monitor the benefits achieved it is imperative that the Health and Social Services Department and Social Security Department work closely. The majority of benefits from IAPT are anticipated to be achieved in Social Security, through a reduction in HIF payments for GP consultations and reduction in benefit payments.

### 3.10.8 Verification procedures and assumptions

The following assumptions have been made:

- Staffing – it will be possible to recruit and retain the necessary staff
- Activity prevalence – based on the recent KPMG and UK analysis
- GP funding – that this will be resolved
- Parish – that low level preventative schemes will be developed

### 3.11 Implementation Actions and Timescales

In the autumn of 2012 a scoping exercise will commence in relation to IT, training providers and accommodation. The detailed scope for the IAPT service will be developed, and metrics and outcome measures devised.

Discussions will continue with potential partner organisations, particularly the Third Sector, and with Primary Care as the service specification is co-developed as part of the FBC.

The service is intended to commence in 2013, and will be brought on line in phases:



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	2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Engage Stakeholders																
Formulate detailed requirement, including job descriptions		HI		LI												
Commissioning structures in place																
IT Scoping		HI			LI											
Accommodation scoping		HI			LI											
Tendering for IAPT					LI											
Agree data collection approach/model with service provider																
Tender for IT system																
Prepare and plan marketing campaign; marketing			HI		LI											
Marketing and media campaigns																
Training providers scoping																
Reconfiguration of existing services to incorporate enhanced service																
Phase 1 – Service commencement 25% of HI workers (2 FTE)				HI												
Training (including IAPT workers training in data collection)																
Phase 2 – 25% HI workers (2 FTE)																
Phase 2 – 50% PWP																
Training staff in brief interventions for alcohol																
Recruit administrators – 1 FTE																
Phase 3 – 25% HI plus 50% PWP																
6 month audit and evaluation																
Phase 4 – 25% remaining HI workers Ensure processes are implemented for production of meaningful reports for use by Service Users, IAPT workers, supervisors and others																

## 4 Stakeholders

### 4.1.1 Stakeholder involvement in service model development

The Working Group that developed this OBC and service model comprised: Stuart Brook (SRO, Director of Community and Social Services) Dr Tracy Wade (Lead, Psychological Assessment and Therapy Service), Chris Dunne (Director of Adult Services), Suzanne Taylor (Public Health), Dr Nigel Minihane (GP, and Chair of the Primary Care Body), Marie Leeming, (HSSD Mental Health) Ronan Mulhearn (HSSD Mental Health), Mrs Sue Duhamel (Social Security Department), Philip Le Claire and Patricia Winchester (MIND, Jersey), Chris Leck (HSSD Finance), Ian de la Cour (HSSD Finance), Lynne Lusby (HSSD Human Resources).

The Working Group identified that key stakeholders for the development of the FBC and implementation of the service change are:

Stakeholder Identified	Are they...			
	Responsible (will work to deliver the OBC)	Accountable (answerable for the delivery of the OBC)	Consulted (opinions sought)	Informed (kept up-to-date on progress)
HSSD Mental Health Service	✓		✓	✓
MIND Jersey	✓		✓	✓
Other Third Sector Organisations/ Voluntary groups				
Primary Care Team (GPs, Practice Nurses, Health Visitors)	✓		✓	✓
HSSD Psychological Therapies and Assessment Department	✓	✓	✓	✓
Social Security Department	✓		✓	✓
Training providers Local-training providers e.g. HSSD Education Department	✓	✓		✓
General Public			✓	✓
Associated Health Professionals including Health Visitors, Midwives, Social Workers, Older Persons Services, Alcohol & Drug Service,	✓		✓	✓

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Emergency Department staff, Occupational Health				
HSSD Public Health Department	✓	✓	✓	✓
Employers and Employee groups	✓		✓	
Politicians	✓	✓	✓	✓

A full outline of stakeholder involvement is presented at Appendix 3.

### 4.1.2 Communications to Internal Stakeholders

The OBC lead will update internal attendees of the OBC workshops via email of progress as developments occur, thereby ensuring all stakeholders are aware of progression through to the Full Business Case. Internal communication via telephone and informal meetings may be necessary as key stakeholders work together to develop the OBC into the FBC.

Monitoring of the pathway will be communicated through existing HSSD governance structures. Infrastructures including Service Level Agreements will need to be put in place for service providers out with HSSD in order to monitor and communicate service developments.

Work will also be ongoing with Primary Care to identify patterns of GP referrals into IAPT.

### 4.1.3 Communications to External Stakeholders

The OBC lead will communicate with all stakeholders via email to ensure that external stakeholders are kept informed of key service developments with an auditable trail of communication.

An awareness campaign will be delivered in three phases, to inform external stakeholders, including the general public, about IAPT services.

In order to develop IAPT it will be necessary to consult across different groups of people, in particular the hard to reach groups such as Portuguese and Polish. Consultation across the population using a variety of methodologies including qualitative data (to be identified in the Full Business Case), will provide opinions from external sources (including Service Users), thereby contributing to building the local evidence base and shaping the future of IAPT.

The citizen's portal will also contain information regarding service availability, along with self help information.

## 5 Conclusion and Next Steps

### 5.1.1 Conclusion

Mental health problems are common and a major source of suffering to individuals and their families.

The cost of mental health is significant, both in terms of HIF payments for GP consultations, social security benefits payments and costs of medication.

Up to 20% of the population report anxiety and depression. Evidence from the UK indicates that early intervention and the provision of stepped care for psychological therapies, provided in non-stigmatising environments, can be effective in supporting an individual's mental health and wellbeing, reducing the time spent on benefits, reducing medication and halting the progression to more long term, severe mental health issues.

Investment is required to establish the IAPT Service. Initial cost-benefit analysis indicates that this will provide value for money, and success will be measured by improved outcomes for individuals.

It is intended that the service will be delivered in partnership between statutory services and the Third Sector, with Primary Care having a significant role.

### 5.1.2 Capacity and project management requirements

There is capacity to develop this OBC into a FBC. However, there will be competing priorities between balancing and managing the current service, clinical work and the development and implementation of the new IAPT Service. Careful consideration needs to be given to how best to manage this.

Tracy Wade from Psychological Assessment and Therapy Service will lead this process and will identify key personnel to provide project management capacity.

### 5.1.3 Next steps

- Continue to work with the Primary Care Body
- Working with a range of stakeholders, develop detailed service scope and specification, including outcome metrics
- Develop a commissioning framework
- Scope potential venues to deliver the service
- Complete the Full Business Case, including developing detailed service design.

The FBC will aim to:

- Verify the continuing need for investment in the project
- Demonstrate that the preferred solution represents value for money
- Establish that the HSSD is capable of delivering the project
- Confirm that the planned investment is affordable
- Demonstrate that HSSD is capable of managing a successful implementation and subsequently sustaining success
- Provide an essential audit trail for decisions taken
- Identify how benefits will be realised and monitored
- Confirm the investment decision

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The FBC will need to be approved and provide sufficient assurance to senior management that the project can proceed and resources can be committed. The FBC is used as a reference point in the event of any business changes during the project lifecycle and in the event of a post project review or equivalent major review following implementation of the project.

Sign off by Minister

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## 6 Appendices

### Appendix 1 – Benefit Log

What is the benefit	Type	'One off' or ongoing benefit?	How will the benefit be measured	What is the baseline	Target
<ul style="list-style-type: none"> <li>Reduced absenteeism and sick certification</li> <li>Increased chances of remaining in employment for those have common mental health difficulties</li> </ul>	<ul style="list-style-type: none"> <li>Service users</li> <li>Families</li> <li>Employers</li> <li>Society</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>Social security data</li> <li>Statistics Unit data</li> </ul>	<p>Social Security Data (2009):</p> <p><b>One certificate claims:</b> Average claims per month: 92 Average length of claim: 13 days</p> <p><b>Multiple certificate claims:</b> Average claims per month: 129 Average length of claim: 105 days</p> <p>Estimated cost per annum based on 2010-2011 rates equates to costing £4,396,862 in both one off and multiple certificate claims</p>	<p>Reduction of 1.17 fewer months on incapacity benefit per year per person</p> <p>Reduced absenteeism by 3 days per year per worker</p> <p>Reduction from 46.8% (2,600 claims) of all claims made for short-term and long-term incapacity allowance for mental health related issues per year</p> <p>Save £365,000 based on applying the recovery rate principle (60,000 working age population) x 18% experiencing anxiety/depression x 46% (on Jersey benefits) (8.3% working age population) (Note - updated data from Social Security may change the target)</p>

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Date

Author

					Increase in employment rates by 4%
Reduce health inequalities across the population	<ul style="list-style-type: none"> <li>• Service Users</li> <li>• Jersey population</li> </ul>	ongoing	<ul style="list-style-type: none"> <li>• IAPT demographic data</li> <li>• Social Security data</li> <li>• Demographic profiling of individuals accessing IAPT with anxiety and depression</li> <li>• Numbers of people accessing IAPT from lower socio economic groups</li> </ul>	No baseline	Reduce health inequalities across Jersey encouraging those most in need to access services
Reduced medication costs	<ul style="list-style-type: none"> <li>• Hypnotics</li> <li>• Antidepressants</li> <li>• Anxiolytics</li> </ul>	ongoing	<ul style="list-style-type: none"> <li>• Social Security data</li> </ul>	£58,445.59 £319,977.64 £58,711.92 Based on Social Security data (2009)	Reduced initiations of hypnotics, antidepressants and anxiolytics by 50% (IAPT Corporate Research Team Poole)
Reduced over-prescribing	<ul style="list-style-type: none"> <li>• Hypnotics</li> <li>• Antidepressants</li> <li>• Anxiolytics</li> </ul>	ongoing	<ul style="list-style-type: none"> <li>• Social Security data</li> </ul>	Waiting for Social Security data	Reduced initiations of hypnotics, antidepressants and hypnotics (target ?)
Reduced pressure on Secondary Mental Health Services	<ul style="list-style-type: none"> <li>• Staff</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>• Secondary will be dealing with less common mental health problems and can focus on moderate/severe and enduring mental health conditions</li> </ul>	Referral output data (no baseline to segment into diagnosis – Chris can you get baseline data from secondary services-we were never able to get this?)	Referral output data (if possible segmented into diagnosis to ensure appropriate referrals received)
Reduced levels of adults experiencing anxiety and depression at population level	<ul style="list-style-type: none"> <li>• Service users</li> <li>• Families</li> <li>• Employers</li> <li>• Society</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>• JASS</li> </ul>	18% reported anxiety and depression in 2010	13% by 2015

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<p>Adult Service User self report reduced levels of anxiety and depression</p>	<ul style="list-style-type: none"> <li>• Adult Service Users</li> <li>• Employers</li> <li>• Society</li> </ul>	<p>Ongoing</p>	<p>From IAPT outcome measures (IAPT Data Handbook June 2011) The IAPT outcome measures are:</p> <ul style="list-style-type: none"> <li>• Patient Health Questionnaire (PHQ-9) for depression</li> <li>• Generalised Anxiety Disorder Assessment (GAD7)</li> <li>• IAPT phobia scales</li> <li>• Work and Social Adjustment Scale (WSAS)</li> <li>• IAPT employment status questions</li> <li>• Relevant anxiety disorder specific measures (ADSMs)</li> <li>• IAPT patient choice and experience questionnaire</li> </ul>	<ul style="list-style-type: none"> <li>• Limited recorded outcome measures</li> <li>• No data currently collected and shared to improve services</li> </ul>	<p>50% of Service Users complete treatment, move to recovery and experience a meaningful improvement in their condition</p>
<p>Reduced waiting lists for IAPT, from increased capacity</p>	<ul style="list-style-type: none"> <li>• Service users</li> </ul>	<p>Ongoing</p>	<p>IAPT activity data</p>	<p>Current waiting time 2 months prior to assessment and over three months following assessment for treatment.</p>	<p>Timely access with Initial contact with Service User within 48hrs</p> <p>Initial assessment of Service User within 14 working days with either step 2 intervention or referral to step 3 intervention</p>
<p>Access to IAPT for over 65 years</p>	<ul style="list-style-type: none"> <li>• Service Users</li> </ul>	<p>Ongoing</p>	<p>IAPT activity data</p>	<p>No current access to psychological therapies for over 65 years</p>	<p>Equal access for all adults over 65 years</p>



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Self Referral into IAPT	<ul style="list-style-type: none"> <li>• Service Users</li> </ul>	Ongoing	IAPT activity data	No self referral into psychological therapies	Infrastructure set up to encourage self referral into IAPT
Increased clinical standards and governance	<ul style="list-style-type: none"> <li>• Service Users</li> <li>• SSD</li> </ul>	Ongoing	IAPT activity data	Different systems are in place for recording, monitoring and sharing information with no co-ordination of data sharing. This increases the risk of data duplication and governance issues around 'doctor shopping' linked to drug misuse	Co-ordinated data recording, monitoring and sharing information in line with data protection and Caldicott principles
Enhanced GP liaison and up-skilling	<ul style="list-style-type: none"> <li>• GPs</li> <li>• Service users</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>• Stakeholder analysis regarding satisfaction and efficiency of service</li> </ul>	No current baseline	Stakeholder survey
More joint working / closer liaison between services and Third Sector partners	Third Sector	Ongoing	<ul style="list-style-type: none"> <li>• Stakeholder analysis regarding satisfaction and efficiency of service</li> </ul>	No current baseline	Stakeholder survey
Increased tax income as more individuals are able to work	<ul style="list-style-type: none"> <li>• SSD</li> <li>• Society</li> </ul>	Ongoing	Social Security data	Social Security data	
Improved health and wellbeing of population	<ul style="list-style-type: none"> <li>• Broader social benefit</li> <li>• Children</li> <li>• Families</li> <li>• Employers</li> <li>• Reducing inequalities</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>• Population wide tool on health and well being of population with Health Intelligence</li> <li>• Collecting audit data of service user outcome measures</li> </ul>	JASS survey	<ul style="list-style-type: none"> <li>• Service user satisfaction survey</li> <li>• Potential mapping exercise with health intelligence</li> <li>• Service User self-reported improvements in health and wellbeing</li> </ul>
Reduced duration of subsequent episodes by 40%	<ul style="list-style-type: none"> <li>• Service Users</li> <li>• GPs</li> </ul>	Ongoing	IAPT data Social Security data Primary Care referral activity	Social Security data	Reduced duration of subsequent episodes of common mental health issues by 40%

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Cost containment to individuals through reduced user-pays GP consultations for psychological therapies	<ul style="list-style-type: none"> <li>• Service Users</li> </ul>	Ongoing	<p>IAPT referral data</p> <p>Social Security data identifying prevalence of GP consultations for IAPT</p>	40% of individuals access GPs under a 'User Pays' model of care for psychological therapies	Promote self referral to increase equitable access to lower socio economic groups increasing financial cost containment to individuals
Improved recruitment and retention of staff	<ul style="list-style-type: none"> <li>• Employee</li> <li>• Employer</li> </ul>	ongoing	<p>HSSD HR recruitment data</p> <p>Third Sector recruitment data</p>	HSSD issues around difficulties recruiting and retaining staff	Organisation reports improvements on recruitment and retention of skilled staff
Sustainable Third Sector	<ul style="list-style-type: none"> <li>• Third Sector Organisations</li> <li>• Service Users</li> <li>• Society</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>• IAPT data gathering, (monitoring, reviewing, sharing, feedback) to enhance and sustain quality services</li> <li>• Access to services and treatments by Service Users experiencing depression and anxiety disorders from all communities within Jersey</li> </ul>	No baseline	<ul style="list-style-type: none"> <li>• Develop a skilled IAPT workforce</li> <li>• Enable local Third Sector Services to put Service Users at the centre of the care pathway, deliver outcomes appropriate to need and improve clinical practice and service quality</li> </ul>
Secondary care Mental Health Services able to focus on clients with more complex needs	<ul style="list-style-type: none"> <li>• Secondary Care Mental Health Services</li> <li>• Service Users</li> </ul>	ongoing	<p>Secondary Care Service data</p> <p>IAPT data</p> <p>Service User satisfaction survey</p>	Inappropriate referrals for common mental health issues to Secondary Care Mental Health Services	<p>Reduced numbers of referrals to Secondary Care Mental Health Services for common mental health issues</p> <p>Reduced stigma of common mental health issues across population</p>
Improved seamless care pathway, with reduced duplication of assessment,	<ul style="list-style-type: none"> <li>• Service Users</li> <li>• Primary Care</li> <li>• Secondary Care Mental Health Services</li> <li>• Psychological</li> </ul>		<ul style="list-style-type: none"> <li>• IAPT data</li> <li>• Qualitative questionnaire (Primary Care/Secondary Care Mental Health Services/Psychological</li> </ul>	Lack of clarity around care pathways between Primary and Secondary Services and Psychological Therapies and Assessment Service	Clear seamless care pathway provided. Understood by Service Users, Carers, families and professionals

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elements of care delivery and review	<ul style="list-style-type: none"> <li>Therapies and Assessment Service</li> <li>Third Sector Organisation</li> </ul>		<ul style="list-style-type: none"> <li>Therapies and Assessment Survey)</li> <li>Commissioning cycle; Monitoring/reviewing/feedback to service provider of care pathway to continually improve quality of service provided</li> </ul>		
Increased empowerment, choice, control and confidence in service users	Service Users	Ongoing	<ul style="list-style-type: none"> <li>Service User satisfaction survey</li> </ul>	Service Users currently have limited choice and control with services available to meet their needs	All Service Users self report improved choices and control of the care they receive for common mental health issues
Less stigmatising services delivered in accessible locations	<ul style="list-style-type: none"> <li>Service user</li> <li>Family</li> <li>Employers</li> <li>Society</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>Service user feedback</li> <li>Increased public and professional awareness</li> <li>Increased profile and visibility of IAPT across the population of Jersey</li> </ul>	No baseline	IAPT activity data
Increased utilisation of self help materials.	<ul style="list-style-type: none"> <li>Service user</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>A sustainable portfolio of psychological interventions in community settings</li> <li>Increased numbers of people receiving self help</li> <li>Increased choice</li> <li>Increased numbers of service users accessing low intensity treatments</li> </ul>	<ul style="list-style-type: none"> <li>CCBT activity data from Psychological Assessment and Therapy Service</li> <li>Data from public libraries on access to self help</li> </ul>	<ul style="list-style-type: none"> <li>Increased CCBT activity data from IAPT Service</li> <li>Increased data from public libraries on access to self help</li> <li>Increased use of self-help materials from Primary Care</li> </ul>
Increased data on patients recorded outcome measures (PROMS)	<ul style="list-style-type: none"> <li>Service users</li> <li>Service providers</li> <li>Commissioners</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>IAPT audit data</li> </ul>	Data currently collected from Psychological Assessment and Therapy Service: <ul style="list-style-type: none"> <li>Number of referrals</li> <li>Number of discharges</li> <li>Number of working days waiting for first appointment</li> </ul>	The following outcome measures should be given to <b>ALL</b> patients seen in IAPT in order to improve care and services provided: IAPT Clinical Outcome

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				<ul style="list-style-type: none"> <li>• Length of treatment</li> </ul>	<p>Measures (IAPT Data Handbook June 2011)</p> <ul style="list-style-type: none"> <li>• Depression: PHQ-9</li> <li>• General Anxiety: GAD7</li> <li>• Phobias: IAPT Phobia Scales</li> <li>• Functioning: WSAS (Worker and Social Adjustment Scale)</li> <li>• Obsessive Compulsive Disorder: Obsessive Compulsive Inventory (OCI)</li> <li>• Generalised Anxiety Disorder: Penn State Worry questionnaire-Short (PSWQ)</li> <li>• Social Phobia: Social Phobia Inventory (SPIN)</li> <li>• Health Anxiety: Health Anxiety Inventory-Short week version (SHAI)</li> <li>• Avoidance/reassurance: Avoidance/reassurance (health) questionnaires</li> <li>• Agoraphobia: The Agoraphobia-Mobility Inventory (MI)</li> <li>• Post-Traumatic Stress Disorder: Impact of Events</li> </ul>
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					Scale-Revised (IES-R) • Panic Disorder: Panic Disorder Severity Scale: self-report version (PDSS)
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**Appendix 2 – Stakeholder Log**

Stakeholder Identified	Are they...			
	Responsible <i>(will work to deliver the OBC)</i>	Accountable <i>(answerable for the delivery of the OBC)</i>	Consulted <i>(opinions sought)</i>	Informed <i>(kept up-to-date on progress)</i>
HSSD Mental Health Service	✓ <ul style="list-style-type: none"> <li>To work in collaboration with IAPT service</li> <li>Staff across the Mental Health Team to understand pathway and when to signpost / refer</li> </ul>		✓	✓
MIND Jersey Other Third Sector Organisations/ Voluntary groups	✓ <ul style="list-style-type: none"> <li>Contributing to development and support of future service</li> <li>Co-production of service specifications and FBC</li> <li>Staff to understand pathway and when to signpost / refer</li> </ul>		✓	✓

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Primary Care Team (GPs, Practice Nurses, Health Visitors), Pharmacists	<ul style="list-style-type: none"> <li>✓</li> <li>• Co-production of service specifications and FBC</li> <li>• To refer appropriate individuals to IAPT</li> <li>• Ongoing feedback on service</li> </ul>		✓	✓
HSSD Psychological Therapies and Assessment Department	<ul style="list-style-type: none"> <li>✓</li> <li>• Responsible for elements of service delivery, referrals and working in partnership</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>• Lead for OBC and FBC development</li> </ul>	✓	✓
Social Security Department			✓	✓
Training providers including H&SS Education Department	<ul style="list-style-type: none"> <li>✓</li> <li>• To provide Evidence Based quality training</li> </ul>	<ul style="list-style-type: none"> <li>✓</li> <li>• Accountable for training delivery</li> </ul>	✓	✓
General Public			<ul style="list-style-type: none"> <li>✓</li> <li>• Awareness and understanding of IAPT services and how to access</li> </ul>	✓
Associated Health Professionals including Health Visitors, Midwives, Social Workers, Older Persons Services, Alcohol & Drug Service, Emergency Department staff, Occupational Health	<ul style="list-style-type: none"> <li>✓</li> <li>• Responsible for elements of service delivery, referrals and working in partnership</li> </ul>		<ul style="list-style-type: none"> <li>✓</li> <li>• Awareness and understanding of IAPT services and how to signpost Service Users into the service</li> </ul>	✓

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HSSD Public Health Department	✓ <ul style="list-style-type: none"> <li>• Co-production of service specifications and FBC</li> <li>• Plan and implement awareness campaign to raise public and professional awareness of IAPT</li> <li>• Assist in monitoring and evaluation of the new service</li> </ul>	✓ <ul style="list-style-type: none"> <li>• Accountable awareness campaign for raising</li> </ul>	✓	✓
Employers and Employee groups	✓ <ul style="list-style-type: none"> <li>• Duty of care to their employees</li> <li>• Impact on business</li> </ul>		✓ <ul style="list-style-type: none"> <li>• Re: potential changes in legislation</li> </ul>	
Politicians	✓ Understanding and agreeing funding	✓	✓	✓

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**Appendix 3 – Risk Log**

<b>Risk (description)</b>	<b>Likelihood (High / Medium / Low)</b>	<b>Impact (High / Medium / Low)</b>	<b>Overall Rating (Likelihood x Impact)</b>	<b>Risk</b>	<b>Controls/Actions (What can we do to prevent this risk becoming reality?)</b>
Lack of funding (in total or in part)	M	H			<ul style="list-style-type: none"> <li>• Robust business case</li> <li>• Clear value for money case</li> </ul>
Inability to recruit trained and experienced staff	M	H	M/H		<ul style="list-style-type: none"> <li>• Identify specific training requirements</li> <li>• Engage with States regarding need for J CAT</li> <li>• Start training and developing staff early</li> <li>• Agree short term contracts</li> <li>• Robust recruitment plan</li> </ul>
Lack of Third Sector capacity reduces ability to respond to opportunity	H	L	H		<ul style="list-style-type: none"> <li>• Continued engagement and co-production of FBC and service specifications</li> <li>• Market stimulation and support</li> <li>• HSSD could deliver High Intensity service, or work in partnership</li> </ul>
Unrealistic expectation from service users, communities and professionals	L	L	L		<ul style="list-style-type: none"> <li>• Awareness campaign</li> <li>• Ongoing stakeholder engagement</li> </ul>
Potential increase in waiting list for Step 4 interventions due to increased volume of Service Users being seen at lower level	M/H	H	H		<ul style="list-style-type: none"> <li>• Analysing impact and plan services accordingly</li> </ul>
Governance and coordination between multiple providers	H	H	H		<ul style="list-style-type: none"> <li>• Agree robust Service Level Agreements</li> <li>• Implement local governance infrastructure</li> <li>• Ensure regular interdepartmental communication and joint working</li> <li>• Agree shared service ethos</li> <li>• Ensure staff have robust job descriptions with clear understanding of roles, responsibilities and accountability</li> </ul>



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Data collection and sharing remains poor - difficulty in measuring effectiveness of services provided	H	H	H	<ul style="list-style-type: none"> <li>• Agree minimum data set</li> <li>• Collect and analyse data</li> <li>• Use data to inform future service development</li> </ul>
Lack of robust commissioning	H	H	H	<ul style="list-style-type: none"> <li>• Develop commissioning function</li> <li>• Co-produce service specification</li> <li>• Identify metrics and outcome measures</li> <li>• Produce robust FBC</li> <li>• Improve data collection</li> <li>• Regular review of services</li> </ul>
Organisations reticence to share data and information	M	H		<ul style="list-style-type: none"> <li>• Agree service ethos</li> <li>• Address data protection issues</li> <li>• Identify minimum data set</li> <li>• Improve communication</li> </ul>
Service continues to be under resourced and cannot provide access for over 65's	M	M	M	<ul style="list-style-type: none"> <li>• Modelling and analysis to confirm resource requirements</li> <li>• Clear access and eligibility criteria</li> <li>• Monitoring of activity and outcomes</li> <li>• Service review</li> </ul>
Service model is not adjusted for Jersey	L	M	L/M	<ul style="list-style-type: none"> <li>• Co-produce service specification</li> <li>• Produce robust FBC</li> <li>• Agree metrics and outcome measures</li> <li>• Monitor service delivery</li> <li>• Robust commissioning and decommissioning</li> </ul>
Media / public misunderstanding of IAPT	H	H	H	<ul style="list-style-type: none"> <li>• Effective awareness and media campaign</li> <li>• Clear service/eligibility criteria</li> <li>• Accessible referral process</li> <li>• Get 'front door' right</li> <li>• Training and awareness for potential referrers, including GPs, employers, schools, Third Sector</li> </ul>

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Reticence from existing service providers to move towards a new model of care for low level mental health issues	M			<ul style="list-style-type: none"> <li>• Co-produce service specification and FBC</li> <li>• Ongoing communication and engagement</li> </ul>
Current Social Security legislation prevents new and flexible approaches for individuals	H			<ul style="list-style-type: none"> <li>• Legislation is currently being examined</li> </ul>
New processes, including referral, are not sufficiently robust to meet waiting time and access targets	L	H	L	<ul style="list-style-type: none"> <li>• Ensure resourced appropriately with high skilled / experienced staff at 'front door'</li> <li>• Review access and service delivery</li> </ul>
Accommodation availability for enhanced team				<ul style="list-style-type: none"> <li>• Work with Estates workstream to identify accommodation</li> </ul>

**Appendix 4 – Issues Log**

<b>Description</b>	<b>Impact (High/Medium/Low)</b>	<b>Lead</b>	<b>Comments (What has been done or will be done to work around the issue?)</b>
Current lack of a clear pathway and sharing of information	M		<p>IAPT requires extremely close working between all elements of health and social services, including Primary Care and the Third Sector. Service specifications, outcome measures and the FBC will be co-produced.</p> <p>Future processes will require improved communication, coordination, joint working and integration.</p>

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**Appendix 5 - Dependencies and enablers log**

Description of Dependency	Dependency Lead	Dependency 'Strength'	Comments
Long Term Conditions OBC	Richard Jouault	H	<ul style="list-style-type: none"> <li>• Significant proportion of individuals with a LTC also have psychological needs</li> <li>• Extra training module on LTC for IAPT team</li> <li>• Communication to align service implementation</li> <li>• Coordination and improved access across services</li> </ul>
J Category permission for High Intensity workers	Lynne Lusby	M	Off-Island recruitment is required in order to minimise risks and costs. If all IAPT staff are recruited from on-Island, costs of training will increase and there may be a higher proportion of trainees which would impact governance and outcomes
Healthy Lifestyles OBC	Andrew Heaven	L	<ul style="list-style-type: none"> <li>• Important not to duplicate low level interventions</li> <li>• Communication to align objectives</li> </ul>
Social Security legislation and potential for 'Fit to Work' schemes	Sue Duhamel	L/M	<ul style="list-style-type: none"> <li>• System would be greatly enhanced by more flexible schemes</li> </ul>
Third Sector – maintain good working relationships and stimulate provider market	Tracy Wade		<ul style="list-style-type: none"> <li>• Liaise with all Third Sector organisations to increase awareness of opportunity</li> <li>• Co-produce FBC</li> </ul>
Political will	Steering Group	H	SRO and Steering Group to champion change and take IAPT initiative forward
Services for Children Service Workstream	Andrew Heaven		<ul style="list-style-type: none"> <li>• IAPT for Children is planned for 2016 onwards</li> </ul>
Public engagement and understanding of new approach to accessing services for common mental health issues	Tracy Wade Public Health-Health Improvement	H	<ul style="list-style-type: none"> <li>• Establish media campaign to raise awareness</li> <li>• Consider social marketing to increase access to IAPT service</li> </ul>
Agreement of GPs, wider Primary Care Team and multidisciplinary teams to refer Service Users to IAPT	<ul style="list-style-type: none"> <li>• Steering Group</li> <li>• Primary Care Body Susan Turnbull</li> </ul>	H	<ul style="list-style-type: none"> <li>• Effective communication with wider professional groups</li> </ul>





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<b>OBC Title: Improved Access to Psychological Therapy - Adults and Older Adults</b>								
<b>Initiative number</b>	<b>Initiative title and resource requirements</b>	<b>Additional FTE required</b>	<b>Basis of any assumptions included in resource requirements</b>	<b>Implementation date</b>	<b>Implementation costs £ ('000)</b>	<b>2013 Revenue £ ('000)</b>	<b>2014 Revenue £ ('000)</b>	<b>2015 Revenue £ ('000)</b>
<b>1</b>	Set up 'High Intensity Intervention' team. 8 high intensity workers are required, a proportion of them will be recruited from outside the island on 'J' categories. Trainee's will only able to work 3 days per week, due to training requirements.	8.00	Based on the IAPT model introduced in Doncaster, it was identified that the contacts capacity for 14 workers (HIW and LIW) would be 20,700 for adults (based on 4 per referral). This equates to 5,175 clients. In Jersey, of the 60,000 working population, 18% suffer with anxiety and depression (JASS survey). If 50% of those were treated for IAPT, then 5,400 people would require treatment through IAPT (60,000 x 18% x 50%). HIW's will be able to support 22 contacts per week. Therefore 8 HIW's x 46 weeks p.a. x 22 contacts = 8096 contacts p.a.	2 in Jun 2012 (50% - UK); 2 in Jun 2013 2 June 2014 2 & June 2015 (50% UK and 50% on-island)	47	176.00	331.00	494.00
<b>2</b>	Set up 'Low Intensity Intervention' team. 5 Psychological Well-being Practitioners are required, all being recruited from on-island. Trainee's will only able to work 3 days per week, due to training requirements.	5.00	Based on the IAPT model introduced in Doncaster, it was identified that the contacts capacity for 15 workers (HIW and LIW) would be 20,700 for adults (based on 4 per referral). This equates to 5,175 clients. In Jersey, of the 60,000 working population, 18% suffer with anxiety and depression (JASS survey). If 50% of those were treated for IAPT, then 5,400 people would require treatment through IAPT (60,000 x 18% x 50%). LIW's (or PWP's) will be able to support 42 contacts per week. Therefore 5 LIW's x 46 weeks p.a. x 42 contacts = 9660 contacts p.a. Of the 42 contacts per week, it has been assumed that 14 contacts will be face-to-face, 14 will be via the telephone and 14 will be through group sessions.	Jun 2013 (50%); Jun 2014 (100%)	9	62.00	126.00	215.00

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**Appendix 6 - Financial Analysis**

3	Set up 'Support' team for HIW's and PWP's. An employment officer is required to provide workforce liaison support and secretary is required to support HIW's and PWP's with day-to-day	1.00	Secretary starts June 2014 & Employment Officer Jan 2015 (Employment Officer now expected to be funded by Soc Sec)	Secretary (June 2014); Employment Officer (Jan 2015)	2	-	17	35
4	Initial set up costs / Ongoing. Marketing campaign, self help workbook will need to be set up and training (inc. flights, accommodation and subsistence) will need to be provided to both HIW's and LIW's (or PWP's).		Media Campaign - assume one-off cost of £10,000 and £7,500 p.a. ongoing; Training costs - course costs have been based on £9,176 per HIW (2 days per week for 1 year) and £4,588 per LIW (1 day per week for 1 year). Flights (£120 return), accommodation (£50 per night) and subsistence (£20 per day) are based on trips to Southampton. 50% of HIW's and 100% of LIW's will require initial training. An ongoing training budget will be required for new staff recruited from on-island.  Implementation: Media campaign and marketing (July to December 2013); Training (50% of PWP's {Jul 2013 to Jun 2014}) and (50% of HIW's and 50% of PWP's {Jan to Dec 2014}); self help workbooks (mid 2013)	In phases from 2013	111	25	26	27
5	Ongoing. Room rental (via GP surgeries, parish halls and other locations)		Hiring GP surgeries - Individual (HIW => 22 contacts per week x 11 workers x 1½ hours per visit x 46 weeks x £10 per hour = £273,000; LIW => 14 contacts per week x 6 workers x 1 hours per visit x 46 weeks x £10 per hour = £77,000); Group sessions (LIW => 2 sessions per week x 6 workers x 46 weeks x £25 per half day = £28,000)	Jul to Dec 2013 (50% of HIW's; 50% of PWP's); Jun 2014 (100% of HIW's and PWP's)	-	49	129	209



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<b>6</b>	Ongoing. IT solutions (including CCBT)		Software to support IAPT => based on a quote from PCMIS, an unrestricted user login licence (3 year agreement) would cost £10,995. Additional training costs will be at £1,000 per day (estimate £10,000) and assume that support and upgrades are included in 3 year licence agreement. CCBT => £10,000 p.a. based on the current licencing and activity	Implement IT system (Jan to Jun 2013)		7	16	16	17
<b>7</b>	Ongoing. CPD training		HIW's only. Estimate £1,000 per HIW (£1,000 x 9) - removed part of "on costs" eg included in staff cost calculator	Jul to Dec 2013 (50% of HIW's); Jun 2014 (100% of HIW's and PWP's)		-	-	-	-
<b>8</b>	Ongoing. Other (publications {booklets, leaflets, self help material}, telephone, mileage, stationery, postage, supplies, etc...)		Publications {booklets, leaflets, self help material} (£5,000); telephone (£1,000); mileage (£2,000 x 18 = £36,000), postage (£500); other (£5,000). For LIW's, of the 42 contacts per week, it has been assumed that 14 contacts will be via the telephone (duration up to 1 hour each).	Jun-13		-	16	51	52
<b>9</b>	Ongoing support through 3rd sector. Within (or after) their		In order that such complementary support can be developed, additional funding is required to	Jun-14		-	-	40	83
<b>10</b>	Accommodation. Additional accommodation required. Includes refurbishment of existing premises		Additional space required dependent on survey of property being done by Estate Cross Cutting workstream. £50k Rental ongoing costs - removed cap implementation as part of JPG prop space review process and reduced rental from £50k to £0k	Jan-13		-	-	-	-
<b>TOTAL COSTS</b>		<b>14</b>				<b>176</b>	<b>344</b>	<b>736</b>	<b>1,132</b>

## References

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<sup>i</sup> Black, C. Working for a healthier tomorrow. *Review of the health of Britain's working age population*. Crown Copyright. 2008.

<sup>ii</sup> Layard, R, Clark, D., Knapp, M. and Mayraz, G. *Cost-Benefit Analysis of Psychological Therapy*. National Institute Economic Review, No 202, October 2007.

<sup>iii</sup> Health and Social Services. *Social Security Department Data*. States of Jersey 2009.

<sup>iv</sup> Health and Social Services. *Social Security Department Data*. States of Jersey 2009.