

Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of Improving Access to Psychological Therapies (IAPT) Implementation Plan	
Stage: Implementation	Version: Final	Date: 21 Feb 2008
Related Publications: IAPT Implementation Plan		

Available to view or download at:

<http://www.mhchoice.csip.org.uk>

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

Depression and anxiety disorders are serious and debilitating conditions, associated with significant human and economic costs. The NICE Guidelines say that people diagnosed with these conditions should be offered evidence-based psychological therapy in addition to appropriate anti-depressant medication. This is also what most people with these problems want. However, due to a lack of therapists in the NHS, psychological therapies are unavailable in many NHS settings around the country. Both demand and supply side problems (discussed further in the "Evidence" section) have resulted in an underprovision of psychological therapies relative to need. Government intervention is required to facilitate a supply of suitably trained psychological therapists adequate to ensure that the NICE guidelines can be implemented, and patient preferences met.

What are the policy objectives and the intended effects?

The objective is to provide Psychological Therapy Services on a national, comprehensive basis. The Government has recently announced additional targeted funding in the Comprehensive Spending Review that will enable PCTs to begin to implement the NICE Guidelines. Ultimately, there will be a service for every PCT's population. The money will be used to pay for the major training programme that is necessary to generate the required number of suitably trained therapists, thereby enabling the progressive expansion of NICE-compliant local Psychological Therapy services. Each SHA will plan how best to achieve these changes along with the DH. The aim is that at roll-out 800,000 patients will be offered evidence-based psychological therapies each year, enabled by a substantial increase in the supply of trained psychological therapists.

What policy options have been considered? Please justify any preferred option.

- 1) Do nothing
- 2) (Preferred option) Improve Access to Psychological Therapies for people diagnosed with clinical depression or anxiety disorders with a large additional investment, increasing over 6 years and national coordination to increase the availability of psychological therapists trained to provide NICE-recommended, evidence-based, therapies and thus to achieve full coverage
- 3) As option 2 (above), but with funding increasing for three years and then remaining at that rate, providing about 70% of the service level of option 2.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? The policy will be overseen by the National IAPT Programme Board co-chaired by the Parliamentary Under Secretary for Care Services (PS(CS)) with monthly reports from all regions to align progress against key national performance indicators. A formal policy review will be undertaken within three years.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

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

Signed by the responsible Minister:

.....Date:

Summary: Analysis & Evidence

Policy Option: 1. Do nothing	Description: Leave access to Psychological Therapies unchanged.
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups'		
	One-off (Transition)	Yrs		
	£ 0			
	Average Annual Cost (excluding one-off)			
	£ 0		Total Cost (PV)	£ 0
Other key non-monetised costs by 'main affected groups'				

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups'		
	One-off	Yrs		
	£ 0			
	Average Annual Benefit (excluding one-off)			
	£ 0		Total Benefit (PV)	£ 0
Other key non-monetised benefits by 'main affected groups'				

Key Assumptions/Sensitivities/Risks n/a
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Price Base Year	Time Period Years	Net Benefit Range (NPV) £ 0	NET BENEFIT (NPV Best estimate) £ 0
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What is the geographic coverage of the policy/option?	n/a			
On what date will the policy be implemented?	n/a			
Which organisation(s) will enforce the policy?	n/a			
What is the total annual cost of enforcement for these organisations?	£			
Does enforcement comply with Hampton principles?	Yes/No			
Will implementation go beyond minimum EU requirements?	Yes/No			
What is the value of the proposed offsetting measure per year?	£			
What is the value of changes in greenhouse gas emissions?	£			
Will the proposal have a significant impact on competition?	Yes/No			
Annual cost (£-£) per organisation	Micro	Small	Medium	Large
(excluding one-off)				
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)	(Increase - Decrease)
Increase of £ 0	Decrease of £ 0
Net Impact	£ 0

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Summary: Analysis & Evidence

Policy Option: 2. (Preferred option)	Description: National roll out over 6 years
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups'	
	One-off (Transition) Yrs	Net savings to Exchequer due to reduced benefit payments and increased tax revenue due to improved employment in treated population (mid-range estimate -£530m after roll-out)	
	£ -99m [DH +187m] 6	DH/NHS: costs of training, salaries etc (approx £270m after roll-out)	
	Average Annual Cost (excluding one-off)	Total Cost (PV)	
	£ -233m [DH +270m]	£ - 2bn	
Other key non-monetised costs by 'main affected groups'			

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups'	
	One-off Yrs	Health benefits to those treated (monetised at £1.7bn after roll-out)	
	£ 1.3bn 6	Increased output (monetised at around £600m after roll-out) PV is £25bn with QALYs valued at £40K, or £19bn if at £20K	
	Average Annual Benefit (excluding one-off)	Total Benefit (PV)	
	£ 2.3bn	£ 19 - 25 bn	
Other key non-monetised benefits by 'main affected groups'			

Key Assumptions/Sensitivities/Risks

Costs & benefits over 15 years and funding for future years (yrs 4-15) will be subject to the success of future CSR settlements. See page 15 costs of recruitment/retraining for replacements for staff joining IAPT unquantifiable – although levels of supply & demand in the mental health workforce will be monitored on an on-going basis. Course fees used in the programme costs have been estimated on the assumption that HEFCE contributions to such courses remain unchanged.

Price Base Year	Time Period Years	Net Benefit Range (NPV) £ 20bn – 33bn (QALY at £40K)	NET BENEFIT (NPV Best estimate) £ 27 bn (with a QALY at £40K)
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What is the geographic coverage of the policy/option?	England			
On what date will the policy be implemented?	1 st April 2008			
Which organisation(s) will enforce the policy?	SHAs, DH			
What is the total annual cost of enforcement for these organisations?	£			
Does enforcement comply with Hampton principles?	Yes/No			
Will implementation go beyond minimum EU requirements?	Yes/No			
What is the value of the proposed offsetting measure per year?	£			
What is the value of changes in greenhouse gas emissions?	£			
Will the proposal have a significant impact on competition?	Yes/No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact	£	

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Summary: Analysis & Evidence

Policy Option: 3.	Description: Embark on a national programme that aims to implement local Psychological Therapy services gradually across all PCTs in England with annual increases in investment for the first three years only
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COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' Net savings to Exchequer due to reduced benefit payments and increased tax revenue due to improved employment in treated population (mid-range estimate -£419m after roll-out) DH/NHS: costs of training, salaries etc (approx £209m after roll-out)
	One-off (Transition)	Yrs	
	£ -21m [DH +123m]	3	
	Average Annual Cost (excluding one-off)	Cost	
	£ -191m [DH +209m]		
Total Cost (PV)			£ -2 bn
Other key non-monetised costs by 'main affected groups'			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' Health benefits to those treated (monetised at £1.4bn after roll-out) Increased output (monetised at around £470m after roll-out) PV is £21bn with QALYs valued at £40K, or £13 bn if at £20K
	One-off	Yrs	
	£ 0.9bn	4	
	Average Annual Benefit (excluding one-off)	Benefit	
	£ 1.9bn		
Total Benefit (PV)			£ 13 - 21bn
Other key non-monetised benefits by 'main affected groups'			

Key Assumptions/Sensitivities/Risks See page 15 costs of recruitment/retraining for replacements for staff joining IAPT unquantifiable – although levels of supply & demand in the mental health workforce will be monitored on an on-going basis. Course fees used in the programme costs have been estimated on the assumption that HEFCE contributions to such courses remain unchanged.

Price Base Year	Time Period Years	Net Benefit Range (NPV) £ 17bn – 28bn (QALY at £40K)	NET BENEFIT (NPV Best estimate) £ 22bn (QALY at 40K)
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What is the geographic coverage of the policy/option?		England	
On what date will the policy be implemented?		1 st April	
Which organisation(s) will enforce the policy?		SHAs, DH	
What is the total annual cost of enforcement for these organisations?		£	
Does enforcement comply with Hampton principles?		Yes/No	
Will implementation go beyond minimum EU requirements?		Yes/No	
What is the value of the proposed offsetting measure per year?		£	
What is the value of changes in greenhouse gas emissions?		£	
Will the proposal have a significant impact on competition?		Yes/No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact	£

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Evidence Base (for summary sheets)

Introduction

Depression and anxiety disorders are serious conditions and have a major impact on how well an individual is able to function. A recent WHO study contrasted depression with angina, asthma, diabetes and arthritis and concluded that the impact of depression on a person's functioning was 50% more serious than the impact of any of the four physical conditions.¹ At present 40% of disability is due to depression and anxiety². These conditions are also associated with significant economic costs.

The NICE Guidelines say that these people should be offered modern evidence-based psychological therapy. This is also what most people with these problems want. However, the guidelines generally have not been implemented.

Evidence shows that there is a high demand and need for psychological therapies but an insufficient number of trained psychological therapists available to the NHS. Thus, there is a supply-side problem which has resulted in an underprovision of psychological therapies. Government intervention is required to correct for this shortage, through the training of more therapists, in order to begin to meet the demand for evidence-based psychological therapies. Demand for services is high because over six million adults suffer from clinical depression and/or chronic anxiety disorders in England³. Only a quarter receive treatment of any kind.

¹ Mousavi et al, Depression, chronic diseases, and decrements in health: results from the World Health Surveys, 2007, *The Lancet*, 370:851-858

² WHO, *The Global Burden of Disease*

³ ONS Psychiatric Morbidity Survey: Singleton et al, Psychiatric morbidity among adults living in private households, 2000.

Evidence Base (for option 1)

Option 1: Do nothing

No additional costs or benefits are associated with this option.

It should, however, be noted that over six million adults suffer from clinical depression and/or chronic anxiety disorders in England, and that only a quarter receive treatment of any kind.

Evidence Base (for option 2)

Option 2: Embark on a national programme that aims to implement local Psychological Therapy services gradually across all PCTs in England over a 6-year period with annual increases in investment over this time (*preferred*)

Overall, the estimates in this (the preferred option) suggest that there should be a net saving to the Exchequer and with health benefits that would recoup the initial investment several times over.

2.1 DESCRIPTION

The national implementation plan covers the phased training of therapists and the progressive expansion of NICE-compliant local Psychological Therapies services across England from 2008/09 until 2010/11. The CSR 2008/09 – 2010/11 has allocated substantial additional investment to the expansion of psychological therapy services, rising to £173 million by 2010/11. This is intended to pay for a major training programme of psychological therapists and a phased expansion of NICE-compliant psychological therapies services. Further roll-out to full coverage is dependent on a positive CSR settlement for the period 2011/12 – 2013/14.

It is the Government's intention to devolve decision-making about the future configuration of services to local level and make the NHS more responsive to the needs and wishes of local populations. However, in the case of building psychological therapy services from a very low baseline, it is unlikely that local level commissioning alone could achieve the national coverage proposed by the IAPT programme, within the same resource.

Some of the underlying reason for this can be characterised as the result of a coordination and information problem, and of a problem of the capture of the returns to investment. These are discussed below.

The commissioning and specification of suitable training programmes necessary to deliver the required workforce will require national and regional co-ordination to ensure that the syllabus, accreditation and competence of the new workforce meets the required national standards. Only by providing this regulation can local commissioners, in future, be expected to commission suitable local services.

The IAPT pilots have demonstrated that psychological therapy services can be effective and provided the basis of developing clear service models, which will be published in the IAPT Implementation Plan. This will provide, for the first time, a clear national service template to enable effective local commissioning. This will be enabled by the publication of an IAPT Commissioning Toolkit and more resources being made available to support the development of effective commissioning.

Finally, the success of the pilots (see annex 2), together with a coherent national Implementation Plan, co-ordinated nationally for and on behalf of the NHS, has provided the confidence required to the Government to enable the publication of PSA indicators (18) and an NHS Operating Framework priority which, for the first time, gives a priority to the delivery of the new services. This would not have been possible nor would it have been achievable without the availability of the additional resources nor the national co-ordination process.

Regional-level coordination will be vital to having sufficient scale for the training programmes to be viable. Individual PCTs may not have sufficient scale to induce training providers to develop accredited courses that are necessary to ensure that services are of sufficient quality. In addition, PCTs that made the large investment required in training and services could find that some of the return to this investment would accrue elsewhere - for example, improved employment rates would generate returns to the exchequer in form of reduced IB payments, while therapists trained at the expense of one particular PCT could find work in another PCTs.

These difficulties suggest that, while local commissioning will play a key role in the IAPT programme, local commissioning unsupported by a strong central lead would be insufficient to make much headway in the problem of unmet demand for psychological therapies.

It is also likely that a fragmented approach to implementation would have taken a very long time. Estimates are unreliable because the baseline of progress has been so limited to date, but at least 10-15 years would be required.

The main costs expected from the programme are those costs associated with the training and salaries of this new workforce, and associated organisational and overhead costs. The benefits expected from the programme are (i) reduced suffering, (ii) benefits to the wider economy, in terms of additional employment and output, and (iii) benefits to the NHS, in terms of reduced visits to family doctors and avoided referrals to acute and specialist mental health services. The implementation plan describes a system of "stepped care", in which the intensity and duration of treatment is tailored to the severity level of the disorder diagnosed.

The three-year implementation plan represents the first three years of a service that is expected to roll-out nation-wide within 6 years, and then to continue on an ongoing basis. Therefore, this Impact Assessment discusses the costs and benefits associated with this option over 15 years. However, it is important to note that funding for years 4 onwards will depend on the outcome of future spending reviews.

National roll-out will be deemed complete when 800,000 patients are treated each year. This is based on evidence that around 6 million people suffer from depression and/or anxiety disorders, of whom around 2.75 million seek assistance from a GP in a year⁴. It is estimated that around a third of these would choose psychological therapies, and, in a world where psychological therapies were more readily available, it is likely that a greater proportion of those suffering from

⁴ London School of Economics and Political Science. Centre for Economic Performance. Mental Health Policy Group (2006). The depression report: a new deal for depression and anxiety disorders [online] London: LSE research. Available at <http://eprints.lse.ac.uk/archive/00000818>

depression and anxiety disorders would seek help⁵. The number of therapists required at roll-out is calculated on the basis of this 800,000 patients and the basis of assumptions about the number of patients that different therapists would be able to see in a year.

2.2 COSTS

The main costs are those directly associated with training and paying the psychological therapists and other staff involved in service delivery. The view of the programme’s workforce experts is that a maximum of 3600 newly trained staff will be available to become IAPT employees over the 3 years of the CSR period. (Around 700 will start in the first year, around 1550 in the second year, and around 1350 in the third year.) Of these staff, around 60% overall will be high intensity⁶ therapists, and 40% overall will be low intensity therapists, based on a range of service models expected at local level, working on ratios of between 70:30 and 50:50. All of these are considered good practice, and the exact mix will vary with local skill-mix and need in each PCT area. Finally, the costs are modelled on the basis of a fixed ratio of trained and experienced staff to trainees, in order to allow for the supervision and work-shadowing that are key parts of training. Costs are, therefore, modelled around four types of therapists: trainee high intensity therapists, trainee low intensity therapists, trained high intensity therapists, and, trained low intensity therapists.

2.2.1 Training costs

Set up costs will be £40,000 for each of the 20 courses required (1 high-intensity and 1 low-intensity training course is expected in each SHA). This is intended to cover the cost of the relevant British Association of Behavioural and Cognitive Psychologists (BABCP) accreditation costs, academic staff set-up costs and course materials, such as training DVDs. These will reach a total of £800,000 (in year 1 only).

Course fees (cost of training) are expected to be in the region of £4300 per trainee for low-intensity training, and £8600 for high-intensity training. These estimates are based on the advice of workforce leads and drawn from existing training provider price structures. These costs include the costs of off-the-job supervision, and training. Training for supervisors (who will be experienced and already-qualified therapists) is expected to cost £500. Given the planned recruitment and training profile, these costs are expected to reach the totals shown in Table 1 below. The number of therapists is set to expand until year 6, after which time training is assumed to be in place to allow for turnover of staff at 10% per year.

Table 1: Course Fees

	Therapist training course fees	Supervisor course fees	Total	“Best” case (-5%)	“Worst” case (+5%)

⁵ Layard, R., The case for psychological treatment centres, BMJ 2006;332:1030-1032 (29 April),

⁶ High and low intensity therapy and therapists are described in the Implementation Plan itself

Year 1	£3,940,000	£180,000	£4,120,000	£3,920,000	£4,320,000
Year 2	£9,650,000	£250,000	£9,900,000	£9,410,000	£10,390,000
Year 3	£9,240,000	£130,000	£9,370,000	£8,900,000	£9,830,000
Year 4	£2,820,000	£50,000	£2,870,000	£2,720,000	£3,010,000
Year 5	£2,820,000	£50,000	£2,870,000	£2,720,000	£3,010,000
Year 6	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 7	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 8	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 9	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 10	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 11	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 12	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 13	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 14	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000
Year 15	£3,510,000	£50,000	£3,560,000	£3,380,000	£3,730,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews

It is important to note that the course fees used in the programme costs have been estimated on the assumption that HEFCE contributions to such courses remain unchanged. The issue is currently under investigation but we are currently unable to quantify the risk or the potential impact.

The total costs associated with training are, therefore:

Table 2: Training Costs

	Total costs associated with training	"Best" case (-5%)	"Worst" case (+5%)
Year 1	£4,920,000	£4,720,000	£5,120,000
Year 2	£9,900,000	£9,410,000	£10,390,000
Year 3	£9,370,000	£8,900,000	£9,830,000
Year 4	£2,870,000	£2,720,000	£3,010,000
Year 5	£2,870,000	£2,720,000	£3,010,000
Year 6	£3,560,000	£3,380,000	£3,730,000
Year 7	£3,560,000	£3,380,000	£3,730,000
Year 8	£3,560,000	£3,380,000	£3,730,000
Year 9	£3,560,000	£3,380,000	£3,730,000
Year 10	£3,560,000	£3,380,000	£3,730,000
Year 11	£3,560,000	£3,380,000	£3,730,000
Year 12	£3,560,000	£3,380,000	£3,730,000
Year 13	£3,560,000	£3,380,000	£3,730,000
Year 14	£3,560,000	£3,380,000	£3,730,000
Year 15	£3,560,000	£3,380,000	£3,730,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews

2.2.2 Salary costs

a) Therapist salaries

Therapists' salary costs have been modelled by assuming different distributions of salaries for the four categories of therapists, based on Agenda for Change (AfC) Paybands as follows:

Table 3: Estimated salaries

	AfC bands used	Estimated weighted average salary
Trainee high intensity therapists	Bands 6 - 7	£26,000
Trainee low intensity therapists	Band 4	£17,000
Trained high intensity therapists	Bands 7 - 8d	£42,000
Trained low intensity therapists	Bands 5 - 6	£25,000

The view of the workforce experts is that roll-out will not be from a standing start and that in year one some therapists will need to be funded from PCT budgets. However, we lack data on current therapist numbers and, as crucially, we lack data about the extent to which current services are operating within NICE guidelines and in the team structure that is associated with the most positive health and employment outcomes. Given this, costs and benefits here include the costs and benefits associated with all the therapists that are expected to work within the IAPT programme – this means that both costs and benefits are overstated to the extent that (i) services are already in operation (ii) services are already operating in compliance with NICE guidelines and producing the expected benefits.

Given the planned recruitment and training profile, the costs of therapists' salaries are expected to reach the totals shown below. A "best" case scenario is considered where all therapists move down 1 Agenda for Change payband. The "worst" case considers all therapists moving up 1 payband and all salaries increasing by 1.5% per year from year 4.

Table 4: Therapist Salary Costs

	Total therapist salaries	"Best" case (all therapists move down 1 band)	"Worst" case (all therapists move up 1 band +1.5% from year 4)
Year 1	£30,180,000	£25,780,000	£36,680,000
Year 2	£97,130,000	£82,660,000	£117,910,000
Year 3	£165,350,000	£139,600,000	£200,560,000
Year 4	£197,910,000	£166,130,000	£243,290,000
Year 5	£215,760,000	£181,080,000	£264,890,000
Year 6	£236,400,000	£198,450,000	£293,870,000
Year 7	£236,400,000	£198,450,000	£298,280,000
Year 8	£236,400,000	£198,450,000	£302,750,000
Year 9	£236,400,000	£198,450,000	£307,290,000
Year 10	£236,400,000	£198,450,000	£311,900,000

Year 11	£236,400,000	£198,450,000	£316,580,000
Year 12	£236,400,000	£198,450,000	£321,330,000
Year 13	£236,400,000	£198,450,000	£326,150,000
Year 14	£236,400,000	£198,450,000	£331,040,000
Year 15	£236,400,000	£198,450,000	£336,010,000

Constant prices, rounded to nearest £10,000. Table includes both the 3600 therapists' salaries expected to be funded from the recent CSR allocation to IAPT, and the approximately 700 additional therapists' salaries expected to be funded from PCTs' existing budgets over the CSR period, and include "on-costs". Funding for years 4 onwards will depend on the outcome of future spending reviews.

b) Non-therapist salaries

Each team of therapists should include employment, housing and benefits experts, a GP with a Special Interest (GPwSI) in mental health, and administrative support. For modelling purposes, the average skill mix is estimated as follows:

Table 5: Skill mix

Role	WTE
Director (Clinical Lead)	1
High intens	
Low intens	
Employment/Housing/Be	
GPs with a special inte	
Administra	

The costs of the salaries of the employment/housing/benefits experts, the GPs, and the Admin support are estimated based on the relevant Agenda for Change bands and unit costs data from Public and Social Services Research Unit (PSSRU). Based on these, total costs are estimated as follows. As above, the "best" case involves all therapists moving down 1 payband, and in the "worst" case, all therapists move up 1 pay band and all salaries increase by 1.5% per year from year 4.

Table 6.1: Non-therapist salaries

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£3,720,000	£530,000	£1,240,000	£5,490,000
Year 2	£11,320,000	£1,610,000	£3,780,000	£16,710,000
Year 3	£17,710,000	£2,510,000	£5,910,000	£26,130,000
Year 4	£19,400,000	£2,750,000	£6,480,000	£28,630,000
Year 5	£21,100,000	£2,990,000	£7,050,000	£31,140,000
Year 6	£23,210,000	£3,290,000	£7,750,000	£34,250,000

Year 7	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 8	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 9	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 10	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 11	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 12	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 13	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 14	£23,210,000	£3,290,000	£7,750,000	£34,250,000
Year 15	£23,210,000	£3,290,000	£7,750,000	£34,250,000

Constant prices, rounded to nearest £10,000. Includes “on-costs”. Funding for years 4 onwards will depend on the outcome of future spending reviews.

Table 6.2: Non-therapist salaries “best” option

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£3,020,000	£450,000	£1,090,000	£4,560,000
Year 2	£9,190,000	£1,370,000	£3,310,000	£13,870,000
Year 3	£14,370,000	£2,140,000	£5,180,000	£21,690,000
Year 4	£15,740,000	£2,340,000	£5,680,000	£23,760,000
Year 5	£17,120,000	£2,550,000	£6,170,000	£25,840,000
Year 6	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 7	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 8	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 9	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 10	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 11	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 12	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 13	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 14	£18,830,000	£2,800,000	£6,790,000	£28,420,000
Year 15	£18,830,000	£2,800,000	£6,790,000	£28,420,000

Constant prices, rounded to nearest £10,000. Includes “on-costs”. Funding for years 4 onwards will depend on the outcome of future spending reviews.

Table 6.3: Non-therapist salaries “worst” option

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£4,500,000	£620,000	£1,500,000	£6,620,000
Year 2	£13,670,000	£1,880,000	£4,570,000	£20,120,000
Year 3	£21,390,000	£2,940,000	£7,150,000	£31,480,000
Year 4	£23,780,000	£3,270,000	£7,960,000	£35,010,000
Year 5	£25,830,000	£3,550,000	£8,640,000	£38,020,000
Year 6	£28,770,000	£3,950,000	£9,620,000	£42,340,000
Year 7	£29,200,000	£4,010,000	£9,760,000	£42,970,000
Year 8	£29,640,000	£4,070,000	£9,910,000	£43,620,000
Year 9	£30,080,000	£4,130,000	£10,060,000	£44,270,000
Year 10	£30,530,000	£4,190,000	£10,210,000	£44,940,000

Year 11	£30,990,000	£4,260,000	£10,360,000	£45,610,000
Year 12	£31,460,000	£4,320,000	£10,520,000	£46,290,000
Year 13	£31,930,000	£4,390,000	£10,670,000	£46,990,000
Year 14	£32,410,000	£4,450,000	£10,830,000	£47,690,000
Year 15	£32,890,000	£4,520,000	£11,000,000	£48,410,000

Constant prices, rounded to nearest £10,000. Includes “on-costs”. Funding for years 4 onwards will depend on the outcome of future spending reviews.

2.2.3 Overheads

Other set up and overhead costs will cover set up costs and the costs of the central premises for each team (office space, computers, etc). Overheads have been estimated using PSSRU capital overhead costs on a per head basis. These are estimated as follows:

Table 7: Overhead costs

	Total	“Best” option (-10%)	“Worst” option (+10%)
Year 1	£ 4,570,000	£ 4,120,000	£ 5,030,000
Year 2	£ 9,670,000	£ 8,700,000	£ 10,630,000
Year 3	£ 13,930,000	£ 12,530,000	£ 15,320,000
Year 4	£ 15,360,000	£ 13,820,000	£ 16,890,000
Year 5	£ 16,700,000	£ 15,030,000	£ 18,370,000
Year 6	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 7	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 8	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 9	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 10	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 11	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 12	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 13	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 14	£ 18,370,000	£ 16,530,000	£ 20,200,000
Year 15	£ 18,370,000	£ 16,530,000	£ 20,200,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews.

2.2.4 Costs to SHAs

The implementation plan notes that SHAs will (i) need to commission their share of training places for high and low intensity trainees, and (ii) need to select at least 2 PCTs to become IAPT sites. This will take a considerable amount of staff time, and thus generate costs. The best available estimate of these costs is as follows:

Table 8: SHA/RDC Implementation Teams

Roles	£000s
o Regional Implementation Lead (Band 8d, 0.5 WTE)	39
o Project Implementation/Service Improvement Lead (8b,1 WTE)	55
o Performance Manager (6, 0.5 WTE)	17

o	Workforce Lead (8b,0.5 WTE)	28
o	Administrator (4, 0.5 WTE)	12
o	Employment Advisor (6,0.4 WTE)	14
o	Primary Care Lead (8b, 0.3 WTE)	17
o	GP Advisor (9, 0.2 WTE)	19
o	Clinical Advisor (9, 0.2 WTE)	19
o	Communications Advisor (7, 0.2 WTE)	8
o	Involving People Leads (8c, 0.2 WTE)	11
Non-Pay/Other		
o	Workforce NWW	23
o	Primary Care leadership and pathway development	25
o	Involving People tools	13

	Estimated gross costs by SHA	£300k

Total national cost (10 x SHAs) is £3m per annum, for years 1-6 only.

2.2.5 Costs to other parts of the NHS

It is conceivable that there could be an impact on other NHS services as staff take the opportunity to develop their careers as psychological therapists. Our expert advice is, however, that this impact will be manageable. A proportion of these staff will come from outside the NHS and, of those that do come from within the service, the availability of a career pathway into psychological therapy will off-set the attrition rate of staff who currently feel they need to leave the service to develop their career in psychological therapy. Consequently, for most staff, we do not expect these costs to be outside normal, existing margins of normal staff turn-over in local services. However, some areas of service may be impacted, if they have to recruit and/or retrain replacements for staff who have joined IAPT, but who would otherwise have stayed with those services. This is an important risk, and levels of demand and supply in the mental health workforce will be monitored by SHAs, and action taken as necessary. We currently lack the evidence required to quantify this potential impact. We have assumed 10% turnover, as data from the Information Centre suggests this rate among both medical and non-medical staff⁷.

2.2.6 Savings to other parts of the NHS

Medically unexplained symptoms (MUS) and co-morbidity of mental ill health with Long Term Conditions are both areas that are amenable to treatment with the Cognitive Behaviour Therapy based interventions that are part of IAPT. Work by NICE in the next year will help further quantify the realisable cost offsets associated with treatment.

Medically unexplained symptoms

⁷ www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-turnover/medical-staff-turnover-2005-2006

Between 20% and 30% of those seen in Primary Care have no clear diagnosis; in Secondary Care this rises to an average of 52% of those seen in most outpatients. (Nimnuan, 2001). In medical inpatients, around 20% of consecutive inpatients had MUS. While estimates are unavailable for the UK Barsky (2005)⁸ estimated that the cost of MUS, in the US was \$256billion. There is clearly, then, scope for IAPT to generate substantial cost savings, if treatment with IAPT interventions is able to reduce the costs associated with MUS.

Long Term Conditions

The term “Long Term Conditions”(LTC) is applied to a variety of conditions such as diabetes, cardiovascular disease (hypertension, ischaemic heart disease, peripheral vascular disease), and Chronic Obstructive Pulmonary Disease. Generally they are conditions that cannot be cured, but can be controlled, usually by medication.

Evidence of the cost savings available in MUS and LTC, in terms of UK based studies, is poor. Therefore, we do not attempt to monetise this here.

2.2.7 Savings to the Exchequer

People suffering from depression or anxiety disorders are much more likely to be in receipt of Incapacity Benefit or Income Support, compared with those who are not suffering from such disorders. Following Layard et al (2007)⁹, we assume that a person *who is treated* will, on average spend around 1.17 months fewer on such benefits, over the course of the next 2 years. This is based on assuming that, among *those who cease to have a diagnosable clinical disorder* following treatment, the propensity to be in receipt of IB will fall from on average of around 38% to an average of around 20%. This seems a reasonable assumption, as it is still more than double the average of 8% among people who do not have a mental disorder. It may also be conservative, as it looks only at the impact on the next two years, whereas we could reasonably expect that the positive results of treatment could be more enduring¹⁰. Although it is too early to reach strong conclusions about longer term impacts of the Demonstration Sites, this result also appears broadly consistent with the early indications available from these sites, at Doncaster and Newham¹¹.

Working on the basis that benefits paid would be an average of £6000 per year, and lost tax revenue at £3000 per year¹², the total savings to the Exchequer if a person left benefit and entered work would be £9000 per year. With an average of 1.17 fewer months on benefits, the gain to the Exchequer in terms of increased tax revenue and reduced benefit payments would be around £900 per person treated, over two years. Letting this stand as our best case (or “high” savings) scenario, and halving the benefits to generate a pessimistic (or “low” savings)

⁸ Barsky AJ, O. J. (2005). Somatisation increases medical utilisation and costs independent of psychiatric and medical comorbidity. *archives of general psychiatry*, 62: 903-910.

⁹ R. Layard, D. Clark, M. Knapp, and G. Mayraz, *Cost-benefit analysis of psychological therapy*, National Institute Economic Review 2007, 202: 90-98

¹⁰ We currently lack data about the longer term impact on receipt of these benefits.

¹¹ Based on draft data from a forthcoming LSE study of the Demonstration sites.

¹² Again, following Layard et al (2007), who proceed “in line with DWP figures”.

scenario, and given the numbers expected to be treated, the total savings to the Exchequer are shown in the table below. In the “worst” case, we assume that the 0.59 extra months not in receipt of benefit occurs in the year of treatment, while in the “best” case we assume that the 1.17 fewer months spent in receipt of benefit over the next two years are split evenly across the two years. (In line with conventional treatment in Impact Assessments, these are shown as negative costs.)

Table 9: Savings to the Exchequer

	"Worst" case	"Best" case
Year 1	-£39,050,000	-£39,050,000
Year 2	-£125,040,000	-£164,090,000
Year 3	-£219,380,000	-£344,420,000
Year 4	-£276,440,000	-£495,810,000
Year 5	-£315,270,000	-£591,710,000
Year 6	-£351,000,000	-£666,270,000
Year 7	-£351,000,000	-£702,000,000
Year 8	-£351,000,000	-£702,000,000
Year 9	-£351,000,000	-£702,000,000
Year 10	-£351,000,000	-£702,000,000
Year 11	-£351,000,000	-£702,000,000
Year 12	-£351,000,000	-£702,000,000
Year 13	-£351,000,000	-£702,000,000
Year 14	-£351,000,000	-£702,000,000
Year 15	-£351,000,000	-£702,000,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews. Savings shown as negative costs.

2.2.8 Total costs

Table 10.1: Summary of costs – mid-range estimate

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£44,530,000	£3,720,000	£9,210,000
Year 2	£125,350,000	£11,320,000	-£7,890,000
Year 3	£200,500,000	£17,710,000	-£63,690,000
Year 4	£228,840,000	£19,400,000	-£137,890,000
Year 5	£248,870,000	£21,100,000	-£183,520,000
Year 6	£272,920,000	£23,210,000	-£212,500,000
Year 7	£269,920,000	£23,210,000	-£233,370,000
Year 8	£269,920,000	£23,210,000	-£233,370,000
Year 9	£269,920,000	£23,210,000	-£233,370,000
Year 10	£269,920,000	£23,210,000	-£233,370,000
Year 11	£269,920,000	£23,210,000	-£233,370,000
Year 12	£269,920,000	£23,210,000	-£233,370,000
Year 13	£269,920,000	£23,210,000	-£233,370,000
Year 14	£269,920,000	£23,210,000	-£233,370,000
Year 15	£269,920,000	£23,210,000	-£233,370,000

Table 10.2: Summary of costs – “Best” case

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£39,240,000	£3,020,000	£3,210,000
Year 2	£108,710,000	£9,190,000	-£46,190,000
Year 3	£171,780,000	£14,370,000	-£158,270,000
Year 4	£194,160,000	£15,740,000	-£285,910,000
Year 5	£211,060,000	£17,120,000	-£363,530,000
Year 6	£231,510,000	£18,830,000	-£415,930,000
Year 7	£228,510,000	£18,830,000	-£454,660,000
Year 8	£228,510,000	£18,830,000	-£454,660,000
Year 9	£228,510,000	£18,830,000	-£454,660,000
Year 10	£228,510,000	£18,830,000	-£454,660,000
Year 11	£228,510,000	£18,830,000	-£454,660,000
Year 12	£228,510,000	£18,830,000	-£454,660,000
Year 13	£228,510,000	£18,830,000	-£454,660,000
Year 14	£228,510,000	£18,830,000	-£454,660,000
Year 15	£228,510,000	£18,830,000	-£454,660,000

Table 10.3: Summary of costs – “Worst” case

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£52,050,000	£4,500,000	£17,500,000
Year 2	£148,660,000	£13,670,000	£37,290,000
Year 3	£239,230,000	£21,390,000	£41,240,000
Year 4	£277,880,000	£23,780,000	£25,230,000
Year 5	£301,960,000	£25,830,000	£12,520,000
Year 6	£334,940,000	£28,770,000	£12,710,000
Year 7	£336,560,000	£29,200,000	£14,750,000
Year 8	£341,240,000	£29,640,000	£19,870,000
Year 9	£345,990,000	£30,080,000	£25,070,000
Year 10	£350,810,000	£30,530,000	£30,340,000
Year 11	£355,700,000	£30,990,000	£35,690,000
Year 12	£360,670,000	£31,450,000	£41,130,000
Year 13	£365,710,000	£31,930,000	£46,640,000
Year 14	£370,830,000	£32,400,000	£52,240,000
Year 15	£376,030,000	£32,890,000	£57,920,000

2.3 BENEFITS

Based on the number of therapists expected to be recruited, and on the numbers of patients that each therapist is expected to be able to see (see Annex 1), the following number of patients is expected to be seen in each year:

Table 11: Number of people treated each year

	Patients treated	"Low" option (-10%)	"High" option (+10%)
Year 1	90,000	80,000	100,000
Year 2	290,000	260,000	320,000

Year 3	500,000	450,000	550,000
Year 4	630,000	570,000	690,000
Year 5	720,000	650,000	790,000
Year 6	800,000	720,000	880,000
Year 7	800,000	720,000	880,000
Year 8	800,000	720,000	880,000
Year 9	800,000	720,000	880,000
Year 10	800,000	720,000	880,000
Year 11	800,000	720,000	880,000
Year 12	800,000	720,000	880,000
Year 13	800,000	720,000	880,000
Year 14	800,000	720,000	880,000
Year 15	800,000	720,000	880,000

Number of people treated, to nearest 10,000

2.3.1 Health benefits

The following section draws heavily on the work of Layard et al (2007)¹³, which used evidence based on the most recent ONS Psychiatric Morbidity Survey¹⁴ and NICE guidelines to produce a cost-benefit analysis of psychological therapies.

On the basis of the evidence available about the effectiveness of evidence-based psychological therapies we can expect around 61% of those who complete treatment (which is, in turn, around 82% of those who begin treatment) to have moved into recovery from their condition within four months¹⁵. Some of this evidence is at Annex 2, and the reader is also directed to Layard et al (2007). This means that around 50% of those who *begin* treatment will recover in four months, an assumption that also broadly consistent with the results of the Demonstration Sites in Newham and Doncaster (see Annex 3). However, clinical evidence also shows that there is some “natural” recovery – that is, some people would be expected to recover in the absence of specialist treatment. This “natural” recovery rate has been estimated at around 22%¹⁶. Therefore, of the 82% of patients expected to persevere with treatment, we can reasonably estimate that 39%¹⁷ will recover, and would not have recovered without treatment. Overall, then, we expect that around 32% (that is, 39% of the 82% who continue with treatment) of those who begin treatment will recover and would not otherwise have recovered.

This can be illustrated slightly differently using two “decision tree” diagrams, which look at the expected outcomes where 100 patients enter treatment, and where 100 patients do not enter treatment:

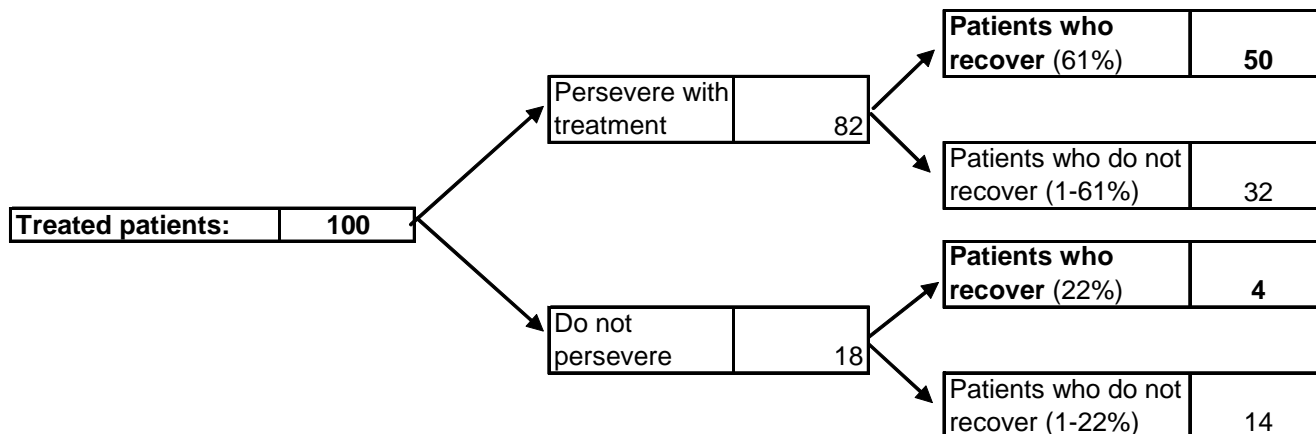
¹³ R. Layard, D. Clark, M. Knapp, and G. Mayraz, *Cost-benefit analysis of psychological therapy*, National Institute Economic Review 2007, 202: 90-98

¹⁴ Singleton et al, Psychiatric morbidity among adults living in private households, 2000.

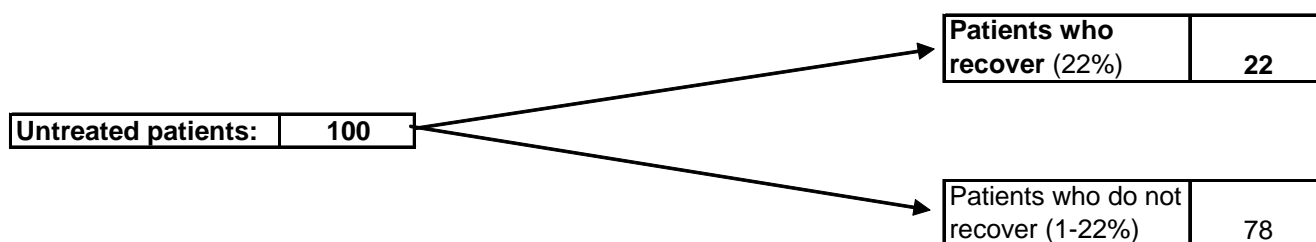
¹⁵ Recovery rates are likely to differ for patients who suffer from different conditions. The expectation that around 60% will recover represents an average of recovery rates expected for each condition, weighted by a relative frequency of disorders based on the Psychiatric Morbidity Survey.

¹⁶ Again, in Layard et al (2007), based on data in NICE guidelines

¹⁷ That is, the 61% who recover, minus the 22% who we would expect to have recovered anyway.



Of the 100 treated patients, around 54 enter recovery.



Of the 100 untreated patients, around 22 enter recovery. So it can be seen that 32 additional patients (that is, the difference between the 54 patients who recover after treatment, and the 22 patients who recover with no treatment) recover in the group of 100 patients that is treated.

Of the 874,000 people who are expected to be treated in the first three years, therefore, we can count the recovery of around 32%, or around 280,000 people, as a benefit of the IAPT programme.

Initially the services will be limited to a few areas, but SHAs will support all PCTs to improve their services through commissioning. Selection of PCTs is an SHA responsibility; while many have indicated that they intend to consider need as a criteria for selection, this must be balanced against the necessity to select PCTs that already have the spine of a service in place. Again, how to handle out of area requests for treatment will need to be decided by PCTs in collaboration with the SHA.

We can monetise the impact on wellbeing using quality-adjusted life years (QALYs) valued at around £40,000 per QALY¹⁸. Layard et al (2007) estimates that a patient will have an average of an extra 6.5 months (or 0.54 years) of good health over the next two years if treated, compared with not being treated. (This estimate represents an average per patient treated, and allows for the impact of both natural recovery and of the reduced rates of relapse associated with treatment with psychological therapy.)

Our central assumption is that each extra year of good mental health represents around 0.11 QALYs. Based on the EuroQol Descriptive system and using the average of (i) a change from

¹⁸ This is standard DH practice, based on anchoring the social value of a QALY to the Department for Transport's figure for a prevented fatality (with one QALY valued at a fortieth of this figure) and uprating in line with nominal GDP.

moderate depression or anxiety for those with good health (rated at 0.152 QALYs¹⁹) and (ii) a change from moderate depression or anxiety for those with moderate other health (rated at 0.071 QALYs).

Clearly, the benefits from treatment will depend on the severity of the condition that the treatment removes. Proceeding on the basis of the QALY deficit associated with “moderate” depression or anxiety is a conservative approach, given that in both the Demonstration Sites presenting levels of morbidity at first assessment were clearly skewed towards more severe levels of depression and/or anxiety disorders. In both sites, the largest single level of severity, both for patients with depression and for patients with anxiety disorders, was the most severe, equivalent to a PHQ9²⁰ score of more than 20 for depression, or a GAD7²¹ score of more than 15 for anxiety disorders²². The number of patients with a level of disorder assessed as “moderately severe” or “severe” was several times the number of patients with a level of disorder assessed as mild. Given this, using the QALY deficit associated with a “moderate” level of disorder is a conservative central assumption.

Valuing each extra year of good mental health at 0.11 QALYs, we can, therefore, quantify the average benefits per patient treated at 0.06 QALYs over 2 years (that is, 0.11 QALYs multiplied by 0.54 years), or around 0.03 QALYs per year. Valuing these at £40,000, as discussed above, we can quantify the benefits in monetary terms at £1206 per patient, in each of the two years after treatment.

This can be seen in Table 12 (Monetised health benefits – high and low estimates), in the column labelled “Benefits in £ terms (high)”. As noted, this column represents the benefits of being treated, as compared with not being treated. While the QALYs available from treatment have been treated conservatively, the assumption in this column that patients would otherwise not be in any treatment is clearly an important assumption – this can be considered, therefore, to represent a high-end estimate of the benefits we can attribute to the IAPT programme.

While this may represent a “best case” scenario of the benefits available from IAPT, it is important to emphasise that a key aim of the programme is to offer treatment to the 75%²³ of adults with diagnosable clinical depression or anxiety disorders who are not in treatment of any kind. Indeed, one of the reasons that individuals may not have accessed treatment is the very limited availability of psychological therapies. The IAPT pilots have, for example, shown that self-referral is an important access route for people suffering from depression and anxiety disorders who, in the main, are not currently in treatment. The main reason stated for not seeking treatment through normal GP services is that they do not want to be prescribed anti-depressants, which remains the first-line treatment response for GPs who are not able to

¹⁹ Based on work by Dolan, Paul, Claire Gudex, Paul Kind and Alan Williams “A Social Tariff for EuroQoL: Results from a UK General Population Survey” CHE Discussion Paper 138 September 1995. The paper uses a a time trade-off (TTO) approach to obtain valuations. (A TTO study asks respondents to sacrifice quantity of life (i.e. life expectancy) to gain improvements in quality of life. This study involved 3395 respondents, designed to be a representative sample of the non-institutionalised population of England, Scotland and Wales, interviewed in 1993.)

²⁰ The nine item depression module of the Patient Health Questionnaire. 20-27 = severe depression

²¹ The seven item anxiety module of the Patient Health Questionnaire. 15+ = severe anxiety

²² Based on data from an unpublished draft LSE report on the Doncaster and Newham IAPT pilots. The final report is forthcoming.

²³ R. Layard, D. Clark, M. Knapp, and G. Mayraz, *Cost-benefit analysis of psychological therapy*, National Institute Economic Review 2007, 202: 90-98

access psychological therapies²⁴. This is consistent with survey evidence finding that around 2 out of 3 people diagnosed with depression or anxiety disorders would prefer psychological therapies, rather than medication – and that the majority of those who prefer psychological therapy choose no treatment rather than going on medication²⁵. Therefore, it is reasonable to expect that most or all of those treated within the IAPT programme would not otherwise have been in treatment.

However, it is likely to be the case that at least some patients would, in the absence of the IAPT programme, receive some treatment of some kind. We can take account of this, and other factors, to generate a low-end estimate for the expected benefits that we can reasonably attribute to the IAPT programme. Patients may, for example, be treated with anti-depressant medication, such as SSRIs, and may therefore experience some additional recovery than that associated with no special treatment. While this will be different for patients suffering from different disorders, and for different levels of severity within each disorder, a rough estimate broadly consistent with the evidence is that around half of patients treated with anti-depressant medications will enter recovery. Some patients will use psychological therapies as a substitute for medication. This would represent further savings in reduced prescriptions, but these are not quantifiable due to lack of research on how many people would be likely to change treatments.

Evidence from the Psychiatric Morbidity Survey²⁶ suggests that overall, around one in four people with a neurotic disorder is currently receiving any treatment. To produce a conservative estimate, we could make the assumption that those who present at IAPT sites are 50% more likely than average to have been in treatment anyway, so that, 37.5% of patients would have been in treatment in the absence of an IAPT programme²⁷.

Therefore, for our low-end estimate, we assume that around 19% of patients (that is, around half of 37.5% of patients) would enter recovery in the absence of the IAPT programme. Therefore, as benefits are calculated on a per patient treated basis, the benefits in the second column (worst estimate) in the table below are around 80% of the benefits in the third column (best estimate)²⁸.

Table 12: Monetised health benefits – high and low estimates

	Benefits in money terms: worst-case (1)	Benefits in money terms: best-case (2)
Year 1	£85,867,200	£107,330,000
Year 2	£360,835,200	£451,040,000
Year 3	£757,368,000	£946,710,000
Year 4	£1,090,280,365	£1,362,850,000
Year 5	£1,301,149,092	£1,626,440,000

²⁴ The people in this category seeking treatment in the pilot sites have been diagnosed as at least as unwell as those who have been referred by GPs, dispelling the view sometimes expressed that these people can be dismissed as the ‘worried well’.

²⁵ R. Layard, D. Clark, M. Knapp, and G. Mayraz, *Cost-benefit analysis of psychological therapy*, National Institute Economic Review 2007, 202: 90-98

²⁶ Singleton et al, *Psychiatric morbidity among adults living in private households*, 2000: Table 5.2

²⁷ Note that this is highly conservative, given that we know that a primary reason not to seek help is the absence of psychological therapies. Given this, we would expect the IAPT sites to see a disproportionate number of those who would otherwise have gone untreated.

²⁸ It is worth noting that both high and low estimates use the same monetary value of benefits per patient treated. Ranges could also be calculated by looking at scenarios in which more or fewer QALYs were expected to result from treatment.

Year 6	£1,465,108,727	£1,831,390,000
Year 7	£1,543,680,000	£1,929,600,000
Year 8	£1,543,680,000	£1,929,600,000
Year 9	£1,543,680,000	£1,929,600,000
Year 10	£1,543,680,000	£1,929,600,000
Year 11	£1,543,680,000	£1,929,600,000
Year 12	£1,543,680,000	£1,929,600,000
Year 13	£1,543,680,000	£1,929,600,000
Year 14	£1,543,680,000	£1,929,600,000
Year 15	£1,543,680,000	£1,929,600,000

(1) Benefits of treatment compared with no treatment, based on quantifying benefits from treatment at £1208 per patient, in each of the two years after treatment; constant prices, rounded to the nearest million pounds.

(2) Benefits of treatment compared with some patients otherwise in treatment, based on quantifying benefits from treatment at £1208 per patient, in each of the two years after treatment; constant prices, rounded to the nearest million pounds.

2.3.2 Benefits to employment and the wider economy

Layard et al (2007) brought together cross-sectional and longitudinal evidence to analyse the effect of health on employment, and thus to estimate the employment benefits of psychological therapies. They conclude that a reasonable estimate is that people who are treated are, on average, 4 percentage points more likely to be in work over the next two years than if they were not treated – equivalent to around 1.1 extra months of work over the first 2 years. Assuming (in line with DWP practice) that a previously disabled person who works earns, on average, £1000 per month, Layard et al estimate that the average benefit per person treated in terms of additional output is £1,100.

It would not be appropriate, however, simply to apply this average benefit to those treated within the IAPT programme, because Layard et al (2007) focused on the benefits of treating adults of working age (i.e. adults aged under 65) whereas the IAPT programme will be targeting all adults. Assuming that the average benefit in terms of additional output per patient would be £1,100 would neglect the fact that many people aged 65 or over are no longer economically active, and so would not have these output benefits associated with their treatment. Unfortunately, there are no robust estimates of the expected age distribution that IAPT will treat. One factor contributing to this is that the Psychiatric Morbidity Survey does not cover adults older than 75, so less is known about the level of need in this older group.

The IAPT services will of course treat all adults who are able to benefit from the treatment offered. However, we know that there is a greater prevalence of disorders, such as dementia, in the older age group that would mean that these services would be less likely to be appropriate, as people with disorders such as dementia may not, in all cases, have an ability to benefit from these therapies. Therefore, we can reasonably hypothesise that services are likely to treat a

smaller proportion of older adults than that found in the population overall. Early data²⁹ on the demonstration sites at Doncaster and Newham suggests that each had around 3% of patients aged over 65. One scenario is that this proportion will expand as IAPT begins to roll out. Taking an assumption that 10%³⁰ of patients will, in future, be over the age of 65, and assuming for the purpose of conservatism, that none of these patients will work or have output increases associated with their treatment, we could assume output benefits at around £1000 per patient treated. Consistent with our approach to estimating savings to the Exchequer, we take this scenario as our best-case benefit scenario, and halve this to generate a worst-case benefit scenario.

Table 13: Output benefits

	Output benefits: worst	Output benefits: best
Year 1	£44,055,000	£88,110,000
Year 2	£141,075,000	£282,150,000
Year 3	£247,500,000	£495,000,000
Year 4	£311,880,000	£623,760,000
Year 5	£355,690,000	£711,380,000
Year 6	£396,000,000	£792,000,000
Year 7	£396,000,000	£792,000,000
Year 8	£396,000,000	£792,000,000
Year 9	£396,000,000	£792,000,000
Year 10	£396,000,000	£792,000,000
Year 11	£396,000,000	£792,000,000
Year 12	£396,000,000	£792,000,000
Year 13	£396,000,000	£792,000,000
Year 14	£396,000,000	£792,000,000
Year 15	£396,000,000	£792,000,000

2.3.3 Total benefits

Table 14: Summary of benefits

	Total benefits	Total Benefits "worst" option	Total benefits "best" option
Year 1	£ 162,683,100	£129,920,000	£195,440,000
Year 2	£ 617,552,100	£501,910,000	£733,190,000
Year 3	£ 1,223,289,000	£1,004,870,000	£1,441,710,000
Year 4	£ 1,694,385,410	£1,402,160,000	£1,986,610,000
Year 5	£ 1,997,327,728	£1,656,840,000	£2,337,820,000
Year 6	£ 2,242,247,318	£1,861,110,000	£2,623,390,000
Year 7	£ 2,330,640,000	£1,939,680,000	£2,721,600,000
Year 8	£ 2,330,640,000	£1,939,680,000	£2,721,600,000
Year 9	£ 2,330,640,000	£1,939,680,000	£2,721,600,000

²⁹ Source: LSE report on demonstration sites, forthcoming

³⁰ In mid-2006, around 17% of the population was aged over 65 (ONS website: <http://www.statistics.gov.uk/cci/nugget.asp?id=6>, accessed at 14.53, on 12th February 2008, using data from Mid-year population estimates: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency) so 10%, although arbitrary, is halfway between the proportion of people treated in the Demonstration Sites who were over 65, and the proportion of the population as a whole that is aged over 65.

Year 10	£	2,330,640,000	£1,939,680,000	£2,721,600,000
Year 11	£	2,330,640,000	£1,939,680,000	£2,721,600,000
Year 12	£	2,330,640,000	£1,939,680,000	£2,721,600,000
Year 13	£	2,330,640,000	£1,939,680,000	£2,721,600,000
Year 14	£	2,330,640,000	£1,939,680,000	£2,721,600,000
Year 15	£	2,330,640,000	£1,939,680,000	£2,721,600,000

Note: All benefits estimates based on 'mid-range' value for number of patients treated.

2.4 Outcome monitoring

Key performance indicators will be agreed regionally and nationally. These will be collated by SHAs and submitted to the national Programme Board, on a monthly or bi-monthly basis. The costs of collating these indicators will be covered by the regional management costs of approximately £300k (see 2.2.4).

There will also be service-level performance indicators, based on a range of standards and an outcomes framework, which is under development and linked to the mental health minimum data set. PCTs/providers will need to collect and analyse service throughput and outcomes data for everyone who uses the services. This will require a computer software system to manage the data. Initially, sites are expected to commission a software provider from a national list of preferred providers, and exact costs cannot be given at the moment. This cost will be met by PCTs. The pilot sites have shown that the costs of providing the necessary data collection platform do range between £3-5K per annum. These costs will either be met by each PCT locally or from the additional management cost overhead to be allocated to each region. These costs will reach a total of around £80,000 in year 1.

More details and further guidance will be provided in the IAPT Outcomes Framework 2008/09, expected to be published in March 2008. A national data set is under development, as part of the Mental Health Minimum data Set. The outcomes collected will predominantly be used for local intelligence to inform continuous service improvement. A formal evaluation of the programme 2006/07 has been commissioned from Sheffield University; further evaluation is likely to be carried out on an ad hoc basis.

Option 3 – Embark on a national programme that aims to implement local Psychological Therapy services gradually across all PCTs in England with annual increases in investment for the first three years only

3.1 DESCRIPTION

This option would allow a minimum of 50% of the country to be covered by psychological therapies services by 2010/11. National investment (CSR funding) would from then on remain at year 3 levels. By this stage, there would be no need for further expansion of the training programme. Spending, however, would need to increase in order to pay the salaries of many of those who had trained in year 3. Keeping year 4 funding at year 3 levels would mean that we would need to cut over 400 HI therapist posts, or over 600 LI therapist posts (or, more likely, some combination of the two). This option therefore assumes that spending on psychological therapies increases, but not via additional national investment. Calculations for this option show that whilst costs level off after year 3, benefits continue to grow for another year. Consequently, the one-off benefits are calculated over a 4-year period.

If PCT coverage was 50% at 2010/11, ongoing service expansion would slow dramatically, as the CSR07 funding (£173 million) would be committed to the services that had been set up so far. Further service expansion could rely on commissioning decisions, although these are unlikely to make any significant improvements (see 2.1). Nevertheless, local decision-making about the future configuration of services is consistent with the Government's intention to devolve this authority to local level and to make the NHS more responsive to the needs and wishes of local populations. However, the relevant NICE Guidelines were published some four years ago and local PCT commissioning has made little progress in delivering these requirements and meeting the challenge of providing services to the one in six of adults that suffer from these problems at any given time. The reason for this is multi-factoral and includes the following inhibiting factors:

- **Capacity** - the lack of sufficient capacity in the form of a suitably trained, competent workforce able to deliver the new services as envisaged in the NICE Guidelines.
- **Priority** - the lack of national and local priority given to the delivery of the required services, compared to other commissioning and performance imperatives such as 18 weeks or the delivery of the Mental Health NSF standards.
- **Service models** – the NICE Guidelines provide clarity about the types of interventions that are deemed effective for different conditions and that the delivery of the services should be delivered in a system of stepped care. They do not, however, provide a clear service framework describing how these services should be appropriately configured, leaving it to commissioners to try to interpret the guidelines locally.

- **Commissioning capability** – this follows from the absence of clear service models and the absence of relative priority placed on the delivery of these new services. The lack of effective mental health commissioning capability, knowledge and experience is a national problem that has been recognised by PCTs, SHA and the DH and has led to the establishment of the NIMHE Commissioning Work Programme.

Consequently, it is unlikely that local level commissioning alone could achieve the national coverage proposed by the IAPT programme.

Therefore, PCT coverage would be unlikely to increase dramatically if it was at 50% in 2010/11. To mitigate this inequitable provision across the country, out of area referrals of people with more severe needs could be accepted.

Alternatively, the CSR07 funding could be re-distributed across all PCTs. This would raise difficult issues in the PCTs who had already set up services, in terms of their sustainability. It would also lead to sub-optimal services and longer waiting times. This could be mitigated by the substantial improvements in access that can be made through service redesign and releasing existing resources. A review of 91 studies showed average savings of 20% resulting from implementing psychological interventions³¹.

Indeed, some SHAs will choose to aim for 100% coverage by 2010/11, stimulating this by releasing CSR07 funds only to PCTs who can match-fund this from their own budgets. Obviously, if 100% coverage was reached by 2010/11, then the £173 million from this point on would flow into PCT baselines to maintain these services.

The main costs expected from the programme are the same as those in Option 2, namely those costs associated with the training and salaries of this new workforce, and associated organisational and overhead costs. The benefits expected from the programme are also the same as in Option 2 (with expected reductions due to the anticipated lower levels of service provision), namely (i) reduced suffering, (ii) benefits to the wider economy, in terms of additional employment and output, and (ii) benefits to the NHS, in terms of reduced visits to family doctors and avoided referrals to acute and specialist mental health services. The implementation plan describes a system of “stepped care”, in which the intensity and duration of treatment is tailored to the severity level of the disorder diagnosed.

3.2 COSTS

The main costs are those directly associated with training and paying the psychological therapists and other staff involved in service delivery. The key assumptions are outlined in 2.2.

3.2.1 Training costs

³¹ Jeremy A Chiles et al. The Impact of Psychological Interventions on Medical Cost Offset: A meta analytic Review.. *Clinical Psychology: Science and Practice*; Summer 1999:6, 2

Set up costs will be £40,000 for each of 20 courses required (1 high-intensity and 1 low-intensity training course is expected in each SHA, see 2.2.1). These will reach a total of £800,000 (in year 1 only).

Course fees are expected to be in the region of £4300 per trainee for low-intensity training, and £8600 for high-intensity training (see 2.2.1).

The number of therapists is set to expand until year 3, after which time training is assumed to be in place to allow for turnover of staff at 10% per year.

Table 1: Course Fees

	Therapist training course fees	Supervisor course fees	Total	"Best" option (-5%)	"Worst" option (+5%)
Year 1	£3,940,000	£180,000	£4,120,000	£3,920,000	£4,480,000
Year 2	£9,650,000	£250,000	£9,900,000	£9,410,000	£10,390,000
Year 3	£9,240,000	£130,000	£9,370,000	£8,900,000	£9,830,000
Year 4	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 5	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 6	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 7	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 8	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 9	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 10	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 11	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 12	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 13	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 14	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000
Year 15	£2,700,000	£40,000	£2,740,000	£2,600,000	£2,870,000

Constant prices, rounded to nearest £10,000

The total costs associated with training are, therefore:

Table 2: Training Costs

	Total costs associated with training	"Best" option (-5%)	"Worst" option (+5%)
Year 1	£4,920,000	£4,720,000	£5,280,000
Year 2	£9,900,000	£9,410,000	£10,390,000
Year 3	£9,370,000	£8,900,000	£9,830,000
Year 4	£2,740,000	£2,600,000	£2,870,000
Year 5	£2,740,000	£2,600,000	£2,870,000
Year 6	£2,740,000	£2,600,000	£2,870,000
Year 7	£2,740,000	£2,600,000	£2,870,000
Year 8	£2,740,000	£2,600,000	£2,870,000
Year 9	£2,740,000	£2,600,000	£2,870,000

Year 10	£2,740,000	£2,600,000	£2,870,000
Year 11	£2,740,000	£2,600,000	£2,870,000
Year 12	£2,740,000	£2,600,000	£2,870,000
Year 13	£2,740,000	£2,600,000	£2,870,000
Year 14	£2,740,000	£2,600,000	£2,870,000
Year 15	£2,740,000	£2,600,000	£2,870,000

Constant prices, rounded to nearest £10,000

3.2.2 Salary costs

a) Therapist salaries

Therapists' salary costs have been modelled by assuming different distributions of salaries for the four categories of therapists, based on Agenda for Change (AfC) Paybands (see 2.2.2). Given the planned recruitment and training profile, the costs of therapists' salaries are expected to reach the totals shown below. A "best" case scenario is considered where all therapists move down 1 Agenda for Change payband. The "worst" case considers all therapists moving up 1 payband and all salaries increasing by 1.5% per year from year 4.

Table 3: Therapist Salary Costs

	Total therapist salaries	"Best" option	"Worst" option
Year 1	£30,180,000	£25,780,000	£36,680,000
Year 2	£97,130,000	£82,660,000	£117,910,000
Year 3	£165,350,000	£139,600,000	£200,560,000
Year 4	£182,470,000	£153,140,000	£224,300,000
Year 5	£182,470,000	£153,140,000	£224,300,000
Year 6	£182,470,000	£153,140,000	£227,660,000
Year 7	£182,470,000	£153,140,000	£231,080,000
Year 8	£182,470,000	£153,140,000	£234,550,000
Year 9	£182,470,000	£153,140,000	£238,060,000
Year 10	£182,470,000	£153,140,000	£241,630,000
Year 11	£182,470,000	£153,140,000	£245,260,000
Year 12	£182,470,000	£153,140,000	£248,940,000
Year 13	£182,470,000	£153,140,000	£252,670,000
Year 14	£182,470,000	£153,140,000	£256,460,000
Year 15	£182,470,000	£153,140,000	£260,310,000

Constant prices, rounded to nearest £10,000. Table includes both the 3600 therapists' salaries expected to be funded from the recent CSR allocation to IAPT, and the additional therapists' salaries expected to be funded from PCTs' existing budgets, and include "on-costs". Funding for years 4 onwards will depend on the outcome of future spending reviews.

b) Non-therapist salaries

Each team of therapists should include employment, housing and benefits experts, a GP with a Special Interest (GPwSI) in mental health, and administrative support (see 2.2.2).

The costs of the salaries of the employment/housing/benefits experts, the GPs, and the Admin support are estimated based on the relevant Agenda for Change bands and unit costs data from PSSRU. Based on these, total costs are estimated as follows. As above, the “best” case involves all therapists moving down 1 payband, and in the “worst” case, all therapists move up 1 pay band and all salaries increase by 1.5% per year from year 4.

Table 4.1: Non-therapist salaries

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£3,720,000	£530,000	£1,240,000	£5,490,000
Year 2	£11,320,000	£1,610,000	£3,780,000	£16,710,000
Year 3	£17,710,000	£2,510,000	£5,910,000	£26,130,000
Year 4	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 5	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 6	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 7	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 8	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 9	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 10	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 11	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 12	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 13	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 14	£18,070,000	£2,560,000	£6,030,000	£26,660,000
Year 15	£18,070,000	£2,560,000	£6,030,000	£26,660,000

Constant prices, rounded to nearest £10,000. Includes “on-costs”. Funding for years 4 onwards will depend on the outcome of future spending reviews.

Table 4.2: Non-therapist salaries “best” option

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£3,020,000	£450,000	£1,090,000	£4,560,000
Year 2	£9,190,000	£1,370,000	£3,310,000	£13,870,000
Year 3	£14,370,000	£2,140,000	£5,180,000	£21,690,000
Year 4	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 5	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 6	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 7	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 8	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 9	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 10	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 11	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 12	£14,660,000	£2,180,000	£5,280,000	£22,120,000

Year 13	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 14	£14,660,000	£2,180,000	£5,280,000	£22,120,000
Year 15	£14,660,000	£2,180,000	£5,280,000	£22,120,000

Constant prices, rounded to nearest £10,000. Includes "on-costs". Funding for years 4 onwards will depend on the outcome of future spending reviews.

Table 4.3: Non-therapist salaries "worst" option

	Employment coach salaries	GPwSI salaries	Admin salaries	Total non-therapist staff salary costs
Year 1	£4,500,000	£620,000	£1,500,000	£6,620,000
Year 2	£13,670,000	£1,880,000	£4,570,000	£20,120,000
Year 3	£21,390,000	£2,940,000	£7,150,000	£31,480,000
Year 4	£22,150,000	£3,050,000	£7,410,000	£32,610,000
Year 5	£22,150,000	£3,050,000	£7,410,000	£32,610,000
Year 6	£22,480,000	£3,090,000	£7,520,000	£33,090,000
Year 7	£22,820,000	£3,140,000	£7,630,000	£33,590,000
Year 8	£23,160,000	£3,180,000	£7,740,000	£34,080,000
Year 9	£23,510,000	£3,230,000	£7,860,000	£34,600,000
Year 10	£23,860,000	£3,280,000	£7,980,000	£35,120,000
Year 11	£24,220,000	£3,330,000	£8,100,000	£35,650,000
Year 12	£24,580,000	£3,380,000	£8,220,000	£36,180,000
Year 13	£24,950,000	£3,430,000	£8,340,000	£36,720,000
Year 14	£25,320,000	£3,480,000	£8,470,000	£37,270,000
Year 15	£25,700,000	£3,530,000	£8,590,000	£37,820,000

Constant prices, rounded to nearest £10,000. Includes "on-costs". Funding for years 4 onwards will depend on the outcome of future spending reviews.

3.2.2 Overheads

Other set up and overhead costs will cover set up costs and the costs of the central premises for each team (office space, computers, etc). Overheads have been estimated using PSSRU capital overhead costs on a per head basis. These are estimated as follows:

Table 5: Overhead costs

	Total	"best" option (-10%)	"worst" option (+10%)
Year 1	£ 4,570,000	£ 4,120,000	£ 5,030,000
Year 2	£ 9,670,000	£ 8,700,000	£ 10,630,000
Year 3	£ 13,930,000	£ 12,530,000	£ 15,320,000
Year 4	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 5	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 6	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 7	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 8	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 9	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 10	£ 14,300,000	£ 12,870,000	£ 15,730,000
Year 11	£ 14,300,000	£ 12,870,000	£ 15,730,000

Year 12	£	14,300,000	£	12,870,000	£	15,730,000
Year 13	£	14,300,000	£	12,870,000	£	15,730,000
Year 14	£	14,300,000	£	12,870,000	£	15,730,000
Year 15	£	14,300,000	£	12,870,000	£	15,730,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews.

3.2.4 Costs to SHAs

The implementation plan notes that SHAs will (i) need to commission their share of training places for high and low intensity trainees, and (ii) need to select at least 2 PCTs to become IAPT sites. This will take a considerable amount of staff time, and thus generate costs (see 2.2.4).

Total national cost (10 x SHAs) is £3m per annum, for years 1-3 only

3.2.5 Costs to other parts of the NHS

It is conceivable that there could be an impact on other NHS services as staff take the opportunity to develop their careers as psychological therapists. Our expert advice is, however, that this impact will be manageable. We currently lack the evidence required to quantify this potential impact (see 2.2.5).

3.2.6 Savings to other parts of the NHS

Medically unexplained symptoms (MUS) and co-morbidity of mental ill health with Long Term Conditions are both areas that are amenable to treatment with the Cognitive Behaviour Therapy based interventions that are part of IAPT. Work by NICE in the next year will help further quantify the realisable cost offsets associated with treatment (see 2.2.6). This will be important in further service expansion beyond 2010/11, in terms of releasing existing resources within the NHS.

3.2.7 Savings to the Exchequer

People suffering from depression or anxiety disorders are much more likely to be in receipt of Incapacity Benefit or Income Support, compared with those who are not suffering from such disorders (see 2.2.7). The total savings to the Exchequer are shown in the table below³². (In line with conventional treatment in Impact Assessments, these are shown as negative costs.)

Table 6: Savings to the Exchequer

³² In the "low" case, we assume that the 0.59 extra month not in receipt of benefit occurs in the year of treatment, while the modeling assumption for the "high" case is that the 1.17 fewer months spent in receipt of benefit over the next two years are split evenly across the two years.

	"worst" case	"best" case
Year 1	-£39,050,000	-£39,050,000
Year 2	-£125,040,000	-£164,090,000
Year 3	-£219,380,000	-£344,420,000
Year 4	-£279,590,000	-£498,960,000
Year 5	-£279,590,000	-£559,180,000
Year 6	-£279,590,000	-£559,180,000
Year 7	-£279,590,000	-£559,180,000
Year 8	-£279,590,000	-£559,180,000
Year 9	-£279,590,000	-£559,180,000
Year 10	-£279,590,000	-£559,180,000
Year 11	-£279,590,000	-£559,180,000
Year 12	-£279,590,000	-£559,180,000
Year 13	-£279,590,000	-£559,180,000
Year 14	-£279,590,000	-£559,180,000
Year 15	-£279,590,000	-£559,180,000

Constant prices, rounded to nearest £10,000. Funding for years 4 onwards will depend on the outcome of future spending reviews.

3.2.8 Total costs

Table 7.1: Summary of costs – mid-range estimate

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£44,530,000	£3,720,000	£9,210,000
Year 2	£125,350,000	£11,320,000	-£7,890,000
Year 3	£200,500,000	£17,710,000	-£63,690,000
Year 4	£208,540,000	£18,070,000	-£162,670,000
Year 5	£208,540,000	£18,070,000	-£192,780,000
Year 6	£208,540,000	£18,070,000	-£192,780,000
Year 7	£208,540,000	£18,070,000	-£192,780,000
Year 8	£208,540,000	£18,070,000	-£192,780,000
Year 9	£208,540,000	£18,070,000	-£192,780,000
Year 10	£208,540,000	£18,070,000	-£192,780,000
Year 11	£208,540,000	£18,070,000	-£192,780,000
Year 12	£208,540,000	£18,070,000	-£192,780,000
Year 13	£208,540,000	£18,070,000	-£192,780,000
Year 14	£208,540,000	£18,070,000	-£192,780,000
Year 15	£208,540,000	£18,070,000	-£192,780,000

Table 7.2: Summary of costs – best-case estimate

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£39,240,000	£3,020,000	£3,210,000
Year 2	£108,710,000	£9,190,000	-£46,190,000
Year 3	£171,780,000	£14,370,000	-£158,270,000
Year 4	£176,510,000	£14,660,000	-£307,790,000

Year 5	£176,510,000	£14,660,000	-£368,000,000
Year 6	£176,510,000	£14,660,000	-£368,000,000
Year 7	£176,510,000	£14,660,000	-£368,000,000
Year 8	£176,510,000	£14,660,000	-£368,000,000
Year 9	£176,510,000	£14,660,000	-£368,000,000
Year 10	£176,510,000	£14,660,000	-£368,000,000
Year 11	£176,510,000	£14,660,000	-£368,000,000
Year 12	£176,510,000	£14,660,000	-£368,000,000
Year 13	£176,510,000	£14,660,000	-£368,000,000
Year 14	£176,510,000	£14,660,000	-£368,000,000
Year 15	£176,510,000	£14,660,000	-£368,000,000

Table 7.3: Summary of costs – worst-case estimate

	Gross costs to DH	Gross costs elsewhere	Net costs
Year 1	£52,210,000	£4,500,000	£17,650,000
Year 2	£148,660,000	£13,670,000	£37,290,000
Year 3	£239,230,000	£21,390,000	£41,240,000
Year 4	£253,790,000	£22,150,000	-£3,650,000
Year 5	£253,790,000	£22,150,000	-£3,650,000
Year 6	£257,310,000	£22,480,000	£200,000
Year 7	£260,890,000	£22,820,000	£4,110,000
Year 8	£264,510,000	£23,160,000	£8,080,000
Year 9	£268,200,000	£23,510,000	£12,110,000
Year 10	£271,930,000	£23,860,000	£16,200,000
Year 11	£275,730,000	£24,220,000	£20,350,000
Year 12	£279,580,000	£24,580,000	£24,570,000
Year 13	£283,490,000	£24,950,000	£28,840,000
Year 14	£287,450,000	£25,320,000	£33,180,000
Year 15	£291,480,000	£25,700,000	£37,590,000

3.3 BENEFITS

Based on the number of therapists expected to be recruited, and on the numbers of patients that each therapist is expected to be able to see (see Annex 1), the following number of patients is expected to be seen in each year:

Table 8: Number of people treated each year

	Patients treated	"Low" option (-10%)	"High" option (+10%)
Year 1	90,000	81,000	99,000
Year 2	290,000	261,000	319,000
Year 3	500,000	450,000	550,000
Year 4	640,000	576,000	704,000
Year 5	640,000	576,000	704,000
Year 6	640,000	576,000	704,000
Year 7	640,000	576,000	704,000
Year 8	640,000	576,000	704,000
Year 9	640,000	576,000	704,000

Year 10	640,000	576,000	704,000
Year 11	640,000	576,000	704,000
Year 12	640,000	576,000	704,000
Year 13	640,000	576,000	704,000
Year 14	640,000	576,000	704,000
Year 15	640,000	576,000	704,000

Number of people treated, to nearest 10,000

The following section draws heavily on the work of Layard et al (2007)³³, which used evidence based on the most recent ONS Psychiatric Morbidity Survey³⁴ and NICE guidelines to produce a cost-benefit analysis of psychological therapies.

3.3.1 Health benefits

On the basis of the evidence available about the effectiveness of evidence-based psychological therapies we can expect around 61% of those who complete treatment (which is, in turn, around 82% of those who begin treatment) to have moved into recovery from their condition within four months³⁵ (see 2.3.1).

Of the 874,000 people who are expected to be treated in the first three years, we can count the recovery of around 32%, or around 280,000 people, as a benefit of the IAPT programme.

Clearly, the benefits from treatment will depend on the severity of the condition that the treatment removes. If the expansion of services beyond 2010/11 used out of area treatments for more severe cases this would increase benefits. We cannot, however, monetise these benefits at this stage due to a lack of clarity on how SHAs and PCTs would choose to manage such a system.

For our low-end estimate, we assume that around 19% of patients (that is, around half of 37.5% of patients) would enter recovery in the absence of the IAPT programme. Therefore, as benefits are calculated on a per patient treated basis, the benefits in the second column (worst estimate) in the table below are around 80% of the benefits in the third column (best estimate)³⁶ (see 2.3.1).

Table 9: Monetised health benefits – high and low estimates

	Benefits in money terms: worst-case (1)	Benefits in money terms: best-case (2)
Year 1	£85,867,200	£107,330,000
Year 2	£360,835,200	£451,040,000
Year 3	£757,368,000	£946,710,000

³³ R. Layard, D. Clark, M. Knapp, and G. Mayraz, *Cost-benefit analysis of psychological therapy*, National Institute Economic Review 2007, 202: 90-98

³⁴ Singleton et al, *Psychiatric morbidity among adults living in private households*, 2000.

³⁵ Recovery rates are likely to differ for patients who suffer from different conditions. The expectation that around 60% will recover represents an average of recovery rates expected for each condition, weighted by a relative frequency of disorders based on the Psychiatric Morbidity Survey.

³⁶ It is worth noting that both high and low estimates use the same monetary value of benefits per patient treated. Ranges could also be calculated by looking at scenarios in which more or fewer QALYs were expected to result from treatment.

Year 4	£1,097,209,977	£1,394,860,000
Year 5	£1,229,619,953	£1,522,520,000
Year 6	£1,229,619,953	£1,429,360,000
Year 7	£1,229,619,953	£1,397,410,000
Year 8	£1,229,619,953	£1,397,410,000
Year 9	£1,229,619,953	£1,397,410,000
Year 10	£1,229,619,953	£1,397,410,000
Year 11	£1,229,619,953	£1,397,410,000
Year 12	£1,229,619,953	£1,397,410,000
Year 13	£1,229,619,953	£1,397,410,000
Year 14	£1,229,619,953	£1,397,410,000
Year 15	£1,229,619,953	£1,397,410,000

(1) Benefits of treatment compared with no treatment, based on quantifying benefits from treatment at £1208 per patient, in each of the two years after treatment; constant prices, rounded to the nearest million pounds.

(2) Benefits of treatment compared with some patients otherwise in treatment, based on quantifying benefits from treatment at £1208 per patient, in each of the two years after treatment; constant prices, rounded to the nearest million pounds.

3.3.2 Benefits to employment and the wider economy

Layard et al (2007) brought together cross-sectional and longitudinal evidence to analyse the effect of health on employment, and thus to estimate the employment benefits of psychological therapies (see 2.3.2).

The table below shows worst and best case estimates for the output benefits:

Table 10: Output benefits

	Output benefits: worst-case	Output benefits: best-case
Year 1	£44,055,000	£88,110,000
Year 2	£141,075,000	£282,150,000
Year 3	£247,500,000	£495,000,000
Year 4	£315,435,000	£630,870,000
Year 5	£315,435,000	£630,870,000
Year 6	£315,435,000	£630,870,000
Year 7	£315,435,000	£630,870,000
Year 8	£315,435,000	£630,870,000
Year 9	£315,435,000	£630,870,000
Year 10	£315,435,000	£630,870,000
Year 11	£315,435,000	£630,870,000
Year 12	£315,435,000	£630,870,000
Year 13	£315,435,000	£630,870,000
Year 14	£315,435,000	£630,870,000
Year 15	£315,435,000	£630,870,000

3.2.3 Total benefits

Table 11: Summary of benefits

	Total benefits	Total Benefits "worst case" option	Total benefits "best case" option
Year 1	£ 162,683,100	£129,920,000	£195,440,000
Year 2	£ 617,552,100	£501,910,000	£733,190,000
Year 3	£ 1,223,289,000	£1,004,870,000	£1,441,710,000
Year 4	£ 1,707,513,724	£1,412,640,000	£2,002,380,000
Year 5	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 6	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 7	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 8	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 9	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 10	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 11	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 12	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 13	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 14	£ 1,856,474,947	£1,545,050,000	£2,167,890,000
Year 15	£ 1,856,474,947	£1,545,050,000	£2,167,890,000

Note: All benefits estimates based on 'mid-range' value for number of patients treated.

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes/No	Yes/No
Small Firms Impact Test	Yes/No	Yes/No
Legal Aid	Yes/No	Yes/No
Sustainable Development	Yes/No	Yes/No
Carbon Assessment	Yes/No	Yes/No
Other Environment	Yes/No	Yes/No
Health Impact Assessment	Yes/No	Yes/No
Race Equality	Yes/No	Yes/No
Disability Equality	Yes/No	Yes/No
Gender Equality	Yes/No	Yes/No
Human Rights	Yes/No	Yes/No
Rural Proofing	Yes/No	Yes/No

Annex 1: Therapist capacity

High and low intensity therapists work differently, and as a result they see a different number of patients in a working week, which makes for a large difference over the working year. These patient numbers seen allow for the fact that all therapists spend a significant proportion of their time not in patient contact, for example, in supervising or being supervised, in management, in contacting patients, or in administrative work.

In training, therapists see far fewer patients, as they spend time away from the services in formal education, as well as spending time observing, in supervision and studying informally.

A low intensity trainee, for example, produce no “output” (in terms of patients seen) in their first 3 months, as they are training and shadowing. In months 4-9 the assumption used for modelling costs is that they work at 4/5 of capacity. (In reality, they work 4 days a week in university term time (they spend one day a week at university) and 5 days a week during university holiday time, so the average may be closer to 4.5. However, we make the assumption that they work only 4 days a week over the next 6 months in order to allow for study time). In the final three months of the training year, trainees work at full capacity. This means that, over the course of a year, a trainee LI therapist will see around 65% of the number of patients seen by a fully trained LI therapist.

Similarly, trainee high intensity therapists are likely to be able to see 8 patients per week, as well as keep up with their study commitments. With 41 working weeks in a year, and each patient needing to be seen 12 times a year on average, this means that a high intensity trainee therapist will see around 27 patients in a year.

Based on information from our expert advisors, the costings model works on the basis that therapists will, on average, see the following numbers of patients in a year.

Trained	High	Low
Number of patients seen per therapist per year	72	263

In training	High	Low
Number of patients seen per therapist per year	27	171

The assumptions here are based on what is expected to be achieved once a service is fully up and running. Therefore the costings model also contains an assumption that even fully trained new staff operate at only 60% of their full capacity for their first six months in the system – this is to allow for a ramp-up in service level, as new services take time to get going at full capacity.

Annex 2: The IAPT Full Business Case Assumptions

Costings and Outputs Methodology and summary tables

1. Model construction and development

The purpose of this annex is to provide an overview of the assumptions within the model built to estimate costs and outputs expected over the 3 years of the CSR period, and expanded to estimate costs and outputs over the next 15 years.

The model was constructed using assumptions that have been developed through consultation with a number of experts, including academics at the LSE, the Workforce Reference Group and the Expert Reference Group, taking into account data from the demonstration sites (at Doncaster and Newham) where these are available and can appropriately be used for extrapolation.

All assumptions represent a national-level, central case. As such, these assumptions are not intended to be prescriptive and some local or regional variation is indeed to be expected. (However, it is, of course, expected that the results of local variations will mean that at an aggregate, national level, these central assumptions hold.) The results of the programme should be kept under review, and these assumptions should be altered as necessary, as and when new data come to light.

2. Overview of Assumptions Made

1. Demand

1.1 Demand will exceed supply

Assumption: The model assumes that demand will exceed supply for the first 3 years

Rationale: The Psychiatric morbidity survey suggests that around 2.75m people present in primary care with depression or anxiety related problems. The relevant literature, and the views of the experts with whom we have engaged, suggests that around 8-900,000 of these cases could benefit from CBT. The model suggests that, by the third year, in the region of 500,000 people would be treated. This is well-below the number expected to accept treatment each year if it were available country-wide. So demand is not a binding constraint and it is excluded from the model.

Key Sources

- Psychiatric Morbidity Survey, ONS, 2002;
- *Cost-Benefit Analysis of Psychological Therapy*, Layard, R. et al, CEP Discussion Paper No 829, LSE, 2007;
- *Delivering the Government's Mental Policies*, Boardman, J., and Parsonage, M., The Sainsbury Centre for Mental Health, 2007

2. Capacity

2.1 Different therapists can see different numbers of patients in a year

Please see "Annex 1 Therapist capacity" for details.

3. Workforce

3.1 Up to 3600 new staff will be available

Assumption: It is assumed that a maximum of 3600 new staff will be available to become IAPT employees over the 3 years of the CSR period. Around 750 will start in the first year, around 1500 in the second year, and around 1300 in the third year.

Rationale: There will be a limit to the number of staff that will be available to start work in the IAPT services, whether these staff join as trainees in the new system or are staff already trained elsewhere. Based on expert advice, we have assumed that up to 3600 staff will become IAPT employees over the 3 years. The majority of these (around 3300 to 3400) will join as trainee therapists, with other staff joining as qualified therapists but receiving additional training to enable them to act as more senior or supervisory-level staff within the IAPT programme.

Key Sources:

- Expert Opinion, based on consultations between our workforce experts, national clinical experts and the range of professional bodies represented on the IAPT Expert Reference Group.

3.2 High/low intensity split

Assumption: The workforce will comprise around 60% high intensity therapists, and 40% low intensity therapists.

Rationale: The 60:40 split is our central modelling assumption. It does not represent our view of what is singular best practice, but is what we expect to happen overall. We expect to see a range of service models at local level, working on ratios of between 70:30 and 50:50 (all of which are good practice, and which will vary with local skill-mix, need, etc).

Key Sources:

- Expert opinion on good practice

3.3 Salaries

Assumption: The following salary distributions are assumed:

High intensity trained staff

High intensity	£mid band	Proportion of high intensity staff at pay band
Band 4	£18,528	0%
Band 5	£22,187	0%
Band 6	£27,388	0%
Band 7	£32,704	35%
Band 8a	£39,579	40%
Band 8b	£46,801	8%
Band 8c	£55,585	8%
Band 8d	£66,592	10%

Low intensity trained staff

AfC band	£mid band	Proportion of low intensity staff at pay band
Band 4	£18,528	0%
Band 5	£22,187	50%
Band 6	£27,388	50%
Band 7	£32,704	0%
Band 8a	£39,579	0%
Band 8b	£46,801	0%
Band 8c	£55,585	0%
Band 8d	£66,592	0%

High intensity trainees

High intensity	£ bottom band	Proportion of high intensity staff at pay band
Band 4	£16,853	0%
Band 5	£19,683	0%
Band 6	£23,458	50%
Band 7	£28,313	50%
Band 8a	£36,112	0%
Band 8b	£42,064	0%
Band 8c	£50,616	0%
Band 8d	£60,669	0%

Low intensity trainees

AfC band	£ bottom band	Proportion of low intensity staff at pay band
Band 4	£16,853	100%
Band 5	£19,683	0%
Band 6	£23,458	0%
Band 7	£28,313	0%
Band 8a	£36,112	0%
Band 8b	£42,064	0%
Band 8c	£50,616	0%
Band 8d	£60,669	0%

Administrative staff wage £ 17,700 (Band 4)

On-costs are added to these salaries at a rate of 25%, and these costs are, along with all costs in the model, uprated for inflation at 2.75% (as per latest estimate of GDP deflator from HMT)³⁷.

Rationale

These distributions of salaries are based on expert advice on the appropriate mix of staff required to run a service. They are also broadly consistent with the patterns of employment seen in the pathfinders.

The assumption that high and low trained therapists will receive the mid-point of the pay band is a central assumption, and local variation is expected.

The costs of administrative staff are also included in the CSR resource envelope.

³⁷ Source:http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_fig.cfm

Outside the CSR settlement, it is assumed that funding will be available to provide for the salaries of the other key members of the multi-disciplinary team (GPs and employment advisors) – this is discussed in section 5.2 of this annex.

Key Sources

- Agenda for Change paybands: <http://www.nhscareers.nhs.uk/details/Default.aspx?Id=766>
- Expert advice

4 Training

4.1 Course costs

Assumption: LI training is assumed to cost on average £4300 per trainee, HI training, £8600. Training for supervisors (who will be experienced and already-qualified therapists) is assumed to cost on average £500.

Rationale: Training costs allow £4300 for LI trainee course fees, and £8600 for HI course fees. These costs include the costs of off-the-job supervision, and training.

Key Sources:

- Expert opinion, based on the advice of workforce leads drawn from existing price structures.

4.2a Set-up costs - training

Assumption: Set up costs will be £40,000 for each course

Rationale: The costs of establishing the 20 courses required in year 1 will reach an average of £40,000. This is intended to cover the cost of the relevant British Association of Behavioural and Cognitive Psychologists (BABCP) accreditation costs, academic staff set-up costs and course materials, such as training DVDs.

Key Sources:

- Expert opinion

4.2b Set-up costs - services

Assumption: Costs of £1,000,000 nationally are allowed for in years 1 and 2, for service set-up costs

Rationale: This is to cover recruitment, marketing and communications in years 1 and 2.

Key Sources:

- Expert opinion

4.3 Supervision ratios

Assumption: The maximum ratio of trained staff to trainees will be 2.1:1 for low intensity therapists, and 1.7:1 for high intensity therapists.

Rationale: It is vital that there are sufficient trained staff in place to supervise the trainee therapists, and, in the case of LI therapists, to allow work-shadowing. The ratios of 2.1:1 and 1.7:1, along with the assumptions about workload, allow sufficient capacity in terms of trained staff to supervise trainees.

Key Sources:

- Expert opinion

5 Contribution from local services

5.1 Therapists available from local commissioning decisions

Assumption:

Over the three years of the CSR period, around 650 - 700 therapists will be provided, over and above the 3600 therapists funded by the CSR settlement.

Rationale: It is assumed that a number of extra staff will be made available from service reconfiguration over the CSR period. Salaries for these staff will be paid by local services, they are assumed already to be trained therapists, and they are assumed to be 60% HI therapists and 40% LI therapists. These staff will receive additional training funded within the CSR settlement to allow them to act as supervisors within the IAPT programme. They will set up and deliver services quickly as well as supervise trainees, who will be delivering low and high intensity interventions. Local services will be required to release these staff, or equivalent, as an IAPT PCT selection entry criterion.

Key Sources:

- Expert opinion

5.2 Other staff funded elsewhere

Assumption:

Employment Coaches

Year 1: 117 employment coaches, costing a total of £3.1 million (to nearest £100,000)

Year 2: 346 employment coaches, costing a total of £9.4 million (to nearest £100,000)

Year 3: 535 employment coaches, costing a total of £15.0 million (to nearest £100,000)

This is based on a salary of £26,495 (AfC Band 6) uprated annually at 2.75% (GDP deflator)

GPs:

Year 1: 5 GP FTEs, costing a total of £0.4 million (to nearest £100,000)

Year 2: 14 GP FTEs, costing a total of £1.3 million (to nearest £100,000)

Year 3: 21 GP FTEs, costing a total of £2.1 million (to nearest £100,000)

This is based on a salary of £94,000 (based on PSSRU data) updated annually at 2.75% (GDP deflator)

Rationale:

Each team of around 40 therapists will require around 5 employment coaches, around 2.5 administrative staff whole time equivalents, and 0.2 GP whole time equivalents.

Employment advisors. These staff are often already in place providing support to local Community Mental Health Teams (CMHTs) for people with more severe and enduring mental health problems. In addition, the Department of work and Pensions (DWP) has recently announced (27 November 2007) a trebling of the number of employment advisers that will be available to support the expansion of the Pathways to Work Condition Management Programme. DWP have agreed with DH that these staff will be directed to support the IAPT programme, as part of the roll-out.

GPwSIs. The costs of these staff will be met through CSIP's Primary Care programme, which will be expanding the availability of training for GPs, directly linked to the expansion of IAPT.

Key Sources:

- Expert opinion

6 Other**6.1 Overhead Costs**

Assumption: It is assumed that overheads will run at £3084 per therapist.

Rationale:

Overhead costs have been estimated using data from the Personal Social Service Research Unit, based at the LSE, the University of Kent, and the University of Manchester, on the unit costs of providing cognitive behavioural therapy. These are based on costs per member of staff, taking into account the new build and land requirements of an NHS office and shared facilities, based on the assumption that there is one office per team³⁸. These costs are also broadly consistent with estimates of accommodation costs received in tender documents from the Pathfinder sites.

Key Sources:

- PSSRU Unit Costs
- Tender documents from Pathfinder sites

6.2 Staff turnover

³⁸ Source: http://www.pssru.ac.uk/pdf/uc/uc2007/uc2007_s02.pdf

Assumption: It is assumed that, once the service has rolled out fully, turnover will run at an average of 10%.

Rationale:

As an approximation, given that the programme will be growing quickly while the programme is rolling up, no staff turnover is assumed during this phase of the programme. However in the medium term it will be necessary for new staff to be trained in order to replace those who leave the service.

Key Sources:

10% represents the order of magnitude of turnover expected. It is consistent with data on turnover in the NHS workforce, available from the Information Centre, at:

<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-turnover>

(accessed 18th February 2008).

Annex 3: Results of the Demonstration Sites in Newham and Doncaster

The two national IAPT demonstration sites at Newham and Doncaster have achieved:

- Impressive recovery rates that replicate clinical trial and are in line with NICE guidelines (50-60% on most rigorous measures)
- Excellent recording of treatment outcomes for the first time in mental health (90%), leading to an opportunity for a nationwide system of routine outcomes monitoring and thus to more improvements
- Significant achievement in helping people off statutory sick pay and back to work/volunteering/education/training
- Treating large numbers of people in a short period of time from a standing start - more than 1,000 in Newham and more than 4,000 in Doncaster
- Meeting previously unidentified & unmet need by opening to self-referral - in Newham's community people came forward who were just as ill as those referred by GPs and whose conditions were twice as chronic (four years long rather than two). They responded as well as those referred by GPs.