

Mental health and the economic downturn

National priorities and NHS solutions

Royal College of Psychiatrists
Mental Health Network, NHS Confederation
& London School of Economics and Political Science



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Executive summary

In September 2009 a 1-day meeting on mental health and the economic downturn was held in London. The meeting was convened by the Royal College of Psychiatrists, the Mental Health Network, NHS Confederation and the London School of Economics and Political Science. The meeting explored the impact the downturn was having on mental health as well as where some of the solutions may lie for those working at a local and national level in service provision and policy.

This briefing builds on the outcomes of that meeting. It outlines the challenges facing the sector and sets out how policy makers, organisational leaders and health and social care professionals should respond.

CONTEXT

- Mental health problems have not only a human and social cost, but also an economic one, costing £110 billion a year (Friedli & Parsonage, 2007).
- Demand for mental health services is likely to increase as a result of unemployment, personal debt, home repossession and other fallout from the recession.
- At the same time, UK government and the devolved administrations are under pressure to reduce levels of spending on public services.

PRIORITIES FOR GOVERNMENT AND NHS ACTION

- Government must better support employers to keep people with mental health problems in work – it saves costs to both business and the public sector.
- Changes in public attitudes and perceptions are critical – we need longer-term investment for anti-stigma and antidiscrimination activity.
- Ensure the right kinds of support are available to people with mental health problems to return to work, through encouraging wider use of the individual placement support model.
- A cross-government strategy for developing better mental well-being for the whole population.
- Encourage initiatives that save the public purse money elsewhere in the system – for example, by investing in mental health diversion schemes for those individuals with mental health problems who come into contact with the criminal justice system.
- Make research a priority for investment – we need to understand the effectiveness of some types of interventions better in order to prioritise investment.

PRIORITIES FOR COMMISSIONERS AND PROVIDERS

- Keep a long-term perspective – avoid short-term gain for longer-term pain.
- Continue investment in early intervention, particularly with children and young people.
- Invest in models delivering savings elsewhere in the health system and beyond – for example, liaison psychiatry services.
- Enable clinicians, in terms of capacity and capability, to lead on redesigning care pathways, with support from managers.
- Share innovations and ideas with others.

PRIORITIES FOR FINDING EFFICIENCIES

- Operational efficiencies – these will typically involve merging back-office functions. This will need careful planning to ensure changes bring about efficiencies and patient benefits, rather than unintended consequences.
- Care pathway efficiencies – service redesign is key. Clinical leaders and managers need to be prepared to take this work forward together.
- Staffing efficiencies – staff are the greatest resource of the NHS. However, staff also account for the vast majority of costs in the NHS. It is therefore inevitable that workforce efficiencies will be made.
- Wider system efficiencies – new offers to primary care, addressing physical healthcare costs through mental health intervention, psychological therapies and joined-up working may lead to savings.
- Allocative efficiencies – we need to acknowledge where disinvestment is needed, consider where we might bring patients back into local services and provide greater support for commissioners.

CONCLUSION

- The challenge of the economic downturn for the mental health sector is clear: a likely increase in demand coupled with potentially reduced funding levels, with all the while an emphasis on maintaining quality, efficiency and patient benefit.
- The Royal College of Psychiatrists, the Mental Health Network, NHS Confederation and the London School of Economics will continue to work together to address these challenges.
- The College will also work with its members and other stakeholders across psychiatric specialties and geographical regions to address service redesign and patient benefit. It will also consider how clinicians can be further supported to co-lead on these initiatives.
- The Mental Health Network, NHS Confederation will continue to work on behalf of its members to encourage the spread of innovative responses to the quality and efficiency challenge nationally and to represent the views of providers in the policy debate.
- The London School of Economics and Political Science will continue to clearly voice the need for improved evidence on care and treatment interventions within mental health and the mechanisms for furnishing commissioners, clinicians and managers with such evidence.

Introduction

In September 2009 a 1-day meeting on mental health and the economic downturn was held in London. The meeting was convened by the Royal College of Psychiatrists, the Mental Health Network, NHS Confederation and the London School of Economics and Political Science. The meeting explored the impact the recession was having and will continue to have on mental health and where some of the solutions may lie for those working at a local and national level in service provision and policy.

This briefing builds on the outcomes of that meeting. It outlines the challenges facing the sector and argues how policy makers, organisational leaders and health and social care professionals should respond.

BACKGROUND

One in four people will experience a mental health problem during their lives and at any one point one in six is living with a common mental disorder.

RISING DEMAND

Mental health problems have not only a human and social cost, but also an economic one. The overall cost to the UK is estimated at more than £110 billion a year (Friedli & Parsonage, 2007). The costs of mental illness are currently greater than the costs of crime and are projected to double over the next 20 years (McCrone *et al*, 2008).

Times of recession are challenging for the nation's mental health. Numerous studies have linked unemployment and other economic circumstances with poor mental health (Dorling, 2009) and as more people find themselves out of work there may be an increased demand for mental health services.

INTERDEPENDENCE

Simultaneously, like other areas of the public sector, mental health is facing a potential squeeze on its finances. This will challenge everyone to deliver more with the resources they have, without compromising quality or safety. Furthermore, any reductions in funding for the mental health sector will have implications for other parts of government. For example, achieving the aim of moving people off incapacity benefit and into employment will be affected if treatment cannot be given to those who need extra help to make this transition because they have common mental health problems. Similarly, mental health provision will be affected by changes in other parts of government, including reductions in criminal justice or social care budgets. Consequently, this challenge will remain, even if NHS resources remain stable over the coming period.

The extent of the challenge

We recognise that the challenge posed by the downturn is twofold:

- 1 demand for mental health services is likely to increase as a result of unemployment, personal debt, home repossession and other fallout from the recession
- 2 the UK government and the devolved administrations are under pressure to reduce levels of spending on public services.

INCREASING DEMAND

There was considerable discussion about the economic downturn exposing more people to known risk factors for mental health problems. These include: unemployment and other major life changes (Dorling, 2009), poverty (Aznar, 2009), unanticipated disruptions in income (Aznar, 2009), uncertain and increasingly stressful work environments, debt and financial strain (Fitch *et al*, 2009). These not only influence psychological well-being, but may also contribute to relationship strain, less leisure time for those in work, and less money to spend on healthier foods and leisure activities for those out of work.

Reduced household income and loss of work is also associated with a wider range of effects including poorer nutrition, less exercise, increased alcohol consumption and the increased likelihood of debt. Furthermore, while many people are suffering materially from the downturn, the harm to the population's psychological well-being is not only caused by actual financial strain, but worries caused by the fear of financial strain and job loss.

SERVICE USE

As more people find themselves out of work or in financial difficulty there is likely to be an associated increase in the demand for mental health services in both primary and secondary care. There are anecdotal reports from mental health providers that demand for services has increased over the past 12 months. This may be inflated by those individuals who are now financially unable to access private support or counselling services, as well as employers pressurised into reducing their own spending on occupational health services.

REDUCED PUBLIC SPENDING

The NHS Confederation's publication, *Dealing with the Downturn*, outlined the funding challenge to the NHS (NHS Confederation, 2009a). The government

has set out the challenge of finding £15–20 billion of efficiencies in the 3 years from 2011. Meanwhile, The King's Fund and the Institute of Fiscal Studies' report, *How Cold Will it Be?*, estimated that from 2011 to 2014 all government departmental budgets could experience a reduction in funding by an average of 2.3% per year (Appleby *et al*, 2009).

Although demand for mental health services is likely to increase in the current economic context, it is apparent that government finances will face difficult challenges. Public sector net borrowing is estimated to be £175 billion this year, representing 12.4% of gross domestic product (GDP) (Chancellor of the Exchequer, 2009). As a result, public services are facing a period of significant uncertainty.

UNCERTAINTY

In the run up to the next election, uncertainty is likely to continue about the level of funding that public services might expect over the coming few years (see Box 1). However, even if there is some degree of protection for the NHS budget, it would be prudent to assume a degree of inflationary pressure in the NHS because:

- Health prices tend to rise faster than those in the wider economy.
- Public spending will be dominated by the need to service debt. Therefore, NHS and social care spending will not follow renewed growth in the economy. However, other prices, particularly energy, may increase as the wider economy recovers or due to inflation.
- New drugs and devices are generally thought to contribute cost pressures of up to 0.5%.
- There is inflationary pressure of up to £410 million built into the NHS pay structure, particularly where the labour market may encourage people to stay in posts rather than move.
- There will be a 0.5% increase in employers' national insurance contributions in 2010–11.
- Clinical negligence scheme for trusts fees will increase, particularly as low interest rates lead to a change in the discount rate for settlements.
- There are significant cost implications in Modernising Medical Careers and the last phase of implementing the Working Time Directive for some providers.
- Social care is in an even more difficult position because it has not had the level of funding increases enjoyed by the NHS. There are likely to be some cost implications for the NHS resulting from reduced resources in social care.

Box 1 WHAT DO THE PUBLIC THINK?

A June 2009 poll for Ipsos Mori found that although only 38% of people thought that taxes should increase to maintain spending on public services, when asked what areas of public spending should be protected from cuts, 82% of people thought the NHS should be afforded protection.

IMPACT

The impact of the downturn is already becoming clear, with anecdotal reports that pressures on local councils are resulting in reductions in social care capacity. The interface between health and social care is a critical one. Without support available to care for vulnerable people in their own homes, there are resulting delays in discharge from acute mental health settings, reducing capacity to deal with new cases.

STARK CHOICES

Alongside that, faced with the situation of reduced resources and rising demand across NHS services, commissioners are being faced with stark local choices about where to prioritise funding. At a local level, mental health services are arguably more vulnerable to funding reductions than other services on NHS budgets.

Reasons for this include the structure of the NHS performance framework and lack of a national tariff for mental health. There are currently relatively few ways in which the quality and value for money of mental health services can satisfactorily be measured, and a corresponding lack of metrics by which commissioners' performance can be measured. The delay in the development of a possible national tariff (now estimated by the Department of Health for 2013–14) creates a risk that mental health services will experience a greater proportional reduction in spending than other services. There needs to be a greater focus on system reform in mental health services at a national level, with support for the development of the skills needed for mental health commissioners locally.

Significant disinvestment in mental health services would, without doubt, deliver immediate, medium- and long-term pain for the NHS and other public services. Most importantly, it would have a negative impact on people experiencing mental distress and illness, as well as their carers and families. Such shortcut commissioning would not only increase their burden, but would ultimately result in a larger economic burden for the nation.

National priorities

A range of actions that should be taken by government and by the NHS were identified (Box 2). At a national level, a number of areas were seen by participants as a focus for action for policy makers, individual providers and commissioners.

Box 2 PRIORITIES FOR GOVERNMENT

- Government must support employers to keep people with mental health problems in work – it saves costs to both business and the public sector.
- Changes in public attitudes and perceptions are critical – we need longer-term investment for anti-stigma and antidiscrimination activity.
- Ensure the right kind of support is available to people with mental health problems to return to work, through use of the individual placement support model.
- A cross-government strategy for developing better mental well-being for the whole population.
- Encourage initiatives that save the public purse money elsewhere in the system – for example, by investing in mental health diversion schemes for those individuals with mental health problems who come into contact with the criminal justice system.
- Make research a priority – we need to understand the efficacy of some types of interventions better to prioritise investment.

UNEMPLOYMENT AND SUPPORT BACK INTO WORK

The number of unemployed people increased by 88000 to 2.47 million in the 3 months to August 2009 (<http://www.statistics.gov.uk/pdfdir/lmsuk0809.pdf>).

KEEP PEOPLE IN WORK

First, we need to make sure that businesses are supported to keep people in work. This makes sound economic sense. It is too often the case that when people develop a common mental health problem, such as anxiety or depression, they can lose their jobs. This has repercussions, not just for the individual, but also for employers themselves.

British business could save up to £8 billion a year if mental health at work was managed more effectively (Sainsbury Centre for Mental Health, 2009a). The CBI calculates that 176 million days were lost in the UK in 2001 for health reasons and that one-third of all sick leave is due to stress, anxiety and depression (Sainsbury Centre for Mental Health, 2003). The impact of sickness absence due to mental health problems alone was nearly £4 billion in 2002–03.

TACKLE STIGMA

Tackling the stigma of mental illness among employees and employers must underpin any strategy. The Department of Health's *Attitudes to Mental Illness* research (TNS UK for Care Services Improvement Partnership & Department of Health, 2009) found that one-third of adults in England think people with mental health problems should not have the same rights to a job as everyone else. On the other hand, research evidence from the Scottish 'See Me' initiative suggests that anti-stigma campaigns are cost-effective and largely pay for themselves (M. Knapp, personal communication, 2009). Despite a growing emphasis on promoting well-being and wider public mental health, spending on mental health promotion has remained largely static in recent years, with £4 million spent in 2007–08.

EARLY INTERVENTION, NOT WAITING LISTS

Unemployment is linked with poor mental health (Dorling, 2009). As more people find themselves out of work we need to ensure that there are services with the capacity to help them if they become unwell. Initially, more people with anxiety and depression will present at a primary and community care level. Sufficient capacity in the system is vital in order to facilitate early intervention and ensure that waiting lists do not grow.

As a national priority, support should be available to help people return to work, especially for those with existing mental health problems. Where people do recover and return to work, evidence shows that there are savings not only in lower welfare spending, but also that individuals make less use of public services, including mental health services (Sainsbury Centre for Mental Health, 2009b).

HELP PEOPLE BACK TO WORK

The individual placement support model, which helps people with mental health problems into paid competitive work, would save money by substantially reducing the use of mental health services. A multi-site European trial found that individual placement support clients had fewer and shorter hospital stays than clients in traditional services (Burns *et al*, 2007), which contributed to significant savings in in-patient costs over an 18-month period. These findings were recently corroborated by a US study which found that mental health service costs over a 10-year period were 50% lower for people supported into regular employment than among other groups (Bush *et al*, 2009).

CONTINUING INVESTMENT IN PREVENTION

There is also a clear need for a long-term perspective. For those making funding decisions, the tension between short-term gains and longer-term consequences will inevitably come into play.

CHILDREN AND YOUNG PEOPLE

The government's *New Horizons* consultation sets out the case for investing in support for families and at-risk children. Investing in this group can prevent mental health problems in later life and lead to better outcomes in health, education, employment and relationships. The *Future Vision for*

Mental Health report (<http://www.newvisionformentalhealth.org.uk>) and evidence from the government's own *Mental Capital and Wellbeing* report also support this (Foresight Mental Capital and Wellbeing Project, 2008).

A range of UK policy initiatives have all recommended a clearer strategic approach – at national, regional and local level – to monitoring, outcomes-focused evaluation and service improvement for children and young people. It is clear that there is an economic cost in not meeting these recommendations:

- Failing to address poor mental health in childhood results in young people facing a poor long-term outlook (including self-harm and increased risk of suicide, low educational and employment achievement, increased substance misuse) (Richards *et al*, 2009).
- Interventions during childhood and adolescence are available which will have both short-term and life-course results including better educational and psychosocial outcomes, reduced antisocial behaviour, reduced crime and violence and reduced ill health, and associated economic benefits.
- Such interventions, as well as mental health promotion and mental illness prevention programmes are cost-effective, with savings achieved mainly through reduced welfare and criminal justice costs and higher earnings. For example, early intervention in mental health and behavioural disorders produces significant economic savings. It has been estimated that one-off intervention programmes targeting parents and pre-school children in the UK with conduct disorder (estimated as 5% of the child population) would cost £210 million but would have potential lifetime benefits equivalent to £5.2 billion (Friedli & Parsonage, 2007). Building and maintaining resilience in this population is key and requires effective multi-agency working.

PUBLIC HEALTH APPROACHES

Improving productivity and keeping service costs manageable will only work if the NHS can also reduce potential demand. Recent shifts towards, and interest in, public mental health approaches are therefore welcomed.

There is now a robust and growing evidence base to support such approaches within mental health, based upon protecting and improving health within communities (through education, promotion, prevention and research), and an emphasis on changing lives and saving money through such preventive efforts.

However, only a small proportion of NHS funding has historically been spent on public health approaches in general (estimated by some as 1–2% of the total budget). Furthermore, in previous periods of financial difficulty, NHS programmes to improve public health – such as the Choosing Health improvement programme – have experienced significant funding reductions, and often to off-set NHS overspends elsewhere.

Clearly, public health strategies set out in documents such as the English *New Horizons* consultation offer an approach which could help to prevent unnecessary mental health problems and improve well-being. This would include an emphasis on early intervention programmes, preventive activity and whole-population well-being programmes, which would require action across government and not just in health (e.g. parenting skills, renewed urban regeneration, employment and educational initiatives, enabling access to quality housing).

However, despite this, these programmes may be at particular risk of not securing necessary funding. This will save money in the short term and could potentially also involve resources being distributed to mental health treatment and care services but it may not save the money that a public health approach could deliver over the longer term.

THE RIGHT INCENTIVES FOR PUBLIC SECTOR COMMISSIONERS

Investing for positive outcomes in mental health will produce savings in other areas of public sector finances. We therefore need a better way of incentivising these sorts of investments. For example, evidence exists that mental health diversion programmes for people who come into contact with police and the courts and who have a mental health problem have been shown to have multiple benefits in terms of reductions in reoffending rates and savings in the criminal justice system – as much as £20000 in each individual case (Sainsbury Centre for Mental Health, 2009c).

In addition to appropriate and equivalent treatment being given to prisoners with mental ill health, the diversion of offenders with mental health problems from the criminal justice system represents a key opportunity to improve individual health and save resources in the long term. For example, the Bradley report (England and Wales) showed that if more comprehensive triage and assessment processes were in place at police stations, this could save up to 4493 remand days, equating to 12 full-time prison places and (based on an annual cost of £23585 per prison place) nearly £300000 in annual savings (Bradley, 2009). Further, a different and thought-out approach to commissioning and producing health and social care status reports and psychiatric court reports would reduce the average period spent in custody on remand and save annual costs of £2.73 million. Finally, focusing on those who receive short sentences who may be experiencing mental health problems and may possibly be eligible for a community sentence, it is estimated that as many as 2000 prison places per year could be saved, equivalent to savings of £40 million per year.

INVESTING IN RESEARCH

There is a palpable gap in the evidence base for some mental health interventions. Historically, a lack of available research funding compounded by difficulties in good outcomes measures in mental health has meant that the evidence base for some services is not as well developed as in other areas of the NHS.

There is a real danger therefore that mental health could lose out disproportionately in future commissioning decisions. In the longer term, we do need to see more resource devoted to research that enables more effective services and interventions to be developed.

Although major advances have been made, important gaps still remain in the evidence base. If these are not mapped and addressed, there is a risk that mental health will again be overlooked in commissioners' decisions. Given the national disease burden represented by poor mental health, this would be a false economy. We need more resources devoted to research which will directly influence clinical and community practice and will make for both improved patient benefit and better national mental health.

NHS solutions

QUALITY AND EFFICIENCY

Delivering on the vision of UK government and the devolved administrations that quality should be the organising principle of the NHS becomes a challenging mission in the economic downturn.

In England, for example, the quality, innovation, productivity and prevention (QIPP) agenda will need to be delivered to make £15–20 billion efficiency savings over the between 2011 and 2014.

Achieving this will require a careful re-examination and selective redesign of individual services, care pathways, multidisciplinary interfaces and the wider systems of care and treatment in which they are located. Action will be called for at all levels of the system, from individual teams and local organisations, both regionally and nationally. Commissioners will also have to be strategic in their investment decisions and providers will have to foster innovative thinking and solutions (Box 3).

Box 3 PRIORITIES FOR COMMISSIONERS AND SERVICE PROVIDERS

- Keep a long-term perspective – avoid short-term gain for long-term pain.
- Continue investment in early intervention, particularly with children and young people.
- Invest in models delivering savings elsewhere in the health system and beyond – for example, liaison psychiatry services.
- Enable clinicians, in terms of capacity and capability, to lead on redesigning care pathways, with support from managers.
- Share innovations and ideas with others.

THE IMPORTANCE OF PEOPLE

Our meeting participants made the point powerfully that the expertise and energy of professionals and frontline workers, service users and carers should be central to the above process.

Importantly, many of those working in mental health already have significant experience and skills in managing change, including the changes involved in the shift from hospital to community care, and the subsequent development of approaches such as early intervention and crisis resolution and home treatment teams. These past experiences provide strong foundations for the future challenge.

INVEST TO SAVE MONEY

Careful investment in mental health services has already saved public money, improved service quality and, most vitally, has changed lives for the better. Now that we live in a very different economic climate, with significant reductions in public spending in real terms on the NHS set to become the norm for many years, such careful and considered investment is required more than ever.

WHAT NOT TO DO

However, there is also a need to learn other lessons from our own history in the NHS. As outlined in the *Dealing with the Downturn* paper (NHS Confederation, 2009a), we know that although we must improve quality while driving greater productivity within the service, there are a number of approaches to avoid. Letting waiting lists grow, diluting quality, 'slash and burn' and 'salami slice' savings, letting pay get out of line, cutting training and cutting prevention are all to be avoided.

We must also ensure that any potential approaches involve proper planning and have an evidence base or a thought-through rationale. Furthermore, as economic pressures increase, organisations should review and develop their 3- to 5-year financial plans and actively seek to avoid making short-term cuts.

QUALITY IMPROVEMENT PROGRAMMES

Reducing spending on quality improvement programmes may prove a false economy. Clinical audit, quality improvement, accreditation schemes and other work that helps direct procedures and systems more efficiently will help to save money, improve productivity and raise quality. This includes the adoption and implementation of existing best practice (including National Institute for Health and Clinical Excellence and Scottish Intercollegiate Guidelines Network guidelines), as well as following best practice standards.

THE INNOVATION CHALLENGE

The challenge we face will necessitate change that goes beyond tinkering around the edges – it requires real innovation. This is a leadership challenge for those working in public services. It requires creativity – we need to include a wider range of actors in developing new, innovative approaches. Our meeting participants made the point powerfully that professionals and frontline workers, service users and carers need to be central to this. Clinicians need to lead, in particular on redesigning care pathways for better quality and efficiency, with the support of managers. We need to embrace new ways and methods of generating ideas, where a wider variety of people can get involved.

Funding for developing ideas, although important, is likely to be scarcer in the current financial climate, although flexibility and organisational culture are thought to be much more powerful factors in producing change. Also critical is the spread of innovative ideas. That needs effective national action and support. As well as being a challenge, this is also an opportunity to redesign or re-orientate service provision to deliver better services.

There are five main areas where efficiencies can be found (Box 4): operational efficiencies, care pathways, staffing, wider system changes, and allocative decisions.

BOX 4 PRIORITIES FOR FINDING EFFICIENCIES

- Operational efficiencies – these will typically involve merging back-office functions. This will need careful planning to ensure changes bring about efficiencies and patient benefits, rather than unintended consequences.
- Care pathway efficiencies – service redesign is key. Clinical leaders and managers need to be prepared to take this work forward together.
- Staffing efficiencies – staff are the greatest resource of the NHS. However, staff also account for the vast majority of costs in the NHS. It is therefore inevitable that workforce efficiencies will be made.
- Wider system efficiencies – new offers to primary care, addressing physical healthcare costs through mental health intervention, psychological therapies and joined-up working may lead to savings.
- Allocative efficiencies – we need to acknowledge where disinvestment is needed, consider where we might bring patients back into local services and provide greater support for commissioners.

1 FINDING OPERATIONAL EFFICIENCIES

Operational efficiencies typically include merging back office functions. Careful planning and follow-through is required to ensure that these changes actually bring about efficiencies and patient benefits, rather than unintended chaotic consequences or risk to patients. Any change, such as reducing administrative overheads for example, does not make sense if it decreases the amount of time clinicians spend doing clinical work or reduces patient benefit. Potentially, however, these sorts of efficiencies can produce savings.

2 CARE PATHWAY EFFICIENCIES

Service redesign refers to the careful re-examination and redesign of individual services, care pathways, multidisciplinary interfaces, as well as the wider systems of care and treatment in which they are located (Box 5). Throughout, the aim is to improve quality and efficiency.

REDESIGN LED BY CLINICIANS AND MANAGERS

Redesign needs to be led together by clinical leaders and managers. This will feature the central involvement of service users and carers as well as health finance professionals.

Consultants and other health and social care professionals need to be prepared to co-lead these changes. They will need to do so using the resources available with the aim of providing the best quality care for patients.

Some clinical leaders will need support and training before fully engaging in this redesign work. Such investment should be provided by local health and social care economies.

Box 5 WHAT IS SERVICE REDESIGN?

Redesign initiatives are conducted to ensure that existing or proposed provision meets three fundamental criteria: appropriate objectives, acceptable cost and demonstrable care or treatment outcomes.

Numerous methods and branded approaches exist to undertake such reviews. However, most require consideration of:

- whether objectives are clearly defined, understood and reflected in the design of services, pathways, interfaces and systems
- whether evidence exists that objectives are being met and how this compares with demand for other services
- whether care or treatment is efficiently provided or whether costs could be reduced through intervention
- what importance or priority different stakeholders place on what is being provided – is there a consensus on whether it is highly valued, or not a priority?

Managers and organisational leaders can both inform and support this process. They can help identify and develop those clinicians with the capability to carry this work forward, while also ensuring that professionals have the time and capacity to do so.

Throughout this process, it should be recognised that decisions will need to be made not only about redesign and reallocation, but also disinvestment in certain services. A transparent and open discussion will be needed.

WHAT SHOULD REDESIGN FOCUS ON?

A key area of focus in the search for efficiency and in driving up service quality is that of the care pathway.

Good design can help avoid situations where people using services are repeatedly or serially assessed by professionals. This is often both uneconomical and unhelpful in terms of improving patient benefit (Box 6).

Box 6 ENSURING THE EARLY PLACEMENT OF PATIENTS ON THE RIGHT CARE PATHWAYS

Royal College of Psychiatrists, Medical Directors' Executive

Considerable variation exists in practice among community mental health teams, particularly in terms of early placement onto consistent care pathways.

The potential exists to simplify the steps in the care pathway by enabling the patient to see a specialist – probably, but not necessarily, a consultant psychiatrist or other specialist – as early as possible in the referral process. This avoids the need for patients to see several healthcare professionals *en route* to the most appropriate specialist.

Thereafter, the pathway should consist of a series of 'pulls' through the system (and not pockets of resistance at interfaces between parts of the system). Risk-sharing would militate against defensive gate-keeping (sometimes characterised by many weeks of assessment followed by the service declining to 'take' the patient). Amalgamation of specialist time into an advisory (case-based discussion) role would similarly reduce process-driven delay and use specialist time more efficiently.

- Here consultants can advocate for patients, recognising that once the right person has assessed a patient there should be no need to repeat the process. This would be based on a culture of trust – that if a further assessment is made, it must be on the basis of obtaining demonstrable added value for the patient.

Redesign can also identify unnecessary admissions, follow-ups or out-appointments. It can also address over-complicated clinical pathways. These can all deliver substantial savings.

Redesign may also consider issues of standardisation and economies of scale. Developing specialist, high-quality units may require a degree of concentration in fewer sites. This could mean smaller local or specialist services being decommissioned.

3 STAFFING EFFICIENCIES

Staff are the greatest resource of the NHS. However, staff also account for the vast majority of costs in the NHS. The NHS now employs 1.4 million people with a pay bill that accounts for around 40% of expenditure overall and up to 65–70% in an acute or mental health trusts. Given this, it is inevitable that workforce efficiencies will be required. The aim will be to make optimum use of natural wastage and service redesign.

EXPENSIVE TOOLS

Using redundancies for cost savings is an expensive tool. In past recessions, staff made redundant have often been re-employed, either in a different part of the NHS or in the wider public sector. This may be a poor use of public funds. Redundancies also have a negative impact on staff morale and motivation, which in turn affects productivity and the ability to deliver the sorts of savings required.

Employers will therefore need to consider ways of reducing the pay bill other than redundancy in the first instance. This includes making the most of natural wastage, eliminating waste in recruitment processes and increasing productivity. Relying less on the use of expensive temporary staffing can also save money.

EFFECTIVE DEPLOYMENT

Where systems and pathways are redesigned, there is a need to ensure there are the right people in place to deliver the service. By using processes like appraisals, and clear job design and planning, organisations can ensure staff are deployed efficiently, make best use of their skills, and align individual objectives with that of the service. Where vacancies arise, redeployment may be the first step before recruiting from outside is considered.

TRAINING: CONTINUED INVESTMENT

Continued investment in training (including human resources) will be essential to ensure that existing and future staff are fully competent in high-quality and innovative practice that drives forward the quality of services provided. It must be ensured that training expenditure is utilised effectively and training is fit for purpose as services are redesigned.

4 WIDER SYSTEM EFFICIENCIES

In addition to finding efficiencies in the pathway, there are also undoubtedly gains to be made in the wider system. Part of the solution involves mental health making a 'new offer' to other parts of the system.

A NEW OFFER TO PRIMARY CARE

For example, efficiencies could be made by making a new offer to primary care. Currently, routes into the mental health system for general practitioners (GPs) referring service users are undeniably complex and contain potential for costly duplication. A single managing referral system could enable GPs to direct their patients to a single point of access, with a team carrying out high-quality risk assessments and directing to the most appropriate point of entry to the mental health system. For example, in Brighton and Hove, primary care trusts (PCTs) and acute services providers developed a system where GPs could directly contact and speak with specialists in the mental health sector, with the aim of ensuring that patients were quickly and correctly referred to the appropriate service.

REDUCE PHYSICAL HEALTH COSTS BY IMPROVING MENTAL HEALTH

There is a clear link between mental and physical health. Investment in liaison psychiatry services can deliver savings for the acute sector of the NHS (NHS Confederation, 2009b). For example, more than one-quarter of patients admitted to general hospital have a mental disorder. Improving the provision of mental healthcare to these people can, and does, produce considerable savings through earlier discharge and reducing re-attendance. Adequately funded liaison mental health services in general hospitals can provide mental healthcare throughout the entire hospital to all who need it, including those with intellectual disabilities, older people and young people (Academy of Medical Royal Colleges, 2009). Furthermore, patients with mental health problems in general hospitals should have the same level of access to a consultant psychiatrist as they would to a consultant specialising in physical health problems. However, while liaison psychiatry attends to the needs of patients with physical and psychiatric comorbidity, a split between 'physical' and 'mental' health in the provision and commissioning of services may increase the risk that liaison services are seen as being someone else's responsibility.

PSYCHOLOGICAL THERAPIES

The impact of the economic downturn is most likely to manifest in an increase in common mental disorders, including heightened levels of anxiety and depression. New programmes, such as the Improving Access to Psychological Therapies (IAPT) programme in England and the development of the psychological therapies matrix in Scotland, were introduced as a cost-effective measure to assist with this. These programmes intervene in the early stages of anxiety or depression and aim to improve individual well-being, reduce further distress and social exclusion and help avoid situations where individuals are unable to work or are in need of long periods of benefit support. Innovative strategies are required, perhaps through job centres, to direct people towards self-help and computerised cognitive-behavioural therapy without the need for clinical assessment.

Although programmes such as IAPT may potentially save significant amounts of money, there are concerns. Many are worried about their continued funding in the current economic climate. For example, IAPT is believed to be particularly at risk after 2011 given that its targets focus on returning individuals to employment at a time when redundancies will be on the increase. There is a risk that the continued funding of such psychological

therapy programmes for common mental disorders could be at the expense of secondary care services for more serious mental illnesses. Such services have the expertise and experience to deal with patients with complex needs that programmes such as IAPT are not able to deal with.

A middle ground is required where doctors and other professionals in secondary care work more closely with programmes such as IAPT to deal with complex and difficult cases, but striking this balance will require careful planning.

POSITIVE OUTCOMES AND INTEGRATION

Investing for positive outcomes in mental health produces savings in other areas of public sector finances. For example, in the previous section we outlined the Bradley review recommendation that investment in criminal justice mental health teams can result in savings in the criminal justice system of as much as £20000 in each case (Sainsbury Centre for Mental Health, 2009c) as well as reductions in re-offending rates. However, there need to be incentives to encourage such cross-sector activity, including better decision-making and planning across different systems in a joined-up way.

5 ALLOCATIVE EFFICIENCIES

As part of a local debate about what to invest in, it may be appropriate to discuss what services to disinvest in. These discussions need to be led locally and the processes involved need to be fully open and transparent.

BRING PATIENTS BACK INTO LOCAL SERVICES

The large amount of money spent by some PCTs on out-of-area treatments (OATs; Box 7) is an expense that should be addressed. Doing so, where appropriate in individual cases, will enable the delivery of appropriate services nearer to a patient's home area, which will provide better care at a lower overall cost.

Box 7 OUT-OF-AREA TREATMENTS

OATs are used by the NHS to fund care that is not available from a local provider. Instead, PCTs commission care from a provider in another geographical area. This can result in service users and families travelling some distance from home to receive care. Even where the distance is not great, being placed outside the local area can lead to a lack of continuity of care coordination and care management, which may result in longer stays and greater costs than necessary.

In 2004–5, OATs cost the NHS £222 million, an increase of 63% on the previous year (Mental Health Strategies, 2005).

Residential and nursing care placements provide an example of the scale to which OATs are being used. A recent freedom of information enquiry to PCTs and local authorities in England found that approximately one-quarter of all placements funded were OATs, costing 65% more than local

placements and with an estimated cost to the NHS and local authorities in 2008–9 of over £300 million. Consequently, some rehabilitation services and PCTs (e.g. Islington, Bromley, Hackney) have set up systems to review and 'repatriate' people placed in OATs to their area of origin, usually to less restricted settings such as supported tenancies. In doing so, one PCT was able to 'repatriate' 17 of its 40 clients in OATs, at a saving of £1 million per year, giving an indication of the size of the potential savings to be made (H. Killaspy, personal communication, 2009).

TO MAKE THE BEST DECISIONS, COMMISSIONERS NEED SUPPORT

A new relationship with commissioners needs to be developed. Far greater support needs to be given to mental health commissioners and increased investment needs to be made in their training and development.

A key reason for this is that given projected levels of public spending for mental health services, commissioners will have fewer resources available to them and will be under increased pressure to make difficult decisions. It is therefore vital that mental health commissioners have the knowledge, skills and access to the latest evidence and service developments in order to make decisions that will generate the best health and economic outcomes. They should also ensure that where patients move between different services during their care and treatment (e.g. because of age or changing need) this transition is well-coordinated and does not have a negative impact on the patient's health. Unfortunately, to date, this has not always been the case.

Conclusion

The challenge of the economic downturn for the mental health sector is clear: a likely increase in demand, coupled with reduced funding levels and an emphasis on maintaining quality, efficiency and patient benefit.

The Royal College of Psychiatrists, the Mental Health Network, NHS Confederation and the London School of Economics will continue to work together to address these challenges.

The College will work with its members and stakeholders across psychiatric specialties and geographical regions to address issues of service redesign and patient benefit. It will also consider how clinicians can be further supported with financial and management training to co-lead on these initiatives.

The Mental Health Network, NHS Confederation will continue to work on behalf of its members to encourage the spread of innovative responses to the efficiency challenge nationally and to represent the views of providers in the national policy debate.

The London School of Economics and Political Science, through Professor Martin Knapp, will continue to clearly voice the need for improved evidence on care and treatment interventions within mental health, and the mechanisms for furnishing commissioners, clinicians and managers with such evidence.

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