



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and NHS England

Mental health services: preparations for improving access

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Department of Health and NHS England

Mental health services: preparations for improving access

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

19 April 2016

This report sets out the landscape of mental health services generally and the access and waiting times programme specifically, and considers the arrangements the Department of Health and NHS England are putting in place to implement the programme.

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Foreword

Around one in four adults reports being diagnosed with a mental illness at some point in their lives. Mental health problems cover a broad range of disorders, including depression and anxiety, psychosis and eating disorders. The conditions vary in nature and severity, but all can have a detrimental effect on the health of the people affected and their quality of life. They also have a significant impact on the economy and society more generally.

The health system faces a huge challenge in preventing, diagnosing and treating mental health conditions. Significant numbers of people with mental health problems are not currently diagnosed or treated. In February 2016, the Mental Health Taskforce concluded that "... many people living with mental health problems struggle to get the right help at the right time, and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable."

In 2011, the government set an ambition to achieve 'parity of esteem' between mental health and physical health. This would mean valuing mental health as much as physical health, for example in terms of access to care and allocation of resources on the basis of need.

There is clear consensus that parity of esteem is a laudable policy objective, which aims to rectify decades of people's mental health being treated as less important than their physical health. But it is also clear that making parity of esteem a reality and improving support for people with mental health problems will not be a quick or easy process. Evidence from past initiatives indicates that it takes years to embed change successfully across the health system.

Furthermore, our work indicates that the health system is embarking on this course of action against a background of considerable uncertainty. The Department of Health (the Department) has not estimated how much it will cost to achieve parity of esteem, but the amount is likely to be significant. The Department expects most of the cost to be met from existing budgets, but at the same time NHS commissioners and providers are under increasing financial pressure. The government has committed to providing additional money to implement the NHS *Five Year Forward View*, but there will be many demands competing for this funding. Clinical commissioning groups will have difficult choices to make. Unless efficiencies can be found or services provided in different ways, there is a risk that they will find it difficult to increase spending on mental health services or achieve the desired pace of change without affecting other services.

In addition, at present the Department and NHS England lack the organised and comprehensive information they need to plan and implement a change programme of this kind. In some service areas, data are not available to help them understand the gap between what is happening now and what would be needed to achieve parity of esteem.

Faced with a challenge of this scale, the Department and NHS England are taking a pragmatic approach. Setting new standards for the time people should wait for mental health treatment and the care they should be able to access is a first step towards making mental health services more consistent with the established approach for physical health.

This report looks at the preparations the Department, NHS England and other arm's-length bodies are making for improving access to mental health services. It is the first output in what we expect to be a long-term programme of work on mental health in the coming years, covering both the health system's progress in improving support for people with mental health problems and how mental health issues are tackled more widely across government.

Key facts

£11.7bn

NHS England’s estimate
of spending on mental
health in 2014-15

12%

estimated proportion
of NHS England’s total
spending that was on
mental health in 2014-15

25%

of people needing mental
health services have
access to them

- 26%** of adults reported, in 2014, being diagnosed with at least one mental illness at some point in their lives
- 3.3 million** people in England known to be suffering from depression in 2014-15
- up to 3 in 100** people may experience psychosis in their lifetimes
- £120 million** additional funding the Department of Health and NHS England made available to support implementation of access and waiting time standards for mental health over the two years 2014-15 and 2015-16
- between 7% and 99%** proportion of patients treated within the six-week target for improved access to psychological therapies in 2014-15, by clinical commissioning group
- 7%** of acute hospitals had a liaison psychiatry service operating 24 hours a day, seven days a week, in 2014-15

Summary

1 Around one in four adults in England is diagnosed with a mental illness at some point in their lives, and may need to use mental health services. Mental health conditions cover a broad range of disorders of varying severity. The most common problems are conditions such as depression, anxiety and panic disorders. In 2014-15, 3.3 million people were known to be suffering from depression. Psychosis is less common but more severe, and may affect up to three in every 100 people during their lives. Other forms of mental illness include eating disorders and personality disorders.

2 In 2014-15, the NHS spent an estimated £11.7 billion on mental health services, some 12% of total spending. Mental health services include a range of interventions offered in community, inpatient and primary care settings, which may need to be integrated and multidisciplinary. Treatment may include medication, such as anti-psychotic drugs, anti-depressants or mood stabilisers, appropriate psychological therapies (sometimes called 'talking therapies') and other interventions that evidence has indicated are effective.

3 The Department of Health (the Department) is ultimately accountable for securing value for money from spending on healthcare, including mental health services. It sets objectives for NHS England through an annual mandate and holds it to account for the outcomes the NHS achieves. In the 2015-16 mandate, the Department set out its expectation that NHS England would introduce access and waiting time standards in key areas of mental health services by March 2016, as part of its wider objective to work towards 'parity of esteem' between mental and physical health. Parity of esteem means that mental health is valued as much as physical health, for example in terms of access to care and allocation of resources on the basis of need.

Why are we looking at improving access to mental health services?

4 Mental health conditions can have a significant impact on the people affected, the health system, and the economy and society more widely. People with mental health conditions are more likely than others to be homeless, to live in areas of high social deprivation and to be unemployed. They are also more likely to have physical health problems and to attend hospital accident and emergency departments. Mental health problems cost the UK economy an estimated £105 billion each year.

5 Good access to mental health services matters. Many people can make a full recovery if they receive appropriate, timely treatment. However, a high proportion of people with mental health conditions do not have access to the care they need. Only around 25% of those estimated to need mental health services have access to them.

6 Over the past decade, the Department and government more widely have had a series of initiatives aimed at improving mental health services. This report is the first in what we plan will be a programme of work on mental health. It sets out the landscape of mental health services generally (Part One) and the access and waiting times programme specifically (Part Two), and considers the arrangements the Department and NHS England are putting in place to implement the programme (Part Three). This first report focuses mainly on services for adults, and concentrates on work being done by the Department and its arm's-length bodies. We set out our audit approach in Appendix One and our evidence base in Appendix Two.

Key findings

7 The Department and NHS England have made a clear commitment, supported by action, to improve mental health services for people who need them. In October 2014, they set, for the first time, standards for the access to some mental health services that people should expect and how long they should have to wait for treatment. The Department and NHS England initially made specific undertakings to improve three particular services: improved access to psychological therapies (IAPT); early intervention in psychosis; and liaison psychiatry. There is consensus that achieving the standards and ambitions set out in these areas should lead quickly to improved services and outcomes for people with a wide range of mental health conditions (paragraphs 1.16 to 1.19, 2.1 and 2.3).

8 Implementing the access and waiting time standards depends on action by many local commissioners and providers working in a complex system.

Most mental health services are commissioned by clinical commissioning groups to meet the needs of the people within their area. There are a variety of service providers including NHS bodies and private and third-sector organisations. These devolved delivery arrangements mean that the Department and NHS England depend on a flow of reliable information about the services patients are receiving. Information is crucial for effective oversight of local performance and to support local and national accountability for how delivery bodies have used public money (paragraphs 1.6, 1.7 and Figure 3).

9 Estimates of the full cost of implementing access and waiting time standards vary widely, and most of the cost will be met from clinical commissioning groups' existing budgets.

The Department and NHS England made available a total of £120 million of additional funding over the two years 2014-15 and 2015-16 to support the access and waiting times programme. NHS England has reviewed clinical commissioning groups' plans but, because the additional money is not ring-fenced, there is limited assurance that it has been spent as NHS England intended. The full cost of implementing access and waiting time standards and meeting ambitions for IAPT, early intervention in psychosis and liaison psychiatry services is not well understood. The Department's 2014 impact assessment estimated the cost would be £160 million a year more than the estimated £663 million that clinical commissioning groups spent in 2014-15 on these services. We have seen subsequent indicative analysis that suggests that the cost of improving access further could be substantially higher (paragraphs 2.12 to 2.21 and Figure 8).

10 Full data do not exist to measure how far the NHS is from meeting the new access and waiting time standards, but it is clear that achieving the standards will be a very significant challenge.

- **Nationally, the access and waiting time standards for IAPT are already being met but performance varies substantially between different areas, and the recovery standard is not being met.** The IAPT programme increases access to approved treatment, usually talking therapies, for depression and anxiety disorders. The programme is well-established and has data to measure performance. In 2014-15, 79% of people entered treatment within six weeks of referral, and 96% within 18 weeks, against targets of 75% and 95% respectively. However, 83 of the 211 clinical commissioning groups (39%) did not achieve the six-week standard. In 2014-15, 45% of those treated moved to recovery against a target of 50% (paragraphs 2.4, 2.5 and Figure 6).
- **Complete data to measure performance for early intervention in psychosis are not yet available.** Early intervention in psychosis services are designed to treat people quickly after they are referred for treatment following the onset of a suspected first episode of psychosis. There are limited data to measure how long people wait compared with the standard that more than 50% of those experiencing a first episode of psychosis should start treatment with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral. Data system changes are being made to collect and publish better information. In March 2016, the Health and Social Care Information Centre published a small set of provisional statistics based on data collected in January 2016. Further work is needed to improve the accuracy and completeness of the new mental health services dataset, so in December 2015 NHS England also started to collect, under interim arrangements, aggregate waiting time information (paragraphs 2.6, 2.7 and 3.17 to 3.22).
- **A survey of acute hospitals in July 2015 indicated that 7% had a liaison psychiatry service operating 24 hours a day, seven days a week.** This is the minimum standard NHS England considers all hospitals should be providing. The Department and NHS England have set an ambition that by 2020 all acute hospital trusts should have a liaison psychiatry service for all ages appropriate to their size, acuity and specialty. These services are designed to ensure people have access, in general acute hospitals, to mental health assessment and short-term care services, and links to follow-up support, if they need them (paragraphs 2.8 to 2.11).

11 The Department and NHS England are making progress, particularly in setting priorities and national leadership, but significant risks to implementing the access and waiting times programme remain. We assessed the arrangements that have been put in place against six criteria that influence whether programmes are likely to be implemented successfully. The strongest areas are the clear objectives and strong leadership, and a clear governance framework is being developed. The greatest challenges for the future are collecting data to show whether the standards are being met, building the mental health workforce and reinforcing incentives for providers (Figure 1 overleaf).

Concluding comments

12 Introducing access and waiting time standards is an important first step towards the ambitious goal of achieving parity of esteem between mental health and physical health. Successfully implementing this programme should help to improve services and outcomes for the large number of people who are affected by mental ill health at some point in their lives. Our review has shown that the Department and NHS England, working with other bodies, are starting to make progress with the actions needed to put their aspirations into practice.

13 Much remains to be done, as the Department and NHS England recognise, and not everything was in place when the access and waiting time standards took effect from April 2016. The Department and NHS England will need to work collaboratively and at pace with other arm's-length bodies and local NHS organisations if the new standards are to be implemented successfully. At this point, we highlight the following particular challenges that will need to be addressed:

- Ensuring there are enough staff with the right skills in the right locations to provide better access to mental health services.
- Generating accurate and up-to-date information so that all parties understand what is happening on the ground and the extent of the performance gap.
- Better integration of mental and physical health services, within and across health and social care services, to meet all the needs of people with mental health problems.
- Identifying the funding to support better access to mental health services, particularly given the financial pressure that many local commissioners and providers are facing.

Figure 1**Assessment of the arrangements for implementing better access to mental health services**

Assessment criteria	Current position	Making further progress
A. Objectives Do the Department and NHS England have clear objectives for the programme (paragraphs 3.4 to 3.8)?	Yes There are clear objectives in terms of national access and waiting time standards, and a timeline for achieving these. There is consistency between successive policy documents aiming to achieve parity of esteem between mental health and physical health.	Medium risk The Department and NHS England are developing interim milestones and targets needed to track progress. At the time of our work, NHS England, Monitor and the NHS Trust Development Authority were assessing the preparedness of local commissioners and providers to translate national objectives into local action plans, targets and milestones.
B. Governance Have the Department and NHS England put in place strong governance arrangements (paragraphs 3.9 to 3.12)?	Partly The Department and NHS England have set up important oversight boards involving all relevant organisations. However, supporting governance structures are not yet fully in place, and there is not yet sufficient evidence to assess whether the boards are effective.	Low risk The Department and NHS England are developing the frameworks, including terms of reference and local reporting structures, needed to implement the new governance arrangements.
C. Leadership Does the programme have effective leadership (paragraphs 3.13 to 3.16)?	Yes The programme has political support and senior civil service and clinical leadership.	Medium risk There is a risk of loss of momentum with the change of national clinical director for mental health in April 2016.
D. Performance information Do the Department and NHS England have robust performance information for the programme (paragraphs 3.17 to 3.22)?	Partly NHS England measures access and waiting times for IAPT, but does not yet have the full data needed to assess whether waiting time standards for early intervention in psychosis services are being met.	High risk For early intervention in psychosis, changing the data collected, and consequential changes to IT systems, is proving complex. NHS England has started to collect aggregate data in the interim, but there is a high risk that complete, high-quality data will not be available when the standards are introduced from April 2016.
E. Workforce capacity and capability Do service providers have enough staff with the right skills to implement the programme (paragraphs 3.23 to 3.28)?	Partly Data to assess the skills, capability and geographical distribution of the current workforce are variable. Data are strongest for staff working in the IAPT programme. Until recently, very limited information was available nationally about the workforce needed for early intervention in psychosis and liaison psychiatry services.	High risk Plans are not yet in place to ensure there will be adequate staff to meet standards for early intervention in psychosis and ambitions for liaison psychiatry services. Local estimates of the number of mental health nurses needed vary markedly from those made by Health Education England.
F. Levers and incentives Are there adequate levers and incentives to help ensure the NHS makes the changes needed to achieve the programme's objectives (paragraphs 3.29 to 3.37)?	Partly The access standards are being incorporated in accountability frameworks and the NHS standard contract. However, payment systems for mental health services are less mature than those for physical health. Nine in ten mental health providers were paid using block contracts in 2015-16. Some mental health services do not fall within the regulatory remit of the Care Quality Commission.	High risk NHS England is working with Monitor to develop alternative payment systems for mental health, but cost data that could be used as the basis for new contracts is of variable quality and may not be comparable between organisations.

Part One

Mental health services

1.1 The World Health Organization defines mental health as ‘a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.¹ Many people experience periods in their lives when they do not have this sense of well-being and may need to draw on mental health services. In 2014, 26% of adults in England reported having been diagnosed with at least one mental illness at some point in their lives. A further 18% reported having experienced a mental illness but not having been diagnosed.²

1.2 This part of the report sets out background information on mental health conditions and services, and recent initiatives to improve services.

Mental health conditions

1.3 Mental health conditions include a broad range of disorders of varying severity (**Figure 2** overleaf). Most conditions may be temporary or intermittent, but some, such as dementia, are permanent or progressive.

1.4 People of all ages may be affected by mental health conditions. An estimated 50% of people with lifetime mental health problems experience symptoms by the age of 14, with 75% experiencing symptoms by their mid-20s. One in ten children between the ages of 5 and 16 has a mental health problem and between 10% and 13% of 15- to 16-year-olds have self-harmed.³

1.5 Many people can make a full recovery from mental health conditions if they receive appropriate, timely treatment consistent with best practice guidance published by the National Institute for Health and Care Excellence (NICE). Mental health services include a range of interventions offered in community, inpatient and primary care settings, which may need to be integrated and multidisciplinary. Treatment may include medication, such as anti-psychotic drugs, anti-depressants or mood stabilisers, appropriate psychological therapies (sometimes called ‘talking therapies’) and other interventions that evidence has indicated are effective. However, only around 25% of those estimated to need mental health services gain access to them.⁴

¹ World Health Organization, *Mental health: a state of well-being*, August 2014.

² Health and Social Care Information Centre, *Health Survey for England, 2014*, December 2015.

³ National Statistics, *Mental health of children and young people in Great Britain 2004*, August 2005.

⁴ London School of Economics, *How mental illness loses out in the NHS*, June 2012.

Figure 2

Examples of mental health conditions

Condition	Description	Prevalence
Depression, anxiety and panic disorders	The most common mental health conditions. Depression, anxiety and panic disorders are classed as severe forms of normal emotional experiences.	In 2014-15, 3.3 million people in England were known to be suffering from depression. Some 10% of new mothers experience post-natal depression.
Psychotic disorders	These include the most severe mental health conditions. Psychosis interferes with individuals' perception of reality, causing them to experience hallucinations or delusions. Psychotic disorders include schizophrenia and bipolar disorder.	In 2014-15, some 500,000 people were known to be suffering from psychotic disorders. It is estimated that psychosis may affect up to three in every 100 people at some point in their lives.
Eating disorders	A range of psychological disorders characterised by abnormal or disturbed eating habits, including anorexia nervosa, bulimia and binge-eating disorder.	In 2013-14, there were around 2,900 admissions to hospital as a result of an eating disorder. It is estimated that anorexia nervosa affects around one in 250 women and one in 2,000 men. Bulimia is two to three times more common than anorexia nervosa, and some 90% of people affected are women. An estimated 5% of the population suffer from a binge-eating disorder.
Degenerative conditions	These conditions tend to be related to ageing, such as dementia and Alzheimer's disease.	In 2014-15, around 419,000 people were known to be suffering from dementia. In 2013, the Department of Health acknowledged that only around half of people with dementia were diagnosed. The Alzheimer's Society estimated that, by 2015, 850,000 people would be living with dementia, rising to one million by 2025.
Substance misuse	This occurs when a user consumes a substance in amounts or with methods that are harmful to themselves or others.	In 2014-15, some 295,200 individuals were in contact with drug and alcohol services. Just over half of those in contact with treatment services presented with problematic use of opiates.

Sources: Health and Social Care Information Centre, *Quality and Outcomes Framework 2014-15*, 2015; Royal College of Psychiatrists, *Postnatal Depression*, 2014; NHS, *NHS Choices: Psychosis* and *NHS Choices: Eating disorders*, 2014; Health and Social Care Information Centre, *Eating Disorders by CCG, 2012-13 to 2013-14*, 2015; Department of Health, *Dementia, A state of the nation report on dementia care and support in England*, 2013; Alzheimer's Society, *Dementia diagnosis rates*, 2015; Public Health England, *Adult substance misuse statistics from the National Drug Treatment Monitoring System*, 2015

Responsibilities and accountabilities

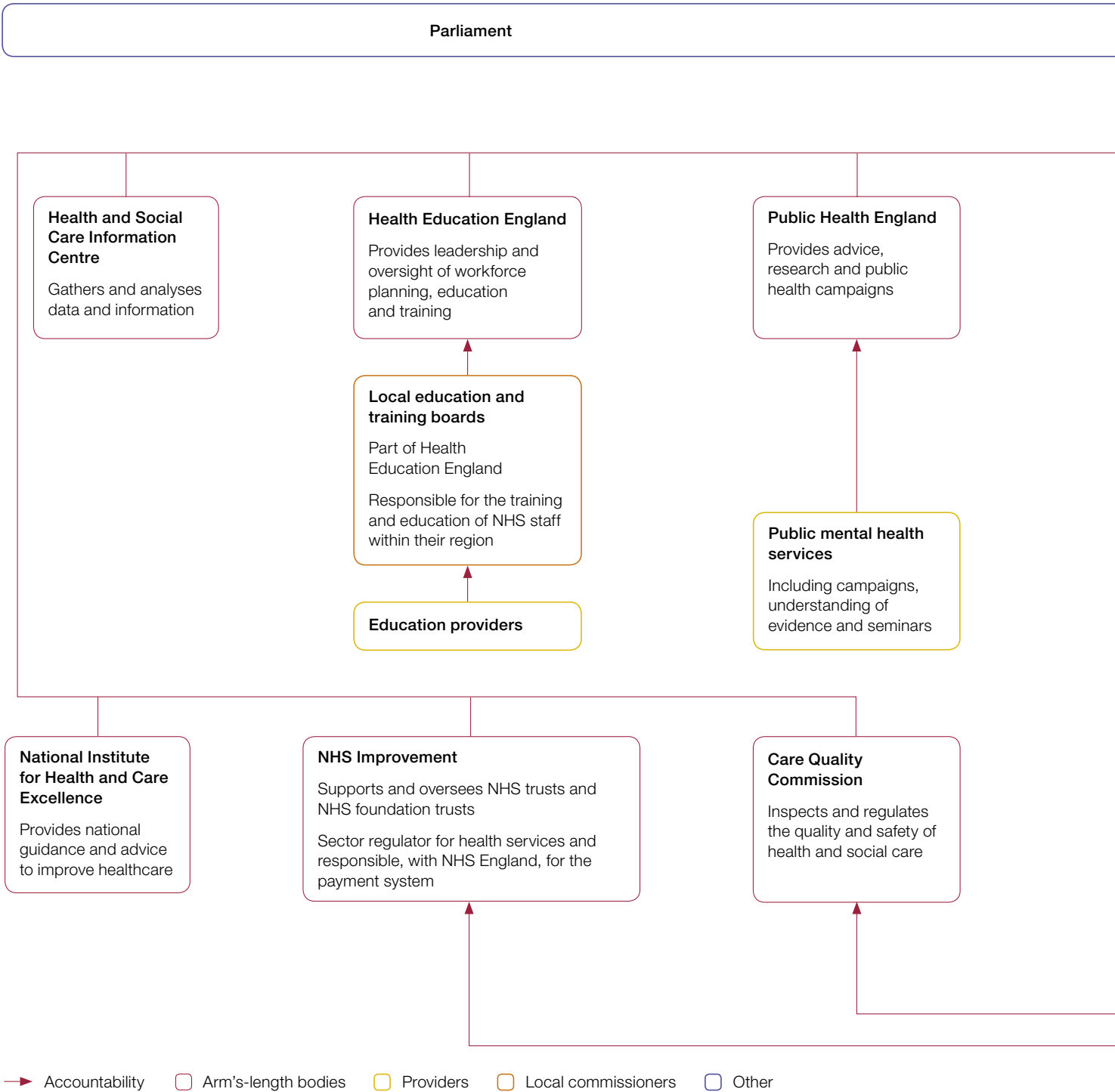
1.6 The Department of Health (the Department) is ultimately responsible for securing value for money from spending on mental health services. The Department is the steward of the health system and relies on a system of assurance around the commissioning, provision and regulation of healthcare.

1.7 The system for delivering mental health services is fragmented, involving a variety of national and local bodies (**Figure 3** on pages 16 and 17). Responsibility for commissioning and providing services is largely devolved to local bodies.

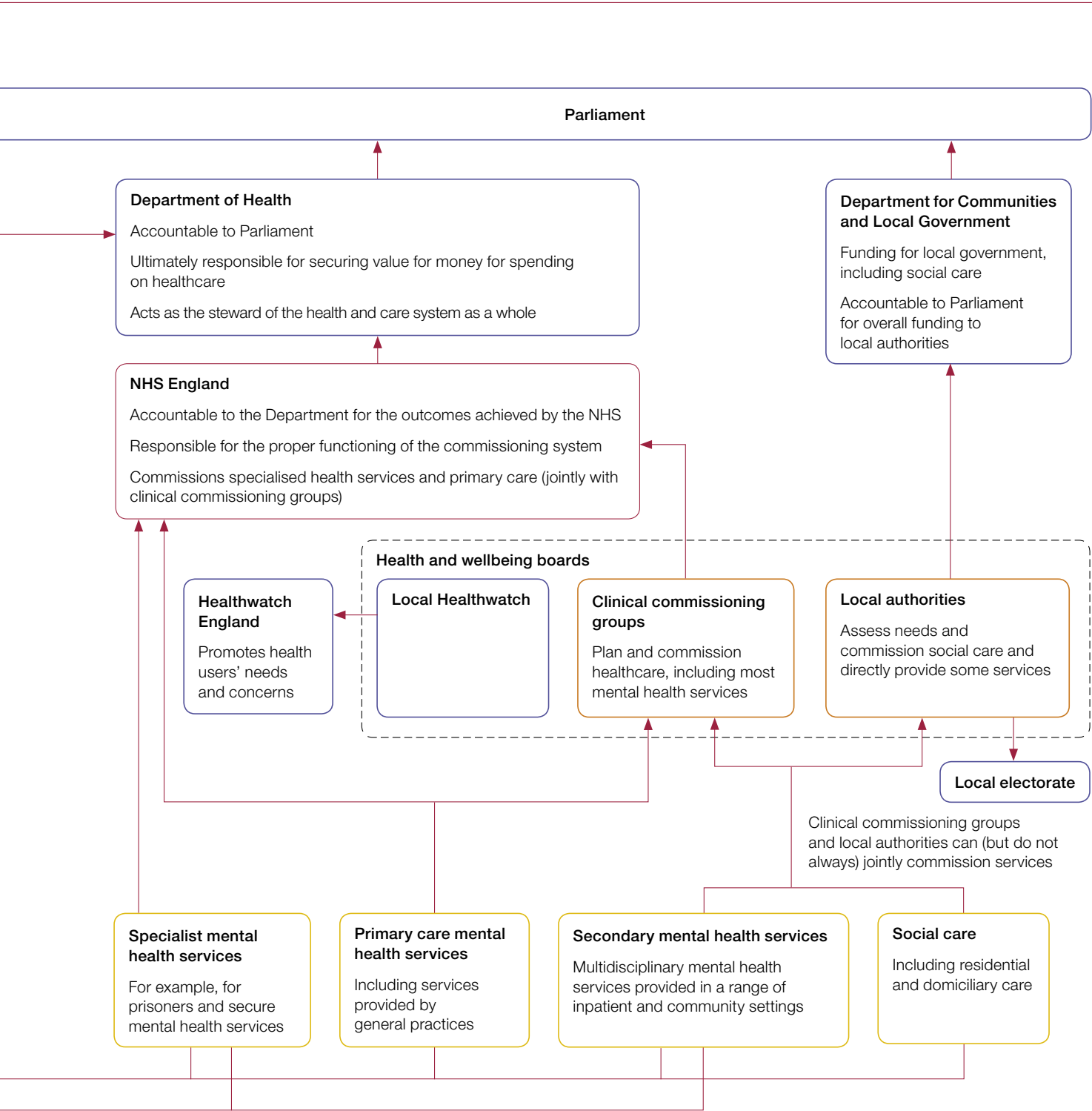
- The Department is responsible for overall policy and funding, within the legislative framework set by Parliament. It routes the majority of funding for mental healthcare through an arm's-length body, NHS England, and sets objectives through an annual mandate.
- NHS England is accountable to the Department for the outcomes achieved by the NHS, and is responsible for the proper functioning of the commissioning system as a whole. It directly commissions primary care services (jointly with clinical commissioning groups in many local areas) and specialised mental health services. It allocates funding to clinical commissioning groups for hospital and community mental health services.
- The 209 clinical commissioning groups purchase most mental health services for their local populations.⁵ Either alone, or jointly with local authorities, they commission mental healthcare from service providers. They are accountable to NHS England, through an assurance process, for delivering their statutory functions, including improving health outcomes for their populations. They are also accountable locally to their governing boards and to health and wellbeing boards.
- Mental health providers include trusts that provide mental health services (NHS trusts and NHS foundation trusts), other NHS providers, third-sector providers (such as charities and social enterprises) and private companies. NHS trusts and NHS foundation trusts are overseen by NHS Improvement, which comprises the NHS Trust Development Authority and Monitor.

⁵ The number of clinical commissioning groups fell from 211 in 2014-15 to 209 in 2015-16.

Figure 3
National and local bodies involved in mental health services



Note
1 NHS Improvement comprises Monitor and the NHS Trust Development Authority.



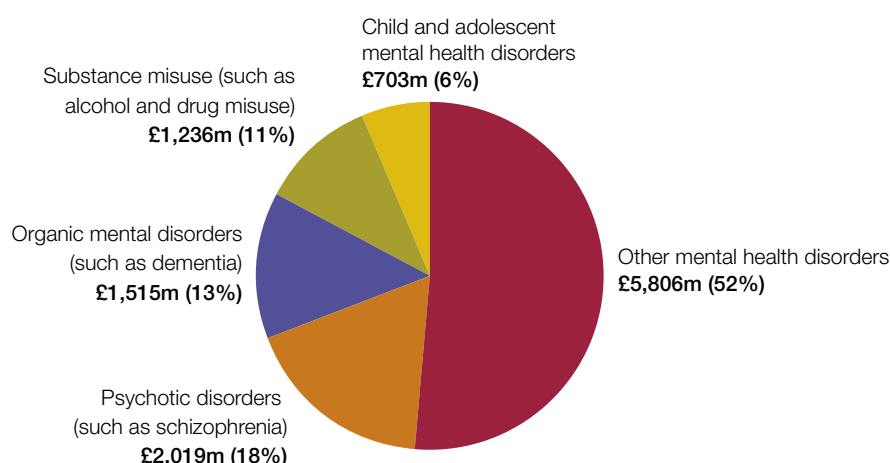
Spending

1.8 Information on how much the NHS spends on mental health services, in total and on treating specific conditions, is limited and not up-to-date. The funding that NHS England allocates to clinical commissioning groups is a combined amount for acute hospital care, community health services and mental health services. The money is not earmarked for particular services and decisions about how to use the funding rest with individual clinical commissioning groups. This means that information about how local commissioners have spent their allocations can only be collected retrospectively. NHS England undertakes an annual 'programme budgeting' exercise to collect information from local commissioners, but there is a considerable time lag. The most recent published data, released in June 2015, relate to spending in 2013-14. In September 2014, NHS England asked commissioners about their spending plans. Using the information provided, NHS England estimated that £11.7 billion would be spent on mental health services in 2014-15.

1.9 In 2014-15, the Department gave a total of £97.4 billion to NHS England for all NHS services. The estimated £11.7 billion spending on mental health services represents 12% of this total. NHS England directly commissioned around £3.7 billion of mental health services, including secure and other specialised services, primary care and services for those in prison or custody or in the armed forces. Clinical commissioning groups estimated that they would spend £7.9 billion on mental health services.

1.10 Limited data are available to attribute spending on mental health services to specific conditions. In its 2013-14 exercise to collect spending data, NHS England asked clinical commissioning groups for information about the care settings in which they had purchased mental health services. Some 86% of spending was on 'community and integrated care'. NHS England has no reliable data matching 2013-14 expenditure to treatment for different mental health disorders. This means that the cost of addressing specific conditions, and the potential cost of meeting currently unmet need, can only be estimated.

1.11 The Department completed a similar data collection exercise for expenditure in 2012-13, before the reforms to the health system, when primary care trusts commissioned services. Primary care trusts spent £11.3 billion on mental health services in 2012-13. That information did categorise spending by disorder, although only in broad terms. More than half of the expenditure was classed as relating to 'other' mental health disorders (**Figure 4**). Because the commissioning arrangements changed, spending in 2012-13 is not directly comparable to spending in subsequent years. For example, substance misuse services are now commissioned by local authorities.

Figure 4**Spending on mental health services by disorder, 2012-13****More than half of spending was not attributed to a specific mental health disorder**

Source: National Audit Office, using spending data collected from the 2012-13 programme budgeting benchmarking tool, NHS England, 2014

Why access to mental health services is important

1.12 Mental health conditions can have a significant impact on all aspects of the lives of those affected. According to the Mental Health Foundation, “people with mental health problems are more likely to be homeless, more likely to live in areas of high social deprivation, more likely to have fewer qualifications, and are less able to secure employment” than the general population.⁶

1.13 People with complex mental health problems are also less likely than others to access services for physical health problems. People with schizophrenia, for example, are almost twice as likely to die from heart disease as the general population, and four times more likely to die from respiratory diseases. In young people, mental illness is strongly associated with behaviours likely to pose a risk to health, such as smoking, drug and alcohol abuse, and risky sexual behaviour.

1.14 For people with mental health conditions, poor access to the mental and physical health services they need may lead to greater pressure on hospital services. The Health and Social Care Information Centre has found that mental health service users are more likely than other people to access accident and emergency services, to arrive by ambulance and to stay in hospital for longer. Our analysis also suggests that people with mental health conditions are more likely to arrive at accident and emergency departments during the night. The Care Quality Commission reported in June 2015 that too many people in crisis have poor experiences of care that fails to meet their needs and is unsafe.⁷

⁶ Mental Health Foundation, *Fundamental Facts about Mental Health 2015*, October 2015.

⁷ Care Quality Commission, *Right here right now*, June 2015.

1.15 Mental health problems cost the UK economy an estimated £105 billion each year. Some 44% of people claiming Employment and Support Allowance report that they have mental health or behavioural problems. For those who are in employment, mental health problems can have a significant detrimental effect on their ability to carry out their work effectively. The Centre for Mental Health estimates that around 70 million days are lost from work each year due to mental ill health, making it the leading cause of sickness absence in the UK.⁸ Some 60% of adults living in hostels have a personality disorder, and an estimated 90% of prisoners have a diagnosable mental health problem or substance misuse problem, or both, with 70% having two or more recognised conditions.

Initiatives to improve mental health services

1.16 Over the past decade successive governments have launched a series of initiatives aimed at improving mental health services (**Figure 5**). The ‘improved access to psychological therapies’ programme was piloted in 2006, nearly ten years ago, and rolled out in 2008. This was a standalone initiative to make clinically proven therapies more widely available, but did not at that stage form part of a broader strategy for mental health.

1.17 Since then outcomes for patients, and corresponding actions and targets, have become better defined. In 2011, the government published an overarching strategy, *No health without mental health, a cross-government mental health outcomes strategy for people of all ages*, which set a new goal to achieve ‘parity of esteem’ between services for people with mental and physical health problems.⁹

1.18 Because the concept of parity of esteem is not well understood, the Department asked an expert reference group established by the Royal College of Psychiatrists to develop a clear definition and recommendations for how to achieve parity in practice.¹⁰ The group’s report described parity of esteem as valuing mental health equally with physical health. This would be demonstrated by:

- equal access to the most effective and safest care and treatment;
- equal efforts to improve the quality of care;
- allocation of time, effort and resources on a basis commensurate with need;
- equal status within healthcare education and practice;
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

⁸ Centre for Mental Health, *Mental health at work: developing the business case*, December 2007.

⁹ HM government, *No health without mental health, a cross-government mental health outcomes strategy for people of all ages*, February 2011.

¹⁰ Royal College of Psychiatrists, *Whole-Person Care: From rhetoric to reality*, March 2013.

Figure 5

The government's main mental health initiatives since 2008

Successive governments have sought to improve mental health services



Source: National Audit Office

1.19 Thirteen government departments along with two other government bodies – the Health and Safety Executive and the Government Equalities Office – committed to taking action to achieve the six specific objectives identified in *No health without mental health*. There were some actions that applied to the whole of government, such as providing a healthy living environment and helping vulnerable groups. Three years later, in 2014, the Department published *Closing the Gap*, which set out 25 priority areas for change to achieve the six objectives.¹¹

1.20 In February 2016, the Mental Health Taskforce, commissioned by NHS England, published *The Five Year Forward View for Mental Health*.¹² The Taskforce was a national group chaired by the chief executive of the mental health charity Mind and also including clinical experts, experts by experience, arm's-length bodies, voluntary-sector representatives and professional bodies. Its report was critical of the quality of support currently provided for people with mental health problems. It concluded that for those experiencing mental health problems the main priorities are prevention, access to services, integration, quality and a positive experience of care. These priorities are consistent with the priority areas that the Department had set out in *Closing the Gap*.

1.21 The Mental Health Taskforce made 58 recommendations. Most of the recommendations were for NHS England, working with other arm's-length bodies in the health system, and were aimed at achieving the ambition of parity of esteem between mental and physical health for all age groups. The Taskforce also highlighted the importance of issues such as employment and housing to people's mental health, and recommended actions for the Department and other parts of government where it considered that wider action was needed.

¹¹ Department of Health, *Closing the Gap: Priorities for essential change in mental health*, February 2014.

¹² Mental Health Taskforce, *The Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England*, February 2016.

Part Two

Access and waiting time standards

2.1 The Department of Health (the Department) and NHS England recognised that making parity of esteem a reality would need changes to give greater priority to mental health services. In October 2014, they jointly published *Achieving Better Access to Mental Health Services by 2020*.¹³ This set new standards for the time people should wait for mental health treatment and the care they should be able to access. The introduction of the standards has made mental health services more consistent with the established approach for physical health.

2.2 This part of the report sets out the main elements of the access and waiting times programme, and the additional funding provided to support the programme.

Main elements of the access and waiting times programme

2.3 The Department completed an impact assessment in September 2014 that envisaged a staged implementation of access and waiting time standards across all mental health services between 2015-16 and 2019-20. However, because of the funding available and uncertainty about future policy priorities ahead of the General Election in 2015, the Department and NHS England developed firm proposals for only three specific areas of mental health provision: **improved access to psychological therapies (IAPT), early intervention in psychosis** and **liaison psychiatry**. From a long-list of options, they considered that these three areas had the strongest evidence base supporting the likelihood of positive outcomes for users. As such, *Achieving Better Access to Mental Health Services by 2020* can be seen as the start of a programme of work rather than a comprehensive plan for all mental health services.

¹³ Department of Health and NHS England, *Achieving Better Access to Mental Health Services by 2020*, October 2014.

Improved access to psychological therapies (IAPT)

Aimed at:	People with depression and anxiety disorders.
Undertaking:	15% of adults with a relevant disorder will have timely access to IAPT services. 50% of those who complete treatment will recover. 75% of people referred to the IAPT programme will be treated within six weeks of referral, and 95% will be treated within 18 weeks of referral.
Implementation date:	Access and recovery standards in March 2015. Waiting time standards in April 2016.
2014-15 performance across England:	An estimated 13% of those with relevant disorders received treatment. The recovery standard was not achieved nationally, with 45% of those treated moving to recovery. The waiting time standards were exceeded nationally: 79% of people referred entered treatment within six weeks of referral and 96% within 18 weeks. There was, however, local variation.
Intended benefits for patients:	More patients treated and shorter waiting times, encouraging fewer patients to drop out and more GPs to refer patients to the service. Treatment leads to health and well-being gains for the individual and savings for the NHS through reduced use of other health services.

2.4 The IAPT programme increases access to National Institute for Health and Care Excellence (NICE) approved treatment for depression and anxiety disorders. Appropriate psychological therapies are offered which may, where necessary, be combined with medication.¹⁴ IAPT was piloted at two demonstration sites in 2006, before being rolled out across the NHS from 2008 onwards. The most recent data show that:

- 1.3 million people were referred to the programme in 2014-15, of whom 496,000 (39%) were self-referrals;
- 816,000 (63%) of the people referred entered treatment; and
- 285,000 (61%) of the 469,000 people who finished the course of treatment showed reliable improvement.¹⁵

¹⁴ The therapies include, for example, cognitive behavioural therapy, interpersonal psychotherapy, brief dynamic interpersonal psychotherapy, couples therapy and counselling.

¹⁵ Health and Social Care Information Centre, *Psychological therapies annual report on the use of IAPT services, England 2014-15 and data reference tables*, November 2015.

2.5 It has taken time for the IAPT programme to reduce how long people have to wait for treatment after being referred. The Health and Social Care Information Centre reported that in 2012-13, four years after the roll-out of the programme, 63% of people who entered treatment did so within four weeks and 84% within eight weeks.^{16,17} In comparison, in 2014-15, 79% of people who entered treatment did so within six weeks and 96% within 18 weeks. This meant the new standards were being achieved nationally (see table above). However, there was significant regional variation (**Figure 6** overleaf). In the worst performing clinical commissioning group only 7% of people entered treatment within six weeks, while the best performing clinical commissioning group achieved 99%. In three clinical commissioning groups fewer than 25% of people entered treatment within six weeks of referral.

Early intervention in psychosis

Aimed at:	People experiencing their first episode of psychosis and people at high risk of developing psychosis.
Undertaking:	More than 50% of people referred with a suspected first episode of psychosis will start treatment with a NICE-approved care package within two weeks of referral.
Implementation date:	April 2016.
2014-15 performance across England:	No data available.
Intended benefits for patients:	People are more likely to have improved clinical, social and employment outcomes as a result of prompt, effective care. Improved outcomes mean people are less likely to need other health services thereby reducing long-term costs to the NHS.

2.6 Evidence suggests that people experiencing a first episode of psychosis are likely to have better mental health outcomes if their condition is identified and treated quickly.¹⁸ Services for early intervention in psychosis are intended to reduce the time people have to wait for treatment after being referred by a GP. Subsequent treatment could be up to three years of interventions, including anti-psychotic medication, psychological therapies, physical health interventions and support with social needs such as education, employment and accommodation.

¹⁶ In 2012-13, 19% of people who had been referred for treatment had not had their first treatment appointment, been referred to another service or been found to not require treatment. These figures do not take these referrals into account even if they waited longer than four or eight weeks.

¹⁷ Before 2014, IAPT waiting times were measured in four blocks: up to four weeks; between four and eight weeks; between eight weeks and three months; and more than three months. In 2014, the standards were brought in line with those for many physical health services, measuring waiting times in blocks of up to six weeks, up to 18 weeks and more than 18 weeks.

¹⁸ Department of Health, *Mental health promotion and mental illness prevention: The economic case*, April 2011.

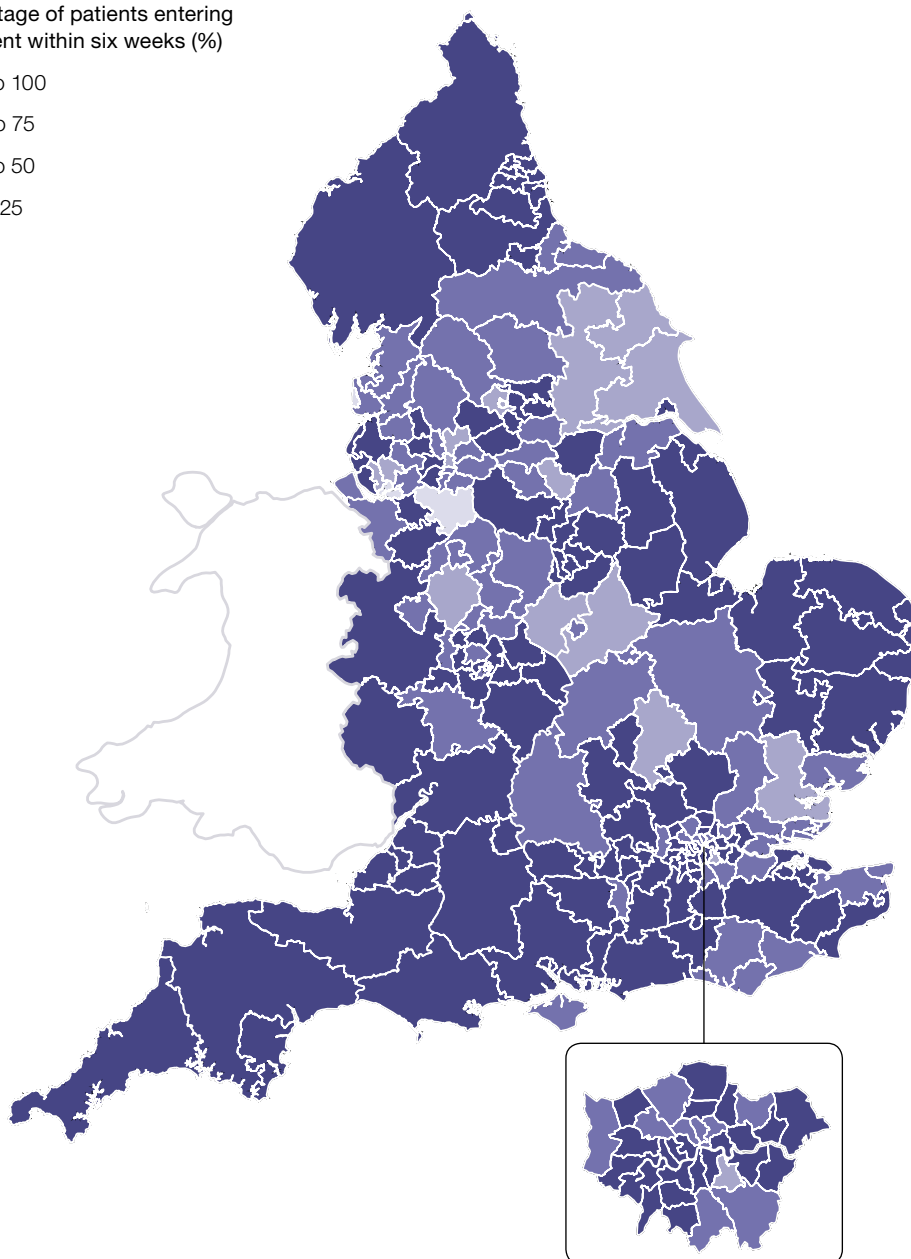
Figure 6

The proportion of people in England referred to IAPT who entered treatment within six weeks, by clinical commissioning group, 2014-15

In 2014-15, 128 out of 211 clinical commissioning groups met the target that at least 75% of patients referred to IAPT should enter treatment within six weeks, meaning that 83 clinical commissioning groups did not meet the target

Percentage of patients entering treatment within six weeks (%)

- 75 to 100
- 50 to 75
- 25 to 50
- 0 to 25



Note

1 The number of clinical commissioning groups fell from 211 in 2014-15, as shown, to 209 in 2015-16.

Source: National Audit Office analysis of Health and Social Care Information Centre data

2.7 There are currently no comprehensive data on how long people experiencing a first episode of psychosis have to wait before they start an appropriate NICE-approved care package (see paragraphs 3.17 to 3.22).

Liaison psychiatry

Aimed at:	People who arrive at accident and emergency departments or are admitted to hospital with both mental and physical health problems.
Undertaking:	<p>A commitment to spend £30 million in 2015-16 to make effective liaison psychiatry services available in more hospitals. The quality of liaison psychiatry will inform the Care Quality Commission's assessment of hospital trusts.</p> <p>A longer-term aspiration that, subject to the views of the next government and the spending review, by 2020 all acute trusts should have a liaison psychiatry service for all ages appropriate to the size, acuity and specialty of the hospital.</p>
Implementation date:	By the end of 2015-16.
2014-15 performance across England:	7% of acute hospitals with emergency departments had a liaison psychiatry service, operating 24 hours a day seven days a week.
Intended benefits for patients:	People have access to integrated mental health and physical health services, leading to better health outcomes, reduced lengths of stay and lower readmission rates.

2.8 The Department and NHS England's ambition for liaison psychiatry is to extend availability of clinical psychiatric diagnosis, treatment and referral services to patients attending general acute hospitals, and for people's mental and physical health needs to be assessed and treated in an integrated way.¹⁹ This ambition covers patients attending outpatient clinics and accident and emergency departments, and those admitted to inpatient wards.

2.9 It is not uncommon for people who come to accident and emergency departments to be experiencing both physical and mental health issues. For example, for some people, physical symptoms such as pain and abdominal conditions have an underlying mental health cause. People with physical health conditions, particularly long-term conditions such as cancer, may also experience psychological problems. Clinical teams with embedded liaison psychiatry services, for example in accident and emergency departments, are better placed to consider people's mental and physical health in an integrated way.

¹⁹ *Achieving Better Access to Mental Health Services by 2020* referred to 'liaison psychiatry' to cover a variety of multidisciplinary mental health services working in integrated clinical teams.

2.10 The Royal College of Psychiatrists has identified four possible models of liaison psychiatry service depending on the size and nature of the hospital. These range from a basic service for emergencies and unplanned visits available during normal working hours only, to an enhanced specialist 24-hour service available seven days a week. There is consensus that general hospitals are not identifying all mental health issues among their patients, and that the quantity and quality of services is likely to vary.

2.11 NHS England considers that a liaison psychiatry service, available 24 hours a day seven days a week, is the minimum level of service that should be expected in any acute hospital with an emergency department operating 24 hours a day, seven days a week. A survey of acute hospitals published in July 2015 indicated that, in 2014-15, 7% were providing this level of service or better, and 6% of acute hospitals had no liaison psychiatry service at all.²⁰ In January 2016, the government announced funding of £247 million over the next five years to help achieve this standard of care in at least half of acute hospitals by 2020. The Mental Health Taskforce recommended in February 2016 that, by 2020-21, every acute hospital should have a liaison psychiatry service appropriate for patients of all ages in emergency departments, and that at least 50% of acute hospitals should have a service available 24 hours a day, seven days a week.

Funding for access and waiting time standards

2.12 The Department and NHS England have allocated some additional funding to support the access and waiting times programme, totalling £120 million over the two years 2014-15 and 2015-16. However, the amounts are relatively small and commissioners are expected mainly to use their existing budgets to fund improvements in services. This will be challenging given the current pressure on the financial position of NHS commissioners and providers.

2.13 The NHS *Five Year Forward View*, published in October 2014, estimated that there could be a £30 billion gap between resources and patient needs by 2020-21. The government has committed to increasing funding by £8 billion by 2020, meaning the NHS will need to make efficiencies of £22 billion to close the gap.

Additional funding in 2014-15

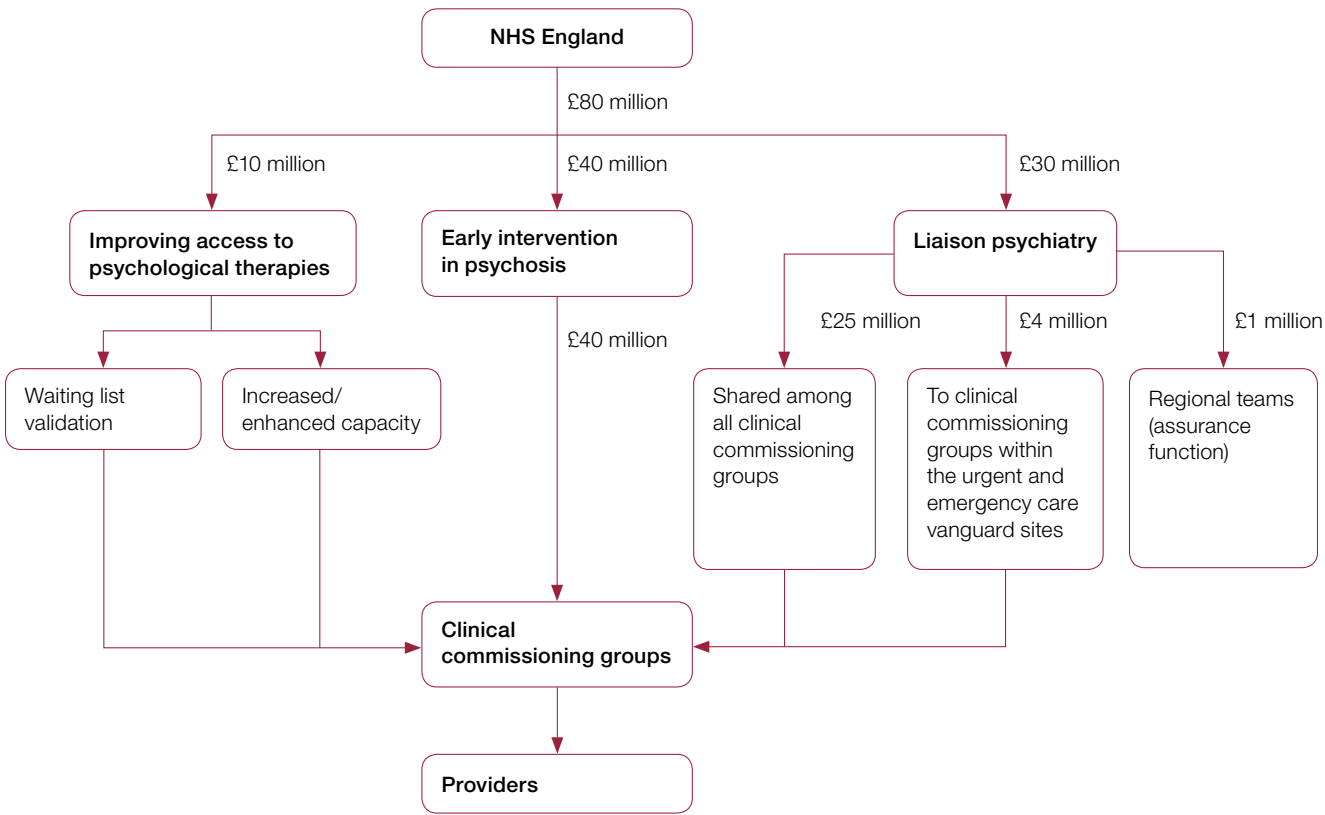
2.14 In October 2014, the Department gave NHS England £40 million of additional, one-off funding for 2014-15. NHS England allocated most of this money to clinical commissioning groups to support extending access to early intervention services and crisis care. It also made a grant of £1.5 million, via NICE, to the National Collaborating Centre for Mental Health to support developing and implementing the ambitions set out in *Achieving Better Access to Mental Health Services by 2020*.

20 NHS England and the National Collaborating Centre for Mental Health, *Report of the 2nd Annual Survey of Liaison Psychiatry in England*, 2015.

Additional funding in 2015-16

2.15 In 2015-16, NHS England made available a further £80 million to support changes needed to implement the access and waiting times programme. **Figure 7** shows how NHS England intended to divide this money between IAPT, early intervention in psychosis and liaison psychiatry.

Figure 7
Additional funding in 2015-16 for access and waiting time standards



Source: National Audit Office

2.16 NHS England made most of the additional money (£79 million) available to clinical commissioning groups to fund locally commissioned services. It allocated the remaining £1 million to its regional assurance teams to support clinical commissioning groups in meeting access and waiting time standards, and to ensure systems were in place to record performance against the standards from April 2016.

Impact of additional funding

2.17 NHS England made most of the additional funding available to clinical commissioning groups. It made clear that the money should be spent on mental health services, although clinical commissioning groups were free to decide exactly how to use the additional money. NHS England has reviewed clinical commissioning groups' plans and challenged those where spending on mental health services was not expected to increase by at least the same percentage as the increase in the group's total funding. However, as for other health services, the funding was not ring-fenced, which means that NHS England has limited assurance that the money is in fact being spent to improve mental health services.

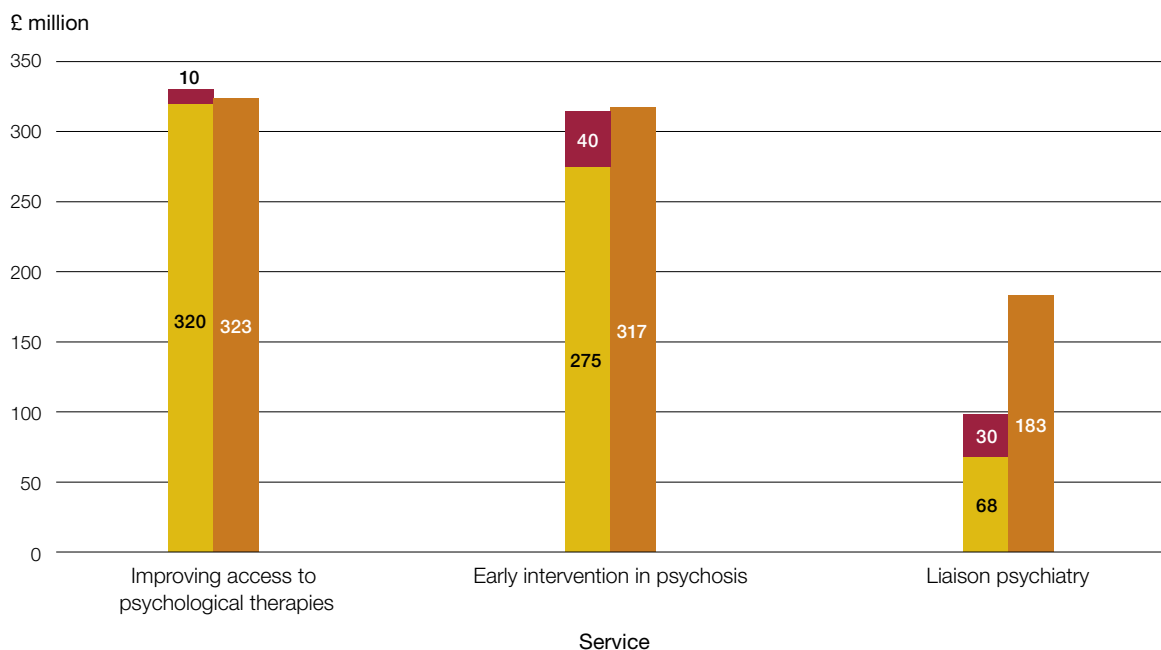
2.18 The Department and NHS England do not view the additional money as intended to cover the full cost of meeting the new access and waiting time standards. The extra funding is small in the context of both the total NHS budget and spending on mental health. The limited available data indicate that the funding represents a small proportion of existing spending on IAPT, early intervention in psychosis and liaison psychiatry (**Figure 8**). Estimates of the cost of fully meeting the access and waiting time standards vary widely. The estimate in the Department's 2014 impact assessment was that the cost would be £160 million a year more than the estimated £663 million that clinical commissioning groups spent in 2014-15 on these services. In common with the other services they commission, clinical commissioning groups will have to meet most of the cost of achieving the standards in future from their general funding allocations rather than relying on additional nationally targeted funding.

2.19 In its impact assessment for the programme in 2014, the Department made indicative estimates that access and waiting time standards for IAPT could be met from existing funds.²¹ The additional £10 million earmarked for IAPT services in 2015-16 was allocated to help poorly performing clinical commissioning groups improve and will not be allocated again in future years. The Department set an aspiration that, subject to the views of the next government and the spending review, by 2020 95% of patients referred to the IAPT programme should enter treatment within six weeks of referral. It estimated that this would cost an additional £63.5 million a year to achieve.

21 Department of Health, *Access and Waiting Time Standards for 2015-16 in Mental Health Services, Impact Assessment*, September 2014.

Figure 8**The cost of IAPT, early intervention in psychosis and liaison psychiatry services**

The limited available data indicate that the additional funding represents a small proportion of existing spending on IAPT, early intervention in psychosis and liaison psychiatry



■ Additional funding provided through the *Achieving Better Access* programme in 2015-16

■ Estimate of current annual spending included in the Department's impact assessment in September 2014

■ Estimates in the Department's impact assessment in September 2014 of: annual spending required to achieve access and waiting time standards for IAPT and early intervention in psychosis, and an adequate liaison psychiatry service in all acute hospitals

Notes

1 In 2015, a survey was conducted to assess spending on liaison psychiatry. It found that, at that time, across all acute hospitals, an estimated £211 million was being spent each year, indicating that the estimate of current spending in the impact assessment was too low.

2 The additional funding provided for IAPT and liaison psychiatry was non-recurrent.

Source: National Audit Office analysis of the Department's impact assessment and NHS England data

2.20 The Department estimated in its impact assessment that providing adequate access to early intervention in psychosis services would cost £317 million per year. In 2015-16, NHS England made available additional funding of £40 million for these services. Clinical commissioning groups will continue to receive this additional funding in future years. The Department set an aspiration that, by 2020, 95% of patients experiencing a first episode of psychosis should be treated with a NICE-approved care package within two weeks of referral. We have seen indicative estimates of the cost of a different level of service. There is substantial uncertainty surrounding these estimates, but putting in place enough staff with the right skills for all people experiencing a first episode of psychosis to access treatment within six weeks of referral could cost £576 million a year.

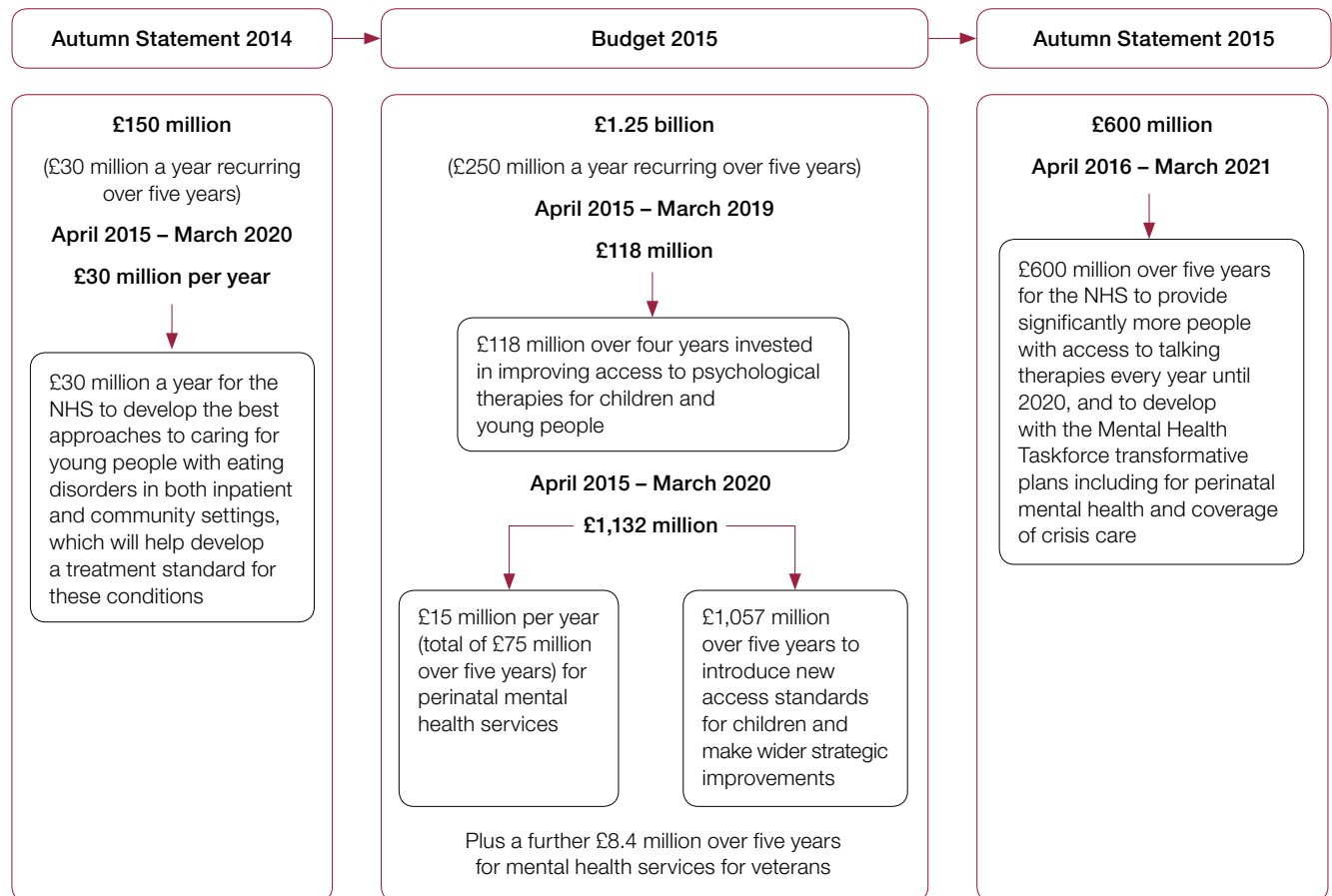
2.21 Additional funding provided for liaison psychiatry will not on its own be enough to put adequate provision in place in all acute hospital trusts. The Department and NHS England currently have insufficient data to support a robust assessment of the extent of unmet need in local communities for liaison psychiatry services. Based on information from the Royal College of Psychiatrists, the Department estimated in its impact assessment that providing an adequate liaison psychiatry service in all trusts would cost approximately £183 million a year. It also estimated that clinical commissioning groups were spending £68 million a year, meaning there was a shortfall of some £115 million. Illustrative analysis in the impact assessment suggested that the additional £30 million allocated in 2015-16 would be sufficient to set up core liaison psychiatry services in around 35 hospitals. This money will not be allocated again in future years. Subsequent indicative analysis suggested that providing a liaison psychiatry service, operating 24 hours a day seven days a week, could cost £538 million a year, although there is substantial uncertainty around this estimate.

Further funding to develop services in the future

2.22 Since October 2014, the government has made several funding announcements about specific areas of mental health services, including eating disorders, perinatal mental health and children's mental health services (**Figure 9**). In January 2016, it announced how £1 billion of additional funding would be used over the next five years. Its proposals include: £290 million for mental health services for new and expectant mothers; £247 million for mental health services in hospital emergency departments (see paragraph 2.11); and more than £400 million to provide treatment 24 hours a day in communities and homes for people experiencing a mental health crisis, as a safe and effective alternative to hospital admission. The government also plans to introduce access and waiting time standards for services for children and young people with eating disorders from 2017-18.

Figure 9

Major funding announcements about mental health services since 2014



Sources: HM Treasury, *Autumn Statement 2014*, December 2014; HM Treasury, *Budget 2015*, March 2015; and HM Treasury, *Spending Review and Autumn Statement 2015*, November 2015

Part Three

Implementing better access to mental health services

3.1 This part of the report assesses how well placed the Department of Health (the Department) and NHS England are to implement the commitments outlined in *Achieving Better Access to Mental Health Services by 2020*.

3.2 Drawing on our work across government, we identified six common criteria that influence whether programmes are likely to be implemented successfully:

- a** clear objectives;
- b** strong governance;
- c** effective leadership;
- d** robust performance information;
- e** sufficient workforce capacity and capability; and
- f** appropriate levers and incentives.

3.3 We applied these six criteria to assess the current position and what further steps may be needed to implement mental health access and waiting time standards. Our findings are summarised in Figure 1 of this report.

A Objectives

Do the Department and NHS England have clear objectives for the programme?

What do we mean?	There is a clear statement of what the programme is seeking to achieve, against which success can be measured.
Why is this important?	As many organisations are contributing to the programme, it is particularly important for them to have a shared understanding of the programme's objectives, and clarity about each individual body's role.
What would we expect to see?	<p>A shared vision for the programme among all parties involved.</p> <p>A limited number of clearly articulated objectives that align with the vision.</p> <p>Clearly identified intermediate steps needed to achieve the longer-term objectives.</p>

Current position

3.4 The Department and NHS England have set five broad objectives split into two phases. Two of the objectives are measurable standards to improve access and reduce waiting times for improved access to psychological therapies (IAPT) and early intervention in psychosis services. The other three objectives are expressed in terms of increased financial investment to help improve the quality of care, but they did not quantify the extent of the improvement expected.

3.5 The new access and waiting time standards are a step towards achieving the parity of esteem envisaged in the 2011 cross-government strategy, *No health without mental health*. The programme's objectives set out in *Achieving Better Access to Mental Health Services by 2020* align well with those previously set out in *Closing the Gap and No health without mental health* (**Figure 10** on pages 36 and 37).

Making further progress

3.6 As the programme progresses, the Department and NHS England will need interim milestones and targets to measure whether they are on track to achieve their objectives. Monitoring can provide assurance that things are progressing as planned or early warning that progress is behind schedule, allowing time for corrective action to be taken.

3.7 Clinical commissioning groups and mental health providers will be responsible for meeting the access and waiting time standards from April 2016. To help achieve this, they will need to translate the national objectives into local plans, milestones and targets. Local commissioners are free to decide how to use resources to meet the needs of their local populations, but NHS England expects them all to meet national standards in order to avoid regional disparities in access and waiting times. At the time of our work, NHS England, Monitor and the NHS Trust Development Authority were assessing the preparedness of local commissioners and providers to translate national objectives into local action plans, targets and milestones.

Figure 10

Alignment of objectives to achieve access and waiting time standards with the longer-term strategy to improve mental health

	Objectives in Closing the Gap (Department of Health, February 2014)			
	Increasing access to mental health services	Integrating physical and mental healthcare	Starting early to promote mental well-being and prevent mental health problems	Improving the quality of life of people with mental health problems
Objectives in Achieving better access to mental health services by 2020 (Department of Health, October 2014)	Phase 1 – 2014-15: Laying the groundwork			
	Continue to roll out children and young people's IAPT programme, so that more children are cared for in appropriate settings ¹	✓	✓	✓
	Invest in early intervention services for psychosis and crisis care, including A&E liaison psychiatry and home treatment teams ²	✓	✓	✓
	Phase 2 – 2015-16: Implementing the first standards³			
	75% of those referred to IAPT to be treated within six weeks and 95% within 18 weeks	✓	✓	✓
	More than 50% of people experiencing a first episode of psychosis should start treatment with a NICE-recommended package of care within 2 weeks of referral	✓	✓	✓
	Invest £30 million in liaison psychiatry in acute hospitals	✓	✓	✓

Notes

1 *Achieving Better Access to Mental Health Services by 2020*, paragraph 27.

2 *Achieving Better Access to Mental Health Services by 2020*, paragraphs 28 and 31.

3 *Achieving Better Access to Mental Health Services by 2020*, paragraph 35.

Source: National Audit Office

Objectives in *No health without mental health*

(cross-government, February 2011)

More people
will have good
mental healthMore people
with mental
health problems
will recoverMore people
with mental
health problems
will have good
physical healthMore people will
have a positive
experience of
care and supportFewer people
will suffer
avoidable harmFewer people will
experience stigma
and discrimination

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3.8 The Mental Health Taskforce's *Five Year Forward View for Mental Health*, published in February 2016, set out a vision for services that was consistent with the objectives of the access and waiting times programme, and the wider ambitions that the government has set out over a number of years.²²

B Governance

Have the Department and NHS England put in place strong governance arrangements?

What do we mean?	There are processes and organisational structures through which the Department and NHS England can oversee, coordinate and control the resources and actions relating to the programme, and manage the risks to successful implementation.
Why is this important?	Strong and active governance is needed to oversee progress, maintain accountability and scrutinise value for money. As implementing the access and waiting time standards is devolved to local commissioners and providers, clearly defined responsibilities and accountabilities are needed to ensure consistency.
What would we expect to see?	Well-defined responsibilities and accountabilities, supported by clear mechanisms for reporting information, and well-understood powers to intervene in the event of unacceptably poor performance. Effective risk management and external scrutiny that is acted upon.

Current position

3.9 The Department and NHS England have set up important oversight boards, involving relevant organisations, but supporting governance structures are not yet fully in place. Because they are relatively new, there is not yet sufficient evidence to assess the effectiveness of these boards in holding programme managers to account.

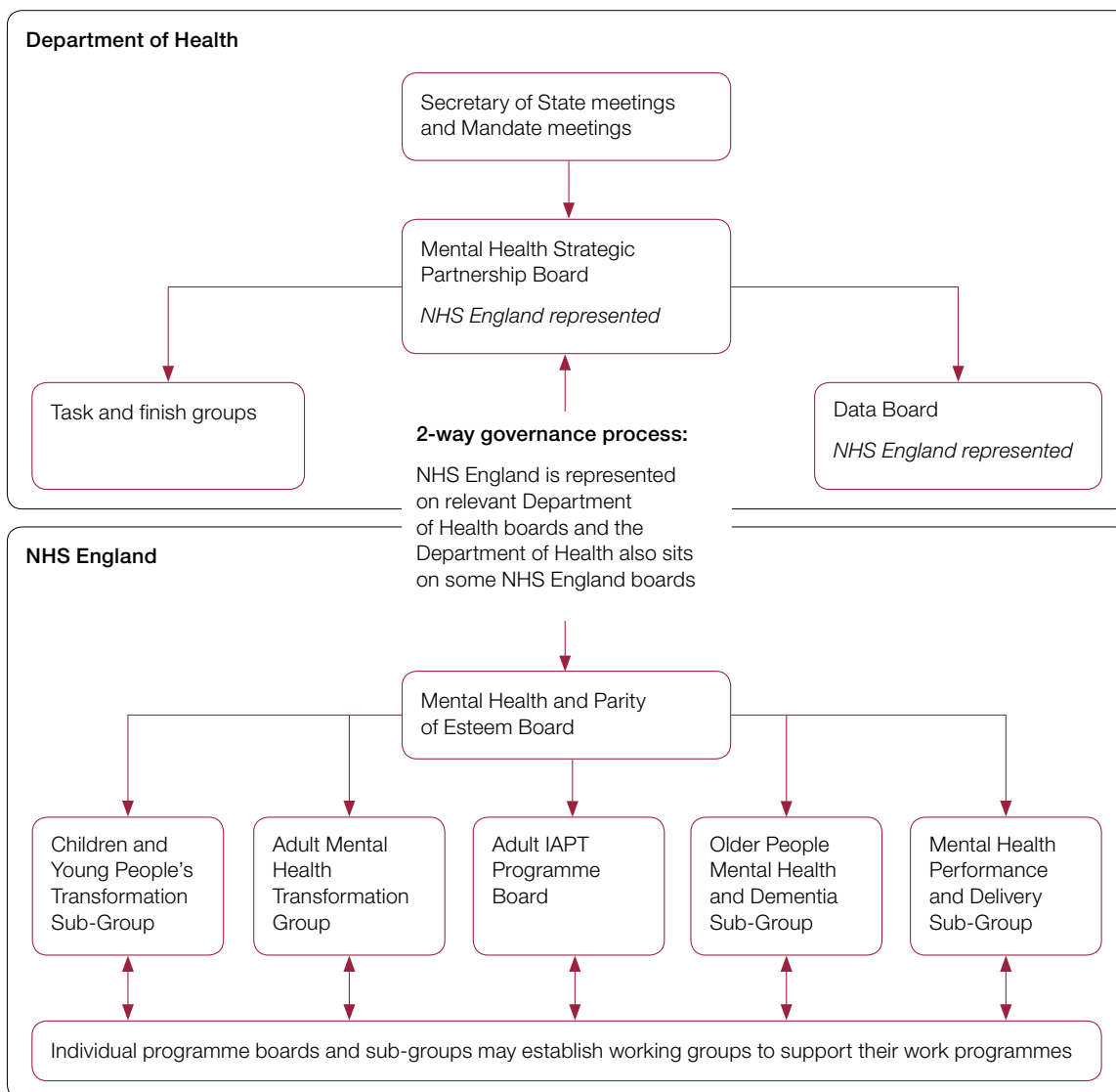
- In the Department, the Mental Health Strategic Partnership Board is responsible for giving high-level strategic direction to the bodies responsible for achieving parity of esteem. The board first met in November 2015. It is a cross-government board and includes representatives from all the major health arm's-length bodies, the Department for Education, the Department for Work & Pensions, the Home Office, the Ministry of Justice and the Local Government Association.
- In NHS England, the Mental Health and Parity of Esteem Board, which held its first meeting in February 2015, focuses on achieving relevant commitments in NHS England's mandate. The board has a particular focus on the mental health and parity of esteem work programme, for which it will be held accountable. Membership of the board includes the national clinical directors for mental health, dementia and young people at NHS England as well as representatives from the Department, Health Education England and the Health and Social Care Information Centre.

²² Mental Health Taskforce, *The Five Year Forward View for Mental Health*, February 2016.

3.10 The Department and NHS England are setting up a complex structure to support the two oversight boards (**Figure 11**). Boards, sub-boards and working groups, cutting across the Department and NHS England, will be responsible for different aspects of mental health services. These include, but are not confined to, the *Achieving Better Access to Mental Health Services by 2020* programme.

Figure 11

The central governance structure for mental health that the Department and NHS England are putting in place



Source: National Audit Office, based on information from the Department and NHS England

Making further progress

3.11 NHS England is continuing to develop the frameworks needed to implement its governance arrangements. For example, the terms of reference for the Mental Health and Parity of Esteem Board were finalised in April 2015 but do not set out who reports to it, and nor do they establish arrangements for external scrutiny of the programme. At the end of 2015, the Mental Health and Parity of Esteem Board had not finalised a risk register that would give assurance that risks across the programme are being well managed.

3.12 Following publication of the Mental Health Taskforce's report, NHS England has started to review the Mental Health and Parity of Esteem Board's work programme and the governance structures that will support the work programme.

C Leadership

Does the programme have effective leadership?

What do we mean?	There is visible commitment to the programme from senior people in national and local organisations.
Why is this important?	Strong and consistent leadership maintains momentum, secures staff commitment and encourages the cultural change required for successful implementation.
What would we expect to see?	<p>The leadership team is stable and leaders are visible and have adequate capacity to lead the programme actively.</p> <p>Leaders encourage honesty and realism about progress and listen to, and act on, feedback.</p> <p>Senior managers support the programme, and have sufficient authority and credibility to progress action.</p> <p>There is clear political support.</p>

Current position

3.13 There is evidence of considerable support, at senior level, for the access and waiting time standards and the wider strategy to achieve parity of esteem. From 2010, the coalition government prioritised improving mental health services, and the current government's manifesto included a commitment to enforce the new access and waiting time standards for people experiencing mental ill-health. The Department advised us that the Secretary of State for Health requests regular updates on progress.

3.14 The national Strategic Partnership Board is chaired by a director general at the Department. Clinical leadership and insight is provided by the national clinical director for mental health, who sits on the NHS England Mental Health and Parity of Esteem Board. The previous and current national clinical directors are consultant psychiatrists.

3.15 There is a central team within NHS England responsible for national elements of the programme such as working with the Health and Social Care Information Centre to identify changes in the data collected to allow performance against the standards to be monitored. It also supports NHS England's regional teams and coordinates work with other arm's-length bodies. NHS England staff have been visible and active, consulting with commissioners and providers, and offering them guidance and information to take the programme forward.

Making further progress

3.16 NHS England announced in January 2016 that the national clinical director for mental health would be stepping down from the role. NHS England appointed a new national clinical director for mental health, and three supporting associate national clinical directors, in April 2016. It will need to manage the change in leadership carefully to maintain momentum and transfer knowledge.

D Performance information

Do the Department and NHS England have robust performance information for the programme?

What do we mean?	The Department and NHS England have information to monitor progress that is accurate, complete and up-to-date.
Why is this important?	Robust performance information, reported at regular intervals, enables organisations to prioritise effort and resources, track risks, measure progress and take prompt action if progress is not as expected.
What would we expect to see?	<p>A clear baseline of performance at the start.</p> <p>A set of evidence-based measures, including interim measures, to assess performance as the programme progresses.</p> <p>Information systems that collect the data required to measure progress.</p> <p>Timely reporting of data, subject to quality control measures to ensure its accuracy and completeness.</p>

Current position

3.17 The Department and NHS England do not yet have all the data needed to assess performance against the access and waiting time standards. In its impact assessment for the programme in 2014, the Department recognised it did not have the same quality of data and transparency about performance for mental health services as for physical health services. It noted that much better information would be needed to make long waits for mental health treatment visible and prompt them to be tackled. Producing data in the format needed to measure performance is an important component of the access and waiting times programme.

3.18 The data available vary in usefulness for measuring performance:

- Data for IAPT are more advanced. This initiative has been in place since 2008, and steps to collect relevant data were built in from the start. NHS England is able to use data published by the Health and Social Care Information Centre to measure how long people wait for psychological therapies. This information shows that most clinical commissioning groups are already meeting the targets.
- Access and waiting time data for early intervention in psychosis have not historically been collected. NHS England therefore worked with the Health and Social Care Information Centre to specify new data collection requirements. The Standardisation Committee for Care Information, a group involving the Department, NHS England, the Health and Social Care Information Centre and other arm's-length bodies, specifies the data providers must submit and that IT system suppliers must be able to generate. As long as they comply with these standards, providers and suppliers are free to configure systems as they see fit. Some suppliers told NHS England that the new specification would involve changes to software and data systems. There will also need to be changes to how clinicians record information about patients, so that the time people wait, and the type of care they get, can be measured.

3.19 Changing the systems to capture the information needed on early intervention in psychosis has proved complicated. The Standardisation Committee for Care Information oversees the development, assurance and approval of information standards, data collections and data extractions in the NHS. The committee must approve all changes to how data is collected before new specifications are published, so that providers and IT system suppliers can make any necessary changes. It approved the changes for early intervention in psychosis data in July 2015. The deadline for suppliers and providers to comply with the new standards was 1 January 2016.

Making further progress

3.20 The Health and Social Care Information Centre hosted workshops for IT system suppliers in September 2015. Feedback from these events was incomplete, but suggested that around half of suppliers considered that their current IT systems could be adjusted to support collection of the new data required, meaning that others would not be ready. The first submission of the new data to the Health and Social Care Information Centre was due by late February 2016. Not all providers submitted data, but in March 2016 the Health and Social Care Information Centre published a small set of provisional statistics on mental health waiting times for early intervention in psychosis based on data collected in January 2016. There remains a risk that the Department and NHS England will not be able to track performance accurately against the access and waiting time standards using data compliant with the new specification.

3.21 In light of the delays in putting in place the arrangements for data collection, the Department and NHS England developed contingency plans to start measuring access and waiting times in April 2016 in a different way. For periods from December 2015 onwards, NHS England has been collecting monthly aggregated waiting time data for early intervention in psychosis. These will show, for each mental health provider and clinical commissioning group, the number of patients starting NICE-recommended treatment within two weeks of referral, as a proportion of all patients starting NICE-recommended treatment in the period. As these data are aggregated, they do not show information for individual patients and their access to mental health services in the way that the full data submission is planned to do. The data will, however, give for the first time an indicative baseline for waiting times for early intervention in psychosis services.

3.22 The Mental Health Taskforce highlighted in February 2016 that mental health lagged behind other areas of health in having consistent and reliable data. Its report noted that, although some good information was available, it was not coordinated or analysed usefully. It made a number of recommendations in this area, including that the Department, NHS England, Public Health England and the Health and Social Care Information Centre should develop a five-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services.

E Workforce capacity and capability

Do service providers have enough staff with the right skills to implement the programme?

What do we mean?	Local service providers have enough staff with appropriate skills to meet local needs and achieve access and waiting time standards.
Why is this important?	To achieve access and waiting time standards, there will need to be sufficient frontline staff with appropriate skills in the right locations.
What would we expect to see?	<p>Providers and Health Education England have a clear understanding of the existing workforce, including numbers, skills and locations.</p> <p>Providers and Health Education England have identified the workforce required, including numbers, skills and locations, and the gap between this and the existing workforce.</p> <p>Recruitment and training plans are in place to address any gaps identified.</p>

3.23 Providers must ensure that they have enough suitably qualified, competent and experienced staff, including psychiatrists, clinical psychologists and mental health nurses, to provide high-quality and safe care. Providers are responsible for employing staff and providing on-the-job training.

3.24 Health Education England, an arm's-length body of the Department, is responsible for providing leadership and oversight of workforce planning, education and training. It seeks to ensure that the NHS has the staff and skills it needs to meet current and future needs of patients. Through its 13 local education and training boards, it commissions and pays for clinical training places. In order to do this it estimates the future need for different staff groups, working collaboratively with local providers. Health Education England also has a limited role in funding training for qualified staff where this is needed to support major service change such as the access and waiting times programme.

Current position

3.25 Until recently, very limited information was available nationally about the capacity and capability of the workforce to support early intervention in psychosis and liaison psychiatry services (**Figure 12**):

- Data about the IAPT workforce are most advanced. NHS England carried out a workforce census for IAPT to collect data from providers in 2012 and 2014, and proposes that this should be a regular exercise. The census covers the number, specialism, seniority and location of IAPT practitioners.
- Health Education England commissioned a survey of the 2014-15 workforce for early intervention in psychosis services that was carried out in September and October 2015. The survey collected data from providers on the number of case coordinators, to inform an assessment of how many additional case coordinators would be needed. The survey also identified the number of therapists trained in the two main interventions, behavioural family therapy and cognitive behavioural therapy, to assess gaps in capacity and skills.
- NHS England commissioned a survey on current liaison psychiatry services in acute hospitals, in collaboration with the Royal College of Psychiatrists. The survey was carried out between January 2015 and April 2015, and collected data on numbers of full-time equivalent staff providing these services.

Figure 12

Data about the current mental health workforce and future requirements

	IAPT	Early intervention in psychosis	Liaison psychiatry
Current numbers known?	Yes	Yes	Yes
Qualifications and skills known?	Yes	Yes	Yes
Locations of workforce known?	Yes	Yes	Yes
Source of the information	Workforce census of service providers (2014)	Workforce survey of service providers (2015)	Survey of acute hospitals (2015)
Future workforce requirements known?	Partly	Limited understanding	Limited understanding
Plans to address gaps between current workforce and future requirements?	Yes	Partly	No

Source: National Audit Office

Making further progress

3.26 There are inadequate data to confirm the capacity and capability of the total mental health workforce needed within the NHS and other providers, particularly to support liaison psychiatry services. For mental health nurses specifically, data are available to show that the number employed by the NHS has fallen significantly since 2010. Health Education England considers that this is due to an increase in non-NHS provision of mental health services, and in the number of nurses employed by these providers, rather than a decline in services.²³ Alternative research conducted by the King's Fund suggests that the sustained drop in the number of mental health nurses within the NHS is unlikely to have been offset by increased private or third-sector provision.²⁴ In February 2016, the Mental Health Taskforce reported that the demand for temporary mental health nurses increased by two-thirds between 2013-14 and 2014-15.

3.27 More work needs to be done to understand the numbers of staff needed to meet access and waiting time standards. There is a considerable discrepancy between numbers that local providers estimate are required, and Health Education England's forecasts. Trusts forecast, for example, that their demand for mental health nurses will fall over the coming years. Health Education England, however, estimated that implementing access and waiting time standards would require the number of mental health nurses to rise from 39,000 in 2014 to 42,000 by 2020, an increase of 7% (**Figure 13** overleaf). Health Education England therefore increased the number of training places for mental health nurses, in line with its own estimates and above the level that providers forecast they would require.

3.28 The Mental Health Taskforce highlighted in February 2016 high vacancy rates in both consultant psychiatrist posts and psychiatry training. It recommended that Health Education England should work with other bodies to develop a strategy for the future shape and skill mix of the workforce that would be needed to deliver improvements in mental health services.

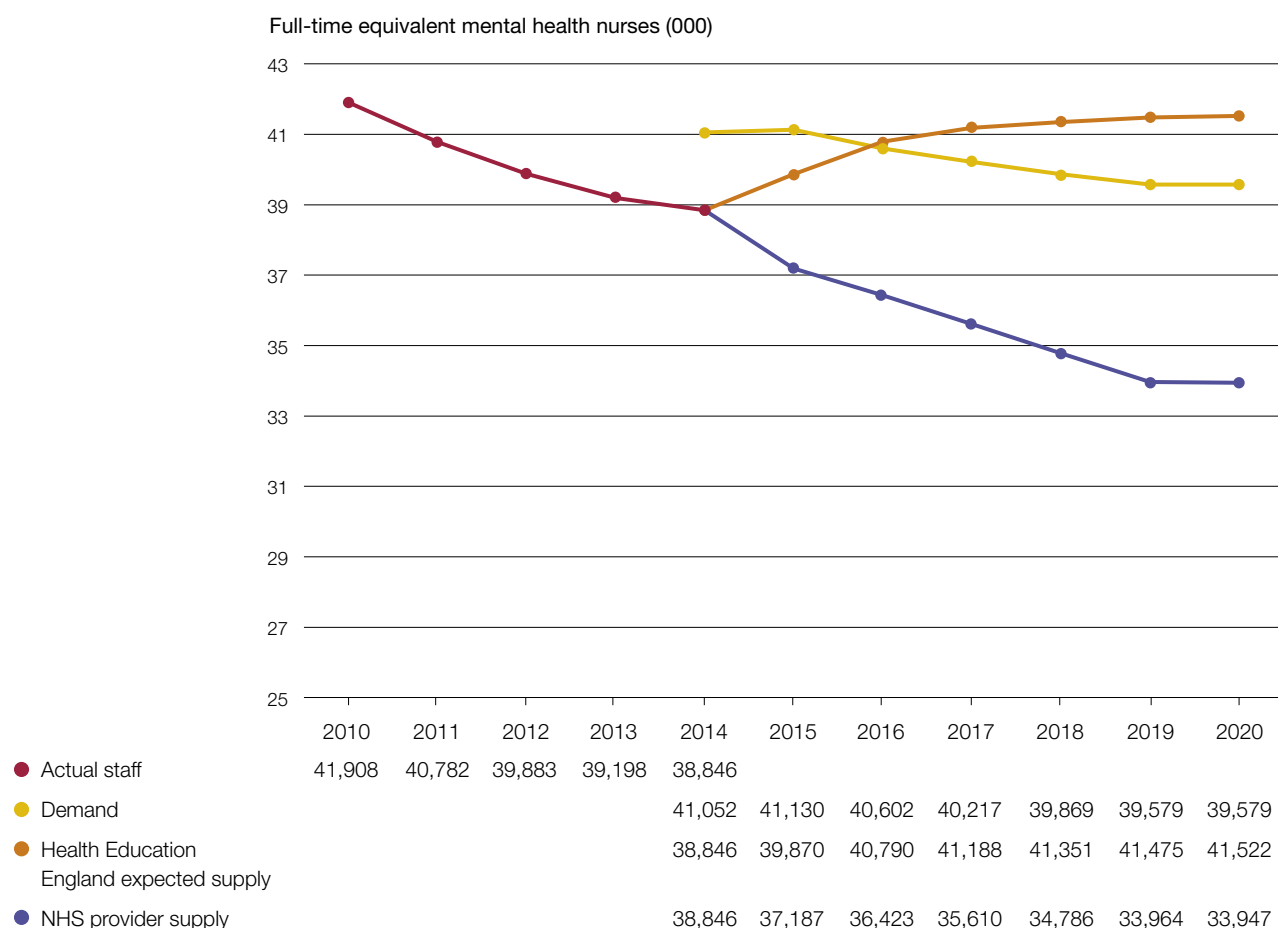
²³ Health Education England, *Workforce plan for England 2014/15*, December 2014.

²⁴ The King's Fund, *Mental health under pressure*, November 2015.

Figure 13

Estimated supply and demand for mental health nurses, 2010 to 2020

Health Education England expects the number of mental health nurses will rise while trusts forecast that their demand for mental health nurses will fall over the coming years

**Notes**

- 1 The actual staff line shows the number of mental health nurses employed within the NHS. This excludes private and third-sector providers.
- 2 The demand line shows the expected future demand for mental health nurses as submitted by providers to Health Education England.
- 3 The Health Education England expected supply line is Health Education England's best estimate in October 2014 of the supply of mental health nurses in the future.
- 4 The NHS provider supply line shows the forecast supply in October 2014 of mental health nurses as submitted by providers to Health Education England.

Source: Health Education England, 2014

F Levers and incentives

Are there adequate levers and incentives to help ensure the NHS makes the changes needed to achieve the programme's objectives?

What do we mean?	There are mechanisms to encourage providers to improve services. Important levers and incentives include the way that providers are paid, and the way that mental health services are regulated.
Why is this important?	Whether access and waiting time standards are met depends on the actions taken by local commissioners and providers. The Department and NHS England have limited direct control over local activity, and rely on other levers and incentives to influence services.
What would we expect to see?	Payment systems incentivise providers to achieve the programme's objectives. Inspection regimes encourage changes to systems and behaviours.

Current position

3.29 The access and waiting time standards are being reflected in the health system's accountability and assurance arrangements. For example, the government's mandate to NHS England for 2016-17 includes the standards associated with IAPT and early intervention in psychosis and a requirement to agree and implement a plan to improve crisis care for people with mental health conditions. The Department will hold NHS England to account for performance against the mandate.

3.30 In addition, the access and waiting time standards will be part of NHS Improvement's oversight and accountability framework for NHS trusts and NHS foundation trusts. They have also been included in the NHS standard contract, which governs the relationship between NHS commissioners and providers.

3.31 The current payment system for mental health services, however, is less mature than that for physical health services. NHS England and NHS Improvement are jointly responsible for the design and implementation of the payment system for NHS services.²⁵ Most physical health services are covered by the 'payment by results' framework, whereby commissioners pay providers for each unit of care, with prices set nationally using providers' cost data. This approach proved to be effective in the past in incentivising trusts to increase activity, thereby reducing waiting lists.

²⁵ NHS Improvement comprises Monitor and the NHS Trust Development Authority.

3.32 There are no national prices for mental health services and the amount that commissioners pay providers is agreed locally. According to a survey of mental health service providers conducted by the Health Financial Management Association in 2015, 89% of respondents said they were paid through block contracts.²⁶ Under block contracts, fixed payments are made that are not related to the numbers of patients treated, the severity of their health conditions or the quality of service provided. Therefore they do not incentivise providers to increase activity or improve performance.

3.33 The inspection regime for mental health services means there are significant gaps in how these services are regulated. Some providers, such as mental health trusts, are subject to routine inspection by the Care Quality Commission. However, there are limits to the Commission's remit and approach that restrict its ability to scrutinise the quality and safety of mental health services:

- Standalone psychological therapy services run by clinical psychologists and the majority of IAPT services are not subject to regulation.²⁷
- The Commission has inspected acute hospitals and mental health services separately: specialist mental health inspectors do not routinely participate in acute hospital inspections, while acute inspection teams do not routinely cover non-core services such as liaison psychiatry. This means that liaison psychiatry has not usually been included within the Commission's first wave of inspections of acute hospitals, which is due to finish in summer 2016. The Commission is committed to improving its assessment of the quality of mental healthcare in acute hospitals with a view to piloting this during 2016-17. These assessments will start to consider how well embedded liaison psychiatry services are, and hospitals' overall approach to mental health.

Making further progress

3.34 Work has been under way for some time to establish robust cost data on mental health services that could be used as the basis for prices, but the available data are of varying quality. The Department began collecting cost data in 2012. However, there is wide variation in the quality and consistency of information collected from different trusts, making it difficult to use this as the basis for a payment system.

26 Healthcare Financial Management Association, *Mental Health Contracting Arrangements: Survey Report*, November 2015.

27 Psychiatrists are registered medical practitioners and are regulated by the Care Quality Commission, but clinical psychologists and psychotherapists are not. There are very limited exceptions, for example if psychotherapists are supporting crisis-resolution care or working in NHS places of safety.

3.35 The shortcomings in data mean that national prices for mental health services are not currently feasible. Following consultation, Monitor published guidance in December 2015 on two alternative payment methods for mental health services for 2016-17:²⁸

- Payment at a locally agreed price for all healthcare provided to a patient for the duration of a single episode of care. The price could be adapted for differences in the mental health condition being treated. Part of the payment might also be linked to patient outcomes.
- A 'capitated payment' model, under which a provider or group of providers offer a range of care for the whole local population in different care settings. This approach should be linked with a payment for achieving agreed quality and outcome measures.

In addition, NHS England is piloting a payment model for IAPT linked to access to treatment and outcomes for patients. It plans to roll out this system from 2016-17.

3.36 The Mental Health Taskforce highlighted in February 2016 the need for payments to incentivise swift access, high-quality care and good outcomes, as well as integrated mental and physical healthcare. It noted that the practice of using block contracts did not provide the right incentives. It recommended, among other things, that NHS England and NHS Improvement should lead work to develop a revised payment system that would encourage the health system to improve outcomes for people with mental health problems.

3.37 To address the gaps in the Care Quality Commission's regulatory remit, the Mental Health Taskforce also asked the Department to consider how it can ensure that all psychological therapy services are regulated.

²⁸ Monitor, *Guidance: New payment approaches for mental health services*, December 2015.

Appendix One

Our audit approach

1 This report covers the Department of Health (the Department) and NHS England's preparations for improving access to mental health services. The report gives an overview of the strategic context and delivery landscape for mental health services and specifically addresses:

- the objectives of the programme, *Achieving Better Access to Mental Health Services by 2020*, and how these relate to other initiatives to improve mental health services;
- the cost of providing mental health services and the funding flows; and
- the preparations the Department and NHS England have made to implement this programme.

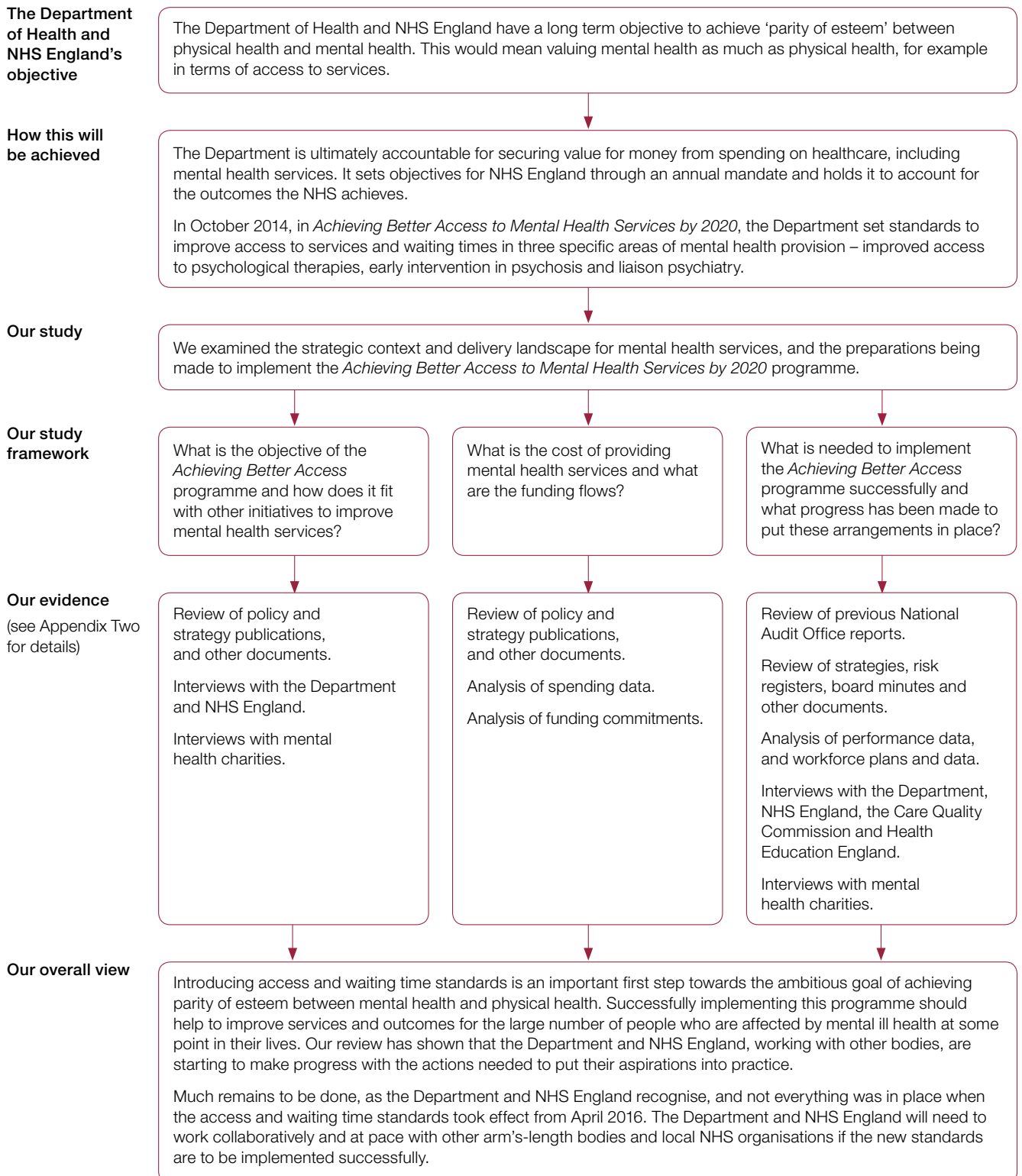
2 We evaluated the Department and NHS England's preparations using a framework of six factors that we consider are needed to implement a strategy effectively. We developed the framework by drawing on previous National Audit Office reports and expertise relevant to project and programme implementation across government. The six criteria are:

- a** Do the Department and NHS England have **clear objectives** for the programme?
- b** Have the Department and NHS England put in place **strong governance** arrangements?
- c** Does the programme have **effective leadership**?
- d** Do the Department and NHS England have **robust performance information** for the programme?
- e** Do service providers have **enough staff with the right skills** to implement the programme?
- f** Are there adequate **levers and incentives** to help ensure the NHS makes the changes needed to achieve the programme's objectives?

3 This report is the first in what we plan will be a programme of work on mental health. It focuses mainly on services for adults, and concentrates on work being done by the Department and its arm's-length bodies rather than by local NHS bodies.

4 Our audit approach is summarised in **Figure 14**. Our evidence base is described in Appendix Two.

Figure 14
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusion on the Department of Health (the Department) and NHS England's preparations for improving access to mental health services by analysing evidence collected between June 2015 and March 2016. Our audit approach is outlined in Appendix One. The work was not designed to support a conclusion on value for money.

2 We developed and applied an evaluative framework to assess the Department and NHS England's preparations for implementing the access and waiting times programme. Our framework consisted of six criteria which previous National Audit Office reports have found to be important in the successful implementation of programmes across government. We assessed the programme against each of these criteria to understand the current position and where further progress needs to be made. The evaluative criteria are detailed in Appendix One.

3 We interviewed staff from the Department and NHS England. The people we interviewed were responsible for developing the access and waiting times programme and putting in place the arrangements for implementing it, or were specialists in particular mental health conditions or services. The interviews helped us to identify key datasets and evidence sources, as well as understanding the landscape of mental health services and the various policy initiatives aimed at improving services.

4 We interviewed staff from other arm's-length bodies:

- Health Education England – about workforce planning for mental health staff;
- the Health and Social Care Information Centre – about the available data on mental health services, and the changes being made to enable performance against the access and waiting time standards to be measured; and
- the Care Quality Commission about how mental health service providers are regulated and its role in holding providers to account for the new standards.

5 We interviewed staff from mental health charities. The organisations were Mind, the Centre for Mental Health and the Children and Young People's Mental Health Coalition. The interviews helped us to understand the landscape for mental health services generally and the access and waiting times programme specifically, and the perspective of service users.

6 We reviewed key documents. The documents included:

- published policy documents relating to previous and current government strategies for mental health, the most important of which are listed in Figure 5. We used these to understand the development of the access and waiting times programme in the broader context of mental health service development, and to consider how the objectives of this programme align with the overall strategy for mental health;
- the impact assessment that had been produced by the Department for the programme, including an in-depth review of the cost–benefit analysis presented in the document. We used this to establish the reasonableness of the assumptions used and the benefits the Department and NHS England expect to gain from implementing this programme;
- academic research documents on the effectiveness of each of the three specific strands of the access and waiting times programme – improved access to psychological therapies, early intervention in psychosis and liaison psychiatry. We used these documents to enhance our understanding of the areas targeted by the programme;
- guidance issued by NHS England to clinical commissioning groups about the implementation of the access and waiting times programme. We used this guidance to understand how the programme is expected to be implemented in practice;
- terms of reference, risk registers and board meeting minutes of the main boards involved in implementing and overseeing the programme. We used these documents to assess the leadership, governance and accountability arrangements in place;
- documents relating to ongoing work, such as the development of new payment mechanisms. We used these documents to establish the current payment incentives for providers and how these incentives are likely to change; and
- the report from the independent Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, published in February 2016. We used this document to understand future priorities for improving mental health services.

7 We analysed spending data collected from NHS England and clinical commissioning groups, and previously primary care trusts, to understand changes in mental health spending (to the extent comparable data are available) and the breakdown of spending between different mental health conditions.

8 We reviewed and analysed the available performance information relating to the three elements included in the *Achieving Better Access to Mental Health Services* programme. The information included:

- data from the Health and Social Care Information Centre, collected from clinical commissioning groups, on performance against targets for improved access to psychological therapies services; and
- surveys conducted for NHS England on the provision of liaison psychiatry services in acute hospitals.

9 We reviewed and analysed information on the mental health workforce.
The information included:

- data from the Health and Social Care Information Centre on the current mental health workforce;
- workforce data from a survey conducted for NHS England on liaison psychiatry and from a census of providers of improved access to psychological therapies services; and
- a workforce model and underlying information, as well as other reports produced by Health Education England, to understand the trends and projections for the supply of, and demand for, mental health nurses and psychiatrists.

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