St. Helens Primary Care Mental Health Service Provision including IAPT Service Specification

Service Specification Number	V4
Service	St. Helens Primary Care Mental Health Service Provision including IAPT Service Specification
Commissioner Lead	St Helens Clinical Commissioning Group
Provider Lead	TBC
Period	1 November 2019 to 31 October 2022
Date of Review	October 2020

1. Population Needs

1. Introduction

This service specification relates to the provision of Primary Care Mental Health Services (PCMH) within St Helens CCG (STHCCG) area and has been developed in accordance with the Improving Access to Psychological Therapies manual published in June 2018.https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual.pdf

Through detailed co-design over the first 12 months of the contract it is proposed that this service will form an essential bedrock of clinical services integrated into a new partnership service bringing together NHS: Primary Care and Secondary care services, Third Sector and Local Authority organisations that are able, through joint-working, to meet the bio-psychosocial needs of people with long term, stable mental health needs in a wrap-round service based in primary care, to be known as***XXXXXXXXXXX.*** This will be enabled through the St Helens Cares Programme which is Health and Social Care working in partnership with our local providers of Health and Social Care.

St Helens has the highest suicide rate Nationally and although there is a suicide prevention strategy in place more preventative work is required in primary care.

1.2 Background

Most people with mental health problems are cared for by their GP with one in four GP consultations containing a mental health component. STHCCG is committed to providing high quality, safe, treatment and care which is known to be effective and accessible.

- Mixed anxiety &depression is the most common mental disorder in Britain, with **7.8%** of people meeting criteria for diagnosis.[1]
- **4-10%** of people in England will experience depression in their lifetime.[2]
- Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society. The poorer and more disadvantaged are disproportionately affected by common mental health problems and their adverse consequences.[3]

Mixed anxiety and depression has been estimated to cause **one fifth** of days lost from work in Britain.[4]

- **One adult in six** had a common mental disorder.[5]

In England, 1 in 6 people report experiencing a common mental health problem (such as anxiety and depression) in any given week. The majority of these people will be cared for in primary care. In St Helens we have 20,758 patients with depression and anxiety (17/18 data).

For patients not receiving the help that they require, prolonged and unnecessary suffering is likely to increase, with mental health and social problems becoming more serious and patients becoming

increasingly reliant on the benefit system. Appropriate psychological interventions will in the long term reduce suffering and help people back to work.

For the vast majority of patient's referral to secondary care mental health services is inappropriate. The management of common mental health problems such as depression and anxiety should be encouraged in primary care. Those with severe mental illness who are stable and able to be managed solely in primary care should be supported to remain in primary care whenever possible.

1.3 National context and Evidence Base

The Improving Access to Psychological Therapies (IAPT) programme was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It had its roots in significant clinical and policy developments. The success of two pilot projects established in 2006 led to the national implementation of the IAPT programme in 2008, which has since transformed the treatment of depression and anxiety disorders in adults in England. In February 2011 the National Mental Health Strategy broadened the benefits of talking therapies to contribute to improved outcomes, wellbeing and recovery of wider groups including older people, people with severe and enduring mental illness and those with long term physical health conditions.

The Five Year Forward View for Mental Health set out plans for expanding IAPT services so that at least 1.5m people can access each year by 2020/21. This is reinforced in the NHS Ten Year Plan (January 2019).

Over 950,000 people now access IAPT services each year. Among those who receive a course of treatment, approximately one in two recover and two in three show a reliable reduction in their symptoms. The Five Year Forward View for Mental Health sets out a commitment to expanding IAPT services and improving quality further, with a view to increasing access to psychological therapies for an additional 600,000 people with common mental health problems each year by 2020/21. This will be achieved by recruiting and training an extra 4500 clinicians, 3000 of whom will be based in primary care.

Improving Access Psychological Therapies (IAPT) Manual published by National Collaborating Centre for Mental Health in June 2018 outlines the national context and evidence base for IAPT services.

Depression is the most common mental health issue in community settings. National guidance suggests that one quarter of routine GP consultations are for people with mental health problems and around 90% of mental health care is provided solely by primary care. Adults with mental health problems are one of the most excluded groups in society. Although many want to work, those living with a mental health problem have the lowest employment rate for any of the main groups of disabled people.

There is strong evidence that appropriate and inclusive services for people with common mental health problems, in particular anxiety and depression reduce the usage of NHS services and contribute to overall mental health wellbeing and economic productivity.

1.3.1 National Institute Health and Care Excellent (NICE) evidence for depression shows:

- Psychological therapies can work as effectively as drug treatments and have fewer side effects;
- Anti-depressant medication should not be used for the initial treatment of mild depression because the risk–benefit ratio is poor.
- Mindfulness Based CBT – MBCBT shows evidence for prevention of relapse

1.3.2 NICE evidence for anxiety shows:

- Psychological therapy, such as Cognitive Behavioural Therapy (CBT), has the best evidence for long term effectiveness.

NICE guidance recommends treatment for common mental health issues should be delivered via a stepped care service model. This ensures that clients receive the least intensive treatment necessary for their recovery, determined by a mixture of need and past experience of treatment.

1.3.3 Computerised Cognitive Behavioural Therapy (cCBT)

NICE Guidance for Common Mental Health problems – Identification & Pathways of Care CG123, published in May 2011 recommends the use of cCBT intervention for the management of mild and moderate depression as well as panic and phobia.

1.3.4 Bereavement

Of the 1,918 plus people who die in St Helens each year many will have family members, friends or carers who experience the bereavement personally. The majority of these will use their own social networks for any support they need. A minority will seek more formal bereavement support and self-refer to the organisation of their choice. This can lead to a disproportionate use of resources across differing providers.

1.3.5Evidence Base and Policy Guidance

- No Health without Mental Health – February 2011
- Five Year Forward View, Mental Health Taskforce Report – February 2016 ▪The '*Closing the Gap: Priorities for Essential Change in Mental Health'* (Department of Health January 2014)
- The Improving Access to Psychological Therapies Manual – June 2018
- Marmot Review (2010) NICE Guidance:
- Depression (NICE CG 90)
- Postnatal Depression (NICE CG 45)
- Self –Harm (NICE CG 16)
- Post-Traumatic Stress Disorder (NICE CG 26)
- Anti-Social Personality Disorder (NICE CG 77)
- Borderline Personality Disorder (NICE CG 78)
- Common Mental Health Disorders (NICE CG 123)
- Anxiety (NICE CG 113)
- Obsessive Compulsive Disorder (NICE CG 31)
- Depression in Adults with a Chronic Physical Health Problem (NICE CG 91) ▪Antenatal and postnatal mental health: clinical management and service guidance NICE guidelines [CG192]

The national mental health strategy (February 2011) has broadened the benefits of talking therapies to contribute to improved outcomes, well-being and recovery for adolescents, older people, those with severe and enduring mental illness (SEMI) and those with long term physical health conditions (LTCs) or medically unexplained symptoms (MUS).

Talking Therapies: a Four-Year Plan for Action' states: The aim is to develop talking therapies services that offer treatments for depression and anxiety disorders approved by the National Institute for Health and Clinical Excellence (NICE) across England by March 2015, the end of the Spending Review period. This involves:

- completing the nationwide roll-out of IAPT services for adults of all ages who have depression or anxiety disorders, paying particular attention to ensuring appropriate access for people over 65;

- initiating a stand-alone programme to extend access to psychological therapies to children and young people
- building on learning from the IAPT programme and using NICE-approved and 'best evidence 'based therapies where NICE guidelines are pending
- broadening the benefits of talking therapies by extending them to people with physical long-term conditions or medically unexplained symptoms, which are physical symptoms caused by psychological distress; and
- Expanding access to talking therapies services for people with severe mental illness.

1.4 Local Context

St Helens CCG recognises that, to enable Primary Care Mental Health Services (PCMH) to successfully deliver expected outcomes and support the recovery of Service Users, services need to work together as a system to provide holistic care and treatment, identify any gaps in service provision and ensure that communication with Service Users, providers and commissioners is maintained.

Mental health issues incorporate a potential myriad of social, interpersonal and psychological distress. On occasions, further interventions and support may be required, be it employment or debt advice or support following bereavement.

During 2018– 19, St Helens CCG and Local Authority have integrated to become St Helens Cares. This Integrated approach has been supported by the Kings Fund and Nationally recognised as good practice.

GP forward View describes the development of GP localities into GP Hubs – which may commission and provide local based services for their population. They may do this a standalone practice from shared premises or GPs coming together /merging as larger practices. ~~GP Hubs?/~~

It will be a service that:

- Is population-based, pro-active, preventative and vigilant in nature;
- Offers support, secures enduring recovery, resilience and well-being for service users and carers;
- Has GPs, as accountable clinicians, at its heart;
- Brings together a robust, vibrant menu of services to wrap round the individual and improve their mental, physical and social resilience.

This service will integrate two broad areas:

- Clinical – primary care mental health services including Case Management, Psychiatry and Psychological Therapies for those whose needs do not require secondary care.
- Well-being – services that support increased functioning and social integration so key to long-term recovery, including Self-Care, Peer Support, Navigators and a specialist integrated Mental Health Employment Service and social prescribing.

These services will be delivered by the NHS, Local Authority and Voluntary Sector working together, providing an integrated offer to support GPs, their patients and carers. St Helens CCG will also act as a coordinating function, aligned with a wider network of other community-based services and providing seamless access to those services.

1.4.1 St Helens Population needs

St Helens CCG is governed by Cheshire and Merseyside Health Partnership.

The CCG population is 197,184 and the estimated prevalence of Common Mental Health Disorders is 29,159 as reported by NHS England (CCG Planning Assurance Guidance).

St. Helens has a high level of deprivation and unemployment, and we are a regional and national outlier for high incidence of suicide.

There is a strong relationship between prevalence of recorded common mental health problems and deprivation of usual residence of patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 National defined Outcomes

No Health without Mental Health outcomes for mental health services are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer from avoidable harm
- Fewer people will experience stigma and discrimination

Improving Access to Psychological Therapies:

The provider of the PCMH service will be required to meet **nationally** defined outcomes set out for Improving Access to Psychological Therapies (IAPT) services, including:

- Building on the baseline access rate of 15% and ensuring an increase in line with the 5 Year Forward View of 22% in 2019/20 and 25% by 2020/21.
- Delivering and maintaining a minimum 50 % recovery rate
- Ensuring that 75% of people referred receive treatment within 6 weeks and 95% within 18 weeks of referral

2.3 KPIs

The Service will be monitored by the collection of non-mandatory and mandatory data including the following **National Key KPIs:**

Prevalence
The Adult Psychiatric Morbidity Survey (2000) identifies the number of people living in the borough of St Helens who have depression and/or anxiety disorders as **29,159.**

Prevalence access standard
The Provider prevalence target is **22.0%** for 2019/20 increasing to **25%** in 2020/21 annum. This Contract covers the delivery of the associated number of Service User first treatments for the Provider to achieve the access prevalence. The Provider must achieve 22% access rate in 2019/20 and 25% thereafter.

Completed Treatments
It is acknowledged that some Service Users will benefit from a single session. However, there is an expectation that the Service will deliver evidence based treatments (NICE recommended) of at least two sessions, to the appropriate dosage for at least 60% of Service Users who enter treatment.

Percentage of Service Users achieving recovery: 50% of Service Users will achieve recovery and a minimum of 70% of Service users will achieve reliable improvements in their recovery.

Percentage of Service Users waiting within 6 weeks for first appointment: 75% Percentage of Service User waiting within 18 weeks for first appointment: 95%

Treatment per Step productivity

The above KPIs will be reviewed in line with national guidance and local demand; this will be conducted as part of the contract monitoring process and will include Service monitoring.

2.4 These are *minimum national standards*.

Outcomes	Indicators	Measures
People are supported to have a good quality of life	The proportion of people reporting a good quality of life	• Improve health related quality of life for older people; • Improve social care related quality of life for adults; • Increase in number of people who feel they have enough social contact.
	The rate of overall mental wellbeing	• Increase in proportion of people who say they are not anxious or depressed; • Decrease in attendances at A&E for self-harm per 100,000 of local population.

People and their carers feel respected and able to make informed choices about services	The proportion of people using services who feel they have been involved in making decisions about their support	• Ensure people using services receive self-directed support • People receiving services feel they have enough choice over their care and support services • People receiving services feel they have as much control as they want over their daily life
	The proportion of carers who feel they have been involved in decisions about services	• Carers feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care for • Carers feel that their needs as a carer were taken into account in planning their support.

We want good communication and access to information for local people

People can find jargon free health and care information in a range of locations and formats	The proportion of people and carers reporting they find it easy to access and use information about services	• People find it easy to find information and advice about support, services or benefits. • Carers find it easy to find information and advice about support, services or benefits.
Health and care services talk to each other so that people receive seamless services	Carers feel connected to their communities, less lonely and socially isolated	• People who contact us about their support have not had to keep repeating their story. • Carers who contact us about support have not had to keep repeating their story. • The proportion of people and carers reporting they have only had to tell their story once; • Carers are signposted to carers groups and or wider support networks.

We want to deliver services that meet people's needs and support their independence

People have access to timely and responsive care	The referral times for health treatment	• Constitutional NHS standards are met

Financial balance is achieved across the system	Single Population Health Budget	• Control totals are delivered across the system

We want to deliver joined up information technology

People and staff working within the system have access to shared and integrated electronic information	The proportion of staff in all health and care settings able to retrieve relevant information about an individual's care from their local system	• Increase in proportion of staff able to retrieve relevant information about an individual's care from their local system using the NHS number • Increase in number of settings across which relevant health and care information is currently being shared • Implementation of Digital Integrated Care Records has started • Use population level health information to improve decision making and to stratify and respond to individual risk

We want to prioritise prevention, early intervention, self-care and self-management

Interventions take place early to tackle emerging problems, or to support people in the local population who are most at risk.	The flow of investment from acute hospital services to preventative, primary GP, and community health and care services	Increase the proportion of funding invested in preventative, primary and community provision
	The proportion of services developed to intervene proactively to support people before their needs increase	Activation measures demonstrate that people have knowledge, skills and confidence in self-care.
People are supported by high quality care and support	The proportion of people reporting satisfaction with the services they have received	• Increase in number of people who report they are satisfied with the care and support they receive. • Increase in number of carers who report they are satisfied with the care and support they receive. • Increase in number of people reporting being treated with care, kindness and compassion.

People are kept safe and free from avoidable harm	People using health and social care services are safe from harm	• Reduction in number of serious incidents in healthcare. • Care is provided in a safe environment, care is provided on the basis of evidence and takes a proportionate view of risk versus choice. • Staff are trained to understand key principles of the Mental Capacity Act and Deprivation of Liberties Standards. • Reduction in the number of adverse incidents.

We want to deliver person centered care through integrated and skilled service provision

People and their families are engaged in the settings of their outcomes and the management of their care	The proportion of people involved in setting the outcomes they want to achieve from their health and care services	• Increase in proportion of people using services who are involved in determining the outcomes that are most important to them
People are supported by skilled staff, delivering person-centered care	The levels of staff satisfaction	• Increase in staff satisfaction levels • Reduction in staff turnover • Reduction in vacancy rate
	The proportion	• Increase in the percentage of staff who have completed at least 80% of their mandated training in person centered care • Increase in the percentage of staff who have their care certificate • Increase in staff who have completed person centered and support planning training

2.5 Locally defined outcomes are:

System

- Reduced incidence of crisis/reliance on secondary care and urgent care services
- More people in stable accommodation and meaningful occupation
- Reduced loneliness and isolation.
- Improved physical health, notably in management of LTCs, supporting those patients with long term conditions to successfully manage their physical symptomatology through psychological support.
- Delivery of an integrated pathway for Primary Care Mental Health Services and Secondary Mental Health services in line with St Helens Cares priority.

Service/access

- Increased proportion of the St Helens population with common mental Health issues who are identified and receive treatment in accordance with appropriate NICE guidance
- Reduced DNA rates – no greater than an average of 12%
- Increased productivity (clinical face to face time)
- Increased proportion of St Helens population with common mental health issues who achieve reliable improvement in their presenting condition.
- Sustainable recovery (i.e. Service Users who have completed treatment and are moving to recovery do not require re-referral into the Service for a second episode of treatment unless deemed appropriate)
- Increased GP and patient user/carer satisfaction
- Increased Staff satisfaction

2.6 Individual

- Is aware of and able to access PCMH services of their choice, flexibly, matched to their needs.
- Has an in date plan of care that reflects their personal goals.
- Achievement of personal goals is demonstrable through validated service user measures and measured through Goal based outcome plans showing improvement in mental health and wellbeing.
- Would recommend the service to others and has a positive experience.
- Is given the opportunity to develop rapport and trust with their therapist by having a consistent member of the clinical team per patient case (where able)
- Improved well-being/reduced social isolation through social participation and community integration of service users.
- Positive impact on (mental and physical) health and well-being (as demonstrated by agreed validated measures)
- Achievement of employment outcomes (retain or gain work or meaningful occupation)

2.7 Specifically for bereavement service:

Service Users express an ability to manage their grief and undertake normal activity after a period of intervention through achievement of their agreed goals.

3. Scope

Aims and objectives of service

The overall aim of Primary Care Mental Health;

"to improve the mental and physical wellbeing of those with mental health needs, and provide better social support so that people are able to maintain good health and wellbeing, maintain independence and achieve their self-determined goals".

The services are population-based with easy access points across the community and a single phone number to call. To facilitate a genuinely integrated operating model, the service will need to work in partnership with the secondary care mental health provider to deliver a Single Point of Access through the contractual values of both services and be aligned to the wider system work being undertaken across St Helens through the single front door. The service will be delivered across a range of health and community venues across St Helens and focused across Primary Care. This provides service users, carers and professionals with a range of access points. It will also capitalise on being co-located and integrated into the wider range of services brought together through the development of Hubs across the neighbourhood model. These access points will be prioritised to sit very close to where people live and work and be fully integrated with GP systems and localities.

By its very nature, the service challenges the stigma often associated with mental ill health. Many of the services it offers, and coordinates access to, are provided in mainstream community service settings.

The aim of this Service is to work in collaboration with St Helens Partners to deliver a coordinated approach to the management of Service Users across mental health services specifically those with common mental health problems, through the provision of an Integrated pathway function to Mental Health Services, which will include the following key Service areas:

- Secondary Care Mental Health services (provided through a separate contract and service specification)
- Improving Access to Psychological Therapies (IAPT)
- Computerised Cognitive Behavioural Therapy (cCBT)
- Level 2 Bereavement Counselling.
- EMDR
- Mindfulness Based CBT
- Social Prescribing Schemes where appropriate

The Provider shall deliver and facilitate access to a range of services within St Helens that are developed

- To work with St Helens partners to develop an integrated care pathway and systems that ensure that service users experience a seamless journey through the service which address mental health and wellbeing needs
- Working in collaboration with St Helens partners to provide a single point of access to PCMH service
- To work closely with GPs and community teams through the neighbourhood model providing

services for older patients and LTCs to ensure clear pathways and protocols are in place to ensure easy access between services

- Improve identification and awareness of common mental health disorders (e.g through awareness training for a range of health, social care, education and welfare professionals including pharmacies and housing organisations) and promote onward referral for assessment and intervention
- To provide a service that offers people a choice of evidence-based interventions appropriate to their condition
- To improve the diagnosis and early intervention for people with common and complex mental illness (e.g. depression, anxiety, OCD, PTSD, phobia and panic), based, where applicable, as per NICE guidelines
- To actively promote co-production and ensure that service users and carers are involved in how services are delivered and developed
- To demonstrate impact via outcome monitoring and reporting, and through regular patient and clinical outcome reporting, and patient and referrer satisfaction surveys
- Provide **timely** interventions, delivered from accessible community venues that will improve mental health and well-being
- To deliver **appropriate** interventions to Service Users with common mental health problems, adopting a stepped care model in accordance with NICE guidelines, using validated evidence based assessment monitoring and outcome tools in line with the IAPT National Quality Standards: http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-qualitystandards.pdf
- To reduce the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders
- To provide signposting, information and support to facilitate access to a range of community based support services
- To provide good quality advice and information to Service Users who access the service
- To facilitate shared decision making underpinned by clinical guidelines and evidence based practice
- To improve the interface between services for people with common mental health disorders
- To increase the proportion of people who make a clinically significant improvement or recover
- To improve emotional well-being, quality of life and functional ability in people with common mental health disorders
- To improve individual's well-being and functionality; this will include people with physical health problems help them into education or training and where appropriate help people to find meaningful activity.
- To ensure that associated social problems are identified and addressed as early as possible and appropriate support is provided, i.e. refer to welfare benefits services, housing support etc
- To promote social inclusion and assist Service Users to retain or gain meaningful employment opportunities
- To improve access and support to maintain people in work, help them return to work help them into education or training and where appropriate help people to find meaningful activity
- To establish strong links with local employment support organisations, particularly to support Service Users with mental health problems to seek and retain work, and with providers of other socially inclusive services (e.g. volunteering, community groups etc.)
- To provide an inclusive Service for all groups within society (as outlined in section 3.1)
- To provide component-level 2 bereavement support.
- To provide evidence based interventions, evidence of positive outcomes for Service Users and value for money.

- To work collaboratively and proactively to reduce Service User attendance at A&E

3.1 Inclusion Criteria

The Provider will be expected to ensure that the Service is accessible to the following target groups to meet local needs:

In the event of a Major Incident you will be required to make short and long term arrangements to provide Psychological support to victims and relatives.

- People aged 16 years and over (there is no upper age limit). Service Users shortly approaching their sixteenth birthday (4 weeks prior) may be referred into the Service, and the provider should consider these on a case-by-case basis.
- People with a physical disability
- People with long-term conditions including chronic pain
- People with medically unexplained symptoms
- People diagnosed with cancer
- Perinatal women
- Military veterans and military veteran family members (immediate family members including partners of any ex-service personnel)
- Black, Asian, Minority Ethnicity (BAME) communities (including Traveller Communities and those where English is not a first language)
- 3rd Sector & Faith Communities
- Lesbian, gay, bisexual and transgender communities
- People with learning disabilities & autism
- People who have experienced sexual and physical abuse (including domestic violence)
- Service Users who use British Sign Language
- People registered with a St Helens GP
- People registered homeless with a St Helens GP.
- Those known or linked with people from the Criminal Justice System (providing that they do not meet the criteria outlined in section 3.2)
- People with mild, moderate or severe common mental health problems, who do not require an enhanced level of care or access to specialist mental health services.
- Asylum seeker Mental Health referrals.

The Service will ensure accessibility for vulnerable adults, for example ensuring access for Service Users with a Learning Disability or Dementia if clinically appropriate, ensuring access to easy read materials and make reasonable adjustments as required.

The Provider will be expected to conduct an audit on a six monthly basis to analyse referrals into the Service for the above target groups and to identify areas of improvement to ensure that the Service is accessible to the groups outlined above and that those referred are entering treatment and complete a course of treatment in line with expected standards, so demonstrating that the Service offered meets the needs of those target groups.

The service will be available to people with the following diagnosis:

- Mild, moderate or severe depression and/or anxiety disorders; Including the following:

- Mild to moderate depression and/or anxiety (PHQ-9 and /or GAD-7 <15)
- More severe levels of depression and/or anxiety (PHQ-9 and GAD-7 >15) and significant impairment of social and occupational functioning
- Long term conditions where the person is also suffering from depression and anxiety and ~~-~~Adjustment disorders
- People with significant life stresses who do not have a diagnosable mental health condition who may benefit from referral to the counselling stream of the service or may be signposted to other voluntary and community services

Anxiety disorders which include the following:

- Phobic anxiety disorders including agoraphobia, social phobia and specific phobias e.g., blood and injury phobias, heights, closed spaces, etc.
- Panic disorder
- Obsessive-compulsive disorder
- phobias (including social anxiety disorder (social phobia))
- post-traumatic stress disorder
- health anxiety (Hypochondriasis)/somatisation

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People with mild eating disorders (BMI>17.5) who do not meet the criteria for referral to specialist eating disorder services. The service does not provide treatment for morbid obesity.

People with medically unexplained symptoms with no currently known physical pathological cause, where there is evidence that the symptoms may be related to a psychiatric disorder or other emotional difficulties.

People presenting with insomnia or sleep related problems.

People with stable serious mental disorders (e.g. mild to moderate Personality Disorders) who would benefit from psychological therapies.

People with LTCs with co-morbid mental health difficulties.

NB: *Patients who are registered with non-St Helens GPs may access services under NHS Choice. The cost to the registered CCG will be recovered by STHCCG.*

The proposed model for PCMH services is largely comprised of IAPT services for common mental health conditions such as anxiety and depression but will also encompass other conditions including:

- Adjustment disorders
- Eating disorders (mild-to-moderate)
- Anger management
- Depression or anxiety in adults with a chronic physical health problem or medically unexplained symptoms
- Substance misuse (drug and alcohol misuse)
- Mild learning disability or cognitive impairment
- Personality disorder (not severe)
- Other co-morbid mental health conditions (e.g. non-acute or stable psychosis) where anxiety or Depression-related symptomatology is present

A broader focus incorporates the delivery of "Step 4" high intensity therapies (often delivered by psychologists for more complex conditions with co-morbidities (e.g. personality disorder, substance misuse).

If the Step 4 psychological therapist is the lead clinician and the service user does not require multidisciplinary case/care management and/or other co-morbidities (e.g. emotionally unstable ~~borderline~~ personality disorder) are not the primary focus of treatment, then these more complex and severe cases could also be treated within the Primary Care Mental Health services.

3.2 Exclusion criteria

The service is not expected to provide crisis response to:

- People who are at immediate significant risk to themselves e.g. presenting as being high risk of suicide, neglect or harm to self. This decision would be validated by the scoring from the PHQ9 and the GAD7.
- People who pose a significant risk to other people e.g. risk of Safeguarding of children or vulnerable adults, expressions of high levels of violence or aggression.

NB: Anyone whom the GP identifies to require an assessment in less than five days, face-to-face, should be referred to the Assessment Team (Mental Health provider) for a Crisis (4 hour) or Urgent (24 hours) face-to-face assessment in line with national crisis standards.

3.3 Personality Disorder

The Service will accept referrals for people with mild to moderate Personality Disorder. However, people with personality disorders, where the primary aim of treatment is to treat long-term maladaptive behaviour patterns and persistent interpersonal problems should be referred to secondary services.

People with Personality Disorders and other co-morbid mental health difficulties that are within the remit of the Psychological Therapies Service should be offered an assessment to determine if they can engage in therapy for their co morbid difficulties. People should not be excluded from accessing the service solely on the basis of having a diagnosis of Personality Disorder.

3.4 Specialist Mental Health Services

The Service is unable to work with people who are under the care of secondary care services through the Care Programme Approach (CPA), except in ensuring the safe transition of people being stepped down for case management by PCMH.

The Service is unable to work with people who require specific specialist mental health services as follows:

- People who are acutely unwell with, or who are being diagnosed for the first time with, Serious Mental Illnesses such as Psychosis or Bi-polar Affective Disorder.
- Patients with severe eating disorders.
- Patients with Substance Misuse issues **as the only diagnosis**. People with co-morbid mental health problems should be assessed to determine whether their substance misuse problems will impede on them being able to engage. **People should not be excluded from receiving Case Management or Psychological Therapies due to not having yet completed treatment for substance misuse.**

3.4.1 Other specialised commissioned mental health services;

The Service is unable to work with people who require specific specialist mental health services as follows:
People with a significant forensic history involving threatened or actual violence to others.

People who require treatment for offending behaviour which may include:

- Sex offending
- Shop lifting
- Actual bodily harm
- Grievous bodily harm
- People with severe ADHD
- Patients requiring treatment for addictions **as the primary issue** including nonsubstance addictions such as shopping, gambling, over eating with no identified psychological therapies needs.

These services may need to be commissioned on an individual funding request (IFR) basis.

3.5 Discharge from Secondary Care Mental Health Services

Some people discharged from secondary care services may benefit from support from PCMH practitioners as part of their transitional plan. A clinical pathway between secondary and primary care mental health services will be agreed under the Service Development Improvement Plan (SDIP) approach for both organisations by the end of Q4 2019/2020.

3.6 Underlying principles

- To provide a "whole person" approach to the delivery of Primary Care Mental Health Services which takes account of the person's socio-demographic characteristics, health co-morbidities and lifestyle;
- To provide a directly accessible primary care driven service
- To provide early access and appropriate interventions to people with common mental health problems adopting a stepped approach according to NICE guidelines
- To promote access to services from all sectors of the community including traditionally underserved/socially excluded groups which may include:
  - Black, Asian and minority ethnic groups, including people who do not have English as their first language,
  - certain age and gender groups e.g. older people, including people living in nursing homes or with dementia;
  - younger people, especially young men & South Asian women
  - service and ex-service personnel
  - refugees and asylum seekers
  - long term conditions
  - perinatal
  - lesbian, gay, bisexual and transgender people

- people from deprived communities, including people who are on low incomes, unemployed or homeless, single-parents and carers

To provide high quality and flexible support to service users that maximizes individual potential. This may include:

- Language and communication support
- Use of multi-media technology
- Crèche facilities

Subsidised transport

- Home-based interventions
- Non-traditional community settings

4. Service Description/Care Pathway

The Primary Care Mental Health Service is based on a stepped care model. The Provider will deliver a stepped care psychological Service providing early access to, and delivery of, psychological therapies in community settings.

The Service will focus on successful outcomes that will offer the least intensive interventions and self-correcting treatments. Interventions will be compliant with NICE guidelines and result in cost effective treatment and support.

The least intensive intervention appropriate to a person's needs is provided first and people can readily "step up or down" the care pathway in accordance with their changing needs and response to treatment. The PCMHS should be part of an integrated care pathway for people with common mental health disorders and should build on existing multi-agency partnerships with a variety of statutory, voluntary and private providers working collaboratively.

The Service will provide access to information and other support for Service Users (i.e. signposting to alternative services, groups or charities) who have been referred, but may not be currently meet the criteria for the Service.

The Service will provide a range of appropriate interventions to Service Users with common mental health disorders, adopting a stepped care model in accordance to NICE guidelines, using validated evidence based assessment monitoring and outcome tools and in line with the IAPT National Quality Standardshttp://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-qualitystandards.pdf.

In addition to the core Primary Care Mental Health service, the CCG commissions a Complex needs service within the secondary care provider to deliver psychological therapies to patients with a diagnosis of Personality Disorder with more complex needs. It is expected that all psychology services commissioned across St Helens for both primary and secondary care will work together to deliver integrated and streamlined pathways. Outcomes for these services will be monitored and reported through local contracting arrangements as appropriate.

The Provider will be expected to provide a range of psychological therapies up to the level St Helens CCG commission from Secondary Care Mental Health Services, to ensure that there are no gaps in service provision between Primary and Secondary Care Mental Health. The Provider must liaise with the

Provider(s) of Secondary Care Mental Health Services to determine service provision for Primary Care psychological therapies.

The stepped care model should ensure that local care pathways:

- provide the least intrusive, most effective intervention first
- have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- do not use single criteria (such as symptom severity) to determine movement between steps
- monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed
- promote a range of evidence-based interventions at each step in the pathway
- Support people in their choice of interventions.

In accordance with NICE guidance some patients (e.g. those with severe depression or anxiety disorders or PTSD) will be routed straight to high intensity (Step 3 interventions) rather than stepped first through low intensity interventions which would not be effective in meeting their treatment needs.

The Stepped Care Service Model for Primary Care Mental Health service acknowledges the crucial role of the promotion of well-being and positive mental health for the population and the role of self-help for lower intensity psychological problems. Promotion of good mental health and psychological well-being (Step 0) and mental health plays an important role in the primary prevention of mental health problems (e.g. promotion of mental health in the workplace/local communities), hence the intrinsic links that will need to be developed between this service and third sector, voluntary organisations.

Services should be easily accessible within the community and incorporate various styles of engagement and delivery ranging from self-help materials, telephone advice and counselling and group approaches. Multiple points of access to the PCMHS service will facilitate links with the wider community and promote access to services from people from a range of socially excluded groups. This may include use of accessible, non-stigmatized community venues (including the person' own home), libraries, sports centres, community centres, supermarkets and large stores.

As part of on-going Service improvements and in line with patient engagement, St Helens CCG has also identified the need to include domiciliary visits as part of the overall PCMH Service provision, to support Service Users who are housebound, have a physical disability or have a severe social phobia or severe agoraphobia. This will ensure that those that are unable to attend clinic appointments are able to access the Service. It is also envisaged that this will also support a reduction in the number of Service Users who DNA appointments. The Provider is also expected to be sensitive to particular conditions that may, in a small number of cases, require treatments to be delivered in a location other than the treatment room or the home to maximize improvement.
There should be clear and explicit criteria for entry into the service and multiple means to access the service, including self-referral.

The Service should encourage self-referral as a recent evaluation of psychological intervention services demonstrated that self-referred service users present with symptoms as severe as those of GP-referred service users but recover with fewer sessions of treatment. Promotion of self-referral pathways may thus improve cost-effectiveness of service and promote better access for hitherto under-served sections of the community.

Promotion of recovery and positive mental health provides an opportunity for collaboration and partnership with other community services and interventions as part of local service delivery (e.g. social care, housing, environmental services, education (including schools, colleges, universities and associated parent groups), criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused services, local employment agencies and children services (for those transitioning into adult services)etc.). This will help to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery.

In addition, collaboration with secondary care professionals in specialist mental health and general health services (particularly physicians involved in treating long term musculoskeletal, respiratory, dermatology, diabetes, heart disease, chronic pain services, neurology and cancer) is vital to ensure that psychological treatment needs are met across the pathway in an integrated, timely and responsive manner.

The Provider will be responsible for the delivery of IAPT Psychological Therapies, cCBT and Level 2 Bereavement Counselling. However, to support the recovery of Service Users accessing the Service, the Provider must also develop and establish strong links with the Secondary Care Mental Health service and other community providers across the faith, voluntary and charity sector.

The Provider will have an understanding of local needs. The Provider will be aware of local services, voluntary groups, charities etc. in place that could be incorporated into the PCMH Services pathway.
The Service will:

- Provide NICE recommended treatment for the presenting problem(s);
- Provide stepped care in line with NICE recommendations;
- Provide access to Step 2 recommended cCBT treatment (where appropriate);
- Provide access to component level 2 bereavement support, ensuring that adult Service Users (16+) have access to sensitive, and responsive level 2 bereavement support in a timely fashion to promote normal grief reactions;
- The Provider will offer a range of level 2 bereavement support Services to meet specific needs;
- Ensure that staff involved in the treatment of 16 and 17-year-old Service Users have appropriate competency and understanding of developmental and legal issues that are part of the legal framework for children. http://www.iapt.nhs.uk/news/working-with-under18-year-olds-guidance-for-commissioners-iapt-service-providers-and-those-working-iniapt-services/;
- Use measures to obtain pre and post treatment outcome data on a minimum of **95%** of all Service Users who start treatment
- Use anxiety disorder specific measures, as well as the PHQ9 and GAD7, to help guide, and monitor the outcome of a course of psychological treatment for specific disorders such as PTSD, OCD, panic disorder, agoraphobia, and social phobia
- Have an agreed protocol for assessing and managing Service Users' risks to self and others
- Take into account the diverse backgrounds of Service Users when providing treatment (the Equality Act 2010 and the principles of Equality and Diversity should be adhered to)
- Offer an assessment which will focus on the presenting problem and level of risk to self and others and signposting requirements
- Record and report the presenting problem during treatment ~~(ICD-10 codes)~~ on a minimum of 95% of all Service Users who enter a course of treatment – current NICE now is using DSMIV for depression with a focus on severity and impact on life.
- Offer an evidence-based treatment to all Service Users appropriate to their condition. Where several options are available, the Service User should be offered a choice
- Have a process in place to evidence that valid consent has been obtained, including from those Service Users who have communication, sensory or language support needs. The Provider will evidence compliance with the Mental Capacity Act 2005 when assessing and working with Service

Users

- Provide a domiciliary therapy Service for Service Users who are housebound. This includes Service Users with physical disability or severe social phobia or severe agoraphobia.
- Domiciliary visits should be undertaken in exceptional circumstances and where possible, Service Users will be expected to attend appointments at community locations sourced by the PCMH.
- Carers should also be identified and offered appropriate signposting and /or support.

The need for domiciliary visits will in most cases be determined by the Service Users' GP or other appropriate health professional and the appropriate section of the referral form completed. The GP may also detail any known risks in the referral form to support the Service to undertake an appropriate risk assessment.

Prior to undertaking home visits, the PCMH must offer an initial telephone assessment to clarify the reason for the home visit request, to carry out a risk assessment (to aid decisions regarding the appropriateness of the home visit request) and to undertake an assessment of the appropriateness of the home environment/circumstances (e.g. quiet, undisturbed space) to undertake therapy. ~~.~~ Home visit requests (including outcome of telephone assessments) to be reviewed by a senior clinician as appropriate. In certain situations, (dependent upon the level of risk assessed) the Service may choose to send two therapists to a home visit.

- Inform the Service Users' GP of any person who present with suspected mild cognitive impairment associated with depression; in case intervention is required by the patients' GP (refer to NICE clinical guideline 123).
- Utilise the use of text reminders to remind Service Users of booked appointments
- To discharge Service Users back to their GP who are deemed ineligible for the Service and where appropriate provide self-help information or signpost Service Users to an alternative Service such as third and voluntary sector.
- Identify and develop links with additional support services, groups and charities (over and above those that are listed in the specification) that will support the recovery of Service Users accessing PCMH Services. This may include the development of pathways to ensure the provision of a seamless integrated pathway for Primary Care Mental Health
- Provide all therapists with outcome-informed, clinical supervision and personal Continuing Professional Development (CPD) plans
- Work to a high volume specification and to response times outlined within this specification.
- Provide each St Helens CCG GP practice with a named Locality Lead (or appropriate deputy where required) who will be the first point of contact for any queries in relation to both Service Users who have accessed the Service
- To be delivered via telephone consultation or email as appropriate. The Provider must be flexible in meeting the needs of GPs for face-to-face conferences/case reviews as required.
- Will identify any educational support needs of St Helens CCG GP Practice Teams.
- Will liaise with St Helens ~~-~~CCG GP Practice Teams on a regular basis to discuss Service Users who do not engage with the Service and with whom the GP feels unsure as to the best treatment/intervention plan.
- The Provider will be expected to provide data in relation to GP queries. Qualitative information regarding the types of GP queries may also be requested by the commissioner
- Ensure that a therapist/member of the therapy team is able to contribute to the integrated care planning of Service Users who are also under the care of the MDT Risk Stratification group.
- The Service will offer a priority response (of 10 days from referral to treatment) to military veterans, military veteran family members (immediate family members including partners of any ex-service personnel), perinatal and asylum seekers Service Users. The service will prioritise access for all referrals as clinically appropriate. In addition, the service will develop links with the National Military Veteran IAPT service as clinically appropriate.
- Ensure and provide evidence that all therapy staff receive training regarding perinatal mental

health which is regularly updated in line with best practice
- Evidence that links have been made with Service Users with a long term physical health condition and older Service Users (65+)
- Keep updated with national guidance and practice through the attendance at regional and national forums for IAPT, acting as a representative of St Helens as appropriate and ensure dissemination of key messages and learning across the system.

The Service will offer a variety of evidence-based clinical interventions (including self-help options) for the treatment of mild to moderate and moderate to severe anxiety and depression. Examples of NICE recommended treatments and evidence based interventions to be offered to Service Users who require psychological therapies are provided below (please note that this list is not exhaustive);

- Guided Self-Help
- Behavioural Activation
- Graded Physical Exercise
- Psycho Educational Groups
- Mindfulness CBT
- CBT for depression and all anxiety disorders
- Behaviour Couples Therapy
- Counselling for Depression
- Brief Dynamic Therapy
- Interpersonal Psychotherapy
- EMDR for Post-Traumatic Stress Disorder
- Couples Therapy for Depression

Interventions will be provided through individual and group sessions (as appropriate), as recommended by NICE guidance and will include both face-to-face contact and telephone support. The Service will also engage with GPs and other referrers in developing and maintaining Step 1 'active monitoring' initiatives and in supporting Service Users to engage.

4.1.1 Number of sessions:

The number of sessions offered to Service Users should be in line with NICE guidelines for the Service Users' condition and in line with person centred principles. As an example, the average number of sessions for Step 2 is up to 6 and for Step 3 is approximately 8-9 sessions (However, a small number of Step 3 clients may require up to 20 sessions). Initial assessment does not constitute a therapeutic/treatment session unless it is considered first treatment with the therapist who will take responsibility for the Service User's course of treatment. On occasions, Service Users may require more sessions, dependent upon clinical need. This should be at the Provider's discretion and on a Service User by Service User basis.

4.2 Computerised Cognitive Behavioural Therapy

The Provider must provide access to cCBT to Service Users (where appropriate), as an alternative to, or in addition to, the Step 2 interventions to increase the choice of treatments offered.

The Provider is fully responsible for the cCBT package delivered as part of the integrated PCMH Services pathway. cCBT Service provision must be community based, or with the option for the Service User to access this in their own place of residence. The Provider will monitor recovery rates and reliable improvement rates for cCBT.

4.3 Bereavement Counselling

The Provider will provide component level 2 bereavement support, ensuring that all Service Users (16+) in St Helens ~~-~~have access to sensitive, responsive level 2 bereavement support in a timely fashion to promote normal grief reactions. The Provider must offer a range of level 2 bereavement support Services to meet specific needs, whether for information or sign-posting, individual or group support.

4.4. Drop-In Support Service

The Provider will provide access to a Drop-in Support Service to enable Service Users to access e.g.

~~for example, a~~ a range of practical and emotional support, self-help guidance, activities e.g. accessing parkrun, walks, running, courses, social prescribing, local resources and advice etc. This Service will be available to both Service Users who are under the care of PCMH Services and to those that are not but require self-help or low level support (e.g. those that have been signposted to the Service by their GP). Drop-In Support should be accessible in line with the GP demands for the Service. The Provider will be expected to provide Drop-In Support 4 days a week as a minimum, at times that are suitable for those Service Users that work and those that do not.

4.5. Service User/Client Forums:

The Provider will facilitate and promote Service User and Carer forums as part of this Contract. This will provide an opportunity for Service Users, providers and others as relevant to come together to discuss their views on all aspects of Primary Care Mental Health, views from forums should be fed into future commissioning discussions and drive service improvements.

4.6. Access to other support services

The Provider will establish and develop links to provide support with social issues such as employment, housing or debt advice.
The Provider will identify, establish links and develop signposting/referral pathways (as appropriate) with other support services, groups and charities (over and above those that are listed in this specification), that will support the recovery of Service Users accessing the Service.

4.7 Interpreting/Translation Requirements

The Provider will ensure that the therapy workforce is culturally aware and sensitive to the specific needs of Service Users from different cultures and backgrounds, and to the needs of those with different religions and beliefs. They should ensure that all therapists have the skills and capabilities to work with such cultural diversity. Therapists should also be aware that, in some cases, engagement may only be possible through a referral to another therapist who is of the same background, culture or faith as the Service User.

Some Service Users wanting to access the Service will not have English as a first language (e.g.

those who use sign language, or those who do not understand or speak English).

The Provider will have processes in place so that Service User language barriers can be overcome so that therapists can provide an effective and appropriate Service. This is particularly important for the provision of written materials for self-help and computerised CBT. If interpreting support is required the Provider will ensure that an appropriate and accredited translation service is provided, that offers Service User choice.
It is not normally acceptable for family members to fulfil a translator's role in psychological therapies.

5.0 Referral

It is accepted that the majority of referrals have traditionally been made via the GP, therefore the provider will need to utilise a referral form and make arrangements for the operation of a 'choose and book' system.

The provider will also take forward and develop:

- alternative routes to meet the needs of specific patient and community groups for example referral routes for other health care professionals, non-healthcare professional where this will improve access and is necessary to meet the needs of the St. Helens population;
- provide a self-referral option. The provider will be expected to maximise the number of people accessing their service and will be encouraged to be innovative in supporting people to access IAPT;
- 'step down' referrals from secondary care for service users who are ready for a less intensive treatment and 'step up' referrals into secondary care for service users who require a more intensive treatment. In such cases where the patient may be transferred form one service to another, the service to whom the initial referral was made, will retain responsibility for the care until the referral is accepted by the other service;
- better access for sections of the community who may find it difficult to access services via primary care
- access to information and other support for people who are referred, but may not be currently eligible for a service.

Referrals can be made by:

- GP
- Self-referral
- Other professional involved in care
- Friend or family (with patient consent)
- Employer (with patient consent)

A key consideration in the referral to PCMH Services is the Service Users' readiness to engage in therapy, and the importance of 'watchful waiting'. The Provider will be responsible for educating/raising awareness of readiness to engage amongst St Helens GP's and relevant Community Teams.

The Provider will also be responsible for ensuring that Service information is made available to GPs to provide to Service Users at the point of referral. This will assist Service Users to make an informed decision regarding 'opting-in' to the Service.

All referrals will be sent to the single point of access who will be responsible for triaging Service Users to the following as appropriate:

- IAPT Psychological Therapies
- Computerised Cognitive Behavioural Therapy - Level 2 Bereavement Counselling.
- Secondary care mental health services
- Voluntary sector organisations

The service will develop direct access for people to self-refer into the service. Early identification of psychological problems and early intervention is associated with better outcomes from IAPT services. The Provider must be able to accept referrals in a range of format e.g. secure email and secure electronic self-referrals and through drop in sessions as defined in section 5.

The Provider(s) via the agreed pathway will be responsible for screening referrals daily to identify Service Users with high risk. Where appropriate, such Service Users should be referred urgently to the secondary care service, via the agreed pathway for assessment and the referring GP informed **within 24 hours of the referral (or the next working day where appropriate to take into account weekends).**

5.1 Assessment Process

There will be an agreed pathway for all Service Users between the provider and the secondary Mental Health provider by end of Quarter 4 2019/20 which will offer assessment, focused on the presenting problem, a basic risk assessment and referral/signposting onto other services/agencies if appropriate. This will include the following elements:

- Prior to the start of treatment all Service Users will receive a comprehensive 'patient centred' assessment that clearly identifies the full range and impact of their mental health problems and any associated employment, social and physical health issues. The Primary and Secondary care providers will work collaboratively to agree a common mental health assessment tool to be implemented by the end of Quarter 4 2019/20 as part of the integrated pathway process.
- Risk (including suicide and harm to others) assessed at initial contact and at each contact thereafter.
- At the end of each Service Users assessment, a decision is made to treat or not. For those where a decision is made not to treat, the Service User should be discharged back to their GP and/or signposted to an alternative service where relevant, clearly outlining rationale for discharge.

5.2 Opt-In Process

The Provider will ensure an appropriate approach to 'opting-in' to PCMH Services outlined in this Contract, ensuring that Service Users are able to access the Service easily and by the most direct route possible for all referrals received.

As a minimum, the provider must review on a monthly basis all Service Users who have not opted into the Service and contact such Service Users by telephone to assess the reasons for not opting in.

The Service will discharge back to the GP, any Service Users who do not opt in to the Service within a one-month period and share with the Commissioner the reasons for not opting in.

5.3 Response Times

•Referrals into the Service will be acknowledged upon receipt of referral within 2 working days (Excludes Sundays and bank holidays).
•Service Users will be offered an assessment appointment within 10 working days from date of 'opt-in'
•Service Users will be offered routine intervention appointments within a maximum of 28 calendar days from date of 'opt-in' (90% of all referrals will have first treatment appointment within 28 days),
•Maximum waits between appointments will be 10 working days (unless the Service User chooses to accept an appointment outside 10 working days)
•The Service will offer a priority response (of 10 days from referral to treatment) to military veterans,

military veteran family members (immediate family members including partners of any ex-service personnel) perinatal and asylum seeker Service Users.

•Following specific interventions, and based on a review of progress, Service Users will be discharged, or stepped up/down, or referred onto other services as appropriate.

- Each Service User will receive a treatment plan and goal based outcome plan which is agreed jointly between the Service User and therapist. The treatment plan should be reviewed regularly and amended accordingly to reflect changes in the therapeutic process. Any changes will be agreed with the Service User.

The responsibilities of the Service will be to ensure that:

- The agreed treatment plan is delivered
- Service Users are contacted/followed up if they do not attend agreed appointments (in line with DNA/Cancellation Policy)
- Progress against agreed outcomes is monitored, reviewed and reported. This is to reflect the additional other outcome measures as outlined in this specification

Responsibility of the goal based outcome plan will be the joint responsibility of the service and the service user.

6. Interface between Primary Care Mental Health Services and Secondary Care Mental Health

Following initial triage as agreed within the Integrated pathway outlined in section 5, if it is identified during further assessment or therapy that the Service User is considered more suitable for secondary care mental health input, then the provider must liaise directly. This may be due to non-responsiveness to interventions offered by the PCMH Service, the complexity, severity and chronicity in presentation and identified ~~and~~ significant clinical risk factors (e.g. actively self-harming and/or considering suicide). These features, consequently, may make it difficult for the Service User to be treated within PCMH Services.

If onward referral to secondary care mental health is required, the Provider can refer **directly** as part of the agreement in creating an Integrated pathway between services, so that a further assessment is undertaken.

Referrals to the secondary care service should detail the reasons why the Service User is not suitable for PCMH Services and provide a clear rationale for the need for secondary care mental health intervention. Supporting assessments or documented therapy appointments (as appropriate) should also be attached to the referral form.

For Service Users where the assessment indicates further treatment is required, the Provider will refer the Service User to the most appropriate secondary care mental health service and inform the GP of the outcome of assessment and further care planning needs**.**

If following assessment by the provider and the Service User is deemed not to be appropriate for secondary care mental health input, the provider will communicate (via email, letter or by telephone as appropriate) to the PCMH service the reasons for any rejection and recommend alternative options for treatment.

Until a referral has been accepted by secondary care mental health, the Service User remains the responsibility of the Provider. The Provider will be expected to negotiate and plan the most appropriate Service User pathway for any Service Users who have been assessed as requiring onward referral to an alternative Service. The Provider must notify the CCG as quickly as possible of any disputes or delays in the Service Users' journey that cannot be resolved in negotiations with other providers.

6.1 Joint working/Onward referral/signposting

Examples of independencies with other services/providers are (the list below is not exhaustive):

- St Helens CCG GP Practices
- Employment and educational support agencies
- CAMHS
- Secondary Care/Specialist Mental Health Services
- Recovery Forums/Groups
- Long Term Conditions Teams (Physical Health)
- Drug and Alcohol Services
- Third Sector Services
- Voluntary Organisations
- Department of Adult Social Services (Peoples Service)
- Carers Groups
- Regional and local IAPT Veteran service
- Social and wellbeing related activities
- Liaison and Crisis Care Teams
- Healthy Living Team
- Other services/providers as appropriate

The Provider will have a good knowledge of local services and develop strong relationships with them (e.g. Job Centre Plus, Occupational Health Services, Specialist Mental Health Services, Social Care, Housing, Leisure, debt management, food-banks, well-being services, the Third Sector and other social support providers, to ensure Service Users have their needs met in a holistic and timely manner (this list is not exhaustive). They should maintain an up to date directory of all these services and regularly liaise with such services.

Service Users who access the Primary Care Mental Health Service should be signposted to alternative services or sources of support where appropriate in collaboration and parallel to the support being provided by PCMH. The PCMH should be able to demonstrate the development and maintenance of links with support services/providers.

6.2. Discharge Process

Discharge from the Service will occur:

- When the Service User has completed therapy and no longer requires services
- The Service Users' level of need has increased and an onward referral to a step up service (outside the scope of PCMH Services) is required
- The Service User 'drops out' of therapy through choice and no risks are identified. However, if the Service User 'drops out' and risks have been identified, the referring GP should be notified within 24 hours. Attempts should be made to actively contact service users who have identified risks
- The Service User has 'did not attend activity' which is in line with the Service discharge policy criteria as agreed with the Commissioner
- The Provider will audit drop-out rates to ascertain reasons for early termination of therapy.

A detailed discharge letter will be sent to the Service Users GP and/or referring GP (if different) within 5 working days of the Service User being discharged from the Service. To include:

- Summary of treatment received
- Psychometric metric scores (such as PHQ9 and GAD7) to report improvement (IAPT Psychological

Therapies and cCBT), ideally in graphical form
- Information regarding additional service(s) Service User accessed within the Primary Care Mental Health Services care pathway (see section 3.2.5)
- Information regarding additional service(s) Service User has been referred/signposted to (outside the scope of this specification)

7. Safeguarding Children and Adults at Risk

7.1.1 Safeguarding Processes and Procedures

- When appropriate the team will assess and make the relevant referral to the appropriate Local Authority and/or partner agencies if there are any concerns regarding safeguarding children, adults at risk and other family members.
- Team members will contribute to the delivery of multi-agency safeguarding plans as appropriate.
- Staffing structures must be in place to ensure induction of new staff and on-going case and clinical supervision of all staff. This must include safeguarding supervision from an appropriately qualified professional.

7.1.2 Safeguarding Training

The provider safeguarding team will ensure staff receive safeguarding training in accordance with statutory guidance "Safeguarding Children and Young People: roles and competences for healthcare staff (2019)", Bournemouth Competencies (2010- Updated 2015) / Adult Safeguarding: Roles and Competencies for Health Care Staff (Adult Intercollegiate Document, 2018) and Prevent Training and Competencies Framework (2017). The provider must ensure that paid staff and volunteers in contact with children and/or adults at risk receive safeguarding adults and safeguarding children training, appropriate to their role and in line with statutory and local guidance. Staff must be trained and competent to be alert to the potential indicators of abuse and neglect and know how to act on those concerns.

7.1.3 Incident Reporting

The Provider will submit a monthly report of any incidents, including near misses and complaints to the Commissioner. Any serious incidents (SI's) identified must be reported to STEIS. A 72-hour review must then be submitted to the CCG following the serious incident and a full investigation where appropriate in accordance with the SI National Framework timescales.

7.2 Skilled Workforce

7.2.1 Staffing

The Provider must ensure that 100% of the staff are IAPT trained and competent to deliver Services as set out in this contract.

The Provider will ensure the following:
- All Staff can demonstrate the relevant qualifications, competencies, supervision arrangements

and access to appropriate work based education and training as necessary to enable them to deliver the Service.

- All Staff will be registered with an appropriate professional body in line with their role and qualifications (where required)
- All Staff will be accountable to the employing authority, in line with its contractual arrangements with St Helens Clinical Commissioning Group
- The Service will demonstrate its ability to recruit and retain a skilled and appropriately qualified workforce to ensure that there are sufficient staffing levels in place (clinical and non-clinical) to deliver the Service as set out in this specification.
- The Service is adequately staffed within designated resources with cover available for annual and other leave, maternity, sickness and training with no interruption to the provision of Service.
- The Service will hold and demonstrate safe recruitment procedures to NHS Employment Check Standards e.g. DBS checks and shall meet the requirements of vetting and barring scheme introduced in October 2009, references obtained for all individuals and appropriate identification checks are undertaken. The Service will demonstrate that arrangements and plans are in place for Continuing Professional Development (CPD) for staff involved in delivering or supporting the delivery of the Service.
- The Service shall demonstrate that contingency arrangements and plans are in place to cover for planned and unplanned increases in workload and/or staff absences.
- The Service will actively support all its employees to promote openness, honesty, probity, accountability, and the economic, efficient, and effective use of resources

7.2.2 IAPT Workforce

The IAPT workforce model is a collaborative one between employers and universities, where trainees are recruited jointly to new posts, provided with training in their first year and may be given substantive posts on successful completion working to an agreed recruitment plan with the CCG, recognizing increasing demand and natural attrition / development of service staff.

Services are required to offer supervision and support to agreed professional standards; these can be found on the IAPT website http://www.iapt.nhs.uk/workforce/The IAPT workforce is quality assured by explicit competency frameworks; national curricula and learning materials, delivered through accredited training courses.

7.2.3. Clinical Supervision

Management and Clinical Supervision must be carried out in accordance with IAPT guidelines and Professional registration requirements.

The Provider will provide evidence of the following;

- The qualifications in supervision held by relevant/applicable Service staff.
- Monitoring the supervision of trainees and qualified staff.
- Monitoring trainee and staff satisfaction with clinical supervision and case management.

8. Insurance

The Service will have in place for the full duration of the Contract, and be fully responsible for medical negligence indemnity insurance and all cases of medical negligence shall be reported to St Helens CCG. Where necessary, services will develop shared care arrangements to ensure the Service Users' needs are fully met and all aspects of their care and treatment are coordinated. This Service will not be expected to take on a care co-ordination role.

Safe, integrated and effective primary care psychological therapies need clear pathways for Service Users to move into, through and out of service provision. The Service will ensure mechanisms are in place for resolution of disputes.

9. Management of DNAs and Waiting lists

9.1 Management of DNAs

The Provider must ensure 'Did not Attend' Service Users are proactively managed in conjunction with St Helens CCG GP Practices, will follow its Service policy that is in place for reducing the annual DNA rate. This policy should include means of enabling the Service User to cancel / rearrange appointments, e.g. cancellation by text, email and other appropriate media, pro-active follow up by the provider to encourage engagement and clear timeframes for contact. The Provider shall manage DNA Service Users in accordance with the DNA/Cancellations standards. The Provider will be monitored in terms of its ability to reduce the DNA rate where necessary.

The Provider will work with the referring St Helens CCG GP Practices to develop a strategy for managing and supporting those Service Users that do not comply with their recommended course of treatment.

Recent research of >280,000 patients showed that patients with long-term mental health conditions who missed more than two appointments per year had a greater than 8-fold increase in risk of all-cause mortality compared with those who missed no appointments.

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9.1.2 Management of Assessment and Treatment Waiting Lists

Assessment and treatment waiting lists will be proactively managed by the Provider on a weekly basis. Waiting lists will be managed in conjunction with individual St Helens CCG GP Practices and St Helens CCG to ensure that all Service Users waiting who still require to be seen by the Service are being held on the most appropriate waiting list for their level of need**.** Adherence must be made to the DNA/Cancellations Standards to support the management of waiting lists and NICE guidance.

The Provider will have a policy to deal with assessment and treatment waiting lists and is fully responsible for achieving and maintaining waiting time related standards as agreed within this Contract.

9.1.3 Communication with GPs and Practice

The Provider will be required to meet with St Helens GPs/Practice Manager members as required on the basis to discuss the operation and Service delivery of the Primary Care Mental Health Service pathway (referral patterns, recovery rates, waiting lists and Service developments). This may take the form of attendance at GP Members meetings, or other forums as agreed between the Provider and GP Members.

Additionally, the Provider will:

- Send GP Practice level data e.g. referrals, numbers entering treatment, numbers completed treatment, recovery, DNAs, cancellations, prevalence etc. (to include actual vs. expected activity) to St Helens CCG Business Intelligence on a fortnightly basis
- Participate in educational events and facilitate awareness sessions for St Helens GPs and other Health Care Professionals as appropriate
- Meet and communicate by the best agreed way possible with GPs to discuss reviews/referrals as

appropriate.

- Keep practices updated with service information including marketing information, leaflets, posters to be available within practice premises. The Provider may choose to have regular communication meetings with GP practices on an agreed scheduled basis.

9.1.4 Information and Data Management

The Service will:

- Use an appropriate data management system and is responsible for monitoring Service User flow from point of referral to Service discharge.
- Use a data system that will provide inter-operability into St Helens Care record.
- Supply and upload the IAPT Minimum Data Set on the required data system as identified by NHSE. The Service will establish high quality IT system which includes as a minimum:
  - Remote access for therapist
  - Online diaries and booking systems
  - Access to online information resources
- Be compliant with Information Governance Toolkit and Data Protection principles
- Director level/ CEO sign off (or appropriate delegation) that will ensure that the data submitted is accurate, complete and in line with national rules
- Have a Health and Social Care Network (HSCN)NHS secure connection
- Provide monthly reports to the CCG on performance in relation to both national and local key performance indicators and other related quality standards agreed in the Contract, ensuring that monthly data is consistent with one data source, the HSCIC prepublication Extracts and published data
- Comply with and provide ad hoc data requests made by the CCG.

9.1.5 Service Monitoring

On a monthly basis, the Provider is required to submit the following in line with the reporting requirements outlined in the Information Schedule:

- IAPT MDS (including cCBT) via the mental health bureau service on the Open Exeter portal in line with timescales outlined in the published guidance. Technical specification and guidance on submission can be found at http://www.hscic.gov.uk/iapt.
- Key Service Outcomes data set (section 2.2) to the Commissioner via the NHS.net email address on the 10th working day following each month.
- Monthly Performance Dashboards to the Commissioner (for IAPT Psychological Therapies (Mandated Targets), cCBT, Level 2 Bereavement and Drop-In Service). It should be noted that the Performance Dashboards included in the Information Schedule are draft versions and therefore, the Commissioner reserves the right to make amendments to the Dashboards as and when required.

The Provider **must** also **submit**:

- Submit an Operational Lead Service Report to the Commissioner on the 15th working day following each month, detailing as a minimum the following:
  - Service performance position; areas of performance met/not met, areas for improvement, communication and pathway work, workforce and any summary examples of good work that has taken place and any complaints received.
  - Outcomes of Service User/Carer forums held.

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The Provider **must** ensure that robust reporting systems are in place to capture reporting requirements. This includes the collation of data from any sub-contracted providers.

9.1.6 Service Promotion

The Provider will promote their Services, targeting all referrers, relevant service providers, general public, Service Users and others as appropriate. Service promotion strategies should include:

- Information on common mental health problems and options for treatment.
- Service leaflets.
- Utilisation of GP practice screens and information boards in local pharmacies, Self- help resources, including downloadable materials and local help lines.
- Links to Alcohol and Substance Misuse Services.
- Fully functioning and accessible Website offering:
  - Information for referrers and Service Users regarding details of the Service including, how to contact, how to refer, what Services are available and waiting times.
- Self -help resources. Links to self-care guides for mental health should be included as a minimum on the website to support Service Users to self-care where appropriate. This should be used as a signposting resource by workers within the Service and St Helens GPs for both Service Users referred to the Service (to bridge the waiting time until treatment commences) and those who have been identified as not appropriate for the Service (at the time of being assessed by the Service or GP) but who would benefit from self-care. Service User feedback
- Links to other relevant websites including those describing NICE guidance, NHS platforms, and Royal College guidance e.g. RCGP and RCPsych
- Utilisation of local publications and alternative media sources to promote service.
- Consider modern technological advances as resources e.g. apps

9.1.7 Complaints & Compliments

- The Provider will have a formal Complaints Policy and Procedures in place, which Service Users can access and raise any issues they have with the Service. The provider must respond to complaints in line with the current NHS Complaints Procedure. All complaints, responses and actions must be reported to the Commissioner on a monthly basis.
- The provider should also have a system in place to record compliments and use compliments to support staff recognition and feedback.

9.1.8 Service Developments

The Provider will develop Services in line with the requirements of the Commissioner, and commit to expanding access to Primary Care Mental Health Services to the wider community, including those communities that do not usually access services (*No Health without Mental Health, Four Year Plan of Action and Five Year Forward View Mental Health Taskforce Report 2016*). Areas for such Service development will include:

- Appropriate access for over 65's
- Extending Services to Service Users with physical Long term conditions or medically unexplained symptoms
- Military Veterans Health and Wellbeing

- Perinatal Services
- BAME Communities (including Traveller Communities and Asylum Seekers)
- Suicide prevention
- Provision of anger management therapy
- Engagement with Third Sector agencies
- Referrals from Service Users who use British Sign Language

The above is not an exhaustive list, the Provider will be expected to examine the need for future initiatives and/or develop relationships with other services at the request of the Commissioner.

9.1.9Days/Hours of Operation

The service will offer flexibility and choice where possible, to reflect the individual service user's needs.

The service will be available for 52 weeks per year excluding bank holidays.

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
From	8.00am	8.00am	8.00am	8.00am	8.00am	8.00am	
To	8pm	8pm	8pm	8pm	8pm	1pm	

The Provider will be flexible in the days/hours of operation, to ensure that the demands for the Service are met. This should include offering appointments that are suitable for Service Users who work between the hours of 9am to 5pm (i.e. evening appointments during weekdays and appointments during the weekend). Appointment times must also take into account the extended hours available across St Helens GP Practices. It is envisaged that offering choice of appointment will support a reduction in the number of Service Users who DNA appointments.

- For telephone, on line and face to face therapy, the service will be available 52 weeks per year excluding public service holiday's and will be expected to provide evening sessions during the week to reflect demand.
- Office base telephones (for referrals and enquiries) to be staffed Mon-Fri 9-8pm and Saturday 8-1pm

9.1.10Population covered

The service will accept referrals for people 16 years and over who are registered with a St Helens CCG General Practice.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- No Health without Mental Health – February 2011 and Five Year Forward View Mental Health Taskforce Report 2016
- The '*Closing the Gap: Priorities for Essential Change in Mental Health*' (Department of Health January 2014)
- NHS England Choice in Mental Health Care Interim Guidance (May 2014) -Improving Access to

Psychological Therapies standards.

The Provider will adhere to the following NICE Clinical Guidelines:

- Depression (NICE CG 90)
- Postnatal Depression (NICE CG 45)
- Self –Harm (NICE CG 16)
- Post-Traumatic Stress Disorder (NICE CG 26)
- Anti-Social Personality Disorder (NICE CG 77) Borderline Personality Disorder (NICE CG 78)
- Common Mental Health Disorders (NICE CG 123)
- Anxiety (NICE CG 113)
- Obsessive Compulsive Disorder (NICE CG 31)
- Depression in Adults with a Chronic Physical Health Problem (NICE CG 91)
- Working Together to Safeguard Children (DE/DH 2010/2013) Children Act 1989 & 2004
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- NICE CG89: When to suspect child maltreatment (2009/2013)
- Antenatal and postnatal mental health: clinical management and service guidance NICE guidelines [CG192].

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Mental Health Policy Implementation Guide (March 2001)
- Our Health, Our Care, Our Say: A New Direction for Community Services (Health and Social Care White Paper, July 2005)
- Improving Access to Psychological Therapies, Department of Health, 2006
- The Future of Mental Health Services (The Sainsbury Centre, January 2006)
- CSIP Choice and Access team, Department of health: May 2007 Commissioning a Brighter Future, IAPT positive practice guide
- NICE Commissioning a service for providing CBT for the management of common mental health problems, April 2008
- IAPT. Improving Access to Psychological Therapies Implementation Plan: Curriculum for High intensity therapies workers 2008
- IAPT. Improving Access to Psychological Therapies Implementation Plan: Equality Impact Assessment 2008
- IAPT. Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit 2008
- IAPT. Black and Minority Ethnic (BME) Positive Practice Guide 2009
- IAPT. Older People Positive Practice Guide 2009 and the Compendium 2012
- IAPT. Commissioning IAPT for the whole community Improving Access to Psychological Therapies 2008
- IAPT. Improving Access to Psychological Therapies Implementation Plan: National Guidelines for regional delivery 2008
- IAPT. Improving Access to Psychological Therapies Implementation Plan: Curriculum for Low intensity therapies workers 2008
- IAPT. Learning Disabilities Positive Practice Guide 2013
- IAPT. Offenders Positive Practice Guide 2013
- IAPT. The IAPT Pathfinders Achievements and Challenges 2008
- Common mental health disorders Identification and pathways to care. Issued: May 2011 NICE clinical guideline 123
- Ministry of Defence. The Nationals Commitment: Cross-Government Support to Our Armed

Forces, their families and Veterans (2008) London

- Closing the Gap: Priorities for essential change in mental health' (DoH, January 2014)
- The 'Mental Health Crisis Care Concordant' (February 2014)
- Interim guidance: Implementing clients' right to choose any clinically appropriate provider of mental health services' NHS England (May 2014)
- Compliance with statutory requirements for safeguarding children and vulnerable adults.
- Bereavement Care Service Standards (Bereavement Services Association and Cruse Bereavement Care 2013).
- NHS 10 Year Plan (January 2019)

4.3 National safeguarding standards

- Working Together to Safeguard Children (DE/DH 2010/2013/2015/2018)
- Children Act 1989 & 2004
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Care Act 2014
- Mental Capacity Act & Deprivation of Liberty Safeguards (2005)
- Prevent Duty Guidance (2015, updated 2019)
- NICE CG89/NG76: When to suspect child maltreatment (2009/2013/2017)
- NICE (QS116): Domestic Violence and Abuse (2016)
- Children & Social Work Act 2017

The Provider will refer to the following guidance and standards in relation to IAPT and all other guidance issued by Health and Social Care Information Centre (HSCIC) deemed relevant by them to an IAPT service http://www.hscic.gov.uk/iapt

http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf

The Provider will refer to the following guidance in relation to IAPT:

http://www.iapt.nhs.uk/silo/files/data-set-v15.pdf**- Summary of changes** http://www.iapt.nhs.uk/silo/files/measuring-recovery-2014.pdf- **Measuring Improvement & Recovery Adult services**http://www.iapt.nhs.uk/silo/files/waiting-time-2014.pdf-

https://www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdfWaiting time guidancehttp://www.iapt.nhs.uk/silo/files/adsm-guidance.pdf- **Guidance note on the use of Anxiety Disorder Specific Measures (ASDMs)in IAPT**http://www.iapt.nhs.uk/silo/files/iapt-kpi-technical-guidance-201213-v20-.pdf-**IAPT Key Performance Indicators (KPI) Technical guidance for 2012-13 v2.0**

4.4Applicable Local Standards

Local strategic context

Mental Health has been identified as a priority within St Helens Cares objectives. This is delivered by the Mental Health and Wellbeing Board.~~Wirral~~

Local Policies and Procedures

- St Helens Safeguarding Children's Board Policies and Procedures
  Web Link - Tri-x

- St Helens Children's Partnership Council's Guide to Integrated Working (which includes comprehensive guidance on information sharing)

- St. Helens Council Multi-Agency Safeguarding Adults Policy, Procedures and Good Practice Guidance Edition – April, 2015.

- Tackling Domestic Abuse – St Helens Strategy 2018-2023 (February 2018)

- St Helens Safeguarding Boards Standards for Safeguarding Children and Adults at risk Annual Audit Section 11 Children Act 2004 /Chapter 14 Care Act 2014)
  Web Link - LSCB

5. Quality Standards

5.1. Applicable Quality Requirements (See Schedule 4A-C)

5.2. Applicable CQUIN goals (See Schedule 4D)

5.3 Payment Schedule

The basis of the contract will be part block and part performance. St Helens CCG wishes to incentivise the successful bidder to achieve a range of outcome/quality measures, as outlined in the specification. In order to facilitate this, the price paid will be based on a block element plus an element related to the successful achievement of a range of outcome/quality measures.

For example if the total maximum payment is to be £1 million the breakdown would be such that , 80% of the total bid price will be paid as a block payment with a further payment to a maximum of 20% of the bid price paid if all National outcome/quality measures are met.

This would mean that ££££££££££will be paid as a block element and £££££££££would be dependent on achievement of the National outcome/quality measures outlined in the specification.

A breakdown of the % payment schedule is shown below for information

Year	% Paid on block	% Paid on the achievement of the National outcome measures
1	80% of total value of annual contract	20 % of total value of the contract broken down into : • 5% will be payable on meeting the prevalence target of 22% for the number of people entering into psychological therapies; • 5% will be payable on meeting the ratio of people moving to recovery the target is a minimum of 50%. • 5% will be payable on meeting the target of 75% of people starting their treatment within 6 weeks • 5% will be payable on meeting the target of 95%

		of people starting their treatment within 18 weeks
2	70% of total value of annual contract	30 % of total value of the contract broken down into : • 7.5% will be payable on meeting the prevalence target of 25% for the number of people entering into psychological therapies; • 7.5% will be payable on meeting the ratio of people moving to recovery the target is a minimum of 50%. • 7.5% will be payable on meeting the target of 75% of people starting their treatment within 6 weeks • 7.5% will be payable on meeting the target of 95% of people starting their treatment within 18 weeks
3	60% of total value of annual contract	40 % of total value of the contract broken down into: • 10% will be payable on meeting the prevalence target of 25% for the number of people entering into psychological therapies; • 10% will be payable on meeting the ratio of people moving to recovery the target is a minimum of 50%. • 10% will be payable on meeting the target of 75% of people starting their treatment within 6 weeks • 10% will be payable on meeting the target of 95% of people starting their treatment within 18 weeks
4	60% of total value of annual contract	40 % of total value of the contract broken down into: • 10% will be payable on meeting the prevalence target of 25% for the number of people entering into psychological therapies; • 10% will be payable on meeting the ratio of people moving to recovery the target is a minimum of 50%. • 10% will be payable on meeting the target of 75% of people starting their treatment within 6 weeks • 10% will be payable on meeting the target of 95% of people starting their treatment within 18 weeks
5	60% of total value of annual contract	40 % of total value of the contract broken down into: • 10% will be payable on meeting the prevalence target of 25% for the number of people entering into psychological therapies; • 10% will be payable on meeting the ratio of people moving to recovery the target is a minimum of 50%. • 10% will be payable on meeting the target of 75% of people starting their treatment within 6 weeks • 10% will be payable on meeting the target of 95% of people starting their treatment within 18 weeks

Commissioners reserve the right to adjust these targets should there be National Policy changes that

requires implementation during the term of the contract.

6. Location of Provider Premises

6.1 Services will be available across local areas in a variety of primary care and community settings

- Each Primary Care team i.e. GP practice shall have direct access to the service with a worker forming an integral aspect of the primary care team through allocated time with each practice;
- Appointments will be directly accessible from the practice, with GP practices providing some infrastructure support (e.g. booking of appointments, room availability) A "clinical hub" capacity is needed which can accommodate the following functions, facilitated by up-to-dated Information and Communications Technology (ICT): this could be provided on a 'locality' basis for a 'base' however must be within easy accessibility of a patients home or registered GP practice.
- Facilities for telephone-based Psychological Well-being Practitioner interventions.

The Provider will cover any accommodation costs associated with the Service. Therefore, any additional costs associated with room hire/building rental or maintenance will be at the expense of the Provider and will not be funded separately by the Commissioner.

The Provider will ensure that all delivery sites are fit for purpose and meet all requirements for health and safety, confidentiality and accessibility.

The location of Service delivery will be for all Services included in this specification as set out below

- IAPT Psychological Therapies (step 2-4)
- Computerised Cognitive Behavioural Therapy
- Level 2 Bereavement Counselling
- Drop-In Support

The use of other locations will reflect the function of the Service and existing arrangements.

The location of Service delivery should be reviewed on a six monthly basis by the Prime Provider, to ensure that Service locations meet the needs of Service Users referred to the Primary Care Mental Health Service. A report should be submitted to the CCG, which (as a minimum) should detail the current Service locations used for each of the main Service elements (IAPT, computerised CBT, Level 2 Bereavement and also Drop-In Support), Service User engagement/attendance levels for each of the Service locations used for each Service area and Service User feedback.

7. References

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- [2]McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (eds), 2009. *Adult Psychiatric Morbidity in England 2007: results of a household survey*. NHS Information Centre for Health and Social Care. [online] Available at:http://www.hscic.gov.uk/pubs/psychiatricmorbidity07[Accessed 25 Aug 2015].
- [3]Patel V, Lund C, Hatherill S, Plagerson S, Corrigall J, Funk M, & Flisher AJ. (2010). Mental disorders: equity and social determinants. Equity, social determinants and public health programmes, 115.
- [4]Das-Munshi et al. (2008) cited in McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016)

Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014.

- Leeds: NHS Digital [Accessed 5 Oct 2016] Available at:http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf
- 5McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-execsummary.... 5 October 2016]
- Ross McQueenie[1]*, David A. Ellis[2], Alex McConnachie[3], Philip Wilson[4] and Andrea E. Williamson[1] Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study https://doi.org/10.1186/s12916-018-1234-0

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