Primary Care Mental Health (PMHC) Service Provision (including IAPT) Service Specification

Service Specification Number	
Service	Primary Care Mental Health Service Provision (including IAPT) Service Specification
Commissioner Lead	NHS Eastern Cheshire Clinical Commissioning Group
Commissioner Lead	Emma Leigh
Provider Lead	
Period	1st January 2016 – 21st December 2019
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

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 also 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.

Improving Access to Psychological Therapies (IAPT) is a national NHS programme being rolled out across England during 2008-2015 – this plan accompanies the cross Government mental health strategy 'No Health Without Mental Health,' which broadened the benefits of talking therapies to contribute to improved outcomes, wellbeing and recovery of wider groups including older people with severe and enduring mental illness and those with long term physical conditions.

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

NICE evidence for anxiety shows:

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

The service is aimed at providing NICE approved interventions to people in a system of stepped care linked to employment and primary care support. The therapists need to have the following competencies, provision of CBT, IPT, EMDR and case management.

IAPT offers increased access to National Institute for Health and Clinical Excellence (NICE) approved treatments for people with depression and anxiety disorders by delivering:

- Trained competent workforce
- Implementing quality standards (recovery, choice, equity)
- Routine monitoring of patient reported outcome measures
- Defined care pathways in a stepped care model

The Local Picture
Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of lives for patients, their family and carers, multiple morbidity, higher levels of service use and many associated economic costs. In 2007, the prevalence (number of cases within the population) of 'mixed and anxiety and depression' was estimated to be 9.0% (Adult Psychiatric Morbidity Study, 2007). This indicator, taken from QOF data allows practices and CCGs to compare the recorded prevalence of depression on their registers against these national figures, and against other areas.

Depression: QOF prevalence (18+)
England: 5.8
NHS Eastern Cheshire CCG: 5.5 (Significantly lower)
Whilst this figure is encouraging, 10 practices in Eastern Cheshire score significantly higher than the England value.

It is estimated that in UK general practices, 50% of attending patients with depressive disorders do not have their symptoms recognised. (Annadale; Meadowside; Priorsleigh; George street; Handforth; Wilmslow: Readesmoor; Toft Road; Bollington and South park)

Depression and anxiety prevalence (GP survey)
England value: 12.0
NHS Eastern Cheshire CCG value: 10.8 (Significantly lower)
Again, whilst this figure is encouraging, there are 7 practices in Eastern Cheshire which have slightly higher score. (High Street; Meadowside; Holmes Chapel; Lawton House; Readesmoor; Park Lane; Handforth)

Evidence Base & Policy Guidance:
No Health without Mental Health – February 2011

NICE Guidance:
- 2005a Obsessive Compulsive Disorder Clinical Guideline 31
- 2005b Post Traumatic Stress Disorder Clinical Guideline 26
- 2006 Cognitive Behavioural Therapy for Depression & Anxiety
- 2009a Depression
- 2009b Depression in Adults with a Chronic Physical Health Problem
- 2011 Common Mental Health Disorders Clinical Guideline 123

2. Key Service Outcomes

2.1 NHS Outcomes and framework

NHS Outcomes Framework domains and indicators

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

2.2 Key service Outcomes

The key service outcomes for Primary Care Psychological Therapies include:

- Increased proportion of people with common mental health issues who are identified and receive treatment in accordance with appropriate NICE guidance (National mandated KPI)
- Improved speed of access and response at key points in the care pathway.
- Increased proportion of people with common mental health issues who make clinically significant improvement or recovery (National mandated KPI).
- Increased social participation and community integration of service users.
- Improved service user choice and experience of services.
- Increased number of individuals successfully treated (recovered).
- Reduce mental health inequalities for those groups that are traditionally excluded.

The service will be monitored by the collection of non-mandatory and mandatory data, as detailed in the Technical Guidance for Improving Access to Psychological Therapies Key Performance Indicators (KPIs).

The provider must ensure that they have adequate IT systems and infrastructure in place for:

- Contract management and business processes and comply with technical specifications expected for NHS service provision
- Preferred data management system is IAPTUS, linked to National Audit.
- Handling information securely and confidentially and have appropriate data sharing arrangement in place with all partner organisations.
- Supporting the delivery of the specified service and management of patient care.

In addition to the key service outcomes the provider will be expected to enable access for the CCG to access appropriate systems for audit requirements.

2.3 Local defined outcomes

The service will be expected to improve the access to the following target groups to meet local needs:

- Over 16 years old (there is no upper age limit).
- Disabled people
- People with long-term physical health conditions

- People with medically unexplained symptoms
- People diagnosed with cancer
- People with Learning Difficulties/Disabilities
- People with Autism Spectrum Conditions
- People who Self Harm
- Military Veterans
- BME communities
- 3rd Sector & Faith Communities
- Lesbian, gay, bisexual and transgender communities
- People who have experienced sexual abuse
- People who have or who are experiencing domestic violence
- People from deprived communities, including people who are on low incomes, unemployed or homeless, single-parents and carers
- Certain age and gender groups e.g. older people, including people living in nursing homes or those with dementia, younger people, especially young men,
- Refugees and asylum seekers
- People whose first language may not be English
- Referrals from Service Users with sensory impairments – including service users who use BSL, ensuring the appropriate pathway is followed, as agreed by local commissioners

This is not an exhaustive list and there may already be specialised services commissioned to provide to meet the needs of a certain group. The IAPT provision may be delivered in conjunction with or as an alternative to these specialist services, as defined by the assessed needs of the individual following Initial Assessment.

The Provider will be expected to develop systems to conduct an audit on a three monthly basis to analyse improvement of access of the above groups.

3. Scope

3.1 Aims and Objectives of the Service

The aim of the service is to provide an initial screening service and interventions to improve the psychological and mental wellbeing of the people of Eastern Cheshire (via the **Access and Referral** point). This will also entail improved access to psychological therapies for the population of Eastern Cheshire, providing timely interventions that will improve mental health and wellbeing. This will be delivered from accessible community venues, so that people feel able to access the services without fear of being stigmatised.

The provider will be required to deliver mental health wellbeing support including interventions at Step 2 & 3 of the stepped care model in accordance to NICE guidelines, using validated evidence based assessment monitoring and outcome tools.

The service will include assessments of need and where necessary, risk assessments for people who have a mild to moderate mental health problem. The service will include prevention therapies (such as brief interventions, and accredited counselling).

The IAPT element of the service will:

- Provide a single point of entry (via the **Access and Referral** point) for all Step 2 and 3 mental health and psychological referrals
- Deliver appropriate interventions at Step 2 & 3 of the stepped care model in accordance to NICE guidelines, using validated evidence based assessment and monitoring and outcome tools
- Treat *common mental health problems* including:
  - Depression
  - Generalised anxiety disorder
  - Mixed depression and anxiety
  - Panic disorder
  - Obsessive-compulsive disorder
  - Phobias (including social anxiety disorder (social phobia))
  - Post-traumatic stress disorder
  - Health anxiety (hypochondriasis)
  - Adjustment disorders
  - Anger management
  - Psycho sexual issues
  - Depression or anxiety in adults with a chronic physical health problem, specifically including pain management, or medically unexplained symptoms
  - Depression or anxiety in adults with a mild learning disability or cognitive impairment
  - Depression or anxiety in adults with an eating disorder (mild-to-moderate)
  - Provide comprehensive provision for Military Veterans locally, if a Veteran wishes to access a local service rather than a specialist IAPT service, and if required, will triage and make referral onto specialist IAPT services for Veterans for those requiring a specialist resource

This is not an exhaustive list and the presenting problem will be defined by the assessed needs of the individual following Initial Assessment

Make use of any of the following methods listed within an integrated therapeutic approach:

- Self-help and bibliotherapy
- Computerised CBT (cCBT)
- Cognitive Behaviour Therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Cognitive therapy
- Generic counselling
- Eclectic therapy
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Problem Solving Therapy
- Group work
- Case management

(This is not an exhaustive list and the appropriate intervention will be defined by the assessed needs of the individual following Initial Assessment – via the **Access and Referral** point)

- Develop and maintain strong links with GPs and local secondary mental health service
- Include employment as a health and wellbeing component part of the initial assessment.
- Develop relationships a strong working relationship with the Wellbeing Wraparound Hub, to ensure that referrals are made and received effectively and consistently

3.2 Underlying Service Principles

- To provide a directly accessible primary care driven service
- To provide a 'whole person' approach to the delivery of Psychological Therapy
- To provide services which takes account of the person's socio-demographic characteristics, health comorbidities and lifestyle
- 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 as defined in 2.3.
- To provide high quality and flexible support to service users that maximises individual potential. This may include:
  - Language and communication support
  - Use of multi-media technology
  - Home-based interventions
  - Non-traditional community settings
- Promoting recovery and minimise the disabling effects of mental ill health. Providing a person-centred service, and recognise the need for all organisations to work in partnership with services users in a holistic and inclusive manner.
- Offering support to families and carers in terms of assessment of their own caring, physical, social, occupational and/or mental health needs and information on how they can support the person or access relevant support groups and networks.
- Evaluating the effectiveness of the Primary Care Psychological Therapies Services through the systematic and comprehensive collection of pre- and post-treatment outcome data of all patients treated.
- To provide an appropriately trained sustained workforce and maintain the training needs, this includes supporting patients in the community.
- Establish a detailed understanding of the work of the Wellbeing Wraparound Hub to ensure effective working relationships.
- Reduce the stigma associated with mental health care.
- Ensure unnecessary treatments are avoided.

3.3 Service Description/Service Pathway

<u>Referrals</u>

The majority of referrals have traditionally been made via GPs and via self-referrals, therefore the provider will need to utilise a self-referral form and make arrangements for the operation of a effective 'options' system operated through the '**Access and Referral**' point.

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 Eastern Cheshire population
- Continue to 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 the Primary Care Mental Health service
- '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 (via signposting to the Wellbeing Wraparound Hub), but may not be currently eligible for a service.

<u>Assessment Procedure</u>

There will be **Access and Referral** point into Step 2 and 3 for all service users which will offer assessment/screening focused on the presenting problems.

Prior to the start of treatment all service users will receive a comprehensive 'person centred' assessment that clearly identifies the full range and impact of their mental health problems, their physical heath and any associated issues.

Assessment of presenting risks (including suicide and harm to others) assessed at initial contact and at each contact thereafter.

The assessment will include:

- IAPT minimum data set
- Obtaining necessary demographics
- Obtaining consent to share information
- Patient aims for treatment and preferences in relation to treatment;

Screening/Assessments/Interventions to be offered include:

- Mental Health Assessment – PHQ9, GAD7
- Risk Assessment – Threshold Assessment Grid (TAG)

All health information will be added to the practice data system of the persons GP and the team will provide signposting/referral to other team such as:

- Prevention/brief interventions
- Social inclusion services

- Lifestyle advisors and health trainers.

The ‘stepped care model’ should ensure that local 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;
- Responsibility for prescribing medication will reside with the service users GP.
- All service users must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the conditions being treated. Key measures should be given at each treatment session so that a clinical end point is available if the patients finish treatment early.
- The service will deliver access and outcomes standards defined in the IAPT Outcome and Data Collection framework

<u>Step 2</u>

At Step 2 low intensity interventions will be delivered by a mix of workers with appropriate training, supported and supervised by professionals with the relevant competencies. The service can be provided through individual and group sessions and will include 1:1 contact, e-therapy and telephone support.
The key elements of Step 2 area range of low intensity interventions (1-6 sessions) usually including:

- Education
- Bibliotherapy
- Behaviour activation
- Guided cognitive-behaviour self-help
- Problem solving
- Guided self-directed exposure therapy
- Computerised Cognitive Behaviour Therapy Concomitant medication advice and support for patients receiving anti- depressant therapies, which will be communicated to primary care.
- Telephone collaborative care support for patients on antidepressant therapies
- Individual CBT sessions with a therapist

<u>Step 3</u>

These interventions generally consist of a range of high intensity provision, which usually includes:

a) Individual Cognitive Behavioural Therapy sessions (6-8 sessions)
b) Group CBT (6-10 patients, x 2 hour sessions).
c) Therapy sessions should be supplemented by guided self-help when

appropriate materials are available.

d) Concomitant medication advice and support for patients receiving antidepressant therapies, which will be communicated to primary care. Telephone collaborative care support for patients on antidepressant therapies.

NB: Only a small minority of people are likely to need treatment in Step 4 services and these treatments will be outside the scope of this IAPT service as they involve complex multi-disciplinary case or care programme approach (CPA) management and medication supervised by secondary or specialist mental health services.

If it is identified that a person requires Step 4 during the **Access and Referral** process the provider will be responsible for communicating with the service users GP when required, who is then responsible for referral to secondary care services.

3.4 Safeguarding

Child Protection:
It is important for the Service to consider the impact of parents' or carers' with mental health conditions, on the welfare of children in their care. In this section the term 'parent' will be used to refer to an adult who has child care responsibilities and includes anyone who may be the parent or carer of that child, or who may be pregnant.

The service will be provided in accordance with the principles of the Children Act 1989 and the Children Act 2005 and comply with Cheshire East's Councils policy for Safeguarding Adults and Children.

In accordance with the Care Plan the service will:

- Liaise with the Service User's family, where appropriate
- Liaise with other agencies involved in the care of the Service User, including Social Care, antenatal/midwifery services, and make referrals as appropriate;
- Attend and contribute to Child Protection or multi-agency planning meeting.

Adult Protection:
All agencies have a responsibility for protecting Vulnerable Adults in Cheshire East from abuse, and promoting their welfare. The service must therefore ensure it follows and complies with Cheshire East's Council Multi-Agency Safeguarding Adults Policy, Procedures and Good Practice Guidance Edition - January 2013. The service must keep abreast of any changes to local and national guidance/policy in relation to safeguarding adults and ensure that any changes are intrinsic within the service philosophies, principles and practice.

(Further information on Children Safeguarding and Adult Safeguarding procedures in Cheshire East are available via the Cheshire East Council website – www.cheshireeast.gov.uk)

3.5 Service Promotion

The Provider will be expected to promote their services to current and potential referrers, general public and current service users.

Service promotion strategies will include:

- Information on common mental health problems and options for treatment
- Service leaflets.
- Self-help resources, including downloadable materials and local helplines.
- Links to other service provision
- Fully functioning Website offering information for referrers and patients regarding details of the service including:
  - how to contact
  - how to refer
  - what services are available
  - waiting times
  - self-help resources
  - service user feedback
  - links to other relevant websites
  - NICE guidance

3.6 Service Developments

The provider will be expected to take forward current service developments in line with the commitment to expanding access to psychological therapies to the wider community, including those communities that do not usually access services (No Health without Mental Health, Five Year Forward View for Mental Health)

3.7 Discharge Process

The Provider is expected to have or develop a robust discharge process and protocols – these should be made available to patients, referrers and commissioners on request.

Discharge from the service if the following occur:

- Treatment ends and satisfactory clinical outcomes are achieved
- Achievement of recovery as assessed by assessment tools such as GAD7,PHQ9,
- Patients who have has 2 successive DNAs, and then only after efforts have been made to contact them
- The patient is signposted to a more appropriate service
- The patient is 'stepped up' to a secondary care service – following agreed protocols – GPs must be notified in writing within 72 hours of the referral being sent
- The service user provides information indicating they do not need a service.

On completion of treatment and/or discharged from the service a copy of the treatment report is always offered to the service user and sent out to the GP within 10 working days. The service will ensure that the patient is given or sent a 'patient experience questionnaire' to complete.

3.8 Referral onto other psychological therapy services

Where patient is referred onto other psychological therapy services, the referral will include:

- A copy of the referral
- A copy of the assessment undertaken
- A copy of the Risk assessment
- Demographic details
- Minimum IAPT dataset
- Any specific preferences in relation to treatment

3.9 Waiting List Management

Chronological Waiting List Management should be the starting point, balanced against presenting clinical need and effective use of clinician time, with clear information provided to patients about the choices that are available to them.

Patients on waiting lists for treatment should be contacted at least every 2 weeks to update them on their status and that they remain on the waiting list, to offer advice regarding their presentation and how to remind them on how to contact the service should their circumstances change. Engagement with our population indicates that this is an important aspect of the treatment they receive and no contact can lead to patients feeling that they have been forgotten. We would want the provider to explore innovative ways of maintaining contact and to continually consider feedback from patients about how to improve the service delivery.

3.10 Staffing

Staff will have the correct clinical qualifications, experience and competencies to deliver this specification effectively. It is incumbent on the provider to ensure it has the correct balance of skills and expertise to deliver to this specification.

3.11 Service Monitoring (Key KPIs)

The Key Service Outcomes (set out in Section 2.2) will be submitted to the commissioner on a monthly basis, no later than 5 business days following the end of each calendar month.

In addition the Provider will produce monthly report detailing:

• **Total Number of people referred for psychological therapies (during the reporting month).**
• **Number of people referred for psychological therapies by source e.g. GP, self-referral etc (during the reporting month);**
• **Number of people who received an initial telephone triage from a mental health practitioner, with the first contact attempt made within 24 hours of the referral being received (during the reporting month).**

• **Number of people who received an initial telephone triage from a mental health practitioner, with the first contact attempt made within 3 working days of the referral being received (during the reporting month).**
• **Number of active referrals (referred and awaiting an initial assessment at the start of the reporting month).**
• **Number of people who have entered psychological therapies (during the reporting month).**
• **Number of people who have completed treatment, dropped out, signed posted on**
• **(during the reporting month).**
• **Number of people who are ‘’moving to recovery’’ (during the reporting month) (of those who have completed treatment, those who at initial assessment achieved “caseness” and at final session did not, during the reporting month).**
• **Number of people moving off sickness pay and benefits (during the reporting month).**
• **Number of high intensity trained staff - Step 3 (at the start of the reporting month).**
• **Number of low intensity trained staff – Step 2 (at the start of the reporting month).**
• **Number of high intensity trainees (at start of the reporting month).**
• **Number of low intensity trainees (at start of the reporting month).**
• **The number of people who have discharged after the service after 18 weeks where the service decides that insufficient progress has been made following discussion with the patients GP to discuss treatment options.**
• **The number of people who have started their treatment within 6 weeks – the target is 75 per cent of people (during the reporting month).**
• **The number of people who have started their treatment within 18 weeks - the target is 95 per cent of people (during the reporting month).**
• **The number of people who are waiting to start their treatment by the number of weeks they have been waiting (during the reporting month).**

The service will be monitored by the collection of non-mandatory and mandatory data including the following key KPIs:

Prevalence

EASTERN CHESHIRE CCG: IAPT ACTIVITY 2015-16

Referrals:

There were a total of 3,295 referrals received during 2015-16. This total includes Self Referrals from July 2015. This equates to an approximate average of 9 referrals per day.

Self referrals:

PERIOD	Number
Jul 15	170
Aug 15	135
Sep 15	210
Oct 15	185
Nov 15	245
Dec 15	150
Jan 16	230

Prevalence:

The prevalence for the CCG has been calculated at 20,469 patients. 15% of these patients must achieve 1st treatment in the year to achieve the current national standard.

25% must achieve access to fulfil the proposed new standard. As a proxy measure, based upon the step numbers entering treatment in 2015/16, this total can be split as follows:

STEP	Estimated Prevalence
Step 2	6,888
Step 3	6,161
Step 3C	6,176
Step 4	1,244

Numbers entering 1st treatment:

A total of 2,814 patients entered 1st treatment during the year; this equates to 235/month. To have achieved the 15% Access Standard for the year, a total of 3,070 was required (256/month). Using a baseline of 15/16 activity, a total of 5,117 patients are required to enter treatment (426/month), in order to achieve the new 25% Access Standard. The current (15%) and proposed (25%) access requirements are summarised, by Step, in the table below:

STEP	Required 1st Treatment Numbers / Month = 15%	Required 1st Treatment Numbers / Month = 25%
ALL	256	426
Step 2	86	144
Step 3	77	128
Step 3C	77	129
Step 4	16	25

Percentage of people moving to recovery:

The ratio of people moving to recovery will be a minimum of 50%. Bidders will need to identify the stepping up ratios for the stepped care system they intend to use to ensure the 50% recovery rate is achieved.

Episodes of care:

As a minimum, it should include the following episodes of care:

Step 2: a minimum of 947 episodes of care per annum
Step 3: a minimum of 847 episodes of care per annum
Step 3c: a minimum of 849 episodes of care per annum

Waiting times for Treatment
The new standards introduced from 2016 onwards are:
•75% of people referred for talking therapies for treatment of common mental health problems, such as depression and anxiety, will start their treatment within six weeks
•95% will start within 18 weeks.

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

3.12 Response Times

The Provider is required to adhere to the following response times for Steps 2 and 3:

- The patient will receive an initial telephone triage or face to face contact from a mental health practitioner, with the first contact attempt made within 3 working days of the referral being received.
- Where there are more immediate concerns the patient will receive an initial telephone triage from a mental health practitioner, with the first contact attempt made within 24 hours of the referral being received.
- Individuals identified to at high risk (e.g. suicidal ideation, severe self-injurious behaviour, psychotic symptomatology) should be urgently referred to the appropriate mental health service. The access standard for referral is the same day.
- Where contact is not easily made then the service will employ a range of options to establish whether the patient does wish to access the service, including as a minimum:
  - Contacting the referrer,
  - Sending a letter outlining the service and the consequences of non – contact;

3.13 Days/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
To	8pm	8pm	8pm	8pm	8pm	1pm	-

- 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 based telephones (for referrals and enquiries) to be staffed Mon-Fri 9-8pm and Saturday 8-1pm

3.14 Population covered

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

Acceptance and Exclusion Criteria

Acceptance
Patient groups covered:

- People aged 16 years and over – there is no upper age limit
- People that are experiencing symptoms consistent with a diagnosis of mild or moderate depression or an anxiety disorder (or both) and who do not require an enhanced level of care or access to specialist mental health services
- People that show low to moderate levels of risk to self and/or others and have deterrents and support. Where there is an indication of severe risk to self and/or others these should referred back to their GP for referral to secondary care services

Exclusion
Patient groups covered:

- People under the age of 16 years
- People that are experiencing acute and/or complex symptoms, usually with inadequate response to previous multiple treatments. This may include evidence of an active episode of severe mental illness and bipolar disorder, severe or unstable personality disorders, and eating disorders
- People that show definite indications of acute or high risk to self and others with intent and means; often with previous attempts to harm self or others; and/or clear signs of serious vulnerability and inability to protect self
- Patients that are receiving active treatment from secondary services and have been assessed as clinically inappropriate
- People that are engaged in physically dependent drinking patterns, or using illicit substances for which they are not receiving support

3.15 Interdependencies with other services

The service will have a particularly close relationship with GPs and other Primary Care Practitioners, as a considerable amount of treatment may occur in primary care settings.

The main interdependency for this service will be with the Wellbeing Wraparound Hub. It is expected that the Service will develop pathways between services to ensure partnership working and improve access to care.

The Provider will also be required to work in partnership with NHS Eastern Cheshire CCG led initiatives.

3.16 Complaints

The Provider must have a formal Complaints Policy and Procedures which patients can access and raise 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 commissioners on a monthly basis.

4. Applicable Service Standards

4.1 Applicable National Standards e.g. NICE, Royal College

This service 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.

1. Use of standardised and validated assessment tools to reduce duplication of assessments.
2. Use of validated outcomes measures.
3. Promote accessibility of services
    a. Hours of operation
    b. Accessible, non-stigmatised community venues (including home)
    c. Accessibility for the 'harder-to-reach' local community (e.g. older people, long-term unemployed)
    d. Use of appropriate technology
4. Workforce competencies to deliver psychological therapies
    a. Appropriate training
    b. Regular supervision
    c. On-going personal development plan and training

4.2 Applicable standards set out in guidance and/or issued by a competent body (Royal Colleges)

The Provider will ensure that supervision and support to agreed professional standards is provided. The Provider will recruit sufficient numbers of appropriately experienced and trained supervisors, familiar with the range of NICE and other locally agreed interventions, so that high-quality supervision is available to all trainees and qualified staff within the service.

Therapists will engage in continuing professional development and see a mixed caseload of patients to ensure that skills levels are maintained.

Staff Competency, Training Education, Supervision and Research activities:

- 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 of their training if agreed by the CCG.

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

The IAPT workforce consists primarily of High Intensity therapists delivering Step 3 and Psychological Wellbeing Practitioners (PWP) delivering Step 2 interventions. The PWP is a fairly new role and can be sustained in the long term by offering wider access to candidates from local communities and ensuring there are career development opportunities within the role.

Guidance on best practice and anticipated workload for Psychological Wellbeing Practitioners and High Intensity Workers is available on the IAPT website.

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

Further information about IAPT is available on the NHS IAPT website – www.iapt.nhs.uk

5. Quality Standards

The service will be required to deliver the following Quality Standards

Quality Indicator	Threshold	Consequence
All staff will undertake annual mandatory training including safeguarding children and vulnerable adults	100% of staff planned or will have undertaken training	
Patient safety incidents resulting in severe harm or death	Zero incidence	
Improved reported patient experience	Improvement (target to be agreed) in patient satisfaction survey Top quartile of Friends and Family Test results	
Reduction in equalities EDS 2	Evidence of engagement with all sectors of the population	
Personalised care planning	100% of patients accessing the service will receive a personal plan of care	
Improving productivity by reducing the DNA rate	Maximum is 15% of patients referred	

Safeguarding adults and children	100% of suspected risk or abuse cases referred to Social Care	
Disclosure and Barring service checks	100% of staff that have contact with service users or their family/carers must attend an induction programme and have a DBS (Disclosure Barring Service check) that has been carried out within the last three years.	
The service has a written policy on managing different levels of risk		
Service user experience Feedback of using the service is routinely collected and used to develop the service	A statistically relevant proportion of patient population are surveyed annually. The survey should be conducted in a way that will enable engagement and is accessible to all. The resulting report is presented to commissioners.	
Service users are told how to access emergency help where needed		
The service can demonstrate that complaints and untoward incidents are reviewed and acted upon.		
Access – the service will be fully accessible to those needing the service, providing that eligibility criteria are met.		

6. Location of Provider Premises

It is the Provider's responsibility to ensure that they have adequate accommodation to meet the needs of the population sited equitably across the CCG locality area. The accommodation should include a clinical base(s) to accommodate the following access and functions:

- Facilities for telephone–based interventions.
- Consulting room(s) for patients whose condition (such as social anxiety disorder, including PTSD) requires treatment where video- taping/role play can take place.
- Group work
- Alternative venue for patients who do not want to be seen in GP practice/Health facilities
- Staff to access supervision

The Provider will be required to ensure that the accommodation used for therapy is in easily accessible locations well served by public transport across.

The provider will ensure that it develops better access for sections of the community who may find it difficult to access services via primary care.