SCHEDULE 2 – THE SERVICES

A. Service Specifications

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Service Specification No.	
Service	Improving Access to Psychological Therapies
Commissioner Lead	
Provider Lead	
Period	1st April 2020 – 31st March 2023. X
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Local
The *Sefton People and Place Introductory Profile* (2019) identified the following:

- Sefton has a population of approximately 274,600 and makes up just 0.5% of the English population. 52% of the Borough are female and 48% are male (slightly different to the 51% - 49% split seen across England).
- 23.1% of Sefton's population is 65 years old or over (63,300), with approximately one in five being aged under 18 (53,514).
- Sefton is ranked 18th out of 326 local authorities for the number of residents aged 65 or over.
- Sefton has a unique socio-economic geography. In its entirety it is in the most deprived quarter of English Local Authorities with five of its lower super output areas (LSOA) in the top 1% nationally. Yet other parts of the Borough, particularly in the middle and North, are some of the least deprived areas, with two LSOAs being in the least deprived 5% of areas nationally.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

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 Local/National 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) within Core IAPT and IAPT-LTC modalities of treatment.
- Increased proportion of people with common mental health issues who make clinically significant improvement or recovery (National mandated KPI).
- Improved speed of access and response at key points in the IAPT pathway.
- Reduce mental health inequalities for those groups that are traditionally excluded.
- Improved access to step 4 Psychological therapies.

3. Scope

3.1 Aims and objectives of service

The aim of the service is to improve access to psychological therapies for the populations of Southport & Formby CCG and South Sefton CCG and provide timely interventions, delivered from accessible community venues that will improve mental health and wellbeing. The provider will be required to deliver interventions at step 2, 3 of the stepped care model in accordance to NICE guidelines, using validated evidence based assessment monitoring and outcome tools. Also as part of a local initiative step 4 will be delivered.

3.2 Service description/care pathway

The Provider will deliver a stepped care psychological service providing early access to, and delivery of, psychological therapies in primary care community settings. The Provider 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 Provider service will provide steps 2 and 3 of a stepped care model as defined in the IAPT Manual which will be delivered by a multi-disciplinary team which will be delivered within the following nationally defined modes of delivery:

1. Core IAPT
2. IAPT-LTC

Core IAPT

Core IAPT services provide treatment for people with the following common mental health problems depression

- Generalised anxiety disorder
- Social anxiety disorder
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder (OCD)
- PTSD
- Health anxiety (hypochondriasis)
- Body dysmorphic disorder mixed depression and anxiety.

Integrated IAPT-Long Term Conditions (LTC) services

IAPT-LTC services will target the needs of people with depression and anxiety disorders who also have LTCs (such as cardiovascular disease or chronic obstructive pulmonary disease (COPD), or have MUS (such as chronic fatigue syndrome or irritable bowel syndrome).

People with a long term health condition who also have depression and/or anxiety and are eligible for IAPT, will receive an integrated approach to their physical and mental health.

The provider will:

- In partnership with commissioners, undertake careful capacity planning to explore the extent of embedding staff in LTC pathways, and put in place a process for implementing the most effective and efficient ways of managing co-location and integration of IAPT and LTC/MUS pathways.
- Work together with the LTC pathways (where IAPT staff are embedded) to jointly provide training to both the LTC and IAPT staff, in order to deliver the best integrated mental and physical health care.

Step 4 is initially a **local** initiative consisting of a range of longer term psychological therapies, including psychotherapy that will be delivered for up to 16 – 18 weeks. This will be a maximum of 101 (TBC) completed episodes of care per annum. These will be patients who would normally be seen in a secondary mental health service, but who will be identified as benefitting from IAPT interventions. Step 4 is subsequently aligned with Core IAPT delivery and involves liaison with secondary mental health. Step 4 should be viewed in the national context of increasing access to IAPT for people diagnosed with Psychosis, Bipolar Disorder and Personality Disorders.

3.3 Population covered

The Provider will accept referrals for people aged 16 and over who are registered with a GP in the South Sefton or Southport & Formby CCG catchment area.

3.4 Acceptance Criteria

The following inclusions apply and the Provider will provide support for people with the following common mental health problems.

- Generalised anxiety disorder
- Social anxiety disorder
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder (OCD) specific phobias (such as heights or small animals)
- PTSD
- Health anxiety (hypochondriasis)
- Body dysmorphic disorder mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

In line with the implementation of The Five Year Forward View for Mental Health, evidence-based treatment will be extended to people with co-morbid LTCs or MUS. IAPT-LTC services will focus on people who have LTCs in the context of depression and anxiety disorders and will also aim to treat the following conditions: irritable bowel syndrome chronic fatigue syndrome MUS not otherwise specified. People with an LTC who also have depression and/or anxiety and are eligible for IAPT, will receive an integrated approach to treatment of their physical and mental health needs.

Drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. However, IAPT does not provide complex interventions to treat drug and alcohol misuse. The level of drug or alcohol misuse should not interfere with the person's ability to attend and engage in therapy sessions. If this is not the case, NICE guidelines recommend treatment for drug or alcohol misuse first. This highlights the need for services to work together to develop locally agreed pathways and criteria for more specialist intervention when indicated.

3.5 Exclusion Criteria

The following exclusions apply:

- People aged under 16 years of age.
- People that are experiencing acute and / or complex symptoms, usually with inadequate response to previous multiple treatments. This may include evidence 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 or 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 care services and have been assessed as clinically inappropriate.

3.6 Referral

The Provider should ensure that access to the service is unhindered by complex opt-in or confirmation systems. Service users should be able to access the service easily and by the most direct route possible.

The Provider should make strenuous efforts to assertively contact both new referrals and those service users with whom the service has lost contact during the course of treatment. Patients will be referred back to their GP

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

Clinical eligibility will be defined on the basis of either a clinical assessment process undertaken by appropriately trained clinicians or a screening process undertaken by staff working under the supervision of appropriately trained clinicians.

3.7 Assessment

Person-centered assessment will be undertaken by a trained clinician

There will be a single point of access for all service users which will offer assessment / screening focused on the presenting problem, a basic risk assessment and referral on to other agencies, if appropriate. This will include the following elements:

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

- Risk (including suicide and harm to others) assessed at initial contact and at each contact thereafter.

Following initial assessment patients will be offered low or high intensity treatments as detailed in the service standards (Section 4 below). This will include the following elements:

- All service users will be offered an evidence-based treatment appropriate to their condition, as indicated in current NICE Guidelines. When several evidence based treatments are recommended by NICE, service users should be offered a choice.
- The evidence based treatment should be given at the minimum treatment that is necessary to achieve full and sustained recovery.
- In addition to being offered an evidenced based psychological treatment, service users may be offered an experimental treatment if the treatment is in the process of being evaluated and there are reasonable grounds to assume that it is likely to be effective. In these circumstances service users should be informed in writing that the treatment is experimental and only after ethical committee approval has been given.
- Responsibility for prescribing medication will normally reside with the service

users GP. However, the Provider should have expertise in how medication can be used in conjunction with psychological therapies so that workers within the service can assist service users to make decisions about their use of medication, in a shared and informed manner and be able to liaise with GPs over any possible medication changes.

- 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 should aim for pre to post treatment data in over 95% of its service users.

High risk service users, for example those with suicidal ideations, severe self- injurious behaviour or psychotic symptomology, identified through clinical judgment and / or objective risk outcome tools, should be urgently referred to the appropriate mental health provider, and the original referrer informed without delay.

3.8 Patient DNA and Cancelled clinic appointments

The Provider will have procedures in place to reduce DNA rates and appointments that are cancelled by patients or by the Provider.

3.9 Discharge Process

The Provider will be 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 may occur if:

- A course of treatment ends and satisfactory clinical outcomes are achieved.
- Achievement of recovery as assessed by GAD-7 and PHQ-9 scores.
- Patients who have had 2 successive DNAs after efforts have been made to contact them.
- The service user is signposted on to a more appropriate service.
- The service user is stepped up to a secondary care service This will involve following agreed protocols. and GPs must be notied in writing within 72 hours of the referral being sent.
- The service user provides information indicating that they do not need a service.
- Discharge from the service may occur after 18 weeks if therapist decides that insufficent progress has been made, however in this circumstance prior to any discharge a cliinical discussion will take place with the patients GP to discuss treatment options.

When a patient has completed treatment and/or is discharged from the service a copy of the treatment report is always offered to the service user and sent to the GP within 10 working days. The service will ensure that the patient will be given or sent a patient experience questionaire to be completed.

3.10 Interdependence with other services/providers

The Provider will be expected to develop integrated process with the emerging Primary Care Networks and Integrated Care Teams.

The Provider will be expected to gain knowledge of local services and develop strong relationships with them for example Job Centre Plus, Occupational Health Services, Specialist Mental Health Services, Social Care, Housing, Leisure, debt management, food-banks, the Voluntary Community and Faith sector and other social support providers, to ensure people have their needs met in a holistic and timely manner.

The Provider will be required to work in partnership with the Sefton Provider Alliance in developing local system approaches to heath needs. Working with the wider system is essential to deliver on the ambition of integrated care.

The Provider will also need to consider how Cheshire and Merseyside Social Value Model can practically and effectively be embedded in to the service.

In respect of employment the Provider will maintain close links with Imagine Independence who are commissioned in Sefton to provide employment support for people. There are poorer employment outcomes for people with co-existing mental and physical health problems. There is a high risk of unemployment, absenteeism and poorer performance. It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety. Therefore it is essential that close links are maintained with Imagine Independence.

3.11 Priority Groups

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 communites that do not usually access services such as:

- Appropriate access for over 65
- Military Veterans
- Children Looked After (16+) and those adults who have been previously Looked After Children
- Peri-natal services
- BAME

This information will be submitted to the Information via the e-mail no later than 10 operational days following the end of each calendar month.

3.12 Days/Hours of operation

People identified to be at high risk (e.g. suicidal ideation, severe self- injurious behaviour, psychotic symptomatology) should be urgently referred to the appropriate mental health service.

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	-

3.13 Patient DNA and Cancelled clinic appointments

The Provider will have procedures in place to reduce DNA rates and appointments that are cancelled by patients or by the Provider.

3.14 Complaints

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

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

	Condition	Psychological therapies	NICE Guidelines
Step 2: delivered by PWPs	Depression	Individual guided self-help based NICE on CBT, computerised CBT, guidelines: behavioural activation, structured, group physical activity programme	CG90 CG91 CG123
	Generalised anxiety disorder	Self- help, or guided self-help, CBT, psycho-educational groups, computerized CBT	CG113 CG123
	Panic disorder	Guided self-help based on CBT	CG113 CG123
	Obsessive compulsive disorder		CG31 CG123
Step 3: High Intensity Interventions	Depression For individuals with mild to moderate severity who have not responded to initial low intensity interventions Depression Moderate to severe Depression Prevention of relapse	CBT (individual or group) or IPT Behavioural activation Couple therapy Counselling for depression Brief psychodynamic therapy CBT (individual or group) or IPT each with medication CBT or mindfulness-based cognitive therapy	CG90 CG91 CG123
	Generalised anxiety disorder	CBT, applied relaxation	CG113 CG123
	Panic disorder	CBT	CG113 CG123
	Post-traumatic stress disorder	Trauma-focused CBT, EMDR	CG26 CG123
	Social anxiety Disorder	CBT specific for social anxiety disorder	CG159
	Obsessive compulsive disorder	CBT (including exposure and response prevention)	CG31 CG123
	Chronic Fatigue syndrome	Graded Exercise therapy	CG53
	Chronic pain	Combined physical and psychological interventions, including CBT and exercise	NG59
	Irritable bowel syndrome	CBT (specialised form)	CG61 Informal consensus of Education Training Group

			(ETG)
	MUS not otherwise specified	CBT (specialised form)	Informal consensus of the ETG

4.2 Workforce

National guidance suggests that approximately 40% of the workforce in IAPT services should be PWPs and 60% high-intensity therapists.

4.3 Staff Competency, Training, Education, Supervision and Research activities

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.

5. Key performance metrics/service Monitoring

5.1 Nationally mandated KPIs

5.2 Access

The Adult Psychiatric Morbidity Survey (2000) identifies the number of people living in the borough of Sefton who have depression and/or anxiety disorders as **43,377**. This figure is the denominator for 2019/20, . ➢Prevalence denominators have been updated as per APMS 2014 which identifies a denominator of 38,718. New targets begin in 21/22 (figures to be confirmed locally)

	2019/20 22%	2020/21 25%	2021/22 25%	2022/23 25%	2023/24 25%*
SS CCG	5,346				
S&F CCG	4,197				
Total	**9,543**				

Step 4: A **maximum** of **101 (TBC)** completed episodes of care per annum. These will be patients who would normally be seen in a secondary mental health service, but who will be identified as benefitting from IAPT interventions. Any increase in Step 4 activity will be determined by local negotiation with commissioners.

5.3 Recovery

The ratio of people moving to recovery - people not at caseness at their last session, as a proportion of people who were at caseness at their first session - will be a **minimum** of **50%.**

5.4 Response Times

The Provider will be expected to adhere to the following response times at each step of the stepped care model:

- 75% of people will start a psychological therapy with 6 weeks of referral
- 95% will start a psychological therapy within 18 weeks of referral

INTERNAL WAITS KPI TO BE INCLUDED

5.2 Service Monitoring

The key service outcomes data set will be submitted to the commissioner on a monthly basis, not later than day 10 operational days following the end of each calendar month, via the NHS e-mail address.

In addition to the data set the Provider will produce a monthly report broken down by catchment, CCG area and by GP practice detailing:

- The number of people referred for psychological therapies (during the reporting quarter)
- The number of active referrals (people who have been referred to psychological therapies and are awaiting an initial assessment at the start of the reporting quarter)
- The number of people who have entered psychological therapies (during the reporting quarter)
- The number and average wait times of people waiting from assessment to follow up appointment.
- The number of people who have completed treatment, for any reason including completed, dropped out, signposted on (during the reporting quarter)
- The number of people who are "moving to recovery" (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not, during the reporting quarter)
- The number of people moving off sick pay and benefits (during the reporting quarter)
- The number of high intensity trainees (at the start of the reporting quarter)
- The number of low intensity trainees (at the start of the reporting quarter)
- The number of high intensity trained staff (at the start of the reporting quarter)
- The number of low intensity trained staff (at the start of the reporting quarter)
- The number of supervisors (at the start of the reporting quarter)
- 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 staff vacancies .

The provider will ensure that all NHS Digital reporting requirements are adhered to.

5.2 Data Quality

The Provider will ensure that ensure that robust data quality and information governance processes are in place and that staff receive the appropriate training to ensure ongoing adherence. Data completeness is critical for:

- Delivery of NICE-recommended treatment
- Effective clinical governance
- Enhanced patient experience
- Local and national service evaluation

5.3 Information Governance

The lead provider must comply with all Information Governance (IG) standards, NHS standards for record-keeping, the Data Protection Act, General Data Protection Regulation (GDPR), Data Security and Protection Toolkit compliance, Caldicott principles and Department of Health standards.

6. Applicable quality requirements and CQUIN goals TBC

The Provider's Premises are located at:

6.1 Applicable Quality Requirements (See Schedule 4A-C)

6.2 Applicable CQUIN goals (See Schedule 4D)

7. Location of Provider Premises

7.1 Estates

It is the Provider's responsibility to ensure that they have adequate accommodation to meet the needs of the population sited across both CCG catchment areas. The accommodation will be available in a variety of primary and community settings. The accommodation should include 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 both Southport and Formby and South Sefton CCG areas.