

# **SPECIFICATION FOR PRIMARY CARE PSYCHOLOGICAL THERAPIES (ANY QUALIFIED PROVIDER)**

**Please note that this specification is based on a document  
developed by Wakefield Clinical Commissioning Group in  
November 2015**

## A. Service Specification

<b>Service Specification No.</b>	1
<b>Service</b>	Primary Care Psychological Therapies in Calderdale (Any Qualified Provider)
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<b>Provider Lead</b>	<i>[To be added in for individual contracts]</i>
<b>Period</b>	
<b>Date of Review</b>	

### PURPOSE

This specification outlines the requirements for the provision of primary care psychological therapies to ensure prompt access to prompt and effective support for people with common mental health disorders in Calderdale.

This service will form part of the wider Care Closer to Home model being developed by Calderdale CCG. This approach provides a blue print for earlier intervention, prevention, greater independence and wellbeing for individuals through community and primary care services.

### 1. Population Needs

#### 1.1 National context

Good mental health is vital for us all to live happy, productive and fulfilled lives. 'No Health Without Mental Health', the cross-government strategy published in 2011, notes that at least one in four of us will experience a mental health problem at some point in our lives and one in six people will have a mental health problem at any given time. One in ten children (aged 5 – 15) has a mental health problem and half of all people with lifelong mental health problems have developed them by the age of 14.

For some people common mental health disorders are recurrent or lifelong conditions, and often they occur within a range of other physical, mental health and behavioural co-morbidities.

Mental health disorders do not just affect individuals, but also their families, friends and colleagues. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity. Mental ill health is the largest single cause of disability in the UK, representing up to 23% of the total burden of ill health. The total cost of mental health in England is estimated to be around £105 billion and it has been established that the cost of health services to treat mental illness could double over the next 20 years.

An estimated 16.2% of adults aged 18 and over<sup>1</sup> meet the diagnostic criteria for at least one common mental health disorder including, for example:

- Depression
- Generalised anxiety disorder
- Mixed depression and anxiety
- Panic disorder
- Obsessive-compulsive disorder
- Phobias

<sup>1</sup> NHS Health and Social Care Information Centre **Adult Psychiatric Morbidity Survey** (2014)

- Post-traumatic stress disorder

## 1.2 Local context

The registered GP list size for Calderdale stood at 217,989 people in October 2015. This would suggest that approximately 169,294 people registered with a GP in Calderdale are aged 18+.

Applying the national prevalence estimate of 16.2%, the likely prevalence of common mental health disorders in Calderdale is 27,426.

ONS data published in Projecting Adult Needs and Service Information (PANSI)<sup>2</sup> and Projecting Older People Population Information (POPPI) predicts increases in prevalence as follows:

	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental health disorder (PANSI)	20,300	20,461	20,517	20,431
People aged 65+ predicted to have depression (POPPI)	3,210	3,519	3,932	4,419
People aged 65+ predicted to have severe depression (POPPI)	1,006	1,099	1,270	1,427

Primary care psychological therapies have an important role to play in delivering 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.

## 1.3 Risk factors

Locally, Calderdale has high levels of risk factors for mental health, these are described below.

### a) Deprivation

Deprivation, low income and associated unemployment and benefit dependency are closely correlated with a wide range of indicators of poor health or low levels of wellbeing. The Indices of Deprivation 2010<sup>3</sup> have recently been published and demonstrate that out of 354 districts in England, Calderdale ranks as the 105th most deprived. The areas in Calderdale with the highest levels of deprivation are Park and Ovenden Wards.

### b) Wider determinants of health

As outlined in its Health Profile 2015<sup>4</sup> Calderdale is significantly worse than the England values in:

- Rate of working age adults who are unemployed per 1,000 population
- Number of adult hospital stays for alcohol related harm per 1,000 population
- Life expectancy at birth (males and females)
- Rate of smoking deaths per 1,000 population aged 35+
- Under 75 mortality rates for cardiovascular disease and cancer

These factors are all likely to have an impact on the demand for low level mental health services, and increase the need for early intervention.

<sup>2</sup> [www.pansi.org.uk](http://www.pansi.org.uk)

<sup>3</sup> [www.poppi.org.uk](http://www.poppi.org.uk)

<sup>4</sup> Public Health England **Health Profile – Calderdale** (2014)

### c) Pregnancy and mental health

Depression and anxiety are common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth. During pregnancy and the postnatal period, anxiety disorders including panic disorder, generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can co-exist with depression. There are approximately 2,500 women who give birth every year in Calderdale.

### d) Domestic abuse

The police recorded 3,753 domestic violence incidents in 13/14, although the true number is more likely to be 11,259, based on an assumption of a third of cases being reported (West Yorkshire Police, 2014). It was recorded that Calderdale has the highest proportion of repeat victims in West Yorkshire at 37.7% (West Yorkshire Police, 2014).

### e) Vulnerable groups

Some populations may need targeted support to access services, for example:

- People from Black and Ethnic Minorities
- People with disabilities
- Refugees, asylum seekers and newly arrived migrants
- Young people
- Frail older people
- Homeless people
- People from the gay, lesbian and transgender community
- People recently released from prison
- People suffering from abuse
- Carers
- People not registered with a GP
- People with severe and enduring mental health problems
- People with substance misuse problems
- Members of the armed forces community and their families (to whom the Armed Forces Covenant<sup>5</sup> applies)
- People with one or more long-term conditions

## 1.4 Evidence base

In 2004, NICE conducted a systematic review of the evidence for the effectiveness of interventions for depression and anxiety disorders. This showed that cognitive behavioural therapy (CBT) was an effective first-line treatment for a large amount of common mental health morbidity, but that it was not readily available. The evidence also showed that CBT could produce impressive recovery rates, and in many cases better prevent relapse, compared with medication alone<sup>6</sup>.

In the same year a series of clinical guidelines were published that strongly supported the use of psychological therapies and CBT for depression and anxiety disorders<sup>7</sup>. NICE also recommended evidence-based, second-line talking therapies treatments for depression where CBT had been unsuccessful, but this was also in limited supply<sup>8</sup>.

Through the national 'Improving Access to Psychological Therapies' programme, CCGs have been supported to commission increased access to CBT and primary care psychological therapies for their populations with common mental health disorders.

<sup>5</sup> NHS England **Armed Forces Covenant** (2013) <https://www.gov.uk/government/publications/the-armed-forces-covenant>

<sup>6</sup> DeRubeis R, Hollon S, Amsterdam J, et al. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry* 62(4): 409–416.

<sup>7</sup> NICE (2004). Depression, Clinical Guideline 23 (replaced by Clinical Guideline 90 in 2009); NICE (2004). Anxiety, Clinical Guideline 22 (replaced by Clinical Guideline 113 in 2011).

<sup>8</sup> As above

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

The service will contribute to the following outcomes:

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

### 2.2 National targets

The Provider must deliver all relevant national targets throughout the life of the contract. At present these are:

1. At least 15% of adults with relevant disorders will have timely access to the service, with a recovery rate of 50%
2. 75% of people referred to the service will begin treatment within 6 weeks of referral, and 95% will begin treatment within 18 weeks of referral<sup>9</sup>.

The Commissioner will work with all providers to ensure that the prevalence rate target for IAPT is met overall in Calderdale (currently 15% of 25,992)

### 2.3 Local defined outcomes

The Provider must deliver the following local service outcomes:

1. A minimum of 95% of people to be assessed within 28 days of referral
2. A minimum of 95% of people to begin their treatment within 6 weeks of referral
3. A minimum of 50% of people entering treatment moving to recovery
4. A year on year increase in the number of people returning to work (baseline data to be gathered in Year 1)
5. A choice of therapy, delivery method, location and therapist, appropriate to individual need; including a process for a service user to change therapist easily on request
6. A year on year increase in the take-up of online therapy (baseline data to be gathered in Year 1)
7. High levels of satisfaction demonstrated through the service user questionnaire
8. Provide evidence of activities to raise awareness and understanding of common mental health conditions and reduce the stigma associated with them
9. Provide evidence that individuals feel empowered to manage their emotional wellbeing on discharge
10. Have in place an effective process for urgent referral of people at high risk to specialist care, demonstrated through a joint audit with the specialist care provider of six cases per year

### 2.4 Service standards

In delivering the above outcomes, the provider must ensure that the following key service standards are achieved:

<sup>9</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdf>

Service Standard:	Description
a) Promote inclusion and involvement	The Provider must be able to demonstrate that the service is built around a culture of inclusion and supporting every individual until they receive the appropriate treatment. Service user involvement should be evident in informing decision-making and embedding continuous improvement
b) Excellent leadership with a real focus on recovery	Leadership must be evident at every level across the service and focus on providing feedback to therapists, supporting Continuous Professional Development (CPD) for staff, benchmarking and active decision-making, individual accountability; and a culture of enquiry
c) Optimised performance management systems	Accessible, reliable and complete data will enable providers to track and report outcomes at an individual therapist level.
d) Workforce stability and experience	The Provider must be able to demonstrate good retention rates and an experienced workforce across the breadth of the service.
e) Assessment and access	There will be an emphasis on effective assessment and getting the client to the right therapist within waiting time targets – this includes an accurate assessment of their presenting problems (including provisional diagnosis using ICD10 codes)
f) Choice of NICE compliant treatments and access to alternative pathways	Treatment choices will be discussed with the client, based on least restrictive intervention first and step-up or step-down options identified when appropriate
g) Flexible number of sessions fitting clients' needs	There will be an open-ended approach to the overall number of sessions that could be offered to an individual client. However, therapists and clients will discuss sessions in terms of relatively short 'blocks' in order to help focus therapist and client on making progress (e.g. six sessions followed by a review and further such blocks as appropriate)
h) Data informed, service level reflective practice	The Provider must be able to evidence how they will sustainably ensure increases in recovery rates by using data, empowering therapists and creating a culture of reflective practice
i) Safeguarding children and adults at risk	The provider will comply with the Calderdale CCG safeguarding standards relevant to the organisation. The provider will ensure that all staff receives the appropriate level of safeguarding training every 3 years. The provider will have an organisational safeguarding policy which references and complies with the West and North Yorkshire adult safeguarding policy and

		procedures.
j)	Work collaboratively with local organisations	The Provider must be able to demonstrate how they will work with partners to support access for vulnerable groups.

### 3. Scope

#### 3.1 Aims and objectives of service

The aims of the service are:

- To improve emotional wellbeing and support the prevention of mental health problems
- To promote self-management of mental health problems
- To focus on recovery
- To ensure services meet physical and mental health needs and no-one falls through the gaps

#### 3.2 Service description/care pathway

1. The service will focus on early intervention and promote self-directed support and recovery. There will be a culture of raising awareness, promoting positive choices and empowering service users to control their own recovery.
2. A stepped care model (see Appendix 1) will be used in order to ensure that people receive the least intensive intervention for their needs. The stepped care model will ensure that the local care pathways:
  - Promote self-directed support.
  - Provide the least intrusive, most effective intervention first.
  - Have clear and explicit criteria for the thresholds determining access to and movement between steps.
  - 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.
3. There will be seamless transition between low intensity and high intensity interventions within the stepped care model regardless of who is delivering the interventions.
4. There will be seamless transition between the primary care psychological therapies service and other mental health provision and this will be clearly documented, regularly reviewed and communicated to all relevant professionals.
5. The service must have capability to safely manage severe and complex cases where required.

##### 3.2.1 Access and referrals

1. The provider will ensure that entry into the system is simple, prompt and via multiple access points which take into account the geography and demand across Calderdale.
2. Proactive promotion and marketing to different sections of the community will include working with the agencies/pathways identified in section 3.6 below to ensure that service users are appropriately signposted.
3. Referrals will be accepted from all sources, including self-referrals, GP practices, other health and social care professionals and the third sector.

4. The service will seek to expand guided self-referral into the service.
5. The service will be expected to be able to receive referrals through:
  - Online/website
  - Secure e-mail
  - Telephone
  - Post
6. There will be prompt access and equitable access for the harder to reach local community such as those identified in the 'Vulnerable Groups' section above.
7. Where a service user requires additional support to access the service, the Provider will ensure that provision is made within the tariff. Such support services might include, but are not limited to:
  - Translation services
  - Easy read
  - Sign language
8. The Provider will ensure that access by people with common mental health problems is unhindered by complex client opt-in or confirmation systems. The Provider will make strenuous efforts to assertively contact both new referrals and those service users for whom the service has lost contact during a treatment episode.
9. The service must monitor the drop out between referral and assessment and take proactive steps to minimise this.
10. Those who pose a high risk to themselves, risk to others or are at significant risk of self-neglect will be urgently referred to the appropriate service and supported to receive the appropriate care.
11. Where it is initially unclear which service is best to meet the needs of the individual, the Provider must ensure that proactive dialogue is made with all relevant agencies and a solution identified.

### 3.2.2 Assessment

1. Assessments will be undertaken face to face, by telephone or by video/web based conferencing with or without prior collection of relevant client information.
2. The assessment will focus on the presenting problem, a basic risk assessment and referral onto other agencies if appropriate. It will include the following elements:
  - 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 and any linked employment, social and physical health issues
  - Risk (suicide, harm to self or harm to others) will be assessed at initial contact and at each contact thereafter.
  - All service users must have their clinical, work and social outcomes assessed using the recognised standardised measures that are appropriate to the conditions being treated.
  - Key measures will be given at each treatment session so that a clinical end point is available even if the service user finishes treatment early.
3. Where an assessment is undertaken, the assessor will discuss the range of options/therapies available (that are appropriate for the clinical presentation) and offer choice where possible.
4. The service must monitor the drop out between assessment and treatment and take proactive steps to minimise this.

5. People assessed as requiring Step 4 intervention should be referred on to the appropriate specialist/secondary care service and a referral protocol will be established with the secondary care provider to support this. The Provider will be expected to be fully involved in developing the protocol.
6. The Provider is expected to signpost people to third sector providers in line with the Commissioner's guidelines.

### **3.2.3 Treatment**

1. Service users will receive information about their condition and be encouraged to identify self-help activities
2. Service users will have a choice of interventions/therapy and a choice of how it is delivered (e.g. face to face, via telephone or online)
3. Service users will have a choice of when and where to be seen and arrangements will be mutually agreed between client and therapist as part of good care planning
4. Treatments will be evidence-based, offered by a trained and accredited workforce
5. The service will include access to online therapy and support via structured courses, audio and video consultation and live chat
6. The service will provide a range of interventions and treatments, in a range of locations to meet the identified demand

### **3.2.4 Discharge**

1. When a client has completed treatment and/or is discharged from the service a service user experience questionnaire should be given to them. This data will be collated and provided to the Commissioner.
2. Consistent arrangements for liaison with GPs at discharge and routine follow-up where indicated must be in place
3. In all instances, the service will ensure that the relevant GP practice has been informed about the referral, assessment and treatment within 10 working days

### **3.2.6 Outcomes data collection**

1. A minimum of 95% data completeness for pre/post treatment scores must be achieved from all client contacts. The Provider will take part in training arranged by NHS England relating to data capture and will have in place requirements relating to Health and Social Care Information Centre data capture.
2. A secure IT system must enable therapists and service managers to have prompt access to outcomes data and to generate reports
3. Routine outcomes data measurement must be used to inform regular clinical supervision (see below) and to improve service quality and accountability.
4. To effectively operate a stepped care service it is essential that clients can be tracked through the full stepped care pathway through, ideally, an interoperable client record.

### **3.3 Population covered**

The service will work with patients registered with a Calderdale CCG General Practice. For patient without a GP registration who self-refers, the Responsible Commissioner guidance<sup>10</sup> applies.

The service will meet the needs of people aged 18 and over and will not discriminate on the basis of age, gender, race, religion/belief, sexual orientation or disability.

### 3.4 Service eligibility

Eligibility criteria include people presenting with at least one of the following conditions, either as a sole or co-morbid diagnosis, where a psychological therapy intervention would be appropriate:

**Depression** (CG90<sup>11</sup>) (including that relating to antenatal and postnatal mental health (CG192<sup>12</sup>):

Mild Depression (4 ICD-10 symptoms and or PHQ-9 score of 5 – 9)

Moderate Depression (5-6 ICD symptoms and/or PHQ-9 score of 10-14)

Moderate – Severe Depression (7 ICD-10 symptoms and/or PHQ-9 score of 15 – 19)

**Anxiety** including:

Generalised anxiety disorder (GAD) (CG113<sup>13</sup>)

Post-Traumatic Stress Disorder (CG26<sup>14</sup>)

Obsessive Compulsive Disorder & Body Dysmorphic Disorder (CG31<sup>15</sup>)

Phobias

Panic Disorders (CG113<sup>16</sup>)

**Other Disorders**

Patients with psychological problems consequent to long term conditions (LTC) or presenting with somatisation disorder

Bereavement or other life events resulting in any of the above

Relationship issues

Anger

The above list is not exhaustive and it recognises that there may be cases that fall outside the above definitions, however, these individuals may still benefit from psychological interventions.

The service will work with people in mental health care clusters 1 – 3:

**Care Cluster 1: Common Mental Health Problems (Low Severity)** – This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms.

**Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need)** – This group has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with

<sup>10</sup> NHS England **Who Pays? Determining responsibility for payments to providers** (2013)

<sup>11</sup> NICE CG90 **Depression in adults** (2009) [www.nice.org.uk/guidance/cg90](http://www.nice.org.uk/guidance/cg90)

<sup>12</sup> NICE CG192 **Antenatal and perinatal mental health: clinical management and service guidance** [www.nice.org.uk/guidance/cg192](http://www.nice.org.uk/guidance/cg192)

<sup>13</sup> NICE CG113 **Generalised Anxiety Disorder and Panic Disorder (with or without agoraphobia)** (2014) [www.nice.org.uk/cg113](http://www.nice.org.uk/cg113)

<sup>14</sup> NICE CG26 **Post Traumatic Stress Disorder** (2005) [www.nice.org.uk/guidance/cg26](http://www.nice.org.uk/guidance/cg26)

<sup>15</sup> NICE CG31 **Obsessive Compulsive Disorder** (2005) [www.nice.org.uk/cg31](http://www.nice.org.uk/cg31)

<sup>16</sup> NICE CG113 **Generalised Anxiety Disorder and Panic Disorder (with or without agoraphobia)** (2014) [www.nice.org.uk/cg113](http://www.nice.org.uk/cg113)

Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

**Care Cluster 3: Non-Psychotic (Moderate Severity)** – This group has moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

### 3.5 Exclusion criteria and thresholds

The service is not targeted towards those who pose a high risk to themselves, risk to others or are at significant risk of self-neglect. This may include 'hard to engage' people who have consistently rejected various treatment options offered.

People suffering from acute psychosis or who are actively suicidal and those who have a pre-existing diagnosis of unstable severe mental illness are not suitable for the service. Such individuals' needs are best met via specialist or secondary community mental health teams and associated services.

Similarly those individuals who have a **significant** impairment of cognitive function (e.g. dementia); or **significant** impairment due to autistic spectrum problems or learning difficulties are best served by specialist services. This also includes individuals who need to be primarily referred for forensic or neuropsychological assessment. For the avoidance of doubt, the service should be offered to individuals with learning disabilities, autistic spectrum or dementia where their cognitive function is not significantly impaired.

Individuals for whom drug and alcohol present as their primary problems are best referred to substance misuse services. However, where the individual has the ability to engage in therapy they will be supported to access the service, potentially via shared care arrangements, where these are in place. The principle of inclusion must apply.

Where a young person, under the age of 18, presents to the service, engagement with CAMHS will take place to ensure the most appropriate provision is secured for the individual.

It is expected that in all cases where a person is not suitable for primary care psychological therapies, the Provider will work with other providers and agencies to ensure that the right care is secured for the individual. This will be monitored.

### 3.6 Interdependence with other services/providers

In delivering an integrated care pathway for people with common mental health problems that considers a person's wider quality of life needs, it will be necessary to build good relationships with a range of organisations and service providers.

The service will need to have a particularly close relationship with primary care with much treatment occurring in GP practices and local community venues. Close relationships with Job Centre Plus, Occupational Health Services, Specialist Mental Health Services, the third sector and other social support advisors are also required.

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. employment, social care, housing, environmental services, weight management services, smoking cessation, lifestyle services, education, criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused 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 health professionals involved in treating long-term musculoskeletal, respiratory, dermatology, diabetes, heart disease, chronic pain services, neurology, stroke services, cancer and pregnancy is vital to ensure that psychological

treatment needs are met across the pathway in an integrated, timely and responsive manner.

Early intervention and prevention is a key aim of the children's mental health transformation programme and good links will need to be established with CAMHS. Transition between CAMHS and adults services is also key.

The service is expected to develop and demonstrate clear pathways in order to move people through and out of service provision. Clear mechanisms to resolve and manage disputes at various stages of the care pathways will be demonstrated.

### 3.7 Days/Hours of Operation

Services will operate during core hours of 9am to 5pm Monday to Friday, with some out of hour's availability to accommodate the needs of people who are unable to attend during office hours.

### 3.8 Workforce/Training and Education/Research

The service will deliver a balanced workforce in relation to local needs, i.e. in terms of skill mix for different modalities and levels to offer best matched care according to client preference, as well as clinical background, gender, ethnicity, etc. to offer culturally acceptable options.

The Service will have a stable core of trained therapists (accredited by an appropriate organisation for psychological therapies) who represent a mix of seniority across the different therapeutic modalities and can support trainees in their clinical development.

The service must have sufficient trained therapists to deliver high intensity and low intensity treatments.

The service will include employment advisor(s) or work closely with such advisors.

Therapists (experienced and trainees) will receive regular and appropriate outcomes-informed supervision; continued professional development; access to appropriate clinical facilities (e.g. clinic rooms, digital recording, telephones, IT systems) and opportunities to see a mixed caseload including some clients who present with mild or moderate symptoms.

Workloads must be consistent with professional and ethical guidelines for sustainable quality of care; however client-facing time must be maximised for every therapist and this will be monitored.

Staff turnover will be monitored, e.g. via "exit interviews".

### 3.9 Information Management and Technology

#### *Infrastructure*

The Provider will already have or be able to demonstrate capability in building infrastructure compliant with HSCIC Guidance, within own resources and associated costs to comprise of as a minimum:

- Securely hosted environment meeting or exceeding N3 standards
- N3 connection, either direct or via another party
- N3 or other secure connection of adequate bandwidth to accommodate onward secure transmission of patient identifiable data
- A supported desktop environment for smart card management services including access to UIM for smart card updating of roles and activities
- A defined hierarchical RA sponsor, or similar, network within the organisation to authorise changes.

#### *Systems*

The service will utilise secured I.T. systems to support and maximise the quality of client care and in particular should be capable of reproducing 'pathway specific' reports and associated data, electronically to other providers where appropriate to avoid unnecessary additional consultations. This will include adhering to the recommendations and implementation guidance of HSCIC and keeping abreast of developments.

All costs associated with the provision and maintenance of equipment (software and hardware) are the responsibility of the Provider, who will also be responsible for training clinical and administrative staff on systems.

All IM & T costs associated with the mobilisation and ongoing delivery of the service are the responsibility of the Provider.

#### *Sharing Clinical Information*

The Provider will work with partners and other key agencies to agree, support and implement appropriate information sharing in line with the inter-provider transfer guidance, NHS Calderdale CCG Local Access Policy and national Information Governance Standards published by HSCIC.

Any information relevant to clinical care will be shared with the client and supplied, within the bounds of confidentiality, in a timely fashion to professionals continuing the care of the client.

### **3.10 Local and National Reporting Requirements**

#### *National Datasets*

The Provider must ensure the Service collects all data required by the IAPT Data Set<sup>17</sup> as published by HSCIC, and any subsequent versions.

#### *Local Requirements*

The provider will be required to submit locally agreed datasets every month to the Commissioner. Data required within the local dataset will include, but not be limited to:

- Number of people referred and source
- Number of people assessed
- Number of people entering treatment, by modality
- Number of people completing treatment, by modality
- Number of people moving to recovery, by modality
- Number and % of people moving off sick pay and benefits
- % recovery rate
- % showing clinically significant improvement
- Referral data by age
- Ethnicity (optional for service users)
- Gender
- Provisional diagnosis to inform the treatment approach
- Waiting times
- Number of people waiting for assessment at the end of the reporting period
- Number of people waiting for treatment at the end of the reporting period
- Service user feedback from Client Experience Questionnaires

#### *Ad hoc Information Requests*

There may be occasions when the Commissioner wishes to request additional information not included elsewhere in the Information Schedule. The Provider will make all reasonable efforts to provide such information within a reasonable timescale.

#### *Data Quality*

The Provider agrees to conduct ongoing validation and reconciliation of data on a monthly basis, in order to try and achieve the closest possible match prior to production of monitoring information. The Commissioner and Provider will agree annually the local data quality and

<sup>17</sup> <http://www.hscic.gov.uk/iapt>

quality improvement standards.

#### 4. Applicable Service Standards

Please note that the guidance referred to below is not an exhaustive list, the Provider will be expected to work to new and emerging policy guidance which relates to and links to the delivery of primary care psychological therapies and the wellbeing of the population of Calderdale.

##### 4.1 Applicable national standards (e.g. NICE)

The following policies and guidance apply:

- NHS Core principles
- NHS Outcomes Framework
- NHS England Guidance
- NICE Quality Standards:
  - QS8 – Depression in adults
  - QS34 – Self Harm
  - QS53 – Anxiety Disorders
- NICE Guidance
  - CG16 – Self harm
  - CG26 – Post-Traumatic Stress Disorder
  - CG31 - Obsessive Compulsive Disorder
  - CG90 – Depression in adults
  - CG91 – Depression in adults with a chronic physical health problem
  - CG113 – Generalised Anxiety Disorder and Panic Disorder (with or without agoraphobia)
  - CG123 – Common Mental Health Disorders
  - CG159 – Social Anxiety Disorder: recognition, assessment and treatment
  - CG192 – Antenatal and postnatal mental health: clinical management and service guidance
- NICE Technology Assessment
  - TA97 – Computerised cognitive behaviour therapy for depression and anxiety

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

Royal College of Psychiatrists - **College Report CR151: Psychological therapies in psychiatry and Primary Care** (2008)

##### 4.3 Applicable local standards

Covered elsewhere in this specification.

#### 5. Applicable quality requirements and CQUIN goals

##### 5.1 Applicable Quality Requirements (See Schedule 4A-D)

Covered elsewhere in this specification.

##### 5.2 Applicable CQUIN goals (See Schedule 4E)

Set out in Schedule 4E.

#### 6. Location of Provider Premises

The Provider's Premises are located at:

***[To be added in for individual contracts]***

**7. Individual Service User Placement**

Not applicable

## APPENDIX 1 – STEPPED CARE MODEL

Focus of intervention	Nature of intervention
<p><b>Step 4:</b>  <b>Depression:</b> severe and complex depression, risk to life, severe self-neglect  <b>Generalised anxiety disorder:</b> complex treatment – refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm  <b>Panic disorder, OCD and PTSD:</b> severe disorder with complex comorbidities, or people who have not responded to treatment at steps 1–3 (see note 1 below).</p>	<p><b>Depression:</b> Highly specialist treatment, such as medication, high intensity psychological interventions, combined treatments, multiprofessional and inpatient care, crisis services, electroconvulsive therapy  <b>Generalised anxiety disorder:</b> Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care  <b>Panic disorder, OCD and PTSD:</b> see note 1 below.</p>
<p><b>Step 3:</b>  <b>Depression:</b> persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression  <b>Generalised anxiety disorder:</b> with marked functional impairment or that has not responded to a low-intensity intervention;  <b>Panic disorder:</b> moderate to severe  <b>OCD:</b> moderate or severe functional impairment  <b>PTSD:</b> moderate or severe functional impairment.</p>	<p><b>Depression:</b> CBT, IPT, behavioural activation, behavioural couples therapy, counselling*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups.  <b>Generalised anxiety disorder:</b> CBT, applied relaxation, drug treatment, combined interventions, self-help groups.  <b>Panic disorder:</b> CBT, antidepressants, self-help groups.  <b>OCD:</b> CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.  <b>PTSD:</b> Trauma-focused CBT, EMDR, drug treatment.  <b>All disorders:</b> Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.</p>
<p><b>Step 2:</b>  <b>Depression:</b> Persistent subthreshold depressive symptoms or mild to moderate depression  <b>Generalised anxiety disorder</b>  <b>Panic disorder:</b> mild to moderate  <b>OCD:</b> mild to moderate  <b>PTSD:</b> mild to moderate.</p>	<p><b>Depression:</b> Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help programmes**), non-directive counselling delivered at home***, antidepressants, self-help groups.  <b>Generalised anxiety disorder and panic disorder:</b> Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups.  <b>OCD:</b> Individual or group CBT including ERP (typically provided within step 3 services; see note 2 below), self-help groups.  <b>PTSD:</b> Trauma-focused CBT or EMDR (typically provided within step 3 services; see note 2 below).  <b>All disorders:</b> Support groups, educational and employment support services; referral for further assessment and interventions.</p>
<p><b>Step 1:</b>  <b>All disorders:</b> known and suspected presentations of common mental health disorders.</p>	<p><b>All disorders:</b> Identification, assessment, psychoeducation, active monitoring, referral for further assessment and interventions.</p>

**Note 1:** The NICE clinical guidance on panic disorder (CG113) and OCD (CG31) uses different models of stepped care to the 4 step model used in the NICE clinical guidance on depression (CG90, CG91) and generalised anxiety disorder (CG113). The NICE clinical guideline on PTSD (CG26) does not use the stepped care model. People with panic disorder, OCD or PTSD that has not responded to treatment at steps 1–3, or who have severe disorders and complex comorbidities that prevent effective management at steps 1–3, should receive specialist services at step 4, according to individual need and clinical judgement. The principle interventions at step 4 are similar to those listed for depression and generalised anxiety disorder, with the exception that electroconvulsive therapy is not indicated.

**Note 2:** The NICE clinical guideline on OCD (CG31) recommends that people with mild to moderate OCD receive individual or group based CBT. The NICE clinical guideline on PTSD (CG26) recommends that people with mild to moderate PTSD receive trauma-focused CBT or EMDR. These interventions may typically be commissioned from, and provided by, trained, high-intensity therapy staff in step 3 services.

\* Discuss with the person on the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

\*\* For people with depression and a chronic physical health problem.

\*\*\* For women during pregnancy or the postnatal period.

**Key:** CBT - cognitive behavioural therapy, ERP - exposure and response prevention, EMDR - eye movement desensitisation and reprocessing, OCD - obsessive compulsive disorder, IPT - interpersonal therapy, PTSD - post traumatic stress disorder.

Source: National Institute for Clinical &amp; Health Excellence (2011)

## SERVICE SPECIFICATION CHECKLIST

<b>Title of Service Specification</b>	Primary Care Psychological Therapies	
<b>Author/Owner</b>	Corinne McDonald, Project Manager – Service Improvement	
<b>Version</b>	0.2	
	<b>Y/N</b>	<b>Comments:</b>
<b>Has Engagement been completed?</b>	N	Key themes from feedback from users of current services collated and used to develop specification
<b>EQIA completed?</b>	Y	
<b>Is there evidence that Evidence Base has been considered?</b>	Y	Evidence base included in specification
<b>Have medicines management been consulted?</b>	Y	Draft specification shared with Helen Foster for comment (6/1/16)
<b>Does this fit with our strategic outcomes?</b>	Y	
<b>Have benefits and risks been considered and outlined?</b>	Y	
<b>KPIs are fit for purpose?</b>	Y	
<b>KPIs are in line with CQUINs where appropriate?</b>	Y	
<b>Approved by Heads of Service:</b>		
<b>Quality &amp; Safety (P Woodhead)</b>		<b>Draft specification shared with Penny Woodhead and Louise Burrows for comment (6/1/16)</b>
<b>Finance (J Lawreniuk)</b>		<b>Draft specification shared with Allison Croft for comment (6/1/16)</b>
<b>Contracting (M Pursey)</b>		<b>Draft specification shared with Yvonne Hoorman for comment (6/1/16)</b>
<b>Approved at Quality and Safety Committee</b>		<b>Date:</b>

## APPENDIX C

List of people invited to comment on the draft specifications

- Dr Caroline Taylor, CCG Mental Health Clinical Lead
- Sarah Antemes, Head of Commissioning for Mental Health, Learning Disabilities and Continuing Care
- Debbie Graham, Head of Service Improvement
- Debbie Robinson, Head of Primary Care Development and Improvement
- Penny Woodhead, Head of Quality and Safety
- Rhona Radley, Senior Service Improvement Manager
- Paul Harding, Programme Manager – Service Improvement
- Helen Wraith, Project Manager – Service Improvement
- Samantha Donaldson, Project Manager – Service Improvement
- Louise Burrows, Quality Manager
- Luke Turnbull, Adult Safeguarding Lead
- Julie Wan-Sai-Cheong, Safeguarding Advisor
- Helen Foster, Medicines Management Lead
- Karen Pollard, Senior Contracts Manager
- Yvonne Hoorman, Principal Contracting Manager
- Gill Jones, Primary Care Quality and Improvement Manager
- Calderdale public health representatives (*comments to be brought to 28<sup>th</sup> January Quality Committee meeting*)