SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	East Kent CCGs
Service	Primary Care Psychological Therapies (IAPT) Service
Commissioner Lead	
Provider Lead	
Period	1st January 2016 – 31st December 2018
Date of Review	1st January 2017

1. Population Needs

1.1 National/local context and evidence base

The IAPT national programme for Improving Access to Psychological Therapies (IAPT) was launched in 2008.

The model of care for this service is based around a stepped care model based upon the Least Intervention First Time (LIFT).The service can provide provision for step 2, step 3, step 3+ and 'On-line support and interventions' to work across East Kent or concentrate on specific CCG or geographical areas. Providers will be accredited against each step and may work in partnership with other providers to provide the range of services specified.

The IAPT 'Three Year Report' states that 'at least one in four people will experience a mental health problem at some stage in their lives. This can place a significant burden on that individual's wellbeing, their family, the NHS and the wider economy. Recognising this, in February 2011 the Coalition Government highlighted its commitment to improving mental health in England through No Health Without Mental Health, a strategy that aims to achieve parity of esteem between mental health and physical health services'.

The report demonstrates that at the end of the first three full financial years of operation of the IAPT service (end of March 2012), more than 1 million people have used the new services across England, recovery rates are in excess of 45% and 45,000 people have moved off benefits.

2. Outcomes

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

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 National benchmark standards(outcomes) will be delivered:

- **% of referrals entering treatment = 80%**
- **% of people entering treatment who complete treatment = 70%**
- **% of people who complete treatment who move to recovery = 50 %**
- **% of people who recover from benefits to work = 5%**
- **It is expected that IAPT teams should be configured with 60% high intensity capacity and 40% low intensity capacity**

Local defined outcomes

- To provide a "whole person" approach to the delivery of this service which takes account of the person's socio-demographic characteristics, health co-morbidities and lifestyle
- To provide a directly accessible primary care driven service
- To provide early access and appropriate interventions to people with common mental health problems in the Contract Area adopting a stepped approach according to NICE guidelines
- To promote access to services from all sectors of the community including traditionally socially excluded groups (see guidance) which may include:
    - Black and minority ethnic groups, including people who do not have English as their first language
    - Certain age and gender groups e.g.
        - Older people, including people living in nursing homes or with dementia
        - Younger people, especially young men
        - South Asian women
    - Persons in prison or in contact with the criminal justice system
    - Service and ex-service personnel
    - Refugees and asylum seekers
    - People with long term conditions
    - Lesbian, gay, bisexual and transgender people
    - People from deprived communities, including people who are on low incomes, unemployed or homeless, single-parents and carers.
- To provide high quality and flexible support to service users that maximises individual potential.
- To provide a person-centred service, and recognise the need for all organisations to work in partnership with Service Users in a holistic and inclusive manner
- To provide 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 with mental illness or access relevant support groups and networks
- To evaluate the effectiveness of the service through systematic and comprehensive collection of pre- and post-treatment outcome data on at least 100% of patients treated

3. Scope

3.1 Aims and objectives of service

- Reduce the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.

- Provide signposting, information and support to facilitate access to a range of community based support services.
- Improving service-user choice and experience of mental health services.
- Improve identification and awareness of common mental health disorders (e.g. through awareness training for a range of health, social care, education and welfare professionals) and promote onward referral for assessment and intervention.
- Improving the interface between services for people with common mental health disorders.
- Increase the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance/evidence based psychological care by appropriately qualified clinicians.
- Improve the proportion of people who make a clinically significant improvement or recover.
- Improve emotional wellbeing, quality of life and functional ability in people with common mental health disorders.
- Improve individual's well-being and functionality; this will include people with physical health problems.
- Improve access and support to maintain people in work, help them to return to work, help them into education or training and where appropriate help people to find meaningful activity.

3.2 Service description

The service operates a stepped care model which means that most patients will enter treatment at Step 2 however some may require to be 'stepped up' to Step 3 treatment if clinically indicated. The least intensive intervention appropriate to a person's needs is provided first and people can readily "step up or down" the care pathway in accordance with their changing needs and response to treatment.

The service is to be delivered as part of an integrated care pathway for people with common mental health disorders and will build on existing multi-agency partnerships with a variety of statutory, voluntary and private providers working collaboratively.

The stepped care model will ensure that local care pathways:

- Provide the least intrusive, most effective intervention first
- Have clear and explicit criteria for the thresholds, determining access to and movement between the different levels of the pathway
- Do not use single criteria (such as symptom severity) to determine movement between steps
- Work with other mental health services to support individuals through transition between services
- 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

The service will primarily address mental health Payment by Results (PbR) Care Clusters 1-3 as follows:

- Care Cluster 1: Common Mental Health Problems (Low Severity) - This group of service users 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 of service users 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 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, (Step 2)
- Care Cluster 3: Non-Psychotic (Moderate Severity) - This group of service users have moderate to severe problems involving depressed mood, anxiety or other disorder (not including psychosis) (Step 3 & Step 3+)

The service will offer a range of evidence based psychological interventions including NICE approved / recommended psychological therapies in line with relevant clinical guidance; associated with improved service user outcomes and recovery rates.

The service will cover the following:

- Depression,
- Generalised anxiety disorder
- Mixed depression and anxiety including peri and post-natal depression
- 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 or medically unexplained symptoms
- Depression or anxiety in adults with a mild learning disability or cognitive impairment

In accordance with NICE guidance some patients (e.g. those with severe depression or anxiety disorders or PTSD) will be routed straight to Step 3 (high intensity interventions) rather than stepped first through Step 2 (low intensity interventions) which would not be effective in meeting their treatment needs.

The Stepped Care Service Model acknowledges the crucial role of the promotion of well-being and positive mental health for the population and the role of self-help for lower intensity psychological problems.

Services will be easily accessible within the community and incorporate various styles of engagement and delivery ranging from self-help materials, telephone advice and counselling, both individual and group approaches. Multiple points of access to the IAPT will facilitate links with the wider community and promote access to services from people from a range of socially excluded groups. This may include use of accessible, non-stigmatised community venues, including the person's own home when housebound or agoraphobic.

The Service will accept self-referral. Recent evaluation of psychological intervention services demonstrated that self-referred service users present with symptoms as severe as those of GP-referred service users and recover with fewer sessions of treatment. Experience has shown that this is associated with higher completion and recovery rates.

Promotion of recovery and positive mental health provides an opportunity for collaboration and partnership with other community services and interventions as part of local service delivery (e.g. social care, housing, environmental services, education, criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused services). The provider will be required to actively target one 'hard to reach' community per quarterly period, i.e. people coming out of the criminal justice system, Gurkha communities, white middle aged men in 'at risk' occupations, this will help to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery.

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

3.3 Care pathway

INSERT NEW PATHWAY

Service description

The service will deliver Step 2, Step 3 or Step 3+ interventions, and clinicians will use GAD7 and PHQ-9 scores to determine the level of intervention required. If treatment offered is not in line with these scores then a clear clinical rationale and justification is required and must be clearly documented in the patient's clinical notes. This activity will also be monitored in the regular performance monitoring data collected from providers.

Step 2 service description

This is generally a low-intensity service and will include the components below. It can be provided through individual and group sessions, in agreement with the patient (when these are recommended in NICE Guidance) and will include both brief face-to-face contact and telephone support. Key elements:

Use of interventions detailed below **(2-6 sessions, average 4 sessions with an expectation that 60% of all referrals will be treated at Step 2):in line with national guidance**

- Education
- Bibliotherapy
- Behavioural activation
- Signposting
- Guided cognitive-behavioural self-help
- Problem-Solving
- Guided self-directed exposure therapy
- Referring to various services including social services and exercise referral
- Introduction to services - this will require the worker to accompany the client to the required service if support is needed.
- Concomitant medication advice and support for patients receiving antidepressant medication
- Telephone 'collaborative care' support for patients on antidepressant medication

Psychological intervention	Disorder
Cognitive behavioural therapy (computerised)	• Depression
Group-based peer support (self-help) programmes	• Depression (with a chronic • physical health condition)
Non-directive counselling delivered at home	• Depression (antenatal and • postnatal)
Psycho-educational groups	• Generalised anxiety disorder • Panic disorder

Step 3 service description

This level is generally a high-intensity service and includes the following components:

- Individual 1:1 brief intervention; to include a choice of modalities where appropriate as recommended in NICE Guidance.
- The average number of 1:1 sessions at Step 3 is expected to be 8 with a range of 6 -12
- **The commissioner would expect 40% of all referrals would be treated at Step 3. In line with national guidance**
- Specialist Psychological treatment groups.
- NICE guidance also recommends considering the concurrent use of medication in moderate to severe (but not mild) depression and, therefore, therapists will work in liaison with the appropriate medical practitioner.
- Computerised CBT (8 sessions)
- Individual CBT sessions with a therapist (6-8 face-to-face sessions, average 7 sessions)

Psychological intervention	Disorder
Applied relaxation	• Generalised anxiety disorder
Behavioural activation	• Depression
Behavioural couples therapy	• Depression
Bibliotherapy based on cognitive behavioural therapy principles	• Panic disorder
Cognitive behavioural therapy (CBT)	• Depression • Generalised anxiety disorder • Panic disorder
Cognitive behavioural therapy including exposure and response prevention (individual and group)	• Obsessive-compulsive disorder
Cognitive behavioural therapy (trauma-focused)	• Post-traumatic stress disorder
Counselling	• Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy)
Eye movement desensitising and reprocessing	• Post-traumatic stress disorder
Interpersonal psychotherapy	• Depression
Self-help groups	• Depression • Generalised anxiety disorder • Panic disorder

Step 3+ service description

- The average number of 1:1 sessions at Step 3+ is expected to be 16with a usual range of 12 – 20. The indication of need to enter Step 3+ will be a PHQ9 >24, GAD7>19 plus TAG risk of 5 or more and one or more additional factors
- ***A decision to treat and to step an individual up to Step 3+ must be agreed by a Senior Clinician.***
- NICE guidance also recommends considering the concurrent use of medication in moderate to severe (but not mild) depression and, therefore, therapists will work in liaison with the appropriate medical practitioner.

Psychological intervention	Disorder
Applied relaxation	• Generalised anxiety disorder
Behavioural activation	• Depression
Behavioural couples therapy	• Depression
Bibliotherapy based on cognitive behavioural therapy principles	• Panic disorder
Cognitive behavioural therapy (CBT)	• Depression • Generalised anxiety disorder • Panic disorder
Cognitive behavioural therapy including exposure and response prevention (individual and group)	• Obsessive-compulsive disorder
Cognitive behavioural therapy (trauma-focused)	• Post-traumatic stress disorder
Counselling	• Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy)
Eye movement desensitising and reprocessing	• Post-traumatic stress disorder
Interpersonal psychotherapy	• Depression
Self-help groups	• Depression • Generalised anxiety disorder • Panic disorder

3.4 Population covered

The service is available to any adult resident (age 18 and above) registered with a GP Practice within the East Kent Clinical Commissioning Groups boundary (this includes Ashford, Canterbury, South Kent Coast and Thanet).

3.5 Days / hours of operation

The service will offer a range of appointments to allow access to meet need, including evening and weekend access to assessment and treatment

Extended hours of operation, to include Saturdays and evening provision, must be considered according to service requirements.

Telephone access will be available to GPs between 8:30am and 6:30pm Monday to Friday excluding Public and Bank Holidays for advice on referrals

3.6 Referral criteria and sources

The service will be available to people experiencing mental distress in relation to common mental health conditions such as anxiety and depression (which may also be linked to a physical health condition). The thresholds for entry to therapeutic services are based on the use of a range of clinical assessment tools which provide an indication of client need. These include details of cut off scores for clinical 'caseness', scores above which correlate with diagnosis of a disorder and indication of client need and appropriate service level.

Table 1: Indicative Thresholds for Entry

Problem area	**Recommended Measure**	**Indication of access to service**		
		Step 2	***Step 3***	***Step 3+***
Depression	PHQ-9	10 - 14	15 – 27	24+ and added needs
General Anxiety	GAD7	8 - 15	16 - 21	19+ and added needs

The IAPT Data Handbook (***http://www.iapt.nhs.uk/silo/files/iapt-data-handbookv2.pdf - page 22-27***) describes the suggested thresholds for entry to therapeutic services, based on the use of a range of clinical assessment tools.

Referrals will be accepted from all healthcare, employment and social care professionals.

Referrals will also be accepted directly from patients, by way of a self-referral to the service, however patients will not be able to re-refer themselves within 12 weeks of completing a course of treatment. systems to accommodate this must be developed by the provider.

Referrals will be triaged on receipt for suitability for the service.

Patients who DNA an appointment that they have previously agreed to attend will be given one further appointment. Patients who DNA an appointment that they have previously agreed to attend for a second time will be discharged from the service and their GP advised

3.7 Referral processes

Access is available through written referral, Choose & Book referral or a self-referral as appropriate from individuals direct to the provider.

Following receipt of referral an individual must be contacted within 3 days and advised of the decision to treat or not, should that be the case.

If the individual is considered suitable for treatment within the service, the individual will be offered their first assessment within 14 days of receipt of referral, with all the next follow-up session in the pathway to start within 28 days of referral.

If the individual is deemed not suitable for this service and were referred by their GP, communication to the individual's GP practice will be made within 7 days of that decision being made, with suitable alternative pathways for the individual or if the individual requires a referral on to another provider then the GP must be informed and sent a copy of the referral letter for their records.

If onward referral to secondary care mental health services is required at any time, this will be undertaken via an agreed inter-provider referral proforma. It is the responsibility of the provider to undertake this referral.

People identified to be at high risk (e.g. suicidal intent, severe self-injurious behaviour, psychotic symptomatology) will be urgently referred to the appropriate mental health service. The access requirement for these referrals is the same day.

Individuals who self-refer themselves back into the service within 12 weeks of their first referral will be review by a Senior Clinician within the provider organisation and directed back to their GP for appropriate clinical review and onward referral or re-referral back into the IAPT service if required.

3.8 Discharge processes

Patients will be transferred back to the care of their GP when the patient has been assessed and treated. If the patient had self-referred, their GP will be informed of the outcome if the patient is in agreement

Once a patient's treatment has been successfully concluded a discharge summary will be sent to the patient's GP within 10 working days.

Each patient discharged will be provided with advice around self-management of their condition and given appropriate advice in a form most suitable to them.

A patient cannot be re- referred within 3 months of discharge unless referred by a GP due to severity and clinical need.

3.9 Any acceptance and exclusion criteria

- The service is only available to persons over 18 years of age.
- Service only available to Patients registered with an East Kent CCG GP practice
- Patients identified as high risk (e.g. suicidal intent, severe self-injurious behaviour, psychotic symptomatology) are excluded and should be passed on immediately to secondary care by the provider receiving the referral

3.10 Interdependence with other services/providers

Links will be made and maintained with:

- Local Community Mental Health Teams
- Specialist secondary care health services
- Kent Community Healthcare NHS Trust
- Local CAMHS provider
- Primary Care – GPs, Nurses, Primary Care Mental Health Specialist Workers and other community based services
- Criminal justice agencies
- Independent and voluntary organisations
- Employment support agencies
- Residential care and Nursing homes
- Kent County Council

Shared care arrangements where appropriate with other relevant services to ensure patients' needs are fully met, and all aspects of their care and treatment are co-ordinated.

The provider may also need to work in partnership with secondary / specialist health services to ensure that people with more complex needs have these met in timely ways which are clinically appropriate.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE Guidelines:

- Common mental health disorders: identification and pathways to care' (NICE clinical guideline 123)
- Borderline personality disorder: Treatment and management (CG78)
- Antisocial personality disorder (CG77)
- Depression in adults (CG90)
- Obsessive Compulsive Disorder (CG31)
- Post-traumatic Stress Disorder (CG26)
- Depression in adults with a chronic physical health problem (CG91)
- Eating Disorders (CG9)

Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.

Department of Health (2010)

NHS Outcomes Framework 2011/12

Department of Health (2011) Talking therapies: a 4 year plan of action.

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

4.3 Applicable local standards

4.3.1 Training, education, supervision and research

All staff will be accredited with a professional organization and will reflect the range of

trainings appropriate to deliver the modalities required. This will include any additional training requirements that may occur during the course of the contract due to new priorities identified by NHSE.

The IAPT specific workforce consists of High Intensity Therapists delivering step 3 interventions and Psychological Wellbeing Practitioners (PWP) delivering step 2 interventions.

Relevant training for staff includes but is not exclusive to:

- Cognitive Behaviour Therapy (CBT) for both High Intensity and PWP
- Other NICE-approved therapies for depression only; (Interpersonal Psychotherapy / IPT; Couple therapy for Depression; Counselling for Depression and Brief Dynamic Interpersonal Therapy/DIT)
- EMDR
- Supervision
- Payment by Results (PbR) Cluster training

The provider will carry out training with other partner agencies in the identification of common mental health problems; will work to educate universal and other services available to the general public on mental health and wellbeing issues relevant to that client group.

Supervision of staff from experienced accredited practitioners is essential and guidance is available on professional standards and requirements.

Services will be encouraged to conduct research where appropriate on issues relevant to the service area and client group and will contribute to local, regional and national networks.

4.3.2 Record Keeping

The Provider will ensure that accurate and up to date electronic records are kept on all individuals seen by the service, in line with both Caldicott and Data Protection Requirements.

The Provider will share data with Commissioners to facilitate the ongoing planning and development of services.

4.3.3 Service promotion and information

Service Leaflets: The provider will produce high quality information leaflets for service users on relevant mental health conditions such as depression, anxiety post-traumatic stress disorder and obsessive compulsive disorder. They will set out the range of available treatments on offer and ways to access them.

This will include signposting to Step 1 and into Step 2, 3 and 3+ with the following features included:

- Information will be available in alternative “easy read” formats and comply with the Disability Discrimination Act
- The material will be circulated widely, provided to all GPs and local key voluntary groups and offered to all service users presenting or sign posted to the service
- The service provider will monitor how patients access the service and adapt information to target hard to reach groups.

Service Website: The provider will develop an up to date website which is linked to the local ‘Live it Well’ site and includes the following contents as a minimum:

- Information on common mental health problems and options for treatment
- Self-help resources, including links to mental health matters telephone help line, cCBT, downloadable materials, the books on prescription scheme, recommended relaxation CDs, details of local self-help and psycho-social education and support groups, other local help-lines
- Links to local substance misuse service websites
- Details of services, including how to contact the service, information on what

happens when you do, what times and places the service is available at and what the waiting times are
    - What service users have said about the service including collated Patient Experience Questionnaire Results for the previous six month period
    - Annual service evaluation report
    - Links to other relevant websites, including those detailing NICE Guidance
    - Signpost to patients for who English is not their first language, to translation or interpretation services.

Useful materials for promoting the service can be downloaded and adapted for local use from *http://www.iapt.nhs.uk/services/providers*

4.3.4 Information technology support

The Provider shall provide appropriate IM&T systems to fully support the Service requirements. IM&T systems means all of the IM&T related infrastructure, computer hardware, software, networking, training and maintenance necessary to support and ensure effective and secure delivery of the Service, management of patient care and contract management. It is the responsibility of the provider to ensure that the IM&T systems are maintained and are kept fit for purpose.

The Provider's IM&T Systems must comply with those NHS standards appropriate to the services commissioned from the Provider, including but not limited to:

- GP Systems of Choice (GPSoC)
- Referrals and booking;
- NHS Terminology Service.

The Provider must use a clinical system that is compatible with clinical systems approved under the GPSoC programme.

The Health & Social Care Information Centre (hscic) supports delivery of IT infrastructure, information systems and standards to ensure that information flows efficiently and securely across the health and social care system, in order to improve patient outcomes.

IM&T systems that are supported by hscic include:

- Choose and Book: the national electronic referral service giving patients choice of place, time and date of their first outpatient appointment will be the mechanism used for all referrals and appointments
- N3: use of the national network, as a third party user, for all external system connections to enable communication and facilitate the flow of patient information
- Summary Care Record (SCR): SCRs provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information
- Electronic Prescription Service (EPS): use of the electronic prescribing service for supply, administration and recording of medications prescribed.
- GP2GP: use of GP2GP so that patient records are transferred electronically when a patient registers with a new practice
- Demographics: including use of the Personal Demographic Service (PDS) to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications
- NH mail: use of the NH mail email service for all email communications concerning patient-identifiable information.
- Quality Management and Analysis System (QMAS): use of QMAS to demonstrate performance against QOF achievement targets to support quality improvements in services provided to patients (QMAS is being replaced by Calculating Quality Reporting Service <CQRS> for the 2013/14 year).

The Provider's chosen IM&T Systems must be effective for referrals and bookings including

appointment booking, scheduling, tracking, management and the onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with Choose and Book requirements.

The Provider must comply with UK Terminology Centre (UKTC) NHS Classifications Service (NHS CS) and Healthcare Resource Groupings Healthcare Resource Groupings (HRG) including:

- Read Codes and migrate to SNOMED
- NHS Dictionary of Medicines and Devices
- Office of Population Census and Surveys (OPCS) version 4.6
- National Intervention Classification Service (NIC)
- International Classification of Disease (ICD) version 10
- Healthcare Resource Groupings v4

Funding for the IM&T systems and associated infrastructure will be the Provider's responsibility.

The Provider must undertake testing of all of the IM&T Systems proposed, including those supplied by the Provider, third party suppliers and also of any interfaces and inter-working arrangements between parties or systems, so as to guarantee compliance with all appropriate standards and to prove operational effectiveness.

The Provider must put in place appropriate governance and security for the IM&T Systems to safeguard patient information.

The Provider must ensure that the IM&T Systems and processes comply with statutory obligations for the management and operation of IM&T within the NHS, including, but not exclusively:

- Common law duty of confidence
- Data Protection Act 1998
- Access to Health Records Act 1990
- Freedom of Information Act 2000 (FOIA)
- Computer Misuse Act 1990
- Health and Social Care Act 2012

There is a statutory obligation to protect patient identifiable data against potential breach of confidence when sharing with other countries.

The Provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively NHS Codes of Practice and legal obligations including:

- NHS Confidentiality Code of Practice
- NHS Records Management Code of Practice
- Information Security NHS Code of Practice, registration under ISO/IEC 17799-2005 and ISO 27001-2005 or other appropriate information security standards
- use of the Caldicott principles and guidelines
- appointment of a Caldicott Guardian
- policies on security and confidentiality of patient information
- clinical governance in line with the NHS Information Governance Toolkit
- risk and incident management system

To ensure the quality and safety of patient care, the IM&T Systems must, when appropriate, also support:

- management of all clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports
- prescribing and where appropriate dispensing
- maintenance of individual electronic Patient health records
- inter-communication or integration between clinical and administrative systems for use of patient demographics
- access to knowledge bases for healthcare, such as Map of Medicine, at the point of patient contact
- access to research papers, reviews, guidelines and protocols
- communication with Patients to support provision of quality care, including printed materials, telephone, text messaging, website, and email, and
- access to provide printed patient information leaflets to support health promotion, provide easily understood information and help the patient to manage their condition

Business Continuity

All providers will be expected to have an up to date Business Continuity Plan (BCP) which clearly outlines their plans for ensuring business continuity in the event of unexpected events, e.g. severe adverse weather, disruption to public transport, etc

Disaster Recovery

No failure of national IM&T infrastructure or of any other sub-contractor supplying IM&T services or infrastructure will relieve the Provider of their responsibility for delivering commissioned services. Therefore, the Provider must have an IM&T Systems disaster recovery plan to ensure service continuity and prompt restoration of all IM&T Systems in the event of major systems disruption or disaster.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

Not applicable to this contract.

6. Location of Provider Premises

The provider must deliver the service in an environment which is conductive to the needs of the individual, offering anonymity (if required) and must:

- Deliver services close to patient's homes wherever possible (and in patients own homes where they are housebound or have prohibitive mobility issues).
- Provide and deliver services in a range of community settings (GP practices, libraries, resource centres, employment settings etc.)
- Providers must be closely aligned with GP practices to ensure good integration with primary care.

The Provider's Premises are located at: ***To be completed when known***

7. Individual Service User Placement

Not applicable to this service.

8. Reporting

The provider is expected to achieve the National Benchmark Standards of:

- % of referrals entering treatment = 80%
- % of people entering treatment who complete treatment = 70%
- % of people who complete treatment who move to recovery = 50%
- % of people who recover from benefits to work = 5%
- It is recommended that IAPT teams should be configured with 60% high intensity capacity and 40% low intensity capacity
-

Providers will also be required to provide locally agree datasets every month and should be submitted to **kmcs.communitycontracts@nhs.net** and **kmcs.kmcsdmic@nhs.net**

Data required within the local datasets are to include:

- Number of people referred
- Number of people entering treatment
- Number of people completing treatment
- Number of people moving to recovery
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- 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 clinical approach
- Waiting times

Invoices must be dated and must include the name of the contract:

And the **Contract Reference Number**

And an **Invoice Number** (from your organisation)

Invoices will be paid only if backed up by the activity data

Providers will also be required to report on the national data requirements, these can be found at - http://www.hscic.gov.uk/iapt

The national IAPT dataset is to be submitted using the IAPT Intermediate Database (IDB). The IDB is a Microsoft Access database which contains four data tables as specified in the dataset specification. The IDB can be requested from the contact centre – 0845 300 6016 or by email to enquiries@ic.nhs.uk

The national dataset must be submitted on a monthly basis and the dates are available on http://www.hscic.gov.uk/iapt

The dataset inclusion rules can be found at:- http://www.hscic.gov.uk/iapt

The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

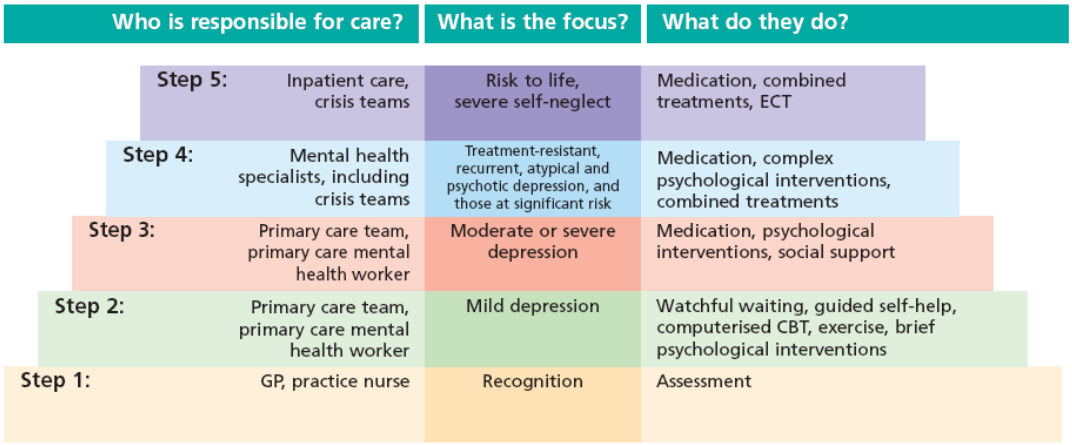
Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

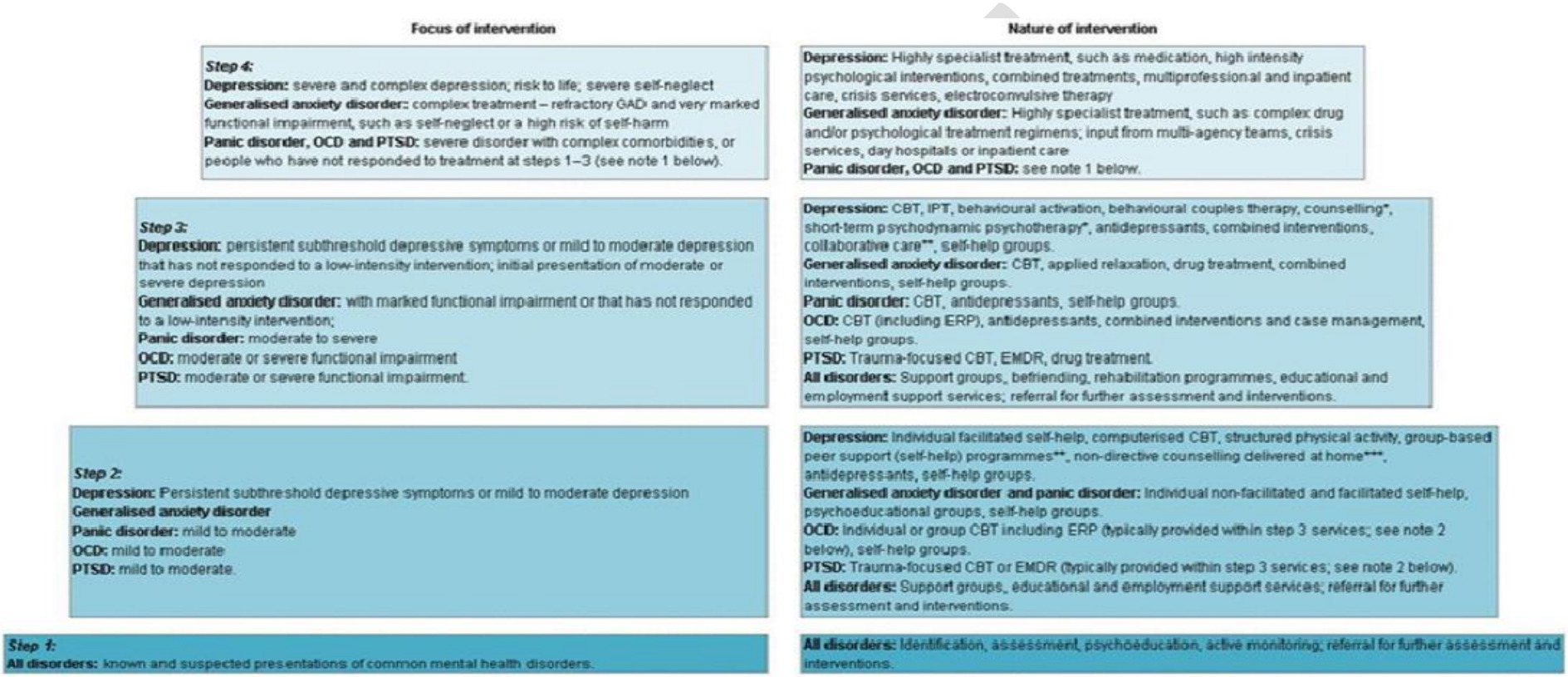
Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression



Appendix



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-focussed 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 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.