Version Control Sheet

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Author	Dan Burningham
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Revision History

Version number	Date	Reviewer	Change Reference & Summary
1	5.9.16	Dr Rhiannon England (CCG) David Maher (CCG)	Internal review with minor amends
2	19.9.16	Primary Care Mental Health Design Group (GP Confederation and CEG Representatives)	Review to inform submission to Priority Investment Committee
3	22.9.16	Priority Investment Committee	Approved
4	14.11.16	Mental Health Programme Board	Approved
5.	22.11.16	Primary Care Mental Health Alliance Board	EPC specification integrated into Alliance specification. Clarifications made to text
6	25.11.16	Contracts Committee	KPIs for LTCs adjusted to focus only on IAPT. Approved subject to Code of Conduct form.
7	28.11.16	LMC	

Distribution History

Version number	Date	Distributed to	Reason for distribution	Action
1	5.9.16	Dr Rhiannon England (CCG) David Maher (CCG)	Internal CCG review	See table above
2	19.9.16	Primary Care Mental Health Design Group (GP Confederation and CEG representatives)	Review	See table above
3	22.9.16	Priority and Investment Committee	Funding review	See table above
4	14.11.16	Mental Health Programme Board	Programme Board Approval	See table above
5.	22.11.16	Primary Care Mental Health Alliance Board	Approval	Approval with minor amends to improve clarity actioned.
6	25.11.16	Contracts Committee	Approval	Approved subject to code of conduct form approval
7.	28.11.16	LMC		

SERVICE SPECIFICATION

Service	Primary Care Mental Health Alliance
Commissioner Lead	Dan Burningham, City and Hackney CCG
Providers	Primary Care Mental Health Alliance: GP Confederation, Clinical Effectiveness Group, Family Action
Provider Lead	GP Confederation
Period	April 1st 2017 – 31st March 2019
Date of Review	December 2017, December 2018

1 Population Needs

The Primary Care Mental Health Alliance covers the full range of mental health problems within Primary Care. Current levels of need are as set out below. These are likely to increase over the next two years due to population growth.

- **Common mental health problems** (depression and anxiety) The City and Hackney population prevalence for common mental health problems is 33,611 (NHSE). Most of these are managed within primary care. Under the Quality Outcomes Framework (QOF) GPs are paid for one initial review for people with newly diagnosed depression or anxiety. However, many patients remain in primary care with symptoms, which persist beyond a year. Based on EMIS data searches conducted by the CEG in June 2016, it is estimated that there are about 8,500 people in primary care, who are on anti-depressants but who have not been reviewed by the GP within the last 12 months. The Primary Care Mental Health Alliance incentive scheme has been addressing this by paying for on-going GP reviews, this mirrors the work done for other long-term conditions.

- **Diabetes:** 475 i.e. 0.15 % of the City and Hackney practice population have both a diagnosis of diabetes and depression (April 2016) However expected prevalence is 0.6% (G.A. Kaplan et al, Journal of Psychosomatic Research, Issue 4, 2002) indicating that there about 950 people who have both diabetes and undiagnosed depression. NHSE estimates that the cost of treating diabetes increases by 50% if the depression is untreated.

- **Psychiatric admissions:** There were 1,113 psychiatric admissions in 2015-16. Whilst many of these are followed up in outpatients or CMHTs there is currently no formal process of GP review to follow up discharges. An estimated 50% of patients (556 patients) discharged from psychiatric wards are discharged directly into primary care.

- **COPD:** There were 499 admissions for COPD and related disorders through emergency departments in 2015-16. Comorbidity with mental health problems, particularly anxiety disorders is estimated to be 55% (MH Disorders in COPD, Respiratory Medicine, Vol. 102, Issue 5, 2008)

- **Frequent attenders:** 940 have had 30+ GP consultations (2015-16). Many of these have an underlying undiagnosed mental health problem. By not addressing mental health issues GP time is not being used effectively.

- **Dementia:** 932 people have a diagnosis of dementia (June 2016).

- **SMI: 4,229** people are on the QOF SMI list.

Although a large number of people with mental health problems are managed within primary care ambiguity and complexity around the coding means that there is no clear register or dashboard that would enable practices to identify and support people with mental health problems. In this regard, primary care mental health falls behind other long-term conditions such as diabetes, which have dashboards to assist management within primary care.

2 Outcomes

2.1 NHS Outcomes Framework

Figure 1: NHS Outcomes Framework domains & Indicators

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

2.2. Sustainability Transformation Plan (STP) objectives

The Primary Care Alliance will address the STP strategic priorities as shown in the table below.

Figure 2: STP objectives

Relevant STP Objective	How the Primary Care Alliance will achieve this
Supported self-management (local STP objective)	Use of the recovery model by GPs to support self-management, in line with the EPC model.
Access standards and care pathways (Five Year Forward View appendix B)	The registers and reviews will improve the identification of mental health problems within primary care and ensure appropriate signposting to treatment. This combined with initiatives to increase psychological therapy capacity will increase access to treatments.
Psychological Therapies for people with long term conditions (Five Year Forward View appendix B)	Increased diagnosis of people with LTCs increased rates of treatment through mental health reviews and referrals on for treatment.
Physical health outcomes in people with mental illness (Five Year Forward View appendix B)	Physical health and mental health checks are combined in GP mental health reviews.
Improve digital offer in primary care to support demand management (local STP objective)	Use of technology to create a dashboard, which makes complex information easy to access and digest.

The Primary Care Alliance will also address the following CCG priorities.

Figure 3 CCG Priorities

Relevant CCG Priority	How the Primary Care Alliance will achieve this
Manage Demand	The register and dashboard will provide tools for analysing and managing mental health demand.
Parity of esteem	The creation of a mental health dashboard will create a parity of esteem with physical health dashboards for long term conditions.

2.3 Cost savings

The combination of registers, a dashboard, reviews and family interventions will support the early identification and treatment of mental health problems. Treating problems early and effectively reduces the number of people reaching an acute phase or entering a mental health crisis. This is particularly true for people with a mental health problem and a long-term condition. As discussed, recent estimates from NHSE are that presence of untreated depression escalates the cost of treating diabetes by 50 This service specification focuses on identifying and reviewing people with long terms conditions and mental health problems and this will support initiatives to expand psychological treatments for this patient group.

2.4 Quality

The primary care mental health dashboard will provide quality indicators. For example, we will be able to see whether people with mental health problems have been reviewed, whether they have been referred on for treatment, whether their medication and physical health has been checked. We will also have alerts that signal a potential quality issue, for example the system will show if someone on anti-depressants does not have a mental health diagnosis.

3. Scope of Service

The alliance covers people registered with a GP within the London Boroughs of Hackney and the City of London. The clinical partners within the Primary Care Mental Health Alliance are:

- The City and Hackney GP Confederation, which represents the 43 GP practices
- Family Action, which undertakes family work within primary care through the 'Well Family Plus Service'
- The Clinical Effectiveness Group, which provides clinical analytical support, information systems and dashboards
- City and Hackney CCG, which commissions the Alliance and monitors the alliance outcomes.

In addition East London NHS Foundation Trust are strategic partners in the Alliance as they co-deliver the EPC contract. They will attend part of Alliance Board meetings. The table below summarises the scope of the services covered by the Primary Care Mental Health Alliance and the key provider responsibilities.

Figure 4: Summary of scope and key responsibilities

Service	City and Hackney GP Confed.	CEG	Family Action
Alliance Lead Representative	To act as Lead Representative for the Alliance and in this capacity a) co-ordinate the work of the Alliance b) represent the other Alliance organisations and act as the central point of contact between the Alliance and the Commissioners c) ordinarily chair Alliance Provider Board meetings		
Alliance Fund Holder	The Fund Holder will receive Alliance payments from the CCG and will distribute these to the Alliance members in line with the agreement of the Alliance Board. The Fund-holder transfers and present quarterly financial reports. NB at present Fund holding does not include payments to ELFT.		
Primary Care Mental Health Dashboard		a) Provision of the dashboard updated on a quarterly basis. b) Ensuring the dashboard information is accurate through conducting annual quality checks on data consistency. c) Development of the dashboard fields as agreed by the Primary Care Mental Health Alliance Board d) The employment of a Mental Health Link Worker to liaise between each GP practice and the Mental Health Alliance.	
Well Family Plus Service			To offer interventions to children and families including: care navigation, sign posting, practical support.
Stratified Primary Care Mental Health Reviews	a) Oversee GP stratified reviews ensuing practices are clear about expectations b) Monitoring the number of completed reviews and completed review templates c) Oversee the distribution of activity and performance payments for practices	a	

EPC-Depot Service	• Manage the delivery of EPC and depot across City and Hackney • Ensure the contract is understood by practices • Ensuring 100% practice coverage • Ensuring mandatory training is completed and that mandatory and optional training is recorded		

3.1 Alliance Lead Representative and Fund Holder

The City and Hackney GP Confederation will act as the 'Lead Representative' for the Alliance. This entails acting as the central point of contract for the commissioners and in this capacity, consulting with other Alliance organisations to represent the alliance as a whole. The Lead Representative will organise and chair Alliance Board meetings. The Lead Representative will also co-ordinate the joint working between alliance organisations. The City and Hackney GP Confederation will also act as the Alliance Fund Holder. The Fund Holder will receive payments from the CCG and will distribute these to the Alliance members in line with the agreement of the Alliance Board. The Board may sanction the transfer of funds between services and work streams and between accounting periods. The Board, in conjunction with the Commissioners, will manage underspends and overspends. The powers of the Board are set out in the Alliance Agreement. The Fund-holder will keep a detailed record of all financial transactions and budget transfers and present financial reports to the Alliance Board on a quarterly basis.

3.2 Primary Care Mental Health Dashboard

The mental health dashboard provides information to practices, the GP Confederation and the CCG for a range of mental health problems. The dashboard aims to assist these organisations to understand: healthcare need, the level of healthcare service being provided and gaps, where patients may be at risk. The focus of the dashboard is to support people with mental health problems, who are not in secondary care, principally through monitoring physical, mental health and medication reviews and referrals on to other services. The dashboard covers depression, dementia, frequent attenders and SMI and psychotic disorders, long-term condition mental health co-morbidity. For each patient cohort it monitors whether the frequency of review, the use of medication, referrals on to other services, engagement in other services, physical health indicators.

As the dashboard develops other conditions and fields may be added through the agreement of the Alliance Board. To help practices interpret dashboard information a link worker will be employed to visit practices The Clinical Effectiveness Group will lead on dashboard maintenance, development and the employment of the link worker. The responsibilities of the Clinical Effectiveness Group are:

- Provision of the mental health dashboard covering depression, dementia, frequent attenders and SMI and psychotic disorders, long-term conditions and mental health co-morbidity monitoring the frequency of review, the completion of review templates, the use of medication, referrals on to other services, engagement in other services, physical health indicators.
- The sending an updated dashboard on a quarterly basis to the GP Confederation, individual City and Hackney GP Practices.

- Ensuring the information is accurate through conducting annual quality checks on data consistency.
- Development of the dashboard fields as agreed by the Primary Care Mental Health Alliance Board
- The employment of a Mental health practice liaison worker to liaise between each GP practice and the Mental Health Alliance. The worker will meet with individual GP Practices and discuss area where the dashboard indicates that patients may be at risk or where the practice appears to an outlier. The Worker will also check that dashboard information is consistent with the reality at practice level.

3.3 The Well Family Plus Service

Family Action will continue to provide the Well Family Plus service to all GP practices in City and Hackney. This service has been provided for a number of years and has been provided as part of the Primary Care Mental Health Alliance over the last two years. By providing the service under the Primary Care Mental Health Alliance umbrella service provision can be integrated with the work of the GP Confederation and the Clinical Effectiveness Group.

The Well Family Plus Service will offer interventions to children and families including care navigation, sign posting, practical support over issues such as accommodation, work, training, healthy lifestyles and finances and recovery planning based on the Family Star, a planning tool. The service is underpinned by a systemic model, which includes physical health and mental wellness but identifies the wider determinants of wellbeing. The Well Family Plus service will also cover the following interventions for children and young people:

- All those aged under 25 who self-harm will be offered a follow up appointment
- Those under 25 who have been discharged from secondary care mental health and/or First Steps and who are deemed to need a “step-down” appointment will be offered a follow up appointment.
- All 16 year olds will be sent a briefing pack for their health check on services, which are available.

The service objectives are to:

- Improve levels of health and wellbeing Reduce the level of harm and neglect in children and vulnerable adults
- Reduce social exclusion, health inequalities, by preparing people to enter mainstream services such as IAPT
- Support the inter-relationship with CAMHS services e.g. Well Family Plus to manage step-down cases from specialist CAMHS provisions
- Actively prepare service users to access the integrated mental health network and other organisations and statutory agencies as required ensuring a positive experience of care.
- Deliver ‘whole family’ intervention to prevent intergenerational issues as a result of parent/carer mental health needs

A more detailed service specification is provided in the NHS Standard Contract between City and Hackney CCG and Family Action.

3.4 Stratified Reviews

To support the effective monitoring of people with mental health problems, who are not in secondary care, the GP Confederation will oversee the undertaking of stratified review by GP practices. The aim of the reviews

These reviews will focus on those not covered by the QOF review. This includes:

- Patients with on-going depression lasting more than a year, who are not being seen in secondary care and who have not been reviewed for over 12 months.
- Patients on anti-psychotic medication, who require monitoring beyond that offered by QOF in order to review medication and undertake a full NICE compliant review of physical healthcare needs.
- The review of patients with an as yet undiagnosed mental health problem for example frequent attenders with medically unexplained symptoms.

Practices will be incentivised to undertake these reviews through an activity based performance payment Reviews may will be undertaken by either: the GP, the Healthcare Assistant or the Practice Nurse. The GP Confederation will be responsible for:

- Ensuring that GP practices are clear about, who is expected to be reviewed and how
- Monitoring the number of completed reviews and completed review templates
- Overseeing the distribution of activity and performance payments for practices

Reviews will be supported by templates, which will set out the fields to be covered in the review. There will be prompts for Child Safeguarding issues.

In line with the Five Year Forward View, City and Hackney GP Confederation will be responsible for overseeing an improvement in the identification of common mental health problems with a particular focus on comorbidity with a physical health long-term condition. The Long Term Conditions template will have optional fields for the completion of two anxiety related questions (GAD2) and two depression related questions (PHQ2). Practices will receive guidance recommending a referral to psychological therapies or social prescribing if a score above 2 is achieved. There will be training for GP practices in identifying and referring common mental health problems.

3.5 Enhanced Primary Care (EPC) and Depot

3.5.1 EPC-Depot Service Overview

The EPC Depot service is provided by GP practices in collaboration with East London NHS Foundation Trust, who provide mental health liaison workers and psychiatric support, and the CEG who provide data. The service supports people with severe and enduring mental health problems in primary care. The GP Confederation are responsible for:

- Managing the delivery of EPC mental health reviews and Depot injections across City and Hackney GP practices
- Ensuring the contract is understood by practices
- Ensuring 100% practice coverage for participation in Depot and EPC

- Ensuring mandatory training is completed and that mandatory and optional training is recorded.

The GP Confederation's delivery of the Enhanced Primary Care (EPC) and depot contract will be delivered under the umbrella of the GP Alliance from April 2017 onwards. This is because the service benefits from a close working relationship between the CEG and the GP Confederation and both are Alliance Partners. Secondly ELFT, who also deliver the EPC service now attend part of Alliance Board meetings as strategic partners. Finally bringing the service under the Alliance umbrella also supports a greater integration between mental health work within the EPC-depot contract and outside of it and it allows resources to be transferred across work streams to meet changing patient needs.

The EPC service is a primary care based service in which the GP is the responsible clinician. All those receiving EPC must have been discharged from secondary care. Consequently the EPC service is not for people who are high risk or who require intensive, acute or specialist treatment. These are typically provided by secondary and tertiary care.

The EPC service is aimed at people, who are a low enough risk and stable enough to be treated in primary care but whose needs are such that they require an additional level of support to that provided by GMS, the QOF or IAPT services. The service is focused on people with severe and/or enduring mental health conditions including anxiety, depression, psychotic disorders and personality disorders. The service is not aimed at people with milder or common mental health problems, whose needs are sufficiently met within a primary care setting under GMS, IAPT or other primary care based services.

The service will support people who:

a) **Step Down -** patients who, after a period of treatment in secondary care, have become stable enough to be transferred to primary care but require support in order to make the transition.
b) **Step Up -** patients who are not currently in secondary care but who have needs that require an enhanced level of support

3.5.2 EPC-Depot service model and aims

The EPC service is underpinned by the Recovery Approach. This focuses on a journey rather than a set outcome. This journey may involve developing hope, a sense of meaning, a secure base, a sense of self, supportive relationships, empowerment and coping skills. The EPC service is a stepping stone that aims to move the patient along a recovery pathway towards a position where they are able to self-navigate and engage in a range of community support and peer support as and when needed manage their own recovery journey. For this reason EPC is offered as a time limited intervention with a recommended duration of up to a year after which the patient will be discharged into GMS services. The time limited nature of the service will be made clear to the patients at the outset. A key part of the service is the Recovery Care Plan. This will cover:

- Recovery goals set by the patient
- Mental health

- Physical health
- Medication
- Healthy lifestyles (including as appropriate weight management, smoking cessation, alcohol and substance use)
- Access to employment
- Relationships and social support
- Cultural needs, including where the patients' first language is not English
- Relapse indicators and contingency plan
- Contact details of key professionals

The achievement of recovery goals will be monitored in the plan and celebrated as part of the recovery journey. Patients will also receive acknowledgment, of their achievement.

The treatment of mental health problems in a primary care setting offers a normalised setting close to home where a long-term relationship with the patient has often been established. Furthermore, people with severe and enduring mental health problems have a much higher prevalence of physical health issues and primary care settings are well placed to integrate mental health and physical health treatments as part of a whole person approach. The service aims are as follows.

- To support service users to achieve their recovery goals through a process of joint planning that places the service users at the centre.
- To empower people to self-manage their own recovery journey and reach a position where they can reduce their contact with mental health services.
- To mark the recovery journey by recognising achievements whilst in EPC and at the point of discharge from EPC.
- To improve service user experience and outcomes through enhanced multi-disciplinary team working that addresses mental health, physical health and social care need as part of an integrated approach.
- To improve service user experience and outcomes through the provision of care in a normalised setting, close to home
- To assist the navigation of service users towards community resources that supports their recovery journey.
- To enable the development of capacity, confidence and competence in relation to mental health treatment and care, in the primary care workforce through the sharing of knowledge and expertise.
- Ensure the best clinical processes are followed in the discharge for patients from secondary to primary care.

3.5.3 Eligibility Criteria

The GP and psychiatrist will jointly decide whether a patient fits the eligibility criteria set out below for the EPC service**.** The following guidelines will be applied.

EPC Inclusion Criteria

- The patient has a diagnosed long term and/or severe mental health problem
- The patient has needs over and above those that would ordinarily be provided under normal GMS care i.e. either medical, psychological or social needs that require additional support
- The patient is over the age of 18, with some flexibility to consider patients in transition from child and adolescent services into adult services. There is no upper age limit to the service

EPC Exclusion criteria

- Patients, who are not a resident of City and Hackney or who are not registered with a City and Hackney GP.
- Patients, who have not been discharged from secondary care.
- Patients at high risk of harm to themselves or others who are more appropriate for emergency services.
- The patient needs to be under the care of a psychiatrist to administer medication or because of medication complexities or because of other diagnostic or care complexities.
- Patients whose mental health needs are sufficiently complex to require key working and a Care Plan Approach.
- Patients below the age of 18 who are not in transition into adult services.
- Patients whose mental state and behaviour is seriously and adversely affected by delusions and hallucinations with severe impact on the patient.
- Patients, who require a higher intensity of mental health care than that offered by EPC. This is quarterly meetings with the Liaison Worker, which can be increased to monthly if required.
- Patients with a primary diagnosis of dementia. These will be seen within primary care by the One Hackney Service.
- Patients, whose assessment is incomplete and/or do not have a clear mental health diagnosis.
- Patients whose mental health needs are sufficiently met in primary care General Medical Services.
- Patients with only a short term mental health problem and/or whose needs are sufficiently met by IAPT services.
- Patients in clusters 1-3. These are largely patients with common and milder mental health problems.

3.5.4 EPC-Depot GP Confederation Deliverables

The City and Hackney GP Confederation will provide the following in relation to the EPC-Depot Contract

- **Leadership.** The Confederation has a named health professional responsible for mental health who provides leadership to practice participation in this CCG Contract
- **Contract compliance.** The Confederation will ensure GP practices comply with the contractual responsibilities set out in the section below.
- **Population coverage.** The Confederation will ensure that there is 100% GP practice population coverage by the EPC service.
- **Quality Assurance.** The Confederation will monitor the performance of GP practices and provide quality assurance to City and Hackney CCG in the form of quarterly performance reports. These will include the KPIs set out in this document. The Confederation will also provide performance information as and when requested by the CCG.

The City and Hackney GP Confederation will ensure that GP practices undertake the following responsibilities:

- **Responsible Clinician**. Upon transfer into the EPC service the GP will assume the role of Responsible Clinician. GPs will be supported in this role through named psychiatrists for each practice, who will provide advice in MDT meetings and telephone advice as and when requested.

- **MDT Meetings.** Practices will hold a regular MDT meeting with the lead consultant psychiatrist for the practice to discuss patients under EPC and other patients with mental health issues. The MDT meeting will be a minimum of quarterly but can be monthly if the practice requires. GPs with EPC patients are expected to attend.

- **Contact with the Liaison worker**. Monthly contact with the mental health liaison worker over current patients

- **Recovery Planning and Reviews**. When the patient enters the service a Recovery Plan will be completed by the Liaison Worker who, with the patient, approve the plan. The plan is saved to EMIS web and the patient will receive a hard copy of the plan. Each patient will receive two mental health reviews: one at the point of entry to review discharge.. For patients on the Quality Outcomes Framework (QOF) one of these reviews can count as a review under QOF.

a) The first review will involve the completion of the "physical health" part of the patient's Recovery Care Plan. The plan must be approved by the GP, but may be completed in the first instance, with the patient and either the GP, the Health Care Assistant, or the practice nurse.

b) This review should be held no more than three months after the patient enters the service..

c) The second review will be completed by the GP. This review will be a discharge review and be undertaken towards the end of the patient's care episode. The review will have one of two outcomes:

i) Discharge – the patient is discharged back to the practice as a regular registered patient

ii) The patient remains on EPC for a further period and has an additional discharge review prior to final discharge.

The timing of the 2nd review will be set in conjunction with the Mental Health Liaison Worker, who may attend the review and who has assessed the patient for discharge. The review will look at the extent to which the mental health and physical health recovery goals set by the service user in the Recovery Care Plan have been achieved.

- **Physical health checks and lifestyle interventions**
The GP will ensure that the physical health section is completed in the patient's Recovery Care Plan, However, as stated above, the review with the patient may be completed in the first instance by either the GP, the HCA or the practice nurse. If patients are above threshold levels for BMI, Q-RISK, alcohol use or if the patients are identified as being a smoker, using non-prescribed drugs, the GP will offer a lifestyle intervention as part of the Mental Health Review. A lifestyle intervention is a brief intervention which can include:

a) an action plan – this is a plan to achieve a target level of change, agreed with the patient and recorded in the patient's recovery care plan

b) a referral on to another service

c) health education literature given to the patient

d) a medical intervention

e) social prescribing

The following criteria apply in determining threshold levels:

a) BMI. Where a patient has been identified as having a BMI of 30 or above at review (QoF MH12) and/or waist circumference of 94-102cm (men) or 80-88cm (women), the practice will engage with the patient to promote healthy lifestyles. This may include referring the patient on to a weight management programme, a dietician, exercise on prescription, an exercise programme, forming an action plan with the patient.

b) Smoking. Where a patient has been identified as being a smoker at review, the practice will engage with the patient to promote healthy lifestyles. This may include referring the patient on to smoking cessation services or formulating an action plan with the patient.

c) Q-RISK. Patients will be assessed for Q-RISK. Where a patient has a QRISK above >20% they will be placed on a HIGH risk register and then called in for an annual review, the practice will engage with the patient to promote healthy lifestyles

d) Alcohol. The Audit C assessment will be followed. Recommendations for a full audit for high risk users and a referral to alcohol services based on the score will be followed. If the patient is below the threshold for referral but their health is being adversely affected by alcohol services then the health education literature or an action plan may be offered as an intervention.

e) Non-prescribed drugs. If the patient is an occasional user of non-prescribed drugs, the practice will provide health education literature and/or a referral to drugs services. If the patient is dependent a referral will be made to drugs services.

- **Medicines management**. All practices are expected to administer and monitor medication for patients in EPC. The anti-psychotic monitoring page will be updated on EMIS at least annually in line with a review of a patient's anti-psychotic medication.

- **Record keeping**. Practices will maintain accurate records on EMIS web for patients in the EPC service. This includes: a record of all patients receiving mental health Enhanced Primary Care services; flows into and from the service by recording admission and discharge dates. Patient flows should match the numbers produced by the secondary care provider, ELFT. Record keeping also includes completed and updated Recovery Care Plans; attendance at MDT meetings, anti-psychotic drug monitoring, training attended and DNAs.

- **Risk management**

  All patients entering the service will be risk assessed to ensure the level of risk is appropriate for a primary care based service. As the Responsible Clinician, the GP is ultimately responsible for clinical risk. The GP will be supported by the Liaison Worker, who has an active role in identifying and managing risk. If the GP is concerned or unsure about a patient, they will have rapid access to psychiatric advice through designated liaison consultant. The patient also has rapid access to step up to secondary care.

  There will be an EPC risk template added to EMIS. This will include a) the patient's risk history) b) an assessment of current risks c) a log to add incidents and issues relating to risk. The Liaison Worker is responsible for completing the template and ensuring that all relevant information from secondary care is included in the risk history and the GP is responsible for ensuring that relevant primary care information is recorded. Both the GP and the Liaison Worker are responsible for updating the risk template with new information. Others involved in the care plan such as support workers and practice nurses and third sector agencies also have a role in identifying and reporting risk to the Liaison Worker.

If a patient is thought to be at risk during working hours, the Liaison worker will be notified immediately. Further actions by the Liaison Worker, include an appointment and/or a home visit. If the patient is considered to be in crisis or too high a risk for the EPC service the Liaison Worker be notified and the patients will follow a fast track referral to the CMHT or crisis services within the ELFT crisis pathway. Crisis referrals from EPC will be seen within 4 hours and urgent referrals from EPC will be seen within 24 hours.

All DNAs will be recorded on the EMIS system by either the EPC team or the GP practice. Practices will notify Liaison Workers of a DNA and the Liaison Worker will follow up with a telephone call. Practices and Liaison nurses should have systems in place to alert one another of DNAs

All Serious Incidents must be reported to City and Hackney CCG within 24 hours of the occurrence by the GP with details of recommendations and actions taken as a result. If the ELFT EPC team are aware of the incident, they firstly have a responsibility to ensure the GP Practice is informed immediately. Practices are expected to have, in place, a serious incident reporting policy, known in primary care as a 'significant events policy' and practices are expected to adhere to this policy in the event of a serious or untoward incident. All incidents must be reported to the Confederation.

The GP practices must have robust policies and procedures in place to ensure that vulnerable adults and children are protected are safeguarded and their welfare is promoted. Safeguarding will form part of the templates for EPC.

- **Mental health leads.** Each practice will identify a mental health lead, responsible for EPC service development and mental health training.

3.5.5 East London NHS Foundation Trust responsibilities (provided here for information only)

East London NHS Foundation Trust's responsibilities are detailed fully in the service specification for the primary care mental health liaison service, which forms part of the East London NHS Foundation Trust 2017/18 contract. ELFT responsibilities include the following:

- **Liaison Workers.** All service users in EPC will have a named Liaison Worker. The Liaison Worker is the key point of contact for the patient is responsible for leading joint the creation of the patient's Recovery Care Plan and care navigation. As part of the patient's Recovery Care Plan, the Liaison Worker may engage and co-ordinate other ELFT EPC team members such as Support Workers and Peer Support Workers. The Liaison worker will provide a minimum of quarterly 1-1 contact with patients in EPC. Liaison workers will be trained to use the EMIS practice note system to facilitate communication with primary care staff and to have an audit trail on patient records.

- **Peer support workers and support workers** will be provided to assist care navigation and engagement in community services if needed. Peer support workers will also offer service users the benefit of lived experience of a mental health recovery journey.

- **Psychiatry.** Psychiatrists will attend practice based MDT meetings in which EPC patients and referrals can be discussed, at least quarterly. In addition, for each patient in EPC there must be access to a named psychiatrist who can be consulted for advice.

- **Recovery Care Plan.** On entry into EPC the Liaison Worker will lead the joint development of a Recovery Care Plan with the patient and the GP. The patient must set their own recovery goals and agree to all parts of the plan. The Liaison Worker will ensure that the patient has a copy and that it is recorded on to EMIS. The Liaison Worker will also participate in the annual GP led recovery plan review. Following meetings with the patient the Liaison Worker will regularly update the Recovery Care Plan.

- **Relapse**. The Liaison Worker will facilitate rapid access to secondary care assessment should a patient relapse, or show signs of relapse

- **Training and support.** Liaison Workers will provide informal training and support to practices, when needed on assessment, treatment and recovery planning, record keeping and depot administration. In addition ELFT, in collaboration with other organisations will provide a formal EPC training programme containing mandatory and non-mandatory modules.

Figure 5: Table summarising contractual responsibilities for the EPC service

GP Confederation	GP Practices	ELFT
	Responsible Clinician. Upon transfer into the EPC service the GP will assume the role of Responsible Clinician. GPs will be supported in this role through named psychiatrists for each practice who will provide advice in MDT meetings and as and when requested.	**Provide a named Liaison Worker** for each EPC patient offering a minimum of quarterly 1-1 contact with patients. Liaison workers lead on care navigation, the MH review. A Liaison worker will also be identified for each GP network.
Leadership. The GP Confederation will identify a clinical lead for mental health responsible for: implementation of the SLA, identifying training needs, minimum of quarterly 1-1s with primary care Liaison Worker identified for the network, KPI oversight.	**MDT Meetings.** A minimum of quarterly meetings with the lead consultant psychiatrist for the practice to discuss patients under EPC.	**Psychiatrists** linked to practice who attend a minimum of quarterly MDT meetings and offer GPs advice on EPC patients as and when requested.
Population coverage. The Confederation will ensure that there is 100% GP practice population coverage by the EPC service.	**Mental Health Review meetings**. The practice will complete two mental health reviews: 1: An initial review (ideally held no more than 3 months after the patient enters the service) to complete and approve the Recovery Care Plan (GP or HCA) 2. Discharge review and review of progress in the Recovery Care Plan	**Provide peer support & support workers** to assist navigation and engagement in services.

	Recovery Planning. When patient enters the service a Recovery Plan is completed with the Liaison Worker. The GP or HCA completes physical healthcare section and records they approve the plan. The GP will also update the plan after the 2nd review meeting to assess progress.	**Recovery Planning.** On entry into EPC the Liaison Worker will lead the joint development of a Recovery Care Plan and will update the plan after patient meetings.
	Physical health checks and lifestyle interventions. GP or HCA completes physical health section in the patient's recovery plan. If patients are above threshold levels for BMI, Q-RISK, alcohol or if the patients are identified as being a smoker, using non-prescribed drugs the GPs will offer a lifestyle intervention.	**Relapse**. The Liaison Worker will facilitate rapid access to secondary care assessment should a patient relapse, or show signs of relapse
	Medicines management. All practices are expected to administer and monitor medication for patients in EPC. The anti-psychotic monitoring page needs to be completed on EMIS at least annually.	**Support** offered over medicines management, recovery planning and record keeping.
	Record keeping. ELFT will maintain accurate records on EMIS web for patients in the EPC service.	**Record keeping**. Practices will maintain accurate records on EMIS web for patients in the EPC service.
	Risk Management. GP as Responsible Clinician is accountable for risk. GPs contact the Liaison Worker to act on identified risks and update the risk log.	**Risk management.** All DNAs will be followed up with contact with the patient within a timescale appropriate to the level of risk of individual patients
	Training. 4 hours mandatory mental health training per practice in set topics with practice time funded. Other optional training will also be available.	**Informal Training** offered to practices to support EPC delivery
	Mental health leads identified for each practice with responsibilities for service development and identifying training needs.	**KPI and outcome measures**. Liaison workers monitor PROM, PREM and other KPIs

3.5.6 EPC-Depot Care Pathway

Some patients in EPC will also be receiving depot medication and will receive extra payments for this. Patients, who are not in EPC, but who are on depot medication, will also receive a payment, as specified in this contract. The key elements of the pathway are as follows:

- **Discharge from secondary care directly GMS.** If patients are well enough they will be discharged directly from secondary care mental health services into primary care general medical services (GMS).

- **Step down from secondary care to EPC.** Some patients may require the half-way step of EPC in order to make the transition from secondary care to primary care. The psychiatrist will send the details of the discharge plan into EPC. Alternatively the GP can recommend a discharge to the psychiatrist. The psychiatrist and GP must both agree that the patient is appropriate for EPC and fits the eligibility criteria set out in this document.

- **Discharge from EPC.** After discharge from the EPC, the patient will be managed under GMS services. However, those receiving depot medication will continue to receive payments for this. Discharge from EPC is the responsibility of the GP, as the Responsible Clinician.

- **Step up from GMS to EPC.** Patients can step up from GMS care. All referrals into EPC will first go through ELFT's single point of access. However, a referral can also be made to the Liaison Worker or psychiatrist or via an MDT meeting and ELFT. These professionals will then put the referral through the single point of access. If the referral is not recently known to the services they will be formally assessed and triaged.

- **Rapid access back.** If a patient in EPC is deteriorating they will have rapid access back into secondary care services.

3.5.7. The Step down (secondary care to EPC) referral process

For patients, who are in secondary care, **both the psychiatrist and the GP must be in agreement that the patient is suitable for EPC** based on their assessment of the patient's needs level of risk and fit with the entry criteria specified in this document. There must be a written communication from the psychiatrist to the GP setting out a) reasons for discharge from secondary care b) why the patient needs EPC c) an assessment of risk. T**he GP must be given two week's notice to raise any concerns with the psychiatrist. The GP can also initiate the step down process if they think a patient may be ready for discharge by contacting the psychiatrist.** The psychiatrist will then confirm their opinion to the GP in writing.

If both the psychiatrist and GP agree that EPC is appropriate, the patient is notified of plans for discharge and the offer of EPC. A meeting is also arranged with the Liaison Worker. If the patient accepts the offer of EPC they will be registered on EMIS by the Liaison Worker and the GP will be notified in writing. In addition the Liaison Worker will use the meeting to assist the patient to develop a Recovery Mental Health Care Plan. The plan will be saved to EMIS and the patient will receive a hard copy. The Patient

Rated Outcome Measure (PROM) will also be completed in this meeting in order to create a base line measure at the start of the service. The final stage of the process involves a 1-1 meeting with the GP, practice nurse or HCA to go through the plan and complete the physical healthcare section. After this meeting the GP then updates the plan and records that they approve the plan on EMIS and that they have met with the patient. Alternatively the GP and Liaison worker can meet the patient together.

If the patient is reluctant to accept EPC, they will be offered support, including peer support, to help them make the transition into EPC for a period of up to three months. If after 3 months the patient still does not want EPC, the psychiatrist will decide whether to discharge them into GMS or whether to continue in secondary care.

3.5.8 Step up Referrals (Primary Care to EPC)

Step referrals can come from the GP or another primary care based service, such as primary care psychology. However, **the explicit consent of the GP must be obtained before the referral can be made.** It is sufficient to simply state the fact the GP has consented in the referral letter. All referrals will go through ELFT's Single Point of Entry. Alternatively a referral can be passed directly to an EPC Liaison Worker or CMHT psychiatrist. Typically this might occur in an MDT meeting. The Liaison Worker or Psychiatrist will then put the referral through the Single Point of Entry.

As with the Step Down pathway, if the psychiatrist and GP agree the patient fits the criteria for EPC set out in this document they will then be offered a meeting with the Liaison Worker. If the patient accepts the EPC service, they will be supported to develop their Recovery Care Plan and registered on EMIS. The patient will also be offered a meeting with GP, practice nurse or HCA, who will complete the physical healthcare section of the recovery care plan and record that they approve the plan. Alternatively the GP and Liaison worker can meet the patient together.

3.6 Training.

To support the deliver of practice based primary care mental health services all practices must complete 4 hours of mandatory training per practice per annum covering agreed topics. All training must be cascaded to the practice. Mandatory training will be locally provided and free. GPs and/or practice nurses can attend the training and both will be reimbursed for time spent receiving the training. Practices will also be reimbursed to undertake optional training over and above the 4 mandatory hours up to a capped limit set out in Figure: 4 KPI table. The GP Confederation will inform practices of the capped amount per practice based on their list size. Group training where more than 1 clinician attends a single course will count as double the hours for single person regardless of many people attend.

3.7 Governance and Structural Support

Individual practices are individually responsible for the clinical governance of clinical work undertaken. The City and Hackney GP Confederation is not within this specification itself providing clinical work. It is providing a framework for clinical work to be undertaken, monitored and paid for. It is also providing

tools (the registers and the mental health dashboard) to be used by GP practices and also the CCG, the CEG and the Confederation itself.

The GP Confederation is responsible for monitoring the delivery of agreed schemes and agreed KPIs and associated spend. The GP Confederation is responsible for keeping within the allocated budget. Any spend above the agreed budget, unless agreed by the alliance board will not be covered by the alliance funds.

The Family Action is responsible for the governance of the Well Family Plus service. The Clinical Effectiveness Group is responsible for the delivery and quality of the mental health dashboard.

3.8 Sustainability

It is planned that the system of the dashboard, register and GP reviews will be sustainable. Most of the initial design costs of creating the register and dashboard have already been met by the Alliance leaving a lower cost for maintenance and updating the register. The allocated budget covers maintenance, further development and the employment of a mental health link worker. The budget also covers a capped level of mental health reviews. The Well Family Plus service has been delivered within the budget allocated for several years.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE, RTT)

- NHSE FYFV: SMI population will receive a comprehensive physical health check – 30% by 2017-18 rising to 60% in 2018-19.
- NHSE FYFV: 25% access to psychological treatments for common mental health problems within next 5 years with a particular focus on patients with a co-morbidity with Long Term Conditions
- NHSE target for Dementia diagnosis: 66.7% of prevalence
- NICE guidance for the use of psychological treatments for depression, anxiety and psychotic disorders
- NICE guidance CG90 for prescribing anti-depressants, which stipulates that: antidepressants should not be used 'routinely to treat persistent sub-threshold depressive symptoms' and that the use of anti-depressants in moderate or severe depression should be combined with high intensity psychological interventions'.
- NICE Quality Outcome Framework indicators for Depression
- NICE Quality Outcome Framework indicators for SMI (Bipolar Disorder and Psychotic disorders) – physical health checks.
- NICE Quality Outcome Framework indicators for Dementia
    - Diagnosis within 12 month of memory clinic assessment
    - Physical health checks
    - Face to face care plan review every 12 months
    - Recorded carer

4.2 Applicable local standards

The City and Hackney Confederation will be responsible for providing high quality care equitably across the City and Hackney GP Practice with 100% population coverage. It will also be responsible for the performance monitoring of GP Practices and for ensuring clear communication and good partnership working with other alliance organisations and East London NHS Foundation Trust.
There are three levels of quality assurance:

- Information quality
- Contract compliance
- Service quality

4.2.1 Information Quality

This level is a necessary foundation that supports the other two levels of assurance. The Confederation will ensure that:

a) Information processes are accessible, clear and standardised across all those engaged in providing the service
b) Clear processes are established with the secondary care provider to support the accurate transfer of information and avoid duplication
c) There is an accurate and up to date set of data, which has been tested for consistency with other data sets, such as that held by the secondary care provider. This data will include the information covering the flow of patients including: referrals into the service, discharges and lengths of time within the service.
d) Information is provided at a practice level and across all practices within the Confederation.
e) The Confederation will provide assurance to City and Hackney CCG that this has been undertaken in the form of reports on data completeness and data quality to accompany quarterly information reports. For the purposes of a more in depth service review, the Confederation will also provide the CCG with access to its data and allow spot audits of data quality to be undertaken, whilst protecting patient confidentiality. The Confederation will attend quarterly Service and Quality Review Meetings and provide reports and responses to queries when requested.

4.2.2 Contract compliance

Through the Alliance Board, the City and Hackney GP Confederation will provide City and Hackney CCG with assurance that the service provided by GP Practices is compliant with the contract specifications through regular reports KPIs which monitor compliance.

4.2.3 Service Quality

The Confederation will:

- Provide assurance that safety procedures are in place for missed appointments
- Monitor DNA's and adherence to safety procedures
- Report on all serious incidents
- Report on re-admissions into secondary care mental health and acute admissions.

5. Key Performance Indicators

5.1 Clinical

- Increase in referrals to psychological treatments and associated services e.g. social prescribing for patients with a diagnosed mental health problem in line with NICE guidance
- Well Family Plus service PROMs: Recovery star, PHQ, GAD7
- Increase in numbers achieving better control of diabetes and reduction in admission rates for COPD for those patients with co-morbid mental health problems.
- Continue to exceed national dementia diagnosis rate target and greater consistency of diagnosis across practices.
- 30% of those on anti-psychotic medication to receive full NICE compliant physical health check

5.2 Process

3,000 additional primary care mental health reviews per annum for common mental health problems, frequent attenders and patients on anti-psychotic medication (not in EPC). Up to 1,605 EPC reviews for patients with severe mental health problems. Up to 2,074 depot injections for SMI patients. All practices to complete 4 hours mandatory mental health training.

5.3 Patients

- Patient focus group report on experiences of the practice review system. Sample of patients ≥30.
- % of SMI with a physical health check
- % of EPC patients above threshold level who are offered an intervention and % of patients accepting an intervention

5.4 Co-designed (1 recommended)

The Confederation and CCG jointly agreed the co-design of diabetes and common mental health problems KPI.

5.5 Strategic Outcomes

The KPIs above address the STP priories of:

- Improving access to psychological therapies for people with long term conditions (5 Year Forward View (Appendix B).
- Improving access and care pathways for people with mental health problems (5 Year Forward View (Appendix B).
- Improving the digital offer 5 Year Forward View (Appendix B).

6 Reporting Requirements

The table below presents the KPIs including the reporting requirements format and frequency of deliver. It also sets out the performance payments and the consequences of not delivering.

Figure 6: KPIs

Performance indicator	Baseline	Indicator/Quality Requirement	Format & Frequency	Performance Incentive
1. Stratified mental health reviews for: people on anti-depressants not seen for 12 months, frequent attenders and people on anti-psychotic medication. Stratification based on mental and physical health risk.	2016-17 baseline to be confirmed in March 2017.	3,000 mental health reviews conducted with completed review templates on EMIS. Proportional Individual practice targets set based on list size.	Data captured on Mental Health Dashboard quarterly	Payment to GP practices: £40 per mental health per completed review and completion of the appropriate template undertaken by GP. The review can be telephone or face to face. Payments capped at 3,000 reviews per annum (£120,000)
2. Dashboard data quality	2016-17 annual qualify check being completed by CEG. Baseline to be confirmed by Jan 2017.	The application of agreed data quality checks including: 1. consistency between use of QOF codes, diagnosis and medication. 2. Data verification by practices.	Annual	Payment to CEG: £10,000 for completing the agreed quality checks and cleaning dashboard registers to ensure data accuracy.
3. Diabetes control.	c500 are have HbA1c above 10	10% of those mental health patients in IAPT with HbA1Cs above 10 move to below 10	Data captured on register via EMIS	Monitoring purposes only
4. COPD outcome KPI: reduction in acute hospital admissions	499 admissions p.a. (2015-16)	Target: reduction in COPD acute admission rates for patients with mental health problems and COPD in IAPT by 10%	Data captured on HUH HRG	Monitoring purposes only
5. Referrals to IAPT Psychological treatments	6,275 referrals p.a. 523 per month (2015-16)	Increase referrals by 500 p.a. based primary on LTC co-morbidity by using the 4 questions on the LTC template	HSCIC quarterly returns	Monitoring purposes only

6. Patient focus groups reporting on GP reviews	Not measured at present	Patient focus group established to report on the experience of GP reviews	Focus group report	Monitoring purposes only
7. Dementia diagnostic rates consistency between practices improved through use of dashboard.	73.60%	Target 80% and greater consistency between practices.	NHSE monthly reports	Performance review
8. Physical health screening for people of anti-psychotics	TBC	30% of those on anti-psychotic medication will receive a full NICE compliant physical health screening	CEG reports quarterly	Monitoring purposes only
9. Anti—psychotic drug monitoring	TBC	% of patients on anti-psychotic medication who have a monitoring template on EMIS web updated in the last year.	CEG annual report	Monitoring purposes only
10. Well Family Plus Activity	TBC	100% of those aged under 25 coded as self- harm or stepped down from secondary care will be offered a follow up appointment	Quarterly report to Alliance Board	Performance review
11. Well Family Plus Outcomes	TBC	Recovery Star, PHQ and GAD	Quarterly report to Alliance Board	Performance review
12. No. of SMI patients offered a physical health check	Not currently measured.	% of SMI patients offered a comprehensive physical health check (Lester tool)	CEG Quarterly report	Performance review
13. EPC mental health reviews	432	Completion of a face to face mental health review with complete and updated recovery care plan on EMIS	CEG quarterly reports	£40 per review, up to £64,224
14. EPC lifestyle interventions	68% of patients above threshold level were offered a lifestyle intervention (2015-16)	% of patients above threshold for BMI, alcohol, Q-Risk, smoking, substance	CEG annual report	EPC service review

		misuse, who are offered an intervention and % accepting the intervention		
15. EPC Depot	423	Administration of Depot injections in primary care.	CEG quarterly reports	£75 per injection up to £155,580
16. GP Practice mandatory training	All practices achieved compliance with mandatory 4 hour training	4 hours mandatory training per practice	GP Confederation report	£130 per hour training backfill costs up to £22,360
17. GP Practice optional training	Optional training fully utilitised.	Payment per hour per practice for approved training courses	GP Confederation report	£130 per hour training backfill costs up to £68,250
Total available performance payments				**£440,414**

7 Financial and Procurement Summary

The table below sets out the recurrent funding for the Primary Care Mental Health Alliance separated in terms of performance payments and delivery payments. The payment recipient is also clarified.

Figure 5: Financial Summary: Annual Payments for FYs 2017-19

Alliance Work stream	Deliverables	Recipient	Quarterly Fixed Delivery Payment	Quarterly Capped Performance Payment	Annual Performance Payment	Total per annum
Maintenance & Building Register and Dashboard	Maintain, cleanse and update existing registers and dashboard for dementia, frequent attenders and depression. Develop dashboard in line with additional specifications agreed by Alliance Board.	CEG	£3,750	£0	£10,000	£25,000
Employment of MH practice liaison Worker	Mental Health worker to work with all individual GP practices the GP Confederation and the CCG over dashboard data.	CEG	£10,000	£0	£0	£40,000
Mental Health Reviews	Undertake up to 3,000 mental health reviews with completed review templates in addition to QOF requirements	City and Hackney GP Practices	£0		£120,000	£120,000

Management and oversight	GP Confederation management costs for oversight of review process, alliance budget management and lead representative role.	City and Hackney GP Confederation	£6,250	£0	£0	£25,000
Depot	Provision of practice based depot service	City and Hackney GP Practices	£0	£38,895	£0	£155,580
EPC mental health reviews	Mental health reviews with physical health checks	City and Hackney GP Practices	£0	£0	£64,224	£64,224
Well Family Plus service	Delivery of the Well Family Plus service to all City and Hackney GP practices	Family Action	£71,250	£0	£0	£285,000
GP Practice Mental Health Training	Backfill for mandatory and optional training	City and Hackney GP Practices	£0	£0	£90,610	£90,610
	Total		**£91,250**	**£38,895**	**£284,834**	**£805,414**

8 Proposed Contractual Terms

- **Type of contract proposed (NHS Standard contract, Grant agreement, Alliance contract):** Alliance contract with NHS Standard Contracts for each organisation
- **Service Commencement date:** 1st April 2017
- **Initial term of service and expiry date:** 31st March 2019
- **Option to extend the initial term? If so, on what basis?** Yes through the contract negotiations process.
- **Details of proposed sub-contractors:** No sub-contracts
- **Contractual interdependence with other existing services / providers:** The CCG contract with the CEG to provide primary care mental health data.