1. The Service Specification

1.1 Background

This document covers the service specification for primary care practices within the City and Hackney Confederation to provide a Mental Health Enhanced Primary Care (EPC) service.

The EPC service is jointly provided with East London NHS Foundation Trust (ELFT) and everyone who is part of the service will also have a named Liaison Worker provided by ELFT. The role of the Trust is covered in this document but greater detail is provided in the ELFT EPC specification.

The EPC service was originally set up to focus on people with psychotic and bi-polar disorders on the SMI register. Hence the previous version of this contract was referred to as the SMI LES. However, in practice a much wider patient cohort was seen including people with anxiety and depression and personality disorders. This contract recognises and reflects the needs of this wider cohort. Furthermore it is now a contract between the CCG and the City and Hackney GP Confederation. For this reason the title has been changed from the SMI LES to the Mental Health EPC Confederation Contract.

Please note, this contract also covers payments for people who are receiving depot medication for mental health problems from primary care practices. Some people on depot will also be receiving an Enhanced Primary Care service and others will be receiving depot only.

1.2. Key elements of the specification

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
1.3. The service philosophy

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 from

1.4 The service aims

The treatment of mental health problems in a primary care setting offers care 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 issue 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 support 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.

1.5 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.

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.

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.

1.3 GP Confederation Responsibilities

i) Leadership. The Confederation has a named health professional responsible for mental health who
provides leadership to practice participation in this CCG Contract

**ii) Contract compliance.** The Confederation will ensure GP practices comply with the contractual responsibilities set out in the section below.

**iii) Population coverage.** The Confederation will ensure that there is 100% GP practice population coverage by the EPC service.

**iv) 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.

### 1.4 GP Practice responsibilities

The Confederation will ensure that GP practices undertake the following responsibilities.

**i) 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.

**ii) 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.

**iii) Recovery Planning.** When the patient enters the service a Recovery Plan will be completed by the Liaison Worker. The GP will check this is complete including the physical healthcare section and will record that they approve the plan. The patient and the Liaison worker also record their approval. The plan will be loaded on EMIS web and the patient will receive a hard copy of the plan. Following a Mental Health Review Meeting the GP will update the Recovery Care Plan.

**iv) Mental Health Review meeting.** The GP will complete two mental health reviews per annum with each EPC patient: a first initial review to complete and approve the Recovery MH Care Plan; a second meeting (at least 90 days apart) to review progress in the Recovery MH Care Plan. For patients on the Quality Outcomes Framework (QOF) one of these reviews can count as a review under QOF.

**v) Physical health checks and lifestyle interventions**

The GP will ensure that the physical health section is completed in the patient’s recovery plan. 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:

- 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
- a referral on to another service
- health education literature given to the patient
- a medical intervention
- social prescribing

The following criteria apply in determining threshold levels:

- **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.

- **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.

- **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

- **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.

- **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.

**vi) 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.

**vii) 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.

**viii) Risk Management**

*Risk assessment and recording risk*

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.

*Risk Response*

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 to be seen within 4 hours
Urgent referrals from EPC to be seen within 24 hours.

**DNA**s

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.

**Serious Incident Reporting**

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 first they have a responsibility to ensure the GP Practice is informed immediately. Please note a detailed Serious Incident Reporting policy for primary care is currently being considered and if agreed reporting will adhere to the processes outlined in the policy.

**Safeguarding**

The GP practices must have robust policies and procedures in place to ensure that vulnerable adults are protected and their welfare is promoted.

**ix) Training.** All practices must complete 4 hours of mandatory training per practice per annum covering agreed topics. At present these cover: recovery, risk and medication. 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. Practices will also be reimbursed to undertake free locally provided training over and above the 4 mandatory hours.

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

**1.5 East London NHS Foundation Trust responsibilities**

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 2012/13 contract. ELFT responsibilities include the following.

i) **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.

ii) **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.

iii) **Psychiatry.** Psychiatrists will chair 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.

iv) **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.

v) **Relapse.** The Liaison Worker will facilitate rapid access to secondary care assessment should a
vi) 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 1: Table summarising contractual responsibilities for the EPC service

<table>
<thead>
<tr>
<th>GP Network</th>
<th>GP Practices</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLA.</strong> Each network will develop and agree a local Service Level Agreement with East London NHS Foundation Trust which will detail how the network and East London NHS Foundation Trust will work together on a local basis to manage the primary care mental health service safely and effectively.</td>
<td><strong>Responsible Clinician.</strong> 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.</td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>Leadership.</strong> Each Network 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.</td>
<td><strong>MDT Meetings.</strong> A minimum of quarterly meetings with the lead consultant psychiatrist for the practice to discuss patients under EPC.</td>
<td><strong>Psychiatrists linked to practice who chair a minimum of quarterly MDT meetings and offer GPs advice on EPC patients as and when requested.</strong></td>
</tr>
<tr>
<td><strong>Population coverage.</strong> The Confederation will ensure that there is 100% GP practice population coverage by the EPC service.</td>
<td><strong>Mental Health Review meetings.</strong> The GP will complete two mental health reviews per annum: 1: An initial review to complete and approve the Recovery Care Plan. 2. A review of progress in the Recovery Care Plan (at least 90 days apart from the initial review.</td>
<td><strong>Provide peer support &amp; support workers to assist navigation and engagement in services.</strong></td>
</tr>
<tr>
<td><strong>Recovery Planning.</strong> When patient enters the service a Recovery Plan is completed with the Liaison Worker. The GP 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.</td>
<td><strong>Recovery Planning.</strong> 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.</td>
<td><strong>Relapse.</strong> The Liaison Worker will facilitate rapid access to secondary care assessment should a patient relapse, or show signs of relapse.</td>
</tr>
<tr>
<td><strong>Physical health checks and lifestyle interventions.</strong> GPs 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.</td>
<td><strong>Medicines management.</strong> 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.</td>
<td><strong>Support offered over medicines management, recovery planning and record keeping.</strong></td>
</tr>
<tr>
<td><strong>Medicines management.</strong> 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.</td>
<td><strong>Record keeping.</strong> Practices will maintain accurate records on EMIS web for patients in the EPC service.</td>
<td><strong>Record keeping.</strong> Practices will maintain accurate records on EMIS web for patients in the EPC service.</td>
</tr>
</tbody>
</table>
### 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 24 hours. Risk log updated.

### Training
4 hours mandatory mental health training per practice in set topics with practice time funded. Other optional training will also be available.

### Training
Offered to practices in partnership with other organisations.

### 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.

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### 2. Care Pathway

#### 2.1 The Care Pathway

A simplified care pathway is shown below. The shaded area refers to the elements covered by this contract i.e. EPC and Depot payments and the overlap between the two. 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:

1. **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).

2. **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.

3. **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.

4. **Step up from GMS to EPC.** Patients can step up from GMS care, as shown by the green arrows. 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.

5. **Rapid access back.** If a patient in EPC is deteriorating they will have rapid access back into secondary care services. Urgent referrals will be seen within 24 hour and crisis referrals will be seen within 4 hours.
2.2 The referral process

2.2.1 Step down (secondary care to EPC).

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. The 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 loaded onto EMIS and the patient will receive a hard copy. The Dialogue 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 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.

**Figure 3: Step Down Process (Secondary Care to EPC)**

2.2.2. 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 in the CMHT linked to the GP practice. The referrals will also clearly state a recommendation for EPC and will be marked FAO the CMHT psychiatrist linked to the practice. 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, 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.
The EPC is essentially a time-limited service, which aims to move people along a recovery pathway to greater autonomy. The target maximum length of stay is 1 year although this can be exceeded if necessary. Based on benchmarking from other EPC services, it assumed that about 15% of the patient cohort may need to exceed the 1 year target. Patients will be informed that the service is time limited and recovery focused at the start of the service. Discharge from the EPC service is to be viewed as an achievement.

Readiness for discharge from EPC will be monitored by the Liaison Worker working with the patient. Once a discharge plan has been made, the Liaison Worker will write to the GP to inform them of the plan and check whether there are any concerns. The GP as R.M.O holds ultimate responsibility for the decision to discharge from EPC into primary care and therefore needs to let the Liaison Worker know if there are concerns about the discharge date.

Referrals are seen within 28 day targets and 18 week targets for medical appointments, with most people being seen within 2-4 weeks on average. The EPC service is for non-urgent referrals only. Patients within EPC can be referred back into secondary care on an urgent basis and will be seen within 4 hours if in crisis and within 24 hours if urgent.
Quality Assurance and Performance Management

The Confederation will be responsible for providing high quality care equitably across the City and Hackney with 100% population coverage. It will also be responsible for the performance monitoring and the performance management of the service specified in this contract, providing quality assurance to City and Hackney CCG. There are three levels of quality assurance:

- Information quality
- Contract compliance
- Service quality

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.

2. Contract compliance

The Confederation will provide City and Hackney CCG with assurance that the service is compliant with the contract specifications through regular reports KPIs which monitor compliance. These cover the following:

- The completion of annual mental health reviews
- Completing, updating and agreeing recovery care plans
- Attendance at psychiatrist led MDT meetings
- Anti-psychotic medication monitoring
3. Service Quality

Assurance will be provided by the Confederation to the CCGs on the three key aspects of healthcare quality:

1. Safety
2. Outcomes
3. The patient experience

3.1 Safety

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.

3.2 Patient Outcomes

The service is expected to support the following improvements in outcomes:

a) The delivery of lifestyle interventions in response to identified physical health problems
b) Improvements in physical health issues: BMI, Q-RISK, smoking, alcohol use, non-prescribed drugs use, following life-style interventions
c) Improvements in psychological well being as measured by the use of Dialogue a Patient Reported Outcome Measure (PROM). This outcome measure will be monitored by East London NHS Foundation Trust. Dialogue will be use when the patient enters the service. Every six months and at the point of discharge.
d) The achievement of Recovery goals. Progress in achieving goals set by the patient will be monitored in the patient’s Recovery Care Plan.

3.3 The Patient Experience

A Patient Reported Experience Measure (PREM) the Friends and Family test will be used as part of the outcome measure form.
Appendix A: Payment Table

Quarterly payments for EPC activity will be made from City and Hackney CCG to the City and Hackney GP Confederation, who will then be responsible for making payments to individual practices. Payments are based on the activities set out below being completed. The quarterly estimates in figure 4 below reflect the maximum likely payment to be achieved based on activity. This assumes transfer targets for 600 patients to annum from secondary to primary care are fully achieved and that Liaison Workers have a full case load of 720 patients per annum. It is also assumed that 18% of the EPC case load receive Depot payments and that Depot activity outside of EPC remains constant from the previous year. Payments will be based on actual activity, however, if the activity data is insufficiently complete, a payment will be made according to schedule below and then an adjustment will be made in the following quarter. Time for completing optional and mandatory training will be reimbursed at the end of the financial year. City and Hackney GP Confederation will be responsible for reimbursing individual practices for time spent training.

The basis for making payments is as follows.

1. **Mental Health Reviews and Recovery Planning (EPC only patients)**
   £100 per patient per annum. This covers two mental health reviews (£50 each), which involve face to face meetings between the GP and patient. These have a recommended duration of 20 minutes of GP time plus 20 minutes for practice nurse time. This equates to £100 an hour for GP time and £50 an hour for practice nurse time. The first review is at the point of the patient’s entry into the service. The second must be at least 90 days apart and is to review the patient’s progress. In addition, the physical health section of the Recovery Care Plan must be completed and updated and the GP must approve the Recovery Care Plan on EMIS web. £100 is the maximum a payment per patient in a 12 month period. For patients on QOF, one of the reviews can also be counted as a QOF review.

2. **Mental Health Reviews and Recovery Planning patients (patients on EPC and Depot)**
   The patients receive the same service as described above however, the reviews are paid at a lower rate of £20 per review/£40 per annum. This payment is lower than that received by EPC only patients as a Depot payment of £300 per annum is already being made for these patients and there is some overlap between the two services.

3. **Depot only**
   Patient on depot administered by the GP practice will receive £75 per quarter/£300 per annum.

4. **Mandatory Training**
   All practices are expected to complete 4 hours of mandatory mental health training in set topics from a recognised local course by April 4th 2016. All training must be evidenced by training records stating who undertook what training, where and when. The training will be free. The training can be completed by either a GP or a practice nurse.
   - £22,360 will be paid to the Confederation to fund backfill costs if all 43 practices (100%) complete their mandatory training
   - £19,760 if 38 practices out of 43 (88.4%) complete
   - £17,160 if 32 practices (74.4%) complete
   No money will be paid to the Confederation if less than 32 out of the 43 practice complete their mandatory training.
5. **Optional Training**

Further mental health training over and above the mandatory training will also be available free from local providers giving authorised training. Participation in this training is optional. The Confederation will be paid the following by the CCG for backfill costs in relation to the number of hours of mental health training undertaken with an authorised local provider completed before April 4th 2016. Training will need to be evidenced by training records.

**Figure 3: Optional training payments**

<table>
<thead>
<tr>
<th>Training Hours</th>
<th>GPs</th>
<th>Practice Nurses</th>
<th>Total Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-100</td>
<td>£13,000</td>
<td>£6,500</td>
<td>£19,500</td>
</tr>
<tr>
<td>100-150</td>
<td>£19,500</td>
<td>£9,750</td>
<td>£29,250</td>
</tr>
<tr>
<td>150-200</td>
<td>£26,000</td>
<td>£13,000</td>
<td>£39,000</td>
</tr>
<tr>
<td>200-250</td>
<td>£32,500</td>
<td>£16,250</td>
<td>£48,750</td>
</tr>
<tr>
<td>250-300</td>
<td>£39,000</td>
<td>£19,500</td>
<td>£58,500</td>
</tr>
<tr>
<td>300-350</td>
<td>£45,500</td>
<td>£22,750</td>
<td>£68,250</td>
</tr>
</tbody>
</table>

The Confederation will decide how it splits the available training hours by practice and the rates of reimbursement for individual GPs and nurses. One option for dividing payment per practice is to allow one hour for GPs and one hour for nurses for every 1,000 of the practice population.

**Figure 4: Table of contracted activity and associated payments to the GP confederation**

<table>
<thead>
<tr>
<th>Contracted Activity</th>
<th>Estimated payment p/quarter</th>
<th>Estimated payment p/annum</th>
<th>Measurement/Evidence</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Review and Recovery Care Planning</td>
<td>£16,056</td>
<td>£64,224</td>
<td>A payment is made for each completed and GP approved recovery care plan on EMIS web + an initial MH review meeting involving the GP and patient. <strong>Rate:</strong> £50 per review (£100 p.a.) for patients on EPC only. £20 per review (£40 p.a.) for EPC patients on also on Depot.</td>
<td>CEG report from EMIS</td>
</tr>
<tr>
<td>Depot administration. This covers payments for the administration by practices for Depot and includes both people in EPC and those not in EPC on Depot only.</td>
<td>£38,895</td>
<td>£155,580</td>
<td>No. of patients on Depot with completed templates as recorded on EMIS. <strong>Rate:</strong> £75 per quarter £300 per annum.</td>
<td>CEG report from EMIS</td>
</tr>
</tbody>
</table>
Mandatory training reimbursement Practices to complete 4 hours mandatory core training modules from local providers in defined topics. NA £22,360 (all 43 practices) £19,760 (38 practices) £17,160 (33 practices) Recorded by individual practices on local enhanced service action tracker. Local service tracker

Optional training reimbursement above the 4 hours is optional. Training NA Up to £68,250 available. Training to be paid according to Figure 3 schedule. Recorded by individual practices on local enhanced service action tracker. Local service tracker

Total Available £54,951 £310,414

The table below shows other contracted activity and associated KPIs. Unlike the previous table these are not linked directly to payments. However as this activity is part of the contract it is expected that these activities will be undertaken.

Figure 5: Confederation Performance Monitoring

<table>
<thead>
<tr>
<th>GP Practice EPC Contact requirements</th>
<th>Measurement/Evidence</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifestyle interventions.</strong> If patients are above the defined thresholds for BMI, Q-RISK, alcohol consumption or are using non-prescribed drugs or smoking the practice should offer a lifestyle intervention. The offer and whether the patient accepted should be recorded on EMIS</td>
<td>1. No. &amp; % of patients above threshold level for BMI, Q-RISK alcohol consumption, non-prescribed drugs, smoking. 2. % above threshold level who are offered a lifestyle intervention regardless of whether they accept 3. % who accept a lifestyle intervention (monitor only).</td>
<td>CEG report from EMIS</td>
</tr>
<tr>
<td><strong>Anti-psychotic drug monitoring</strong> will be completed for all patients on anti-psychotic medication (NB this includes patients beyond EPC. A template will be completed on EMIS web. The template updated annually.</td>
<td>No. &amp; % of EPC patients on anti-psychotic medication, who have a completed monitoring template on EMIS web updated annually.</td>
<td>CEG report from EMIS</td>
</tr>
<tr>
<td><strong>Attendance at MDT meetings</strong>, led by the psychiatrist at least quarterly. Recorded on EMIS web</td>
<td>No. and % of practices compliant with attendance and quarterly MDT meetings led by psychiatrist.</td>
<td>CEG report from EMIS</td>
</tr>
<tr>
<td><strong>SUI reporting.</strong> SUIs to be reported to CCG will follow up investigation.</td>
<td>Investigation and review completed. Time taken for follow up investigation.</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Service Activity.</strong> The flow into and out of the EPC service will be monitored quarterly per practice and benchmarked against other practices and the targets set for the year. Re-admissions into secondary care will also be monitored with the aim of keeping these as low as possible.</td>
<td>No. in EPC and no. of referrals and discharges per practice population. No. of re-admissions into secondary separated into acute and non-acute admissions. Length of stay in EPC.</td>
<td>CEG report from EMIS</td>
</tr>
</tbody>
</table>
100% population coverage. The networks will be responsible for ensuring that the EPC service is accessible to 100% of the population. This could mean arrangements for one practice to cover another.

| Network assurance that all practices are covered. No. of referrals per practice to EPC as a percentage of practice population. | TBD |