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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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MÄNNYSTRIE O

**Poustie, Resydènter Heisin  
an Fowk Siccar**

## **NORTHERN IRELAND 2009/10 ENHANCED SERVICES SPECIFICATIONS**

- **ACCESS TO PRIMARY CARE SCHEME**
- **LONG-TERM CONDITION MANAGEMENT SCHEME**
- **CARDIOVASCULAR SERVICE FRAMEWORK SUPPORT SCHEME**
- **OSTEOPOROSIS/SECONDARY PREVENTION OF FRACTURES SCHEME**
- **HEALTH CARE FOR HOMELESS ON THE MOVE ROUGH SLEEPERS SCHEME**
- **HEALTH CARE FOR ADULTS WITH SEVERE LEARNING DISABILITY SCHEME**
- **MILD TO MODERATE DEPRESSION SCHEME**

## **ACCESS TO PRIMARY CARE SCHEME: 2009/10**

### **Introduction**

1. It is the Department's continuing priority for Northern Ireland to improve patient access to primary medical care. These improvements will mainly be delivered in and by general practice.
2. The Health and Social Care Board (the Regional Board) will have a duty in 2009/10 to work with local contractors (and other providers) to develop and implement plans to secure improvements in access. This DES therefore focuses on four key dimensions of access for patients:
  - a. Opportunity of a consultation with a GP or appropriate primary care professional by the end of the second normal working day after the day on which the request was made (48 hour access) for clinical advice or treatment, where this is requested;
  - b. Opportunity to book appointments in advance of 24 hours
  - c. Ease of telephone access
  - d. Opportunity to be seen by a preferred GP (without a timeframe)
3. This specification is for 2009/10. The investment for 2009/10 will be £1.322 million for Northern Ireland. The incentive payments will be weighted by the patient population of each participating contractor against the Northern Ireland average practice population and will provide a sign-up payment to contractors in response to a written commitment from the contractor to work towards delivery of all the access areas referred to in paragraph 2 above.

### **Service Specification**

4. The introduction of the DES will be accompanied by a local press campaign by the Regional Board will inform all patients of the service that should be offered in relation to each of the four key areas of the DES. The press campaign may, at the Regional Board's discretion, be repeated on further occasions during the year. It will also be a requirement for participation in the DES that a notice (to be provided by the Regional Board and agreed with the Patient Council) shall be placed in a prominent position in all the premises used by the contractor clearly outlining to patients their DES Access rights under the contract. The content of such press campaigns and the content of notices to be displayed in contractors' premises should be agreed with the appropriate LMC with a view to agreeing the content and discussed with bodies which are representing patient interests.

### **Measurement**

5. Failure to display the DES Access rights notice in a prominent position may result in a reduced monthly payment.
6. The Regional Board will need to monitor contractors to ensure that they comply with the DES access criteria outlined in paragraph 5 above. In the

event of a contractor's failure to prominently display the access rights notice  
The Regional Board may wish to consider whether the signup payment should be withdrawn.

7. Achievement under the QOF is not contractually linked to participation in this DES and achievement under the QOF will not affect any signup payment made to a contractor.

### **Pricing and Payment**

8. The total amount of this Access DES payment per contractor will be £3640 to be weighted by a ratio of the practice population against the average Northern Ireland practice population (5173 at January 2009). This to be paid as 50% of the total payment on completion of the contractor signing-up to the DES and the balance paid as a 1/12th monthly payment.
9. The Regional Board will have a duty in 2009/10 in respect of this DES to make a 50% of the total amount at the beginning of the year to participating contractors who sign-up to provide the DES (an amount of £1820), the balance being paid via 12 monthly payments subject to a contractor continuing to meet the specification (£1820/12).
10. From 2010 onwards, it is likely that there will be a continuing emphasis on improved access to general practice. This DES will be reviewed in the light of experience and developing policies.

### **Definitions**

**The following definitions of terms used in the target provide a fuller explanation:**

- a) Patients** – Patients (including temporary patients) registered with the practice;
- b) Consultation with** – Face-to-face personal contact where professional, clinical advice, diagnosis or treatment is requested. The use of alternative consultations such as telephone can be used to reduce demand for face-to-face appointments where these alternatives appropriately deliver, to the patient's satisfaction in terms of access the necessary professional, clinical advice, diagnosis or treatment during that contact. These alternatives can be used to support delivery of the 48 hour target but should also be delivered within the target. Where such consultations result in referral to another professional the delivery of this will not be contained within the 48 hour standard;
- c) Primary Care Professional** – any health or social care professional, member of the primary care team, including practice nurses, allied health care professional or other health care staff within the practice with which the patient is registered or is co-ordinated by the practice and who is competent to deal with the patient's clinical needs;

**d) Ease of telephone access** – means that where patients contact the contractor by telephone, that:

(i) contractor has in place a telephone system appropriate to meet the demand in respect of that practice population;

(ii) where there are delays in initially answering calls during times of high call volume, the practice has in place a system to inform patients within a reasonable time, about the situation; and

(iii) when the call is answered by a person in the practice, the patient receives clear information as to how the matter which is the subject of the call is to be dealt with.

**e) A GP** – a general practitioner, not necessarily the preferred GP.

### **Exclusions**

11. The target definition excludes:

- a) Situations where the patient specifies a particular individual or professional where an appropriate, alternative is available within 48 hours;
- b) Requests for emergency or urgent treatment which should be dealt with immediately in accordance with the clinical need;
- c) Pre-planned courses of elective treatment or care programmes where access arrangements are established in advance, for example, chronic disease management, treatment or screening programmes;
- d) Out-of-hours coverage, that is, outside the normal working hours of the practice;
- e) Planned closures, for example, public holidays or staff training;
- f) Requests for non-clinical advice or input.

## **LONG-TERM CONDITION MANAGEMENT SCHEME: 2009/10**

### **Introduction**

1. This DES focuses on three regional health priorities. It builds on the QOF and should contribute to reduced pressure on secondary care and improve the long-term health and well-being of patients. The investment for 2009/10 in this DES will be £4.066m.
  - a) Patients with Chronic Obstructive Pulmonary Disease (COPD)
    - Specialist smoking cessation
    - Effective self-management training and action plans
    - Referral to community services e.g. pulmonary rehabilitation.
  - b) Patients with Asthma
    - Specialist smoking cessation
    - Effective self-management training and action plans
    - Urgent care and high risk patients.
  - c) The early detection and follow up of patients with a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus
    - Specialist smoking cessation
    - Identification and follow-up of patients with increased risks of morbidity
    - Provision of a resource kit to motivated patients.

The detailed service specifications for each of the three elements (clinical domains) for this Directed Enhanced Service are outlined below.

### **Service Specification – Intervention**

#### **Part 1 - Practice-based service for patients with COPD**

1. This part of the DES builds on activities already being provided by contractors under QOF for this condition.
2. It further enhances treatment and care to ensure that disease management is optimized and disease progression and adverse outcomes are minimized. In order to provide the service contractors will require liaising effectively with community-based schemes commissioned or provided by Trusts, the Regional Board and others. This may include non-HPSS services e.g. Ulster Cancer Foundation. Trusts and the Regional Board are already providing a range of services which will support contractor activities under this DES e.g. community based pulmonary rehabilitation and specialist smoking cessation services including those provided in contractors. Contractors will therefore need to have an awareness of local provision and how patients may access

other community-based services. The Regional Board should facilitate the provision of this information to contractors by ensuring that Trusts provide the relevant information to participating contractors. Implementation of this part should contribute to reduced pressure on secondary care.

### **Service Description**

- a. For all patients on the COPD register identify the severity of airflow obstruction. Severity should be assessed annually for each patient.

Severity	FEV <sub>1</sub> , % predicted
Mild	50-80
Moderate	30-50
Severe	<30

- b. For all patients with COPD who smoke a proactive approach to encourage patients to take advantage of specialist smoking cessation services. The contractor should be aware of all local specialist smoking cessation services and provide information on these to motivated patients. The Regional Board will assist contractors with information about local specialist smoking cessation services including those provided by contractors.
- c. Record and review against best practice those patients using home nebulisers to determine if the continued use of home nebulisers are clinically appropriate and that patients are using them correctly (see NICE guidance).
- d. Ensure that patients with moderate and severe COPD are assessed with pulse oximetry and referred for long-term oxygen therapy in line with NICE guidance.
- e. Contractors need to become aware of local pulmonary rehabilitation programmes (where available) and should refer all appropriate patients in accordance with local guidance e.g. MRC dyspnea score 3 or greater, moderate/severe COPD.
- f. Specific educational packages should be developed for patients with COPD. The education provided should take account of the different needs of patients at different stages of their disease. Contractors will provide annual review and updating of patient education. Suggested topics, some of which are compulsory, are included in Annex A. All patients should be provided with self management training and a written action plan. Patients should have their BMI recorded and MRC dyspnoea score recorded annually in the patient held plan. Patients with severe COPD should have S<sub>a</sub>O<sub>2</sub> measured and recorded twice a year.
- g. Ensure that patients with COPD are on appropriate pharmacological treatment.
- h. Record the number of admission(s) and readmissions within 28 days to hospital and A&E attendances the patient has had for an exacerbation of

COPD or where COPD was a major contributory factor over the previous 12 months.

- i. Where appropriate GPs should ensure that patients with 2 or more admissions or an exacerbation of COPD in the past 12 months should be referred to a community respiratory team for case management by March 2011.
- j. Provide data at year-end to the HSSB using the standardized format provided. The Regional Board will give comparative data feedback to contractors.
- k. Relevant contractor staff must be appropriately trained to meet modern authoritative standards e.g. on the correct use of spirometers and oximeters. Training needs of staff should be reviewed regularly.
- l. Patients with grade 5 MRC dyspnoea should, where appropriate, be considered for inclusion in the palliative care register.

### **COPD Self Management Plan**

Patients, or their carers, must be offered the opportunity of face to face meeting and be provided with information and a patient management plan for the patient and action plan, which is reviewed at least annually and is held by patients. For patients with severe COPD, it should include a record of assessment and referral for long-term oxygen therapy. For all patients, it should include relevant education topics.

### **Education Topics which must be included in all plans**

- Disease education (Anatomy, physiology, pathology and pharmacology, including oxygen therapy and vaccination)
- Smoking cessation (All smokers)
- Exacerbation management (including when to seek help, self-management and decision making, coping with setbacks and relapses). This should be included in all patient plans.

### **Other Suggested Education Topics for patients with COPD as and when relevant to individual needs**

- Dyspnoea/symptom management, including chest clearance techniques
- Energy conservation/pacing
- Nutritional advice
- Managing travel
- Benefits system and disable parking badges
- Advance directives (living wills)
- Making a change plan
- Anxiety management
- Goal setting and rewards
- Relaxation
- Identifying and changing beliefs about exercise and health related behaviours
- Loving relationships/sexuality

- Home care support
- Managing surgery (non thoracic)
- The benefits of physical exercise
- Support groups – such as the Lung Foundation (NI) Breathe Easy groups, which operate throughout the UK and local groups for example those associated with the Northern Ireland Chest Heart and Stroke Association.

The patient or contractor should record which topics have been covered. Contractors may wish to consider using the NICE guidance: CG12 Chronic Obstructive Pulmonary Disease: Information for the public. It is a comprehensive document.

### **Part 2 - Practice based service for patients with Asthma**

3. This part of the DES builds on activities already being provided by contractors under QOF for this condition.
4. Implementation of this part should contribute to reduced pressure on secondary care. It further enhances treatment and care to ensure that disease management is optimized and disease progression and adverse outcomes are minimized. In order to provide the service contractors will require liaising effectively with community-based schemes commissioned or provided by Trusts, the Regional Board and others. This may include non-HPSS services e.g. Ulster Cancer Foundation. Trusts and the Regional Board are already providing a range of services which will support contractor activities under this DES e.g. specialist smoking cessation services including those provided in contractors. Contractors will therefore need to have an awareness of local provision and how patients may access other community-based services. The Regional Board should facilitate the provision of this information to contractors by ensuring that Trusts provide the relevant information to participating contractors.

### **Service Description**

- a. Provide each patient (aged 15 or over) with step 2 and above, on discussion with a Health Professional, with a written self-management plan and a patient held asthma action plan on an annual basis. Patients ideally should contribute to their own written plans over time. Examples of such plans are available e.g. from Asthma UK. The content of a basic action plan is described below. For patients under 15 years of age the contractor will provide the child or parent (as appropriate) with the action plan.
- b. Patients with difficult asthma (defined as symptomatic at Step 4 and all at Step 5) should be considered for referral to specialist.
- c. Identify patients at risk of developing near fatal or fatal asthma using BTS/SIGN guidelines. Contractors will have a proactive approach for each of these high risk patients to ensure that the identified risks are minimised. This should be documented in the patient's records.

- d. Ensure that all relevant staff have training on the assessment of acute and effective immediate treatment of asthma that may be provided in the surgery.
- e. Record the number of A&E attendances or hospital admissions for asthma within the past year.
- f. For all patients with asthma who smoke, a proactive approach to encourage patients to take advantage of specialist smoking cessation services. The contractor must therefore be aware of all local specialist smoking cessation services and how patients may access services.
- g. Review and record patient inhaler technique.
- h. Ensure that patients with asthma are on appropriate pharmacological treatment.
- i. Provide data at year-end to the HBSB using the standardized format provided. The Regional Board will provide comparative data feedback to contractors.
- j. Relevant contractor staff including doctors should be appropriately trained to meet modern authoritative standards e.g. on the correct use of spirometers. Training needs of staff should be reviewed regularly.

#### **Contents of a basic action plan for asthma**

- Advice about taking medication for asthma (reliever and preventer inhalers and other asthma medication);
- A definition of a deterioration in asthma that requires action (increasing symptoms or a peak flow level at which medication should be changed);
- What to do in the case of a deterioration (what change to make in medication to be used and how long for);
- When to go back to maintenance medication;
- When to seek urgent medical help.

#### **Part 3 - The early detection and follow up of patients with a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus**

5. This part of the DES seeks to build the capacity of contractors to play an important role in the service provision for early detection and provision of necessary follow-up in patients who have a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus. It builds on the new QOF indicators for obesity introduced from 1 April 2006. The service will be of help to patients with obesity with or without other co-morbidities. In Northern Ireland 17% of men and 20% of women are clinically obese (CMO Report 2004).

#### **Service Description**

- a. Provide appropriate training for contractor employed clinical staff and who are involved in the management and treatment of patients with a BMI greater than 30. The contractor should have a written protocol for their management of such patients. It includes as a minimum the frequency of repeat weight measurement, testing for blood lipids and glucose, physical activity referral process (if service available) criteria for anti-obesity drug treatment of patients and a description of the typical contents of the contractor resource kit which is provided to patients. It should also include a description of the follow-up of patients whose BMI>30. Blood pressure checking and thyroid function should be offered routinely.
- b. Develop a contractor resource kit for motivated patients whose BMI is greater than 30, which provide information and guidance on both sides of the “energy equation”. The Regional Board and LMCs will co-operate in assisting contractors to develop this kit and will supply material/data where available. It should include up to date information on local opportunities for sport and leisure, quality physical activity including physical activity referral schemes and active travel. Written information given to patients should be relevant to their needs e.g. patients with physical disability, patients whose families are obese. The Regional Board will provide information on other relevant local initiatives e.g. Health Action Zones. Contractors should provide information to patients about the availability of their resource kit to patients e.g. in a leaflet, notice boards, contractor website.
- c. As a minimum, patients identified with lipid or glucose abnormalities, e.g. impaired glucose tolerance (IGT) should be offered annual follow-ups as they have increased risk of future morbidity. The patient’s follow-up treatment plan should be documented in the patient record.
- d. For all patients with BMI greater than 30 who smoke contractors should adopt a pro-active approach to encourage them to take advantage of specialist smoking cessation services. The contractor should be aware of all local specialist smoking cessation services and provide information on these to motivated patients. The Regional Board will assist contractors with information about local specialist smoking cessation services including those provided by contractors.
- e. Provide information to the HSSB at year-end which will assist with service planning for future public health initiatives. The Regional Board will provide contractors with comparative data feedback.

### **Support and Monitoring by the Regional Board**

#### **Part 1 - Practice-based service for patients with COPD**

6. The Regional Board will facilitate contractor training and will review individual anonymised patient records for a sample of patients admitted to hospital to review the care arrangements made. The Regional Board also, subject to their resources, should consider funding the provision of relevant equipment in contractors e.g. oximeters where the equipment is not already

available. In particular the effectiveness of clinical assessment prior to admission decisions should be discussed to ensure that only these patients who need to be admitted are so. The patient's exacerbation management plans should also be reviewed for these patients. This should include their content and usage.

**Part 2 - Practice based service for patients with Asthma**

7. The Regional Board should review the effectiveness of care arrangements made for patients. This would include assessment of the written patient plans (content and usage), hospital admissions, A&E attendances and results of inhaler technique checks.

**Part 3 - The early detection and follow up of patients with a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus**

8. The Regional Board should review the effectiveness of this DES including contractor referrals to physical activity schemes and/or appropriate use of antiobesity drugs and/or follow-up of patients where lipid or glucose abnormalities are detected. Contractors should be able to demonstrate their call and recall system.

## Service Specification – Measurement

DES Data Return to HSSB 09/10 for patients with COPD				
Practice Name:				
Practice Address:				
Practice Code:				
Practice List size:	<input type="text"/>			
Total number of smokers in practice	<input type="text"/>			
<b>Number of....</b> <i>FEV, % predicted</i>	<b>Mild</b> 50- 80	<b>Moderate</b> 30-50	<b>Severe</b> <30	<b>Total</b>
1. Patients with COPD	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Patients with COPD provided with self management training and written plan (to include assessment and referral for Long Term Oxygen Therapy for severe cases)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Patients with COPD on optimal pharmacological treatment	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Patients with COPD who are smokers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Patients with COPD who are smokers referred to specialist smoking cessation services in last 12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Patients with COPD assessed and referred for Long Term Oxygen Therapy	N/A	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Patients with COPD referred for pulmonary rehabilitation in last 12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. Patients with COPD using home nebuliser (see NICE guidance)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9. Patients with COPD admitted to hospital A&E because of COPD in past 12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10. Patients with COPD attending A&E because of COPD more than 2 times in past 12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Whilst the measurement of percentage achievements by individual contractors will be measured by the information in box 2 only, participating contractors must complete the remaining data collection boxes before achievement payment can be made.

DES Data Return to HSCB 09/10 for patients with Asthma			
Practice Name:			
Practice Address:			
Practice Code:			
Practice List size:			
Total number of smokers in practice			
Age	0 – 14 years	15+ years	Total
1. Patients with Asthma			
2. Exacerbation self management training and written plan covering relevant topics to patients provided			
3. Patients with Asthma on optimal pharmacological treatment			
4. Patients with Asthma who are smokers			
5. Patients with Asthma who are smokers referred to specialist smoking cessation services in last 12 months			
6. Patients at risk of near fatal Asthma			
7. Patients using inhalers			
8. Patients with good inhaler technique			
9. Patients with moderate inhaler technique			
10. Patients with poor inhaler technique			
11. Patients with Asthma admitted to hospital because of Asthma in past 12 months			
12. Patients with Asthma attending A&E because of Asthma in past 12 months			

Whilst the measurement of percentage achievements by individual contractors will be measured by the information in box 2 only, participating contractors must complete the remaining data collection boxes before achievement payment can be made.

<b>DES Data Return to HSSB 09/10 for patients with a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus</b>					
<b>Practice Name:</b>					
<b>Practice Address:</b>					
<b>Practice Code:</b>					
<b>Practice List size:</b>					
<b>Total number of smokers in practice</b>					
Age		16 – 24 years		25+ years	
Sex		Male	Female	Male	Female Total
1. Patients with a BMI between 30 – 39.9 (Obese)					
2. Patients with a BMI greater than 40 (Severely obese)					
3. Patients with a BMI greater than 30 who are smokers					
4. Patients with BMI greater than 30 who are smokers referred to specialist smoking cessation services in last 12 months					
5. Patients in whom diabetes mellitus has been detected					
6. Patients in whom abnormal/high lipids have been detected					
7. Patients with abnormal Impaired Glucose Tolerance/Fasting Glucose Testing					
8. Patients in whom Hypertension has been detected					
9. Patients in whom Hypothyroidism has been detected					

Whilst the measurement of percentage achievements by individual contractors will be measured by the information in boxes 1 and 2 only, participating contractors must complete the remaining data collection boxes before achievement payment can be made.

**Pricing and Payment**

- 9. The DES is a single entity and participating contractors must undertake to deliver on all three parts set out in the specification.

### **Set up Payment**

10. A percentage of the overall investment for the DES is to be paid up front and referred to as a set-up payment. This amounts to £1.423m or £3,888 per contractor and, given the current absence of a prevalence figure for Part 3 of the DES, this should be weighted by practice population against the NI average at January 2009.

### **Data collection**

11. Whilst the measurement of percentage achievements by individual contractors will be measured by the information in the shaded boxes only, participating contractors must complete the remaining data collection boxes before achievement payment can be made.

### **Achievement Payments**

12. Whilst the DES will be a single entity, in view of differing prevalence in each clinical domain and to reflect differences in contractors in the distribution of appropriate patients, the pricing structure will separately reflect achievement in each area. To concur with Departmental priorities and to reflect the level of work required within each part of the DES, the overall distribution of funding should be as follows:

- 50% for COPD
- 30% for Asthma, and
- 20% for the early detection and follow up of people who are likely to suffer from diabetes focusing on patients with a BMI greater than 30

13. Payment for achievement of the DES should be banded depending on the level of achievement reached in relation to the numbers of patients on the lists for each clinical domain in each contractor. The overall banding for each element of the DES is as follows:

#### **Achievement payment per contractor for part 1 of the DES (COPD)**

Lower Rate For 60% - 69% achievement	Middle Rate For 70% - 79% achievement	Full Rate For at least 80% achievement
£2,775	£4,163	£5,551

#### **Achievement payment per contractor for part 2 of the DES (Asthma)**

Lower Rate For 50% - 64% achievement	Middle Rate For 65% - 74% achievement	Full Rate For at least 75% achievement
£1,667	£2,501	£3,334

### **Achievement payment per contractor for Part 3 of the DES**

**NB: The total numbers on the data collection sheet will be compared with the numbers on the contractor register of patients in this clinical domain to produce the percentage achievement figures set out below.**

Lower Rate For 10% - 24% achievement	Middle Rate For 25% - 39% achievement	Full Rate For at least 40% achievement
£1,108	£1,667	£2,221

NB: The above figures represent the achievement payment for each contractor based on the FULL amount of the overall investment apportioned for each element of the DES. Therefore, this amount must be subjected to the appropriate weighting (see paragraph 15 below) and the amount of start-up payment paid to the contractor must then be deducted.

### **Weighting**

14. All of the above achievement payments should be subjected to a weighting of the practice prevalence within a particular clinical domain against the Northern Ireland average prevalence within that domain. After this calculation has been conducted, the cash totals for each clinical domain should be added together and multiplied by the contractor's CPI before deduction of the amount of start-up payment made to the contractor.

### **Overall investment in the DES**

15. Where the highest level achievement standard is not achieved and the full funding under this DES has not been fully utilised, the Regional Board must use any shortfall to secure the most effective and equitable delivery of this service.

**CARDIOVASCULAR SERVICE FRAMEWORK SUPPORT SCHEME:**  
**2009/10 – 2010/11**

**Introduction**

1. GP contractors in Northern Ireland all participate in the Quality and Outcomes Framework which incentivises a number of activities which, it is anticipated will provide enhanced outcomes for patients in the future. A number of these activities relate to cardiovascular disease. The DES has been revised to reflect the fact that from 1 April 2009 Heart Failure forms part of QOF. The investment in DES for 2009/10 will be £935k.
2. The Department of Health, Social Services and Public Safety has published a Cardiovascular Service Framework. Development of the service frameworks was undertaken in partnership with the HSC, service users and carers. Each service framework uses a multidisciplinary approach, recognising that the majority of care is delivered in the primary/community sectors with active participation of individuals and carers. In addition service frameworks recognise that care can go beyond traditional HSC boundaries.
3. Service frameworks link to key policies and strategies already developed and draw on evidence from established sources e.g. National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence, QOF. Where appropriate, they include standards which have been developed elsewhere. Each service framework uses a common template which will include a care pathway from prevention, promotion, protection of health and wellbeing, to appropriate assessment, diagnosis, treatment and care provision, rehabilitation and end of life care.
4. Service frameworks are an opportunity to:
  - Further integrate health and social care;
  - Enhance public health and wellbeing, to include identification of those at risk and prevent and protect individuals and local populations from harm and disease;
  - Promote evidence informed practice;
  - Focus on safe and effective care; and
  - Enhance multi-disciplinary and intersectoral working.
5. This Northern Ireland Directed Enhanced Service builds on QOF and resources a practice based contribution to the NI Cardiovascular Framework.

The DES area includes providing preventative health advice to patients who assessed as at risk of peripheral vascular disease using ABPI.

## **Service Specification – Intervention**

### **Patients with Peripheral Vascular Disease or who may be at risk of developing Peripheral Vascular Disease**

6. The Service Framework for Cardiovascular Health & Wellbeing is developing standards which cover risk assessment for those patients who have a high risk of or have PVD.
7. Atheroma development can result in peripheral vascular disease (PVD). Under the age of 55 years, intermittent claudication is rare, but the prevalence increases steeply to around 5% of those over 55 years. There is also an association with socio-economic group. The prevalence was found to be 3.6% in Class I and 5.9% in Classes IV & V.
8. It is also known that patients who have an ABPI measurement of less than 0.9 have a much greater risk of coronary heart disease and stroke. The aim of this part of the DES is therefore to identify these patients with ABPI < 0.9 and offer them good preventative advice.

## **Service Description**

- a. The contractor should develop two disease registers, the first will be of patients suffering from peripheral vascular disease, and the second will be a register of patients aged 50 and over who smoke, known as the At-Risk of Peripheral and Cardio Vascular Disease Register.
- b. The contractor to acquire ABPI equipment and train an appropriate member of staff to carry out ABPI assessment.
- c. For all patients on the At-Risk of Peripheral Vascular Disease Register to conduct and record an Ankle Brachial Pressure Index (ABPI) assessment.
- d. An annual review for all patients on both registers to ensure BP is controlled and that the patient is on appropriate pharmacological treatment, e.g. taking antiplatelet and lipid-lowering agents as clinically appropriate.
- e. Use of the DES recording template (which will also enable the contractor to be paid under the DES).

**Note: Practices may contract with local HSC Trusts or neighbouring practices to provide the service to their patients.**

**NB: Patients who have non-compressible vessels are excluded from the DES as their ABPI readings are unreliable e.g. many patients who have end stage renal failure.**

### **Patients with Peripheral Vascular Disease or who may be at risk of developing Peripheral Vascular Disease**

9. It is anticipated that the first year of the DES will concentrate on provision of support to contractors with the Regional Board facilitating contractor training. The Regional Board also, subject to its resources, should consider funding the provision of relevant equipment in contractors e.g. sphygmomanometer and hand held Dopplers for ABPI assessment, where the equipment is not already available.

### **Pricing and Payment**

10. Participating contractors in this DES must undertake to deliver on the specification.

### **Sign up Payment**

11. A percentage of the overall investment for the DES is to be paid up front and referred to as a set up payment. This amounts £335 per contractor and, given the current absence of a prevalence figure for Part 2 of the DES, this should be weighted by contractor population against the NI average at January 2009.

### **Achievement Payments**

12. Payment for achievement of the DES should be banded depending on the level of achievement reached in relation to the numbers of patients on contractor's list. The overall banding for the DES is as follows:

### **Achievement payment per contractor for The DES (Peripheral Vascular Disease)**

NB: The total numbers on the data collection sheet will be compared with the numbers on the contractor register of patients in this clinical domain to produce the percentage achievement figures set out below.

<b>Year</b>	<b>Target/Payment Stage</b>
1 (2008/09)	Necessary equipment have been purchased and staff have been trained to conduct ABPI assessment and a disease register of patients with Symptomatic Peripheral Vascular Disease has been compiled
2 (2009/10)	All patients on the contractor's Symptomatic Peripheral Vascular Disease have received treatment in accordance with the Directed Enhanced Service in Support of the Northern Ireland Cardiovascular Framework service specification; and  The contractor has commenced compilation of a Peripheral Vascular Disease Assessment register of patients over the age of 50 who smoke
3 (2010/11)	Patients on the contractor's Peripheral Vascular Disease Assessment register have received the appropriate assessment and treatment in accordance with the Directed Enhanced Service in Support of the Northern Ireland Cardiovascular Framework service specification  Payment Stages

50 – 69%	60% Achievement Payment (£1344)
70% +	100% Achievement Payment (£2240)

The Full Annual Achievement Payment for Peripheral Vascular Disease under the Directed Enhanced Service in Support of the Northern Ireland Cardiovascular Framework will be £2240.

NB: The above figures represent the achievement payment for each contractor based on the FULL amount of the overall investment apportioned for each element of the DES. Therefore, this amount must be subjected to the appropriate weighting (see paragraph below).

**Weighting**

- 13. The above achievement payments within this clinical domain should be multiplied by the contractors CPI to determine the contractor’s overall achievement payment.

**Overall investment in the DES**

- 14. Where the highest level achievement standard is not achieved and the full funding under this DES has not been fully utilised, the Regional Board must use any shortfall to secure the most effective and equitable delivery of this service.

## **OSTEOPOROSIS/SECONDARY PREVENTION OF FRACTURES SCHEME: 2009/10 – 2010/11**

### **Introduction**

1. The National Service Framework for Older People (NSF), published in England in March 2001, set out a model for service provision for falls and bone health. In the UK, 28-33% of the population is over 65 years, and 32-42% of the population over 75 years will fall each year. The associated mortality, physical injury, loss of function and loss of independence from a fall is great. The investment for this DES in 2009/10 will be £1.173m.
2. In Northern Ireland each year approximately 2000 hip fractures, 1500 forearm fractures and a similar number of vertebral fractures occur each year. The cost of hip fracture alone exceeds £40 million per annum. Effective evidenced based treatments are available to prevent subsequent further fracture.
3. In 2007, the National Clinical Audit of Falls and Bone Health for Older People funded by the Healthcare Commission examined for the first time the clinical services provided for patients who had sustained a fragility fracture of the hip, wrist, humerus, pelvis or vertebra. The audit included patients in Northern Ireland.
4. Audit standards and indicators were derived from a number of best practice documents. These included the National Service Framework for Older People, the National Institute for Health and Clinical Excellence (NICE) Guidelines on Falls (CG 21, 2004), the Scottish Intercollegiate Guideline Network on Prevention and Management of Hip Fracture (SIGN 56, 2002) and the British Orthopaedic Association (BOA) good clinical practice guide on the management of fragility fractures – “the blue book” (BOA, 2003).
5. The latest “blue book 2” (the care of patients with fragility fracture September 2007) advocates six standards of care endorsed by both the British Orthopaedic Association and the British Geriatrics Society. Standard 5 recommends that all patients presenting with a fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fracture. Standard 6 indicates that all patients with a fragility fracture should be offered multidisciplinary assessment and intervention to prevent further falls and fractures. These standards are also supported by the NHS Institute for Innovation and Improvement Delivering Quality and Value Focus on: Fractured Neck of Femur.
6. Key findings from the audit report included:
  - After 3 months only a fifth of patients returning home from A&E after a fragility fracture were on appropriate treatment for osteoporosis.
  - After hip fracture surgery less than half of patients were on appropriate treatment for osteoporosis.

- Most patients returning home from A&E after a fragility fracture were not offered a falls risk assessment and only 22% were referred for exercise training to reduce future falls

### **Service Specification – Intervention**

- a. The contractor should develop a register of female patients aged 50 and over who have suffered at least one hip or non-hip fragility fracture to be known as the Osteoporosis/Secondary Prevention of Fractures.
- b. Conduct a review for each patient to ensure all key elements of care pathway are completed. These are: -:
  - Assessment of the cause of the relevant fragility fracture;
  - Provision of written advice on bone health and falls;
  - Advice on the consultation of an optician e.g. for assessment of visual acuity, etc.;
  - Assessment and treatment of signs of orthostatic hypotension;
  - Ensure patients are on appropriate pharmacological treatment, e.g. bisphosphonates or other bone sparing therapy;
  - Referral of patients, as appropriate, for DEXA scans. However patients over the age of 75 should not be referred for a DEXA scan.

### **Support and Monitoring by the Regional Board**

#### **Pricing and Payment**

##### **Aspiration Payment**

7. A percentage of the overall investment for the DES is to be paid up front and referred to as an Aspiration Payment. This amounts £1922 per contractor and this should be weighted by practice population against the NI average at January 2009.

##### **Achievement Payments**

8. Payment for achievement of the DES will be dependent of achievement of the annual targets outlined below:

Year	Target
1 (2008/09)	In year 1 Contractors were required to compile a disease register of female patients over the age of 50 who have had a hip or non-hip fragility fracture (the Osteoporosis/Secondary Prevention of Fractures disease register) and one third of the patients on the contractor's Osteoporosis/Secondary Prevention of Fractures disease register were to have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification
2	Two thirds of the patients on the contractor's Osteoporosis/Secondary

(2009/10)	Prevention of Fractures disease register have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification
3 (2010/11)	All patients on the contractor's Osteoporosis/Secondary Prevention of Fractures disease register have received the appropriate assessment and treatment in accordance with the Osteoporosis/Secondary Prevention of Fractures Scheme service specification

The Full Annual Achievement Payment for the Osteoporosis/Secondary Prevention of Fractures Scheme will be £1282 multiplied by the contractor's CPI. Practices will have to demonstrate that they have undertaken a full assessment of all their registered patients to identify those patients to put on the register.

British Orthopaedic Association (BOA) good clinical practice guide on the management of fragility fractures – “the blue book” (BOA, 2003) indicates that practices should expect to have approximately 42 patients in the target group per 1700 patients on their list who have suffered a fragility fracture. Practices will be expected to have provided the full intervention to a minimum of 42 patients per 1700 patients on their list per annum to receive the full achievement payment.

The Regional Board may reduce payment on a pro-rata basis if Practices fail to identify and treat patients according to the care pathway.

## **HEALTH CARE FOR HOMELESS ON THE MOVE ROUGH SLEEPERS SCHEME: 2009/10**

### **Introduction**

Note: Throughout this document the word homeless specifically refers only to homeless on the move rough sleepers.

1. The homeless person faces difficulty accessing most primary services and tends to make use of emergency health care services. This may be due in part to these services having difficulties in keeping track (and therefore forwarding appointments) of individuals on the move and in addition to access some services there is a requirement to retrieve and verify medical history, which may require waiting for medical notes/reports etc to be forwarded. Additionally, the fact that a person without an address will have difficulties in availing of general medical/dental services may inhibit the use of community pharmacy services.

### **Pricing and Payment**

2. The overall investment in this DES for Northern Ireland will be £250k in 2009/10.
3. This DES is intended to fund the provision of a range of services which should include, amongst others:
  - A central repository for the homeless person's primary care records.
  - A register of Homeless rough sleepers
  - A registered address or point of contact for primary care providers who wish to contact a registered homeless and or rough sleeper
  - The development of clinics providing access to medical, dental and community pharmacy services

### **Service Specification – Intervention**

- a. The contractor should develop a register of patients who are homeless/on the move rough sleepers.
- b. undertakes to ascertain, record and maintain current contact details for the patient.
- c. undertakes to develop and maintain, in liaison with other health care professionals involved in the patient's treatment and care, appropriate patient records that are to be maintained in such a way that they may be accessed by other health care professionals providing treatment and care to the patient under the Order.

## **HEALTH CARE FOR ADULTS WITH SEVERE LEARNING DISABILITY SCHEME: 2009/10**

### **Introduction**

1. This Directed Enhanced Service (DES) is for the provision of more specialised delivery of health care (including health checks) in primary care for adults with severe learning disabilities. The overall investment in this DES for Northern Ireland will be £1m in 2009/10. The specification of this service is designed to cover enhanced aspects of clinical care of adult patients with severe learning difficulties, which go beyond the scope of essential services.
2. An increasing number of people with a learning disability are living longer and healthier lives. Greater numbers of children with complex health needs and multiple disabilities are surviving into adulthood. Increasingly people with a learning disability who experience mental health problems are living in local communities rather than having their homes in specialist hospitals.
3. In order to ensure that people with a learning disability enjoy the benefits of such changing circumstances, commissioners and service providers will need to actively ensure that there is equity of access to the full range of healthcare provision enjoyed by the general population.
4. This guidance emphasises the need for multidisciplinary working and partnership planning. It makes the point that one of the keys to success is joint working between Trusts, GP practices, voluntary bodies, users and carers. One of the service principles set out in the guidance is that people with learning disabilities have an equal right of access to primary health care services. This DES is intended to assist multidisciplinary teams to use enhanced services to deliver better healthcare to adults with learning disabilities.
5. Evidence shows that:
  - a GMS doctor with a list of 2,000 patients will have about 8 patients with severe learning disabilities.
  - people with learning disabilities, as a group, have much greater health needs than the general population. They are more likely to have general health problems, sensory impairments, mental health problems, epilepsy, cerebral palsy and other physical disabilities. Adults with learning disabilities have particular issues in relation to the availability of service provision.
  - many adults with learning disabilities have undetected conditions that cause unnecessary suffering or reduce the quality or length of their lives.

- Some people with a learning disability are at higher risk of physical ill health arising from problems associated with particular conditions or syndromes.
- physical and sensory impairments are more frequent amongst people with a learning disability.
- they may also develop further difficulties related to cardiovascular problems, resistance to infections and their immune systems.
- there is an increased prevalence of physical and sensory impairments amongst people with a learning disability.
- there is an increased prevalence of epilepsy which occurs within 25% of people with a learning disability and 1/3 of people with profound learning disability.
- there are significantly higher levels of obesity.
- increasing numbers of people with a learning disability require intensive nursing care and technological support owing to complex health needs, have higher risk of infection or respiratory difficulties.
- the uptake of breast and cervical screening by women with learning disabilities is poor.
- people with learning disabilities tend to access primary care much less than they need to.

### **Service Specification – Intervention**

- a. The contractor, for each patient on the relevant Health and Social Care Trust Severe Learning Disabilities Register, conducts a detailed physical and mental health check, on an annual basis, to ensure that the specific and complex health needs of the patient are identified and treated.
- b. Provides a written person centred health action plan, a copy of which should be held by the patient's carer, or the health facilitator, that takes account of the patient's specific needs.
- c. undertakes to offer referral for further treatment, investigation or screening, as is necessary and appropriate, to other services, including general dental services, and liaise with other health care professionals involved in the patient's treatment and care.
- d. Demonstrates systematic recall system for patients on the register.

## **Actions that must be included in the annual health checks**

- **Health Action Plans**

Health Action Plans should detail the actions that are required to maintain and improve the health of people with a learning disability. They encompass a personal plan that outlines the help needed to enable a person with a learning disability to stay healthy,

- **Person Centred Plan**

The Health Action Plan where possible should form part of a Person Centred Plan. In order to reduce the inconsistencies that can result from local initiatives it is recommended that the broad format for the Health Action Plans be agreed at a regional level.

Health Action Plans should include details of the need for health interventions, oral health, fitness and mobility, emotional needs and records of screening tests. They should also identify clearly who is responsible for taking action.

- **Health Facilitator**

The responsibility for the development of Health Action Plans should rest with a named Health Facilitator working in partnership with primary health care staff. Health Action Plans involve people with a learning disability and their family carers in effective multi-agency and multi-disciplinary care planning prepared with and for the individual concerned.

- **Dental Health**

The oral health of people with a learning disability is worse than the general population with poorer oral hygiene, higher untreated diseases and more extractions.

- **Screening**

Expectations of health checks and health screening for people with a learning disability with particular reference to key areas that have particular risks e.g. cervical/breast screening, thyroid function tests for people with Down's Syndrome

Specific health promotion initiatives and interventions that focus on improving the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and dental health

- **Health Promotion**

Requirements for health promotion initiatives to take account of the particular difficulties experienced by adults with a severe learning disability in accessing information

In order to ensure that the specific individual health needs of people with a learning disability are identified and addressed it is proposed that arrangements be set in place to ensure that all are offered a personal Health Action Plan.

- **Liaison**

Involve carers and support workers. Where family or paid carers are involved, they can play a vital role in the patient's health care. With the consent of the patient where possible, they should be fully informed of the patient's health care needs, and supported as necessary.

Liaise with relevant local support services. Liaison with community and learning disability health professionals, social services and educational support services is necessary to provide seamless care for their patients and their carers. Patients and their carers should be informed of local and national voluntary support groups for vital information and support.

### **Support and Monitoring by the Regional Board**

6. The Regional Board should review the effectiveness of this DES by seeking annual returns from providers of the scheme which will include:
  - A return indicating that an individual review of the needs identified following completion of the health check and the outcome of the actions that were identified in order to meet these needs.
  - A patient experience survey return from patients and carers should be included in the patient's record as this may be required for claims purposes.
  - Report on the number of health checks delivered to adults with severe learning disabilities the as a percentage of total on the register.
7. Evidence and confirmation that the necessary reports, plans and returns have been completed and sent to the patient and carer, where appropriate, will form part of the reporting process.

### **Pricing and Payment**

8. It is expected that the cost for each health check should be approximately £100 per patient and contracts should be priced on that basis.

## MILD TO MODERATE DEPRESSION SCHEME: 2009/10 – 2010/11

### Introduction

1. NICE has published a stepped care model in its clinical guideline on the management of depression in primary and secondary care (CG23). This service will enable the employment of practice based counsellors who will provide non-drug treatment of patients with mild and moderate depression in the practice setting enabling a more efficient and effective service for patients. Contractors can also sub-contract with HSC Trusts for the provision of counsellor or therapist services to their practice patients.
2. The investment in this DES for 2009/10 will be £1.6m.
3. This DES encourages contractors to provide non-drug therapies in the treatment of mild-moderate depression and to adopt a staged approach with patients.
4. Contractors have already been recording those patients with new diagnoses of depression under the Quality and Outcomes Framework DEP2 indicator. Contractors have also been assessing the severity of the patients' depression using a validated tool.

### Strategic Context

This service has a strong strategic and evidence base as reflected in the following range of policy papers.

- **Primary Care Strategy** – highlights under Goal 1 the need to make Primary Care services more responsive and accessible and stresses the need to encompass a wider range of services in the community. Objective 7 of the framework emphasises the need to develop and implement strategies to provide for effective community based and person centred services for people with Mental Health needs. It further proposes that Health and Social Care Organisations should bring forward Primary Care reform and modernisation plans demonstrating how services can be redesigned to better respond to emerging need and provide a greater range of services, e.g. in the area of Mental Health and depression.
  - a. to promote better mental health and wellbeing
  - b. encourage the development of self-help and development of locally based counselling services/psychotherapy services
  - c. to increase the skill levels in Primary Care so that more mental health problems are managed
  - d. prevent/reduce the incidence and impacts of mental and emotional distress by promoting and developing self help and locally based counselling services.
- **The Bamford Mental Health Review** – highlights that Primary Care has a crucial role to play in early identification and treatment of common Mental

Health problems – notably anxiety, depression and phobias as well as a wider role in promoting Mental Health and Wellbeing. The majority of Mental Health problems are managed within Primary Care and a huge percentage of problems presented in Primary Care are psychosocial. Again, this service supports the development of Primary Care capacity in addressing Mental Health needs.

### **Service Specification**

- a. The contractor should develop a register of patients aged over 18 years old who have a new diagnosis or episode of mild or moderate depression since 1 April 2009 (it should be possible to extract this data from the QOF DEP2 indicator information).
- b. Provide treatment and review of all patients with mild depression in accordance with the appropriate stepped care model, to include:
  - Watchful Waiting - In mild depression, if the patient does not want treatment or may recover with no intervention, arrange further assessment – normally within 2 weeks;
  - Sleep and Anxiety Management - Consider advice on sleep hygiene and anxiety management;
  - Exercise - Advise patients of all ages with mild depression of the benefits of following a structured and supervised exercise programme. Effective duration of such programmes is up to 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks;
  - Guided Self-Help - For patients with mild depression, consider a guided self-help programme that consists of the provision of appropriate written materials and limited support over 6 to 9 weeks, including follow up, from a professional who typically introduces the self-help programme and reviews progress and outcome;
  - Computerised Cognitive Behavioural Therapy - Computerised CBT should be considered for the treatment of mild depression
  - Psychological Interventions - In mild and moderate depression, consider psychological treatment specifically focused on depression (problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks. Offer the same range of treatments to older people as to younger people. In psychological interventions, therapist competence and therapeutic alliance have significant bearing on the outcome of intervention. Where significant co- morbidity exists, consider extending treatment duration or focusing specifically on co-morbid problems;
  - Antidepressants - Antidepressants are not recommended for the initial treatment of mild depression, because the risk-benefit ratio is poor. Where mild depression persists after other interventions, or is associated with psychosocial and medical problems, consider use of an antidepressant. If a patient with a history of moderate or severe depression presents with mild depression, consider use of an antidepressant

- Review in Mild Depression - Consider contacting all patients with mild depression who do not attend follow-up appointments.
- c. Provide treatment and review of all patients with moderate depression in accordance with the appropriate stepped care model, to include:
- Antidepressants - In moderate depression, antidepressant medication should be offered to all patients routinely, before psychological interventions.
  - Psychological Interventions - Should also be considered and offered by the practice in line with the stepped care model where there is a limited response to initial treatment in moderate depression:
    - CBT is the psychological treatment of choice. Consider interpersonal psychotherapy (IPT) if the patient expresses a preference for it or if you think the patient may benefit from it
    - CBT and IPT should be delivered by a healthcare professional competent in their use – treatment typically consists of 16 to 20 sessions over 6 to 9 months
    - Consider CBT (or IPT) for patients with moderate or severe depression who do not take or refuse antidepressant treatment
    - For patients who have not made an adequate response to other treatments for depression (for example, antidepressants and brief psychological interventions), consider giving a course of CBT of 16 to 20 sessions over 6 to 9 months.
- d. For all patients with mild or moderate depression - referral to the Pathways to Work Team within the local Jobs and Benefits Office/Jobcentre in circumstances where work rehabilitation, training or employment may be of benefit to the patient's health and wellbeing (contractors will be required to record this intervention)
- e. Use of the DES recording template (which will also enable the contractor to be paid under the DES).

### **Service Specification – Counsellor/Therapist Requirements**

5. Contractors will be required to ensure that counsellors or therapists providing sessions in their practice, to their practice patients, have appropriate qualifications, experience and supervisory arrangements.
6. Practices must ensure that their service meets the requirements of one of the following:-
  - a. Practitioners should be registered or accredited with one of the bodies. Fully accredited counsellors should have supervisors in place (see BACP recommendations below). Ensuring knowledge of these arrangements, and compliance with them should form part of the practices system for clinical governance.

For purposes of this DES the standards (point 1) for counsellors who are accredited or eligible to be accredited with the British Association for Counselling and Psychotherapy (BACP) will apply. There are a number of equivalent bodies who accredit to the same or higher standard. These include:

- IACP – (Irish Association for Counselling and Psychotherapy)
- UKCP – (Uk Council for Psychotherapy)
- ICP – (Irish Council for Psychotherapy)
- BACBT – (British Association of Cognitive Behavioural Therapists)
- Clinical / Counselling Psychologist registered with the BPS (British Psychological Society) or IPS (Irish Psychological Society).

**OR**

- b. The service may be subcontracted to an organisation which has in place a robust system of clinical supervision by trained supervisors and of accountability for the service delivered to each patient e.g. an HSS Trust.

**OR**

- c. The practice accepts clinical responsibility for the treatment provided to the patients by a counsellor working towards accreditation.

In these circumstances the practice should complete an undertaking (attached) to ensure the counsellor meets the required standards. The signature of the undertaking also denotes acceptance of clinical responsibility for this practitioner.

7. Contractors are required to demonstrate compliance with these requirements by submission of the completed undertaking to the Regional Board.

**Directed Enhanced Service for Cognitive Behavioural Therapy/ Interpersonal Therapy for Patients with mild/ moderate Depression 2009 / 2010**

Practice Under-taking for the employment of a counsellor working towards accreditation.

**Details of Counsellor employed to provide service:**

\_\_\_\_\_  
Details of primary qualification: see Note 1 (a)

\_\_\_\_\_  
Expected date of Accreditation (date forms will be submitted):

\_\_\_\_\_  
Details of supervisor (counselling): see Note 1 (b)

\_\_\_\_\_  
Details of Indemnity: see Note 1 (c)

**Practice Responsibilities**

The Practice in accepting clinical responsibility for the work of counsellors in training should ensure the following:

- Clients are triaged by the GP to assess their suitability for CBT / IPT
- The counsellor has the appropriate training as per the requirements of this DES
- That the service provided to clients is evaluated
- That the required clinical and managerial supervision of the counsellor is in place for services provided to every client

**Declaration**

The practice undertakes to accept full clinical and managerial responsibility for the services provided by the above named counsellor in line with the local enhanced service for CBT/ IPT.

As with all members of staff on recruitment the practice will follow its usual employment checks.

Signed on behalf of the Practice: \_\_\_\_\_

Date: \_\_\_\_\_

Practice Code \_\_\_\_\_

Note 1:

**BACP Recommendations:**

**a. Primary qualification:**

- If Providing CBT

The practitioner should have already undertaken counselling training to Diploma level via a BACP accredited course or equivalent followed by a post graduate qualification in CBT which contained an element of not only theory but the use and practise of CBT which was supervised by a qualified CBT practitioner.

- If Providing IPT meet BACP standards.

**b. Supervision:**

Counsellors should make arrangements themselves to ensure that they receive supervision / consultative support independently of any managerial relationships. Supervisors need to be appropriately qualified themselves to be very experienced practitioners with experience of working in the NHS and knowledge of NHS counselling standards and governance arrangements, and/or have a qualification in counselling supervision.

Please refer to BACPs Ethical Framework for Good Practice in Counselling and Psychotherapy (2002) page 5.

**c. Indemnity:**

All counsellors must have appropriate professional indemnity insurance. BACP also recommends that all counsellors take out professional indemnity insurance even if they have insurance via their employer.

Should you have any general queries with regard to qualifications and supervision, the BACP are happy to offer advice to practices on contact through their website ([www.BACP.co.uk](http://www.BACP.co.uk)).

## **Pricing and Payment**

### **Annual Payment**

8. Contractors will receive an annual payment of £750 multiplied by the Contractor's CPI for signing-up to deliver the appropriate interventions in line with the stepped care model for patients with mild to moderate depression, undertaking the appropriate training (e.g. CCBT), use of the appropriate Read Codes and preparing the data for the payment returns.
9. In 2009/10 and 2010/11 the Annual Payment (£750) will be paid in four quarterly instalments, in the last month of each quarter of the appropriate financial year.

### **Sessional Payment**

10. As outlined in the introduction and service specification, this scheme will enable the employment of practice based counsellors who will provide non-drug treatment of patients with mild and moderate depression in the practice setting enabling a more efficient and effective service for patients. Contractors can also sub-contract with HSC Trusts for the provision of counsellor or therapist services to their practice patients.
11. Reimbursement to contractors for the provision of counsellor or therapist sessions in their practice/to their practice patients will be on a per session basis at a rate of £85 per session. The number of sessions to be reimbursed to a contractor will be determined by the size of the contractor's patient list, in accordance with the table below:

Contractor's Patient List Size	No of Sessions
<4000	1 per fortnight
4000 – 9000	1 per week
>9000	2 per week

12. Contractors will be required to submit monthly claims for Sessional Payments. Reimbursement will be subject to the condition that contractors demonstrate compliance with requirements for registration/accreditation, experience and supervisory arrangements of counsellors outlined in paragraph 5 of this specification.