NHS Highland

NORTH HIGHLAND CHP
Locally Enhanced Service (LES) for
Specialised care of patients with depression

Service Level Agreement

PRACTICE:

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1. Financial Details

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

This agreement is to cover the 12 months commencing 1 April 2008

Payment Rate:

Annual Retainer	£1,065.54
Annual Payment per patient	£80

Payment Criteria

Annual retainer - Will be paid at the start of the contract. The Practice will carry out Screening, Objective Screening, Register maintenance, Exit Scoring, where possible, participate in the agreed clinical audit cycle and participate in the Lithium Monitoring scheme as defined in QOF.

Payment per patient – Will be made for provision of Enhanced care and treatment over a period of up to 12 months (as per the service outline)

<u>Aspirational payments</u> – To minimise bureaucracy and improve cash flow, "aspirational payments" will be made with reconciliation at the end of the financial year.

Annual retainers (where applicable) will be paid at the end of June 2008. Monthly, in arrears, 1/12 of 66 2/3% of the value of aspired activity for the year will be paid to the Practice. The aspired activity must be agreed between the CHP and the Practice based on previous years activity, and any other relevant evidence. A process of reconciliation of actual vs estimated activity will take place at the end of the financial year, and a final payout will be made at the end of April 2009.

Monthly activity figures must be submitted throughout the contract to facilitate monitoring by both parties. If a Practice falls more than 2 months in arrears with activity submissions, aspirational payments will be stopped pending satisfactory monitoring arrangements. At the discretion of the Practice, aspirational payments can be reduced in year, if they feel actual activity is falling significantly below the aspirational level.

Aspirational Activity	

Payment Verification

Practices entering into this contract must participate fully in the verification process determined by the PCO and LMC. Practices should ensure that they keep proper records to ensure a full and proper audit trail.

Practice computer systems will be utilised to enable this condition to be met.

Practices must be able and willing to evidence service delivery if required/requested by the PCO.

<u>PAYMENT WILL ONLY BE MADE UPON RECEIPT OF THIS SIGNED CONTRACT</u>

2. Signature Sheet

This document constitutes the agreement between the practice and the PCO in regards to this locally enhanced service.

PRACTICE………………………………………………….

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the PCO:

Signature	Name	Date

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3. Service Aims

1.The purpose of this LES is to build on the excellent achievements of the NES and LES whilst supporting the Scottish Government's HEAT targets for training in Suicide Awareness and Antidepressant Prescribing.

We seek to help Practice to:

- ☑ Promote screening in At Risk Groups
- ☑ Standardise objective testing with the adoption of PHQ9 (and Edinburgh Depression Rating Scale in Post-natal Depression)
- ☑ Promote the adoption of evidence based "Care Pathways" (proven to reduce the number of required GP consultations)
- ☑ Promote the use of "Guided Self Help"
- ☑ Encourage the use of CBT where a timely service is available.
- ☑ Facilitate evidence based cost effective prescribing
- ☑ Encourage joint working between primary and secondary colleagues to produce seamless patient centred care.
- ☑ Facilitate Highland-wide audit
- ☑ Participate in suicide risk assessment and crisis management training.

2. Evidence shows that:
(i) depression is one of the top three leading causes of disability
(ii) clinical depression affects up to 2.3 million people in Britain (5 per cent of the population) at any one time
(iii) one in four patients presenting to their GP suffer with depression
(iv) 80 per cent of people identified as having depression are managed entirely in a primary care setting – the average GP will see at least one patient with depression during each surgery session
(v) depression accounts for at least 3,000 of the 4,000 people who commit suicide in England and Wales each year
(vi) as many as three in four cases of depression are neither recognised nor treated.

3. Depression causes much suffering to the patient and is potentially life threatening. It can also severely affect the quality of life of the patient's family. Untreated, depression is likely to worsen and become more difficult to treat, with both serious personal and financial implications. It is imperative, therefore, that the condition is diagnosed and treated as early as possible in primary care.

4. GPs are well placed to help their depressed patients, who may have social problems and physical illness to cope with in addition to their depression. Treatment at home is usually best for the patient, who is then able to maintain ties with family and friends and may be able to continue at work.

5. Failure of treatment is often due to the patient stopping the treatment too soon. Compliance with therapy is improved through regular monitoring by a healthcare professional.

4. Service Outline

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This enhanced service will be based on episodes of care, and a formal enhanced service annual administration review will now be mandatory. When the patients' condition has been resolved, or the patient is no longer being **"actively treated"** by the Practice, the Practice will be required to close an episode of care.

Each new episode of care will require the following minimum information recorded:

- ☑ PHQ9
- ☑ Diagnosis recorded during the patient's time on the register for this current episode of care (note VISION requires first or new)
- ☑ Patient management plan
- ☑ 1st review of management plan
- ☑ 2nd review of management plan

Each episode will require 3 management plan entries in a 6 month period.

Reference to the Care Pathway (Appendix 1) should be made throughout this section.

Management Plan

The precise detail of what constitutes a Management Plan will not be proscribed, rather leaving this for the Doctor and Patient to agree. Key areas to be covered, however, would include the agreed:

- ☑ Diagnosis
- ☑ Treatment Plan/Review of Progress
- ☑ Review Period

Screening

Practices are expected to actively promote screening for depression in At-Risk groups:

- ☑ Chronic physical health problems (coronary heart disease, CVA, arthritis, cancer, chronic pain, diabetes)
- ☑ Women around the time of child birth
- ☑ High risk life events (bereavement, unemployment, divorce)
- ☑ Drug and alcohol misuse

Screening will normally take the form of the "2 Question Test" (Appendix 2).

Note – preferred code to record screening carried out – 6896

Registers

Practices are required to maintain a register of patients currently being actively treated for depression using the care pathways as defined in the Care Pathway (Appendix 1).

- ☑ With active depression
- ☑ With bi-polar illness
- ☑ With long-term use of antidepressant medication.

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Patients on the register for more than a year will be automatically marked as inactive. Facilities will be added to the ESCRO SV tool software (G Pass and VISION only) to allow cases to be extended, or to close episodes of an enhanced service review.
On and off active enhanced service register will be recorded using the following READ codes (already updated as part of ESCRO V2 release).

Depression enhanced service commenced 9k4..
Depression enhanced service complete 9k40.

Where patients are already on the active register and a commenced code is entered again, this will be taken as an extension of an existing episode of care (this will be compulsory after 12 months). Diagnosis and PHQ9 will not be re-entered again in a 6 month period.

Where a patient has been added to the register after having previously been removed, a new PHQ9 will be required along with diagnosis and 3 management plans.

In order to comply with both QoF and enhanced service requirements, diagnosis should be entered on the same date as the PHQ9. (QoF requirement is diagnosis entered between day of diagnosis to one month after diagnosis).

Where episodes of care cross a year end boundary and 3 management plans have not been recorded in the previous year and therefore no payment has been made in the previous year, any management plans will carry forward to the next year providing they are within a year of being added to the register, and meet the 6 month criteria. For the 1st year of this new criteria, data will not be sought prior to 1 April 2008 ie for the year 2008/09 there must be 3 management plans recorded within a 6 month period during the calendar year 1 April 2008 to 31 March 2009, and during the patient's time on the register, for a claim to be submitted.

The diagnosis and PHQ9 can be recorded prior to 1 April 2008 provided it is recorded during the patient's time on the depression register.

Objective Testing

Use of PHQ9 as a monitor of progress and particularly as an "exit score" is also to be encouraged. It is accepted, however, that patient compliance can be particularly problematic at the end of treatment.

Care Pathways

While acknowledging GPs must choose, in collaboration with their patient, the care most appropriate, Practices must demonstrate commitment to the Care Pathways document. It is accepted that local service provision is variable across Highland, but work is continues to improve the range of local services available in year.

Variances from best practice, as described in the Care Pathways document, will be monitored. The PCO reserve the right to seek explanation and agree modification to persistent and significant variance.

Adherence to the Care Pathways should deliver a multi-disciplinary approach, where available, and evidence-based cost effective prescribing. It is hoped that Guided Self-help (proven to reduce the number of required GP consultations) and timely CBT services can be made more widely available over Highlands.

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Training

As part of the adoption of “Doing Well by Depression” and the “Care Pathways”, the CHP will ensure a program of training is available which will include evidence based prescribing, use of CBT and Talking Therapies.

Suicide Training

Up to 60% of deaths by suicide occur in people with mood disorders. Management of suicide risk is therefore an important part of the management of depression. Practices should ensure that at least half of their clinical staff have completed a training session on management of suicide risk by March 2010. Sessions will be arranged by NHS Highland, will last no longer than half a day, and there will be no charge for attendance.

Audit/Review

Participation in a Highland-wide Audit Cycle for treatment of depression will be expected. This will be kept as unbureaucratic as possible, making use of ESCRO wherever possible.

Activity such as recording alcohol and drug history, maintaining Personal Health Plans, etc continues to remain highly desirable, and annual audit of their recording will be required.

As part of the Annual Review of Enhanced Service contracts, the CHP will discuss Practices progress against the Scottish Government HEAT Targets for reducing use of Antidepressant prescribing.

5. Accreditation

Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

6. Dispute Resolution

Every attempt will be made to resolve any dispute informally between the Practice and the PCO. Failing that, the Dispute Procedure contained within the sections 464 to 474 of the Scottish General Medical Services Contract 2004 will apply.

7. Variation and Termination of Contract

Any variation to the terms and conditions contained herein requires to be agreed between the Practice and the PCO.

Any termination of services, or any part of the services covered by this contract, requires to be agreed between the Practice and the PCO before any termination takes place.

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