

**SPECIFICATION FOR A NORTHERN IRELAND DIRECTED
ENHANCED SERVICE IN:
LONG-TERM CONDITION MANAGEMENT SCHEME 2006/07**

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

Part 1 - Practice-based service for patients with COPD

Introduction

1. This part of the DES builds on activities already being provided by practices 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 practices will require liaising effectively with community-based schemes commissioned or provided by Trusts, LHSCGs, Boards and others. This may include non-HPSS services e.g. Ulster Cancer Foundation. LHSCGs, Trusts and Boards are already providing a range of services which will support practice activities under this DES e.g. community based pulmonary rehabilitation and specialist smoking cessation services including those provided in practices. Practices will therefore need to have an awareness of local provision and how patients may access other community-based services. Boards should facilitate the provision of this information to practices by ensuring that Trusts provide the relevant information to participating practices. 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 ₁ , % 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 practice should be aware of all local specialist smoking cessation services and provide information on these to motivated patients. Boards will assist practices with information about local specialist smoking cessation services including those provided by practices.
- 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. Practices 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. Practices 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_aO_2 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. Provide data at year-end to the HSSB using the standardized format provided. Boards will give comparative data feedback to practices.
- j. Relevant practice 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.

Support and Monitoring by HSSB

- 3. Boards will facilitate practice training and will review individual anonymised patient records for a sample of patients admitted to hospital to review the care arrangements made. Boards also, subject to their resources, should consider funding the provision of relevant equipment in practices eg 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.
- 4. It is intended that the DES will be reviewed regionally with a view to making it recurrent.

ANNEX A

1. Patients must be provided with a written self-management 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.
2. The patient or practice should record which topics have been covered. Practices may wish to consider using the NICE guidance: CG12 Chronic Obstructive Pulmonary Disease: Information for the public. It is a comprehensive document.

DES Data Return to HSSB 06/07 for patients with COPD					
Practice Name:					
Practice Address:					
Practice Code:					
Practice List size:					
Total number of smokers in practice					
Number of...	<i>FEV₁ % predicted</i>	Mild 50-80	Moderate 30-50	Severe <30	Total
1. Patients with COPD					
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)					
3. Patients with COPD on optimal pharmacological treatment					
4. Patients with COPD who are smokers					
5. Patients with COPD who are smokers referred to specialist smoking cessation services in last 12 months					
6. Patients with COPD assessed and referred for Long Term Oxygen Therapy					
7. Patients with COPD referred for pulmonary rehabilitation in last 12 months					
8. Patients with COPD using home nebuliser (see NICE guidance)					
9. Patients with COPD admitted to hospital A&E because of COPD more than 3 times in past 12 months					
10. Patients with COPD attending A&E because of COPD more than 3 times in past 12 months					

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

Part 2 - Practice based service for patients with Asthma

Introduction

1. This part of the DES builds on activities already being provided by practices under QOF for this condition.
2. 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 practices will require liaising effectively with community-based schemes commissioned or provided by Trusts, LHSCGs, Boards and others. This may include non-HPSS services e.g. Ulster Cancer Foundation. LHSCGs, Trusts and Boards are already providing a range of services which will support practice activities under this DES eg specialist smoking cessation services including those provided in practices. Practices will therefore need to have an awareness of local provision and how patients may access other community-based services. Boards should facilitate the provision of this information to practices by ensuring that Trusts provide the relevant information to participating practices.

Service Description

- a. Provide each patient (over age 15 years) with self-management training and a patient held asthma action plan. 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 practice will provide the child or parent (as appropriate) with the action plan.
- b. Identify patients at risk of developing near fatal or fatal asthma using BTS/SIGN guidelines. Practices 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 patients records.
- c. 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.
- d. Record the number of A&E attendances or hospital admissions for asthma within the past year.
- e. For all patients with asthma who smoke, a proactive approach to encourage patients to take advantage of specialist smoking cessation services. The practice must therefore be aware of all local specialist smoking cessation services and how patients may access services.
- f. Review and record patient inhaler technique.
- g. Ensure that patients with asthma are on appropriate pharmacological treatment.

- h. Provide data at year-end to the HBSB using the standardized format provided. Boards will provide comparative data feedback to practices.
- i. Relevant practice 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.

Support and Monitoring by HSSB

3. Boards 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.
4. It is intended that the DES will be reviewed with a view to making it recurrent.

DES Data Return to HSSB 06/07 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 practices must complete the remaining data collection boxes before achievement payment can be made.

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

Introduction

1. This part of the DES seeks to build the capacity of practices 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 to be 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 practice employed clinical staff and who are involved in the management and treatment of patients with a BMI greater than 30. The practice 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 practice 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 practice resource kit for motivated patients whose BMI is greater than 30, which provide information and guidance on both sides of the “energy equation”. Boards and LMCs will co-operate in assisting practices 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. Boards will provide information on other relevant local initiatives e.g. Health Action Zones. Practices should provide information to patients about the availability of their resource kit to patients e.g. in a leaflet, notice board, practice 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 practices should adopt a pro-active approach to encourage them to take advantage of specialist smoking cessation services. The practice should be aware of all local specialist smoking cessation services and provide information on these to motivated patients. Boards will assist practices with information about local specialist smoking cessation services including those provided by practices.

- e. Provide information to the HSSB at year-end which will assist with service planning for future public health initiatives. Boards will provide practices with comparative data feedback.

Support and Monitoring by HSSB

2. Boards should review the effectiveness of this DES including practice 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. Practices should be able to demonstrate their call and recall system.
3. It is intended that the DES will be reviewed with a view to making it recurrent.

DES Data Return to HSSB 06/07 for patients with a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus

Practice Name:

Practice Address:

Practice Code:

Practice List size:					
Total number of smokers in practice					
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 practices must complete the remaining data collection boxes before achievement payment can be made.

PAYMENT FOR LONG-TERM CONDITION MANAGEMENT SCHEME DIRECTED ENHANCED SERVICE

General

1. The overall investment in the DES is £4m and this proposed pricing structure sets out to ensure that the maximum coverage in relation to the provision of the enhanced service achieves that level of spend using 366 practices. The DES is a single entity and participating practices must undertake to deliver on all three parts set out in the specification.

Set up Payment

2. 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 £1.4m or £3,825 per practice 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 2006.
3. The payment structure for achievement described below should ensure that at least a minimum percentage of patients in each clinical domain should be provided with the service to the level specified. Boards should put in place a mechanism to recover from all available funding streams, the set up payment from practices which do not achieve this minimum level of achievement.

Data collection

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

Achievement payments

5. Whilst the DES will be a single entity, in view of differing prevalence in each clinical domain and to reflect differences in practices 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
6. 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 practice. The overall banding for each element of the DES is as follows:

Achievement payment per practice for parts 1 of the DES (COPD)

Lower Rate For 70% - 79% achievement	Middle Rate For 80% - 89% achievement	Full Rate For at least 90% achievement
£2,730	£4,095	£5,460

Achievement payment for part 2 of the DES (Asthma)

Lower Rate For 60% - 69% achievement	Middle Rate For 70% - 79% achievement	Full Rate For at least 80% achievement
£1,640	£2,460	£3,280

Achievement payment per practice for Part 3 of the DES

NB: The total numbers on the data collection sheet will be compared with the numbers on the practice 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% - 29% achievement	Full Rate For at least 40% achievement
£1,090	£1,640	£2,185

NB: The above figures represent the achievement payment for each practice 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 7 below) and the amount of start-up payment paid to the practice must then be deducted.

Weighting

7. 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 before deduction of the amount of start-up payment made to the practice.

Overall investment in the DES

8. The agreement reached on the GMS contract in this respect was that the new funding for each country (equivalent to the value of 100 QOF points, some £4m for Northern Ireland) would be used to establish additional directed enhanced services which may be specific to each country. The pricing structure above guarantees the delivery of that £4m where all practices achieve at the highest level across the clinical areas concerned. Where this standard is not achieved or

where start up payments are recovered, in order to meet the terms of the agreement, Health and Social Services Boards must use any shortfall to secure the most effective and equitable delivery of this service. This may be in the securing of providers other than GP practices to deliver, or improve the delivery of, the service in areas of low, or no, delivery or by further rewarding practices which have achieved only the highest levels of achievement.