Clinical directed enhanced services (DESs) for GMS contract

Guidance and audit requirements for 2011/12

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BMA

NHS Employers

Contents

Clinical directed enhanced services (DESs) for GMS contract: guidance and audit requirements for 2011/12

Introduction

NHS Employers and the General Practitioners Committee (GPC) of the British Medical Association (BMA) agreed five new clinical directed enhanced services (DESs) as part of the 2008/09 contract negotiations. These DESs focused on the health and service priorities of the Department of Health that would benefit patients and were for:

- heart failure
- alcohol
- learning disabilities
- osteoporosis
- ethnicity.

All of the DESs were effective from 1 April 2008 and, apart from heart failure, were originally intended to run for two years, finishing on 31 March 2010. Heart failure was a one-year DES and an indicator measuring prescribing of beta blockers for heart failure was included in the Quality and Outcomes Framework (QOF), effective from 1 April 2009. The remaining four clinical DESs – alcohol, learning disabilities, osteoporosis and ethnicity – were extended for a further year until 31 March 2011.

It has now been agreed that the alcohol, learning disabilities and osteoporosis DESs will be extended for an additional year until 31 March 2012. Although the ethnicity DES has now come to an end, we expect practices will continue to record their patients' first language and ethnicity in order to assess the needs of their population. The codes for first language and ethnicity are published separately and will be available on the BMA website[1]. The DESs are applicable in England only.

About this guidance

This document provides primary care trusts (PCTs) and practices with updated information to help support continuation of the DESs for 2011/12. It supersedes the guidance *Clinical directed enhanced services (DESs) for GMS contract: Guidance and audit requirements for 2010/11*, published in March 2010. This document provides detailed guidance and audit requirements for each of the three remaining DESs:

Appendix 1 – Alcohol

Appendix 2 – Learning disabilities

Appendix 3 – Osteoporosis

[1] www.bma.org.uk/employmentandcontracts/independent_contractors/enhanced_services/index.jsp

Amendments to the Directed Enhanced Services Directions and to the Statement of Financial Entitlements to underpin the continuation of the three remaining DESs, are available on the Department of Health website (linked below). The detailed requirements for taking part in the DESs are set out in the Directions. PCTs and practices taking part should ensure they have read and understood the requirements in the Directions[2], as well as the guidance in this document.

[2] http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/Enhanced/index.htm

Appendix 1

Guidance and audit requirements for the alcohol-related risk reduction scheme

Background and purpose

It is a government priority to address the issue of illness associated with increasing alcohol consumption. This DES aims to reward practices for case finding in newly-registered patients aged 16 and over. It also aims to deliver simple brief advice to help reduce alcohol-related risk in adults drinking at increasing or higher risk levels, and consideration of specialist referral for dependent drinkers.

Introduction

This DES does not include a requirement to set up a register of increasing or higher risk drinkers.

Practices are required to screen newly-registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete. Patients with a positive score should be given the full screening test and offered brief advice for a score between eight and 19, or be considered for referral to specialist services for a score of 20 or more.

Initial screening

For this continued DES, screening will apply to all patients registered between 1 April 2011 and 31 March 2012, who are aged 16 or over at the time the short case finding test is applied. For the purposes of this DES the test must be applied within the financial year in which the patient registered. The following Read Codes are recommended:

	Read v2	Read CTV3	Snomed CT
FAST alcohol screening test	388u.	XaNO9	303471000000106
AUDIT C Alcohol screening test	38D4.	XaORP	335811000000106

There are currently no codes available which indicate a positive FAST or AUDIT-C test result so it will be necessary to add a value to a field associated with the code (please consult your computer system supplier for details). A value of 3+ is regarded as positive for FAST and a value of 5+ is regarded as positive for AUDIT-C.

Full screening

If a patient is identified as positive, the remaining questions in the ten-question AUDIT questionnaire should be used to determine increasing, higher risk or likely dependent drinking. The following codes are recommended:

	Read v2	Read CTV3	Snomed CT
AUDIT Alcohol screening test	38D3.	XM0aD	273265007

Again, a value should be added to a field associated with the code to record the score:

- 0–7 indicates sensible or lower risk drinking
- 8–15 indicates increasing risk drinking
- 16 -19 indicates higher risk drinking
- 20 and over indicates possible alcohol dependence.

Brief intervention

Those patients identified as drinking at increasing or higher risk levels (scores 8 -19) should be offered brief advice. The recommended brief advice is the basic five minutes of advice used in the WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle "How Much is Too Much? The tools[3] from this programme have been further refined. The following codes are recommended for recording the intervention offered:

	Read v2	Read CTV3	Snomed CT
Brief intervention for excessive alcohol consumption completed	9k1A.	XaPPv	366371000000105

Brief lifestyle counselling

In some areas patients drinking at higher risk levels (scores 16-19) may receive brief advice or brief lifestyle counselling (20 - 30 minutes) within the practice, or be referred to, for example, a community-based counselling service for this advice, but this distinction is not recognised for the purposes of this DES. Practices may find the following codes helpful:

Referral for specialist advice

	Read v2	Read CTV3	Snomed CT
Extended intervention for excessive alcohol consumption completed	9k1B.	XaPPy	366421000000103

[3] www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/

Patients identified as possibly alcohol dependent (scores of 20 or more) should be considered for referral for specialist services. Although providing brief alcohol advice is still recommended, on its own, brief advice has not been shown to be effective for this group of patients. The following codes are recommended for recording specialist referral:

	Read v2	Read CTV3	Snomed CT
Referral to specialist alcohol treatment service	8HkG.	XaORR	431260004

Validation and payment

Within 28 days of the end of the financial year (31 March 2012) practices will be required to complete and send to the PCT an audit of:

- the number of newly-registered patients aged 16 and over within the financial year who have had the short standard case finding test (FAST or AUDIT-C)
- the number of newly-registered patients aged 16 and over who have screened positive using a short case-finding test (as above) during the financial year, who then undergo a fuller assessment using a validated tool (AUDIT) to determine increasing risk, higher risk or possible dependent drinking
- the number of increasing or higher risk drinkers who have received brief advice to help them reduce their alcohol-related risk
- the number of patients scoring 20 or more on AUDIT who have been referred for specialist advice for dependent drinking.

In 2011/12 practices will receive £2.38 for each newly-registered patient aged 16 and over (as defined above) who have received screening using either the FAST or AUDIT-C tool.

PCTs are encouraged to audit the claims of their practices to ensure that not only the screening was conducted but that the full protocol described above was followed; i.e. that those individuals who screened positive on the initial screening tool were then administered the remaining questions of AUDIT and that a full AUDIT score was determined and that appropriate action followed, such as the delivery of brief advice or referral to specialist services if needed.

Further information

Further information regarding the audit tools and brief intervention can be found at:
www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/

Appendix 2

Guidance and audit requirements for the learning disabilities health check scheme

Background and purpose

There is good evidence that patients with learning disabilities (LD) have more health problems and die at a younger age than the rest of the population. The existing QOF registers do not differentiate LD by severity.

This DES is designed to encourage practices to identify patients aged 18 and over with the most complex needs and offer them an annual health check. Local authority (LA) lists of people known to social services primarily because of their learning disabilities, are to be used as the basis for identifying patients to be offered the checks. The rationale is to target people with the most complex needs and therefore at highest risk from undetected health conditions (usually people with moderate to severe learning disabilities). From the prevalence figures available, it is estimated that approximately 240,000 patients fall into this category across the country. Generally Local Authority criteria for access to social care services are related to complexity of need, although sometimes individuals with mild learning disabilities and other additional health needs, usually associated with mental health needs, will meet social services eligibility criteria.

Introduction

The pre-requisites for taking part in the DES are as follows:

- practices will have liaised with their LA to share and collate information, in order to identify the people on their practice list who are known to social services primarily because of their learning disabilities
- practices will include those of its registered patients identified by this liaison in a health check learning disabilities register
- practices will keep this register up-to-date and ensure that their QOF learning disabilities register includes all patients on the health check register
- practices providing this service will be expected to have attended a multi-professional education session.

The minimum expectation of staff attending will include the lead general practitioner (GP), lead practice nurse and practice manager/senior receptionist. Practices may also wish to involve specialist LD staff from the community learning disability team to provide support and advice.

Learning disability (LD) register

PCTs should work with their LA (or LAs where practices' registered patients are resident in more than one authority area) to produce a register of patients who are known to social services primarily because of their learning disabilities, determine which practice they are registered with and share this with their constituent practices.

Using this information and integrating it with data about patients already on the practice's register, practices should establish a health check learning disabilities register using the following recommended Read Codes which are in line with those used for the QOF learning disabilities register:

	Read v2	Read CTV3	Snomed CT3[4]
Mental retardation	E3...%	E3...%	91138005 86765009% 61152003% 31216003% 40700009% 401201000000109 410331000000103% 192157003 192154005%
[X]Mental retardation	Eu7..%	Included in E3...%	Included in 91138005%
[X]Developmental disorder of scholastic skills, unspecified	Eu81z	Eu81z	192577001
[X]Mild learning disability	Eu816	XaREt	526331000000104
[X]Moderate learning disability	Eu814	XaQZ3	508191000000109
[X]Severe learning disability	Eu815	XaQZ4	508171000000105
[X]Profound learning disability	Eu817	XaREu	526341000000108
On learning disability register	918e.	XaKYb	416075005

It is understood that work on the registers is ongoing in some areas. The DES requires the data to be in reasonable order to proceed with offering and delivering checks but recognises that improvement of lists may need to continue at the same time.

[4] Please note that SNOMED codes are not included in the 2009/10 Quality and Outcomes Framework Learning disability (LD) indicator 1

Training

Multi-professional education sessions for primary healthcare staff should be established by PCTs and offered to primary healthcare staff. The training should be provided by the strategic primary health care facilitator for people with learning disabilities (where PCTs have invested in this support) and/or members of the local community learning disability team (this may need to be commissioned via the local specialist NHS trust) in partnership with self advocates and family carers (as paid co-trainers).

Each PCT should use their internal procedures to approve the content of the training for their locality using this suggested framework:

- an understanding of learning disabilities
- identification of people with learning disabilities and clinical coding
- understanding of the range and increased health needs associated with learning disabilities
- understanding of what an annual health check should cover (see below)
- information that should be requested prior to an annual health check
- understanding of health action plans
- understanding and awareness of 1:1 health facilitation and strategic health facilitation
- ways to increase the effectiveness of health checks
- overcoming barriers including:
    - communication needs
    - using accessible information and aids
    - physical access
    - social and cognitive attitudes
- collaborative working including:
    - working in partnership with family carers
    - the role of the community learning disability team
    - the role of social care supporters
    - the role of other health care professionals and services
- experiences and expectations
- consent
- Disability Discrimination Act and the Disability Equality Duty
- resources – local contacts, networks, practitioners with special interest and information.

The training should be completed by practice members before health checks are conducted.

Further information regarding training for primary healthcare staff, together with good practice examples, is available on the Valuing People[5] website.

[5] www.valuingpeople.gov.uk/dynamic/valuingpeople144.jsp

Health checks

As a minimum, the health check should include:

- a review of physical and mental health with referral through the usual practice routes if health problems are identified, including:
  - health promotion
  - chronic illness and systems enquiry
  - physical examination
  - epilepsy
  - dysphagia
  - behaviour and mental health
  - specific syndrome check
- a check on the accuracy of prescribed medications
- a review of coordination arrangements with secondary care
- a review of transition arrangements where appropriate.

Practices taking part in the DES should base their health checks on the Cardiff health check[6] protocol which is available through the Royal College of General Practitioners website or a similar protocol agreed with the PCT. Health checks should integrate with the patient's personal health record or health action plan. Where possible and with the consent of the patient, this should involve carers and support workers. Practices should liaise with relevant local support services such as social services and educational support services, in addition to learning disability health professionals.

	Read v2	Read CTV3	Snomed CT
Learning disability health examination	69DB.	XaPx2	381201000000100

Validation and payment

Once a practice has agreed the health check LD register with their PCT, it will receive a £51.08 aspiration payment for each patient on the register.

Final payment will be based on a report to the PCT within 28 days after 31 March 2012, on the number of patients on the health check LD register who have received the health check within the financial year, and after training has been completed. In 2011/12, the reward for each health check will be £102.16.

The cost of aspiration payments will be deducted from payments made for the health checks. If practices do not complete enough health checks to fund the full cost of their aspiration payment, the PCT will recover any overpayment made as result, in line with normal practice.

[6] www.rcgp.org.uk/docs/CIRC_Cardiff%20Healthcheck%20Template.doc

Appendix 3

Guidance and audit requirements for the osteoporosis diagnosis and prevention scheme

Background and purpose

Osteoporosis is an important health problem through its association with age-related (fragility) fractures. Fractures of the hip, wrist and spine are the most frequent osteoporotic fractures.

Introduction

The aim of the DES is to encourage practices to confirm the diagnosis and prescribe appropriate pharmacological secondary prevention in patients with osteoporosis. A pre-requisite for taking part in this continued DES is that the practice holds and maintains a register of women aged 65 years and older, with fragility fractures sustained after 1 April 2008. It is the responsibility of the contractor to demonstrate that they have systems in place to maintain a high-quality register and PCTs will be expected to verify this, comparing reported prevalence with expected prevalence.

Details of the DES

Practices will be expected to compile an audit of:

- **Criterion 1**: the proportion of women aged between 65 and 74 years (inclusive) who have sustained a fragility fracture during the previous 12 months, who have been referred for a DEXA scan during the previous 12 months (excluding any women who have had a diagnosis of osteoporosis confirmed prior to 1 April 2011).
- **Criterion 2**: the proportion of women aged between 65 and 74 (inclusive) who have sustained a fragility fracture during the previous 12 months, with a positive diagnosis of osteoporosis confirmed by a DEXA scan, who are receiving treatment with a bone-sparing agent.
- **Criterion 3**: the proportion of women aged 75 and over who have sustained a fragility fracture during the previous 12 months who are receiving treatment with a bone-sparing agent.

The following sections are intended to clarify which codes are recommended, and the criteria, and timing, to be applied to audit searches.

Identifying and coding fragility fractures

For the purpose of the audit it is suggested that practices should run a search on their clinical database to capture all fractures in women aged 65 and over between 1 April 2011 and 31 March 2012. Women who have had a diagnosis of osteoporosis confirmed prior to 1 April 2011 should be excluded. The patients' records should then be reviewed to ascertain whether the fracture was a fragility fracture.

	Read v2	Read CTV3	Snomed CT
Fracture	S1...% S2...% S3...%	XA0FK%	125605004%

A fragility fracture is any clinically apparent fracture sustained as a result of low trauma or lesser force such as a fall from a standing height. It includes vertebral fractures but usually not fractures of the skull or bones of the hand or feet. The site of the fracture does not need to be captured for the purpose of the DES, though it would be good record keeping practice to do so. It is suggested that in addition to recording the type and site of any fracture, an additional code should be used to indicate that the fracture is a fragility fracture. The recommended codes are:

	Read v2	Read CTV3	Snomed CT
Fragility fracture	N331N	XaNSP	306171000000106

DEXA scanning

The audit for the first two criteria will also require that appropriate codes have been recorded to indicate that a DEXA scan has been referred and performed (criterion 1 requires a referral for a scan and criterion 2 requires that the scan has been performed), and whether or not this was positive. Recognising that it may take time to obtain a DEXA scan, the audit should be done at the end of the first quarter, i.e. 30 June 2012. The search should exclude DEXA scans performed prior to 1 April 2011. The suggested codes for DEXA scanning are:

	Read v2	Read CTV3	Snomed CT
Forearm DXA scan T score	58E2.	XaITK	391058006
Forearm DXA scan result osteoporotic	58E4.	XaITM	391060008
Heel DXA scan T score	58E8.	XaITP	391063005
Heel DXA scan result osteoporotic	58EA.	XaITR	391065003
Hip DXA scan T score	58EE.	XaITU	391068001
Hip DXA scan result osteoporotic	58EG.	XaITW	391070005
Lumbar spine DXA scan T score	58EK.	XaITZ	391073007
Lumbar DXA scan result osteoporotic	58EM.	XaITb	391075000

Femoral neck DEXA scan T score	58ES.	XaPDy	440050006
Femoral neck DEXA scan result osteoporotic	58EV.	XaPE2	440100002
DEXA scan T score	58EP.	XaP6z	440035002

Practices will probably wish to standardise their coding on the basis of the type of DEXA scan performed in their area and in order to simplify the final audit queries.

Treatment with bone-sparing agents

Finally, in compiling the audit queries for the last two criteria, practices will need to identify how many patients have been prescribed bone-sparing agents at 30 June 2012 for criterion 2 and at 31 March 2012 for criterion 3. The following codes will pick up drugs which are indicated and licensed for the treatment of osteoporosis:

	Read v2	Read CTV3	Snomed CT
Disodium etidronate	fo1..%	fo1..%	96284009%
Alendronic acid	fo4..%	fo4..%	421552005%
Risedronate sodium	fo6..%	fo6..%	126136003%
Ibandronic acid	fo8..%	fo8..%	404840001%
Raloxifene hydrochloride	fv1..%	fv1..%	419530003%
Teriparatide	fu3..%	fu3..%	398823001%
Strontium Ranelate	fu5..%	fu5..%	415633000%

Only the 'parent' term for the generic drug is shown. Actual preparations and branded products are 'children' of these codes.

Validation and payment

Using the codes and 'rules' outlined above practices will be expected to provide an audit report to the PCT. The audit should be completed at the end of the first quarter, i.e. 30 June 2012, in order to ensure inclusion of patients referred for DEXA scan on or before 31 March 2012. Practices taking part must supply the audit to the PCT by 31 July 2012.

In 2011/12 payment for each criterion will be triggered once the following proportions are reached:

Criterion	Proportions reached in 2011/12 (%)
1	Lower threshold 40 Upper threshold 60
2*	Lower threshold 70 Upper threshold 90
3	Lower threshold 70 Upper threshold 90

*of those women as identified in criterion 1

For each criterion:

- **Criterion 1**: A practice will receive £200.30 if the proportion of women identified is equal to, or more than, 60 per cent. A practice will receive £120.18 if the proportion is 40 per cent. Any achievement between 40 per cent and 60 per cent will be paid out on a sliding linear scale, for example if a practice were to achieve 55 per cent they would receive £180.27.
- **Criterion 2**: Of those women with a positive diagnosis of osteoporosis, a practice will receive £200.30 if the proportion of those women identified who are receiving treatment with a bone-sparing agent is equal to or more than 90 per cent. A practice will receive £120.18 if the proportion is 70 per cent. Any achievement between 70 per cent and 90 per cent will be paid out on a sliding linear scale in the same way as criterion 1.
- **Criterion 3**: A practice will receive £200.30 if the proportion of women identified is equal to or more than 90 per cent. A practice will receive £120.18 if the proportion is 70%. Any achievement between 70 per cent and 90 per cent will be paid out on a sliding linear scale in the same way as criterion 1.

The payment to each practice will be adjusted by the relative number of women aged 65 and over on the practice list, compared to the national average.

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