

# Clinical directed enhanced services (DES) guidance for GMS contract 2008/09

Delivering investment in general practice

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# Clinical directed enhanced services (DES) guidance for GMS contract 2008/09

## Introduction

NHS Employers and the General Practitioners Committee of the BMA, have agreed five new clinical directed enhanced services (DES) as part of the 2008/09 contract negotiations. These DESs focus on health and service priorities of the Department of Health (DH) that will benefit patients and are for:

- heart failure (beta blocker)
- alcohol
- learning disabilities
- osteoporosis
- ethnicity.

This document provides primary care trusts and practices with detailed information to help support the implementation of the new DESs. These DESs are applicable in England only.

## Directed Enhanced Services (DES)

All of the DESs start from April 2008 and will run for two years with the exception of heart failure, which is a one-year DES. Due to the delays in the negotiating process we have been unable to publish these until now.

The DH aims to publish directions and amendments to the Statement of Financial Entitlements (SFE) to underpin these DESs in October 2008. Until the publication of the DES directions and the amended SFE, we advise that PCTs and practices should not enter into a local enhanced service (LES).

All of the DESs reward achievement at the end of the financial year. Practices wishing to take up any of the DESs can begin working on the basis of the specifications and record what they have done on their clinical systems, to be used as part of the evidence of achievement at the end of the year.

The attached appendices provide the detailed specification for each DES:

Appendix 1 - DES specification for heart failure

Appendix 2 - DES specification for alcohol

Appendix 3 - DES specification for learning disabilities

Appendix 4 - DES specification for osteoporosis

Appendix 5 - DES specification for ethnicity

# Appendix 1

## Specification for a directed enhanced service in England: heart failure (beta-blocker)

### Introduction

1. Heart failure is an important cause of morbidity and mortality. Prevalence of heart failure increases steeply with age, so that while around 1% of men and women aged under 65 have heart failure, this increases to about 7% of those aged 75-84 years and 15% of those aged 85 and above. Based on these figures, it is estimated that as many as 570,000 people in England are affected. It is also estimated that of patients with a current diagnosis of heart failure, 50% will be due to left ventricular systolic dysfunction (LVSD) and will benefit from the appropriate prescribing of beta-blockers.
2. For further information:
  - Kitzman DW, Gardin JM, Gottdiener JS et al. *Importance of heart failure with preserved systolic function in patients > or = 65 years of age*. CHS Research Group. Cardiovascular Health Study. *Am J Cardiol*. 2001; 87:413-419.
  - Senni M, Tribouilloy CM, Rodeheffer RJ et al. *Congestive heart failure in the community: a study of all incident cases in Olmsted County, Minnesota, in 1991*. *Circulation*. 1998; 98:2282-2289.
  - Vasan RS, Larson MG, Benjamin EJ et al. *Congestive heart failure in subjects with normal versus reduced left ventricular ejection fraction: prevalence and mortality in a population-based cohort*. *J Am Coll Cardiol*. 1999; 33:1948-1955.
3. A pre-requisite for taking part in this DES is that the practice holds and maintains a register of patients with heart failure (HF), which is already rewarded through the Quality and Outcomes Framework (QOF). 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

4. Practices will be rewarded for the number of patients with a current diagnosis of HF due to LVSD who are not recorded as intolerant or having a contraindication to beta-blockers and who are treated with a beta-blocker.
5. This DES will be current for one year.
6. The total investment available for this DES is £10m per year.

### Validation and payment

7. Practices will be required to provide the PCT with an annual report of those patients treated under the terms of this DES. This needs to be completed at the end of the financial year.
8. Practices will receive £35 per patient treated under the terms of this DES.

# Appendix 2

## Specification for a directed enhanced service in England: alcohol

### Introduction

1. It is a government priority to address the issue of illness associated with increasing alcohol consumption. The DES is to reward practices for case finding in newly registered patients aged 16 and over. It also aims to deliver a simple brief intervention to help reduce alcohol-related risk in adults drinking at hazardous and harmful levels.
2. This two-year DES does not include a requirement to set up a register of hazardous or harmful drinkers.
3. The total investment available for this DES in England in 2008/09 and 2009/10, is £8m per year.

### Details of the DES

4. Practices will be 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.
5. If a patient is identified as positive, the remaining questions of the ten question AUDIT questionnaire are used to determine hazardous, harmful or likely dependant drinking.
6. Following identification, the practice should deliver a brief intervention to those identified as drinking at hazardous or harmful levels. Dependent drinkers should be referred to specialist services.
7. The recommended brief intervention is the basic five minutes of advice used in 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?*
8. Further information regarding the audit tools and brief intervention can be found at : <http://www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement>

### Validation and payment

9. Practices will be required to provide 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 hazardous, harmful or likely dependent drinking

- the number of hazardous or harmful drinkers who have received a brief intervention to help them reduce their alcohol-related risk
- the number of patients scoring 20+ on AUDIT who have been referred for specialist advice for dependent drinking.

10. Payment will be made at the end of the year (31 March each year) following receipt by the PCT of the audit.
11. Each year, practices will receive £2.33 for each newly registered patient aged 16 and over who have received screening using either FAST or AUDIT-C. It is expected that practices participating in this DES will respond to identified need and provide the intervention as required.

# Appendix 3

## Specification for a directed enhanced service in England: learning disabilities

### Introduction

1. 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.
2. The existing QOF registers do not differentiate LD by severity. There are estimated to be 240,000 people with moderate to severe LDs in England known to social services. The DES is designed to encourage practices to identify those patients with moderate to severe LD as defined by the same criteria used by the local authority (LA).
3. The pre-requisites for taking part in the DES are as follows:
  - practices will have liaised with the LA to share and collate information, in order to identify the people on their practice LD register with moderate to severe learning disabilities
  - a practice providing this service will be expected to have attended a multi-professional education session (refer to paragraphs 13 to 15 for further information). 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.
4. The total investment available for this two-year DES in England is £22m per year for 2008/09 and 2009/10.

### Details of the DES

5. Practices will be expected to provide an annual health check to patients on the local authority LD register. Practices are recommended to use the Cardiff health check protocol or a protocol as agreed locally with the PCT.
6. Further information on the Cardiff Protocol is available at:  
[http://www.rcgp.org.uk/PDF/clinical\\_Welsh\\_Health\\_Check\\_newA.pdf](http://www.rcgp.org.uk/PDF/clinical_Welsh_Health_Check_newA.pdf)
7. 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:
    - health promotion
    - chronic illness and systems enquiry
    - physical examination
    - epilepsy
    - 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.
8. Health checks should integrate with the patients' 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.

## Payment and validation

9. Payment will be based on a report to the PCT at the end of each year (31 March) on the number of patients on the health check LD register who have received the health check.
10. Once a practice has agreed the health check LD register with their PCT, it will receive a £50 aspiration payment for each patient on the register.
11. The reward for each health check will be £100.
12. 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.

## Multi-professional education session – training for primary healthcare staff

13. Further information regarding training for primary healthcare staff, together with good practice examples, is available on the Valuing People website at: <http://valuingpeople.gov.uk/dynamic/valuingpeople144.jsp>
14. A framework for the content that the training should include is:
- 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
  - 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
    - values and 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 professional and services
  - experiences and expectations
  - consent
  - Disability Discrimination Act and the Disability Equality Duty
  - resources – local contacts, networks, practitioners with special interest and information.
15. 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 (as paid co-trainers). Each PCT should use their internal procedures to approve the content of the training for their locality using the framework provided as guidance.



# Appendix 4

## Specification for a directed enhanced service in England: osteoporosis

### Introduction

1. 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.
2. The total investment available for this DES in England in 2008/09 and 2009/10 is £5m per year.

### Aim of DES

3. The aim of the DES is to encourage practices to confirm the diagnosis and prescribe appropriate pharmacological secondary prevention in patients with osteoporosis.

### Register

4. A pre-requisite for taking part in this two-year 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
5. 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

6. Practices will be expected to compile an audit of:
  - Criterion 1: the proportion of women aged between 65 and 74 years with a history of fragility fracture in the previous 12 months who have had a diagnosis of osteoporosis confirmed by a DEXA scan
  - Criterion 2: the proportion of women aged between 65 and 74 with a positive diagnosis of osteoporosis confirmed by a DEXA scan (i.e. criterion 1) who are receiving treatment with a bone-sparing agent
  - Criterion 3: the proportion of women aged 75 and over with a history of fragility fracture in the previous 12 months who are receiving treatment with a bone-sparing agent.

### Validation and payment

7. Practices will be expected to provide the audit report to the PCT. Timing of the audit to be adjusted to accommodate local waiting period for DEXA scanning but should be completed by the end of the first quarter in order to ensure inclusion of patients referred before 31 March.

8. For each criterion, payment will be triggered once the following proportions are reached in the first and second year respectively:

Criterion	Proportions reached in year 1 (%)	Proportions reached in year 2 (%)
1	Lower threshold 20 Upper threshold 50	Lower threshold 40 Upper threshold 60
2*	Lower threshold 70 Upper threshold 90	Lower threshold 70 Upper threshold 90
3	Lower threshold 70 Upper threshold 90	Lower threshold 70 Upper threshold 90

\*of those women as identified in criterion 1

9. For each criterion:

- Criterion 1: in year one an average practice will receive £196.07 if the proportion of women identified is equal to or more than 50%. An average practice will receive £117.64 if the proportion is 20%. Any achievement between 20% and 50% will be paid out on a sliding linear scale e.g. if an average practice were to achieve 35% they will receive £156.86.

In year two an average practice will receive £196.07 if the proportion of women identified is equal to or more than 60%. An average practice will receive £117.64 if the proportion is 40%. Any achievement between 40% and 60% will be paid out on a sliding linear scale e.g. if an average practice were to achieve 55% they will receive £176.46.

- Criterion 2: of those women identified through criterion 1 - an average practice will receive £196.07 if the proportion of those women identified who are receiving treatment with a bone-sparing agent is equal to or more than 90%. An average practice will receive £117.64 if the proportion is 70%. Any achievement between 70% and 90% will be paid out on a sliding linear scale in the same way as criterion 1.
- Criterion 3: an average practice will receive £196.07 if the proportion of women identified is equal to or more than 90%. An average practice will receive £117.64 if the proportion is 70%. Any achievement between 70% and 90% will be paid out on a sliding linear scale in the same way as criterion 1.

10. The audit report and subsequent payment will be based on work undertaken within the previous 12 months<sup>1</sup>.

<sup>1</sup> For the purposes of this DES, an "average practice" is defined by the number of women aged 65 and over. The amounts above will need to be multiplied by  $y/x$  where  $y$  = the number of women aged 65 and over on the practice list and  $x$  = the average number of women aged 65 and over per practice in England.  $x$  will be taken from the latest available GMS census. For 2008/09  $x$  = 560, based on the census taken at 30 September 2007.  $y$  will be the number of women aged 65 and over on the individual practice list on the first day in the quarter in which payments are due, as measured through the Exeter payments system. For payments due on 31 March 2009,  $y$  will be measured on 1 January 2009. Therefore, a practice with 200 patients who are women aged 65 and over would receive £70.02 if it achieved the upper threshold for criterion 1 in year one ( $200/560 * 196.07$ ).

# Appendix 5

## Specification for a directed enhanced service in England: ethnicity

### Introduction

1. It is a government priority to implement the outcomes of the recent Black Minority Ethnic (BME) Access Review. The aim of this DES is to enable practices and PCTs to assess the needs of their population and to address inequalities in access and health outcomes for BME patients.
2. This two-year DES supports the drive to deliver these priorities to patients.
3. The total investment available for this DES in England in 2008/09 and 2009/10 is £3m per year.

### Details of the DES

4. Practices will be expected to record the ethnicity and first language of all patients on their list. This will include children and babies where ethnicity and first language will be as defined by the parent or guardian.
5. Contractors will be required to report aggregated data to the PCT on an annual basis.
6. The NHS Data Dictionary codes are to be used for recording ethnic origin and first language (the codes for first language in the NHS Data Dictionary are the same as the 'Count Me In' census codes).
7. The NHS Data Dictionary codes can be found at :

Ethnic origin:

[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/e/enh/ethnic\\_category\\_code\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1)

First language:

[www.datadictionary.nhs.uk/data\\_dictionary/attributes/l/language\\_classification\\_code\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/l/language_classification_code_de.asp?shownav=1)

### Validation and payment

8. Payment will be based on practice list size as at 1 April.
9. Payment will be made after the PCT receives the practice's annual report of patient ethnicity and first language. Payment will only be triggered once the practice has recorded this information for 50% of its patients in the first year and 90% in the second year (as measured on 31 March each year).
10. Practices will receive 5.6 pence per registered patient per year for this DES.

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