



SCOTTISH ENHANCED SERVICES PROGRAMME FOR PRIMARY AND COMMUNITY CARE

Directed Enhanced Service (DES) – Assessment of Patients with moderate/severe COPD with regard to their suitability for participation in a community COPD rehabilitation Programme, onward referral, and subsequent follow up.

Service Level Agreement

PRACTICE

Contents:

1. Introduction & Context
2. Finance Details
3. Signature Sheet
4. Service Aims
5. Criteria
6. Accreditation
7. Dispute Resolution
8. Variation and Termination of Contract

1. Introduction & Context

Introduction

COPD is the fourth commonest cause of death after Cancer, CHD, and Stroke.

The first UK national audit of acute COPD care, demonstrated that 31% of patients admitted (and then discharged) due to an acute exacerbation of COPD, are readmitted within 90 days.

Whilst much of the disability and functional impairment of such patients cannot be cured by medical interventions, it can be greatly improved through rehabilitation ie although there is no cure, patients can still lead a healthy life by learning how to cope with COPD through training and education including-

- Following a diet suitable for COPD.
- Effective breathing and coughing techniques.
- Exercising chest muscles and diaphragm
- Planning the management of tasks.

- Monitoring air Quality.

PULMONARY REHABILITATION

Pulmonary rehabilitation can be defined as a multidisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise each patient's physical and social performance and autonomy. It is widely used for patients with COPD

Pulmonary rehabilitation is an increasingly popular and effective option for patients with moderate to severe COPD. Rehabilitation aims to prevent deconditioning and allow the patient to cope with their disease. Most programmes are hospital based and comprise individualised exercise programmes and educational talks.

Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above). Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

The benefits of Pulmonary rehabilitation fade with time and with deterioration of the underlying illness. This can be ameliorated with good follow up and support.

South East Highland Community Health Partnership is developing a Pulmonary Rehabilitation Service to cater for each of the localities within the CHP.

The Key areas of action for the COPD Rehabilitation team will include-

- Take comprehensive patient histories, perform a systematic clinical examination, review care provision, establish baseline data to inform a patient held care plan
- Identification of Carers
- Analyse signs and symptoms, laboratory tests and other measures of function in formulating diagnosis; collaborating with appropriate colleagues to plan and implement treatment for acute illness/ injury/ chronic illness as required, using skills in nurse prescribing and medicines management
- Promote self care skills and recognition of deterioration through the provision of health information and education.
- Visit patients prior to discharge from hospital in order to assess the risk of re-admission within the subsequent 12 months.
- Co-ordinate and integrate care across health and social care, preventing duplication, fragmentation and delay as patients move between care settings
- Review care/ treatment plans and monitor indicators, anticipating and managing possible decline
- To review and develop competencies as required to support clinical practice

- Implement training strategies to “roll out” skills and competencies around COPD.

This service will provide physical training and education in self-care, and facilitate access to dietetic and other advice, in a programme lasting 8 weeks.

Patients will be eligible for this if they have an MRC dyspnoea score of 3 or above, or if post bronchodilator FEV1 is 50% or less than predicted for age and build.

This Enhanced Service is designed to fund Practices for –

1. **Reviewing patients with moderate/severe COPD to establish whether or not they fit the criteria, which would indicate that they would benefit from a Pulmonary Rehabilitation Programme.**
2. **Referral onto the Programme in the locality of choice.**
3. **Further review 4 months after completion of the Programme, to assess benefits, and decide whether the patient would benefit from a further Programme.**

2. 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.

Each practice contracted to provide this service will receive the following funding package.

2006/07 QOF data showed that there were 1,174 patients on the Registers of South East Highland CHP Practices (1.34% of population), which is considerably lower than the most recently estimated national prevalence of 7% of the population.

For the purposes of costing this service it has been estimated that 25% of the patients currently on Registers would be suitable for onward referral.

The payment per participating GP Practice will be a retainer payment of £1,500 per annum plus £80 per qualifying patient. (Retainer to support the cost of suitable Spirometers, including Domiciliary/Hand held and, Pulse Oximeters)

However, the CHP is mandated to ensure that total expenditure on this Enhanced Service does not exceed the allocated budget. Therefore, each Practice will have a ceiling set on the total number of patients who can be claimed for under this SLA. The ceiling for each Practice is based on 25% of the number of COPD patients on their QOF Register.

Your Practice ceiling is –

Number of Patients with COPD on QOF Register	Number x 25%

Payment Verification

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

It is anticipated that Practice computer systems will be utilised to enable this condition to be met, and that an ESCRO screen will be provided to facilitate data entry. Practices must be able and willing to evidence service delivery if required/requested by the CHP.

Annual Review of Contract

This contract will be reviewed annually, and will be in line with the annual review of the GMS Contract set out in the NHS (General Medical Services Contracts)(Scotland) Regulations, or other legislation as appropriate. Practices will be expected to return to the CHP their end of year evaluation/results, in order to confirm compliance with the contract.

PAYMENT WILL ONLY BE MADE UPON RECEIPT OF THIS SIGNED CONTRACT, INCLUDING DETAILS OF PRACTICE PLANS AS INDICATED

3. Signature Sheet

This document constitutes the agreement between the practice and the CHP in regards to this directed enhanced service.

PRACTICE.....

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the CHP:

Signature	Name	Date

4. Service Aims

It is not intended to duplicate any of the services provided already through General Medical Services or the Quality and Outcomes Framework, but to provide additional services to those patients who require or have had Pulmonary rehabilitation for COPD.

The aim of the pulmonary rehabilitation programme is to:

- Provide a tailored exercise programme
- Provide education about the disease and its management
- Provide psychological support

BTS/NICE guidelines issued in 2004 made the following evidence statements;

1. Pulmonary rehabilitation leads to statistically significant and clinically meaningful improvements in health related quality of life, functional exercise capacity and maximum exercise capacity.
2. Pulmonary rehabilitation reduces dyspnoea (breathlessness)
3. Several non randomised and observational studies show that there is a trend towards a decrease in the total number of hospitalisation days as well as total number of hospitalisations required for a patient with COPD in the years following completion of pulmonary rehabilitation programmes.

Patient Selection

Criteria for patient selection and referral to the service are, as per BTS guidelines:

1. MRC dyspnoea score of 3 or above, and,
2. Post bronchodilator FEV1 or 50% or less than predicted for age and build

Rehabilitation Programme - Class format

1. The class format is an initial patient assessment appointment, followed by,
2. An 8-week rolling programme of 1 x 2 hour class, on completion of the 8 weeks patients will be re-assessed to evaluate the outcome.
3. Maximum number of participants per class is 6.

Exercise Class - Prescribed exercise to educate patient to work within their own tolerance levels using the BORG scale

Education Programme - Informal talk from members of MDT including Clinical Psychologist, Pharmacist and Dietician.

Pre and post patient assessment

1. The Chronic Respiratory Questionnaire - Self Reported (CRQ-SR)
A questionnaire which measures quality of life in patients with COPD by assessing four dimensions- dyspnoea, fatigue, emotional function and mastery.
2. A six minute walk test
Patients are asked to walk between two cones that are placed 10m apart. The total distance the patient covers within six minutes is measured.
3. The Hospital Anxiety and Depression Scale (HADS)
A 14-item questionnaire consisting of 2 subscales- anxiety and depression.

Service provision across South East Highland CHP

Anticipated numbers of patients fulfilling the selection criteria indicate a rolling programme of classes based at Nairn Town and County, Ian Charles and St. Vincents Hospital, excluding the months of December and January.

5. Criteria

The patient must have COPD, and be present on the practice register of patients with COPD.

The patient must have undergone an assessment to ascertain that they are a suitable candidate for the Pulmonary Rehabilitation Programme,

Patients who are unable to walk, who are unable to leave the house, or have unstable angina are unsuitable for NHS Highland COPD rehabilitation programme, and are therefore excluded from this enhanced service. Exceptions to this might be made for otherwise mobile wheelchair bound patients by prior agreement with the Programme.

The patients for inclusion should have a MRC dyspnoea score of 3 or above (but patients with a score of 5 are unlikely to be fit enough for inclusion) OR have a FEV1 of less than 50% of that predicted for a person of their age, sex and build OR have been referred to the service via admission to hospital.

Follow up

Follow up of all patients with COPD should include (as part of GMS/QOF):

- highlighting the diagnosis of COPD in the case record and recording this using Read codes on a computer database

- recording the values of spirometric tests performed at diagnosis (both absolute and percent predicted)
- offering smoking cessation advice
- recording the opportunistic measurement of spirometric parameters (a loss of 500 ml or more over five years will select out those patients
- with rapidly progressing disease who may need specialist referral
- and investigation).

For most patients with stable severe disease regular hospital review is not necessary, but there should be locally agreed mechanisms to allow rapid access to hospital assessment when necessary.

Patients with severe disease requiring interventions such as long term non-invasive ventilation should be reviewed regularly by specialists.

Summary of follow up required for patients who have had Pulmonary rehabilitation for COPD (Enhanced Service)

Frequency

at least twice per year

Clinical assessment

The areas below can be considered as part of the assessment . All investigations that form part of this assessment list need only be carried out where they are felt to be clinically appropriate.

- smoking status & desire to quit - **(QOF)**
- adequacy of symptom control:
 - breathlessness
 - exercise tolerance
 - estimated exacerbation
- frequency
- presence of complications -
- presence of cor pulmonale
- Need for long-term oxygen therapy
- effects of each drug treatment (review of medication is part of QOF)
- inhaler technique **(GMS, QOF)**
- patient's nutritional state
- presence of depression
- need for Social Services & Occupational Therapy input (GMS)
- need for pulmonary rehabilitation (GMS)
- need for referral to specialist and therapy services(GMS)

Measurements

- FEV1 (& FVC where clinically indicated)
- calculate BMI
- MRC dyspnoea score
- SaO2 (measured with pulse oximeter)

References:

Chronic Obstructive Pulmonary Disease: National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care{ *Thorax* 2004;59(Suppl I):1-232 doi: 10.1136/thx.2004.022707)

Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2007. Available from: <http://www.goldcopd.org>

American College of Chest Physicians/American Association of Cardiovascular and Pulmonary Rehabilitation (ACCP/AACVPR). Pulmonary rehabilitation: joint ACCP/AACVPR evidence-based clinical practice guidelines. *Chest* 2007 May;131(5 Suppl):4S-42S.

Payment per patient will require evidence of recording FEV1, BMI, SaO2, MRC dyspnoea score, depression screening, frequency of exacerbations twice yearly.

6. Accreditation

Those doctors who had previously provided services similar to this 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.

7. Dispute Resolution

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

8. Variation and Termination of Contract

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

