



Dear Colleague

## GP CONTRACT AGREEMENT FOR 2008/09

### Introduction

1. This circular summarises the changes to the GMS contract for 2008/09, attaches specifications and guidance for four new Directed Enhanced Services; provides notification of a future enhanced payment rate in the existing DES for nursing provision for extended hours access; and provides details of a Closer Working allocation to Health Boards.

### Doctors and Dentists Review Body recommendation and investment guarantee package

2. The Doctors and Dentists Review Body (DDRB) recommended a 2.7 per cent increase for GP practices on global sum in 2008/09 but for those on the Minimum Practice Income Guarantee (MPIG) a corresponding fall in Correction Factor.

3. These changes took effect from 1 October 2008 and a new SFE has been issued [PCA(M)(2008)9] [http://www.sehd.scot.nhs.uk/pca/PCA2008\(M\)09.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)09.pdf) The equivalent value for non-GMS practices has been allocated to Boards on a pro-rata basis through NHS Board funds.

### Content of the investment guarantee package

4. As part of the agreement between NHS Employers and the General Practitioners Committee of the BMA, UK Health Departments agreed to make up the value of the DDRB award to 1.5 per cent of the contract envelope. This means an investment guarantee of £9.3m in Scotland. The guarantee is for 2008/09 only.

5. The Scottish Government has consulted the Scottish General Practitioners Committee on the content of

26 November 2008

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### **Addresses**

#### **For Action**

Chief Executives NHS Boards

Director of Practitioner Services  
Division, NHS National Services  
Scotland

PC Leads

#### **For Information**

GP Practices

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### **Enquiries to:**

David Notman  
St Andrew's House  
EDINBURGH  
EH1 3DG

Tel: 0131-244 5080  
Fax: 0131-244 2621

[david.notman@scotland.gsi.gov.uk](mailto:david.notman@scotland.gsi.gov.uk)

- New Directed Enhanced Services for (i) palliative care (ii) osteoporosis (iii) ethnicity monitoring and (iv) management information;
- An enhanced payment rate for the Directed Enhanced Service for nursing provision for extended hours access;
- An allocation to Health Boards to encourage closer working with GP practices towards common purposes.

6. The table in the attached Annex A sets out the estimated costings for 2008/09 alongside the full year cost for each of the recurring items.

#### New Directed Enhanced Services from 1 November 2008

7. The specifications and guidance for each of the new Directed Enhanced Services are attached at Annex B. We anticipate that palliative care, osteoporosis and ethnicity monitoring will run through to 2009/10, with palliative care and osteoporosis to be reviewed at the end of 2009/10 and ethnicity monitoring to finish at the end of 2010/11.

#### *Palliative care*

8. Because of the late starting of the DES we have afforded a discretionary period of up to 8 weeks for patients registered on the palliative care register between 1<sup>st</sup> November and 30<sup>th</sup> November, 6 weeks for patients registered between 1<sup>st</sup> December and 31<sup>st</sup> December 2008; and 4 weeks for patients registered between 1<sup>st</sup> January and 31 January 2009.

#### *Management information*

9. The DES will be available until 31 March 2009 in the first instance. The exercise is divided into parts A and B, part A being a basic requirement that GP practices participate in the National Primary Care Workforce Planning Survey.

10. Part B of the DES would require practices to provide a range of additional management data, including information about appointments. The DES indicates that the supplementary information element is optional and sets out payment levels for participation in both parts A and B or part A only.

#### Enhanced service for nursing provision for extended hours access

11. The Directed Enhanced Service for nursing provision for extended hours access was released to the service on 25 June 2008 [[PCA\(M\)\(2008\)7](#)]. Uptake of the service has been low and we have been discussing with SGPC and Boards how best to increase participation in the current and future years. The general consensus is that nurses who participate might expect to receive payment at time and a half and we are therefore increasing the DES payment rate to £0.74 per registered patient per year (or pro rata under concurrency arrangements). Where a practice is unable to provide full nursing cover during their extended practice opening, Health Boards will now have discretion to agree partial nursing cover with payments reduced pro rata as for the concurrency arrangements. This rate change is effective from the 1 December 2008.

## Health Board allocation to encourage closer working with GP practices

12. We are providing an allocation to Health Boards to encourage closer working with GP practices towards common purposes. The aim is to focus Boards, CHPs and general practice in developing local solutions to meeting HEAT and the 18 week referral to treatment targets while driving forward the 'Shifting the Balance of Care' agenda.

13. The allocation will be initially for 2008/09 and will be £3.75m as set out in Annex A. Each NHS Board will receive an allocation weighted with 50 per cent of the funding distributed using the Scottish Allocation Formula (SAF); 25 per cent distributed according to the percentage of population that are 65 years and over (older people) and 25 per cent using the Scottish Index of Multiple Deprivation (SIMD).

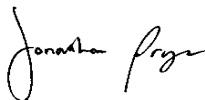
## Changes to the QOF

14. Changes to the QOF for 2008/09 are set out on the NHS Employers website at <http://www.nhsemployers.org/pay-conditions/primary-890.cfm>. A new SFE which will reflect further changes to the QOF effective from 1 November 2008 will be issued in the near future.

## **Action**

15. NHS Boards and CHPs are requested to bring this Circular and the attached specifications to the attention of GP practices in their area and their Local Medical Committee.

Yours sincerely \_



DR JONATHAN PRYCE  
Deputy Director, Primary Care Division

**ANNEX A GMS CONTRACT - INVESTMENT GUARANTEE PACKAGE – ESTIMATED FUNDING BREAKDOWN FOR 2008/09 AND 2009/10 LIKELY SPEND**

	2008/09 Investment guarantee (£m)	Full year spend (£m)
1.5%	9.7	
DDRB 2008-09	0.42	
Net investment guarantee	9.3	
Recurring:		
Nursing	2.42	3.90
Palliative Care	1.25	3.00
Osteoporosis	0.55	0.45
Ethnicity	0.46	0.46
Sub-Total	4.68	7.81
Non-recurring:		
Management Information	0.87	0
Better Working	3.75	
Total	9.3	

# **ANNEX B GMS Contract 2008/09 - Directed Enhanced Services and Better Working Programme**

## **Specifications and Guidance**

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# **Palliative Care (Scotland)**

## **Directed Enhanced Service Specification**

### **Purpose**

This specification summarises the arrangement for the Palliative Care Directed Enhanced Service in Scotland.

### **Rationale**

Palliative and end of life care are integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition. Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards.

The Scottish Government published [Living Well and Dying Well](#), a national action plan for palliative and end of life care in Scotland on 2 October 2008.

In keeping with this action plan, this DES supports practices in taking a systematic approach to palliative and end of life care, to ensure that they identify appropriate patients for the palliative care register, that these patients have care plans and that a summary of their needs is available in the out of hours period. This all to be done alongside the wider multidisciplinary team both within and out with the practice.

### **Eligibility**

Participating practices must achieve the QOF Palliative Care clinical indicators, PC2 and PC3, and QOF indicator Records 13.

### **Requirements**

Participating practices will:

1. Ensure that they include patients identified with palliative and end of life care needs irrespective of diagnosis on their QOF palliative care register.
2. Ensure that patients on the QOF palliative care register have been assessed and a care plan compiled within 2 weeks of inclusion on the register.
3. Ensure that, for each patient on the QOF palliative care register, an up to date palliative care summary is made available to professionals involved in their care in the out of hours period within 2 weeks of inclusion in the register.
4. Ensure that practices assess when patients on the palliative care register reach the last days of their life and use a recognised integrated care pathway (e.g. Liverpool Care Pathway).

## Reporting arrangements

Practices will provide a report to their local NHS Board each year on the above criteria.

This will take the form of a template including as a minimum the patient identifier and the parameters described in the requirements section above.

A description of how the practice ensures the summary and care plan are kept up to date and their approach to end of life care should also be included. Practices may wish to combine this with the report for QOF indicator PC 2.

Guidance has been issued to assist practices and a standard reporting template has been made available.

## Funding and payment arrangements

GP practices will be paid a sliding-scale fee for completion of both items (2) and (3) as follows:

Coverage at year end (%)	Fee (per patient)
0 – 49	£0
50 – 84	£50 - £84
85 & above	£85

GP practices should note that sliding scale payments will increase by £1 per patient for every one percentage point increase in coverage rates over 50% up to a maximum of £85.

GP practices will also receive an additional payment of £15 per patient for completion of item 4 where appropriate.

### Arrangements for Practice Achievement

For 2008/9, practice achievement will be measured for those patients placed on the palliative care register from 1 November 2008 until 16 March 2009.

For 2009/10, practice achievement will be measured for those patients placed on the palliative care register from 17 March 2009 until 16 March 2010.

Because of the late starting of this DES:

For patients placed on the palliative care register between 1<sup>st</sup> November and 30<sup>th</sup> November 2008, practices will have up to 8 weeks to complete requirements (2) and (3).

For patients placed on the palliative care register between 1<sup>st</sup> December and 31<sup>st</sup> December 2008, practices will have up to 6 weeks to complete requirements (2) and (3).

For patients placed on the palliative care register between 1<sup>st</sup> January and 31<sup>st</sup> January 2009, practices will have up to 4 weeks to complete requirements (2) and (3).

From 1<sup>st</sup> February 2009, the requirement will revert to the 2 weeks default setting. This has been built into the reporting template.

#### Maximum Payments

GP practices total remuneration will be capped at £555 per 1,000 registered patients.

#### Duration

This DES will be funded from 1 November 2008 and will be reviewed from 1<sup>st</sup> April 2010.

## Palliative Care Directed Enhanced Service - Guidance

### Rationale

1. The World Health Organization (WHO) defined palliative care in 2004 as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Planning for care at the end of life should be responsive to patient choice regarding place of care and place of death.
2. Palliative and end of life care are integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition. Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards. A palliative care approach should be used as appropriate alongside active disease management from an early stage in the disease process. Palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.
3. The Scottish Government published [\*Living Well and Dying Well, a national action plan for palliative and end of life care in Scotland\*](#) in October 2008, following their commitment in the *Better Health, Better Care Action Plan 2007*, and in line with the recommendations of *Palliative and end of life care in Scotland: the case for a cohesive approach*, the 2007 report from the Scottish Partnership for Palliative Care.
4. In keeping with this action plan, this DES supports practices in taking a systematic approach to palliative and end of life care, to ensure that they identify appropriate patients for the palliative care register, that these patients have care plans and that a summary of their needs is available in the out of hours period. This all to be done alongside work with the wider multidisciplinary team both within and out with the practice.
5. Although patients with cancer are typically thought of as needing palliative care, the main causes of death in the UK - organ failure, cancer, dementia and / or, frailty - are fairly evenly distributed and all of these patients can benefit from effective palliative and end of life care. The valuable knowledge and experience gained from care of patients with cancer can now be adapted and shared and people living with and dying from a range of other conditions can benefit from a palliative approach to their care.
6. However, the pattern of progression of advanced respiratory, cardiac or other organ failure will differ from that of cancer. End stage cancer is likely to be characterised by a gradual and steady deterioration while end stage respiratory disease may be characterised by acute exacerbations and

remissions. End stage cardiac disease may be similar but the risk of sudden death is greater. Understanding the differences between these trajectories can help in planning care more appropriately to meet patients' and carers' needs.

7. A palliative care approach and the subsequent stepping up and stepping down to appropriate types and levels of care should be triggered at the initial diagnosis of a life-limiting condition, as well as at times of critical events and changes in disease progression. This will include:
  - holistic assessment, with the patient and carer, of their physical, social, emotional, cultural, religious and spiritual care needs and other relevant life circumstances
  - planning, coordination and delivery of appropriate care based on the needs identified
  - appropriate sharing and communication across all care settings of the needs, and plans identified and actions taken
  - regular review and repetition of the assessment and planning cycle.

## Outline of the DES

**This guidance is intended to support practices in meeting the requirements of this DES. Sections in the specification are highlighted in the boxed sections below followed by guidance notes.**

## Eligibility

**Participating practices must achieve the QOF Palliative Care indicators, PC2 and PC3, and QOF indicator Records 13**

8. Practices should refer to the Guidance on these QOF indicators which are reproduced, in part, for convenience in Annex A and which are available electronically at :

<http://www.paymodernisation.scot.nhs.uk/gms/quality/index.htm>.

9. Please note that practices with a null register at year end will be eligible for payment under PC3 if they are able to demonstrate that they had a register during the year.

## Requirements

Participating practices are required to:

**1. Ensure that they include patients identified with palliative and end of life care needs irrespective of diagnosis on their QOF palliative care register.**

10. The palliative care register should include patients with all life limiting conditions who are identified as having palliative care and end of life needs,

not just cancer. The QOF guidance for PC3 gives guidance on how to decide whether a patient should be on the palliative care register (see Annex A). The Gold Standards Prognostic Indicator Guide, a valuable aid to identifying patients with palliative and end of life needs, is reproduced in Annex B for convenience.

**2. Ensure that patients on the QOF palliative care register have been assessed and a care plan compiled within 2 weeks of inclusion on the register**

11. Anticipatory care planning is at the core of good palliative care. Tools such as the Gold Standards Framework (GSF) provide a valuable mechanism in primary and community care for effective patient centred planning during the last 12 months of life. The Framework relies on effective communication, co-ordination and continuity and emphasises in particular the following aspects of care:
- identification, assessment and planning
  - individual case discussions and case management by a multidisciplinary team
  - carer assessment and support.
12. Pro-active care planning and management and early management of symptoms can enhance quality of life for patients and carers and help to prevent crises and unscheduled hospital admissions. This should include the use of anticipatory prescribing, particularly for conditions such as advanced heart failure and COPD where sudden exacerbations are likely, and for end of life medication. Steps should be taken to ensure that patients living in care homes also have access to the benefits of this approach.

Further information on the Gold Standards Framework is available at <http://www.goldstandardsframework.nhs.uk/>

13. The precise way in which a care plan is recorded is for the practice and clinician to decide. A form has been developed for the forthcoming electronic Palliative Care Summary (attached at Annex C) and could be used as a guide for practices.

**3. Ensure that, for each patient on the QOF palliative care register, an up to date palliative care summary is made available to professionals involved in their care in the out of hours period within 2 weeks of inclusion on the register.**

14. It is essential for high quality, coordinated care that health professionals working in the out of hours period have information pertinent to the care of patients with palliative and end of life care needs, with the patient's consent.
15. Currently information is transferred to Out of hours (OOH) services through each Board's "special notes" arrangement. As this varies between Boards, practices should seek clarification of their local system from their OOH

Primary Care Services, if not already known to the Practice. The Board OOH service will ensure that the special note is then automatically and securely, uploaded to NHS 24.

16. A national electronic Palliative Care Summary (ePCS) is being developed for Scotland and is currently being piloted in NHS Grampian with both INPS and EMIS practices involved. The national rollout of ePCS is planned to start in April 2009, and will be led within Health Boards by the appropriate clinical and technical leads.
17. This means that gradually practices will be able to use the ePCS system to fulfil requirement 3 of this DES but that initially the special notes scheme will be used.
18. The form developed for ePCS or any suitable alternative, can be used by practices as a special note for the purposes of this DES.
19. Boards that have electronic systems for the submission of palliative care special notes may wish to adjust any templates to fit with ePCS developments and the requirements of this DES.

<b>4. Ensure that practices assess when patients on the palliative care register reach the last days of their life and use a recognised integrated care pathway (eg Liverpool Care Pathway).</b>
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20. During the last days of life, care is necessarily more intensive so implementation of an integrated care pathway such as the Liverpool Care Pathway for the Dying Patient (LCP) can facilitate effective planning and provision of care during this dying process. [Living and Dying Well](#) makes a recommendation that the LCP should be implemented across all care settings with the support of education and training from NES and NHS Boards.
21. The aim of the LCP is to improve the care of the dying in the last hours/days of life. The LCP guidance suggests that a patient is likely to have reached the end of their life if,
  - a) all possible reversible causes for the current condition of the patient have been considered and,
  - b) the multi professional team has agreed that the patient is dying and
  - c) some or all of the following apply to the patient
    - they are bedbound
    - they are semi- comatose
    - they are only able to take sips of fluid
    - they are no longer able to take tablets
22. Key Sections of the LCP are
  - Initial Assessment
  - Ongoing Assessment
  - Care after death

23. The LCP provides guidance on aspects of care including:

- Symptom Control
- Comfort measures
- Anticipatory prescribing of medication
- Discontinuation of inappropriate interventions
- Psychological and spiritual care
- Care of the family (both before and after the death of the patient)

More information about the Liverpool Care Pathway is available through the link below:

[http://www.mcpcil.org.uk/liverpool\\_care\\_pathway](http://www.mcpcil.org.uk/liverpool_care_pathway)

### Reporting arrangements

**Practices will provide a report to their local NHS Board each year on the above criteria.**

**This will take the form of a template including as a minimum the patient identifier and the parameters described in the requirements section above.**

24. Practices need to collect information on patients they put onto their palliative care register from 1 November 2008, and whether they have compiled a care plan and sent a summary to OOH services within the required time period, in order to support their claim for payment at year end. They also need to report the number of patients on the register who have had an end of life plan as in criterion 4.
25. As the palliative care register, by its very nature, changes throughout the year, an electronic search is not feasible. A reporting template, using Excel, has been devised to enable practices to keep a record for the purposes of this DES. A few additional optional items (e.g. diagnosis) have been included to enhance the practical usefulness of the template for wider practice use- for instance a print out could be used as a check list for multi-disciplinary meetings.
26. This template is attached at Annex D. The template allows practices to calculate their achievement for payment purposes and thus to complete the declaration to Boards at year end. Guidance on its use is included in the template.
27. Please note that the sliding scale for payment per person for criteria 2 and 3 requires achievement of **both** items.

**A description of how the practice ensures the summary and care plan are kept up to date and their approach to end of life care should also be included. Practices may wish to combine this with the report for QOF indicator PC 2.**

28. This will take the form of a simple report. The reporting template at Annex D allows for recording of date of most recent update of the care plan. Guidance on the report for QOF indicator PC2 is at Annex A.

### **Payment arrangements**

29. Practices must provide a report to Boards at year end containing:
- a. Number of patients on palliative care register during the reporting period
  - b. Number of these for whom criteria 2 and 3 have been fulfilled and as % of a.
  - c. Number of patients for whom criterion 4 has been fulfilled.
30. The form to be used for this purpose is included as part of the template at Annex D.

### **References**

**Living and Dying Well- a national action plan for palliative and end of life care in Scotland**, The Scottish Government, Edinburgh 2008  
Available at  
<http://www.scotland.gov.uk/Publications/2008/10/01091608/0>

**Illness trajectories and palliative care.** Murray, S; Kendall, M; Boyd, K; Sheikh, A. [BMJ 2005;330;1007-1011. doi:10.1136/bmj.330.7498.1007-1011](http://www.bmj.com/lookup/doi/10.1136/bmj.330.7498.1007-1011)

**Gold Standards Framework:** <http://www.goldstandardsframework.nhs.uk/>

## Annex A Quality and Outcomes Framework Indicators

### **Palliative care (PC) indicator 3**

The practice has a complete register of all patients in need of palliative care/support, irrespective of age.

#### **Palliative care 3.1 Rationale**

Criteria for inclusion on the register are consistent with prognostic criteria for advanced disease described in the GSF and with the use of the DS 1500.

A patient should be included if:

1. their death in the next 12 months can be reasonably predicted and/or
2. they have clinical indicators of need for palliative care that are prognostic clinical indicators of advanced or irreversible disease and include 1 core and 1 disease specific indicator in accordance with the GSF. [www.goldstandardsframework.nhs.uk/gp\\_contract.php](http://www.goldstandardsframework.nhs.uk/gp_contract.php) and/or
3. they are the subject of a DS 1500 form. (The DS 1500 form is designed to speed up the payment of the Disability Living Allowance, Attendance Allowance or Incapacity Benefit. It is usually issued when the patient is considered to be approaching the terminal stage of their illness. In Social Security law a patient is terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

### **Palliative care indicator 2**

The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.

#### **Palliative care 2.1 Rationale**

The aims of the case review meetings are to:

- improve the flow of information (particularly out of hours and between different teams)
- ensure that each patient has a management plan as defined by the practice team and that decisions are acted upon by the most appropriate member of the team
- ensure that the management plan includes preference for place of care
- ensure that the support needs of carers are discussed and addressed where ever reasonably possible.

#### **Palliative care 2.2 Reporting and verification**

The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.

**Records Indicator 13**

There is a system to alert the out-of-hours service or duty doctor to patients dying at home.

**Records 13.1 Practice guidance**

Good Medical Practice (2001) states that when off duty the doctor ensures there are arrangements which “include effective hand-over procedures and clear communication between doctors”. It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

## **Annex B Extract from Gold Standards Framework – Clinical Prognostic Indicator Guidance Revised Vs 5.Sept 08**

**Three triggers for Supportive/ Palliative Care are suggested-** to identify these patients we can use any combination of the following methods:

- 1. The surprise question ‘Would you be surprised if this patient were to die in the next 6-12 months’** - an intuitive question integrating co-morbidity, social and other factors. If you would not be surprised, then what measures might be taken to improve their quality of life now and in preparation for the dying stage. The surprise question can be applied to years/months/weeks/days and trigger the appropriate actions enabling the right thing to happen at the right time e.g. if days, then begin a Care Pathway for the Dying. (See Needs Support Matrices)
- 2. Choice/ Need - The patient with advanced disease makes a choice for comfort care only, not ‘curative’ treatment, or is in special need of supportive / palliative care e.g. refusing renal transplant**
- 3. Clinical indicators - Specific indicators of advanced disease for each of the three main end of life patient groups - cancer, organ failure, elderly frail/ dementia (see over)**

### **Trigger 3 – Specific clinical indicators of advanced disease**

*These clinical prognostic indicators are an attempt to estimate when patients have advanced disease or are in the last year or so of life. These are only indicators and must be interpreted with clinical judgement for each individual patient, but they can help to alert clinicians to the need for extra supportive care. They have been drawn from a number of expert sources from the UK and abroad, and are updated regularly. Some use such indicators routinely, to assess patients’ need for palliative/supportive/hospice care. Although these are intrinsically only a very approximate guide to prognosis, these clinical indicators can therefore act as a rough guide to indicate to those in primary care and in secondary services that patients may be in need of palliative / supportive care. Primary care teams may include these patients on their Supportive/palliative care registers and hospital staff may suggest to GPs in discharge letters that such patients are included on the registers, if helpful.*

### **Co-morbidities or other General Predictors of End Stage illness**

**Co-morbidity is increasingly the biggest predictive indicator of mortality and morbidity.** Also-

- Weight loss - Greater than 10% weight loss over 6 months
- General physical decline
- Serum Albumin < 25 g/l
- Reducing performance status / ECOG/Karnofsky score (KPS) < 50%. Dependence in most activities of daily living(ADLs)

### **1. Cancer Patients Cancer3**

Any patient whose cancer is metastatic or not amenable to treatment, with some exceptions – this may include some cancer patients from diagnosis e.g. lung cancer. ‘The single most important predictive factor in cancer is performance status and functional ability’ – if patients are spending more than 50% of their time in bed/lying down, prognosis is estimated to be about 3 months or less. More exact predictors for cancer patients are available elsewhere on the GSF website.

## **2. Organ Failure Patients**

### **2.1 Heart Disease - CHF 4**

At least two of the indicators below :-

- CHF NYHA stage III or IV – shortness of breath at rest or minimal exertion
- Patient thought to be in the last year of life by the care team - the 'surprise' question
- Repeated hospital admissions with symptoms of heart failure
- Difficult physical or psychological symptoms despite optimal tolerated therapy

### **2.2 Chronic Obstructive Pulmonary Disease – COPD 5**

- Disease assessed to be severe e.g. (FEV1 <30% predicted – with caveats about quality of testing)
- Recurrent hospital admission (>3 admissions in 12 months for COPD exacerbations)
- Fulfills Long Term Oxygen Therapy Criteria
- MRC grade 4/5 – shortness of breath after 100 meters on the level or confined to house through breathlessness
- Signs and symptoms of right heart failure
- Combination of other factors e.g. anorexia, previous ITU/NIV/resistant organism, depression
- >6 weeks of systemic steroids for COPD in the preceding 12 months

### **2.3 Renal Disease 6**

- Patients with stage 5 kidney disease who are not seeking or are discontinuing renal replacement therapy. This may be from choice or because they are too frail or have too many co-morbid conditions.
- Patients with stage 5 chronic kidney disease whose condition is deteriorating and for whom the one year 'surprise question' is applicable i.e. overall you would not be surprised if they were to die in the next year?
- Clinical indicators:
  - CKD stage 5 (eGFR <15 ml/min)
  - Symptomatic renal failure -Nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload)
  - Increasingly severe symptoms from co-morbid conditions requiring more complex management or difficult to treat NB. many people with Stage 5 CKD have stable impaired renal function and do not progress or need RRT.

### **2.4 Neurological Disease - a) Motor Neurone Disease7**

MND patients should be included from diagnosis, as it is a rapidly progressing condition  
Indicators of rapid deterioration include:

- Evidence of disturbed sleep related to respiratory muscle weakness in addition to signs of dyspnoea at rest
- Barely intelligible speech
- Difficulty swallowing
- Poor nutritional status
- Needing assistance with ADL's
- Medical complications e.g. pneumonia, sepsis
- A short interval between onset of symptoms and diagnosis
- A low vital capacity (below 70% of predicted using standard spirometry)

## **b) Parkinson's Disease 8**

The presence of 2 or more of the criteria in Parkinson disease should trigger inclusion on the Register

- Drug treatment is no longer as effective / an increasingly complex regime of drug treatments
- Reduced independence, need for help with daily living
- Recognition that the condition has become less controlled and less predictable with “off” periods
- Dyskinesias, mobility problems and falls
- Swallowing problems
- Psychiatric signs (depression, anxiety, hallucinations, psychosis)

## **c) Multiple Sclerosis 9**

Indications of deterioration and inclusion on register are:-

- Significant complex symptoms and medical complications
- Dysphagia (swallowing difficulties) is a key symptom, leading to recurrent aspiration pneumonias and recurrent admissions with sepsis and poor nutritional status
- Communication difficulties e.g. Dysarthria + fatigue
- Cognitive impairment notably the onset of dementia
- Breathlessness may be in the terminal phase

## **3. Patients with Frailty and Dementia**

### **Frailty 10**

- Multiple co-morbidities with signs of impairments in day to day functioning
- Deteriorating functional score e.g. EPOC/ Karnofsky
- Combination of at least 3 symptoms of: weakness, slow walking speed, low physical activity, weight loss, reduced weight loss, self reported exhaustion

### **Dementia11**

- Unable to walk without assistance, and
- Urinary and faecal incontinence, and
- No consistently meaningful verbal communication, and
- Unable to dress without assistance
- Barthel score < 3
- Reduced ability to perform activities of daily living

Plus any one of the following:

10% weight loss in previous six months without other causes, Pyelonephritis or UTI, Serum albumin 25 g/l, Severe pressure scores eg stage III / IV, Recurrent fevers, Reduced oral intake / weight loss, Aspiration pneumonia

### **Stroke 12**

- Persistent vegetative or minimal conscious state / dense paralysis / incontinence
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / Post-stroke dementia

## Annex C Electronic Palliative Care Summary - pilot version

<b>Patient &amp; Carer Details</b>	<b>Section 1</b>	<b>Patient's Own GP and Nurse</b>
Review date		Usual GP name
Patient Surname		Nurse
Patient Forenames		Practice details
CHI Number		
Patient Address & Tel Number		
Carer Details		
Access Info/potential issues		
Next of kin details		
<b>Section 2 Patient medical Condition</b>		
Main diagnoses		
Other relevant issues		
Allergies/Drug reactions		
Current drugs and doses		
Additional drugs available at home		
<b>Section 3 Current Care Arrangements</b>		
Care arrangements		
Syringe driver at home		
Catheter continence prods at home		
Move & Hand equip at home		
<b>Section 4 Patient's and Carer's Awareness of Condition</b>		
Patient's understanding of Diagnosis		
Patient's understanding of Prognosis		
Carer's understanding of Diagnosis		
Carer's understanding of Prognosis		
<b>Section 5 Advice for Out Of Hours Care</b>		
Care Plan agreed		
Preferred place of care		
Should GP be contacted OOH?		
GP Home tel/mobile/pager		
Resuscitation status agreed		
Actual resuscitation status		
GP sign death cert in normal circumstances		
Additional useful OOH information		

## Annex D Reporting Template

The embedded spreadsheet has been developed to aid practices in collating the data required for fulfilling the criteria for this DES. If filled in correctly, your achievement for this DES will be automatically calculated and included in the payment claim form for year end. Please ensure you refer to the guidance for use of the spreadsheet included as the first tab. A further form will be sent for financial year 2009/10.

It was felt that the spreadsheet could also prove useful for practices as a check list, for instance at multi-disciplinary meetings, so several optional fields have been included which go beyond the requirements of the DES. For example, there is a field to add diagnosis and fields to give dates of updates and date of death. Whether or not practices use these optional fields will not affect payment in any way. It is recommended that practices use this reporting template to record the requirements for this DES.



PalliativeDES-v6.xls  
(305 KB)

## **Osteoporosis (Scotland) Directed Enhanced Service**

### **Purpose**

This specification summarises the arrangements for the Osteoporosis Directed Enhanced Service in Scotland.

### **Rationale**

Osteoporosis is associated with age related (fragility) fractures. It is a public health issue with a significant impact on hospital admissions and community and social care. Bone sparing medication can reduce the risk of future fractures and is recommended following fragility fracture in women aged 60-74 years with confirmation of osteoporosis on DEXA scan and following fragility fracture in all women aged 75 and over (SIGN 71).

### **Requirements**

The GP practice will be required:

- a. To compile a prospective register of women aged 60 years and over with a history of fragility fracture sustained on or after 1 November 2008.
- b. To ensure those patients (aged 60-74 years) on the register at (a) have had or have been referred for a DEXA scan for osteoporosis assessment.
- c. For women aged 75 years and over on the register at (a), all these women to be offered preventative treatment with bone sparing drugs.
- d. For the women aged 60-74 years in (a), those with confirmed diagnosis of osteoporosis to be offered preventative treatment with bone sparing drugs.

### **Eligibility**

GP practices must be offered the opportunity to provide this Directed Enhanced Service.

### **Funding and Payment Arrangements**

The DES will run from 1 November 2008 until 31 March 2010. Total funding will be approximately £550k for year 1 and £450k for year 2 of the DES.

The structure of payments will be as follows:

### Engagement Payment

Participating practices will be eligible to receive an engagement payment of £100, payable on signing-up to provide the DES. The payment will be the same for all practices, regardless of practice size. The payment is only payable in year 1 of the DES and is subject to the practice signing-up for both years.

### Achievement Payment

The practice will be eligible for a full payment under the DES by achieving a minimum percentage coverage for the two intervention elements in the target group as described in the following table (the percentages are cumulative for year 2.)

	Year 1	Year 2
DEXA scan performed or referral (b.)	60%	80%
Offered treatment with Bone sparing drugs (c +d)	60 %	80 %

The achievement payment will be determined by the number of women aged 60 years and over on the practice list. An average-sized practice in Scotland that achieves the above minimum thresholds can therefore expect to receive an achievement payment of £450 in years 1 and 2 of the DES.

### **Payment Verification**

Payment will be authorised by NHS Boards on (a) receipt of an audit at the end of the financial year from the practice and (b) confirmation by NSS PSD that the minimum percentage coverage(s) in each year has been reached.

### **Guidance**

Guidance has been issued to assist practices including preferred Read codes and GP IT suppliers have been approached to provide practices with support to provide the audit report at year end.

Advice for practices on making a claim for payment will follow in due course.

## Osteoporosis DES - Guidance

### Rationale

1. Osteoporosis is an important health problem through its association with age related (fragility) fractures. Fractures arise due to a combination of age related bone loss and trauma, with most occurring following a fall. Fractures of the hip, wrist and spine are the most frequent osteoporotic fractures.
2. In Scotland, there are over 20,000 osteoporotic fractures annually with over three quarters of these affecting women. At least one in three women will sustain one or more osteoporosis related fractures in their lifetime. Having one such fracture increases the risk of a further fracture. However, studies have shown that only around a third of these patients are on preventative bone sparing medication known to greatly reduce the risk of future fractures.
3. Following a fracture, patients suffer an increase in morbidity and mortality, with the risk of hospital admission, loss of confidence leading to increasing dependency and inability to remain in their own home or becoming housebound.
4. [SIGN Guideline no 71](#) (2003) includes the recommendation that women aged 60 and over who have had one or more fragility fractures (defined as a fracture occurring after a fall from standing height or less) should be targeted for investigation for, and treatment of, osteoporosis.
5. This DES seeks to incentivise practices to systematically identify women aged 60 and over who have had a fragility fracture, to ensure those aged 60-74 years are investigated for possible osteoporosis and to offer bone sparing preventative treatment both to those women under 75 who are diagnosed with osteoporosis and to those women aged 75 years and over who have had a fragility fracture.

### Outline of the DES

#### Requirements

**This guidance is intended to support practices in meeting the requirements of this DES. Sections in the specification are highlighted in the boxed sections below followed by guidance notes.**

<b>a. To compile a prospective register of women aged 60 years and over with a history of fragility fracture sustained on or after 1 November 2008.</b>
---

6. Practices should identify all women aged 60 and over who sustain a fragility fracture (defined as a fracture occurring after a fall from standing height or less) on or after 1 November 2008. Women should be included who are aged 60 and over on the date of the fracture.
7. Where there is doubt as to the presence of a fragility fracture, practices should include rather than exclude patients from the register.

8. Practices should use the Read code **N331N fragility** fracture in addition to any other fracture codes used.

**b. To ensure those patients (aged 60-74 years) on the register at (a) have had or have been referred for a DEXA scan for osteoporosis assessment.**

9. For women aged 60-74 years who have had one or more fractures which are assessed clinically as fragility fractures, DEXA scan assessment is recommended to confirm (or otherwise) osteoporosis before embarking on treatment.
10. Practices should record that a referral for DEXA scan has been made for women aged 60-74 following a fragility fracture using the Read codes in annex A.
11. For women aged 75 years and over with a clinical history of fragility fracture(s), there is no necessity for further investigation prior to treatment as the likelihood of osteoporosis is so high. However, in cases of doubt, DEXA scan assessment can be arranged for these women but will not be part of the target for the DES.
12. Where a woman aged 60 or over has a fragility fracture on or after 1 November 2008, but has previously had a diagnosis of osteoporosis confirmed by DEXA scan, (and who indeed may already be on treatment), there is no need for a further DEXA scan to be arranged. Practices should ensure the earlier DEXA scan is recorded in the record with the appropriate date using the Read codes in Annex A.

**c. For women aged 75 years and over on the register at (a), all these women to be offered preventative treatment with bone sparing drugs.**

**d. For the women aged 60-74 years in (a), those with confirmed diagnosis of osteoporosis to be offered preventative treatment with bone sparing drugs.**

13. Women aged 60-74 years with confirmed diagnosis of osteoporosis following a fragility fracture and women aged 75 and over with presumed diagnosis of osteoporosis following a fragility fracture are at increased risk of further fractures with all the associated morbidity and mortality. This risk of fracture can be reduced by the use of bone sparing drugs i.e. bisphosphonates, teriparatide and strontium ranelate.
14. This DES supports practices in systematically offering appropriate female patients preventative treatment but acknowledges that not all such women will choose to take up the offer, that some will be unable to tolerate the medication and that some will have contraindications which preclude them from taking it.
15. Practices should refer to current local and national guidelines when offering this medication to patients in the target group and should ensure women have the information they require in order to make an informed decision.

16. For women aged 60-74, who have had a fragility fracture on or after 1 November 2008, and who have a diagnosis of osteoporosis confirmed on DEXA scan before or after that event, this diagnosis should be recorded using the Read code [**N330. osteoporosis**] as designated in Annex A.
17. For women aged 75 and over, who have had a fragility fracture on or after 1 November 2008, these women have a presumed diagnosis of osteoporosis and practices may find it simpler to record this using the Read code in paragraph 16 above. However, for the purposes of the DES, it is only necessary to record the fragility fracture for these women to include them in the target group.
18. There is no current Read code that matches the requirement to offer bone sparing drugs. The nearest suitable code is

**66a0. Initial osteoporosis assessment .**

Practices should use this Read code to record this requirement.

19. Some women in the target group will already be taking bone sparing medication because of an earlier diagnosis of osteoporosis. The nearest suitable Read code for these women is

**66a1. Follow-up osteoporosis assessment.**

Practices should use this Read code to record this requirement in these circumstances.

20. Practices should use the recommended codes for this DES, as described above and in Annex A, as these will be used to provide a report on achievement of the requirements of the DES at year end.
21. GP IT system suppliers have been approached to provide practices with support for the audit report at year end.
22. Practices should also be aware that the target group for the DES is cumulative, so that all women aged 60 and over sustaining a fragility fracture on or after 1 November 2008 will be included in the target group for achievement at the end of subsequent financial years. Women reaching the age group as the DES continues will also be included but only if they have a fragility fracture on or after 1 November 2008.

## Annex A Recommended Read Codes

Osteoporosis DES- Recommended Read Codes		
5-byte Version 2 Read Codes (Scottish)	Term	Comments
<b>Fragility fracture</b>		
N331N	Fragility fracture	Use in addition to fracture codes
<b>Referral for DEXA scan</b>		
8HQ8.	Referral for dual energy X-ray photon absorptiometry scan	
8HQA.	Referral for DXA scan of hip and spine	
8HQB.	Referral for DXA scan of forearm	
8HQC.	Referral for DXA scan of heel	
<b>DEXA scan</b>		
58E%.	DEXA - Dual energy X-ray photon absorptiometry	Use any codes in this hierarchy
58F..	Bone density scan	
<b>Diagnosis of osteoporosis</b>		
N330.	Osteoporosis	
<b>Proxy codes for "offered bone sparing drugs"</b>		
66a0.	Initial osteoporosis assessment	For use if no previous diagnosis
66a1.	Follow-up osteoporosis assessment	For use if already diagnosed with osteoporosis

## **Ethnicity Monitoring and Interpreter Needs (Scotland) Directed Enhanced Service Specification**

### **Purpose**

This specification summarises the arrangements for the Ethnicity Monitoring and Interpreter Needs Directed Enhanced Service in Scotland.

### **Rationale**

Routine recording of ethnicity in NHS settings is supported at a Government and NHS Board level by policy commitments to promote equality and to eliminate discrimination, as set out in the Fair for All Policy (HDL56, 2002). This committed the NHS to promote equality and diversity and a fairer society where everyone is valued and respected. "Fair for All" requires all parts of the NHS to respond sensitively to the needs and circumstances of individuals from all backgrounds.

For practices, data on their patients' ethnicity can help to ensure that patients from all ethnic groups are receiving care at the same level for services such as cervical screening or immunisation, and that patient groups at particular risk of disease

Systematically recording patient needs for an interpreter or sign language (and the specific language or signing support needed) will provide NHS Boards with aggregated data from practices on the scale of the interpreter needs and the range of languages required. This will enable NHS Boards better to plan their interpreter services to meet demand so that practices will have good access to these services for their patients.

### **Requirements**

GP practices will be expected, for their whole practice population, to systematically ask for and record:

- a) information on ethnicity
- b) the need for an interpreter.

The DES builds on the current QOF indicator Records 21 for ethnicity recording in newly registering patients, extending to the whole practice population.

GP practices will be required to report to their Board, on an annual basis:

- a) the % of their practice population who have ethnicity recorded (including if they refused to give this information).
- b) the number of patients with recorded interpreter needs and the languages included.

## **Eligibility**

GP practices must be offered the opportunity to provide this Directed Enhanced Service.

## **Funding and Payment Arrangements**

The DES will run from 1 November 2008 to 31 March 2011. Total funding will be equal to £464k per annum. The payment to the average practice in Scotland will amount to £450 per annum.

Payment to the GP practice will be based on the list size at 1<sup>st</sup> April. Practices will receive a payment for 2008/9 on achievement of ethnicity recording of 30 per cent of the practice population; for 2009/10 of 60 per cent of the practice population; and for 2010/11 of 85 per cent of the practice population.

Practices must be able to demonstrate to their Board how they have identified interpreter needs.

## **Payment Verification**

Payment will be authorised by NHS Boards on (a) receipt of the audit report and (b) confirmation by NSS PSD that the target level in each year has been reached.

## **Guidance**

Guidance has been issued to assist practices including preferred Read codes and GP IT suppliers have been approached to provide practices with support to provide the audit report at year end.

Advice for practices on making a claim for payment will follow in due course.

## Directed Enhanced Service for Recording Ethnicity and Interpreter Needs - Guidance

### Rationale

1. Routine recording of ethnicity in NHS settings is supported at a Government and NHS Board level by policy commitments to promote equality and to eliminate discrimination, as set out in the Fair for All Policy (HDL56, 2002). This committed the NHS to promote equality and diversity and a fairer society where everyone is valued and respected. "Fair for All" requires all parts of the NHS to respond sensitively to the needs and circumstances of individuals from all backgrounds.
2. QOF Indicator Records 21, introduced in April 2006, incentivises practices to record ethnic origin on all newly registering patients. The guidance for this indicator states that:

*"The UK is an increasingly ethnically diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes".*

3. This DES builds on the requirements of Records 21 to extend to the whole practice population.
4. Systematically recording patient needs for an interpreter or sign language (and the specific language or signing support needed) will provide NHS Boards with aggregated data from practices on the scale of the interpreter needs and the range of languages required. This will enable NHS Boards better to plan their interpreter services to meet demand so that practices will have good access to these services for their patients.

### Outline of the DES

**This guidance is intended to support practices in meeting the requirements of this DES. Sections in the specification are highlighted in the boxed sections below followed by guidance notes.**

### Requirements

<p><b>GP practices will be expected, for their whole practice population, to systematically ask for and record</b></p> <ul style="list-style-type: none"><li><b>a) information on ethnicity</b></li><li><b>b) the need for an interpreter</b></li></ul>
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5. It is for practices to decide how they will gather this information but the guidance below can be used as desired and as appropriate.
6. Statistics show that more than 80% of patients on a practice list will attend at least once during the year. A systematic approach to gathering the required

information opportunistically over the 3 years of the DES should help practices achieve the required coverage.

7. Scotland uses a standard classification of ethnic groups both for the population Census and for official statistics.<sup>1</sup> In July 2008 the Scottish Government announced a new ethnicity classification which is recommended for Scotland's 2011 Census and for use in all relevant Scottish Official Statistics. The new classification, which replaces the previous classification, allows specific groups (such as Polish people) to be recognised. An official classification allows consistency of recording across the NHS and also allows information to be linked to population counts that use the classification.
8. Practices are encouraged to use the new classification (shown in Annex A) for this DES. Practices will probably also wish to change to this new classification for newly registering patients under the QOF indicator Records 21. Scottish Read codes are not available for all of the categories in this new classification but nearest suitable codes have been identified: Scottish codes will be requested for future use. However, for the purposes of estimating coverage of the practice population, all codes in the 9S%. and 9i%. range will be acceptable, including the options of specifying a group not on the list and of refusing to provide the information.
9. Practices may choose to obtain information about ethnicity and interpreter needs by asking the patient face to face or by using a form which can be given to the patient to complete. Experience in pilots has shown that a form given to patients as they attend the surgery works well and that postal requests for such data, as well as being expensive and administratively burdensome, do not yield so high a response.
10. If the information is collected by direct questions to the patient, it is important that this is done in a setting where confidentiality and privacy can be maintained. Staff should explain why the information is being collected. Collection of ethnic group through direct questioning requires a "show card" (Annex B) that allows the patient to choose from the official list of ethnic groups.<sup>2</sup>
11. Alternatively, practices may choose to collect this information from patients using a form. This may help to address the issue of privacy, ensures the patient sees the list of ethnic categories, removes the need for a "show card" and can include a brief written explanation of why the questions are being asked. The data included on the form could be recorded in the electronic record by administrative staff and some practices may find that this approach saves administrative staff time. A specimen form, with information for patients on the back, is included at Annex C.
12. Whatever method is used, practice staff need to understand the reason for collecting this information so they are supportive and can answer concerns

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<sup>1</sup> It should be noted that the Census classification in Scotland is slightly different from that used in England and Wales

<sup>2</sup> This list should include the options of specifying a group not on the list (Other, please specify) and of refusing to provide the information.

patients may raise. Helpful educational material is available to support the collection of data on ethnicity. A “Q&A” resource for staff is provided at Annex F. In addition, there is an ethnicity monitoring toolkit produced by ISD,<sup>3</sup> and equalities guidance from the GMC<sup>4</sup>. NHS Health Scotland and ISD have produced a training DVD “Happy to Ask, Happy to Tell” which includes a range of equality and diversity topics including ethnicity. This will be available for practices early in 2009.

13. For interpreter needs, Read codes are available for most languages and other languages will need to be coded as “other” with a text narrative to indicate the specific language. New Read codes will be requested as the need arises.
14. The recommended Read codes for the ethnicity categories and for interpreter needs are attached at Annex G but, as explained above, all 9S% and 9i% codes will be acceptable for payment purposes.

**GP practices will be required to report to their Board, on an annual basis, a) the % of their practice population who have ethnicity recorded (including if they refused to give this information). b) the number of patients with recorded interpreter needs and the languages included.**

15. GP IT suppliers have been approached to provide practices with support to provide the audit report at year end, including the % coverage for ethnicity status and how to provide an aggregated report on the number of patients requiring interpreter services and the languages required for that practice.
16. Payment will be based on the percentage of registered patients who have ethnicity data recorded. Patients who have been asked for this information but have refused to provide it will be included in the total of valid responses, as long as the appropriate code has been recorded. This reflects the approach in QOF indicator Records 21.
17. Practices will need to demonstrate to their NHS Boards that they are systematically asking appropriate patients about interpreter needs and recording them but, as only a small number of patients will fall into this category, recording of “no need for interpreter” will not be required.

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<sup>3</sup> [www.isdscotland.org/ethnicmonitoringtoolkit](http://www.isdscotland.org/ethnicmonitoringtoolkit)

<sup>4</sup> [http://www.gmc-uk.org/publications/valuing\\_diversity/index.asp](http://www.gmc-uk.org/publications/valuing_diversity/index.asp)

## **Annex A New Scottish Census Ethnicity Categories<sup>5</sup>**

### **A White**

- ◇ Scottish
- ◇ English
- ◇ Welsh
- ◇ Northern Irish
- ◇ British
- ◇ Irish
- ◇ Gypsy/ Traveller
- ◇ Polish
- ◇ Any other white ethnic group

### **B Mixed or multiple ethnic groups**

- ◇ Any mixed or multiple ethnic groups

### **C Asian, Asian Scottish or Asian British**

- ◇ Pakistani, Pakistani Scottish or Pakistani British
- ◇ Indian, Indian Scottish or Indian British
- ◇ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ◇ Chinese, Chinese Scottish or Chinese British
- ◇ Other,

### **D African, Caribbean or Black**

- ◇ African, African Scottish or African British
- ◇ Caribbean, Caribbean Scottish or Caribbean British
- ◇ Black, Black Scottish or Black British
- ◇ Other

### **E Other ethnic group**

- ◇ Arab
- ◇ Other

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<sup>5</sup> The Font size can be changed to suit your patients needs.

## Annex B Show Card for Asking about Ethnic Group

If patients are being asked directly about their ethnic group, they need to know the list of ethnic groups they can choose from, and showing a list is generally easier than reading out a list of options. A “show card” is a laminated page listing the options patients can choose from. An example is shown below.

Choose **ONE** section from A to E, then choose **ONE** box which **best describes** your ethnic group or background.

### **A White**

- ◇ Scottish
- ◇ English
- ◇ Welsh
- ◇ Northern Irish
- ◇ British
- ◇ Irish
- ◇ Gypsy/ Traveller
- ◇ Polish
- ◇ Any other white ethnic group

### **B Mixed or multiple ethnic groups**

- ◇ Any mixed or multiple ethnic groups

### **C Asian, Asian Scottish or Asian British**

- ◇ Pakistani, Pakistani Scottish or Pakistani British
- ◇ Indian, Indian Scottish or Indian British
- ◇ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ◇ Chinese, Chinese Scottish or Chinese British
- ◇ Other

### **D African, Caribbean or Black**

- ◇ African, African Scottish or African British
- ◇ Caribbean, Caribbean Scottish or Caribbean British
- ◇ Black, Black Scottish or Black British
- ◇ Other

### **E Other ethnic group**

- ◇ Arab
- ◇ Other

## **Annex C Specimen Form and Information Sheet for Self Completion by Patients <sup>6</sup>**

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<sup>6</sup> It is recommended that patient information should be set as Arial Font 12 as a minimum. You can enlarge text to suit your patients' needs.

**XXXXXXXXXX Medical Practice : PATIENT QUESTIONNAIRE**

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care. More information about it is on the back of this form but please ask a member of staff if you need more explanation.

We should be grateful if you could complete one for each family member within/joining the practice.

Name ..... DOB \_\_ / \_\_ / \_\_

Do you need an interpreter or sign language support?  Yes  No

If you do need an interpreter what language do you speak?

Please state .....

**What is your ethnic group?**

Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

**A White**

- Scottish
- English
- Welsh
- Northern Irish
- British
- Irish
- Gypsy/Traveller
- Polish
- Any other white ethnic group, please write in .....

**B Mixed or multiple ethnic groups**

- Any mixed or multiple ethnic groups

**C Asian, Asian Scottish or Asian British**

- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Other, please write in.....

**D African, Caribbean or Black**

- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Other, please write in.....

**E Other ethnic group**

- Arab
- Other, please write in.....

If you do not wish to give this information, please tick here

## **Annex E Patient Information**

People registered with this practice and others in Scotland are being asked to give their ethnic group. Your ethnic group is the group you identify with because of your language, culture, family background or country of birth. It is not necessarily the same as your nationality. For example you may see yourself as White Scottish, Polish or Pakistani. Your ethnic group is important for your care as it may influence your risk of disease. Knowing your ethnic group may also help us to provide services that meet your individual needs and to check that our services treat people from all backgrounds fairly and equally. For children, information about ethnic group can be provided by their parents or guardians.

People are also being asked to say whether they need an interpreter when talking with NHS staff, including the need for sign language support.

### **Why am I being asked these questions?**

Practices across Scotland which are participating in this exercise are asking all their patients to give their ethnic group and if they need interpreter support when talking with NHS staff.

### **What do you mean by ethnic group?**

An ethnic group is the group we identify with as a result of our culture, family background, the language we speak and the food we eat. For example most people in Scotland would identify themselves as White Scottish, while others might identify themselves as Indian. Ethnic group is different from nationality - for example people of many different ethnic groups have British nationality.

### **What has my ethnic group got to do with my health care?**

Diseases like diabetes, heart disease and cancer are more common in some ethnic groups than others. We want to make sure that NHS services treat people equally whatever their ethnic group, gender, age, religion, disability or medical background.

### **Isn't it obvious what my ethnic group is?**

No it isn't. Only an individual can say which ethnic group they identify with. It is important not to make assumptions about people without asking.

### **Why do I need to answer a question about needing an interpreter?**

We know that most of our patients can speak English, but some people may find it difficult to explain their health problems in English. By collecting information on patients' needs for an interpreter, the NHS will be able to better plan their provision of interpreter services.

### **Who will have access to this information?**

Only staff in the practice will have access to information that identifies you personally. Sometimes it would be helpful to share this information with other NHS staff to make sure that your health care needs are met. This might happen for example if you are being referred to hospital. We sometimes prepare statistical reports for the NHS to help plan services and to check that the NHS is treating people from different backgrounds fairly. These reports will never identify you individually.

## **Annex F Information for Staff**

### **Why are we asking patients these questions about ethnicity?**

There is a Scotland wide target to collect ethnic group of all patients registered with a GP. The NHS has a legal duty under the Race Relations Amendment Act (2000) to make sure that we do not discriminate against anyone on the ground of their ethnic group, gender, age, religion, disability or medical background and that we are promoting equality of opportunity to use our services.

### **What does ethnic group have to do with health care?**

We know for example that South Asians are at greatly increased risk of diabetes, yet a study of diabetes care in Scotland reported that 69% of primary care respondents did not have their ethnic group recorded. Similarly a Scottish data linkage project found that the incidence of acute myocardial infarction was substantially higher in South Asians than in the remainder of the population.

### **Isn't a patient's ethnic group obvious?**

No it isn't. You are the only person who can say what ethnic group you belong to, as ethnicity is based on things like our culture, background, language we speak and the food we eat. It is important not to make assumptions about people on the basis of things like their skin colour or name.

### **Isn't ethnic group a very subjective thing?**

Yes it is, that is why we must ask patients what their ethnic group is. We cannot make assumptions based on colour of the skin. Although ethnic group is subjective, people can be asked to classify themselves using accepted groupings. Information about ethnic group has been successfully collected as part of the National Census in the UK since 1991.

### **Almost all of my patients speak English - why do we need to ask about the need for an interpreter?**

Probably most of them do but the makeup of the Scottish population is changing rapidly. It is important to know what the demand is for interpreters and to record this systematically to help NHS Boards to plan services for interpreting and translation. This also means the practice will know if a patient needs interpreter support in advance of their appointment.

### **What do we say to patients when we are challenged about collecting this new information?**

We have been collecting ethnic group for all our newly registering patients for over 2 years. This is about ensuring that we treat people fairly regardless of their personal characteristics. It's also part of our clinical assessment as a means of identifying patients who may be at increased risk of disease. The information about interpreter needs will clearly benefit patients. Information about a requirement for signing support (a signer) will also help to provide care that meets patients' needs.

### **Further information is available at:**

[http://www.gmc-uk.org/publications/valuing\\_diversity/index.asp](http://www.gmc-uk.org/publications/valuing_diversity/index.asp)  
[www.isdscotland.org/ethnicmonitoringtoolkit](http://www.isdscotland.org/ethnicmonitoringtoolkit)

## Annex G Read Codes for Ethnicity and Interpreter Needs

<b>Ethnicity</b>		
<b>2008 Scottish Census classification</b>	<b>Preferred Codes</b>	
<b>A White</b>	Note all capital 'S'	
Scottish	9S13.	White Scottish
English	9i20.	English- ethnic category 2001 census
Welsh	9i22.	Welsh - ethnic category 2001 census
Northern Irish	9i24.	Northern Irish- ethnic category 2001 census
British	9S10.	White British
Irish	9S11.	White Irish
Gypsy/ traveller	9i2E.	Gypsy/Romany-ethnic category 2001 census
Polish	9i2F.	Polish- ethnic category 2001 census
Any other white ethnic group	9S12.	Other white ethnic group
<b>B Mixed or multiple ethnic groups</b>		
Any mixed or multiple ethnic group	9SB..	Other ethnic, mixed origin
<b>C Asian, Asian Scottish or Asian British</b>		
Pakistani, Pakistani Scottish or Pakistani British	9S7..	Pakistani
Indian, Indian Scottish or Indian British	9S6..	Indian
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	9S8..	Bangladeshi
Chinese, Chinese Scottish or Chinese British	9S9..	Chinese
Any other Asian background	9SH..	Other Asian ethnic group
<b>D African, Caribbean or Black</b>		
African, African Scottish or African British	9S3..	Black African
Caribbean, Caribbean Scottish or Caribbean British	9S2..	Black Caribbean
Black, Black Scottish or Black British	9S41.	Black British
Other black background	9S4..	Black, other, non-mixed origin
<b>E Other ethnic group</b>		
Arab	9iF9.	Arab - ethnic category 2001 census
Other	9SJ..	Other ethnic group
<b>Ethnic group not given- patient refused</b>	9SD..	Ethnic group not given - patient refused
<b>Interpreter needs</b>		
Interpreter needed-(language)	9NU%	All codes under this hierarchy
(Language) interpreter needed	9Nm%	ditto
Ditto	9Nn%	ditto
Sign language- BSL	9NUw.	Interpreter needed- British Sign Language
Sign language – Makaton (used for special groups)	9NUx.	Interpreter needed- Makaton Sign language
<b>Note- no need to record interpreter not needed</b>		

## **Management Information Directed Enhanced Service**

### **Purpose**

The purpose of this DES is to support GP practices in the provision of information to Health Boards in connection with their contract. The information to be provided by this DES is increasingly required by NHS Boards for workforce planning purposes (which contributes to the process for determining the number of training places needed for doctors and nurses) and to help Boards manage the provision of primary medical services across their area taking account of current patterns of investment and enable better use of scarce resources.

The expectation is that the DES will facilitate a strong mutually beneficial relationship between the NHS Board and GP practice, by the supply of high quality management information to the NHS Board.

### **Conditions and Eligibility**

The DES is available to all GP practices and cannot be withheld by the NHS Board should a GP practice wish to participate in the enhanced service. The DES will be available as a one year DES in the first instance.

There are two elements to the DES:

- Part A which is the basic information element; and
- Part B which is a supplementary element.

The supplementary information element (Part B) is optional but practices wishing to participate must also complete part A.

#### Part A: Basic Information Element

Any participating GP practice must complete the National Primary Care Workforce Planning Survey as agreed between Scottish Government and SGPC. This survey will be available for completion early in 2009.

GP practices may, if they wish, participate in the DES by providing the basic information element only. Practices can indicate their intention to participate in this survey to Boards in advance of its availability if they wish to proceed to part B.

#### Part B: Supplementary Information Element

Any participating GP practice must supply the following information:

- a. Total number of appointments available per week.
- b. Numbers of appointments available per week defined as routine, emergency and extended hours (if applicable.)

- c. Total number of appointments filled per week.
- d. Numbers of appointments filled per week defined as routine, emergency and extended hours (if applicable.)
- e. Of these appointments at part c, the number that were DNA.
- f. The information at parts a to e broken down by appointments with GP, practice nurse and other member(s) of primary care team.

NHS Boards, in agreement with their Local Medical Committee, can vary the dataset required under the supplementary information element.

### **Supply of the Information**

The information for part A will be supplied by the GP practice on a nationally agreed template.

The particular timing for the supply of the information for part B is to be agreed between the NHS Board and individual GP practice, or Local Medical Committee. It is recommended that the information supplied under the supplementary element should amount to data from a minimum of six consecutive weeks.

### **Dialogue with the NHS Board**

The NHS Board and GP practice will meet to discuss the information provided for part B, which will provide an opportunity for both Board and practice to raise any significant issues highlighted by the data. For example, primary care managers will be able to use this information to identify areas where capacity is limited and discuss with practices what options to improve matters may be available.

The NHS Board and GP practice should agree a short descriptive report and action plan following this meeting.

### **Payment Arrangements**

At the successful completion of the data release exercise and action plan, GP practices will receive a completion payment as follows:

- For GP practices that completed part A only, a payment equal to £0.04 for each registered patient; and,
- For GP practices that completed parts A and B, a payment equal to £0.16 for each registered patient.

The payment to the average practice (based on an average list size of 5370 patients) will amount to £215 for part A only and £859 for parts A and B. Actual payments will depend on the practice list size at 1 April.

# BETTER WORKING WITH GP PRACTICES ON NATIONAL INITIATIVES AND TARGETS

## Purpose

To facilitate GP practices working with NHS Boards on meeting the range of HEAT targets and other priorities, including 18 weeks referral to treatment targets. It should also focus on the important role of general practice in driving forward the agenda of *Shifting the Balance of Care*.

## Rationale

GP practices have a lot to offer in terms of influencing how patients are cared for and in knowing how to address better ways to deliver services. The current configuration leans heavily towards secondary care and it is recognised that *Shifting the Balance of Care* and other linked initiatives and targets will require GP-led solutions. This funding package will provide the opportunity for NHS Boards to tap into the expertise of GPs and for support to GP practices to work with NHS Boards to this end.

## Objectives

The basis for the discussions should focus on setting a number of joint objectives for GP practices and Boards to address national initiatives and targets. NHS Boards will be expected to work with LMCs and GP Sub-committees in determining the range of appropriate objectives and what might be expected of participating practices including how and what relevant data will need to be shared (or what information is required to be sourced) that will help inform these objectives and how the practice work will be funded.

We anticipate some or all of the following areas or topics would be reflected in these discussions:

- Referrals e.g. alternatives to hospital referral; understanding variation in referral rates (scheduled and unscheduled) and addressing as appropriate;
- Measures to encourage patients to use the most appropriate setting for on demand care e.g. how to reduce inappropriate attendance at A. & E. or NHS 24/ Out of Hours services (given the limits to practices' control of their patients' behaviour);
- Measures to prevent avoidable hospital admissions e.g. a greater focus on those with complex needs to ensure their needs are being addressed;
- Ways in which the secondary care sector and GP practices could coordinate joint care of patients (in patient and outpatient) e.g. by identifying when inpatients could be supported medically at home (given adequate availability of social and other support) thus reducing the stay of patients in hospital;

- Discharge planning to prevent readmissions e.g. involving GPs in the development of discharge planning arrangements including the provision of appropriate discharge information.
- Shifting the balance of care in tangible ways (taking account of resource implications): e.g. patient care that might be transferred from secondary to primary care; pre-assessment screening prior to hospital referral; shared care arrangements for ongoing care of patients (as exemplified by diabetes care but looking at other suitable clinical areas)
- Use of the QOF Plus process to include referrals, admissions, prescribing as well as QOF data to identify areas for improvement and to show impact of primary care on outcomes and other service activity and how shifting the balance of care towards primary/ community care could increase this positive trend and provide best value for money for Health Boards overall.

## **Outcome**

NHS Boards will demonstrate through a short report, a copy of which must be provided to the GP Subcommittee, the way in which they used this resource, their consultation with LMCs and GP sub-committees, the involvement of practices and the resulting actions and outcomes. It is recognised that in 2008/2009 the bulk of the investment will be used for planning and initial engagement between GP practices and NHS Boards/CHPs and that outcomes are more likely to follow in 2009/2010.

## **Eligibility**

GP practices must be offered the opportunity to participate in this programme.

## **Funding**

The funding package will be equal to £3.75m.

Each NHS Board will receive an allocation weighted with 50 per cent of the funding distributed using the Scottish Allocation Formula (SAF); 25 per cent distributed according to the percentage of population that are 65 years and over (older people) and 25 per cent using the Scottish Index of Multiple Deprivation (SIMD).