Vision 3 English DES 2008-2010 Audits

INPS

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Date	Version	Contents	Output
10.06.09		Directed Enhanced Services (England) 2008-2010	

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DES (England) 2008-2010

What's New

Five new clinical directed enhanced services (DESs) are part of the 2008-2009 contract negotiations:

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

All of the DESs started with effect from 1 April 2008 and will run for two years, with the exception of heart failure, which is a one-year DES. An indicator measuring prescribing of beta blockers for heart failure is being included in the QOF from 1 April 2009. The DESs are applicable in England only.

Vanilla Reporting allows for the fact that not all PCTs will want the same audit lines. The audits provided, therefore, are a template which can be developed further.

Alcohol for DES 2008-10

Criteria for audit Alcohol for DES 2008-2010

Patients aged 16 and over registered in last 1Y

Only for patients 16y and over that were registered in the last year.

Screened using FAST

Patients screened using FAST in the last year (Read code 9k16 and 388u).

9k16 Alcohol screen - fast alcohol screen test completed

388u Fast alcohol screening test

Patients with a FAST score 3 +

Patients screened using FAST with a score of 3 and over - only Read code 388u allows for a value.

Screened using AUDIT-C

Patients screened using Audit C in the last year (Read code 9k17 and 38D4).

9k17 Alcohol screen - AUDIT C completed

38D4 Alcohol use disorder identificatn test consumptn questionnaire

Patients with AUDIT-C score 5 +

Patients screened using Audit C with a score of 5 and over – only Read code 38D4 allows for a value.

38D4 Alcohol use disorder identificatn test consumptn questionnaire

Patients who will require a Full Audit

Patients that require to take a full audit – any patients that scored 3+ in FAST and 5+ in Audit C.

Patients screened using the Full 10 Audit questions

Patients that have been screened using Full audit (Read code 9k15 or 38D3). These patients will be the combined groups from patients that took a FAST and Audit C screenings.

9k15 Alcohol screen - AUDIT completed

38D3 Alcohol use disorders identification test

Patients with a FULL Audit score (8+) who will be eligible for brief intervention

Patients with a Full Audit score of over 8 (for Read code 38D3 only) who will be eligible for brief intervention (will just report patients with this score).

38D3 Alcohol use disorders identification test

Hazardous (8-15) or Harmful (16-19) drinkers who already received a brief intervention

Patients with a Full audit score of between 8–15 or 16–19 who have received a brief intervention (Read code 9k1A).

9k1A Brief intervention for excessive alcohol consumption

Hazardous (8-15) or Harmful (16-19) drinks who have NOT received a brief intervention

Patients with a Full audit score of between 9–15 or 16–19 who have NOT received a brief intervention.

Hazardous (8-15) or Harmful (16-19) drinkers who have DECLINED brief intervention

Patients with a Full audit score of between 9–15 or 16–19 who have DECLINED (Read code 8IAF) a brief intervention.

8IAF Brief intervention for excessive alcohol consumptn declin

Patients with an Audit score (20+) who are eligible for a referral for specialist advice

Patients with a Full audit score of 20+ that are eligible for specialist advice (will just report patients with this score).

Possible dependence drinking (20+) already referred for specialist advice

Patients with possible dependence drinking (score of over 20) that have been referred for specialist advice (Read codes 8H7p, 9k1B and 8HkG).

8H7p Referral to community alcohol team

9k1B Extended intervention for excessive alcohol consumptn complt

8HkG Referral to specialist alcohol treatment service

Possible dependence drinking (20+) NOT referred for specialist advice

Patients with possible dependence drinking (score of over 20) that have NOT been referred for specialist advice.

Possible dependence drinking (20+) DECLINED referral for specialist advice

Patients with possible dependence drinking (score of over 20) that have DECLINED (read code 8IAJ) specialist advice.

8IAJ Declined referral to specialist alcohol treatment service

NOT screened using FAST or AUDIT-C

Patients that have NOT been screened using FAST or Audit C.

NOT screened using the full 10 AUDIT questions

Patients that have NOT been screened using the Full Audit.

Introduction to Alcohol DES

Illness is associated with increasing alcohol consumption. This DES aims to reward practices for case finding in newly registered patients aged 16 and over. It also aims to deliver a simple brief intervention to help reduce alcohol related risk in adults drinking at hazardous and harmful levels, and specialist referral for dependent drinkers.

This two-year DES does not include a requirement to set up a register of hazardous or harmful drinkers.

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

brief intervention for a score between 8 and 20, or referral to specialist services for a score greater than 20.

Initial screening

Screening applies to all patients registered between 1 April 2008 and 31 March 2009, who are aged 16 or over at the time the short case finding test is applied. For the purposes of this DES the test must be applied within the financial year in which the patient registered.

The following official Read Codes are recommended:

9k16. FAST alcohol screening test completed

388u. FAST alcohol screening test

9k17. Alcohol screen - AUDIT C test completed

38D4. AUDIT c Alcohol screening

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

Full screening

If a patient is identified as positive, the remaining questions of the ten question AUDIT questionnaire should be used to determine hazardous, harmful or likely dependent drinking.

The following codes are recommended:

9k15. AUDIT test completed

38D3. AUDIT Alcohol screening test

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

0 - 7 indicates sensible or lower risk drinking

8 - 15 indicates hazardous or increased risk drinking

16 - 20 indicates harmful or high risk drinking

20+ indicates dependence

Brief intervention

Those patients identified as drinking at hazardous or harmful levels (scores 8-20) should be offered a brief intervention. The recommended brief intervention is the basic five minutes of advice used in WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle – How Much is Too Much? The following codes are recommended for recording the intervention offered:

9k1A. Brief intervention for excessive alcohol consumption completed

For 2008/09 only, the following codes will also be permissible for recording brief interventions:

6792. Health ed. – alcohol

67A5. Pregnancy alcohol advice

67H0. Lifestyle advice regarding alcohol

8CAM. Patient advised about alcohol

9k11. Alcohol consumption counselling

Extended intervention

In some areas patients drinking at harmful levels (scores 16-20) may be referred for an extended intervention, for example from a community based counselling service, but this distinction is not recognised for the purposes of this DES. Practices may find the following codes helpful:

8H7p. Referral to community alcohol team

9k1B. Extended intervention for excessive alcohol consumption completed

Referral for specialist advice

Patients identified as dependent drinkers (scores greater than 20) should be referred for specialist advice. Brief intervention is not effective for this group of patients. The following codes are recommended for recording specialist referral:

8HkG. Referral to specialist alcohol treatment service

Validation and payment

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

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

Recommended Alcohol Read codes

Alcohol Consumption

1361. Teetotaller

1362. Trivial drinker <1u/day

1363. Light drinker 1-2u/day

1364. Moderate drinker 3-6u/day

1365. Heavy drinker 7-9u/day

1366. Very heavy drinker >9u/day

1367. Stopped drinking alcohol

6792. Health Ed. Alcohol

Initial screening

388u. FAST audit + value

38D4. Audit C + value

8IA7. Screen declined

136L. Within recommended limits

136K. Above recommended limits

136R. Binge drinker

Full Screening – required for Positive Initial screen

38D3. Audit + value

Audit scores

0 - 7 sensible drinking

136S. 8 - 15 hazardous drinking

136T. 16 - 19 harmful drinking

1369. Suspected alcohol abuse - denied

Brief Intervention – required for scores 8 -20

9k1A. Brief intervention - April 09

Referrals – required for score > 20

8HkG. Specialist Alcohol treatment services

8iAJ Declined referral to specialist alcohol treatment services alcohol team - April 09

Changes in Alcohol records for DLM 280

From DLM 280 in Vision, the 38D hierarchy of alcohol screening now goes to the Scoring Test Result SDA rather than Medical History. This will allow the Result of Scoring Test field to be used if necessary and optionally.

388u Fast alcohol screening test - Scoring Test Result, Result scoring test field available - filed under Tests

38D2 Single alcohol screening questionnaire - Scoring Test Result, Result scoring test field available, filed under Tests (previously filed to History).

38D3 Alcohol use disorders identification test - Scoring Test Result, Result scoring test field available - filed under Tests (previously filed to History)

38D4 Alcohol use disorder identification test consumption questionnaire - Scoring Test Result, Result scoring test field available - filed under Tests (previously filed to History)

38D5 Alcohol use disorder id test Piccinelli consumption questionnaire - Scoring Test Result, Result scoring test field displayed - filed under Tests (previously filed to History)

The following are filed under Medical History:

8HkG Referral to specialist alcohol treatment service - No result scoring test field available - filed under Medical History

9k1B Extended intervention for excessive alcohol consumption complt - No result of scoring test field available - filed under Medical History.

Ethnicity for DES 1008-10

Criteria for Ethnicity DES 2008-10

Ethnicity recorded

Patients with ethnicity (Read code 9i% and 9S%) recorded.

9i% Ethnic category - 2001 census etc.

9S% Ethnic groups (census) etc.

9T% Ethnic groups (census) etc.

Ethnicity NOT recorded

Patients with NO ethnicity recorded.

Ethnicity not given (declined)

9Sd% Patients declined ethnicity recording.

First Language recorded

Patients with language recorded.

13l Main spoken language

13u Additional main spoken language

13w Supplemental Main language spoken

13Z6 Language spoken

13ZM Using British sign language

13ZP Using Makaton sign language

First Language NOT recorded

Patients with NO first language recorded.

First Language not given

13ZG Patients declined first language recording

Background and purpose

The Government is committed to reducing health inequalities: ensuring that whatever their economic or ethnic background, patients receive the highest possible quality of care. PCTs and practice based commissioners require accurate information

in order to ensure that the services they commission fulfil this obligation: they are required to conduct Equity Impact Assessments and this, in turn, depends on high quality data.

The ethnicity DES requires practices taking part to record the ethnicity and first language of each patient registered in the practice. This makes it possible to report aggregated information on the numbers of patients in each category to the PCT.

The aim of this DES is to enable practices and PCTs to assess the needs of their population and address inequalities in access and health outcomes for BME patients. It will support practices and PCTs in implementing the recommendations of the report on access to primary medical care services by black and minority ethnic (BME) communities

Ethnicity can be defined by social background, shared culture and traditions that are distinctive.

It is also defined by a common language. No patient left behind commented on the barriers GPs faced when communicating with BME patients who do not speak English as their first language.

These language differences can compound difficulties, with implications for correct diagnosis and patient safety. The report recommends the collection of first language which would help practices to organise the provision of appropriate interpreter services.

Details of the DES

Practices taking part will be expected to record the ethnicity and first language of all patients on their list. This will include children and babies where ethnicity and first language will be as defined by the parent or guardian.

Practices will be required to report aggregated data to the PCT on an annual basis. The NHS Data Dictionary codes are to be used for recording ethnic origin and first language (the codes for first language in the NHS Data Dictionary are the same as the 'Count Me In' census codes).

Data recording

The DES is specifically based on NHS Data Dictionary codes which can be found at:

Ethnic origin:

http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1

First language:

www.datadictionary.nhs.uk/data_dictionary/attributes/l/language_classification_code_de.asp?shownav=1

The experience of the UK census now means that there are nationally used ethnic categories that have been thoroughly tested and that are known to be acceptable to the majority of the population. Codes for ethnic origin should be familiar to general practices as they have been in use for some time, and their computer systems should have standard templates for recording the information. It should be noted that the

Census codes enable the patient to refuse to divulge their ethnicity by using codes 9SD for ethnicity and 13ZG for language and therefore this will not affect the practice's ability to achieve the required targets – 50% by March 31, 2009 and 90% by March 31, 2010.

Recording of first language is more complex, in that the list in the NHS Data Dictionary is incomplete. For example, Bulgarian, Danish and Irish are not included and would have to be recorded and reported as 'Other'. The minimum requirement for the DES is that languages not included in the Dictionary should be reported as "Other". (13Z6 – requires a value to be entered)

Other points to note:

1. In the case of children, or adults lacking the capacity to provide the information, the carer (as defined in the DES directions at Section 6(3)(c)) may supply the information required.

2. Although the NHS defines codes for both 'Not stated' and 'Patient Refused', we would urge practices only to use the 'Patient Refused' code, to indicate that patients do not wish to supply the information or have it recorded in their notes. Only 'Patient Refused' codes will count towards the 50% and 90% targets, as described above.

3. 005 Bengali & Sylheti: although there are codes available for both Bengali and Sylheti individually, there is no single code for both together. Therefore we would recommend that practices use one or the other. However, care and attention should be given to selecting the most appropriate one. The same applies to 006 Brawa & Somali, 009 Cantonese & Vietnamese & 044 Serbian & Croatian.

4. 010 Creole: There are many different types of Creole and Creole by itself is not recognised as an individual language, therefore we would recommend that end users use the same entry as that stated for 200 Other, i.e. Language Spoken, this would then require the user to input the language stated.

5. 200 Other: Language Spoken (observable entity): an observable entity requires a value to be entered, for example Irish.

6. 007 British Sign Language and 034 Makaton: although codes are available and stated for these entries, please note that from a terminology aspect the READ codes will not map to the Snomed-CT Codes in this instance due to differences in the meanings.

Categories of ethnicity and first language

These are clearly described in the national standards document (which is also linked above) and laid out in Annex A of the national standards document.

Asking for the information

What is really important is to respect the autonomy of the patient, as described in How to identify, collect and report ethnicity data, extract below:

Recording the information

Practice staff may find it helpful to have a standard tick box document for self completion by the patient or completion by practice staff. An example for ethnicity is

attached below. This should be then transposed into Read codes as described elsewhere in the document.

Standard Tick Box for recording ethnic group

What is your ethnic group? Choose ONE section from A to E, then tick the *appropriate box on the right to indicate your ethnic group.*

A : White

- British
- Irish
- Any other White background (please write in line below)

B : Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background (please write in line below)

C : Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please write in line below)

D : Black or Black British

- Caribbean
- African
- Any other Black background (please write in line below)

E : Chinese or other ethnic group

- Chinese
- Any other (please write in line below)

Not stated/declined

- • Declined: patient chooses not supply this information

Validation and payment

Payment will be made after the PCT receives the practice's annual report of patient ethnicity and first language. Payment will only be triggered once the practice has recorded this

information for 50% of its patients in the first year and 90% in the second year (as measured on 31 March each year). Within 28 days of the end of the financial year

(31 March) each practice taking part will be required to provide the following information to the PCT as measured at 31 March:

- the number of patients recorded against each of the NHS Data Dictionary codes for ethnic group and the number who refused to divulge their ethnic group
- the number of patients recorded against each of the NHS Data Dictionary codes for first language and the number who refused to divulge their first language.

Heart Failure for DES 2008-10

Criteria for Audit Health Failure for DES 2008-10

QOF HF Register

Patients on the QOF register for HF (as per QOF rules).

G58..% Heart failure

G1yz1 Rheumatic left ventricular failure

662f. New York Heart Association classification - class I

662g. New York Heart Association classification - class II

662h. New York Heart Association classification - class III

662i. New York Heart Association classification - class IV

QOF HF due to LVD Register

Patients on the HF register due to LVD (Read codes: G581, G5yy9, G5yyA, 585f and 585g).

G581% Left ventricular failure

G581.11 Asthma - cardiac

G581.12 Pulmonary oedema - acute

G581.13 Impaired left ventricular function

G5810 Acute left ventricular failure

585f. Echocardiogram shows left ventricular systolic dysfunction

585g. Echocardiogram shows left ventricular diastolic dysfunction

G5yy9 Left ventricular systolic dysfunction

G5yyA Left ventricular diastolic dysfunction

Patients with a record of heart failure due to LVSD

Patients on the HF register (all patients on the line above) due to LVSD (Read codes 585f and G5yy9).

585f Echocardiogram shows left ventricular systolic dysfunction

G5yy9 Left ventricular systolic dysfunction

Betablocker allergy ever

Patients with a beta-blocker allergy (Read code TJC6, U60B7, 14LL and ZV14C) ever (all patients on line above).

14LL. H/O: betablocker allergy

TJC6% Adverse reaction to betablockers

U60B7 [X] Beta-adrenorecep antag caus advers eff in their use

ZV14C [V] Personal history of betablocker allergy

Betablocker contraindicated, refused, not tolerated or not indicated in last 15 months

Patients with beta blocker contraindicated, refused or not tolerated in last 15 months (read codes 8I26, 8I36, 8I62 and 8I73).

8I26. Beta blocker contraindicated

8I36. Beta blocker therapy refused

8I62. Beta blocker not indicated

8I73. Beta blocker not tolerated

Patients with a record of heart failure due to LVSD not exception, who are treated by betablockers

Patients with HF due to LVSD not excepted who are treated by beta blockers (patients as above with drug codes bdf%, bdl% and bdm%).

Patients with a record of heart failure due to LVSD not exception, who are NOT treated by betablockers

Patients with HF due to LVSD not excepted who are NOT treated by beta blockers.

Background and purpose

Heart failure is an important cause of morbidity and mortality. Prevalence of heart failure increases steeply with age, so that while around 1% of men and women aged under 65 have heart failure, this increases to about 7% of those aged 75-84 years and 15% of those aged 85 and above. Based on these figures, it is estimated that as many as 570,000 people in England are affected. It is also estimated that of patients with a current diagnosis of heart failure, 50% will be due to left ventricular systolic dysfunction (LVSD) and will benefit from the appropriate prescribing of beta-blockers (see further information, below). There is clear evidence to support the clinical and cost effectiveness of this intervention.

Introduction

A pre-requisite for taking part in this DES is that the practice holds and maintains a register of patients with heart failure (HF), which is already rewarded through the Quality and Outcomes Framework (QOF). It is the responsibility of the contractor to demonstrate that they have systems in place to maintain a high-quality register and PCTs will be expected to verify this, comparing reported prevalence with expected prevalence.

Practices will be rewarded for the number of patients with a current diagnosis of HF due to LVD who are not recorded as intolerant or having a contraindication to beta-blockers and who are currently treated with a beta-blocker.

This DES will be current for one year (2008/09). From 2009/10, this DES will be succeeded by a specific QOF indicator – HF 4.

Coding

Patients with heart failure due to LVD can be identified from practices' QOF registers. The same codes will apply, as detailed in the QOF Business Rules. Details can be accessed via: http://www.pcc.nhs.uk/145 Codes for beta-blockers (derived from the current QOF Business Rules), but including only those licensed for treating heart failure (bisoprolol, carvedilol and nebivolol) are as follows:

Beta blockers

bdf..%

bdl..%

bdm..%

On or after 31 March 2009 practices will need to establish a one-off computer search which will identify all of those patients on the heart failure register, who were taking a beta-blocker on 31 March 2009.

Switching from a beta blocker not licensed for heart failure is difficult because of the need to titrate from low doses and small increments over repeated visits. If a patient is being prescribed a beta blocker not listed above and is in a stable condition, and the GP judges that it would be dangerous for that patient to make a switch, then the patient may be included in the achievement data for the DES. Practices will want to record a list of patients where this applies, as well as marking their notes and then to agree this list with the PCT medical director.

For the purpose of preparing for the changes in QOF from April 2009, practices may use the QOF codes for recording beta-blocker intolerance.

Validation and payment

Practices taking part will be required to provide the PCT with a report of the number of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction (who are not recorded as intolerant or having a contraindication to beta blockers) who are being treated with a beta-blocker as at 31 March. This report needs to be supplied within 28 days of the 31 March.

Learning Disabilities for DES 2008-10

Criteria for audit Learning Disabilities for DES 2008-10

Learning Disability Register

Patients 18 and over on learning disability register as per QOF rules.

E3...% Mental retardation

Eu7..% [X]Mental retardation

Eu81z "[X]Developmental disorder of scholastic skills, unspecified

918e. On learning disability register

LD health check done using Cardiff Health Check protocol or PCT agreed protocol

Patients on learning disability with Cardiff Health Check protocol done (Read code 9HB5, 9HB3 and 69DB).

9HB5 Learning disabilities annual health assessment

9HB3 Learning disabilities health assessment

69DB Learning disability health examination (Read 2009 Quarter 1 dictionary new addition)

LD health check NOT done using Cardiff Health Check protocol or PCT agreed protocol

Patients on learning disability with Cardiff Health Check protocol NOT done.

Background and purpose

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

The DES is designed to encourage practices to identify patients aged 18 and over with the most complex needs and offer them an annual health check. Local Authority (LA) lists of people known to social services primarily because of their learning disabilities are to be used as the basis for identifying patients to be offered the checks. The rationale is to target people with the most complex needs and therefore at highest risk from undetected health conditions (usually people with moderate to severe learning disabilities). From the prevalence figures available it is estimated that approximately 240,000 patients fall into this category across the country.

Generally Local Authority criteria for access to social care services are related to complexity of need, although sometimes individuals with mild learning disabilities and other additional health needs, usually associated with mental health needs, will meet Social Services eligibility criteria.

Introduction

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

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

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

Health checks

As a minimum, the health check should include:

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

Practices taking part in the DES should base their health checks on the Cardiff health check protocol which is available through the Royal College of General Practitioners website[1] or a similar protocol agreed with the PCT. Health checks should integrate with the patients' personal health record or health action plan. Where possible, and with the consent of the patient, this should involve carers and support workers. Practices should liaise with relevant local support services such as social services and educational support services in addition to learning disability health professionals.

For 2008/09, practices can use the existing codes for learning disabilities health assessment (9HB3 and 9HB5). From the 2009/10 financial year we recommend use of a new code which has been requested for the April 2009 release: 69DB. Learning disability health examination.

Osteoporosis for DES 2008-10

Criteria for audit Osteoporosis for DES 2008-10

Women aged 65 and over (used to adjust payment for average practice)

This audit only searches for women over the age of 65

Women aged 65-74 with a DEXA scan in the last 12M

Women between 64-75 with a entry for a DEXA (Dual energy X-ray photon absorptiometry) scan

58E% Dual energy X-ray photon absorptiometry

58F Bone Density scan

Women aged 65-74 with a history of Fragility Fracture in the last 12M

Women between 64-74 with a history of fragility fracture in the last 12 months (read code N331N):

N331N Fragility fracture

Women aged 65-74 with a Fracture but NO diagnosis of Osteoporosis ever and no Fragility Fracture in the last 12M

Women between 64-74 with a Fracture (S1%, S2%, S3%) with NO diagnosis of Osteoporosis and NO fragility Fracture (as above) in last 12 month

S1...% Fracture of neck and trunk

S2...% Fracture of upper limb

S3...% Fracture of lower limb

Women aged 65-74 with a history of Fragility Fracture in the last 12M treated with bone-sparing agent

Women with fragility fracture (as above) treated with bone sparing agent (drug codes: fo1, fo4, fo6, fo3, fo5, fo8, fv1, fu3, fu5).

Women aged 65-74 with a history of Fragility Fracture and diagnosis of Osteoporosis in the last 12M

Women with fragility fracture (without bone treatment) but with a diagnosis of Osteoporosis (read code N330) in the last 12 months.

N330 Osteoporosis

Women aged 65-74 with a history of Fragility Fracture and diagnosis of Osteoporosis in the last 12M treated with bone sparing agent

Women with fragility fracture with osteoporosis in the last 12 months treated with bone sparing agent.

Women aged 65-74 with a history of Fragility Fracture in the last 12M and a DEXA scan in the last 12M

Women 65-74 with a Fragility Fracture (read code N331N) in the last 12 months and a DEXA scan (read code 58E% and read code 58F) in the last 12 months

58E% Dual energy X-ray photon absorptiometry

58F Bone Density scan

Women aged 65-74 with a history of Fragility Fracture in the last 12M with a DEXA scan in last 12M explicitly confirming Osteopenic

Women 65-74 with a fragility fracture (read code N331N) in the last 12 months with a DEXA scan in the last 12 months explicitly confirming Osteopenic (read code 58E5, 58EB, 58EH, 58EN, 58EW)

58E5. Forearm DXA scan result osteopenic

58EB. Heel DXA scan result osteopenic

58EH. Hip DXA scan result osteopenic

58EN. Lumbar DXA scan result osteopenic

58EW. Femoral neck DEXA scan result osteopenic

Women aged 65-74 with a history of Fragility Fracture and diagnosis of Osteoporosis in the last 12M and DEXA scan in last 12M explicitly confirming Osteoporotic

All women as line above with diagnosis of Osteoporosis confirmed by a DEXA scan (read codes: 58E4, 58EA, 58EG, 58EM, 58EV).

58E4 Forearm DXA scan result osteoporotic

58EA Heel DXA scan result osteoporotic

58EG Hip DXA scan result osteoporotic

58EM Lumbar DXA scan result osteoporotic

58EV Femoral neck DEXA scan result osteoporotic

Women aged 65-74 with a history of Fragility Fracture and diagnosis of Osteoporosis in the last 12M NOT confirmed by DEXA scan

Women 65-72 with diagnosis of Osteoporosis without any DEXA scan.

Women aged 65-74 with a history of Fragility Fracture in the last 12M NO diagnosis of osteoporosis

Women 65-74 with a history of fragility fracture and NO diagnosis of Osteoporosis.

Background and purpose

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

Introduction

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

Details of the DES

Practices will be expected to compile an audit of:

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

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

Identifying and coding fragility fractures

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

S1...% Fracture of neck and trunk

S2...% Fracture of upper limb

S3...% Fracture of lower limb

A fragility fracture is any clinically apparent fracture sustained as a result of low trauma or lesser force such as a fall from a standing height. It includes vertebral fractures but usually not fractures of the skull or bones of the hand or feet. The site of the fracture does not need to be captured for the purpose of the DES though it would be good record keeping practice to do so.

It is suggested that in addition to recording the type and site of any fracture, an additional code should be used to indicate that the fracture is a fragility fracture. The recommended codes are:

Fragility fracture N331N

DEXA scanning

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

Treatment with bone-sparing agents

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

Disodium etidronate fo1..%

Alendronic acid fo4..%

Risedronate sodium fo6..%

Sodium clodronate fo3..%

Disodium tiludronate fo5..%

Ibandronic acid fo8..%

Raloxifene hydrochloride fv1..%

Teriparatide fu3..%

Strontium Ranelate fu5..%

Only the ‘parent’ term for the generic drug is shown: actual preparations and branded products are ‘children’ of these codes.

Validation and payment

Using the codes and 'rules' outlined above practices will be expected to provide an audit report to the PCT. The audit should be completed at the end of the 1st quarter, i.e. 30 June, in order to ensure inclusion of patients referred for DEXA scan on or before the 31 March. Practices taking part must supply the audit to the PCT by 31 July following the end of the relevant financial year.

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

Condition 1

Lower threshold 20

Upper threshold 50

Lower threshold 40

Upper threshold 60

Condition 2*

*of those women as identified in criterion 1

Lower threshold 70

Upper threshold 90

Lower threshold 70

Upper threshold 90

Condition 3

Lower threshold 70

Upper threshold 90

Lower threshold 70

Upper threshold 90

For each criterion:

- Criterion 1: In year one a practice will receive £196.07 if the proportion of women identified is equal to or more than 50%. A practice will receive £117.64 if the proportion is 20%. Any achievement between 20% and 50% will be paid out on a sliding linear scale for example if a practice were to achieve 35% they will receive £156.86.
- In year two a practice will receive £196.07 if the proportion of women identified is equal to or more than 60%. A practice will receive £117.64 if the proportion is 40%. Any achievement between 40% and 60% will be paid out on a sliding linear scale, for example if a practice were to achieve 55% they will receive £176.46.
- Criterion 2: Of those women identified through criterion 1 – a practice will receive £196.07 if the proportion of those women identified who are receiving treatment with a bone-sparing agent is

equal to or more than 90%. A practice will receive £117.64 if the proportion is 70%. Any achievement between 70% and 90% will be paid out on a sliding linear scale in the same way as criterion 1.

- • Criterion 3: A practice will receive £196.07 if the proportion of women identified is equal to or more than 90%. A practice will receive £117.64 if the proportion is 70%. Any achievement between 70% and 90% will be paid out on a sliding linear scale in the same way as criterion 1.

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