



**SCOTTISH ENHANCED SERVICES PROGRAMME  
FOR PRIMARY AND COMMUNITY CARE  
North Highland Community Health Partnership**

**Locally Enhanced Service (LES) for-**

Identification, referral, follow up and management of Patients with moderate/severe COPD as part of COPD rehabilitation Programme

**Service Level Agreement**

**PRACTICE -**

**MEDICAL PRACTICE**

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**1. Financial Details**

***All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.***

This agreement is to cover the 12 months commencing **1 April 2008**.

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

The payment per participating GP Practice will be £500 set up fee, plus a further 0.30p per registered patient (as at 1<sup>st</sup> April 2008) plus £80 per qualifying patient pa (i.e. patients who have completed pulmonary rehab) who have had follow-up.

The payment will be in two stages - £500 plus 0.30p per patient on return of the signed SLA. £80 for follow up will be calculated and paid at the end of the 12 months.

GP Practices will be required to produce a summary of the audit process to the CHP, which will trigger payment of the fee for this service.

### **Payment Verification**

Practices entering into this contract must participate fully in the verification process determined by the CHP and LMC. Practices should ensure that they keep proper records to ensure a full and proper audit trail. Practices must be able and willing to evidence service delivery if required/requested by the CHP.

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

## **2. Signature Sheet**

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

..... **MEDICAL PRACTICE**

### **Signature on behalf of the Practice:**

Signature	Name	Date

### **Signature on behalf of the CHP:**

Signature	Name	Date

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### 3. Pulmonary rehabilitation and follow up for patients with COPD

#### 3.1 Rationale:

##### **PULMONARY REHABILITATION**

Pulmonary rehabilitation can be defined as a multidisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise each patient's physical and social performance and autonomy. It is widely used for patients with COPD. Pulmonary rehabilitation is an increasingly popular and effective option for patients with moderate to severe COPD. Rehabilitation aims to prevent deconditioning and allow the patient to cope with their disease. Most programmes are hospital based and comprise individualised exercise programmes and educational talks. Pulmonary rehabilitation should be made available to all appropriate patients with COPD.

Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above).

Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

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

**The North Highland CHP Pulmonary Rehabilitation service** will provide physical training and education in self-care, and facilitate access to dietetic and other advice, in a programme lasting 6 to 8 weeks. Patients will be eligible for this if they have an MRC dyspnoea score of 3 or above, or if post bronchodilator FEV1 is 50% or less than predicted for age and build, or if they have been referred following hospital admission.

Following discharge from this programme, long term follow up as specified below is to be provided in General Practice.

#### 3.2. Service Aims:

The aim of this initiative is to identify and build on good practice to ensure that **the patients who meet the above referral criteria are identified and referred to the**

**North CHP Pulmonary Rehab service.** The aim is also to ensure that following rehabilitation for COPD, services and support at primary care level is available to maximise the wellbeing of patients with COPD, to identify deterioration, and enable quick referral back into the programme when the patient requires it.

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

### **3.4 Criteria:**

The practice must review its COPD register and refer to the Pulmonary Rehab service as appropriate as per the agreed referral criteria. The practice must make available to the CHP the number of patients eligible to be referred to the service. The practice must ensure that they have the appropriate equipment i.e. Spirometer and Pulse Oximeter (which is regularly maintained and calibrated) and that staff have had appropriate training in its use and interpretation.

The patient must have COPD, and be present on the practice register of patients with COPD. The patient must have undergone Pulmonary rehabilitation, or has been found unfit for rehabilitation by virtue of a medical condition which is likely improve sufficiently that they become fit for pulmonary rehabilitation in the future. (examples include recent MI, current respiratory infection, acute gout)

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

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

#### **3. 4.1 Follow up**

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

- > highlighting the diagnosis of COPD in the case record and recording this using Read codes on a computer database
- > recording the values of spirometric tests performed at diagnosis, (both absolute and percent predicted)

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

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

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

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

#### Frequency

at least twice per year

#### Clinical assessment

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

#### Measurements

- FEV1 (& FVC where clinically indicated)
- calculate BMI

- MRC dyspnoea score
- SaO<sub>2</sub> ( measured with pulse oximeter)

#### References:

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

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

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

Payment per patient will require evidence of recording FEV<sub>1</sub>, BMI, SaO<sub>2</sub>, MRC dyspnoea score, depression screening, frequency of exacerbations twice yearly

#### **4. Dispute Resolution**

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

#### **5. Variation and Termination of Contract**

Any variation to the terms and conditions contained herein requires to be agreed between the Practice and the CHP.

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