LOCAL ENHANCED SERVICE (LES)

MANAGEMENT OF PEOPLE AGED SIXTEEN AND OVER WITH DIABETES

Service Level Agreement 1/4/08 to 31/3/12

PRACTICE –

Contents:

1. AIMS

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The aim is to provide high quality diabetic care in the community ,whilst ensuring appropriate access to all specialist services when required.

Patients with diabetes not on insulin will receive all routine screening and clinical management by General Practices. Advice from specialist services can be sought when required and referral guided by the local referral criteria.

Patients on insulin will be provided by either **"shared care"** or **"practice based care"**.

"Shared care" will involve all routine screening being performed in General Practice, with interim management in General Practice with routine review by the

Diabetic Specialist Team on at least an annual basis with additional specialist review if required.

"Practice based care" will involve all screening and management in General Practice, with advice being sought from specialist services only when clinically required for specific problems, and without routine follow up by specialist services.

2. SUMMARY OF SERVICE TO BE PROVIDED

1. A minimum annual and 6 monthly review of people with diabetes.

2. A recall system for people overdue for 6 monthly or annual diabetic checks.

3. In the three months prior to 31st March a check should be made that all people on insulin are correctly recorded as either shared or practice based care. This information must be recorded at least once during this period to qualify for payment.

4. Performance of all routine screening for **all people over 16 with diabetes** .This includes height, weight, all routine blood test (annual lipids, renal function, TSH and six monthly HbA1c), further blood tests as required, microalbumin screening and foot screening.

5. The above screening tests will no longer be routinely performed at the hospital clinic. People with diabetes will be advised to attend practice before hospital appointments in order to have screening completed. Patients requiring further screening tests following hospital appointments would normally be referred back to practices.

6. Results of screening blood tests should be available at the time of reviews.

7. Clinical management and ongoing education of people with diabetes:

a. Act on abnormal results found in the screening process by managing or referral, if appropriate.

b. Foot screening, advice on foot care and referral, as appropriate. People with low risk feet should not be referred to a podiatrist unless they have an identified podiatric need.

c. For people who are attending the hospital for regular review, practices are responsible for interim management for lipids, blood pressure, HbA1c and other diabetes related conditions.

d. Referral of patients, as clinically appropriate. The referral guidelines in the Highlands Diabetes Guidelines should be used in combination with clinical judgement and consideration of the patient's wishes.

8. Initial management of a person/s newly diagnosed with diabetes:

a. confirm diagnosis in accordance with Highland Guidelines.

b. identifiy those who are likely to require immediate insulin therapy, and refer appropriately. This may be to a Consultant, or a Diabetic Nurse Specialist.

c. for the remainder, who do not require immediate insulin therapy, perform a comprehensive review and assessment, as in the Highland Diabetes Guidelines.

d. for those diagnosed with Type 2 Diabetes, provide initial education on the implications and management of diabetes, diet and exercise and arrange referral to a state registered dietician. Educational information is available within the Highland Diabetes Guidelines, and Diabetes UK also provides booklets for people who are newly diagnosed with Diabetes, which can be obtained from the CHP Primary Care Managers.

9. Responsibility for accepting and holding for collection of sharps for patients using injectable therapies following Clinical Waste Guidelines.

3. USE OF GUIDELINES

In combination with clinical judgement and consideration of the patient's wishes, the following guidelines should be used:

1. Highland Diabetes Guideline

   http://www.diabetes-highland.scot.nhs.uk/Guidelines/

2. Highland Joint Formulary (HJF)

3. Highland Lipid Lowering Guideline
4. SIGN Guideline – Management Of Diabetes

   http://www.sign.ac.uk/guidelines/fulltext/55/index.html

4. OCCUPATIONAL ASSURANCE

There are 4 standards, which are outlined below. All members of the practice team should complete the standard required for the activities they perform. New members of the practice team should complete occupational assurance within nine month of joining the practice team, if not already completed in a previous post. Appendix two contains the document to be completed annually confirming the practice team has undertaken occupational assurance. **This should be returned by 31st December each year.**

Training support will be made available through The Diabetic Specialist Nurses, Dietetic and Podiatry Teams.

1) Foot screening and advice on routine foot care
2) Providing initial and continuing education for people with Type 2 Diabetes:
   - diabetes
   - foot care
   - lifestyle
   - diet
3) Advising patients on urine and blood glucose monitoring
4) Measuring BP, Weight and Height and performing urinalysis

1. Foot Screening

For Whom: All Clinicians (General Practitioners, Practice Nurses and District Nurses), doing foot screening.

Those providing diabetes foot screening are required to attend training on the nationally agreed standards for foot screening and the use of the SCI-DC foot risk assessment tool.

The training will involve the following:

a) Undertaking loss of protective sensation screening, using calibrated, 10g monofilament supplied to the 5 standard pressure points on each foot.
b) Palpation of foot pulses on each foot.
c) Classification of foot risk of ulceration, ie. low, moderate high, or active foot disease.
d) Familiarity with the SCI-DC foot screening tool.
e) Giving consistent basic foot care by pertinent to identified level of risk.
f) Familiarity with referral pathways.
g) Read the required literature as advised the specialist diabetes podiatrist.

FREQUENCY OF FOOT SCREENING OCCUPATIONAL ASSURANCE: ONCE

2. Initial education about life's diet and lifestyle for those with Type 2 Diabetes

FOR WHOM: All clinicians who provide initial education (ie. doctors, practice nurses and district nurses).

Requirement: To have attended training, which includes the current European dietary recommendations for diabetes, and training on how to interpret these into practical advice and using the "balance of good health" model.

AND

To read educational material listed below. It is recommended that this should involve between 4 to 6 hours of work.

Suggested Reading List;-

- Weight Management – Managing Diabetes in Primary Care, February 2004, (Diabetes UK).
- Eating Well with Diabetes – Initial stopgap dietary advice. (Diabetes UK) see the following URL.
  http://www.diabetes.org.uk/Guide-to-diabetes/Food_and_recipes/
- Obesity: epidemiology and possible prevention; I. Caterson, T. Gill. Best Practice & Research Clinical Endocrinology and Metabolism http://www.diabetes.org Vol. 16, NO. 4 pp. 595 -610, 2002.
  http://www.idealibrary.com
- Motivating people to lose weight: self-help and treatment. P. Dyson. Journal of Diabetes Nursing Vol. 8 No. 9, 2004.

Recommended Dietary Literature for Patients

- Diabetes UK "Eating Well with Diabetes" – for initial stop-gap advice
- Diabetes UK "Food Choices and Diabetes" – for more detailed advice.

Further information can be obtained via the "Diabetes UK" website. Literature may also be available from dietetic departments locally.

FREQUENCY OF OCCUPATIONAL ASSURANCE FOR INITIAL EDUCATION ABOUT DIET AND LIFESTYLE: 5 YEARLY

3. **Blood glucose monitoring**

FOR WHOM: All clinicians, (doctors, practice nurses and district nurses), advising on blood or urine monitoring.

Requirement: To read the NHS highland guideline for blood glucose monitoring(http://www.diabetes-highland.scot.nhs.uk/Guidelines/Appendices/25Glucose Monitoring.pdf), and confirm in writing that this has been done.

FREQUENCY OF OCCUPATIONAL ASSURANCE FOR BLOOD GLUCOSE MONITORING: ONCE

4. **Measurements**

FOR WHOM: Practice nurses, phlebotomists or healthcare workers who perform these measurements.

a. Read the British Hypertension guidelines on blood pressure measurement (http://www.bhsoc.org/bp_monitors/BLOOD_PRESSURE_1784a.pdf)

FREQUENCY OF OCCUPATIONAL ASSURANCE FOR BLOOD PRESSURE:ONCE

b. Measuring height, the requirement is to read the following summary for taking height.

The patient's height should be measured without the patient wearing shoes, with the feet together and heels ,buttocks and upper part of the back, touching the scale.

FREQUENCY OF OCCUPATIONAL ASSURANCE FOR MEASURING HEIGHT: ONCE

c. Measuring weight. The instrument of choice is a beam balance or portable electronic scales incorporating a load cell. Both should be accurate within a 100gms.

Requirement is to read the following:

The patients weight should be recorded using scales, which are regularly maintained and calibrated, with the patient wearing minimal indoor clothing and the right shoes.

d. Urinalysis. The requirement is to read the highland guideline for diabetes section on urinalysis http://www.diabetes-highland.scot.nhs.uk/Guidelines/24Appendices/microalbumin%20algorithm.pdf

Most patients will normally require an early morning urine sample to be sent for albumin testing at Biochemistry. Dipstick testing should be carried out for protein initially and dipstick positive patients should have urine sent for microscopy and culture and a Protein Creatinine Ratio. Thereafter, the guidelines should be followed for screening patients correctly for microalbuminuria and proteinuria.

FREQUENCY OF OCCUPATIONAL ASSURANCE FOR URINALYSIS: ONCE

5. DEFINING THE THREE DIFFERENT TREATMENT GROUPS

The three groups are:

People with Diabetes not on insulin.
People with Diabetes on insulin "shared care".
People with Diabetes on insulin "practice based care"

People on insulin require to have the type of care, shared or practice based, recorded in the three months prior to 31st March (the audit date). This signifies that during this period there should be some form of formal review to ensure that the type of care is accurately recorded.

For the purposes of audit and therefore payment these three groups are identified as follows.

1. People with Diabetes not on insulin

All those on the practice register with any type of diabetes. The options are Type 1 Diabetes (READ code C10E.), Type 2 diabetes (READ code C10E.), or MODY (READ code C10C.), or any other diagnostic code for diabetes mellitus commencing C10…

And
Most recent entry for type of treatment recorded in the 8 months prior to 31st March (the audit date) is
Diet only (Read code 66A3.) **Or**
Tablets only (Read code 66A4.)

And
No record of a drug prescription with a BNF code commencing 6.1.1 (insulin) in the preceding 6 months.

2. People with Diabetes on insulin "shared care".

All those on the practice register with any type of diabetes. The options are Type1 Diabetes (Read code C10E.), Type 2 diabetes (Read code C10E.), or MODY (READ code C10C.), or any other diagnostic code for diabetes mellitus commencing C10…

And
Most recent entry for type of treatment recorded in 8 months prior to 31st March (the audit date) is

Insulin and oral treatment (Read code 66AV.)
Or On Insulin (Read code 66A5.)

And
The most recent entry for arrangement for diabetic care recorded in the **three** months prior to the 31st March (the audit date) is
Diabetes:shared care (Read code 66AQ.)

And
There is a record of a drug prescription with a BNF code commencing 6.1.1 (insulin) in the preceding 6 months.

3. People with Diabetes on insulin "practice based care".

All those on the practice register with any type of diabetes. The options are Type 1 Diabetes (Read code C10E.), Type 2 diabetes (Read code C10E.), MODY (READ code C10C.) or any other diagnostic code for diabetes mellitus commencing C10

And
Most recent entry for type of treatment recorded in 8 months prior to 31st March (the audit date) is

Insulin and oral treatment (Read code 66AV.)
Or On Insulin (Read code 66A5.)

And
The most recent entry for arrangement for diabetic care recorded in the **three** months prior to the 31st March (the audit date) is

Diabetes:practice programme (Read code 66AP.)

And
There is no record of the patient being on the return appointment waiting list or with a booked return appointment at a specialist lead general diabetic clinic in Highland.

And
There is a record of a drug prescription with a BNF code commencing 6.1.1 (insulin) in the preceding 6 months

6. SCREENING AUDIT CRITERIA

The screening audit refers to a number of criteria, some of which could be considered screening, some of which could be considered process of care items. For simplicity, this will be called the screening audit. This audit is the same regardless of which care group the people with diabetes fall into.

There are 16 items detailed in the table below which should be recorded, electronically, using the read codes recognised by SCI-DC (see appendix 1). ESCRO screens are available to help with this. These items are audited and part of the payment for this enhanced service is based on these audits.

Diabetes Screening Items	Frequency
Ethnicity	Once
BMI	Six Monthly
Blood Pressure	Six Monthly
HbA1c	Six Monthly
Smoking Status	Annually
eGFR	Annually
Serum Cholesterol	Annually
Urinary Microalbumin screening: There is a Urinary Microalbumin (ACR) result unless there is a urinary PCR result of >45mg/mmol within six weeks of the audit date or the Albumin Excretion Stage is Albuminuria.	Annually
Foot Screening and education: Foot risk Status Foot Pulses Foot Sensation to Monofilaments	Annually
ACE / ARB - For patients with current albumin excretion stage of microalbuminuria or	Annually *

macroproteinuria a record within past 15 months of treatment with an ACE Inhibitor or ARB or a record of contraindication/intolerance/patient declined for both drug classes	
Record of patient care plan	Annually
Alcohol intake recorded	Annually
Hypoglycaemic Drug Therapy recorded	6 monthly
Arrangement for Formal Diabetes Care	Annually
Record of the Albumin Excretion Stage	Annually
Smoking cessation advice for those who smoke (standard applies only to this subset)	Annually **

* For patients without microalbuminuria or macroalbuminuria will be assumed to have passed this audit standard.

** For people who do not smoke, it will be assumed they have passed this audit standard.

For the purposes of audit annual, shall mean " once within the 15 months prior to 31st March (the audit date) at the end year being audited".

For those items that require to be done 6 monthly the audit standard will be between 4 to 8 months prior to 31st March (the audit date). This audit standard will be confirmed by a computer search to confirm that there is at least one reading in the previous 8 months. If a match cannot be found using the most recent result, ESCRO will move to next most recent result and recalculate the window. If this also fails ESCRO moves to the next most recent until a pass is generated, or all results in the previous 8 months are exhausted.

If there are no records in the previous 8 months or, there has been a gap in activity of more than 8 months this will generate a fail.

Apart from drug intolerance or contraindication in the standard relating to Ace inhibitor use, there is no exception reporting. It is therefore accepted that no practice will achieve the audit standards for all patients. For example because of non-attendance or a sound clinical reason for omitting part of the screening process. This approach is administratively simpler for all parties .An acceptance that some patients will fail the screening audit despite the practices best efforts is reflected in the level of finance.

Full payment for the screening audit component will be made if 15 or 16 items pass the audit standard.

A reduced payment will be made if 11-14, inclusive; of the audit, standards are passed.

No payment will be made if 10 or less of the audit standards are reached.

7. OUTCOME CRITERIA

The outcome audit will be of 3 items. These are HbA1c, total cholesterol and blood pressure most recently recorded electronically within 15 months of the audit date. If there is no reading within the previous 15 months of the audit date, the missing item will count as having failed the audit standard. There is no exception reporting for these audits and this is reflected in the standard set.

Unlike the screening audits, which apply to individual patients, the outcome audit will apply to the total population of each of the 3 care groups. The two "insulin" care groups are audited as one.

For each person with diabetes there are 3 items. Therefore, for example, if there are 100 people with diabetes in a care group there are a possible 300 items, which can be either passed or failed. The audit standard for each group is a percentage of these items will require to be passed. For example in the group not treated with insulin the standard is 60%, therefore 180 items would require to pass out of a total of 300 in order to achieve full payment.

Outcome Criteria	Standard
Blood Pressure	< 140/80
HbA1c	< 7.5%
Serum Cholesterol	< 5.0

OUTCOME AUDIT STANDARD FOR PEOPLE WITH TYPE 2 DIABETES NOT ON INSULIN

60% or more of audit items passed – full payment
40 –59% of audit items passed – reduced payment
Less than 40% of audit items passed – no payment

OUTCOME AUDIT FOR PEOPLE ON INSULIN RECEIVING "SHARED CARE" AND "PRACTICE BASED CARE"

For period 1 January to 31 March 2009, payment will assume an achievement of 60% of maximum for those patients who meet either the Shared or Practice Based criteria.

For period 1 April 2009 to 31 March 2010,

55% or more of audit items passed - full payment
45 –54% of audit items passed – reduced payment A
30-44% of audit items passed – reduced payment B
Less than 30% of audit items passed - no payment

It is agreed that these figures will be reviewed before setting standards of the remainder of the contract. These discussions to be based on the principle that

standards should be challenging but achievable, used as a means to improve clinical standards rather than a means of cost control.

8. FINANCE

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 on a 3 year rolling basis with an initial 4 year period from 1 April 2008 to 31 March 2012.

The agreement will be reviewed annually in line with the annual review of the GMS Contract set out in the NHS (General Medical Services Contracts)(Scotland) Regulations, or other legislation as appropriate.

If any terms of commissioning of any service require to be changed, either party will give 6 months notice. Both parties agree that this clause would only be invoked under exceptional circumstances and will be in consultation with the GP Sub Chairman's Group.

There are 4 components to payment for this enhanced service:

- start up fee
- screening audit payment
- outcome audit payment
- potential penalty related to occupational assurance.

START UP PAYMENT

For years 08/09, and 09/10 only a start up payment of £1000 will be made per year. (The total budget will be uplifted annually by the greater of the DDRB pay uplift or global sum uplift for inflation, however the cost per service will only increase if an increase in GMS Enhanced Services payments is awarded.)

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PAYMENT RELATED TO SCREENING AUDIT

Details of these audits as described in section 6, screening audit criteria. This is the same for each of the 3 care groups.

Full payment will be £50 per patient reaching the required standard.
Reduced payment will be £25 per patient meeting the required standard.

PAYMENT RELATED TO OUTCOME AUDIT CRITERIA

The standard required and the related payment is different for each of the care groups.

FOR PEOPLE WITH DIABETES NOT ON INSULIN

The full payment, which will be made if the required audit standard is reached, is the number of eligible patients (as defined in section 5 of this contract) multiplied by £50. The reduced payment is 75% of the full payment.

FOR PEOPLE WITH DIABETES ON INSULIN RECEIVING "SHARED CARE" AND PRACTICE BASED CARE

The full payment, which will be made if the required audit standard is reached, is the number of eligible patients for shared care (as defined in section 5 of this contract) multiplied by £15 **plus** the number of eligible patients for "practice based care "(as defined in section 5 of this contract) multiplied by £130.

Reduced payments will be made based on % achievement:

Achievement	% of payment
55%+	100
45 –54% - reduced payment A	85
30-44% - reduced payment B	38
Less than 30%	0

Due to the problem of small numbers of patients causing relatively larger percentage changes in the smaller diabetic numbers in small Practices, an appropriate statistical calculation involving 95% confidence intervals will be applied to thresholds for each Practice. This means that threshold values can be fairly applied to both smaller and larger Practices. No Practice will be disadvantaged. This calculation will be automatically applied by ESCRO.

Quarterly reports will be run on 1 June, 1 September, 1 November and 1 March from the PAS/hospital system to identify the CHI numbers of all patients who are on the waiting list, or have a booked appointment for a 'Review' with the Diabetic Specialist service. The ESCRO system will compare this list with the data from ESCRO to highlight any patients who have been claimed as 'Total Practice Care' but who has a review appointment planned. These patients will then revert to Shared Care in ESCRO and practices will have to submit a 'forced claim' if they feel that this is incorrect.

POTENTIAL PENALTY FOR OCCUPATIONAL ASSURANCE

If the occupational assurance requirements described in section 4 of this contract are not met, there will be a penalty of 25% of the total payment for the sections described above.

Payment will be made monthly, in arrears, 1/12 of 66.66% of the value of aspired activity for the year will be paid to Practices with the first 3 months payment being

made at the end of June. A process of reconciliation of actual Vs aspired activity will take place at the end of the financial year.

At the discretion of the Practice, payments can be reduced in year if it is felt that actual activity is falling significantly below the minimum level.

9. SIGNATURE SHEET

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the NHS Highland:

Signature	Name	Date

APPENDIX 1
Mandatory Dataset

The mandatory dataset describes the data, which practices providing this LES require to record and the frequency with which it should be recorded.

There are four possible frequencies of recording parameters:-

Once = Once
If = If patient has this conducted or if this activity/treatment is indicated and has been performed
Six monthly
Annually

The ref numbers referred to in this paper are the reference numbers in the Scottish Diabetes Core Dataset Primary Subset and Extension.

Items included in the requirements for the screening and/or management criteria are identified in the table.

Ref Number From the Scottish Diabetes Core Dataset	Data Item	Parameter to be recorded, if applicable	Parameter = Read Term *(the shaded areas below are not required for LES)	Read Code *	Frequency	Screening or Outcome Criteria?
18	Ethnic Grouping		White Scottish	9I21	Once	Screening
			White Irish	9I1..		
			Other White British	9I0..		
			Other White	9I2..		
			Black Caribbean	9IB..		
			African	9IC..		
			Other Black	9ID..		
			Indian	9I7..		
			Pakistani	9I8..		
			Bangladeshi	9I9..		
			Chinese	9IE..		
			Other Asian	9IA..		
			Other ethnic group	9IF..		
			Other ethnic mixed	9I6..		
			Ethnic Group not provided	9IG..		
24	Type of diabetes	2, 6 *	1 = Type 1 Diabetes Mellitus	C10E.	Once – with date of entry being changed to date of diagnosis	
			2 = Type 2 Diabetes Mellitus	C10F.		
			3 = Impaired glucose tolerance	R10E.		
			4 = Impaired fasting glucose	R10D0		
			5 = Gestational	L1809		
			6 = Maturity onset diabetes of youth	C10C.		
			8 = Other diabetes mellitus			
26	Arrangement For Formal Diabetes Care	1	1 = Diabetes: practice programme	66AP.	annually	
			2 = Diabetes care by hospital only	66AU.		

			3 = Diabetes: shared care program	66AQ.		
31	Patient weight		O/E – weight	22A..	Six monthly	Screening
32	Patient height		O/E – height	229..	once	Screening
33	Patient body mass index		Body Mass Index	22K..	Six monthly	Screening
34	Systolic blood pressure		O/E – Systolic BP reading	2469.	Six monthly	Screening & Outcome
35	Diastolic blood pressure		O/E – Diastolic BP reading	246A.	Six monthly	Screening & Outcome
36	Smoking status at date of contact	1, 2 or 3	1 = Current smoker	137R.	annually	Screening
			2 = Ex smoker	137S.		
			3 = Never smoked tobacco	1371.		
38	Alcohol intake per average week		Alcohol consumption	136..	annually	Screening
39	Erectile failure		1 = Impotence	E2273	If	
46	Hypoglycaemic drug therapy	1, 2, 3 or 4	1 = Diabetic on insulin	66A5.	Six monthly	Screening
			2 = Diabetic on oral treatment	66A4.		
			3 = Diabetic on insulin and oral treatment	66AV.		
			4 = Diabetic on diet only	66A3.		
47	Serum creatinine		Serum creatinine	44J3.	annually	Outcome
48	Serum total cholesterol		Total cholesterol measurement	44PH.	annually	Outcome
49	Serum HDL Cholesterol		Serum HDL cholesterol level	44P5.	annually	Outcome
51	Albustix	0,1,2,3,4 or 5	0 = Urine protein test not done	4671.	annually	Screening
			1 = Urine protein test negative	4672.		
			2 = Urine protein test = trace	4673.		
			3 = Urine protein test = +	4674.		
			4 = Urine protein test = ++	4675.		
			5 = Urine protein test = +++	4676.		

			Proteinuria	4678.		
52	Urinary microalbumin test done		Urine microalbumin	46W..	Annually	Screening
52a	Urinary albumin test method used and result	1,2,3 or 4	1 = Urine albumin	46N4.	Annually	Screening
			2 = Urine albumin:creatinine ratio	46TC.		
			3 = Overnight albumin excretion rate	44JG.		
			4 = 24hr urine albumin output	46N6.		
53	Albumin excretion (stages 1-4)	1,2 or 3	1 = Urine protein normal	46N1.	1-annually unless 2 or 3 which recorded once if present	Screening
			2 = Microalbuminuria	R1103		
			3 = Albuminuria	R1100		
54	Glycated haemoglobin (HbA1c)		Haemoglobin Alc level	44TB.	Six monthly	Screening and Outcome
58	Myocardial infarct		Acute myocardial infarction NOS	G30z.	If	
59	Year of diagnosis of hypertension		Essential hypertension	G20..	If	
60	CABG/coronary revascularisation procedure		Coronary artery operations	792..	If	
61	Year of diagnosis of angina/CHD		Ischaemic heart disease NOS	G3z..	If	
63	Stroke – date of		Stroke and cerebrovascular accident unspecified	G66..	If	
65	Year of diagnosis of peripheral vascular disease		Peripheral vascular disease NOS	G73z.	If	
70	Year of end-stage renal failure		End stage renal failure	K050.	If	
71	Diabetic foot risk status – left	1,2,3 or 4	1 = O/E – Left diabetic foot at low risk	2G5I.	annually	Screening
			2 = O/E – Left diabetic foot at moderate risk	2G5J.		

			3 = O/E – Left diabetic foot at high risk	2G5K.		
			4 = O/E – Left diabetic foot – ulcerated	2G5L.		
71a	Diabetic foot risk status – right	1,2,3 or 4	1 = O/E – Right diabetic foot at low risk	2G5E.	annually	Screening
			2 = O/E – Right diabetic foot at moderate risk	2G5F.		
			3 = O/E – Right diabetic foot at high risk	2G5G.		
			4 = O/E – Right diabetic foot – ulcerated	2G5H.		
72	Amputation, left lower limb – event	1,2,3 or 4	1 = Amputation above knee	7L062	If	
			2 = Amputation below knee	7L064		
			3 = Amputation of foot	7L07.		
			4 = Amputation of toe	7L08.		
74	Amputation, right lower limb – event	1,2,3 or 4	1 = Amputation above knee	7L062	If	
			2 = Amputation below knee	7L064		
			3 = Amputation of foot	7L07.		
			4 = Amputation of toe	7L08.		
76	Any foot pulse – left	1 or 2	1 = O/E left foot pulses – present	24FB.	annually	Screening
			2 = O/E – absent left foot pulses	24FA.		
77	Any foot pulse – right	1 or 2	1 = O/E right foot pulses – present	24EB.	annually	Screening
			2 = O/E – absent right foot pulses	24EA.		
78	Foot sensation to monofilaments – left	1 or 2	1 = 10g monofilament sensation left foot normal	29BC.	annually	Screening
			2 = 10g monofilament sensation left foot abnormal	29BA.		
79	Foot sensation to monofilament right	1 or 2	1 = 10g monofilament sensation right foot normal	29BB.	annually	Screening
			2 = 10g monofilament sensation Right foot abnormal	29B9.		

95a	Screening for diabetic retinopathy		Diabetic retinopathy screening	68A7.	Annually – provided by the National Screening Programme	
97	Permanent blindness as defined	3	Blindness both eyes NOS 1 = diabetic cause 2 = non-diabetic cause 3 = Blind, cause unknown 4 = Blind, potentially reversible cause	F490z	If	
139 (1. management	Dietary advice given	1 and / or 2	1 = Pt advised re diabetic diet	8CA41	Once and if	
			2 = Pt advised re wt reducing diet	8CA40		
140	Influenza immunisation	1, 2 or3	1 = Influenza vaccination	65E..	annually	
			2 = Influenza vaccination contraindicated	812F.		
			3 = Influenza vaccination declined	90X5.		
141 (2. management)	ACE inhibitor prescription status	1,2,3 or 4	1 = ACE inhibitor prophylaxis	8B6B.	If have proteinuria or microalbuminuria (reference number 53)	Screening
			2 = Angiotensin converting enzyme inhibitors contraindicated	8128.		
			3 = ACE inhibitor declined	813D.		
			4 = ACE inhibitors causing adverse effects in therapeutic use	U60C4		
142 (2. management)	Angiotension II receptor antagonist prescription status	1,2,3 or 4	1 = Angiotension II receptor antagonist prophylaxis	8B6E.	If have proteinuria or microalbuminuria (reference number 53) parameter and adverse reaction to ACE inhibitors (reference number 141 parameter 4)	Screening
			2 = Angiotension II receptor antagonists contraindicated	812H.		
			3 = Angiotension II	813P.		

			receptor antagonist declined			
			4 = Angiotension II receptor antagonist causing adverse effects in therapeutic use.	U60CB		
143 (3. management)	Smoking Care Management		Smoking cessation advice	8CAL.	If smoker annually	Screening
144	Physical activity assessment outcome	1,2,3,4 or 5	Exercise physically impossible	1381.	annually	
			Avoids even trivial exercise	1382.		
			Enjoys light exercise	1383.		
			Enjoys moderate exercise	1384.		
			Enjoys heavy exercise	1385.		
145 (M but not audited)	Physical activity care management		Health Education exercise	6798.	If	
146 (4. management)	Diabetes care plan agreed		Diabetes management plan given	66AR.	annually	Screening
147 (M but not audited)	Alcohol intake care management		Health ed. Alcohol	6792.	If	
148 (M but not audited)	Psychosexual counselling		Psychosexual counselling	677A.	If	

This can be accessed via:-

www.show.scot.nhs.uk/

Then click on ‘Publications’ and it is available under the heading

‘Primary Care Subset and Extension – Scottish Diabetes Core Dataset’ December 2003

APPENDIX 2 Occupational Assurance Certification

This appendix contains that Occupational Assurance Forms for practices and individuals.
Each practice is required to complete and retain the statement of compliance for their practice and to retain records for each individual providing health care under this enhanced service using these forms.

Practice……

Practice Code……

The following clinical staff are involved in the provision of the Local Enhanced Service for Diabetic Patients.

We can confirm that these staff all comply with the standards of Occupational Assurance as specified in Appendix 4 of the Service Level Agreement.

PRACTITIONER – NAME & JOB TITLE	FOOT SCREENING	DIET & LIFESTYLE	BLOOD GLUCOSE MONITORING	MEASUREMENTS

Signed…….Date……..

Name……

On behalf of……..

1. Foot Screening

I confirm that I have attended a course on foot screening for people with diabetes and have the knowledge and skills to enable me to provide foot screening to the nationally agreed standards.

Enter Details do the course and/or trainer below:

Date of training:

Venue :

Signature:

2. Diet and lifestyle

I confirm that I have read an education pack including the documents listed in the enhanced services contract appendix 4. I have the knowledge and skills to provide initial education and advice about diet and lifestyle for people with diabetes to the agreed standards

Signature:

3. Blood Glucose Monitoring

I confirm that I have read NHS Highland guideline for blood glucose monitoring and I have the knowledge and skills to provide advice about Blood Glucose Monitoring for people with diabetes to the agreed guideline and will promote that guideline.

Signature:

4. Measurements

I confirm that I agree to measure BP, height and weight for people with diabetes to the agreed standards as defined in the enhanced service contract appendix 4 and I have the knowledge and skills to do so.

Signature: