LOCAL ENHANCED SERVICE (LES)

MANAGEMENT OF PEOPLE AGED SIXTEEN AND OVER WITH DIABETES

Service Level Agreement - To 31 March 2015

PRACTICE –

Contents:

1. INTRODUCTION/AIMS

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Diabetes Mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the UK identified as having the condition. Effective control and monitoring can reduce both mortality and morbidity.

The aim of this local enhanced service is to allow continuation of the high quality diabetic care provision for people aged 16 and over with diabetes in the community, whilst ensuring appropriate access to all specialist services as clinically required.

Patients with diabetes not on insulin will receive all routine screening and clinical management by General Practice. Advice from specialist services can be sought when required, and referral guidelines are in place.

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, along with interim management, Routine review will be undertaken by the

Diabetes Specialist Team on at least an annual basis. HbA1C testing will be carried out within secondary care during this review. Additional specialist review is available 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.

Treatment group definitions are included at Appendix 1.

Practices will have the option to provide services for all patients with diabetes, or can opt to provide services for patients with diabetes not on insulin only.

2. SUMMARY OF SERVICE TO BE PROVIDED

1. Review of people with diabetes as clinically required.
2. A recall system for people overdue for diabetic checks as clinically required.
3. Performance of all routine screening for all people over 16 with diabetes, however for those receiving shared care services, HbA1c will be provided by secondary care when they attend for their routine review .
4. Clinical management and ongoing education of people with diabetes:
    - Act on abnormal results found in the screening process by managing or referral, if appropriate.
    - 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. See http://www.nhshighland.scot.nhs.uk/YourHealth/Diabetes/Documents/traffic%20light%20finalx3.pdf
    - For people who are attending the hospital for regular review, practices are responsible for interim management for lipids, blood pressure and other diabetes related conditions
    - 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.
5. Initial management of a person/s newly diagnosed with diabetes Confirm diagnosis in accordance with Highland Guidelines (http://guidelines.nhshighland.scot.nhs.uk/Diabetes/Diabetes%20New%20Patient/index.htm).
    - Identify those who are likely to require immediate insulin therapy, and refer as appropriate to a Diabetes Specialist Nurse or Consultant Diabetologist (usually by telephone call) .
    - For those who do not require immediate insulin therapy, perform a comprehensive review and assessment, as in the Highland Diabetes Guidelines (http://www.nhshighland.scot.nhs.uk/YourHealth/Diabetes/Pages/TreatHypo.aspx).
    - 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

6. 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://nhshighland.scot.nhs.uk/Your Health/Diabetes/Pages/default.aspx
2. Highland Formulary
3. SIGN 116 Guideline – Management Of Diabetes http://www.sign.ac.uk/guidelines/fulltext/116/index.html

4. ACCREDITATION

Those doctors who had previously provided services similar to this local enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so. This is in accordance with the Highland (and Scottish) Diabetes Education and Training Strategy.

By agreeing to provide this service the Practice agrees to ensure all healthcare professionals maintain the appropriate skills required.

5. MONITORING AUDIT CRITERIA

The monitoring 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 monitoring 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 2). 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 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	Annually *
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 those items that require to be done annually, the audit standard shall mean once within the 15 months prior to 31st March.
For those items that require to be done 6 monthly the audit standard will be twice within the 15 months prior to 31st March.

6. 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 for the period 1st Oct 2012 to 31 March 2015.

Transition Arrangements

As this agreement begins part way through a financial year, transition arrangements will be as follows: For the period 1st October 2012 to 31st March 2013, payment will be based on the number of patients per pathway, paid at 6/12 of the new tariff rate. Screening will be paid at the higher rate, rather than the stepped rate.

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. Capping of payments is specifically excluded.

The Commissioners guarantee a cap on budget or patient numbers for any care pathway will not be imposed during the life of this agreement.

Payment Rate

Service	Payment	Rate
Monitoring	Per Patient on LES Register	Full Payment - £25 Reduced Payment - £20

Payment relating to Monitoring
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.

Practices will be eligible for a per patient payment for diabetic care provision for those included on the local enhanced services register if their Quality Outcome Framework (QoF) overall achievement for the Diabetes Mellitus (DM) indicator, as reported via QoF Calculator, is ≥ 90% within the financial year relating to payment.

(Full details of treatment group definitions are included at Appendice 1)

Treatment Group	Payment	Rate
Non Insulin	Per Patient on LES Register	£35
Insulin Shared Care	Per Patient on LES Register	£25
Insulin Practice Care	Per Patient on LES Register	£55

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.

Quarterly payments will be made in May, August, and November based on 100% of the value of aspired activity for the year, and assuming outcomes meet QoF achievement of ≥ 90% as detailed above. A process of reconciliation of actual Vs aspired activity will take place at the end of the financial year with any balancing payment paid in April.

(Payment for services provided for the period from 1 April – 30 September 2012 will be made at the end of October and will equal 50% of payment made for the financial year 2011/12.)

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.

7. SIGNATURE SHEET

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the NHS Highland:

Signature	Name	Date

Practices have the option to provide services for all patients with diabetes, or can opt to provide services for patients with diabetes not on insulin only.

Please indicate below which services your Practice wishes to provide.

Service	Wish to Provide	Do Not Wish to Provide
Non Insulin Patient Service		
Insulin Patient Shared Care Service		
Insulin Patient Practice Based Care Service		

(Practices can offer the shared care service only to Insulin patients.)

APPENDIX 1 Treatment Group Definitions

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 diabetes 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

APPENDIX 2
Mandatory Dataset

The mandatory dataset describes the data, which practices providing this LES are required 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
6 monthly = twice within the 15 months prior to 31 March
Annually = once within the 15 months prior to 31 March

	Read Code	Screen Description	Read Code Description	Frequency
	Diagnosis			Once with date of entry being changed to date of diagnosis
	C10E.	Type 1 diabetes mellitus	Type 1 diabetes mellitus	
	C10F.	Type 2 diabetes mellitus	Type 2 diabetes mellitus	
	C10..	Diabetes mellitus – other/unknown	Diabetes mellitus	
	C10C.	Maturity onset diabetes of youth	Maturity onset diabetes of youth	
	Locus of Care			Annually
	66AP.	Practice programme	Diabetes: practice programme	
	66AQ.	Shared care programme	Diabetes: shared care programme	
	Current Treatment			6 monthly
	66A3.	On diet only	Diabetic on diet only	
	66A4.	On oral treatment	Diabetic on oral treatment	
	66A5.	On insulin	Diabetic on insulin	
	66AV.	On insulin+oral treatment	Diabetic on insulin+oral treat	
	Ethnicity			Once
White				
	9i21.	Scottish	Scottish – Ethnic cat 2001 census	
	9i0..	Other British	British or mixed British 2001 cen	
	9i1..	Irish	Irish – Ethnic category 2001 cen	
	9i2..	Any other White background	Other white – Ethnic categ 2001 cen	

Mixed			
9i6..	Any mixed background	Other mixed – Ethnic cat 2001 cen	
Asian, Asian Scottish or Asian British			
9i7..	Indian	Indian or British Indian 2001 cen	
9i8..	Pakistani	Pakistani or Brit Pakistani 2001 cen	
9i9..	Bangladeshi	Bangladeshi or Brit Bangl 2001 cen	
9iE..	Chinese	Chinese – Ethnic category 2001 cen	
9iA..	Any other Asian background	Other Asian – Ethnic cat 2001 cen	
Black, Black Scottish or Black British			
9iB..	Caribbean	Caribbean – Ethnic categ 2001 cen	
9iC..	African	African – Ethnic category 2001 cen	
9iD..	Any other Black background	Other Black – Ethnic cat 2001 cen	
Other Ethnic background			
9iF..	Any other Ethnic background	Other Ethnic – Ethnic cat 2001 cen	
Refused / Not stated by patient			
9iG..	Ethnic category not stated	Ethnic category not stated	
Height & Weight			
229..	Height	O/E - height	Once
22A..	Weight	O/E - Weight	6 monthly
22K..	Body Mass Index	Body Mass Index	6 monthly
22N0.	Waist circumference	Waist circumference	
Blood Pressure			
2469.	Systolic BP reading	O/E - Systolic BP reading	6 monthly
246A.	Diastolic BP reading	O/E - Diastolic BP reading	6 monthly
8BL0.	Maximal tolerated antihypertensive therapy	Pt on max tol antihypert ther	
8I3Y.	Blood pressure procedure refused	BP procedure refused	
Urinalysis			Annually
4671.	Urine protein test not done	Urine protein test not done	
4672.	Negative	Urine protein test negative	
4673.	Trace	Urine protein test = trace	
4674.	+	Urine protein test = +	
4675.	++	Urine protein test = ++	
4676.	+++	Urine protein test = +++	
4678.	Proteinuria	Proteinuria	

Lifestyle			
137R.	Current smoker	Current smoker	Annually
137S.	Ex smoker	Ex smoker	
1371.	Never smoked tobacco	Never smoked tobacco	
1381.	Exercise physically impossible	Exercise physically impossible	Annually
1382.	Avoids even trivial exercise	Avoids even trivial exercise	
1383.	Enjoys light exercise	Enjoys light exercise	
1384.	Enjoys moderate exercise	Enjoys moderate exercise	
1385.	Enjoys heavy exercise	Enjoys heavy exercise	
136..	Alcohol consumption	Alcohol consumption	Annually
6896.	Depression screening completed	Depression screen using quest	
Lifestyle advice			
8CA41	Patient advised re diabetic diet	Patient advised re diabetic diet	Once and if
8CA40	Patient advised re weight reducing diet	Patient advised re weight reducing diet	
6798.	Health education - exercise	Health education – exercise	If
6792.	Health education - alcohol	Health education - alcohol	If
8CAL.	Smoking cessation advice	Smoking cessation advice	Annually if smoker
Foot Examination			
24EB.	Right foot pulses present	Right foot pulses present	Annually
24EA.	Right foot pulses absent	Right foot pulses absent	
24FB.	Left foot pulses present	Left foot pulses present	Annually
24FA.	Left foot pulses absent	Left foot pulses absent	
29BB.	10g monofilament sensation R normal	10g monofilament sensation R normal	Annually
29B9.	10g monofilament sensation R abnormal	10g monofilament sensation R abnormal	
29BC.	10g monofilament sensation L normal	10g monofilament sensation L normal	Annually
29BA.	10g monofilament sensation L abnormal	10g monofilament sensation L abnormal	
2G5E.	Right diabetic foot at low risk	Right diabetic foot at low risk	Annually
2G5F.	Right diabetic foot at moderate risk	Right diabetic foot at moderate risk	
2G5G.	Right diabetic foot at high risk	Right diabetic foot at high risk	
2G5H.	Right diabetic foot ulcerated	Right diabetic foot ulcerated	

2G5I.	Left diabetic foot at low risk	Left diabetic foot at low risk	Annually
2G5J.	Left diabetic foot at moderate risk	Left diabetic foot at moderate risk	
2G5K.	Left diabetic foot at high risk	Left diabetic foot at high risk	
2G5L.	Left diabetic foot ulcerated	Left diabetic foot ulcerated	
HbA1c Diabetic control			6 monthly
42W5.	HbA1c level - IFCC standardised	HbA1c level - IFCC standardised	
8BL2.	Maximal tolerated therapy for diabetes	Maximal tolerated therapy for diabetes	
eGFR / Creatinine			
451F.	eGFR	Glomerular Filtration Rate	
44J3.	Serum creatinine	Serum creatinine	Annually
Serum Cholesterol & HDL			
44PH.	Total cholesterol measurement	Total cholesterol measurement	Annually
44P5.	Serum HDL cholesterol level	Serum HDL cholesterol level	Annually
8I63.	Statin not indicated	Statin not indicated	
8I27.	Statin contraindicated	Statin contraindicated	
8I3C.	Statin declined	Statin declined	
U60CA	Statin causing adverse effect	Statin causing adverse effect	
8I76.	Statin not tolerated	Statin not tolerated	
8BL1.	Maximal tolerated lipid lowering therapy	Maximal tolerated lipid lowering therapy	
Other Blood Tests			
414..	Sample sent to lab. for test	Sample sent to lab. for test	
Urine Albumin Status			
46W..	Urinary microalbumin test done	Urinary microalbumin test done	Annually
46TC.	Urine albumin/creatinine ratio	Urine albumin/creatinine ratio	
44lD.	Urine protein/creatinine ratio	Urine protein/creatinine ratio	
46N1.	Urine protein normal	Urine protein normal	One annually unless 2 or 3 which are recorded once if present
R1103	Microalbuminuria	Microalbuminuria	
R1100	Albuminuria	Albuminuria	
ACE/A2 Antag Use			

8B6B.	ACE inhibitor prophylaxis	ACE inhibitor prophylaxis	If patient has proteinuria or microalbuminuria
8I28.	ACE inhibitor contraindicated	ACE inhibitor contraindicated	
8I3D.	ACE inhibitor declined	ACE inhibitor declined	
U60C4	ACE inhibitor causing adverse effects	ACE inhibitor causing adverse effects	
8B6E.	Angiotensin II antagonist prophylaxis	Angiotensin II antagonist prophylaxis	If patient has proteinuria or microalbuminuria parameter and adverse reaction to ACE inhibitors
8I2H.	Angiotensin II antagonist contraindicated	Angiotensin II antagonist contraindicated	
8I3P.	Angiotensin II antagonist declined	Angiotensin II antagonist declined	
U60CB	Angiotensin II antagonist causing adverse effects	Angiotensin II antagonist causing adverse effects	
Agreed Management Plan/Med Review			
66AR.	Diabetes management plan given	Diabetes management plan given	Annually
8B3V.	Medication review done	Medication review done	
6719.	Care discussed with consultant	Discussed with consultant	
Retinal Screening			
68A7.	Diabetic retinopathy screening	Diabetic retinopathy screening	Annually
9N2e.	Seen by ophthalmologist	Seen by ophthalmologist	
8I6F.	Diabetic retinopathy screening not indicated	Diabetic retinopathy screening not indicated	
8I3X.	Diabetic retinopathy screening refused	Diabetic retinopathy screening refused	
Influenza Vaccination			
65E..	Influenza vaccination given	Influenza vaccination given	Annually
14LJ.	Influenza vaccination allergy	Influenza vaccination allergy	
8I2F.	Influenza vaccination contraindicated	Influenza vaccination contraindicated	
9OX5.	Influenza vaccination declined	Influenza vaccination declined	
Exception reporting			
9h41.	Patient unsuitable	Patient unsuitable	

9h42.	Informed dissent	Informed dissent	
Sexual Dysfunction Complications			
677A.	Psychosexual counselling	Psychosexual counselling	If
E2273	Impotence	Impotence	If
1D711	No sexual dysfunction symptoms	Free of symptoms	
Cardiovascular Complications			
G20..	Essential hypertension	Essential hypertension	If
G30z.	Acute myocardial infarction	Acute myocardial infarction	If
792..	Coronary artery operations	Coronary artery operations	If
G3z..	Ischaemic heart disease	Ischaemic heart disease	If
G64z.	Cerebral infarction	Cerebral infarction	
G61..	Intracerebral haemorrhage	Intracerebral haemorrhage	
G66..	Stroke/CVA unspecified	Stroke/CVA unspecified	If
G73z.	Peripheral vascular disease	Peripheral vascular disease	If
Renal Complications			
R1103	Microalbuminuria	Microalbuminuria	
R1100	Albuminuria	Albuminuria	
K050.	End stage renal failure	End stage renal failure	If
Feet Complications			
M271.	Foot ulcer	Foot ulcer (S)	
G73z.	Peripheral vascular disease	Peripheral vascular disease	
7L062	Amputation above knee R	Amputation above knee	If
7L064	Amputation below knee R	Amputation below knee	
7L07.	Amputation of foot R	Amputation of foot	
7L08.	Amputation of toe R	Amputation of toe	
7L062	Amputation above knee L	Amputation above knee	
7L064	Amputation below knee L	Amputation below knee	
7L07.	Amputation of foot L	Amputation of foot	
7L08.	Amputation of toe L	Amputation of toe	

Eye Complications			
F490z	Blindness both eyes	Blindness both eyes	If
F420.	Diabetic retinopathy	Diabetic retinopathy	
F421.	Background retinopathy	Background retinopathy	
F4202	Preproliferative diabetic retinopathy	Preproliferative diabetic retinopathy	

Once a suitable READ code becomes available for non insulin injectable therapy Practices will be notified.