DIABETES SERVICE SPECIFICATION

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Contents

1 INTRODUCTION 3
2 CLINICAL SPECIFICATION 3
3 TRAINING & RESOURCES 8
4 FEEDBACK AND LEARNING 10
5 RECORDING OF INFORMATION 10
6 QUALITY 14
7 FINANCE 15
8 CONTRACT MONITORING 16
Appendix 1 – Insulin Initiation Documents 17
Appendix 2 – Diabetes Enhanced Service Codes (ESCRO) 20

DIABETES SERVICE SPECIFICATION

1 INTRODUCTION

This Service Specification along with the Contract Details in Part 1 forms the Local Enhanced Service (LES) for the enhanced care of diabetes in primary care.

This Service Specification works towards meeting the Scottish Government priorities and NHSH Annual Delivery Plan (ADP): Outcome 3, Stay well and Outcome 4, Anchor well.

The numbers and prevalence of people with diabetes in Scotland continues to increase year on year. At the end of 2023 there were 353,088 people with a diagnosis of any type of diabetes in Scotland recorded in SCI-Diabetes - 310,541 (88%) are people with type 2 diabetes.

The number of new cases of type 2 diabetes (T2DM) has risen in Highland over the past 3 years, with Highland ranking third nationally in crude incidence of T2DM (559 per 100,000 population).

Associated with this will be a significant increase in the number of patients, with T2DM, who will be converted to insulin or GIP/GLP therapy. Traditionally these treatments would be managed in Secondary Care.

Practices should refer to appropriate local and national guidelines (including but not limited to TAM, SIGN and NICE).

2 CLINICAL SPECIFICATION

Purpose
The purpose of the LES is to provide a systematic, safe and reliable approach to diabetes care (for people aged 16 and over) to ensure patient care and safety; beyond what would be expected as core essential GMS services.

To encourage the setting of personalised targets; increase the proportion of people with diabetes receiving practice-based care; and to support the initiation of insulin and GIP/GLP1 in General Practice.

Definition
For the purposes of this LES:

- T2DM - Those with Hba1c at diagnosis >47 excluding those with Type1 Diabetes and Gestational Diabetes.
- Non-Complex T2DM - Treated with two or fewer than two oral therapies for hyperglycaemia.
- Complex T2DM – Treated with three or more oral therapies for hyperglycaemia or on an injectable therapy for diabetes.

Service Aims

(i) To continue to support the development and maintenance of high-quality care for people with diabetes in Primary Care.
(ii) To increase the proportion of people with diabetes being cared for in Primary Care and enable the referral and discharge of patients from Secondary Care in accordance with appropriate clinical guidance (including but not limited to TAM, SIGN and NICE).
(iii) To support all patients being cared for in Primary Care to receive appropriate reviews conducted by the practice.
(iv) To provide standardised and clinically effective insulin or GIP1/GLP initiation and management to patients.

General Requirements

(i) Practices should maintain an accurate register of patients with diabetes using appropriate READ codes; and ensuring that patient ethnicity is coded (with appropriate consent)
(ii) Record the 'locus of care' (Practice Based or Shared Care or Specialist Care)

Part 1 – Patients with Non-Complex Diabetes:

To provide care, including that expected as part of core essential GMS, to patients on the diabetes register with non-complex diabetes for whom the level of care expected, or required.

Service Requirements

(i) Ensure appropriate level of competency, through training (as appropriate, and dependant on clinician's role in care), to deliver an appropriate level of care for patients with non-complex diabetes (as defined above).
(ii) Provide full support for non-complex T2DM patients in relation to their diabetes care
    a) Practices would manage patients with non-complex T2DM either independently; or that have been referred to, and discharged from, DSN/secondary care services and maintained on a non-complex regime of treatment and where ongoing monitoring, support and education is provided in general practice:
        i) As a minimum it is expected that these patients receive standard diabetes care as stated below:
            1. weight/BMI, BP
            2. bloods (including HbA1c, lipids & creatinine/eGFR),
            3. urinary ACR
            4. recording of alcohol & smoking status (+/- brief intervention/smoking cessation advice)
            5. foot screening (frequency as appropriate based on risk – pulses, sensation & risk categorisation)
            6. support self-monitoring of BMs/ketones where appropriate
        ii) It is expected that patients with non-complex diabetes are offered at least 6 monthly reviews in Primary Care, as per NICE recommendations. As a minimum this would include updating HbA1c, weight/BMI & BP; and providing any appropriate adjustment to clinical care. Where individual clinical circumstances require more frequent review this should be provided.

iii) Create/review & update a Personalised Diabetes Management Plan – and agree personalised targets for HbA1c, Blood Pressure and weight/BMI.
iv) Practices should refer to appropriate local and national guidelines (including but not limited to TAM, SIGN and NICE).
v) Practices would be expected to monitor and manage risks associated with T2DM is the standard way (e.g. cardiovascular – management of cholesterol, BP; renal – management of micro/macroalbuminuria); and ensure that appropriate foot screening and engagement with vaccination and retinal screening programmes is supported.
vi) Ensuring all relevant data is recorded within GPIT systems and transferrable to SCI-diabetes.

The contractor can trigger a claim for a patient under this service at any time; the following conditions apply:

a) The contractor will ensure all requiring criteria has been met and coded prior to triggering a claim. Where a claim is triggered and the criteria has not been met within the required time frame, the claim will fail resulting in no payment. Where all criteria have been met with exception of the ACR, the lower fee will be paid.
b) The overall payment will be paid at ½ of the annual fee for each of the annual and 6 monthly claims triggered.
c) The maximum of one claim per patient within a 6-month period. Where a claim is triggered, in circumstances where criteria hasn't been met, no further claim(s) will be accepted for that patient until the 6-month period has lapsed.
d) Where a patient moves practice, no further claim will be permitted against that patient CHI until the 6-month period has lapsed.

The use of DSNs and secondary care teams for advice and support on an ad-hoc basis would not preclude claiming under this LES, provided the full provision of care is based in General Practice.

Part 2a – Patients with Complex Diabetes:

To provide care, including that expected as part of core essential GMS, to patients on the diabetes register with complex diabetes for whom the level of care expected, or required, can reasonably be delivered in a Primary Care setting.

Service Requirements

(i) Ensure appropriate level of competency, through training (as appropriate, and dependant on clinician's role in care), to deliver an enhanced level of care for patients with complex diabetes (as defined above).

(ii) Provide full or partial support for complex T2DM patients and/or those on injectable treatments for diabetes.

a) Practices signed up to deliver **Practice Based Care** would manage patients with complex T2DM either independently; or that have been referred to, and discharged from, DSN/secondary care services where they have been counselled and initiated by DSNs or secondary care; but where ongoing monitoring, support and education is provided in general practice (this could include complex oral diabetes regimens, and/or all forms of injectable therapies):

i) As a minimum it is expected that these patients receive standard diabetes care as stated below:

1. weight/BMI, BP
2. bloods (including HbA1c, lipids & creatinine/eGFR)
3. urinary ACR
4. recording of alcohol & smoking status (+/- brief intervention/smoking cessation advice)
5. foot screening (frequency as appropriate based on risk – pulses, sensation & risk categorisation)
6. support self-monitoring of BMs/ketones where appropriate

ii) It is expected that patients with complex diabetes receiving Practice Based Care are offered at least 6 monthly reviews in Primary Care, as per NICE recommendations. As a minimum this would include updating HbA1c, weight/BMI & BP; and providing any appropriate adjustment to clinical care. Where individual clinical circumstances require more frequent review this should be provided.

iii) Create/review & update a Personalised Diabetes Management Plan – and agree personalised targets for HbA1c, Blood Pressure and weight/BMI.

iv) Practices should refer to appropriate local and national guidelines (including but not limited to TAM, SIGN and NICE).

v) Practices would be expected to monitor and manage risks associated with T2DM is the standard way (e.g. cardiovascular – management of cholesterol, BP; renal – management of micro/macroalbuminuria); and ensure that appropriate foot screening and engagement with vaccination and retinal screening programmes is supported.

vi) Ensuring all relevant data is recorded within GPIT systems and transferrable to SCI-diabetes.

b) Practices signed up to deliver **Shared Care** for patients with either Type 1 or complex Type 2 Diabetes support delivery of care for patients, who remain under the care of the DSN or secondary care team, by providing annual:

i) Data collection

1. weight/BMI, BP
2. bloods (including HbA1c, lipids & creatinine/eGFR),
3. urinary ACR
4. recording of alcohol & smoking status (+/- brief intervention/smoking cessation advice)
5. foot screening (frequency as appropriate based on risk – pulses, sensation & risk categorisation)
6. support self-monitoring of BMs/ketones where appropriate

ii) Practices would be expected to manage risks associated with T2DM is the standard way (e.g. cardiovascular – management of cholesterol, BP, renal – management of micro/macroalbuminuria); and ensure that appropriate foot screening and engagement with vaccination and retinal screening programmes is supported.

iii) Ensuring all relevant data is recorded within GPIT systems and transferrable to SCI-diabetes.

The contractor can trigger a claim for a patient under this service at any time; the following conditions apply:

a) The contractor will ensure all requiring criteria has been met and coded prior to triggering a claim. Where a claim is triggered and the criteria has not been met within the required time frame, the claim will fail resulting in no payment. Where all criteria have been met with exception of the ACR, the lower fee will be paid.
b) The overall payment for Practice Based Care will be paid at ½ of the annual fee for each of the annual and 6 monthly claims triggered. The overall payment for Shared Care will be paid when claims triggered.
c) The maximum of one claim per patient within a 6-month period (Practice Based Care) and one claim per patient within a 12-month period (Shared Care). Where a claim is triggered, in circumstances where criteria hasn't been met, no further claim(s) will be accepted for that patient until the 6-month period has lapsed.
d) Where a patient moves practice, no further claim will be permitted against that patient CHI until the respective 6-month or 12-month period has lapsed.

Initiation of injectables, including initial titration and optimisation, may be managed in specialist diabetes services, or under part 2 of this LES – but ongoing support/supervision could take place in primary care where individuals have stable glucose control and are achieving personal glucose targets, or in individuals treated with injectables who chose to have their ongoing care only within the general practice setting; and where primary care clinicians are competent to provide this level of care.

The use of DSNs and secondary care teams for advice and support on an ad hoc basis would not preclude claiming under either full or shared care.

Part 2b – Initiation of Injectables for T2DM Patients with complex diabetes:

(i) Practices signed up to deliver Initiations would be competent to counsel, initiate and monitor patients being escalated to injectable T2DM treatment regimens including the use of injectable GIP/GLP1 and insulin; including patient education.
(ii) Payment covers only the initiation of treatment; and should be claimed in addition to either Practice Based or Shared Care for maintenance (see part 1 above).
(iii) Initiation of injectable GIP/GLP1s
   a) This would include counselling, initiation and monitoring of patients being started on injectable GIP/GLP1s; including patient education (and/or their carer and support staff where necessary).

b) This would include a review at 3 and 6 months (including but not limited to HbA1c and weight) to assess ongoing appropriateness of therapies e.g. if no significant weight loss/reduction in HbA1c after 6 months of GIP/GLP1.
c) The contractor will be eligible to claim for a patient if all the following conditions apply:
    i) The contractor has the full clinical responsibility for the initiation and monitoring of the injectable GIP/GLP1 as above, and
    ii) The contractor has issued a prescription for an injectable GIP/GLP1 within 1 month of the claim
    iii) Note - only one claim for initiation of GIP/GLP1 per patient can be made. The contractor should claim for monitoring (Practice Based or Shared, as appropriate) in addition to initiation.

(iv) Initiation of Insulin in T2DM

a) This would include counselling, initiation and monitoring of patients being started on insulin including patient education (and/or their carer and support staff where necessary).
b) The contractor will be eligible to claim for a patient if all the following conditions apply:
    i) The contractor has the full clinical responsibility for the initiation and monitoring of the insulin as above, and
    ii) The contractor has issued a prescription for insulin within 1 month of the claim
    iii) Note - only one claim for initiation per patient can be made. The contractor should claim for monitoring (Practice Based or Shared, as appropriate) in addition to initiation.

The use of DSNs and secondary care teams for advice and support on an ad-hoc basis would not preclude claiming, provided the practice is undertaking the roles set out above.

3 TRAINING & RESOURCES

Medical Staff:
Core capabilities and competencies will have already been achieved in their GP training. All clinicians involved in delivering diabetes care will be expected to engage in appropriate updates to maintain their clinical knowledge every year as part of the annual appraisal process and work within their scope of practice as per the GMC's Good Medical Practice.

Prior to commencement of the service, providers must complete and submit the pre-audit for providers of diabetes care within the practice.

Doctors involved in diabetes care should conduct regular audits (including review of uptake and outcomes), be appraised on what they do and take part in necessary supportive educational activities.

Examples of generic core diabetes educational resources are listed below.

For Lead Clinicians looking to develop an extended role/GP with Specialist Interest (GPwSI) The University of Warwick offers a Postgraduate Diploma which can lead to an MSc in Diabetes is an online course over a year: Diabetes

Nursing Staff:

Registered nurses can provide care and support to patients for diabetes care. Nurses providing diabetes care should be appropriately trained and competent taking into consideration their professional accountability and the Nursing and Midwifery Council guidelines on the scope of professional practice.

Where the practice initiates insulin, the Practice Nurse (or person initiating insulin with the patient) will need to ensure that they have also satisfactorily completed appropriate training. It is accepted that for practices new to an injectable initiation service (either insulin or GLP1/GIP) more support/advice may be required from specialist teams during the first year.

If a Practice has been undertaking the services as described above for several years, but does not possess an accredited qualification, then NHS Highland Deputy Medical Director and Associate Nurse Director for Community will consider each application to conduct the enhanced service on its merits.

Practices commencing on 1st April 2025 are permitted a one-year grace period for Primary Care Healthcare professionals to evidence and/or upskill their competencies.

Practices commencing after initial sign-up of 1st April 2025 are expected to have training in place prior to sign-up.

This training should be evidenced in the return audit.

Competency Assessments:

Practices may wish to complete competency framework assessment for members of staff delivering diabetes care in Primary Care:
https://www.diabetes.org.uk/for-professionals/learning-and-development/competency-frameworks

In particular, the diabetes foot screening competencies and the Cambridge Diabetes Education Programme:

Diabetes Foot Screening – Foot Risk Awareness and Management Education (FRAME)

The Cambridge Diabetes Education Programme (CDEP) | Diabetes UK

Available sources of Training & Education:

Online diabetes journals, education and resources for healthcare professional:
DiabetesontheNet | Online diabetes journals, education and resources for healthcare professionals.

Diabetes courses for healthcare professionals | Diabetes UK

Pitstop Diabetes Training | Online and live courses are now available

Additional Support Resources:

TAM: DIABETES | Right Decisions
Diabetes UK: Diabetes UK - Know diabetes. Fight diabetes. | Diabetes UK
My Diabetes My Way: Homepage | Information Site
New to Type 2 - Highland Diabetes App
Live It Highland Information Pack

4 FEEDBACK AND LEARNING

The Practice will use the results of the Diabetes Clinical Audit and SCI-diabetes data as part of a discussion within the Practice on the effectiveness, efficiency and value of their practice services.

The Practice is encouraged to share any learning or action points from this discussion with other practices in their cluster.

5 RECORDING OF INFORMATION

Ensure the correct clinical coding and toolbar template is used to ensure compliance with the recording and monitoring requirements of the contract.

In addition to ensuring appropriate coding in line with provision of essential services, SCI-diabetes and the enhanced elements of the service; read codes will be used for monitoring and payment purposes:

ESCRO templates and codes are detailed in Appendix 2.

The following tables detail the required criteria and frequency for each patient group:

Specification Standards	Proposed Payment
All Non-Complex T2DM standards **including ACR** in previous 12m	£25.52
All Non-Complex T2DM standards **without ACR** in previous 12m	£20.52

All required criteria must be met and coded prior to triggering a claim. Where a claim is triggered, items that require to be done annually will be coded once within the preceding 12 months. Where a claim is triggered, items that require to be done 6 monthly will be coded once within the preceding 6 months.	
Ethnicity	Once
Type 1 Diabetes or Type 2 Diabetes	Once
T2DM Care or Complex T2DM or Shared Care - Complex T2DM or Shared Care - Type 1 Diabetes Care	Annually
BMI	Six Monthly
Blood Pressure	Six Monthly
HbA1c	Six Monthly
Smoking Status	Annually
U&E	Annually
ACE-i or ARB	Annually * Once if contraindicated / not tolerated / not indicated
Foot Screening Frequency as appropriate based on risk – pulses, sensation & risk categorisation	Annually
Alcohol intake recorded	Annually
Health Education – Exercise, Diet & Weight Reduction	Annually
Diabetes Dietary Review	Annually
Personalised Target Weight	Annually
Personalised Target HbA1c	Annually
Personalised Target BP	Annually
Lipids	Annually
Titrate Lipid Lowering Therapy or Maximum Tolerated Lipid Lowering Therapy or Statin	Annually * Once if contraindicated / not tolerated
Diabetes Management Plan Given	Annually
Urinary ACR	Annually
Albuminuria or Microalbuminuria or Normal Urinary Albumin	Annually

Specification Standards	Proposed Payment
Complex T2DM – **Practice Based Care** including ACR in previous 12m	£105.33
All Complex T2DM – **Practice Based Care** without ACR in previous 12m	£100.33

All required criteria must be met and coded prior to triggering a claim. Where a claim is triggered, items that require to be done annually will be coded once within the preceding 12 months. Where a claim is triggered, items that require to be done 6 monthly will be coded once within the preceding 6 months.	
Ethnicity	Once
Type 1 Diabetes or Type 2 Diabetes	Once
T2DM Care or Complex T2DM or Shared Care - Complex T2DM or Shared Care - Type 1 Diabetes Care	Annually
BMI	Six Monthly
Blood Pressure	Six Monthly
HbA1c	Six Monthly
Smoking Status	Annually
U&E	Annually
ACE-i or ARB	Annually * Once if contraindicated / not tolerated / not indicated
Foot Screening Frequency as appropriate based on risk – pulses, sensation & risk categorisation	Annually
Alcohol intake recorded	Annually
Health Education – Exercise, Diet & Weight Reduction	Annually
Diabetes Dietary Review	Annually
Personalised Target Weight	Annually
Personalised Target HbA1c	Annually
Personalised Target BP	Annually
Lipids	Annually
Titrate Lipid Lowering Therapy or Maximum Tolerated Lipid Lowering Therapy or statin	Annually * Once if contraindicated / not tolerated
Diabetes Management Plan Given	Annually
Urinary ACR	Annually
Albuminuria or Microalbuminuria or Normal Urinary Albumin	Annually
*Complex patient check based on three or more oral therapies for hyperglycaemia or on an injectable therapy for diabetes as defined in diabetic STU clusters. Automated – no coding required.	

Specification Standards	Proposed Payment
Complex T2DM or T1DM – **Shared Care** including ACR in previous 12m	£53.76
All Complex T2DM or T1DM – **Shared Care** without ACR in previous 12m	£48.76

All required criteria must be met and coded prior to triggering a claim. Where a claim is triggered, items that require to be done annually will be coded once within the preceding 12 months.	
Ethnicity	Once
Type 1 Diabetes or Type 2 Diabetes	Once
T2DM Care or Complex T2DM or Shared Care - Complex T2DM or Shared Care - Type 1 Diabetes Care	Annually
BMI	Annually
Blood Pressure	Annually
HbA1c	Annually
Smoking Status	Annually
U&E	Annually
ACE-i or ARB	Annually * Once if contraindicated / not tolerated / not indicated
Foot Screening Frequency as appropriate based on risk – pulses, sensation & risk categorisation	Annually
Alcohol intake recorded	Annually
Health Education – Exercise, Diet & Weight Reduction	Annually
Diabetes Dietary Review	Annually
Personalised Target Weight	Annually
Personalised Target HbA1c	Annually
Personalised Target BP	Annually
Lipids	Annually
Titrate Lipid Lowering Therapy or Maximum Tolerated Lipid Lowering Therapy or Statin	Annually * Once if contraindicated / no tolerated
Diabetes Management Plan Given	Annually
Urinary ACR	Annually
Albuminuria or Microalbuminuria or Normal Urinary Albumin	Annually

Specification Standards	Proposed Payment
Other Injectable Initiation	£92.12
Insulin Initiation	£182.03
All required criteria must be met and coded, with insulin/GLP prescribed prior to triggering a claim at point of initiation. Payment covers only the initiation of treatment. Claimed in addition to either Practice Based or Shared Care for maintenance. All standards and coding complex and non-complex Practice based or Shared Care are required to be in place for the initiation claim to pass.	
Diabetic on oral treatment & GLP-1	Once *Only claimable once, per patient
Insulin treatment initiated	Once *Only claimable once, per patient
Insulin initiation – Enhanced Service Admin	Once per GLP / Insulin
Diabetic Education	Once per GLP / Insulin
Diabetic injection administration education	Once per GLP / Insulin
HbA1c	Three and Six Months post initiation
Weight / BMI	Three and Six Months post initiation
*Prescription check for GLP / Insulin within one month of claim. Automated – no coding required.	

6 QUALITY

The GP will hold medical responsibility for the patient under this LES.

The service is provided by appropriately trained and qualified Practice Nurses, Advanced Nurse Practitioners and General Practitioners.

A collaborative approach between General Practice and Secondary Care colleagues (DSNs and Consultants) to provide specialist advice to support GPs to manage these patients, where necessary, is encouraged.

Diabetes should be managed in line with TAM, SIGN and NICE guidance.

Record keeping:

Production of an appropriate clinical record using appropriate read codes and adequate recording should be made in the patient's electronic record and appropriate national systems (such as SCI-diabetes).

Referral policies:

When appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines.

Monitoring and Feedback:

Where practices have undertaken work through this service, feedback may be provided where patients have required significant subsequent input by DSNs to support ongoing quality improvement. This may require service providers to undertake additional training.

7 FINANCE

No payment can be claimed for patients being fully monitored under secondary care.

Contract value
Payment per patient claimed:

All Non-Complex T2DM standards without ACR in previous 12m: £20.52
All Non-Complex T2DM standards including ACR in previous 12m: £25.52

Contractors can claim for non-complex care when they are satisfied ALL standards with exception of ACR (as per Part 1) for the patient have been met, failure to meet any other required standards will result in no payment. Failing to record an ACR will reduce the payment by £5.00, adjusted annually as per 4.0 of Part 3 of the overall contract. Maximum of one claim (paid at ½ of the annual fee for each) per patient within a 6-month period.

All Complex T2DM – Practice Based Care without ACR in previous 12m: £100.33
All Complex T2DM – Practice Based Care including ACR in previous 12m: £105.33
All Complex T2DM or T1DM – Shared Care without ACR in previous 12m: £48.76
All Complex T2DM or T1DM – Shared Care including ACR in previous 12m: £53.76

Contractors can claim for practice based complex care when they are satisfied ALL standards with exception of ACR (as per Part 2a) for the patient have been met, failure to meet any other required standards will result in no payment. Failing to record an ACR will reduce the payment by £5.00, adjusted annually as per 4.0 of Part 3 of the overall contract. Maximum of one claim (paid at ½ of the annual fee for each) per patient within a 6-month period.

Contractors can claim for shared complex care when they are satisfied ALL standards with exception of ACR (as per Part 2a) for the patient have been met, failure to meet any other required standards will result in no payment. Failing to record an ACR will reduce the payment by £5.00, adjusted annually as per 4.0 of Part 3 of the overall contract. Maximum of one claim per patient within a 12-month period.

Other Injectable Initiation: £92.11
Insulin Initiation: £182.03

DSNs and Diabetes Specialists will support feedback on individual patient care. Where significant additional input to patient care is required to reach the standard set out in this specification the payment associated will be recovered.
Maximum of one claim per patient per GLP and Insulin.

Payment

Payments will be made in accordance with claims by practice, paid in arrears. Satisfying all Practice Based Non-complex and Complex T2DM standards within the preceding 12 months will trigger 1/2 payment. Full payment achievable by making two claims in 12-month period. Satisfying all Shared Care Complex T2DM or T1DM standards within the preceding 12 months will trigger full payment on making a claim.

Payments for Initiation (as per part 2b of specification) will be made on a monthly basis in arrears. Practice will trigger a claim in the same month as the initiation prescription is generated and all initiation of injectables standards have been met. 3 and 6 monthly post-initiation reviews and standards are subject to quality assurance / payment verification as detailed in Part 1, Paragraph 5 of the overall contract. The practice will provide evidence in instances of unmet standards. Failing to demonstrate intent will result in recoveries as detailed in Part 1, Paragraph 5.3 of the overall contract.

Payment is subject to the practice meeting the terms and conditions of the Clinical Specification in section 2.

8 CONTRACT MONITORING

Specific Requirement
Monitoring of this LES will be done through monthly submission/extraction via the reporting tool managed by NSS (Albasoft) analytics using the appropriate READ codes as defined in the clinical specification.

Contract Review
Quality indicators are as detailed in section 3.0 of the contract. For the Contract period the contract review element of the Annual Review will be on the items covered in Section 2.0

Verification
Ad hoc post payment verification will take place as per 4.2 of the contract agreement.

Appendix 1 – Insulin Initiation Documents

Stage 1 – Day of insulin initiation

Topics of discussion and practice
Benefits of insulin for people with Type 2 Diabetes
Injection technique: Clinician demonstrates injection technique and patient demonstrates technique back to Clinician. Dummy injection or actual injection completed by patient. Details of injections: Provide written simple instructions When to take doses How much insulin to take Injection site rotation Storage of insulin How and when to discard needles and pen devices. Blood glucose testing: Frequency of testing Blood glucose targets Inform patients insulin commenced at low dose with expectation doses will need to be increased.
Hypoglycaemia: Inform patient what level is a hypo Signs and symptoms Treatment Causes/prevention Driving regulations: Inform patient of legal obligation to inform DVLA and insurance company Regulations around blood glucose testing and driving Provide written documentation Basic dietary advice: Importance of carbohydrates at each meal Define carbohydrates Advise of possible weight gain with insulin Obtain consent to refer to Dietitian and refer
Ensure patient has supply/prescription arranged for: 4 mm needles Insulin pens/cartridges Sharps box Knows what medications to stop/continue Follow up details: Provide contact details Indicate when to call after commencing first injection. Arrange follow up appointment within 1 week

Stage 2 – Review within 1 week of insulin initiation

Topics of discussion and practice
Discuss patients concerns/issues with treatment
Review injection technique: Patient is able to demonstrate to Clinician or talk through correct insulin injection technique
Review details of injections: Timing of when patient is taking their doses How much insulin patient has been taking Injection site rotation Storage of insulin Ensure needle changed every injection. Review hypoglycaemia and driving regulations Patient is able to re-iterate to Clinician how to identify and treat a hypo Ensure patient has informed DVLA and insurance company of insulin commencement Review blood glucose readings and discuss with patient principles of insulin dose adjustment using patient's own readings. Provide patient with insulin adjustment algorithm Basic Dietary Advice: Discuss importance of healthy eating in the management of diabetes and benefits even with some weight loss. Remind patient of importance of having carbohydrates at each meal.
Sick day rules: Ensure patient is aware to continue insulin Advise increase in blood glucose testing Suggest food substitutes if experiencing nausea/vomiting Medicines advice card discussed and given When to seek help and who from
Support networks: Provide Diabetes UK contact details and inform of local group Inform about My Diabetes My Way ENGAGE Inform of follow up contact/appointment Appointment within a month Consider telephone/email contact prior

Stage 3 – Review within 1 month of insulin initiation

Topics of discussion and practice
Discuss patients concerns/issues with treatment
Review blood glucose readings: Encourage patient to consider where patterns in readings are emerging. Encourage patient to consider which doses of insulin and by how much should be adjusted. Long term complications of diabetes: How to reduce risk factors Annual screening Smoking (if applicable) Need for contraception until glycaemic control in target range (if applicable).
Physical activity: Discuss benefits of exercise in the management of type 2 diabetes If appropriate, discuss possible insulin dose adjustment relating to physical activity
Review sick day advice: Ensure patient is aware to continue insulin Need to increase blood glucose tests Discuss food substitutes if experiencing nausea/vomiting Patient can re-iterate when to seek help and who from
Alcohol: Explain alcohol increases the risk of delayed hypoglycaemia Advise of need to have food while drinking alcohol Advise not to take extra insulin to counteract high blood glucose levels. Inform of follow up contact/appointment

Appendix 2 – Diabetes Enhanced Service Codes (ESCRO)

ESCRO – Diabetes V4.1 (13/03/2025)

Note: [P] next to header means 1 tab from each line is required for payment
[P] next to line indicates that 1 tab from that line is required for payment

Purple highlight – QoF related minimum requirements for all patients
Green highlight – All annual requirements
Yellow highlight – 3mthly review requirements for GIP/GLP1 initiation claims
Orange highlights – 6mthly review minimum requirements for all practice based care patients

Enhanced Service Claim [P]

Non-Complex T2DM Care or

Practice Based Care - Complex T2DM or

Shared Care - Complex T2DM or Shared Care - Type 1 Diabetes Care and / or

Initiation GIP/GLP1s or Initiation of Insulin

Diagnosis & Care (code once rather than annual)

[P] Ethnicity – See below (code once not annual – pull existing codes if possible)

[P] Type 1 Diabetes – C10E or Type 2 Diabetes – C10F

Diabetes in Remission – C10P or Gestational Diabetes – C2B or Pre-Diabetes

Data Collection [P] (required for ALL patients with Diabetes, regardless of type or care arrangement)

Height (m) – 229 and Weight (kg) – 22A and BMI – 22K

3 month review weight – 22A (required for GIP/GLP1 initiation) 6month weight – 22A and 6month BMI – 22K

Blood Pressure – 246 or BP declined – 8I3Y. and 6month Blood Pressure – 246 or

6month BP declined – 8I3Y.

Smoking Status
Never smoked – 1371 or Current Smoker – 137R or Ex-smoker – 137S

Smoking cessation advice given – 8CAL (if appropriate)

Physical Activity

Alcohol Consumption - 136 FAST score +/- Alcohol Brief Intervention (if appropriate)

Bloods taken (HbA1c – 42W5, U&E's – 451F, lipids – 44PH) Urine sent (urinary ACR – 46W)

3 month HbA1c – 42W5 (required for GIP/GLP1 initiation claim) 6 month HbA1c – 42W5

Depression Screening (freetext comments)

Foot screening (via SCI diabetes link)

Left foot pulse(s) present – 22FB or Left foot pulses absent – 24FA

Right foot pulse(s) present – 24EB or Right foot pulses absent – 24EA

Left foot monofilament normal – 29BC or Left foot monofilament abnormal – 29BA

Right foot monofilament normal – 29BB or Right foot monofilament abnormal – 29B9

Left foot Risk Category and Right Foot Risk Category (?use existing drop boxes)

Low risk – 25GI	Low risk – 2G5E
Moderate risk – 2G5F	Moderate risk – 2G5F
High Risk – 2G5K	High Risk – 2G5G
Ulcerated – 2G5L	Ulcerated – 2G5H

Retinal Screening (not attached to payment)

Digital Retinopathy Screening or Retinopathy Screening Declined/Refused

Left Eye no Diabetic Retinopathy or Left Eye Diabetic Retinopathy

Right Eye no Diabetic Retinopathy or Right Eye Diabetic Retinopathy

Immunisation (can add additional options if required to record vaccines given/declined)

Influenza Vaccine recommended or Influenza Vaccine contraindicated or Influenza Vaccine declined

COVID Vaccine recommended or COVID Vaccine contraindicated or COVID Vaccine declined

Other Vaccine recommended or Other Vaccine contraindicated or Other Vaccine declined

Diet & Lifestyle Advice [P] (required for patients with Diabetes not under alternate service)

Smoking cessation Advice Given and/or Signposted/referred to Smoking Cessation Support

Health Education - Alcohol FAST score +/- Alcohol Brief Intervention (if appropriate)

Health Education – Exercise

Health Education – Diet in Diabetes

Type 1 Diabetes Dietary Review or Type 2 Diabetes Dietary Review

Health Education – Weight Reduction (agree target 5-10% reduction) Target Weight – 66CF

Target BMI – 22KA

Diabetes Review [P] (required for patients with Diabetes not under alternate service)

Annual Diabetes Review or 3 month review or 6 month review

HbA1c [ ] mmol/mol [Personalised Target HbA1c – 66Ae]

[Diet/Lifestyle Only] or [Oral Treatment] or [Non-insulin Injectable] or [Insulin Injectable]

[Diabetes Control] – add freetext box to document changes to diabetes treatments

Total Cholesterol [ ] (add units) Serum HDL [ ] (add units)

[Titrate Lipid Lowering Therapy] or [Maximum Tolerated Lipid Lowering Therapy]

or [Statin not Indicated – 8I63] or [Statin Contraindicated] or [Statin Not Tolerated – 8I76]

or [Statin Declined 8I3C] [Show Statin Scripts]

BP [ ] mmHg [Personalised Target BP – 246K / 246L]

eGFR [ ] (add units) serum Creatinine [ ] (add units) Urinary ACR [ ]

[Albuminuria – R1100] or [Microalbuminuria – R1103] or [Normal Urinary Albumin – 46N1]

[ACE-i Prophylaxis – 8B6B] or [ACE-i Contraindicated – 8I28] or [ACE-i not Tolerated – U60C4]

or [ACE-i Declined – 8I3D] or [ACE-i /ARB Not Indicated – 8I64]

[ARB Prophylaxis – 8B6E] or [ARB Contraindicated – 8I2H] or [ARB not Tolerated – U060CB]

or [ARB Declined – 8I3D]

Management

[P] [Diabetes Management Plan Given – 66AR] (freetext comments) [Add recall]

[Refer to Diabetes Consultant] (freetext comments)

[Seen by Diabetes Consultant] (freetext comments)

[Refer to Diabetes Specialist Nurses] (freetext comments)

[Seen by Diabetes Specialist Nurses] (freetext comments)

GIP/GLP1 Initiation

[Initial Educational Appointment] or [3 month review] or [6 month review]

[3 month HbA1c – 42W5] and [3 month review weight – 22A]

[Injection Technique]

[Awaiting DSN info. but aim similar to insulin section]

Insulin Initiation

[Initial Educational Appointment]

[Injection Technique] [Blood Glucose Testing] [Hypoglycaemia Advice]

[Driving Dietary Advice] [Follow up arrangements]

Resources

(Add links to TAM and referral/signposting info for SilverCloud, CBT, Weight Management, Smoking Cessation, My DiabetesMy Way, New to Type 2, LiveIt Highland etc)

Read codes 13/03/25	Screen description	Read code description	When to be used	SCI DC Check	Old ES Check
Enhanced Service Claim [P]					
C10F	Type 2 diabetes mellitus	Type 2 diabetes mellitus	Non-Complex T2DM Care	Y	Y
66AP. + C10F + C1093	Practice programme	Diabetes: practice programme	Practice Based Care - Complex T2DM	Y	N (C1093)
66AQ. + C10F + C1093	Shared care programme	Diabetes: shared care programme	Shared Care - Complex T2DM	Y	N (C1093)
66AQ. + C10E			Shared Care - Type 1 Diabetes Care	Y	Y
66o5.	Diabetc on oral trtmnt & GLP-1		Initiation GIP/GLP1s	N	N
9kL..		Insulin init - enh serv admin	Initiation GIP/GLP1s	N	N
.66Ap	Insulin treatment initiated		Initiation of Insulin	Y	N
9kL..		Insulin init - enh serv admin	Initiation of Insulin	N	N
Diagnosis & Care (code once rather than annual)					
Ethnicity (Drop down) - (code once not annual – pull existing codes if possible)					
9i21.	Scottish	Scottish – Ethnic cat 2001 census		N	Y
9i0..	Other British	British or mixed British 2001 cen		N	Y
9i1..	Irish	Irish – Ethnic category 2001 cen		N	Y
9i2..	Any other White background	Other white – Ethnic categ 2001 cen		N	Y
9i6..	Any mixed background	Other mixed – Ethnic cat 2001 cen		N	Y
9i7..	Indian	Indian or British Indian 2001 cen		N	Y
9i8..	Pakistani	Pakistani or Brit Pakistani 2001 cen		N	Y
9i9..	Bangladeshi	Bangladeshi or Brit Bangl 2001 cen		N	Y
9iE..	Chinese	Chinese – Ethnic category 2001 cen		N	Y
9iA..	Any other Asian background	Other Asian – Ethnic cat 2001 cen		N	Y
9iB..	Caribbean	Caribbean – Ethnic categ 2001 cen		N	Y
9iC..	African	African – Ethnic category 2001 cen		N	Y
9iD..	Any other Black background	Other Black – Ethnic cat 2001 cen		N	Y
9iF..	Any other Ethnic background	Other Ethnic – Ethnic cat 2001 cen		N	Y

9iG..	Ethnic category not stated	Ethnic category not stated	Refused by patient	N	Y
C10E.			Type 1 Diabetes	Y	Y
C10F.			Type 2 Diabetes	Y	Y
C10P.		Diabetes mellitus in remission	Diabetes in Remission	N	N
C2B..		Gestational diabetes mellitus	Gestational Diabetes	N	N
14O80	High risk of diabetes mellitus	High risk of diabetes mellitus	Pre-Diabetes	N	N
Data Collection [P] (required for ALL patients with Diabetes, regardless of type or care arrangement)					
229..	Height	O/E - height	Height (m)	Y	Y
22A..	Weight	O/E - Weight	Weight (kg)	Y	Y
22K..	Body Mass Index	Body Mass Index	BMI	Y	Y
22A.	Weight	O/E - Weight	3 month review weight	Y	Y
22A.	Weight	O/E - Weight	6month weight	Y	Y
22K..	Body Mass Index	Body Mass Index	6month BMI	Y	Y
246.	Blood pressure	O/E - blood pressure	Blood Pressure	Y	N
8I3Y.	BP Refused	BP procedure refused	Blood pressure procedure refused	Y	Y
246.	Blood pressure	O/E - blood pressure	6month Blood Pressure	Y	N
8I3Y.	BP Refused	BP procedure refused	Blood pressure procedure refused	Y	Y
Smoking (Drop down)					
1371.	Never smoked tobacco	Never smoked tobacco	Never smoked	Y	Y
137R.	Current smoker	Current smoker	Current Smoker	Y	Y
137S.	Ex smoker	Ex smoker	Ex-smoker	Y	Y
8CAL.	Smoking cessation advice	Smoking cessation advice	Smoking cessation advice given	Y	Y
Physical Activity (Drop down)					
1383.	Enjoys light exercise	Enjoys light exercise		Y	Y
1384.	Enjoys moderate exercise	Enjoys moderate exercise		Y	Y
1385.	Enjoys heavy exercise	Enjoys heavy exercise		Y	Y
1382.	Avoids even trivial exercise	Avoids even trivial exercise		Y	Y
1381.	Exercise physically impossible	Exercise physically impossible		Y	Y
136..	Alcohol consumption	Alcohol consumption	Alcohol Consumption	Y	Y
388u	Record FAST Screening + Score	Fast alcohol screening test	FAST score	N	N
9k16.	NA - automated	Alcohol screen completed	Automated when recording FAST using Escro - claim	N	N
38D3	AUDIT Score	Alcohol use disorders identification test	To record AUDIT score	N	N
9k1A.	Record Brief Intervention provided	Brief intervention for excessive alcohol consumption completed -	To record ABI provided under LES - claim	N	N

		claim			
Bloods taken We need to check this is the codes recorded when bloods are recorded					
42W5.			HbA1c	Y	Y
451F.			U&E's	Y	Y
44PH.	Total cholesterol measurement	Total cholesterol measurement	Lipids	Y	Y
46W.	Urine microalbumin (& level)	Urine microalbumin (& level)	Urine sent	Y	Y
42W5.			3 month HbA1c	Y	Y
42W5.			6 month HbA1c	Y	Y
Screening [P] (required for ALL patients with Diabetes, regardless of type or care arrangement)					
6896.	Depression screening completed		Depression Screening	Y	Y
Foot screening					
24FB.			Left foot pulse(s) present	Y	Y
24FA.			Left foot pulses absent	Y	Y
24EB.			Right foot pulse(s) present	Y	Y
24EA.			Right foot pulses absent	Y	Y
29BC			Left foot monofilament normal	Y	Y
29BA			Left foot monofilament abnormal	Y	Y
29BB			Right foot monofilament normal	Y	Y
29B9			Right foot monofilament abnormal	Y	Y
Left foot Risk Category (Drop down) & Right foot Risk Category (Drop down)					
2G5I.	L		Low risk	Y	Y
2G5J.	L		Moderate risk	Y	Y
2G5K.	L		High Risk	Y	Y
2G5L.	L		Ulcerated	Y	Y
2G5E.	R		Low risk	Y	Y
2G5F.	R		Moderate risk	Y	Y
2G5G.	R		High Risk	Y	Y
2G5H.	R		Ulcerated	Y	Y
Retinal Screening					
68A7.			Digital Retinopathy Screening	Y	Y
8I3X.			Retinopathy Screening Declined/Refused	Y	Y
	Background? Preproliferative?		Left Eye no Diabetic Retinopathy		
	Background? Preproliferative?		Left Eye Diabetic Retinopathy		
	Background? Preproliferative?		Right Eye no Diabetic Retinopathy		
	Background? Preproliferative?		Right Eye Diabetic Retinopathy		
Immunisation					
			Influenza Vaccine recommended		

8I2F			Influenza Vaccine contraindicated	Y	Y
9OX5			Influenza Vaccine declined	Y	Y
			COVID Vaccine recommended		
			COVID Vaccine contraindicated		
			COVID Vaccine declined		
			Other Vaccine recommended		
			Other Vaccine contraindicated		
			Other Vaccine declined		
Diet & Lifestyle Advice [P] (required for patients with Diabetes not under alternate service)					
8CAL.	Smoking cessation advice	Smoking cessation advice	Smoking cessation advice given	Y	Y
8H7i.			Signposted/referred to Smoking Cessation Support	Y	N
.6792			Health Education - Alcohol	Y	Y
388u	Record FAST Screening + Score	Fast alcohol screening test	FAST score	N	N
9k16.	NA - automated	Alcohol screen completed	Automated when recording FAST using Escro - claim	N	N
38D3	AUDIT Score	Alcohol use disorders identification test	To record AUDIT score	N	N
9k1A.	Record Brief Intervention provided	Brief intervention for excessive alcohol consumption completed - claim	To record ABI provided under LES - claim	N	N
6798.			Health Education – Exercise	Y	Y
8CA41			Health Education – Diet in Diabetes	Y	Y
66At0			Type 1 Diabetes Dietary Review	N	N
66At1			Type 2 Diabetes Dietary Review	N	N
8CA40			Health Education – Weight Reduction	Y	Y
66CF			Target Weight	N	N
22KA.			Target BMI	N	N
Diabetes Review [P] (required for patients with Diabetes not under alternate service)					
9OLZ 66AS		Diabetes monitoring administration	Annual Diabetes Review	Y (66AS)	N
9OLZ 66Ai		Diabetic 6 month review	6 month review	Y (66Ai)	N
9OLZ (code on own without 6m or Annual?)			3 month review	N	N
42W5.			HbA1c	Y	Y
66Ae			Personalised Target HbA1c	Y	N
66A3.			Diet/Lifestyle Only	Y	Y

66A4.		Diabetic on oral treatment	Oral Treatment	Y	Y
66As.		Diab on subcutaneous treatment	Non-insulin Injectable	Y	N
66A5.		Diabetic on insulin	Insulin Injectable	Y	Y
66AH.		Diabetic treatment changed	Diabetes Control	Y	N
44PH.		Total cholesterol:HDL ratio	Total Cholesterol	Y	Y
44P5.		Serum HDL cholesterol level	Serum HDL	Y	Y
66X2.	Lipid disord treatment changed	Lipid disord treatment changed	Titrate Lipid Lowering Therapy	N	
8BL1.		Pt on max tol lipid low ther	Maximum Tolerated Lipid Lowering Therapy	Y	Y
8I63.		Statin not indicated	Statin not Indicated	Y	Y
8I27.		Statins contraindicated	Statin Contraindicated	Y	Y
8I76.		Statin not tolerated	Statin Not Tolerated	Y	Y
8I3C.		Statin declined	Statin Declined	Y	Y
	For NSS to advise if possible		Show Statin Scripts		
246.	Blood pressure	O/E - blood pressure	Blood Pressure	Y	N
8I3Y.	BP Refused	BP procedure refused	Blood pressure procedure refused	Y	Y
246K		Target systolic blood pressure	Personalised Target BP	Y	N
451F.		Glomerular filtration rate	eGFR	Y	Y
44J3.		Serum creatinine	serum Creatinine	Y	Y
46TC.		Urine albumin:creatinine ratio	Urinary ACR	Y	Y
R1100		[D]Albuminuria	Albuminuria	Y	Y
R1103		[D]Microalbuminuria	Microalbuminuria	Y	Y
46N1	Urine protein normal	Urine protein normal	Normal Urinary Albumin	Y	Y
8B6B.		ACE inhibitor prophylaxis	ACE-i Prophylaxis	Y	Y
8I28.		ACE inhibitors contraindicated	ACE-i Contraindicated	Y	Y
8I74.		ACE inhibitor not tolerated	ACE-i not Tolerated	Y	N
8I3D.		ACE inhibitor declined	ACE-i Declined	Y	Y
8I64	ACE inhibitor not indicated	ACE inhibitor not indicated	ACE-i /ARB Not Indicated	Y	N
8B6E		Angtens II recep antag prophyl	ARB Prophylaxis	Y	Y
8I2H		Angtensin II recpt ant contra	ARB Contraindicated	Y	Y
8I75		Angioten II recpt antg not tol	ARB not Tolerated	Y	N
8I3D		ACE inhibitor declined	ARB Declined	Y	Y
Management					
66AR	Diabetes management plan given	Diabetes management plan given	Diabetes Management Plan Given	Y	Y

	For NSS to advise if possible		Add recall		
8H4F	Referral to diabetologist	Referral to diabetologist	Refer to Diabetes Consultant	Y	N
9N2d	Seen by diabetologist	Seen by diabetologist	Seen by Diabetes Consultant	Y	N
8HI4 or 8H7C	Referral to community diabetes specialist nurse or Refer, diabetic liaison nurse		Refer to Diabetes Specialist Nurses	N (8HI4) Y (8H7C)	N
9N0n or 9N2i	Seen in community diabetes specialist clinic or Seen by diabetic liaison nurse		Seen by Diabetes Specialist Nurses	N (9N0n) Y (9N2i)	N
GIP/GLP1 Initiation					
66Af	Pt diabetes education review	Pt diabetes education review	Initial Educational Appointment	Y	N
66Af	Pt diabetes education review	Pt diabetes education review	3 month review	Y	N
66Af	Pt diabetes education review	Pt diabetes education review	6 month review	Y	N
42W5.		HbA1c levl - IFCC standardised	3 month HbA1c	Y	Y
22A..		O/E - weight	3 month review weight	Y	Y
679l	Diabetic injection administration education		Injection Technique	N	N
			Awaiting DSN info. but aim similar to insulin section		
Insulin Initiation					
679c.	Insulin administratn education	Insulin administratn education	Initial Educational Appointment	N	N
679l	Diabetic injection administration education		Injection Technique	N	N
8CAQ	Advice about blood gluc contrl	Advice about blood gluc contrl	Blood Glucose Testing	N	N
679L1	Hypoglycaemia education	Hypoglycaemia education	Hypoglycaemia Advice	N	N
679L2	Advice about diabetes driving		Driving Dietary Advice	N	N
			Follow up arrangements		
Resources					
TAM		https://rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/adult-therapeutic-guidelines/diabetes			
Referral/signposting info for SilverCloud		https://rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/adult-therapeutic-guidelines/mental-health/psychological-services-guidelines/computerised-cognitive-behavioural-therapy-ccbt-guidelines/?searchTerm=silvercloud		https://patientinfo.nhshighland.scot.nhs.uk/patient%20information/LIVE%20TAM450%20SilverCloud%20patient%20info%20sheet.pdf	
CBT					

Weight Management	https://rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/adult-therapeutic-guidelines/food-fluid-and-nutrition/weight-and-health-guidelines/dietetic-service-referral-guidelines/?searchTerm=weight%20management	https://www.myself-management.org/
Smoking Cessation	https://rightdecisions.scot.nhs.uk/tam-treatments-and-medicines-nhs-highland/adult-therapeutic-guidelines/mental-health/smoking-cessation-guidelines/?searchTerm=smoking%20cessation	https://www.smokefreehighland.scot.nhs.uk/
My DiabetesMy Way	https://mydiabetesmyway.scot.nhs.uk/	
New to Type 2	https://www.nhshighland.scot.nhs.uk/media/oeoaldnk/new-to-type-2-highland-app.pdf	
LiveIt Highland	https://www.nhshighland.scot.nhs.uk/media/phmlov0a/live-it-highland-participants-pack.pdf	
NHS Highland Website	https://www.nhshighland.scot.nhs.uk/health-and-wellbeing/diabetes/diabetes-resources-in-highland/	