

Service Specification for Structured Diabetes Education

Project	Type 2 Structured Diabetes Education Service v6
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Period	September 2016 – August 2017

1. Population Needs

1.1 National/local context and evidence base

All of the National Service Frameworks relevant to long term conditions refer to self-management support and education. The NSF for Long Term Conditions (2005), The NSF for diabetes (2001), and now High Quality Care for All: NHS Next Stage Review Final Report (2008) make clear the requirement for self-management support to be available for patients.

NICE issued guidance in 2005 detailing the quality requirements of structured education in Diabetes (TA60).

Good self-management education has been shown nationally to have effects on;

- Reduced attendances at A&E
- Less contacts with GP's and Practice Nurses
- Appropriate reductions of medication
- Reduced outpatient appointments.

These outcomes have been reported nationally we would expect similar outcomes locally. Further to this, monitoring at 6 months after a programme of structured education, national results show;

- reduction in HbA1c
- weight loss
- reduction in waist circumference
- Reduced total cholesterol, LDL and Triglycerides
- Increased HDL Cholesterol

Local Context/Information

- NHS East Lancashire CCG
 - NHS East Lancashire CCG has a registered GP practice population of approximately 372,000 people.
 - The registered population of patients with diabetes is 19,481 (QOF 2013-14).

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

2.2 Local defined outcomes

- For patients within the identified cohort:
 - Improved glycaemic control
 - Reduced Blood pressure
 - Reduced body weight
 - Reduced waist circumference
 - Improved lipid levels
 - Empowerment to self-manage their diabetes
 - Improve Quality of Life

3. Scope

3.1 Aims and objectives of service

The service commissioned is a package of structured education for people with type 2 Diabetes.

The objectives of type 2 diabetes structured education service are:

- Increased healthy eating
- Increased levels of physical activity
- Increased treatment satisfaction
- Increased empowerment
- How to set effective goals
- Improving wellbeing
- Sharing of Self-Management skills
- Increased knowledge of diabetes, including consequences of poor glycaemic control
- Reduced inappropriate attendances at A&E
- Optimisation of contacts with GP's and Practice Nurses
- Support initiation and optimization of insulin therapy as appropriate

3.2 Service description/Care Pathway

There are 2 distinct services that utilize the same pathway.

- Provider delivered courses
- Provider Train the Trainer Courses (TTT)

A. Provider Delivered Courses

The service will provide education programmes in line with models of structured education outlined in NICE guidance. The program is evidence based, structured around a formal curriculum and updated with the latest evidence as appropriate. The provider will deliver sufficient programmes to meet the needs of the diabetic population in East Lancashire.

The service will promote the programmes to key partners and patients registered with GP practices in the CCG.

The courses will include appropriate provision of content and materials developed to meet NICE HTA 60 and Clinical Guidelines 87.

Courses will be delivered in a range of local settings and a variety of times of day, including evenings and weekends where required, at venues agreed with local service managers. The location of each course will be arranged according to population demand (i.e. courses will be local to the location that patients are being referred from).

Type 2 diabetic patients will be able to self-refer to the programme or be referred by any health, social care, or local authority professional.

The service will be made available to all adults (aged 17 and over) with diabetes regardless of age, race, gender, sexual orientation, disability or religion.

Carers and/or family members will be able to attend the courses with the service user (one

person per service user), in order to support the learning of the participant and increase their own personal knowledge of the participant's needs.

3.3 Service model:

- Patients will be referred/self-refer to the Provider Type 2 diabetes structured education service and the Provider will offer them the next available course. Where this is not suitable for the patient alternatives will be offered or the patient placed on a waiting list if future courses are not available.
- The provider will confirm the booking with the patient in writing. Course overview and joining instructions will be enclosed with the booking confirmation.
- The patient attends the booked course and receives an initial evaluation to baseline information.
- Patient completes the course and an end of course evaluation is carried out.
- The GP practice that the patient is registered with is informed of patient attendance and outcomes (if patient consents), including non-attendance and failure to complete the course
- 6 month telephone evaluation is carried out to monitor patient adherence.
- Quarterly reports on outcomes will be provided to the commissioner.

B. Provider Train the Trainer Courses (TTT)

The provider may be requested to deliver training and accreditation to local clinicians as appropriate in order for them to be able to deliver the approved course. Once accredited the clinician becomes the service provider and would be required (as appropriate) to contract directly with the CCG for additional services.

The primary provider will ensure that individuals accredited by them are trained to a standard that ensures they know the course content and are able to deliver effectively to achieve the desired outcomes.

Qualification criteria for entry into the train the trainer program and an outline syllabus are below.

All educators must be trained and meet the following criteria.

Qualification Criteria:

At least 12 months' experience of working with people with diabetes, and be able to demonstrate a sound working knowledge of diabetes. This includes a capability to advise adults with diabetes on insulin-dose adjustment for those that use insulin to manage their diabetes.

In addition, evidence of Trainer capabilities as defined within the NHS Employers Knowledge and Skills Framework (<http://www.nhsemployers.org/SimplifiedKSF>)

- Communication – Level 3 minimum
- Personal and People Development – Level 2 minimum
- Health Safety and Security – Level 2 minimum
- Service Improvement – Level 1 minimum
- Quality – Level 2 minimum
- Equality and Diversity – Level 3 minimum

Outline TTT Syllabus

- Attendance/observation of Provider delivered sessions (1/2 day)
- Full training course:
 - Education theory – Group self-learning
 - Course content
 - Observed delivery of a section of an approved provider module
 - Viva/Test on course content
- Following the course (and at 12 month re-accreditation) each accredited trainer is observed in field (within 3 months of the course)

- Each accredited trainer needs to deliver a minimum of 4 courses in each 12-month period

Care Pathway:

- Patient Referred/Self Referred and express interest in course
- Provider Contacts patient and offers next suitable course to patient. Provider Confirms in writing
- Patient attends course, completes initial evaluation and post course evaluation
- Follow up information sent to GP's
- Provider follows up with patient 6 months after course completion

Population covered

The service will cover East Lancashire CCG

- **Any acceptance and exclusion criteria and thresholds**

3.4.1 Location(s) of Service Delivery

The locations of service delivery will vary dependent upon the population demands. Each venue will be required to have been risk assessed for access for clients

- **Days/Hours of operation**

These will vary according to demand; options will include evening and weekend courses as required.

This will be subject to an agreed timetable with the commissioner.

- **Referral criteria & sources**

Provider will be expected to market the service with Health Care Professionals and Patients. Any costs associated with this will be included with in the contract costs.

Patients will be able to self-refer to the programme or be referred by any health, social care, or local authority professional.

Participants for the course should have Type 2 diabetes. It is acknowledged that some Type 1 diabetic patients will benefit from this structured education and therefore referrals will be accepted on a case by case basis.

Participants of the course will be permitted to have their carer and/or family attend the course with them (one person per participant). This will give the carer and/or family an understanding of the participants needs to help control their diabetes.

Provider will be expected to ensure all required licenses are renewed in line with programme requirements.

- **Referral route**

Patients will be able to self-refer to the programme or be referred by any health, social care, or local authority professional.

Promotion materials should be provided to all GP practices to help GPs and clinical staff to emphasise the benefits of attending courses and encourage diabetes patients to do so.

Promotion material should also be prominently displayed in public locations including, but not limited to, Pharmacies, Opticians, Libraries and Community Centres to give widespread publicity of the courses and their availability to maximise attendance and reach as many of the local diabetes population as possible.

- **Exclusion criteria**

Those who do not meet the requirements above.

Delivery staff will receive training in the handling of situations where it may be appropriate to cease participation or recommend alternative educational options.

The provider will inform the commissioner of these exclusions.

- **Response time & detail and prioritisation**

Patients interested in attending a course should be offered a next available course within 6 weeks and should not wait any longer than 18 weeks to attend a course. This will be reviewed on regular basis at contract management meetings.

- **Discharge Criteria & Planning**

As part of completion participants will be offered the opportunity to take part on a user questionnaire to evaluate the course. Where consented to do so patients' GP will be contacted to update on outcomes of structured education in a timely and appropriate manner.

- **Interdependence with other services/providers**

This service is dependent on the referral process and receipt of referrals. Referrals can be via self-referral, referrals from diabetes clinicians and health care professionals.

The service will integrate with local healthcare professionals to promote the benefits of the service and to increase uptake onto the education programme.

- A Data sharing Agreement will be signed in advance of referral from each practice where appropriate; a copy of which is attached to this contract. This document details clearly who will have access to data and in what form (eg aggregation and anonymisation), how, where and by whom data will be manipulated and to what purpose that data will be put.

- **Outcomes - Process**

- Number of sessions delivered in alternative language
- Number of SDE sessions delivered
- Average time from referral to access to course
- Number and % of type 2 diabetic patients referred into SDE
 - **Outcomes - Clinical**
- % of patients completing SDE
- Average time from referral to completion of the course
- No patients declining SDE course
- Patient satisfaction average rating based on survey

4. Applicable Service Standards

4.1 Applicable Standards

- NICE TA60
- NICE CG87
- NHS EL/BWD
 - Policy for Relations with the Pharmaceutical Industry and other Commercial Organisations
 - Safeguarding



**East Lancashire
Clinical Commissioning Group**