Service	Structured Education Programme for Adults with Type 2 Diabetes – Mid Nottinghamshire
Service Specification number	DB02

National/ local context and evidence base

Diabetes is a chronic and progressive disorder that impacts upon almost every aspect of life. The number of people within the UK that are diagnosed with the condition is growing rapidly. In Mansfield and Ashfield the prevalence rate is higher than the national average, possibly linked to higher levels of social deprivation and obesity. There are currently approximately 500 newly diagnosed diabetes patients across the area each year.

The table below shows the number of people diagnosed with diabetes and prevalence in Mansfield and Ashfield (ref QOF data 2013/ 14)

NHS area	No. on Diabetes Register	% prevalence
Mansfield and Ashfield April 2013/ March 2014	9991	6.65
Newark and Sherwood April 2013/ March 2014	6693	6.36

Supporting patients to manage their condition is critical to enable effective day-to-day management of Diabetes; and this, in turn, can significantly improve quality of life and reduce long term complications. It is essential that people with diabetes are provided with the knowledge and confidence to minimise the impact of the condition on their daily life.

The National Service Framework (NSF) for diabetes (2001) states that structured diabetes patient education can improve knowledge, blood glucose control, weight and dietary management, physical activity and psychological well-being, particularly when it is tailored to the individual. It is a key intervention required to deliver standard 3 of the NSF.

Current and previous NICE guidance also emphasises the importance of structured education in the role of managing Diabetes; NICE Technology Appraisal Guidance 60 (first issued April 2003, modified December 2014) and NICE Clinical Guidance 87 (issued May 2009, modified December 2014).

Under the NICE Quality Standard for Diabetes in adults (QS6, 2011), Statement 1 – Structured Education: “People with diabetes and/ or their carers should receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education”.

The All-Party Parliamentary Group for Diabetes (APPG) report, Taking Control: Supporting people to self-manage their diabetes (March 2015) reiterates the importance of Diabetes education and considers some of the barriers and solutions for patients accessing education programmes.

Five key criteria for a structured education programme were laid down by the Department of Health and the Diabetes UK Patient Education Working Group (2005):

- Any programme should be evidence-based and suit the needs of the individual. The programme should have specific aims and learning objectives. It should support the learner plus his or her family and carers in developing attitudes, beliefs, knowledge and skills to self-manage diabetes.
- The programme should have a structured curriculum that is theory-driven, evidence-based and resource-effective, has supporting materials, and is written down.
- The programme should be delivered by trained educators who understand educational theory appropriate to the age and needs of the learners, and who

are trained and competent to deliver the principles and content of the programme.
- The programme should be quality assured, and be reviewed by trained, competent, independent assessors who measure it against criteria that ensure consistency.
- The outcomes from the programme should be regularly audited.

Initially it is estimated that the provider will be required to provide diabetes education for at least 700 patients with Type 2 Diabetes, although the expectation is that the demand and uptake for courses will increase. A tolerance of +/ - 10% will be applied to the activity basing, with requirement to monitor activity levels throughout the contract period.

There is also potentially a large portion of unmet need for the provision of education to patients with an existing diagnosis of Diabetes who may need a refresher or may need to participate in education programmes. The case mix of patients referred for the Structured Education Programme should be monitored to understand ongoing demand.

Local defined outcomes

Effective delivery of the Structured Education Programme will result in a range of outcomes for:

Patients

- Improve Quality of Life. Measured using nationally recognised QOL questionnaire at 3 agreed stages before and after course completion.
- Increase participants' knowledge and awareness of their condition, including a greater understanding of the need to attend screening appointments (e.g. retinopathy, podiatry).
- Improve participants' motivation and confidence to enable them to manage their condition effectively and stay as healthy as practicably possible for longer (reducing risk or delaying onset of complications).
- Support patients to be able to set their own goals and develop their own personal action plan regarding their future diabetic management.
- Increase choice for patients to attend the Structured Education Programme at a time and place convenient for them.
- Improve participants understanding of their condition using programme delivery techniques and resource materials that are tailored to suit their needs.

Commissioners

- Reduce inequality of provision of services across the Mid-Nottinghamshire.
- Improve the effective use of available resources for commissioners.
- Reduce the quality and financial implications associated with treatment of complications of Diabetes, by improved patient self-management to reduce risk or delay their onset.
- Ensure patient choice is offered.
- Improve integration of the Structured Education Programme within the care pathway.

3.1 Aims and objectives of service

Service Aims

To provide high quality structured education for adults diagnosed with Type 2 Diabetes, to improve knowledge of their condition and enable effective self-management of their condition to reduce the risk of onset of complications.

The Structured Education Programme for Type 2 Diabetes will meet required national and local criteria, be tailored to patient need, and be responsive to address anticipated increases in the numbers of people diagnosed with Diabetes. It will reduce health inequalities across Mid-Nottinghamshire, provide value for money for commissioners, and make best use of available resources.

Service Objectives

The service aims will be delivered by:

- Ensuring that the Structured Education Programme is offered to all newly diagnosed patients and to people with an existing diagnosis where participation is deemed to be beneficial.

- Ensuring that the Structured Education Programme is designed and accredited against nationally and locally defined criteria.
- Embedding the Structured Education Programme as an integrative element of the Diabetes care pathway for patients.
- Providing programme sessions from local premises which are suitable for programme delivery and accessible to patients.
- Flexing capacity to facilitate changes in the number of people diagnosed with Diabetes.
- Enabling patients to be signposted to other appropriate services which enable them to manage their condition effectively.
- Improving patient access to structured education programmes.
- Ensuring the Structured Education Programme is accessible and responsive to patient need, e.g. materials printed in languages other than English.
- Maintaining the Structured Education Programme through regular audit and accreditation.
- Ensuring that staff are appropriately trained and competent to deliver the Structured Education Programme.

3.2 Service description/ care pathway

When first diagnosed with Type 2 Diabetes, patients will be provided with a range of information and advice about their condition. They will also be offered the opportunity to attend a Structured Education Programme.
Alternately, where a patient has existing Diabetes and it is considered that participation in structured education would be beneficial, they should be offered opportunity to attend a programme.

Referral to the service

Patients will be referred to the service via their Diabetes specialists, GPs or Practice Nurse using agreed referral processes, i.e. electronic email referral. The provider will explore future opportunities to streamline referral in agreement with commissioners, e.g. e-referral.

The GP or Diabetes specialist will refer patients for a Structured Education Programme as soon as possible after diagnosis, within 9 months. The patient's current HbA1c reading, taken within the last 6 months, should also be provided at the time of referral.

The GP or nurse will ensure that a record of the offer for structured education is documented in the patient's care plan, which will include the expected aims and outcomes. It should be noted that patients will also receive a tailored self-management plan on completion of the Structured Education Programme.

The provider will be responsible for ensuring that the once a patient is referred for a programme they are:

- Contacted within 2 weeks of initial referral
- Offered a choice of location and time for a programme
- Offered a place on a programme within 4 weeks of initial referral
- Sent a letter of confirmation within 5 days of the booking
- Contacted either by telephone, SMS text or email within 3 days prior to the course to confirm attendance

The Structured Education Programme should have been completed for every patient within twelve weeks of their referral to the programme.

Discharge from the service

Patients will be discharged from the service if:

- They decline to partake in the Structured Education Programme or tailored alternative, e.g. face-to-face contact.
- They do not attend a scheduled programme and fail to attend one further programme onto which they are re-booked.
- Move out of area and register with a GP practice outside of Mid Nottinghamshire.

The provider must inform the patient's GP in writing within 2 weeks of the end of the Structured Education Programme to advise them the outcome of attendance, e.g. programme completed, DNA, failed to complete and another date offered.

Where a patient has not attended the programme, the provider should follow up with the patient to find out reasons for non-attendance. The patient should be offered a place on one further programme, up to a maximum of 2 programmes offered. Learning from DNA analysis should be factored into future programme improvement and delivery, e.g. offering alternative venues, times, dates for the programme.

Programme Structure
The provider is expected either to adopt an existing recognised education programme or develop a locally accredited programme which meets national and local criteria. The proposed programme, including curriculum, lesson plans, quality of life questionnaires, evaluation surveys and other supporting materials should be shared to commissioners for approval prior to delivery.

The Structured Education Programme will have a written curriculum and will be developed and accredited to meet national and local criteria and standards. It will be reflective of the latest evidence and be regularly audited and evaluated. The programme curriculum will include key lessons to equip patients with the knowledge and confidence to manage their condition effectively.
The provider will co-ordinate staff who possess relevant training, competence and expertise to deliver education that covers all elements of the programme and its lesson plans, e.g. nutrition, exercise, podiatry.

The provider will provide details of staffing mix, staffing levels and appropriate qualifications, which will be agreed with commissioners as minimum standards.

The emphasis of the programme is to encourage self-care and action planning which helps the patient to understand what their goals and healthcare targets are, and how they can achieve them.

The Structured Education Programme will be accessible to a broad range of people considering their culture, ethnicity, any special needs (e.g. language, learning disability, hard to reach groups) that they might have, and where they live. Programme materials will be adapted to support delivery to all participants, e.g. translation to other languages, easy read format, braille. The provider will ensure that interpretation services are available when needed.

The provider will ensure that the diabetes education needs of people caring for patients with diabetes are met. They will encourage carers to attend classes either independently or with the patient.

The provider will maximise opportunities to promote telehealth and e-health education alongside the programme, e.g. signposting to the self-care hub, use of Florence assistive technology.

Programme Content
The provider must ensure that the Structured Education Programme provides psychological support for adults diagnosed with diabetes, aimed at improving mental wellbeing by supporting the development of self-management or self-care skills.
Any advice relating to use of medicines, blood glucose meters and self-monitoring of blood glucose levels must be consistent with national/ local guidelines and Nottingham and Nottinghamshire ICB Prescribing recommendations.

Programme Delivery
The Structured Education Programme will be delivered primarily through group sessions, supported by face-to-face contacts and alternative education media forms where appropriate.

The Structured Education Programme will be delivered in accessible and appropriate settings. Participants will be offered flexibility with regard to dates, days and times that sessions are held (e.g. extended hours and weekends), to reflect their commitments and provide convenience and choice, to encourage maximum attendance.

The provider will be responsible for producing all course resources, e.g. workbooks, evaluation questionnaires, venue hire, refreshments, teaching aids and administration.

The provider will be responsible for following up anyone who does not attend a scheduled education programme, to establish the reasons and to offer an appropriate alternative.

The provider will be responsible for providing monthly reports regarding patient uptake and programme delivery. See Schedule 6 for reporting requirements.

Service Integration
The provider must ensure that the Structured Education Programme is integrated across the Diabetes care pathway, and that all information provided during the programme is consistent with the care pathway.

The provider must proactively promote and ensure that all members of the healthcare teams are familiar with the content of the Structured Education Programme, to ensure that consistent advice is given to all patients.
The provider will establish links with a range of community groups and special interest organisations, to ensure that educational needs are being met, awareness of diabetes as a health issue remains high, and to support other health promotion work on risk reduction in diabetes.

The provider shall raise awareness of access to self-care support, e.g. through the Self-Care hub, due to be established at Ashfield Health & Wellbeing Centre.

Service Improvement
The provider must ensure that patients with diabetes and their carers have the opportunity to contribute to the design and provision of local programmes.
Any proposed significant changes, including complimentary modules that may enhance the programme for the local population needs, should be agreed with commissioners before they are implemented.

3.3 Population covered
The service is available to adults aged 18 and over who are registered to a GP practice within one of the Mid Nottinghamshire Primary Care Networks (i.e. Ashfield North PCN, Ashfield South PCN, Mansfield North PCN, Newark PCN, Rosewood PC or Sherwood PCN).

3.4 Any acceptance and exclusion criteria and thresholds
Acceptance Criteria

- All adult patients newly diagnosed with Type 2 Diabetes
- Adult patients with existing Diabetes where participation in a Structured Education Programme would be beneficial to their ongoing self-management of their condition, e.g. poor diabetic control and/ or 3 or more emergency admissions relating to their Diabetes
- Current HbA1c reading that has been taken within the previous 3 months before referral

Exclusion criteria

- Adults who are not registered with a GP practice which is a member of Mansfield & Ashfield or Newark & Sherwood PCNs.
- Children and adolescents
- Patients with severe & acute complications related to their diabetes
- Pregnant women with established and gestational diabetes

3.5 Interdependence with other services/ providers

The provider must ensure that the Structured Education Programme is integrated with the rest of the Diabetes care pathway. The service should not be delivered in isolation to other services. All information provided during the programme must be consistent with the care pathway.

To ensure that the Structured Education Programme is integrated within the care pathway, the provider will be expected to work with and in conjunction with other health professionals and care providers, including (but not limited to):

- GPs and the Diabetes GP network (lead/ hub) practices
- Intermediate Tier services
- Integrated Care teams (Prism)
- Acute healthcare
- Commissioners
- Patients and carers
- Patient and Participation leads
- Community and voluntary sector
- Public Health
- Community teams
- Medicines management teams
- Community pharmacists

4.1 Applicable national standards (e.g. NICE)

The provider must ensure that the Structured Education Programme meets current national guidance, e.g. NICE Guidance, QISMET

Guidance and recommendations from other groups or organisations should be considered in the development and delivery of the Structured Education Programme, e.g. Diabetes UK - Patient Education Working Group Report, All-Party Parliamentary Group for Diabetes

The Structured Education Programme will be delivered from a range of premises that are accessible to patients and suitable for programme delivery.

Premises will be approved by commissioners and will provide acceptable coverage across Mid-Nottinghamshire to promote participant inclusion.