Service	Structured Education Programme for Adults with Type 2 Diabetes – South Nottinghamshire
Service specification number	DB03

1.1 National/local context and evidence base

The provision of high-quality patient education is an important element of a diabetes service. It supports self-care, helping people to manage their own condition. The need to provide structured diabetes education was set out in the National Service Framework (NSF) for Diabetes (2001). This was subsequently reinforced by NICE Health Technology Appraisal 60 – "Guidance on the use of patient education models for diabetes" (2003). This stipulated that 'structured patient education is (to be) available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal regular assessment of need'.

South Nottinghamshire Place Based Partnership work to develop and improve services for people living with diabetes. This is an important priority. It is estimated that there are 14,600 people with diabetes living in South Nottinghamshire County and of these 13,000 have been diagnosed. Approximately 1100 have Type 1 diabetes, with the remainder having Type 2. The levels of diabetes are rising in line with the national rates.

In accordance with the Department of Health/Diabetes UK Working Party Report on structured patient education in diabetes (2005) and to fulfil the NICE requirements this service will meet the following key criteria:

- 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.

2.1 Local defined outcomes

Patients will:

- Be better informed about diabetes and how to control it, particularly in terms of self-management
- Make lifestyle changes to positively impact on their condition
- Be supported to manage their condition to prevent their condition from deteriorating

3.1 Aims and objectives of service

The aim of this service is to deliver standardized, structured group education for adults with Type 2 diabetes and at risk of developing diabetes. Patient education is regarded as an important element of care.

The objectives of the service are to:

- Provide high quality structured diabetes education in line with NICE guidance
- Improve patients' knowledge, skills and confidence, and to support self-care and promote healthy lifestyles
- Improve clinical outcomes for people with diabetes and reduce their risk of developing associated complications
- Provide an equitable and culturally appropriate service
- Improve access to education and reduce inequality
- Offer choice and convenience

3.2 Service description/care pathway

All aspects of this service specification must be fully complied with. If any aspect is not achieved this constitutes non-compliance and must be discussed with Commissioners at the earliest opportunity for a way forward to be agreed.

It is important that structured patient education is delivered in an appropriate manner to make it accessible for potentially vulnerable groups such as:

- People with poor basic skills, such as language and literacy
- People (both patients and carers) with learning difficulties
- Difficult-to-reach groups such as travellers, refugees, and asylum seekers

The service should be delivered by a specialist/trained team. The trainers should:

- Understand the education theory appropriate to the age and needs of the recipients of the education.
- Be trained and competent in the delivery of the education theory of the curriculum they are teaching.
- Be trained and competent in the delivery of the principles and content of the programme they are teaching.
- Have experience of delivering group education sessions.
- Have previous experience of diabetes management and relevant nutrition knowledge. 'Skills for Health' have developed a range of competencies for staff providing group education to people with type 2 diabetes, which should be able to be demonstrated.

The curriculum delivered will be agreed by the Commissioners. Whilst a degree of flexibility in delivery is expected to maximise uptake and minimize the dropout rate, any change will have to be agreed with the Commissioner.

The service provider shall:

- Have a named service lead that will be responsible for all aspects of service delivery and for all communications with the Commissioner
- Ensure all staff involved in the provision of this service will be appropriately qualified and experienced. Staff delivering group education sessions will receive regular support, mentorship and training.
- Provide high quality education materials as required to deliver the curriculum, and will be responsible for their transport and storage
- Be expected to maintain strong working relationships with other providers of diabetes care in Nottinghamshire, and patient groups, to enable people with diabetes to receive an integrated service and continuity of care.

The service will be responsible for:

- Triaging patients to the appropriate structured education programme
- Proactive marketing and patient recruitment
- Organising suitable venues
- Supporting course delivery
- Communication with course participants including written information and telephone support
- Communication with GP practices (including following patient completion of the education or otherwise) within two weeks of a patient completing the course
- Supporting evaluation/audit
- Service reporting and monitoring requirements
- Ensuring that all data is handled in accordance with the Data Protection Act and to the satisfaction of the local Caldicott Guardian

Care Pathway

Patients may self-refer or are referred for enrolment onto the relevant programme when they are newly diagnosed (within the first year of diagnosis), or if they have been identified as having a need for structured education. They will continue their care pathway according to their care plan/discussions with their GP/practice nurse.

Patients will be booked onto the Programme on a 'first come first served' basis. The Provider should monitor waiting list times and be prepared to alter marketing/referral arrangements, as necessary to benefit patients and reduce waits.

Patients will be discharged from the relevant programme once they have completed the full number of sessions as applicable to their condition and:

- Patients understand their condition
- Lifestyle changes and risks are understood
- Appropriate actions have been taken to keep their condition well controlled

Transition from Children's to Adult Services:
The service will work in partnership with Children's and Adult commissioners, the Community Children and Young People's Service and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring support specific to this service specification to ensure seamless continuity of care during transition from children's to adult services.

Proactive planning and care pathways will be developed in line with local and regional transition guidance and the Together for Short Lives transition care pathway (http:/www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework that can be adapted locally to plan services specifically for teenagers and young adults with life threatening, life limiting or complex medical conditions. The pathway sets out six standards that should be developed as a minimum, with the aim of achieving equality for all young people and families, wherever they live.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young adults during and following transition
- Use of Nottingham ICCYPH Programme Families' Statement of Expectations as guiding principals
- Continuation of the personalisation approaches and systems used by the young person/adult
- Statutory duty to contribute to and provide services to young people/adults within Education Health and Care Plans (EHCP) up to age 25 in line with SEND legislation (http://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014)
- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions
- Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Networks. Further work is being undertaken locally regarding this document and therefore should not be seen as definitive guidance.

3.3 Population covered
The service will be accessible to patients registered with a GP practice in South Nottinghamshire Place Based Partnership (PBP).

3.4 Any acceptance and exclusion criteria and thresholds
The service will be accessible to ALL patients diagnosed with Type 2 diabetes aged 18 and over and who are:

- Registered with a GP practice in South Nottinghamshire PBP.
- Newly diagnosed (up to one year) with Type 2 diabetes or Impaired Glucose, or has been identified as someone with an identified need for diabetes structured education (Refresher)

Service exclusion criteria:

- Patients not registered within the South Nottinghamshire PBP.
- Patients diagnosed with Gestational Diabetes

3.5 Interdependence with other services/providers

Patients receiving the service may also be receiving other support or treatment associated with their diabetes, through Primary, Community or Secondary Care.
The service will rely heavily on referrals from GPs. The Provider will work closely with GPs to facilitate effective referrals.

Programmes will be delivered in suitable local venues across the South of the County and organized by the service provider (linked to public transport routes ensuring that all patients do not need to travel more than 2 miles/one bus journey).

Programmes will be delivered at a range of times/days that optimize accessibility for patients. The Provider will review the days/hours of operation on a regular basis taking into consideration patient feedback.