

Final Diabetes Education Service Specification

Service Specification Number	03/CVDS/0001
Care Pathway/Service	Services for Long Term Conditions: Diabetes Education
Commissioner Lead	CCP for Cardiovascular Disease and Stroke
Provider Lead	Chris Kennedy/Sam Leonard
Period	2011/12

1. Purpose

1.1 Aims

To provide an education service, in partnership with Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, for people with newly diagnosed diabetes within Bournemouth, Poole and East Dorset

1.2 Evidence Base

In developing a service specification for the proposed Scheme, the Commissioner(s) have drawn on advice and guidance provided in a number of publications relating to diabetes education programmes including NICE Guidance; 'Guidance on the use of patient-education models for diabetes', 2003 and 'Structured Patient Education in Diabetes, Department of Health' 2005.

The PCT has reviewed the "National Service Framework for Diabetes 2003". This publication demonstrates that there is a drive to empowering the individual with diabetes to adopt a healthy lifestyle and to manage their own diabetes through education and support. Structured education is the cornerstone of effective diabetes care.

The Commissioner(s) have also taken account of the White Paper 'Our Health, Our Care, Our Say', 2006, in relation to the development of accessible healthcare services in the Community.

1.3 General Overview

Type 2 diabetes is known to correlate closely with a range of factors including obesity, ethnicity, as well as age in populations. The increasing incidence of overweight and obesity within the general population is resulting in increased incidence of type 2 diabetes. We are aware that the incidence of cardiovascular disease and stroke is higher in patients with diabetes. Prevalence data is available through a Public Health Observatory model which provides this data at practice level. It is essential to the patient to empower them to manage their own diabetes, through optimal self care, in order to improve the patients risk of developing diabetes complications.

1.4 Objectives

1. A patient centred education programme in groups of no more than 10 patients;
2. An education programme that is made available to adults with newly diagnosed Type 2 diabetes within 7 days of the time of referral;
3. An education programme which is underpinned by adult learning principles:
4. An education programme that promotes empowerment and self care for patients;
5. An education programme that is evidence based;

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6. A dynamic education programme that will be flexible to the needs of the individual;
7. For patients to be able to complete initial education programme within 6 weeks of diagnosis;
8. Programme delivered in community settings to ensure easy access for individuals;
9. Appropriately skilled and trained educators to deliver this education programme;
10. Provide staff delivering the education with appropriate ongoing education to ensure that competence is maintained
11. To provide the patient with written information regarding their Type 2 diabetes;
12. To record biomedical data for monitoring;
13. To make better use of clinical skills available in Primary Care;
14. To avoid unnecessary referrals to secondary care, therefore releasing time from the diabetes specialists that can be utilised by those patients requiring expert support;
15. To undertake regular patient satisfaction survey to ensure quality and effectiveness.
16. Communicate with primary care referrers to ensure referrals are made at the time of diagnosis;

1.5 Expected Outcomes including improving prevention

- For all those patients who are newly diagnosed with Type 2 Diabetes, who are registered with a GP in Bournemouth and Poole and East Dorset, who meet the access criteria, to be offered the opportunity to attend the group education programme;
- For patients to learn how to manage/live with their diabetes and understand the care they should expect to receive for long term management of their condition;
- For patients to have a greater understanding on self management of their diabetes and how to achieve optimal self care.

NHS Outcomes Framework Domains & Indicators

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

2. Scope

2.1 Service Description

The service delivered shall be an empowerment based, group education service for adults with newly

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diagnosed Type 2 diabetes provided in a range of community settings. This service will deliver effective education which promotes self care and encourages patients to self manage their condition.

The Service will not be able to accept referrals for the treatment of any child or any adult with;

- Type 1 diabetes
- Any condition which prevents the individual participating in a group education session

2.2 Accessibility/acceptability

Open access to this service will be available for all patients registered with a Bournemouth or Poole GP or GP in East Dorset.

Any patient referred to Providers under the Service will be offered a first education session within 7 days of referral.

2.3 Whole System Relationships

Providers of the Service shall establish and maintain contact, communication links and appropriate clinical supervision arrangements with appropriate clinical colleagues working within primary and secondary care settings. The diabetes education programme service will engage with other services as appropriate. For example: patient attends the programme with other co morbidities that require onward referral/consultation with health care professional, ensuring that this is undertaken with the consent of the patients referring GP.

2.4 Interdependencies

Referrals to the programme are reliant upon appropriate signposting by primary care (GP's, Practice nurse) at the time of initial diagnosis. Patients attending the programme who are incorrectly diagnosed will be referred back to primary care e.g. for those with Impaired glucose tolerance or to secondary care e.g. urgent referral for type 1 diabetes.

2.5 Relevant networks and screening programmes

The diabetes education programme service will report to the Diabetes Care Implementation Network and other local PCT lead groups as is required by the Commissioner(s).

3. Service Delivery

3.1 Service model

The education sessions will provide access to a registered nurse and a registered dietitian both of whom will have specialist training and experience of managing patients with diabetes in a group setting.

The programme comprises of three sessions each of two hours length following an established curriculum and working to an agreed philosophy. Gaps between sessions are between 2-4 weeks. Blood test between sessions 2 and 3 are taken for the purpose of goal setting and monitoring of outcomes.

Group education with a focus on self management/personal goal setting will aim to enable patients to understand their diabetes condition and how they can best manage their own health. The sessions will ensure that patients understand when and how to access further care in their own GP practice.

The inclusion of two educators at every session is in line with the only nationally recommended patient education model DESMOND (Patient Education Working Group, DH 2005). The use of two educators allows people to ask questions in private that they would not wish to share in the group (although educators are very careful to create an environment where people are happy to speak out). There is also the opportunity to take a person aside if they cannot contribute to the group discussion e.g. due to learning or communication difficulties, thus

allowing the chance to talk 1:1 with one of the professionals.

The final session focuses on target setting which patients are encouraged to take back to their primary care provider as a starting point for discussing their longer term lifestyle changes.

Where anthropometric and biochemical results were lacking on the initial referral form, these will be taken at session 1 to ensure completeness of data and full understanding of patients results.

Standard communication letters with primary care are sent after attendance at the programme.

3.2 Care Pathway(s)

See Attachment Pathway for Type 2 Diabetes

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Bournemouth and Poole and East Dorset

4.2 Location(s) of Service Delivery

To ensure an equitable distribution of the service in East Dorset in suitable accommodation

4.3 Days/Hours of operation

Days and location of operation

Two days in Poole locations and two days in Bournemouth locations. Days will be different in each location to offer patient choice where practicable. Programmes will run 51 weeks per year i.e. 204 programmes per year. GP practices will be advised/reminded that there will be no service between Christmas and New Year. There will be no sessions on bank holidays.

Times of sessions

9.30 -11.30am and 12-2pm and 2.30-4.30pm on four different days.

Two days per month in Wimborne

Three days per month in Christchurch

One day per month in Wareham

(in line with section 7 service improvement plan "To ensure that there is not wasted capacity within the service" – sessions at Christchurch and Wimborne are currently under review with a proposal to increase Wimborne, reduce Christchurch and pilot an evening programme.

4.4 Referral criteria & sources

Referral Criteria

Referrals direct from the GPs supported by a referral form for people with newly diagnosed with type 2 diabetes. Referrals must be in accordance with WHO definition and diagnosis of diabetes mellitus 2006.

Providers shall reject any referral received for patients not considered suitable for education in a group setting or whom fall outside of the WHO diagnostic criteria.

4.5 Referral route

Open access but patient must bring written referral using agreed form

4.6 Exclusion criteria

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The Service will not be able to accept referrals for the treatment of any child or any adult with;

- Type 1 diabetes
- Any condition which prevents the individual participating in a group education session

The provider shall immediately refer directly to the local acute diabetes services any patient assessed as having Type 1 diabetes for urgent management.

Provider will refer back to the GP those patients who are inappropriate to attend a group education session with explanation for return.

4.7 Response time & detail and prioritisation

Any patient referred to Providers under the Service will be offered a first education session within 7 days of referral.

5. Discharge Criteria and Planning

All patients will be referred back to primary care following completion of the programme. Providers shall confirm in writing, by fax or secure e-mail the discharge of patients to the original referral source indicating the action taken.

If a patient DNA's any appointment the service will write back to the referrer informing them of such. It is the responsibility of the GP to follow this up with the individual patient.

6. Prevention, Self-Care and Patient and Carer Information

All patients attending the sessions will receive the following:

- Pre programme patient information leaflet
- Diet sheet- Healthy eating for Type 2 Diabetes
- Diabetes UK booklets – Understanding Diabetes and Diabetes for beginners, your complete guide to living with Type 2 diabetes.
- Urine test sheet/ medication letter
- Patients personal target sheet for BP, Lipids, HbA1c, smoking, weight

All the above information will be professionally printed and can be made available in large print upon request.

7. Continual Service Improvement/Innovation Plan

<i>Description of Scheme</i>	<i>Milestones</i>	<i>Expected Benefit</i>	<i>Timescales</i>	<i>Frequency of Monitoring</i>
To ensure that there is not wasted capacity within the service (see comment in section		Maximise capacity	2011/12	Review 6/12

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4.3 To work towards developing personal target sheet to become an enhanced self management plan with greater value to the patient		Enabling patients to use the target sheet more effectively in the longer term to facilitate better follow ups in primary care	To plan to develop by September 2011 if financially viable To implement by March 2012, all patients will have a personal target sheet if financially viable	Three times a year in line with Diabetes Network meetings
Promotion of programme to ensure GPs are aware of and refer in to the programme		Ensure equity of access across Bournemouth and Poole	ongoing	In line with reports for diabetes network and commissioners (three times a year)

8. Baseline Performance Targets – Quality, Performance & Productivity

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Frequency of Monitoring</i>
<u>Quality</u>				
Service User Experience	Patient satisfaction and improvement in knowledge		User satisfaction form	All patients will receive user feedback form at end of their programme. Results summarised for Diabetes Network meetings and commissioners
Outcomes	HbA1c For those with HbA1c of 7.5% or more, 75% will achieve a reduction by end of session 3		HbA1c at session 1 compared to session 3	Quarterly
Access	Attendance rates 85% will attend all three sessions		Attendance at sessions	Quarterly reports with fully validated results for the Diabetes network meetings

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<i>Additional Measures for Block Contracts:-</i>				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

* some people may take a long time to complete the programme and this cannot be validated in time for monthly reports.

9. Activity

9.1 Activity

<i>Activity Performance Indicators</i>	<i>Method of measurement</i>	<i>Baseline Target</i>	<i>Threshold</i>	<i>Frequency of Monitoring</i>
Total contacts	Attendance at sessions 1, 2 and 3	3,200 (Anticipated split new 1200/Follow up 2000)		monthly

9.2 Activity Plan / Activity Management Plan

Monthly activity reports as defined by a minimum of total and new contacts
 To report contacts separately for each PCT
 To report course completers separately for each PCT

9.3 Capacity Review

The provider will monitor attendance figures to ensure adequate resources are in place to provide effective robust service.

10. Currency and Prices

10.1 Currency and Price

Basis of Contract	Currency	Price	Thresholds	Expected Annual Contract Value
		£		£

