SERVICE SPECIFICATION

Service	Diabetes Education (Adults – 18 years+)
Commissioner Lead	Community & Primary Care Commissioner
Provider Lead	
Period	1st December 2013 – 31st March 2017 (with annual reviews in March)

1. Purpose

The purpose of this specification is to

- Provide standardised high quality structured education for adults with diabetes in Croydon through group sessions and individual face to face contacts where appropriate
- Empower adults with diabetes to manage their condition by enabling them to develop the necessary knowledge and skills to manage their condition
- Provide psychological support for adults diagnosed with diabetes aimed at improving mental wellbeing by supporting the development of self-management / self-care skills
- Reduce the risk of people with diabetes from developing complications

AND

- Inform the provider of the services and standards that commissioners require and which the provider shall seek to meet and provide.
- Seek to ensure that the provider is clear about its responsibilities and ensures co-ordination and development of the service.
- Inform others of the scope of the service.
- Require the provider to co-operate and collaborate with others involved in the process of providing diabetes care to Croydon's resident population .

The contract will operate for three years from 1st December 2013, but will be reviewed on the completion of each year of the contract, when contract variations / termination may be possible subject to agreed contractual arrangements. The contract will initially operate for 4 months during 2013/14, but will then become an annuarised contract matching the financial year cycle until 31st March 2017.

1.1 Aims

Provide diabetes education for adult patients diagnosed with diabetes within the Croydon area to support them in the effective self-management of their condition. Programmes should be delivered by appropriately trained educators, evidence-based and suit the needs of the individual. The programmes should have specific aims and learning objectives and support individual plus his or her family and carers in developing positive attitudes, beliefs, knowledge and skills to self-manage their diabetes.

1.2 Evidence Base

NICE Diabetes in adults quality standard 1 (2011) states: "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 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.

A patient educational programme should meet five key criteria 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 have an understanding of 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.

Provider to ensure that the services provided reflect national guidance on diabetes (e.g. NICE, QISMET standards)

Structured diabetes education programmes currently being delivered in Croydon are:

- ***X-PERT*** - a 6 week group education programme for people with type 2 diabetes, helping them to learn to self-manage their condition and reduce the need for medication.

- ***X-PERT INSULIN-*** a structured patient education programme for people with type 1 and type 2 diabetes using insulin.

- ***DAFNE-*** a structured patient education programme for people with type 1 diabetes.

Supporting evidence for these programmes are:

- **X-PERT** has been shown to increases skills, knowledge and confidence for diabetes self-management resulting in increased health and well-being.

- **X-PERT INSULIN** has been shown to improve clinical, lifestyle & psychosocial outcomes & reduces the requirement for diabetes medication[1]

- **DAFNE** The UK Feasibility study[2] revealed that DAFNE led to significant improvements in glycaemic control, quality of life, psychological wellbeing and treatment satisfaction. An economic analysis performed by York Health Economics Consortium (YHEC)[3] also revealed that DAFNE would pay for itself within 4-5 years due to the reduced complication rate expected due to improved glycaemic control for patients with type 1 diabetes.

1

Deakin TA (2011) The diabetes pandemic: is structured education the solution or an unnecessary expense? Practical Diabetes; 28 (8): 358-361.

2 DAFNE Study Group. Training in flexible, intensive insulin management to enable dietary freedom in people with type 1 diabetes: dose adjustment for normal eating (DAFNE) randomised controlled trial. BMJ: 2002; 325: 746

3 Shearer A, Bagust A, Sanderson D, Heller S, Roberts S. Cost-effectiveness of flexible intensive insulin management to enable dietary freedom in people with Type 1 diabetes in the UK. Diabetic Medicine 2004; 21 (5):460-67

1.3 General Overview

Diabetes is a chronic and progressive disorder that impacts upon almost every aspect of life. The number of people within the UK and in Croydon diagnosed with the condition is growing rapidly. There are a large number of different ethnic minority communities in Croydon whose members account for an estimated 42% of the borough's total population. There is a variance in prevalence across the borough of Croydon which will identify differing patient education needs. The provision of educational programmes will need to reflect the needs of these communities.

Currently in Croydon there are approximately 800 patients diagnosed with diabetes annually, approximately 10% of these with type 1 diabetes. As diabetes is a long term condition in which self-management plays a central role, it is essential that people with diabetes have access to the knowledge and the confidence to minimise the impact of the condition on their daily life.

The table below shows the number of people diagnosed with diabetes and prevalence in Croydon as of 31st March 2012.

NHS area	No. on Diabetes Register	% prevalence
Croydon March 2012	18,352	4.9%
Croydon March 2013	19,219	5.3%

1.4 Objectives

Diabetic education programmes will be offered to all newly diagnosed adult diabetic patients.

Mechanisms must be put in place to maximise attendance at each education session and to reduce the number of non-attenders and overall dropout rates.

For people with type 2 diabetes currently at least 50% of newly diagnosed patients take up structured education programmes within the timeframes outlined in this specification. We will expect the providers to aim to improve on this percentage each quarter.

There is also potentially a large portion of unmet need for the provision of education to long standing diagnosed patients who may need a refresher or who may benefit from participation in distinct education programmes. These patients would be identified by their GPs where the GPs believe there would be benefit for the patient's further developing self-management skills. Providing programmes for this potential unmet demand would only be taken forward following agreement of the commissioners.

1.5 Expected Outcomes

Improve bio-medical outcomes & quality of life indicators. To include:

Improved ability to self-manage condition through:

- Improved glycaemic control
- Reduced BMI, cholesterol & blood pressure
- Increased levels of physical activity
- Increased smoking cessation rates
- Lower levels of depression

- Reduced use of unscheduled care, including LAS
- Reduced levels of emergency hospital admissions

Help to increase participants' self-efficacy, increase motivation and attitudes to self-care, thereby reducing complications and unplanned use of secondary care health services

Patients are able to set their own goals and develop their own personal action plan with regard to their future diabetic management

Patients have a greater understanding of the need to attend screening appointments (e.g. retinopathy, podiatry)

2. Scope

2.1 Service Description

There are two broad categories of structured education programmes that providers can deliver:

- Structured education programmes for patients with type 1 diabetes.
  The majority of these patients within this category will be under the care of a secondary care consultant and /or being cared for under a shared care agreement with primary care
- Structured education programmes for patients with type 2 diabetes
  The majority of patients within this category will be under the care of primary care and / or the intermediate tier service

Providers are able to provide services for either of or both of the two categories above.

Providers wishing to provide any such programmes will need to ensure that they conform to all national / local standards and guidance in how the programmes are delivered.

Providers will need to conform to the standards defined within this specification

Payment will be made on a per patient basis:

- Full payment will be made for each patient completing a full course
- Part payment (50%) will be paid for each patient that starts the programme but fails to complete the full course (as long as they have attended a minimum of 50% of the course content)
- On receipt of the quarterly information received from the provider commissioners will be entitled to withhold up a percentage value of these payments if all the standards contained within the specification are not achieved. The month following the end of the underperforming quarter will be used by the provider to rectify any under-performance from the preceding quarter. Commissioners will be entitled to apply such financial penalties if any under-performance has not been addressed following that month period
- If the position is not rectified by the provider by the end of the subsequent quarter commissioners will be entitled to withhold a further 10%, and in subsequent quarters up to a maximum of 30%

We will expect the provider to ensure that the standards contained within the specification are achieved ensuring that waiting lists / times do not exceed acceptable standards.

2.2 Accessibility/acceptability

The service will be available to all adults registered with a Croydon GP practice.

The provider will ensure that education programmes are offered that reflect the needs of general population in Croydon in terms of culture, ethnicity, any special needs (e.g. language, learning disability). The provider is also

expected to offer flexibility with regard to days and times sessions are held (e.g. extended hours and weekends) to reflect peoples' commitments and to encourage maximum levels of attendance.

2.3 Interdependencies

Commissioners of diabetic services are committed to ensuring that structured education is an integral part of the diabetes care pathway. Education is an integral part of treatment and not an add-on to regular services.

The provider will be expected to work with and in conjunction with other health professionals regarding patients' diabetic care. For example:

- GPs & diabetes GP network (lead/hub) practices
- Intermediate Tier services
- Acute healthcare
- Commissioners
- Patients and carers
- Patient and Participation leads
- Public Health
- Community nurses
- Medicines management
- Community pharmacists

It is vital that the provider ensures that they are conforming to local standards / guidance as well as national standards / guidance and that they liaise with other providers of diabetic care within Croydon to maintain continuity of care and continuity of information provided to patients. They must also ensure that, through such mechanisms, they keep abreast of any locally agreed service developments which may impact on the way in which diabetes care is delivered.

3. Service Delivery

Providers will deliver structured education programmes meeting the five key criteria laid down by the Department of Health and the Diabetes UK Patient Education Working Group for patients diagnosed with Type 1 diabetes, patients diagnosed with Type 2 diabetes and patients diagnosed with diabetes who are administering insulin. Examples of validated structured education programmes include the following:

  - The DAFNE programme for people with Type 1 diabetes
  - The X-PERT programme for people with Type 2 diabetes
  - The DESMOND programme for people with Type 2 diabetes
  - The X-PERT insulin programme for people with Type 1 and Type 2 diabetes who are administering insulin

- The provider will be able to propose other structured programmes for consideration and agreement by commissioners, including additional complimentary modules that may meet the needs of specific local populations and GP networks
- The provider should also offer and deliver alternative education programmes for those unable to complete validated programmes (e.g. due to time commitment, language barriers, cultural or education needs)
- The provider will provide programmes that are delivered through group sessions as well as individual face to face contacts
- The provider will provide details of processes to be put in place for prioritising newly diagnosed patients onto programmes. The provider needs to inform the commissioner of any intentions to design or provide new additional programmes and the commissioners will need to approve these prior to the provider

delivering these as part of this specification

- People diagnosed with diabetes will be offered an appropriate structured education programme, as soon as possible after diagnosis. The provider will ensure that anyone referred for induction education will be contacted by a healthcare professional from the provider within two weeks of the referral to discuss the options and agree what is most appropriate programme for that individual / unless the healthcare professional has already made the decision on patient suitability to be included in the programmes. A place on an education programme is to be offered within 4 weeks of referral. For people with type 2 diabetes, all education should have been completed within twelve weeks of diagnosis. For people with type 1 diabetes, the education programme (including DAFNE where appropriate) should commence within six months after diagnosis.
- The structured education programme offered to newly diagnosed patients must be consistent with relevant NICE and other guidance (including local guidance)
- Provide psychological support for adults diagnosed with diabetes aimed at improving mental wellbeing by supporting the development of self-management / self-care skills
- Providers wishing to provide any such programmes will need to ensure that they conform to all national / local standards and guidance in how the programmes can be delivered.
- 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 Croydon Prescribing Committee recommendations.
- The nature of any structured education to be offered, its aims, and outcomes will be documented in the patient's care plan.
- Participants must be able to define and agree personal healthcare targets and develop strategies for meeting them
- The provider must ensure that programmes are integrated with the rest of the care pathway and that all information provided during the programme is consistent with the care pathway
- The provider must ensure that patients with diabetes and their carers have the opportunity to contribute to the design and provision of local programmes
- The provider will ensure that all education programmes are accessible to a broad range of people taking into account their culture, ethnicity, any special needs (e.g. language, learning disability) that they might have, and where they live.
- There is a particular high level of and mixture of ethnic groups within Croydon and the provision of educational programmes will need to reflect their needs.
- The provider must ensure that all members of the healthcare team are familiar with the content of local education programmes, to ensure that consistent advice is given to all patients.
- The provider will ensure that education programmes will be delivered in accessible and appropriate settings, with patients being offered a choice of dates and venue.
- The provider will be responsible for following up anyone who does not attend a scheduled education session to establish the reasons for this and to offer an appropriate alternative.
- 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 has the option to provide commissioners with details of proposals to ensure that all patients who have completed the structured education programme delivered also receive on-going education. Commissioners will decide if they wish to commission any such option
- The provider has the option to propose the provision of "fast track" introductory sessions to improve the uptake of structured education programmes, particularly for those of highest need. Commissioners will decide if they wish to commission any such option

- The provider will establish links with a range of community groups and special interest organisations, in order 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 will provide details of staffing mix, staffing levels and with appropriate qualifications which will be agreed with commissioners as minimum standards
- The provider must inform the patients GP in writing of DNAs and the failure of any patient to complete an education programme.

4. Referral, Access and Acceptance Criteria

Geographic coverage/boundaries

The service will be delivered in the borough of Croydon.

Location(s) of Service Delivery

The provider will offer classes at a number of locations throughout Croydon, with broad geographical coverage of the borough area to ensure patients are easily able to attend the classes. The provider is to propose the locations which will be agreed by the commissioners.

Days/Hours of operation

Services should be provided at a range of times to increase convenience and choice for people with diabetes

Referral criteria & sources

Inclusion Criteria:

- All adult patients newly diagnosed with type 1 (18 years +) and type 2 diabetes
- All adult patients diagnosed with diabetes using insulins. think , and with commissioner agreement, all adult patients with diabetes should be invited annually

Referral route

Patients can be referred via their GPs / GP network practice , through the current Croydon patient referral management processes. Provider to detail how the referral process will operate and the mechanisms involved, which will need to be agreed with commissioners.

Exclusion criteria

- Adults living outside of the borough of Croydon who are not registered with a Croydon GP
- Children & adolescents
- Severe & acute complications related to their diabetes
- Pregnant women with established & gestational diabetes

Response time and prioritisation

Once a patient is referred for a course they are:

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

The provider may offer more places than can take up on each course e.g. offer 12 places although capacity is 10 as this takes into account any potential DNAs.

5. Discharge Criteria & Planning

Patients are discharged if they:

- Decide not to partake in education classes / face to face contacts
- Move out of area and register with a non Croydon GP.

Post course there will be a letter sent detailing the outcome to the GP within 2 weeks of completing or not attending the course

6. Self-Care and Patient and Carer Information

The emphasis of the courses is on self-care and action planning which helps the patient to understand what their goals are and how they can achieve them. This information can then be used as part of the care planning process at any subsequent meetings with health care professionals.

7. Quality and Performance Standards

7.1 Quality Assurance

- Provider must demonstrate robust quality assurance processes which ensure their educators are fully competent
- Quality assurance processes must ensure high quality consistent delivery of the education programmes
- Quality assurance process must include self-assessment, peer review and external review
- Provider should demonstrate user involvement and feedback in the delivery and review of the service
- Any untoward incidents will be recorded on appropriate documentation with and details sent to the commissioners as part of the contact reporting mechanisms. Providers must inform commissioners immediately if the untoward incident will or has impacted on patient safety.

7.2 Audit

The service will be audited on an on-going basis which will include: quarterly reports, monthly activity data and an annual service report

7.3 Risk Management

The provider must assess the risks of the service they are providing and develop plans to reduce and manage

the risks. The provider shall ensure that appropriate contingency plans are in place to minimise disruption to the delivery of services.

7.4 Insurance and Liability

The Commissioner and the Provider shall maintain in force at its own cost such insurance policies as are appropriate and adequate having regard to its obligations and liabilities under this agreement. The provider shall on the reasonable request of the commissioner from time to time:

- Provide the commissioner with evidence that insurance policies are fully paid and in force
- Allow the commissioner to inspect its insurance policies
- Provide the commissioner with copies of relevant fully policy documents for its insurance purposes

7.5 Information Governance

All confidential patient information will be stored and accessed according to NHS national standards on confidentiality.

Data Protection

The provider shall maintain the confidentiality of personal data entrusted to it in accordance with the provisions of the Data Protection Act 1998 and Access to Health Records Act 1990.

The Provider shall comply with the Data Protection Act 1998 ("the 1998 Act") and any other applicable data protection legislation. In particular the Provider agrees to comply with the obligations placed on NHS Croydon by the seventh data protection principle ("the Seventh Principle") set out in the 1998 Act, namely: to maintain technical and organisational security measures sufficient to comply at least with the obligations imposed on NHS Croydon by the Seventh Principle; only to process Personal Data for and on behalf of NHS Croydon, in accordance with the instructions of NHS Croydon and for the purpose of performing the Services in accordance with this Agreement and to ensure compliance with the 1998 Act; to allow NHS Croydon to audit the Provider's compliance with the requirements of this Clause on reasonable notice and/or to provide NHS Croydon with evidence of its compliance with the obligations set out in this Clause.

Both Parties agree to use all reasonable efforts to assist each other to comply with the 1998 Act. For the avoidance of doubt, this includes the Provider providing NHS Croydon with reasonable assistance in complying with subject access requests served on NHS Croydon under Section 7 of the 1998 Act and the Provider consulting with NHS Croydon prior to the disclosure by the Provider of any personal data in relation to such requests.

Freedom of Information

Each of the parties acknowledges the requirements of the Freedom of Information Act 2000 and each of the parties shall assist and cooperate with the other party (at their own expense) to enable the other party to comply with these information disclosure requests as appropriate.

Where any party receives a request for information in relation to or in connection with this agreement which it is holding on behalf of the other party, it shall, where possible and appropriate (and shall procure that any subcontractor shall), transfer the request for information to the other party as soon as practicable after receipt.

8. Activity

There are currently approximately 800 newly diagnosed diabetes patients in the Croydon area each year and about half of these patients currently take advantage of the diabetes education courses on offer.

It is estimated that the provider will be required to provide diabetes education for at least 400 type 2 and 40 type 1 patients annually, although the expectation is that the uptake for courses will increase.

There is also potentially a large portion of unmet need for the provision of education to long standing diagnosed patients who may need refresher or may need to participate in distinct education programmes. Providing programmes for this potential unmet demand will only be developed following agreement from commissioners.

Providers will be expected conform to all the standards specified within the specification.

All those referred for education programmes following commencement of the contract must be managed within the standards as specified within the specification.

9. Key Performance Indicators

The following information will be provided on or before 10th of each month for the previous month on the data capture example template (Appendix A):

- The number of referrals for patient education by type I & type 2
- The number, makeup and time of classes offered
- The number of places available in each class
- The number of patients attending in each class
- The number of people declining to attend
- Information on reason for why people decline to attend
- The number of DNAs
- The number of people completing the education programmes by type I & type 2
- The number of people who failed to complete their education programme
- The above information also to be broken down by patients' GP practices & sources of referral
- Breakdown of the above by ethnicity

The provider will also ensure that a quarterly audit report is provided to commissioners on or before 10th each month for the previous quarter.

The provider will also ensure that a comprehensive annual report of the years' activity is produced for commissioners.

Information will be provided on the following targets on or before 10th each month for the previous month:

- 95% of patients have been offered a structured education programme within 2 weeks of referral to start within 4 weeks of referral
- 60% uptake of structured education programme offered to patients
- The number of patients who DNA classes is below 10%
- 90% of patients who start a structured education complete the course

Service user experience – an evaluation sheet to be completed by each patient at the end of each course (to be agreed with commissioners). A summary of the outcomes from the evaluation sheets will be reported in each quarterly return :

- 75% of attendees to complete evaluation
- 90% rate the course at a level 3 or above
- Quarterly report to CCG…

The provider is expected to identify shortcomings with any ability to achieve performance targets contained within the specification and provide commissioners with action plans outlining how the provider will ensure the targets will be met.

10. Price

Also refer to references to payment mechanisms within section 2.1

The provider will submit this information to NHS Croydon CCG on or before 10th of April, July, October, and January in order to process payments.

Payment will be made quarterly, based on activity relating to nationally accredited programmes, based on the following costs for per patient attending the whole education sessions:

X-PERT	£138 per patient
X-PERT with Insulin	£208 per patient
DAFNE -	£550 per patient
DESMOND	£70er patient

Exclusive of VAT

The CCG will also be entitled to consider whether to withhold payment (amount to be determined) for sessions, resulting from provider(s) failure to maintain adequate performance against the key performance indicators for a period of greater than 3 consecutive months without adequate rectification.

These prices are to include all costs associated with the provision of the training courses. No additional costs or charges are to be made by the provider(s).

Volume Discounts

All providers are expected to be able to offer price discounts based on the volume of business, with such discounts increasing as the volume of business rises. Providers should indicate the volume discounts available, which will be agreed with the CCG.

Once the agreed discount has been reached it remains in place for the remaining tenure of the contract. Provider(s) should note that the proposed discount(s) should cover all aspects of the service(s) provided.

Appendix A – Diabetes Education Monthly Monitoring Form (example)

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number and time of classes:												
The number and time of X-PERT classes offered												
The number and time of X-PERT with Insulin classes offered												
The number and time of DAFNE classes offered												
The number and time of DESMOND classes offered												
Capacity and uptake of classes:												
The number of places available and uptake of X-PERT classes												
The number of places available and uptake of X-PERT with Insulin classes												
The number of places available and uptake of DAFNE classes												
The number of places available and uptake of DESMOND classes												
KPI's:												
The number of referrals for patient education (type 1)												
The number of referrals for patient education (type 2)												
Percentage of patients offered a structured education programme within 2 weeks of referral - target >95%												
Percentage of patients who take up offer of education - target >60%												
The percentage of patients who DNA'd classes - target <10%												

The percentage of patients who completed their education course - target >90%												

Breakdown of above information by patients GP practice, source of referral & ethnicity