SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Type 2 Diabetes Structured Education
Commissioner Lead	NHS Devon Integrated Care Board
Provider Lead	TBC
Period	April 2023 to March 2026
Date of Review	March 2024 and annually throughout the contract

1. Population Needs

1.1 National/local context and evidence base

National
More than 4.9 million people in the UK have diabetes. It costs the NHS £10 billion every year (which is around 10% of its entire budget) and around 80% of this spend is on treating complications (Diabetes UK).

Public health forecasting predicts that an aging population and rising prevalence of obesity will increase NHS spending on diabetes to £16.9 billion by 2035, accounting for 17% of the NHS budget. It is a leading cause of blindness in the UK and over 100 amputations are carried out each week in people with diabetes due to complications – 80% of which are preventable.

Type 2 diabetes is a progressive long-term condition which is predominantly managed by individuals themselves. Whilst it is a complex and challenging condition, if individuals are supported with the skills and confidence to manage it, it can improve health outcomes and reduce the onset of serious complications (NICE QS6).

The NICE Quality Standards (QS6, 2016) recommends that adults with type 2 diabetes are offered access to a structured education programme at the point of diagnosis. Structured education programmes can help adults to improve their knowledge and skills and, also help them to take control of their condition and self-manage it effectively.

The NHS Long Term Plan (2019) states that Sustainability and Transformation Plans (STPs) are required to set out intentions to deliver improved services which include expanded provision of structured education for people with Type 1 and Type 2 diabetes and the introduction of a range of methods for accessing structured education.

Local
There are 75,301 people diagnosed with Type 2 Diabetes in Devon (QoF 2020/21).

NHS Devon Integrated Care Board are seeking to commission QISMET accredited type 2 structured education programmes that offer consistency in access and improve bio-psychosocial outcomes across Devon. These programmes will need to offer patient choice to support improved uptake through delivery models that enable a mixture of provision options inclusive of in-person and digitally delivered education, along with delivery that aims to improve people's motivation, psychological wellbeing, and confidence with behaviour change.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

Person level

To increase peoples:

- Knowledge and understanding of diabetes and importance assigned to good diabetes control (HbA1c of 58.0mmol/mol or less, cholesterol below 5mmol/l and blood pressure less than 140/80).
- Knowledge and understanding of healthy eating for diabetes.
- Knowledge and understanding of physical activity for diabetes.
- Knowledge and understanding of diabetes footcare.
- Knowledge, understanding, and importance assigned to annual reviews.
- Levels of motivation, psychological wellbeing, and confidence with behaviour change.

Service level

To increase the number of:

- Referrals to education within 9 months of a newly diagnosis of type 2 diabetes.
- People who start education within 12 months of diagnosis.
- People who start a programme within three months of referral.
- People who complete* education within 12 months of diagnosis.
- People with personalised goals.
- People accessing ongoing diabetes education.

Strategic level

For the cohort who complete* education:

- Improvements (reduction) in HbA1c, BMI and Cholesterol at 12 months.

- Increase in people achieving remission (HbA1c remaining below 48mmol/mol or 6.5% for at least six months).
- Increase in people's activation (knowledge, skills, and confidence) in managing their own wellbeing at 12 months.

*Commissioners will determine the definition of a completer of education once a preferred provider/s delivery model has been agreed.

3. Scope

3.1 Aims and objectives of service

The aim of this service is to improve the long term clinical, lifestyle and psychosocial outcomes for people diagnosed with type 2 diabetes through the provision of on-going, individualised self-management education to facilitate the knowledge, skills and behaviour change necessary for diabetes self-care.

The objectives are to:

- Undertake a learning needs assessment to understand the requirements, goals, and life experiences of the person with diabetes.
- Undertake an initial assessment of individuals knowledge, skills, and confidence to manage their own health using a validated tool e.g., Patient Activation Measure (PAM).
- Develop a personalised plan of education to tailor support to 'meet individuals where they are' and to enable to service to determine what to deliver to influence people's levels of activation.
- Support informed decision making to enable individuals to be aware of their choices relating to the management of their diabetes, the potential outcomes of these choices and to have their personal values considered in decisions about their care.
- Improve self-care behaviours relating to knowledge, attitudes, communication, family support, financing, self-efficacy, and motivation to improve quality of life.
- Develop individual's problem-solving skills and capabilities to enhance independence and resilience.
- Encourage active collaboration with individual's health care team.
- Offer ongoing access to education offerings via a variety of approaches to enhance engagement in long term diabetes self-care.

3.2 Service description/care pathway

The provider shall achieve the following minimum requirements for the given stages of the pathway:

Diagnosis / pre referral

- Service level information/literature shall be widely available for referrers to enable them to provide patients with information about the service to support in engagement in a referral/self-referral. This information shall be in a language that is meaningful to the service user.

Referral

- Key messages about the service shall be provided for referrers to offer bite sized summations that articulate what the service offers and the benefits along with tools and techniques to help referrers enhance patient engagement to encourage referrals.
- People who will benefit from accessing education shall be identified through targeted work with GP practices, PCNs and specialist diabetes services.
- Referrals shall be accepted from primary care and specialist diabetes services e.g., podiatry, specialist nurses, diabetic dieticians along with self-referrals to enable individuals to build confidence in the management of their own condition.
- Clear advertising for self-referral to the service shall be undertaken across Devon.
- SNOMED codes shall be used to communicate the outcome of the referral to enable quick and accurate data capture by GP practice administrators (see section 4.2).
- Data shall be provided to all referrers on a quarterly basis to show referral uptake rates and where 'hot spots' (high referral uptake rates) and 'cold spots' (where referral uptake is low) are with the provider having plans in place to target 'cold spots' with the aim of increasing referrals.
- There will be an overall increase in the number of referrals to education for people newly diagnosed with diabetes.

Onboarding

- A range of approaches shall be utilised to encourage attendance within three months of referral e.g., using motivational interviewing as part of an initial triage, making every contact count conversations.
- A baseline assessment of individual's learning needs shall be undertaken to understand the requirements, goals, and life experiences of the person with diabetes and how these may relate to other long-term conditions that they may have.
- A baseline assessment of individual's level of knowledge, skills, and confidence (activation) to manage their own health shall be undertaken.
- Information related to individual's HbA1c, BMI and Cholesterol shall be recorded.
- A personalised plan of education to tailor support to 'meet individuals where they are' shall be developed to enable to service to determine what to deliver to influence their levels of activation.
- Individuals shall be offered access to graduate peers to provide support, encouragement, and motivation to increase potential engagement in joining an education programme if the timing isn't right.
- There will be an overall increase in the number of people who start an education programme.
- Primary Care shall be notified when individuals start or decline the offer to start a programme, with the provider entering the relevant code directly onto the patient electronic record where there is an integrated system, and the diabetes education provider has access to the GP system.

Delivery

- Education delivered shall be QISMET accredited.
- Education shall be flexible to adjust to individual's needs and seasonal changes / times of the year.
- The use of validated tools shall be utilised to support in individualising content e.g., the Outcomes Star, the Problem Areas in Diabetes questionnaire (PAID).

- Individuals shall be offered a range of education options and a mix of provision models inclusive of face to face, telephone and online.
- The content shall focus on knowledge, motivation, psychological wellbeing, and behaviour change to achieve the outcomes in section 2.2.

Completion

- An assessment of individual's level of knowledge, skills, and confidence (activation) to manage their own health shall be undertaken with results analysed from the baseline during onboarding.
- An assessment of individuals experiences of undertaking the programme shall be undertaken.
- Information shall be collated to determine uptake of onward diabetes related activity e.g., ongoing education, local exercise group.
- There will be an overall increase in the number of people who complete* education.
- A summary of the education provided shall be communicated back to the individuals GP upon completion along with any agreed goals.

*Commissioners will determine the definition of a completer of education once a preferred provider/s delivery model has been agreed.

Follow Up

A 12-month post completion assessment shall be undertaken consisting of:

- Individual's level of knowledge, skills, and confidence (activation) to manage their own health with results analysed from the baseline during onboarding.
- Individual's HbA1c, BMI and Cholesterol with results analysed from the baseline during onboarding.
- If any individuals have resolved their diabetes through measuring if their HbA1c has remained below 48mmol/mol or 6.5% for at least six months.
- If individuals are engaging with continued education, or if there are barriers, with a reinforcement of self-management advice.

Continued education

- People shall be offered ongoing access to type 2 diabetes education via a variety of approaches e.g., live Q&A sessions, podcasts, Facebook live sessions and refresher sessions to enhance engagement in long term diabetes self-care. These approaches shall provide a modern forum of service user led education and peer support ensuring that the agenda is led by individuals enabling them to prioritise topics accordingly.

3.3 Population covered

People who live within the NHS Devon Integrated Care Board footprint who are registered with a GP who meet the referral criteria.

3.4 Any acceptance and exclusion criteria and thresholds

The referral acceptance criteria shall be as follows:

- People aged 18 or over.
- People registered with a GP practice in Devon.
- People with a confirmed diagnosis of type 2 diabetes.

The provider shall address inequalities in access particularly amongst people who:

- Are housebound or live-in care homes.
- Have a mental health illness or physical disability.
- Have poor literacy or a language barrier.
- Have childcare or caring responsibilities.
- Are in employment including shift work.
- Are from the travelling community or asylum seekers.
- Are living in deprivation or homeless.
- Are from black, Asian and minority ethnic backgrounds (BAME).
- Have a learning disability.

For people who are in prison or other involuntary residence literature shall be provided to prison medical services to support people in accessing education on release.

People shall be discharged from the service if:

- They cannot be contacted following three telephone calls/emails/letters.
- They advise the provider that they do not wish to partake in the initial assessments or the subsequent education programme.
- They advise the provider that they do not want to access continued education.

Following discharge, the individuals GP shall be informed advising of the appropriate coding.

3.5 Interdependence with other services/providers

- All GP practices across Devon.
- Diabetes prevention programme providers across Devon.
- All mental health providers across Devon.
- All diabetes specialist services across Devon e.g., podiatry, secondary care.

3.6 Workforce

The provider shall ensure that staff delivering the education can demonstrate that they are qualified and competent in the following areas:

- Diabetes self-management.
- Teaching.
- Motivational interviewing.
- Coaching.
- Making every contact count.

Staff delivering the service shall be trained in line with national and professional recommendations.

The provider shall ensure that regular staff training, and development is undertaken.

4. Activity Planning, Data Reporting and Key Performance Indicators

4.1 Activity Planning

The indicative plan that sets out the expected activity for the service is as follows:

	Year one	Year two	Year three
Number of people completing education	1,787	2,171	2,325
Number of people accessing on going education that is provided by the service	1,072	1,519	1,628

4.2 Data reporting

Coding

The provider shall improve the recording of the outcome of each referral using SNOMED codes to enable quick and accurate data capture by GP practice administrators. This shall be communicated in the most efficient way by either:

- Directly onto the patient electronic record, where there is an integrated system, and the diabetes education provider has access to the GP system
- Using a letter or email, incorporating the standardised SNOMED codes minimum data set.

Outcome of referral to diabetes structured education	SNOMED code	Vision/ EMIS/other systems	System One
Diabetes structured education declined	306591000000103	9OLM	XaNTH
Did not attend diabetes structured education	306861000000107	9NiA	XaNTa
Attended diabetes structured education	413597006	9OLB	XaKHØ
Diabetes structured education completed	755491000000100	9OLF	XaX5D

Service level data

Service level data shall be provided to Commissioners on a quarterly basis to demonstrate achievement of the outcomes in section 2.2.

Service activity

- Number of referrals split by GP practice (including which practice) or self-referral.
- Total referrals split by newly diagnosed (referral within 12 months of diagnosis) and existing diagnosis (referrals beyond 12 months of diagnosis).
- Time from referral to first contact.
- Waiting times to start a programme (from the point of referral).

- Number of people starting a programme.
- Number of people completing* a programme.
- Number of people engaging in continued education that is directly provided by the type 2 diabetes structured education service.
- Protected characteristics and deprivation decile of those who complete a programme.
- Individual's experiences.
- Service and individual level outcomes (as defined in section 4.2).

*Commissioners will determine the definition of a completer of education once a preferred provider/s delivery model has been agreed.

4.3 Key performance indicators (KPIs)

To determine successful achievement of the service outcomes the provider shall be required to report achievement against the following indicators:

4.3 Key Performance Indicators

Performance indicator	Measure	Outcome	Baseline	Level of achievement		
				Year one	Year two	Year three
Referrals.	The number of referrals to diabetes education within 9 months of diagnosis.	Increased number of referrals to education within 9 months of diagnosis.	Newly diagnosed population 2,492 (QoF 2019-21).	70%	80%	85%
Programme engagement.	The number of people who start a programme within three months of referral.	Increased number of people who start an education programme within three months of referral.	N/A	50%	60%	65%
	The number of people who start a programme who complete* a programme within 12 months of diagnosis.	Increased number of people who complete* an education programme within the first 12 months of diagnosis.	N/A	70%	80%	80%
	The number of people with personalised goals.	Increase in the number of people with personalised goals.	N/A	70%	75%	80%
Continued education.	The number of people accessing ongoing education that is directly provided by the service following completion of a programme.	Increased access to ongoing education via a variety of approaches e.g., live Q&A sessions, podcasts, Facebook live sessions, refresher sessions.	Provider to determine baseline by end of year 1.	N/A	To be determined at end of year 1.	To be determined at end of year 2.
Programme outcomes.	Individuals HbA1c, BMI and Cholesterol results pre and 12 months post completion*.	Improvements (reduction) in HbA1c, BMI and Cholesterol at 12 months for the cohort who complete education.	Provider to determine baseline by end of year 1.	N/A	To be determined at end of year 1.	To be determined at end of year 2.
	Individuals HbA1c results remaining below 48mmol/mol or 6.5% for at least six months.	Increase in people achieving remission at 6 months for the cohort who complete education.	Provider to determine baseline by end of year 1.	N/A	To be determined at end of year 1.	To be determined at end of year 2.
	Patient Activation Measure pre and 12 months post completion*	Increase in people's activation (knowledge, skills, and confidence) in managing their own diabetes wellbeing (healthy eating, physical activity, footcare at 12 months.	Provider to determine baseline by end of year 1.	N/A	To be determined at end of year 1.	To be determined at end of year 2.
	Service level evaluation.	Increase in knowledge, understanding, and importance assigned to annual reviews.	Provider to determine baseline by end of year 1.	N/A	To be determined at end of year 1.	To be determined at end of year 2.

*Commissioners will determine the definition of a completer of education once a preferred provider/s delivery model has been agreed.

5. Applicable Service Standards

5.1 Applicable national standards

NICE Diabetes Quality Standard QS6.
NICE Guideline NG28.
QISMET accreditation.

5.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

Diabetes UK Diabetes Self-Management Education.