Specialist Medical and Surgical Services

Diabetes Services Service Specification Tier 2

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑ RECOMMENDED ☒

2. Review History

Review History	Date
Published on NSFL	**October 2011**
Working Group Review: **Diabetes Services tier two service specification (Dec 2003).** Updated content: Included Additional Reporting Table. Editing and formatting. Removed Appendix 1: Schematic Illustration of Diabetes Information Flows Added reporting table. Includes Appendix one: Diabetes Care and Education service specification.	**October 2011**
Consideration for next Service Specification Review	**within five years**
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	**September 2024**

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the Service Specification Programme Manager, Service Commissioning, Ministry of Health to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications. Nationwide Service Framework Library web site here

3. Introduction

The overarching tier one specifications contain generic principles and content common to all the tiers of specifications below it. This tier two service specification for Diabetes Services (the Service) is used in conjunction with the tier one Specialist Medical and Surgical Services and, as age appropriate, the tier one Services for Children and Young People and the tier two General and Community Paediatric Services service specifications.

Refer to the relevant tier one service specifications headings for generic details on:

- Service Objectives
- Service Users
- Access
- Service Components
- Service Linkages
- Exclusions
- Quality Requirements

The above sections are applicable to **all** Service delivery.

The Service is also linked to the tier two Allied Health Services service specification - Dietetic Services (AH01001) and tier three Podiatry for People with at Risk / High Risk Feet service specification (AH01006).

The tier two Diabetes Services service specification includes common elements specific to this service and generic requirements for the delivery of a range of specific primary, secondary and tertiary services for individuals with diabetes in the tier three diabetes service specifications listed in the table below.

Each specific service specification includes a reference to its generic overarching service specification so that the total service requirements are explicit.

Diabetes Tier Three Service Specifications	Purchase Unit Codes
Assessment and Support for People with High Risk Type 1 Diabetes (Insulin Pumps) (2003 version)	M20010 M20015
Diabetes Education and Management	M20006
Diabetes Retinal Screening Services	M20007
Free Annual Check Service	COGP0006
Local Diabetes Team or equivalent service	M20020

The Diabetes Care and Education Services service specification is to be used as DHBs transition services from M20006. (Refer Appendix One in tier two Diabetes Services service specification).

Diabetes Care and Education Services	**M20006**

Background

The impact of diabetes in New Zealand is significant and will continue to increase as the prevalence of type 1 and type 2 diabetes accelerates. Diabetes is a major contributor to inequalities in life expectancy, cardiovascular outcomes and diabetes-specific health outcomes for Māori, Pacific and South Asian[1]. Māori have approximately twice the risk of developing type 2 diabetes, and Pacific peoples have approximately 3 times the risk of developing type 2 diabetes during their lives compared with New Zealand Europeans, and on average develop diabetes 10 years earlier[2].

There are inequalities in access, quality of care and outcomes for individuals with diabetes; therefore, improving outcomes for Māori and Pacific individuals with diabetes will make a major contribution to reducing inequalities in life expectancy and quality of life.

Diabetes is the major preventable cause of renal failure requiring dialysis, lower limb amputation and avoidable blindness (in working age adults).

Addressing diabetes is a well established health priority for New Zealand and is outlined in health policies such as the *New Zealand Health Strategy*, *He Korowai Oranga the Māori Health Strategy,* Whakatātaka and Whakatātaka Tuarua, *the Primary Health Care Strategy* (2001); *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014* and *Reducing Inequalities in Health* (2002), and the *Diabetes and Cardiovascular Disease Quality Improvement Plan (2008)*.

Reducing the incidence and impact of diabetes and cardiovascular disease is one of the Government health priorities, with emphasis on:

- improving care and services
- improving the participation rates of people with diabetes in the Diabetes annual review programme, and
- strengthening good quality markers of diabetes and cardiovascular disease management in all population groups.

4. Service Definition

The Services are provided for eligible individuals[3] with a clinical diagnosis of diabetes (the Individual)[4]. Some services will be provided to people with gestational diabetes[5].

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[1] 2008 *Diabetes and Cardiovascular Disease Quality Improvement Plan*. Wellington: Ministry of Health.
[2] 2008 *New Zealand Health Survey: A Portrait of Health*. Wellington: Ministry of Health.
[3] Eligibility criteria: - Not all people who are referred or present to the Service are eligible for publicly funded services. Refer to website: http://www.moh.govt.nz/eligibility for more eligibility information
[4] Individuals with type 1, type 2 diabetes mellitus and other specific types of diabetes mellitus. Other specific types of diabetes (previously classified as secondary diabetes) include diabetes as a result of: diseases of the exocrine pancreas (eg, pancreatitis, cystic fibrosis), drugs or chemicals (eg, steroid therapy), genetic defects of ß-cell (formerly referred to as Maturity Onset Diabetes of the Young), genetic defects in insulin action, endocrinopathies, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes that are sometimes associated with diabetes.
[5] Gestational diabetes -diabetes in pregnancy includes both women with Type 1 diabetes who become pregnant and women who develop diabetes during pregnancy.

Reference to primary health care in the context of these services specifications refers to certain specific diabetes programmes or services provided within the primary health care sector that are not covered by the Primary Health Organisation Agreement.

The Services are delivered by a multi-health professional team that includes: medical practitioners, Registered Nurses and, for example, community health workers, allied health professionals, and Nurse Practitioners working in a range of primary health care settings that are most appropriate for the Individual and depending on the Service being undertaken.

Services are increasingly moving from being delivered by traditional hospital based services to community based health service providers for the management of chronic disease.

The Services may have one or more of the following components:

- coordinated assessment, diagnosis, treatment and ongoing care
- provision of education, training and resources for both health providers and Individuals
- be working towards the provision by health providers of collaborative patient centred approaches to care which include: assessment of self-management, collaborative problem definition, goal setting and care planning, self-management training and support services, and active and sustained follow up of the Individual
- emergency or acute referrals and / or secondary health care or allied support services for investigation, opinion and / or treatment of diabetes and its complications.
- provision of required reports and information to contribute to the future planning of diabetes services.

5. Service objectives

5.1 General

The objectives of the Service are to:

- achieve the best possible health outcomes and maximum coverage for the population being served by providing services in the most appropriate setting for the type of services being undertaken
- be interdisciplinary, intersectoral and able to deal with the different disease stages in the life of an Individual and disease complications to :
  - improve the individual's self-management support and empowerment
  - and improve the individual's access to supportive systems.
- ensure that the cultural integrity of each Individual is acknowledged and respected and are delivered in a culturally appropriate manner
- reduce disparities by meeting the particular needs of the Individual, whānau or community group so that:
  - there are reduced barriers to access
  - effective communication occurs
  - and the Service is safe for all Individuals
- ensure that, regardless of an Individual's health literacy, that the services provide effective written and spoken communication.

5.2 Māori Health

Diabetes is a health priority area for Māori. There are significant disparities between Māori and non Māori in disease rates and outcomes for type 2 diabetes. Prevalence, morbidity, and mortality rates from diabetes are all higher in Māori than in non Māori.

The Service providers will improve the effectiveness and appropriateness of services for Māori as well as outcomes at the individual, whānau and population levels. This includes consultation with and the involvement of Māori in strategic, operational and service decisions.

In addition, refer to tier one Specialist Medical and Surgical Services and / or Services for Children and Young People service specifications as appropriate.

6. Service Users

Service users are all Eligible[6] Individuals who also meet the diagnostic criteria for either type 1 or type 2 diabetes or other specific types of diabetes.

7. Access

7.1 Entry and Exit Criteria

7.1.1 Entry Criteria

Specifically for Diabetes Services the Individual will have a confirmed clinical diagnosis of diabetes and be referred to the Service. Refer to the tier one Specialist Medical and Surgical Services specification for generic criteria. More specific criteria are described in each of the linked tier three diabetes service specifications.

Note that an opportunistic diabetes annual review, regardless of the setting, may be undertaken when an Individual is receiving care for another condition or diabetes. The result will be communicated to the Individuals' General Practitioner.

7.1.2 Exit Criteria

Diabetes is a chronic, lifelong condition and as such the individual will remain part of the service indefinitely. Exit from the Service may be temporary, or by way of:

- referral into acute secondary / tertiary specialist medical services which may include acute paediatric services (for acute diabetic episodes in children and young people with type 1 diabetes) and / or acute endocrinology services where these specialist services are available. Where these specialist services are not available, the acute Services will be provided through the acute general medical services.
- discharge to another Service when the Individual will be transferred with a management plan to another provider
- voluntary exit
- death

[6] Refer to website: http://www.moh.govt.nz/eligibility for more eligibility information.

8. Service Components

8.1 Processes

8.1.1 General

The care of an Individual by the Service involves a level of interaction and intervention that will depend on the condition of the Individual, their consent for treatment, the qualifications / training and experience of the clinical staff and the level of clinical support available.

All diabetes services providers will provide their services to improve access and utilisation for their prioritised groups and may include specific roles within their services to provide outreach and support services, and improve access to care.

The Services described in this service specification will be responsible for the complete and coordinated assessment, diagnosis, treatment, referral and ongoing management of an Individual throughout the course of their long term chronic health conditions. Treatment will span the range from primary to tertiary health care including support services.

The Services must also include:

- provision of required reports and information to contribute to the future planning of diabetes services
- working with services for children and young people to ensure a smooth transition for Individuals to adult diabetes services
- referral to:
  - allied health support services for investigation, opinion and / or treatment
  - emergency or acute services
  - other specialties for opinion and / or management ongoing management and treatment as indicated by the Individual's condition(s)
- provision of education, training and resources for health providers and Individuals
- support for enabling Individuals to become self managing.

8.1.2 Outpatient services

The Service includes: Diabetes First Attendance (M20004), Subsequent Specialist Assessment (M20005) that may involve a generalist physician, diabetes specialist, endocrinologist or Nurse Practitioner, and Nurse Led Outpatient Clinics (MS01001)

8.1.3 Inpatient Services

The provision of inpatient hospital services (M20001) will be undertaken utilising a multidisciplinary team approach. Inpatient services for the acute and chronic management of diabetes (including treatment for complications) is available and involves liaison with the appropriate clinical specialty eg, specialist medical or surgical services where these specialties are available. Where these specialists are not available, general internal medical services (M00001) will provide the Service.

8.1.4 Lead Responsibilities

The lead health specialty for services for women with gestational diabetes in tertiary settings will be obstetric / maternity services, however, strong links to speciality diabetes services will be maintained. In secondary health settings maternity services will be the lead team and will be expected to maintain close links with District maternity and diabetes services.

8.2 Settings

The Service settings depend on the Service being undertaken eg, inpatient, outpatient / ambulatory or community services will be provided in an appropriate facility for diagnosis or treatment.

Considerations in determining the settings for diabetes services should include (but not be limited to) issues such as cultural appropriateness, accessibility and most effective / efficient use of resources.

8.3 Support Services

Laboratory, pharmacy and radiology services may be an input into aspects of service delivery depending on the service funding model.

8.4 Key Inputs

All health professionals and non clinical health care personnel working in the field of diabetes must be familiar with working within long term condition models of health care delivery that focus on increasing individual / family group strengths, resiliency and, where possible, independence. Knowledge of the wider determinants of health and the impact of social support, community participation and community-led initiatives is inherent within these models. Timely and definitive diabetes care will be provided by appropriately trained, qualified and experienced clinical and support health care personnel.

Other requirements for clinical and support health care personnel are recommended to include:

- experience working across diverse communities
- experience in working with other agencies / community organisations to deliver a holistic health care service for Individuals and their family and whānau
- access to peer supervision
- experience in the provision of diabetes services
- access to clinical supervision (where necessary)

- excellent communication and networking skills – particularly within the community and between health care providers
- a patient and whānau approach to programme delivery and
- developing the capability to deliver self-management support.

8.5 Pacific Health

Pacific populations are amongst the highest risk groups for diabetes. To ensure the effectiveness of services for Pacific peoples, healthcare providers must acknowledge that the role cultural values, beliefs and the involvement of the family and the community can impact on an individual and their families health and wellbeing.

Improving the quality of service to Pacific families will require services that are:

- culturally competent
- responsive to Pacific people's needs and expectations
- more acceptable to a wider spectrum of Individuals and families and that empower Pacific people to make healthy choices and facilitate access to other services.

Access to services and reduction of the incidence and impact of diabetes is needed in Pacific Communities. This will be achieved by better connectivity between diabetes services and existing Pacific initiatives.

Aligning Service provider delivery to the objectives of the Ministry of Health's frameworks for improving the health of Pacific peoples will deliver on the Government's priority outcomes set out in 'Ala Mo'ui Pathways to Pacific Health and Wellbeing 2010-2014 Minister of Health and Minister of Pacific Island Affairs, 2010.

8.6 Asian Health

The term 'Asian' includes South Asian ethnic groups, who have prevalences of diabetes similar to Māori and Pacific ethnic groups, as well as East and South-East Asian ethnic groups (who have prevalences similar to the European ethnic group)[7].

The Service will improve access to diabetes services and reduce the incidence and impact of diabetes in South Asian communities within New Zealand

8.7 Neighbourhood deprivation

Diabetes is associated with higher neighbourhood deprivation. Adults living in the most deprived neighbourhoods[8] are more than twice as likely to be diagnosed with diabetes than adults in the least deprived neighbourhoods[9] adjusted for age[10]. Variables that determine

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[7] Public Health Intelligence. September 2007. Diabetes Surveillance, Population-based estimates and projections for New Zealand: 2001–2011. Occasional Bulletin No. 46.
[8] Most deprived neighbourhoods 6.2% prevalence in NZ Deprivation 2006 quintile 5 compared with 2.7%.
[9] Least deprived neighbourhoods 2.7%, in NZ Deprivation 2006 quintile 1.
[10] Ministry of Health. 2008. New Zealand Health Survey: A Portrait of Health. Wellington: Ministry of Health.

deprivation include: income, home ownership, family support, employment, qualifications, living space, communication and transport.

All diabetes care providers will provide their services to improve access and utilisation in this group and may include specific roles within their services to provide outreach and support services and to improve access to care.

9. Service Linkages

Diabetes services must be well integrated with other general and specialist services and ensure that there is effective consultation, liaison and referral between services and sub-specialties. The costs of the services below are not included in the price of this Service; however the costs of liaison and linkages with these services are included in the Purchase Unit price.

The linkages include, but are not limited to the following:

Service Provider	Nature of Linkage	Accountabilities
General Practitioner (GP), Nurse Practitioner or other primary health practitioners	Referral and consultation	Assessment, treatment and intervention to support seamless service delivery and continuity of care.
Specialist Hospital Services	Referral and consultation	Obtain expert clinical consultation and referral services and support continuity of care and improved diabetes management.
Local diabetes teams or an equivalent service	Collaboration and facilitate information flow	Provision and sharing of information that contributes to improved service delivery
Allied health services, eg, podiatry, orthotics, dietetics services	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery, continuity of care and improved diabetes management.
Community organisations and services eg, Diabetes Society, health educators	Facilitate Service access and participation	Provision of information and services to support seamless service delivery and continuity of care and improved diabetes management.
Social services, counselling, psychologists, home help	Referral and consultation	Assessment, treatment and intervention that supports seamless service delivery and continuity of care and improved diabetes management.
Disability support services	Referral and liaison	Assessment, treatment and intervention to support seamless service delivery and continuity of care and improved diabetes management.
Long term supports for chronic health conditions	Referral and consultation	Assessment of needs and arrangements for provision of support services to enable families to best manage the individual's diabetes and ensure family function is maintained.

Service Provider	Nature of Linkage	Accountabilities
District nurses or specialist community health nurses	Referral and consultation	Assessment, treatment and intervention to support seamless service delivery and continuity of care and improved diabetes management.
Māori, iwi and Māori communities	Facilitate Service access and participation	Liaison with local iwi and communities to ensure cultural appropriateness and accessibility to services.
Pacific Peoples community health workers	Facilitate Service access and participation	Liaison with local communities, community leaders, churches to ensure cultural appropriateness and accessibility to services.
Migrant community health workers	Facilitate Service access and participation	Liaison with local communities, community leaders, churches, temples, mosques to ensure cultural appropriateness and accessibility to services.

10. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

The Service should actively monitor up-take of the Service, respond to non-attendees, monitor complaints and manage outcomes across the Service users by seeking out areas and individuals where further input would create improvements.

11. Purchase Units and Reporting Requirements

11.1 Purchase units

Purchase Units are defined in Health New Zealand's Nationwide Service Framework Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
M00010	Medical non contact First Specialist Assessment - Any health specialty	Following a request from a GP or community based Nurse Practitioner, a review by a registered medical practitioner of registrar level or above, or registered	Written plan of care	Written plan of care provided by the specialist to the referrer / GP	NNPAC

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
		nurse practitioner of patient records and any diagnostic test results, development of a written plan of care for the patient and provision of that plan and other necessary advice to the referring GP or Nurse Practitioner. This does not include the triaging of referral letters. The patient should not be present during the assessment.			
M20001	Endocrinology & Diabetic - Inpatient Services (DRGs)	DRG WIESNZ Discharge. Additional Information is found in the NZ Casemix Framework for Publicly Funded Hospitals which gets updated every year.	Cost Weighted Discharge	A numerical measure representing the relative cost of treating a patient through to discharge.	National Minimum Data Set (NMDS)
M20004	Diabetes 1st attendance	First attendance to endocrinologist or medical officer at registrar level or above or nurse practitioner for specialist assessment.	Attendance	Number of attendances to a clinic/ department/ acute assessment unit.	National Non Admitted Patent Collection (NNPAC)
M20005	Diabetes subsequent attendance	Follow-up attendances to endocrinologist or medical officer at registrar level or above or nurse practitioner.	Attendance	Number of attendances to a clinic/department/acute assessment unit.	NNPAC
M20006	Diabetes Education and Management	Diabetes education and care by multi-disciplinary teams in hospital or community-based setting.	Client	Number of clients managed by the service in a year ie caseload at the commencement of the financial year plus all new cases year to date.	NNPAC
M20006	Diabetes Care and	Diabetes care and education services for individuals with diabetes and their families. Service is	Client	Number of clients managed by the service in a year ie caseload at the commencement of	NNPAC

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
	Education service[11]	provided by multi-disciplinary teams in hospital or in a community-based setting. Excludes clinical education eg medication and management of diabetes emergencies.		the financial year plus all new cases year to date.	
M20007	Diabetes - Fundus Screening	A procedure for the purpose of fundus screening as part of a diabetic retinopathy programme. This includes the taking of photographs and the consultant examination and interpretation of the photographs.	Procedure	An individual operative/diagnostic/assessment procedure.	NNPAC and Contract Management System (CMS) (as per contract)
M20010	High Risk Type I Diabetes Support	Regional service for people over 18 years of age with Type 1 diabetes who are not achieving satisfactory control of hypoglycaemia or are at risk of diabetic keto-acidosis using multiple daily insulin injection regimes (MDI). The service includes supply and provision of continuous sub-cutaneous insulin injections (insulin pumps) and consumables, clinical support (dietetic advice) and on-going review.	Service	Service purchased in a block arrangement or uniquely agreed at a local level.	NNPAC and Contract Management System (CMS) (as per contract)
M20015	High Risk Type I Diabetes Support for up to 18 year olds	Regional service for people under 18 years of age with Type 1 diabetes who are not achieving satisfactory control of	Service	Service purchased in a block arrangement or uniquely agreed at a local level.	NNPAC and CMS (as per contract)

[11] The Diabetes Care and Education Services M20006 is to be used as DHBs transition services from Diabetes Education and Management M20006. (Refer Appendix One in tier two Diabetes Services service specification).

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
		hypoglycaemia or are at risk of diabetic keto-acidosis using multiple daily insulin injection regimes (MDI). The service includes supply and provision of continuous sub-cutaneous insulin injections (insulin pumps) and consumables, clinical support (dietetic advice) and on-going review.			
M20020	Local Diabetes Teams (or equivalent service)	Service responsible for linkage information analysis and reporting of data for people with diabetes within a District local area.	Service	Service purchased in a block arrangement.	NNPAC or reporting as per contract in the Contract Management System (CMS)
M20025	Diabetes Screening Initiative	Initiative to improve case detection of people with Type 2 Diabetes and identify those people who may also have congestive heart failure.	Programme	A set of related measures or activities that is purchased in a block arrangement or is uniquely agreed at a local level	NNPAC
MS01001	Nurse Led Outpatient Clinics	Assessment, treatment, or education and/or management outpatient clinics led by a nurse specialist for specialist groups of clients. This excludes clinics led by a Nurse Practitioner.	Attendance	Number of attendances to a clinic/ department/ acute assessment unit or domiciliary.	NNPAC
COGP0006	Diabetes Annual Review	Diabetes annual review for all individuals with a diagnosis of type 1 or type 2 or another specific type of diabetes (no co-payment may be charged to the patient).	Attendance	Number of attendances to a clinic/ department/ acute assessment unit or domiciliary.	NNPAC

The Service must comply with the requirements of national data collections where available.

11.1 Summary of Reporting

There are no reporting requirements under the Diabetes Services tier two service specification. Specific reporting requirements are described in each tier three diabetes services service specifications as described in the summary table below.

Reporting is to an LDT or an equivalent service as locally agreed by the District/Region.

Tier three Service Specifications	Reporting by PHO	Reporting by District	Reporting to LDT or an equivalent service Frequency	Reporting to LDT or an equivalent service Date
Diabetes Annual Review	Primary Health Care (PHC) practices to Primary Health organisation (PHO) Monthly PHO to PHC practices 6 Monthly	All reporting as detailed in the contract Appendix A and B.	Annually	by 20th July
Diabetes Care and Education	N/A	Purchase Unit data reporting via NNPAC Appendix A and	Annually	by 20th July
Podiatry for People with At-Risk / High Risk Feet	N/A	Purchase Unit data reporting via NNPAC Appendix A and B.	Annually	by 20th July
Local Diabetes Teams, or equivalent service	N/A	Narrative report to Board and Ministry	Annually	by 20th August
Diabetes Retinal Screening	Reporting is provided under the PHO contract	Purchase Unit data reporting via NNPAC Appendix A and B.	Annually	by 20th July
Children and Young Persons Diabetes Services	N/A	Purchase Unit data reporting via NNPAC Appendix A and B.	Annually	by 20th July

12. Appendices

12.1 Appendix One

This service specification is for nationwide mandatory description of services that will be provided as Districts move away from contracting Diabetes Education and Management Services M20006 under the 2003 version of this service specification.

SPECIALIST MEDICAL AND SURGICAL SERVICES

DIABETES SERVICES - DIABETES CARE AND EDUCATION SERVICE

TIER LEVEL THREE

SERVICE SPECIFICATION

M20006

This tier three Specialist Medical and Surgical Services - Diabetes Services - Diabetes Care and Education Service, service specification (the Service) is to be used in conjunction with the tier one Specialist Medical and Surgical service specification and the tier two Diabetes Services service specification.

1. Service Definition

This Service is for diabetes care and education services for Individuals with diabetes (the Individual) and their families and whānau. The extent of the involvement of the family and whānau is determined by the Individual and the Service provider. The Service is provided in addition to the Diabetes Nurse Specialist or Nurse Practitioner clinics (MS01001) under the tier two Diabetes Services service specification.

Diabetes care and education services will be provided across the health care continuum by multidisciplinary teams working in secondary health or in community based settings. The need for diabetes care and / or education services must be assessed during all consultations with the Individual.

Services should be developed within national frameworks[12] to best meet the needs of the target group. Diabetes Clinical Nurse Specialists, Nurse Practitioners, paediatricians / diabetologists or specialist physicians, dieticians, pharmacists and podiatrists are likely to include diabetes education as an integrated component of one-on-one diabetes care.

The Service may be provided by primary health care in the community and / or specialist diabetes service providers as follows:

- community based non-clinical services that provide education to Individuals with diabetes, and their families and whānau. This education does not include clinical topics such as medications and management of diabetes emergencies
- focussed education services (excluding clinical care services[13]) that act to support the Individual and their family and whānau.

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[12] National Diabetes Nursing and Knowledge Framework (2009) - www.midcentraldhb.govt.govt.nz/newsevents/publicnews/2009/DNFL.htm

[13] Clinical care includes one-on-one assessment, diagnosis, treatment, management and evaluation of the individual's health needs relating to their diabetes and co-existing (potential or actual) medical conditions.

2.0 Exclusions

- Clinical care such as one-on-one clinical assessment, diagnosis, treatment, management and evaluation of the individual's health needs relating to their diabetes and co-existing (potential or actual) medical conditions.

3. Service Objectives

3.1. General

The objectives of this Service are:

- to allow for broad and innovative approaches to diabetes care and education to support both self management of the Individual and their clinical diabetes specific care, along with education and support for their family and whānau
- to build a relationship in which health professionals and the Individual are genuine partners seeking together to achieve the best solutions for each Individual's care

Where appropriate, one or more family or whānau members are encouraged to attend education and care sessions as family members and whānau of Individuals also have learning needs in relation to a family member having diabetes.

3.2 Maori Health

Refer to the tier one Specialist Medical and Surgical Services, and tier two Diabetes service specifications

4. Service Users

Diabetes care and / or education services are for all Individuals with a clinically confirmed diagnosis of diabetes.

Families and whānau of Individuals with type 2 diabetes are often at high risk for diabetes or associated conditions. An episode of care and education for Individuals may be an opportunity to provide / refer for risk factor management interventions for these family members in any or all of the following services:

- ***Primary Health Care Services*:** are provided for Individuals with stable health care needs, and where appropriate, their family and whānau members.
- ***Specialist Services:*** are provided for those Individuals with specific needs as a result of:
  - type 1 diabetes, type 2 diabetes with advanced disease and significant co-morbidities
  - acute / chronic complications
  - multiple co-morbidities
  - complex therapies
  - end stage disease / palliation, and
  - where appropriate, their family and whānau members.

  In addition, the Service will also be provided for:
  - children and young people with diabetes
  - pregnancy care for women with gestational diabetes and pre-pregnancy, antenatal, intra-partum and post partum care for women with pre-existing diabetes
  - Individuals in inpatient hospital care, and

- Individuals with other specific types of diabetes (as defined in the tier two Diabetes Services service specification) and, where appropriate, their family and whānau members.

- ***Community Based Non-Clinical Services*** are provided for individuals with type 2 diabetes with stable health needs and, where appropriate, their family and whānau members, and Individuals with type 1 diabetes for generic diabetes education as agreed and supported by the local specialist diabetes service.

5. Access

5.1 Entry Criteria

- ***Specialist Services:*** Individuals may be referred for diabetes care and education by primary health care teams or specialists according to local arrangements. Self-referral may also occur depending on the referral criteria operating within local settings, but should be guided by national referral criteria.

- ***Community - Based Non-Clinical Services:*** Individuals with type 2 diabetes with stable health needs may be referred for education through primary or specialist services. They may also self refer to programmes or be referred by other community organisations. Generic diabetes education can be delivered for Individuals with type 1 diabetes or as agreed and supported by the local specialist diabetes service.

5.2 Exit Criteria

- ***Primary Health Care Services***: The Individuals require ongoing life long care and education from primary health based care and education services.

- ***Specialist Services***: completion of the identified episode of diabetes care and education will occur once the Individual's achievable learning needs, goals and desired clinical outcomes have been met.

  In the case of women with gestational diabetes, exit from the Service will usually occur 6 weeks following the birth of the child. In children, young people and adults with type 1 diabetes the specialist services may offer ongoing care and education services.

- ***Community - Based Non-Clinical Services***: may choose to be available for education and support services to Individuals accessing their services on an ongoing basis (eg, through Diabetes Support groups or regular newsletters / events).

  Community services will work with Individuals to ensure that they are receiving regular clinical services from health providers and regular annual review from their primary health services, usually General Practitioner (GP) based.

5.3 Time

If ongoing demand for the Service cannot be met, referrals will be prioritised to ensure patients with the greatest need are seen within the resources available.

- ***Primary Health Care:*** On referral into the Service, the Individual and / or their family and whānau are offered an episode of assessment and care as soon as possible, preferably within two weeks.

- ***Specialist Services*****:** On referral into the Service, the Individual and / or their family and whānau should be offered an episode of assessment and care, which will usually include education, within three months of referral.

- ***Community - Based Non-Clinical Services:*** On contact with, or referral into, the Service the individuals with diabetes and / or their family and whānau should be

offered diabetes education or support at the next available opportunity (eg, at the next diabetes education programme if these are run, or immediate supply of appropriate brochures / information / support).

6. Service Components

6.1 General

Three sector groups deliver diabetes care and education services in one-on-one, or in groups in appropriate settings:

- primary health care services
- specialist secondary health services
- non clinical services (includes non government organisations (NGO's), kaiawhina, community health workers and expert patients).

All services delivering diabetes care and/or education must:

- work collaboratively with their LDT (or an equivalent service)
- work with other service providers to ensure that health services are provided to priority groups who are not accessing existing diabetes care and/or education services, particularly the high deprivation groups

6.2 Processes

6.2.1 Diabetes Care Services

- **Provided by Primary Health Care Services**

Individuals who have stable health needs and their family and whānau receive the Service from primary health care providers from the point of diagnosis. This requirement is ongoing. Specialist services may be involved in the delivery of education according to local arrangements

- **Provided by Secondary Health Services**

Collaboration with primary health care services and other specialist services must occur to best meet the needs of the Individual and their family and whanau. This includes clinician to clinician consultation (where required) and timely sharing of patient information.

- Episodes within the care journey for any of these patient groups may be delivered face to face or through telephone consultation, email, text, videoconferencing or other technologically assisted means.
- Specialist services are delivered to Individuals with type 1 diabetes (and their family and whānau) and all other Individuals with complex health needs and their family and whānau

6.2.2 Diabetes Education Services

Diabetes education services may be delivered by a variety of health professionals working in primary / secondary health care or community based non clinical services using a range of methods, provided they are working in collaboration with accredited Clinical Nurse Specialists and within nationally accredited programmes.

6.2.3 Non Clinical Diabetes Education Services

The education programmes are required to be based on evidenced informed education and motivational enhancement techniques and to provide evidence based information. Where possible, the programmes are to meet nationally agreed standards and be based on the principles and practice of adult education. Services delivering education should seek to empower the Individuals and their families to engage in effective self management.

Community-based non clinical services will be delivered to Individuals with type 2 diabetes who have stable health needs and their family and whānau, and Individuals with type 1 diabetes as agreed and supported by the local specialist diabetes service. Community based non-clinical services have strong links to specialist diabetes services to review their curriculum and provide support for their programme and knowledge base (this review will occur annually, at a minimum).

Diabetes Clinical Nurse Specialists, Nurse Practitioners, paediatricians / diabetologists or specialist physicians, dieticians and podiatrists are likely to include diabetes education as an integrated component of one-on-one diabetes care. Diabetes education will be delivered either one-on-one or in groups within a structured programme following an assessment of the learning needs of the group or the Individual.

The delivery of diabetes Group Education Programmes will:

- be based on age appropriate education principles and recommendations
- be provided to meet the Individual and / or their family and whānau member's needs
- be flexible to take into their account cultural and spiritual needs.
- use techniques of delivering education that have:
  - a structured written curriculum
  - trained educators
  - a quality assurance programme
  - an audit programme

The audit programme will assess the following documentation:

- the date of the review of the Individual's education requirements
- the date of the Individual's last Diabetes Annual Review
- the date when a structured education programme was offered to the Individual
- the date(s) the Individual attended / and the date they completed the programme
- measurement of the Individual and / or their family and whānau member's health or knowledge outcomes.

The essential components of the Individual's Education Programmes[14] are as follows:

- nature of diabetes
- symptoms of the disease
- risk of complications and in particular foot care
- individual targets of treatment

[14] Recommended by the International Diabetes Federation Asian- Pacific Type 2 Diabetes Policy Group. Type 2 Diabetes Practical Targets and Treatments. 4th Ed. 2005

- the Individual's lifestyle requirements and meal planning
- importance of regular exercise
- interaction of food, physical activity and medication
- self monitoring of blood glucose and the meaning of the results as well as information on what action needs to be taken.
- how to cope with emergencies, illness, hypoglycaemia, stress and surgery
- requirements during pregnancy (where appropriate).

The required outcomes of the programmes are to help the Individuals and their families and whānau build effective self management skills such as:

- problem solving
- goal setting / action planning
- adjustment strategies
- relapse management
- recognition and exploration of barriers to self management.

6.4 Providers of Diabetes Education Service Delivery

In the first instance, Individuals with type 1 diabetes are referred to specialist health services for their specific diabetes education needs, however, generic diabetes education may be provided for Individuals with type 1 diabetes in group education sessions as locally agreed and supported by the local specialist diabetes service.

Diabetes Education Services provided by:

- ***primary health care teams*** will be delivered one-to-one or in groups to Individuals who have stable health needs and their family and whānau from the point of diagnosis. This requirement is ongoing. Specialist services may be involved in the delivery of education according to local arrangements
- ***community-based non clinical services*** will be delivered to Individuals with type 2 diabetes who have stable health needs and their family and whānau, and Individuals with type 1 diabetes as agreed and supported by the local specialist diabetes service. Community based non-clinical services have strong links to specialist diabetes services to review their curriculum and provide support for their program and knowledge base (this review will occur annually, at a minimum).
- ***specialist services*** are delivered to Individuals with type 1 diabetes (and their family and whānau) and all other Individuals with complex health needs and their family and whānau
- ***non-clinical people***, focuses on highlighting what diabetes is, non clinical management strategies, the Individual's goal setting, coping and adjustment strategies, family and whanau issues and cultural / spiritual issues. It should not include education on clinical issues of management such as medications, management of diabetes emergencies, management of illness or medical issues.

  Non-clinical services may collaborate with clinical services (primary health care or specialist health services) for additional information to be delivered within their education programs by clinical personnel. Examples of this may be: foot care sessions by podiatrists, information about food and food management by dietitians, coping and adjustment strategies by psychologists and information on medications and managing

diabetes emergencies by Registered Nurses who are appropriately trained to deliver diabetes education.

6.4.1 Table of Diabetes Education Service Delivery by Reason

- ***for Individuals (and their families and whānau):***

Reason	Services delivered by
referred after initial diagnosis of type 2 diabetes	primary health care, specialist and community based services.
with type 2 diabetes starting insulin therapy	specialist services, or primary health care services where they are well supported and trained by specialist services.
with diabetes management issues	primary health care, or specialist and community based services depending on the complexity of the management issues.
with type 1 diabetes	specialist services, or primary health care depending on the complexity of the management issues.
with other types of diabetes eg, drug or disease induced	delivered by primary health care, or specialist services depending on the complexity of the management issues.
with gestational diabetes	specialist services through the duration of their pregnancy and through the peri-natal period.

- ***for Individuals:***

Reason	Services delivered by
with type 2 diabetes with co-morbidities	primary health care, or specialist services depending on the complexity of the management issues.
requiring nutrition advice and foot care advice that are not included under the dietetics (AH01001) and podiatry (AH01006) purchase units	primary health care, or specialist and community based services depending on the complexity of the Individual's health care needs.
with specific clinical indications on referral	primary health care, or secondary health care providers.
who need psychological and educational support in growing up with diabetes, particularly during childhood and adolescence	specialist services with referral for support to advocacy / support groups for children and young people with diabetes.

- ***for families and caregivers of children and adolescents with diabetes:***

Reason	Services delivered by
who need psychological and educational support	by specialist services with referral for support to advocacy/support groups for children and young people with diabetes.

6.5 Electronic Record Keeping

An electronic data repository for long term conditions must be maintained that registers Individuals receiving the Service. Where possible, community and non-clinical services, must maintain a register of contacts with Individuals.

The information recorded by specialist secondary and primary health care Service Providers is specified in Appendix A. Summary information must be reported annually to the Local Diabetes Team (LDT) or an equivalent service (refer to Appendix A). Non-clinical services should also supply a summary of their activities annually to the Local Diabetes Team (LDT) or equivalent service.

The Service provider will have a system for contacting Individuals (and their families and whānau) who fail to attend the programme, and notifying the Individual's primary health care provider.

6.6 Settings

The Service may be delivered through outpatient clinics / community sites / marae / inpatient settings / at the individual's home or in other settings as are appropriate to achieve the best possible health outcomes for Individuals their families and whānau and to achieve maximum coverage of the population being serviced.

Considerations in determining the setting should include (but not be limited to) issues such as:

- cultural appropriateness
- accessibility
- most effective/efficient use of resources.

It is particularly important to reach Individuals and groups who have difficulty in gaining access to services, such as those Individuals, their families and whānau*:*

- living in rural or isolated locations
- whose ethnicity, culture or language may present barriers
- living in conditions of high deprivation
- who might not see themselves as able to actively participate in their own care.

6.7 Key Inputs

6.7.1 Diabetes care and education programmes

Diabetes care and / or education programmes are provided in community or outpatient based settings by multidisciplinary team members that may include:

- expert patients
- non government organisations, local diabetes societies
- primary health care nurses, and GPs
- allied health professionals such as dieticians, podiatrists
- Māori health providers, Pacific health providers, kaiawhina
- pharmacists
- community health workers
- Diabetes Clinical Nurse Specialists, Nurse Practitioners, paediatricians / diabetologists or specialist physicians, dieticians and podiatrists.

Specialist services maybe involved in the delivery of education according to local arrangements.

6.7.2 Training Requirements for Service Providers

Where health care providers are providing training / workforce development activities for nurses to provide diabetes care and education services, the nurses will be trained in accordance with the Diabetes Nurse Specialist Section of the New Zealand Nurses' Organisation's endorsed National Diabetes Nursing Knowledge and Skills Framework (NDNKSF)[15].

Training for other health care providers should be closely aligned with the NDNKSF and reflect the care recommendations contained within the NZ Guidelines Group (NZGG)[16] for management of type 2 diabetes.

6.7.3 Non Clinical Staff

Non clinical staff who deliver diabetes care and education in the community setting are excluded from this training requirement in section 6.7.2. Non clinical staff will continue to work with other agencies to implement a holistic approach to diabetes care and education.

Diabetes Education provided by non-clinical people focuses on highlighting what diabetes is, non clinical management strategies, the Individual's goal setting, coping and adjustment strategies, family and whanau issues and cultural / spiritual issues. It should not include education on clinical issues of management such as medications, management of diabetes emergencies, management of illness or medical issues.

Non-clinical services may collaborate with clinical services (primary health care or specialist health services) for additional information to be delivered within their education programmes by clinical personnel. Examples of this may be: foot care sessions by podiatrists, information about food and food management by dietitians, coping and adjustment strategies by

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15 http://www.nzssd.org.nz/documents/dnss/National%20Diabetes%20Nursing%20Knowledge%20and%20Skills%20Framework%202009.pdf

16 The New Zealand Guidelines Group. 2003 *The Treatment of Type 2 Diabetes*. Wellington.

psychologists and information on medications and managing diabetes emergencies by Registered Nurses who are appropriately trained to deliver diabetes education.

6.7.4 Nursing Training Requirements

Primary health care nurses should achieve or be working towards a minimum of level two in the NDNKSF for generalist diabetes care and education services, or level three for primary health care nurses providing specialty diabetes care and education.

Clinical Nurse Specialists in specialist services should achieve a minimum of level four in the NDNKSF.

7. Service Linkages

All diabetes education services will have appropriate formal support and relationship linkages with other local diabetes education services in order to maintain quality and currency with the education services they provide. Where possible these linkages should be with specialist diabetes services. Linkages with local organisations providing adult education may also be of benefit.

For other linkage information refer to the tier two Diabetes Services service specification.

8. Quality Requirements

8.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

Services will also be actively involved with quality improvement activities in relation to local diabetes care delivery, such as quality audit, outcome measures and research to encourage innovative, adaptive and responsive practice.

For other quality requirements refer to the tier two Diabetes Services service specification.

8.2 Effectiveness

Where appropriate, and within a primary health care setting, an Individual's family members at high risk of developing type 2 diabetes should be entered onto a screening recall database at recall intervals as indicated by the NZGG guidelines for type 2 diabetes management[17]. They should also be offered risk reduction and health promotion interventions and information aimed at reducing their risk of developing diabetes or pre diabetes.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in Heath New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service:

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
M20006	Diabetes Care and	Diabetes care and education services for individuals with	Client	Number of clients managed by the service in a year ie	NNPAC

[17] The New Zealand Guidelines Group. 2003 *The Treatment of Type 2 Diabetes*. Wellington.

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Unit of Measure Definition	National Collections or Payment Systems
	Education services	diabetes and their families. Service is provided by multi-disciplinary teams in hospital or in a community-based setting. Excludes clinical education eg medication and management of diabetes emergencies.		caseload at the commencement of the financial year plus all new cases year to date.	
MS01001	Nurse Led Outpatient Clinics	Assessment, treatment, or education and/or management outpatient clinics led by a nurse specialist for specialist groups of clients. Excludes clinics led by a Nurse Practitioner.	Attendance	Number of attendances to a clinic/ department/ acute assessment unit or domiciliary.	NNPAC

The Service must comply with the requirements of national data collections where available.

9.2 Reporting Requirements

Reporting to Local Diabetes Teams or equivalent service

The aggregated information that must be provided annually to LDTs or equivalent service is due by the 20 July and is listed in Appendix B. The LDT or equivalent service may choose to analyse or present extra information differently but the core information must be provided.

Tier three Service Specifications	Reporting by PHO	Reporting by District	Reporting to LDT or equivalent service Frequency	Reporting to LDT or equivalent service Date
Diabetes Care and Education	N/A	Purchase Unit data reporting via National Non Admitted Patient Collection (NNPAC) Refer to Appendix A and B.	Annually	by 20th July

The Annual Report to the LDT or equivalent service is also due by 20 July and must include:

- general issues / highlights and concerns
- the professional resources required by full time equivalent staff or total funding (whichever is more convenient) for clinical nurse specialists or other nurses meeting nationally-approved accreditation standards, podiatrists, dietitians and allied or non clinical staff supporting the service
- training needs analysis and planning undertaken to meet ongoing staff training need
- a review of the provision of diabetes care and / or education services
- outcome measures of services delivered
- report on utilisation of diabetes care and / or education services by Māori and Pacific individuals and families
- the information required in Appendix B
- provision of an annual outline of plans / intentions for the coming year, aimed at addressing the opportunities and concerns identified
- a report on linkages with other services that support the Service being delivered.

12.2 Appendix 2: Data Collection

These items should be recorded in the patient management system in primary and specialist services

Field	
NHI	
Gender	
Surname	
First names	
Residential Address	
Domicile Code	
Contact phone(s)	
Date of birth	
Ethnicity	
Type of diabetes	
Year diabetes diagnosed	
General Practitioner	

Type of diabetes care and education service delivered	
Date person enrolled in care and education episode / programme	
Date person exited care and education episode / program	

12.3 Appendix 3: AGGREGATED DATA REPORTED ANNUALLY TO LOCAL DIABETES TEAMS

Primary health care service/specialist service/community based non clinical service	**Number of individuals for whom Care and Education and management programmes were provided in the last year**	**Number of individuals who completed Care and Education and management programmes completed by the individual in the last year**
Maori		
Pacific Island		
NZ European		
Others		
Not stated		