Building the right workforce for diabetes care

A toolkit for healthcare professionals

NHS
London
Strategic Clinical Networks

Aimed at those in primary care, this toolkit emphasises the need to adapt education and development to local settings within a general level of knowledge and competence of diabetes care across teams.

ASSESSING SKILLS

ONGOING DEVELOPMENT

ENHANCING SKILLS

ENTER THE TOOLKIT

Foreword | Dr Stephen Thomas

Dr Stephen Thomas, Clinical Director, London Diabetes Strategic Clinical Network

Across the whole of the NHS in London, healthcare professionals will interact with people with diabetes on a regular basis.

People with diabetes and carers describe the variation in expertise and knowledge about diabetes that they encounter in healthcare. This variation undermines their confidence, and leads to variations in outcomes and greater use of unscheduled care.

This guide seeks to align training and educational needs with service requirements, emphasising a framework to ensure adequate competency across teams and how to access appropriate training in London.

It emphasises the call for adaption to local needs but within a general level of knowledge and competence.

Whilst we recognise the many demands on time, we believe adequate competency of diabetes is essential and, ultimately, time saving. We hope this guide is used to achieve this.

Foreword | Dr Charles Gostling

Dr Charles Gostling, Chair, Education work stream, London Diabetes Strategic Clinical Network

Diabetes is a word well known to most health and social care professionals, as well as to most people in London.

We discuss how to prevent diabetes, how to make people more aware of diabetes and how to minimise the impact of diabetes on the lives of those who are known to have it. It is one of the most complex long term conditions to manage, and its impact can be devastating, but can be substantially improved with the right self management skills and continued professional support.

The skills required by healthcare professionals to support people with diabetes are many and varied, from supporting behaviour change to appropriate use of complex therapeutic interventions. All this must be achieved in a supportive care system. It is scarce wonder that there is huge variation in the quality of care provided.

This guide is aimed at those working in primary care, where a multiplicity of skills and knowledge must be maintained, diabetes being only one area of care.

Lifelong learning needs to be easily accessible, relevant to the job and hopefully enjoyable. We hope this guide can help healthcare professionals acquire and maintain the skills required to help support people with diabetes, and at risk of developing diabetes, in their local populations.

Executive summary

Diabetes is a long term condition that will increasingly challenge London's healthcare system. There is significant variation in the quality of care provided. Whilst much of this can be attributed to London's diverse demographics and NHS workforce turnover, there are also differences across organisations in the skills and training of those treating people with diabetes. Patient groups point out that they are keen to ensure that equitable skills and competencies are available across all care settings providing services for people with diabetes.

As healthcare systems evolve, there is likely to be greater integration across primary and specialist care, giving rise to services that are more proactive, accessible and better coordinated. There is already considerable evidence that new models of care, as illustrated in this guide, alongside workforce development and education, can lead to improved experience and outcomes for people with diabetes.

There is growing recognition that clinical competencies, both generic and specific to diabetes, are fundamental to delivering high quality, consistent care. Competencies can be acquired in a variety of ways, whether attending existing training courses or other education channels more closely aligned to service delivery, including learning on the job.

With greater numbers of people now living with more than one long term condition,workforce education is an essential component of an evolved healthcare system. At present, there are a variety of diabetes related courses available to primary care health professionals varying in cost and time commitment, both accredited and non-accredited. They are often commissioned in a piecemeal fashion, and may not always relevant be to a local population. Such courses can address different aspects of diabetes care--general diabetes knowledge, injectable therapies or psychological aspects, to name a few.

Whilst courses and training can give a sound grounding in the competencies required for diabetes care, there is a need to maintain competency through a commitment to continued professional development (CPD). Exemplars of innovative delivery of continued professional development are considered in section 3, *Enhancing skills*, and in more depth in on the *Case studies* page.

The London Diabetes Strategic Clinical Network supports the use of competency frameworks in ensuring that individuals and teams possess the requisite skills to deliver diabetes care. Such frameworks can be used to develop a minimum skillset for diabetes care and to establish more advanced competencies for teams delivering care that is more complex.

The embedding of education and training within service delivery can be both an efficient and effective way of building and maintaining competencies relevant to an organisation's geography and population. It can build relationships between local healthcare professionals as well as allowing education and training to occur with minimal disruption to services. Ideally, staff should be able to carry out programmes, even beyond training and education embedded within service delivery.

How to use this guide

This guide is aimed at commissioners, providers of services and individual practitioners involved in out of hospital care for people with diabetes. It may also help to inform patient groups involved in design of diabetes services.

There is a focus on multidisciplinary working, placing the person with diabetes at the centre of care. The term *primary care* in this document is intended to imply more than general practice, and may include newly developing models of community based care.

The guide presents the case for change in improving education and training for community based healthcare professionals involved in delivery of diabetes care.

Assessing skills	Section 1 considers the **use of competency frameworks in assessing team and individual skills**, although it is recoognised that progression to the use of competency based learning and assessment is not inevitable and very much dependent on future service development.
Ongoing development	Section 2 documents **currently available education and training programmes for diabetes care** and related generic skills. All organisations were approached, and the information provided is correct (as of August 2015). Some of the courses and training are accredited by higher educational organisations. Others provide non-accredited training in specific areas of care, recognised by members of the diabetes clinical network to be of an appropriate standard that can be included in continued professional development. Provider organisations and individuals may find this a useful resource in accessing appropriate education and training.
Enhancing skills	Section 3 considers **how skills and knowledge can be maintained** through continued professional development. There is a particular emphasis on embedding learning within local models of care, making them relevant to local workforce and populations. Specific examples are described in detail in Appendix 3. Commissioners, providers and individual practitioners will find this an invaluable resource in designing local bespoke learning and training.

The case for change | Burden of diabetes

There are 2.8 million people living with diabetes in England, and this number is increasing by 5 per cent annually[1].

About 10 per cent of those with diagnosed diabetes have type 1 diabetes. In London there are an estimated 475,000 people with diabetes, and this is expected to rise by a further 200,000 by 2025[2].

Diabetes is the cause of significant morbidity and premature mortality, with the burden of illness shared unequally across diverse populations[3].

A higher prevalence of type 2 diabetes is strongly associated with increasing social deprivation, being of Asian or black African / Caribbean ethnicity and with increasing age. There are no such associations for type 1 diabetes[4].

The case for change | Inequalities related to diabetes

Variation in care is one of the biggest problems in London.

The *Diabetes Guide for London*[5] highlighted the variations in care:

"Overall diabetes care is poorly structured in London with organisational boundaries significantly affecting diabetes care provision and access to services for patients."

Variation in Quality and Outcome Framework (QOF) performance varies not only from one clinical commissioning group to another but also between practices within CCGs:

"More important to us than the physical location of the setting (of care) is the level of expertise available there.

"Primary care professionals providing diabetes care [should] receive training [for diabetes care], development and support including training on care planning."

In response to the above, the London Assembly Health Committee has recommended the need for a minimum standard for the education of general practitioners and practice nurses involved in delivering diabetes care[2].

Current care provision and design caters for some populations better than others. Younger people with diabetes and Asian and black people are less likely to complete essential care processes. Blood glucose control targets are less likely to be achieved by younger people, those with lower socio-economic status and people from Asian and black populations[6].

These variations in outcomes must be addressed. An essential part of this is the development of a workforce that possesses the skills to offer effective diabetes care that meets the needs of a diverse population at high risk of premature morbidity. It is well recognised that primary care in London can be challenged by organisational structures, and that a high turnover of staff can compromise the effective delivery of care[5].

High quality diabetes care is dependent on a number of key enablers identified in the guide[5]:

- Greater collaboration and integration across primary and specialist care.
- People with diabetes being at the centre of their care with increased knowledge, skills and confidence to manage their diabetes.
- Services that are quality assured and evaluated across all levels of care.

The case for change | New models of care

The London Diabetes SCN toolkit for improving the management of diabetes care[7] cites healthcare professional education and development as a key mechanism to improve outcomes for people with diabetes.

Primary care in London is transforming towards a service that is more proactive, more accessible and better coordinated[8]. This process offers the potential for better integration between primary care and specialist services, as well as with social care. Two models (*right*) have been identified to drive this forward: *Multispecialty community providers* (MCPs), building on emergent primary care federations, and *Primary and acute care systems* (PACS), building on a vertically integrated model with one organisation (such as a foundation trust) taking a lead[9].

An appropriately skilled workforce, with access to locally relevant education and training, will be an essential component of such models - as is evidenced by examples given in this guide.

Many people will have more than one long term condition. Data from Scotland suggests that 42 per cent of the population suffer from one long term condition and that 23 per cent will have two or more[10]. The number of people in England with multiple long term conditions is set to rise from 1.9 million in 2008 to 2.9 million by 2018[11]. It is therefore necessary that for many, diabetes is managed alongside other existing conditions in a system using a care planning approach to care, with suitably skilled healthcare professionals[12].

Multispecialty community providers (MCPs)

- Larger GP practices that could bring in a wider range of skills - including hospital consultants, nurses and therapists, employed or as partners
- Shifting outpatient consultations and ambulatory care out of hosptial
- Potential to own or run local community hospitals
- Delegated capitated budgets - including for health and social care
- Addressing the barriers to change to enable access to funding and maximising use of technology.

Primary and acute care systems (PACs)

- A new way of 'vertically integrating services
- Increased flexibility for Foundation Trusts to utilise their surpluses and investment to kick-start the expansion of primary care
- Contractual changes to enable hospitals to provide primary care services in some circumstances
- At their most radical, PACs could take accountability for all health needs for a registered list - similar to accountable care organisations.

The case for change | New models of care

There are many existing examples of how new models of care, built around population need and workforce development, have enhanced diabetes services.

There is a need for training to support these evolving models of care, and healthcare teams will require differing levels of competency according to the complexity of care provided. All practitioners should possess basic competencies for diabetes care; others will require enhanced skills to provide more complex care such as insulin management.

At present, there is a wide variety of educational programmes for primary care healthcare professionals wishing to engage in diabetes management (*see Section 2, Ongoing development*).

Many focus on the underlying pathophysiology of diabetes along with lifestyle, therapeutic interventions and prevention, identification and management of complications. Some training focuses more on complex injectable therapies, and other training specifically targets the behaviour change or psychological aspects of diabetes care. Most require considerable time investment from the healthcare professional, and this is often a barrier to engagement.

Local knowledge suggests that training packages are often introduced without an assessment of population or workforce need (training needs assessment, or TNA).

Training packages may be commissioned that do not take into account the cultural and demographic nuances that might exist.

Continued personal and professional development should be founded on population and multidisciplinary workforce needs, taking into account the changing face of care settings[15]. If done correctly, a workforce can be developed with competence and skills relevant to current and future need.

The case for change | New models of care

Existing examples of how new models of care, built around population need and workforce development, have enhanced diabetes services include...

In **Tower Hamlets**, a strong drive to improve education for primary care, alongside formation of GP networks, shared IT systems and care planning built around *Year of Care* care planning process helped to deliver significant improvements in diabetes outcomes[13].

In **Portsmouth**, services have been reconfigured to focus on the essential services that must continue to be provided by specialists, as well as developing an equally important specialist role to support primary care through rapid access to advice and support and provision of ongoing education[14].

(*Section 3, Enhancing skills, provides further examples and techniques.*)

The case for change | Need for education: Survey results

We surveyed primary care healthcare professionals to learn more about education and training levels, access to diabetes training and perceived need.

What they told us reiterates the need for diabetes specific education.

Whilst roughly half of the respondents held a lead role for diabetes care in their practice, 31.8 per cent of these had not undertaken any diabetes training nor held an accredited qualification.

Some staff groups had less access to training courses than others did. Administrative and reception staff, healthcare assistants, and part-time staff were recognised as having the least access to training.

Barriers to training were uncovered for staff at all levels, such as availability of suitable courses, funding, approved leave, and a general lack of knowledge of available courses.

Survey conducted spring 2015. Of the 262 responses received, GPs made up 41.2%, followed by nurses (24%).

Section 1 | Skills needed to deliver effective diabetes care

Doctors and nurses are required to demonstrate they remain fit to practice via professional registrations, appraisals and revalidation. However, primary care teams include many others, such as reception staff and healthcare assistants.

This section considers the competencies for clinical teams in effective diabetes management.

The provision of care should adapt to local service models and population needs. As primary care has an evolving workforce, this document is not proposing to define specific competencies for individual team members; this is something to be determined by provider organisations. There are several well-recognised competency frameworks available, and use of such frameworks is endorsed in the following Diabetes UK position statement[16].

This statement, whilst clearly aspirational, sets of some clear and desirable qualities to be built into any diabetes care system:

- Organisations identify all staff roles that could impact on the safety and quality of care for people with diabetes.
- Organisations should ensure professional development plans exist for all relevant posts that reflect the diabetes competencies required (including knowledge, skills and attitudes).
- Organisations should demonstrate that staff have appropriate time for continuing professional development.
- Commissioners should expect all staff in NHS funded organisations, including primary, community and secondary care, to be credentialed in diabetes through assessment against existing competency frameworks, to the appropriate level for their position. This requirement should be embedded within existing and new contracts.
- Registration and professional organisations such as the GMC, NMC and Royal Colleges should adopt a competency-based approach to ongoing CPD and revalidation.

The Diabetes UK statement accepts that the use of a framework to develop competencies will prove a challenge to an already stretched health service. For this reason, a staged introduction is advocated.

Section 1 | Skills needed to deliver effective diabetes care

The skills required to support effective diabetes care include many that are generic to all long term conditions, as well as others that are specific to diabetes.

Skills and competencies were collated from competency framework documents[17-21].

As yet there is no formal competency framework for doctors, although the *Cambridge Diabetes Education Project (CDEP)*[22], an online training resource, does take into account the needs of the medical profession.

The composition of primary care teams is likely also to evolve to include new roles such as pharmacists, physician associates, dieticians and perhaps psychologists. It is hoped that the competencies described will ensure consistency and quality of message from all healthcare professionals within the team, thereby providing the person with diabetes with sufficient support to enable them to effectively manage their diabetes.

This guide supports the introduction of competency frameworks and provides a resource to assist the development of local frameworks (*see Appendix 1*). This resource lists a comprehensive set of clinical competencies appropriate to diabetes care performed in primary care, each of which is categorised by type and suggested tiers of care.

Nationally there are examples of how competency based training with mentorship can lead to improvement in primary care diabetes management. The Leicester *Effective Diabetes Education Now (EDEN)* project[23] aims to provide primary care with appropriate skills and knowledge through a competency based primary care education programme.

Section 1 | Key elements for quality diabetes care

Here we consider key qualities for primary care diabetes services.

Detailed examples of competencies that might apply to community based diabetes care may be found in Appendix 2.

- **Early detection and screening** for diabetes.
- **Self care and self management** (including care planning and effective referral to structured education).
- **Parity of esteem** (identifying fears/anxieties around diabetes and depression as long term conditions).
- **Special patient groups with other significant considerations** (eg cardiovascular disease, patients with chronic kidney disease, mental illness, learning difficulties, nursing home residents with diabetes, young people, pregnant women with diabetes and preconception advice).
- **Dietary advice** (management of diabetes, weight management, bariatric surgery referral, eating disorders).
- **Oral hypoglycaemic agents** in the management of diabetes.
- **Injectable therapies** (GLP-1 agents, insulin, sick day rules, hypoglycaemia, intercurrent illness).
- **Management of hypoglycaemia and hyperglycaemia**.
- **Laws on driving** and diabetes.
- **Long term complications, prevention and risk management** (eg cardiovascular disease, foot disease, neuropathy, nephropathy and retinopathy).
- **Diagnosis** for patients with type 1 diabetes, and knowledge of the referral pathways.
- **Process / organisational competencies required to provide a robust, integrated person focussed care system.**

Section 2 | Continuing development for healthcare professionals

Diabetes UK divides healthcare professional education into three components:

- **Foundation**
  Initial education leading to qualification to practice, including degrees and medical specialist training
- **Continuing professional development**
  Ongoing education to maintain one's competence to practice
- **Personal development**
  Research, teaching and management

The Royal College of General Practitioners, in conjunction with the Royal Pharmaceutical Society of Great Britain, the Department or Health and NHS Primary Care Contracting have developed a suite of guidelines for accreditation of practitioners with special interests based on *Skills for Health* competencies. However, there is currently no such framework for diabetes care[24]. Given this gap, this guide considers the use of competency frameworks to guide service providers.

Nurses, general practitioners and other allied healthcare professionals working in primary care will have undergone basic foundation training that included varying levels of diabetes related training.

Most healthcare professionals will have acquired further skills and knowledge in diabetes care through their work as well as ongoing education and training.

Some courses, in particular university based certificates and diplomas, will offer content that covers a very broad range of diabetes related competencies.

Some courses have university or other professional body accreditation; others do not, but are recognised to have specific quality and relevance in providing ongoing education in diabetes care.

Section 2 | Continuing development | General diabetes courses

Download full list of courses

Courses in gold indicate MSc, post graduate and diploma courses.
Courses in green indicate short courses.

University of Warwick	University of Bradford	Cambridge Diabetes Education Programme	M & K Update
University of South Wales	University of Greenwich	City University London	Practitioner Development UK
University of Cardiff	King's College London	Diabetes UK	Primary Care Diabetes Society
University of Highlands and Islands	AstraZeneca	Imperial College London	Primary Care Training Centre
University of Leicester	Lilly	London Southbank University	The Open University
University of Huddersfield	Novo-Nordisk	Sanofi Aventis	Virtual College

Section 2 | Continuing development | Focus areas

Download full list of courses

Courses designed for injectable therapies, including insulin

- University of Warwick
- Lilly
- Pitstop Diabetes
- Novo-Nordisk
- AstraZeneca
- Sanofi Aventis

Behavioural change and psychological wellbing in diabetes care

- Positive Diabetes
- SDS Training
- Association for Psychological Therapies
- Successful Diabetes

Section 3 | Enhancing and developing skills for diabetes

Whilst training courses are an important means of gaining competence in diabetes care, maintaining skills is equally as important.

There is no single way to do this. Maintaining skills should be as unique as local needs.

Ten example continuing education programmes from around England have been identified, ranging from 'in practice support' educational activity to a wider regional approach across primary and secondary care.

Programmes have been reviewed to identify key attributes, steps to take and techniques used in setting up and delivering primary care diabetes services with built in on-going educational elements.

A local programme for continued professional development around diabetes care should be based on key diabetes service attributes, follow the process to co-produce a programme and use an amalgam of the techniques to deliver education (*below*). The educational content of programmes will be determined by training needs assessments and the core skills or competencies required by teams to support population and service needs.

We consider here the key attributes, steps required and techniques used to deliver education in the exemplar programmes. (*Further details are provided in the Case studies map.*)

Above: Pathway to developing successful diabetes educational programmes for primary care health professionals

Section 3 | Enhancing and developing skills for diabetes

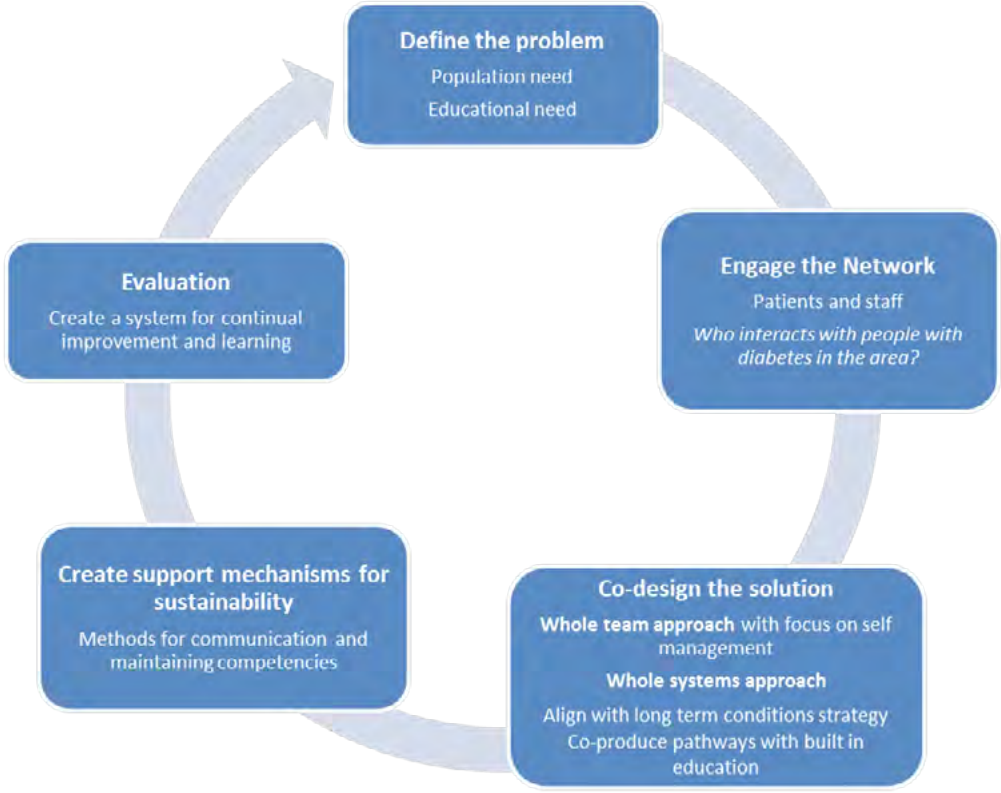
Key attributes

- Education and service delivery go hand in hand.
- Strong leadership with a clear vision, ownership driven by local education champions, patient engagement and focus on self management and psychological wellbeing for long term conditions.
- Communication and teamwork.
- Sharing and creating resources
  - Continued professional and personal development (CPPD) funding is available for community care.
  - Aligning training with other local long term condition training strategies for health professionals allows development of general skills.
  - Embedding education in commissioned services allows resources to be used for both service and educational delivery.
  - Collaboration with non NHS partners, including the third sector and others, is another possible resource.

Section 3 | Enhancing and developing skills for diabetes

Steps required

» The process (right) is essential to ensure ownership and engagement of models across the different stakeholders. Attempting to replicate models established in other areas without this process risks compromising local engagement and sustainability.



Techniques used

» Integrating primary and secondary care with regular multi-disciplinary meetings that can be used flexibly to discuss cases (virtual clinics), review practice or network performance (practice 'surgeries'), update local guidelines, deliver teaching on desired topics and in some examples also deliver shared clinics following the meetings.

» Bespoke training programs and/or comprehensive education programs delivered locally to improve competencies of staff.

Section 3 | Enhancing and developing skills for diabetes | Techniques for use

Integrating primary and secondary care

- Multidisciplinary meetings with virtual clinics and practice / network surgeries
- Educational sessions
- Shared clinics
- Communication

Maintaining individual competencies

- Education programmes
- Bespoke education
- Reviewing training competencies
- Online learning
- Internal practice meetings

Promoting patient involvement, self management and psychological wellbeing

- Co-design and delivery of education to HCPs and patients
- Patient pathway simulation
- Care planning
- Coaching, motivational interviewing and psychological support

Building systems which incorporate education

- Co-design services
- Access to specialist expertise
- Clinical information systems

Rollover the themes to see each case study.

- Integrated primary and secondary care
- Maintaining individual staff member competencies
- Promoting patient involvement, self management and psychological wellbeing
- Building systems that incorporate education

Section 3 | Case studies

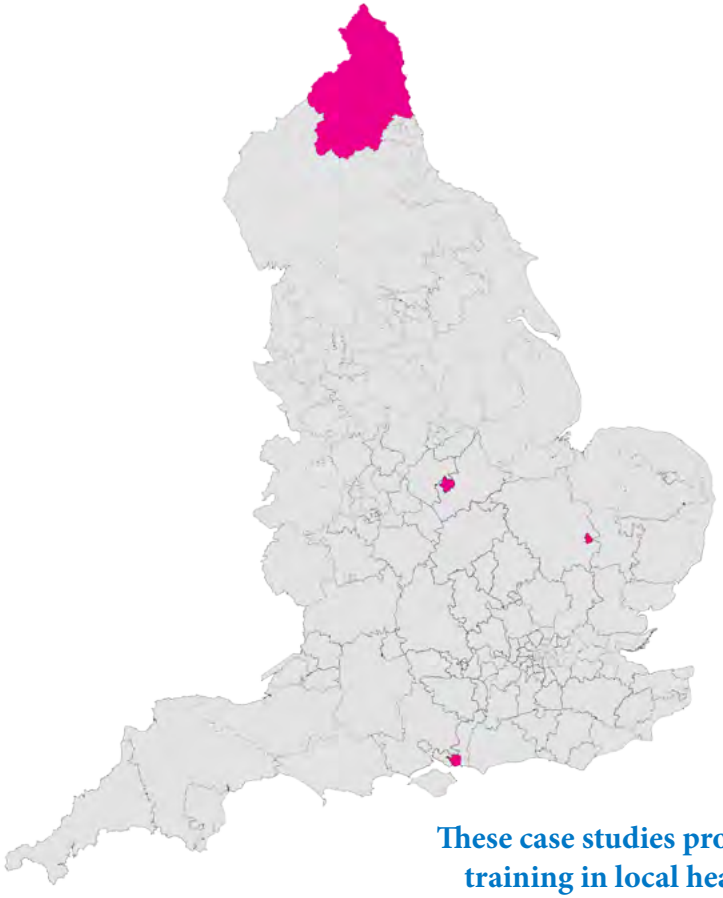
Rollover the locations below to show where they are in the map. Click map location for case study.

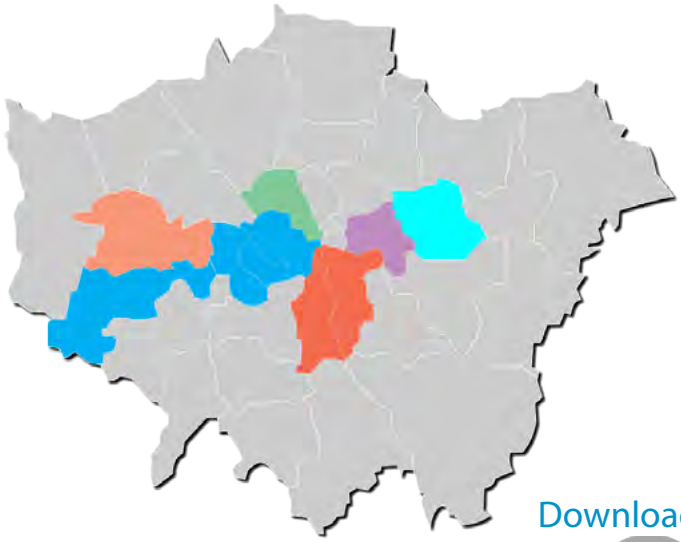
Diabetes service models with aligned training

- Camden
- CWHHE
- Lambeth and Southwark
- Newham
- Northumbria
- Portsmouth
- Tower Hamlets

Training programs developed to support diabetes services

- Cambridge
- Leicester
- Ealing





These case studies provide methods to deliver training in local healthcare environment.

Download all case studies

Section 3 | Enhancing and developing skills for diabetes

Integrating primary and secondary care

Multidisciplinary meetings
Regular scheduled meetings involving diabetes consultants, diabetes specialist nurses, GP with special interest, GP's, practice nurses, psychologists and other members responsible for patient care in a particular practice network. Usually led by diabetologist.

Virtual clinics
Case based discussions, reflection on cases with shared multi-disciplinary learning and opportunity to teach on cases

Practice / network surgeries
Review practice/ network performance with reference to local targets, performance, guidelines to improve performance

Educational sessions
Delivered by diabetologist, diabetes specialist nurses and other MDT members on desired topics usually informed by feedback on local performance or cases and often combined with MDT or virtual clinics.

Shared clinics
Diabetologist, diabetes specialist nurses, or psychologist shared clinics with GP on complex cases. Opportunity to teach as well as offer patient specialist advice close to home.
These can be arranged following the multi-disciplinary meetings at a practice, dedicated sessions (eg with diabetes specialist nurse) or even in patient's home

Communication
E-mail and telephone advice by consultant or diabetes specialist nurses directly to practice nurse and GPs offers an opportunity for learning from advice given but also efficient use of resources
Shared IT (eg Tower Hamlets and Portsmouth) helps in facilitating this

Case studies

Tower Hamlets Northumbria Newham CWHEE	Portsmouth Lambeth Camden	Tower Hamlets	Camden Portsmouth Tower Hamlets	Tower Hamlets Portsmouth Northumbria	Lambeth CWHHE Cambridge

Section 3 | Enhancing and developing skills for diabetes

Maintaining individual staff competencies

Education programmes
Comprehensive accredited university programs delivered locally covering a variety of topics (see section 2 of guide)

Bespoke education
Focused training programs to support pathways (eg complex oral, injectable therapies). This can be accredited (eg by Royal Colleges or universities)

Reviewing training competencies
Mentor (eg diabetes specialist nurse) reviewing and setting competencies for individual staff (eg practice nurses)

Online learning
Access to learning resources online; can be part of university programs

Internal practice meetings
Buddy groups that meet regularly in the practice with self-directed learning by sharing cases and teaching. This can be supported by mentors who help facilitate and direct learning.

Case studies

Education programmes	Bespoke education	Reviewing training competencies	Online learning	Internal practice meetings
Tower Hamlets	Tower Hamlets	Camden	Tower Hamlets	CWHHE
Portsmouth	Portsmouth	Portsmouth	Portsmouth	Leicester
Camden	Camden	Leicester	Cambridge	
CWHEE	Newham		Leicester	
Cambridge	Northumbria			
Leicester	Ealing			
	Cambridge			
	CWHHE			
	Leicester			

Section 3 | Enhancing and developing skills for diabetes

Promoting patient involvement, self management and psychological wellbeing

Co-design and delivery of education to HCPs and patients
Patient involvement in designing education for HCP e.g. using patient case studies to improve education focus on professional behavioural aspects and self management. Expert patient in delivering HCP education.

Case studies
Ealing

Expert patient involvement in designing resources or delivering education for patients alongside HCP

Patient pathway simulation
Use actors to simulate patient pathway and cases to highlight problems in pathways, improving consultation skills and understand what patient support is necessary to encourage concordance and self management.

Case studies
Lambeth
Cambridge

Care planning
Staff are trained to conduct care planning which is built around patient needs identified via patient co-design. Shared holistic care planning addresses care, education and support needs which improve self management and engagement.

Case studies
Ealing

Coaching, motivational interviewing and psychological support
Coaching for health, motivational interviewing techniques and cognitive behavioural training, with emphasis on motivating, supporting and education patients to improve engagement and self management. These may be a part of education programs or delivered separately

Case studies
Tower Hamlets
Camden
Northumbria
CWHHE

Case studies
See Education programmes
Ealing
Camden

Section 3 | Enhancing and developing skills for diabetes

Building systems which incorporate education

Co-design services
Shared strategies, pathways , guidelines and service specification across stakeholders allow engagement but also encourage learning.

Access to specialist services
Ensuring time and resources are built in for education across various stakeholders through contracts and job plans for access to specialists.

» Enable determination of skills and support required for practices to enable pathways to work

Clinical information systems
Clinical information systems that:

» Provide alerts, messages, links to guidelines as reminders during patient consultation

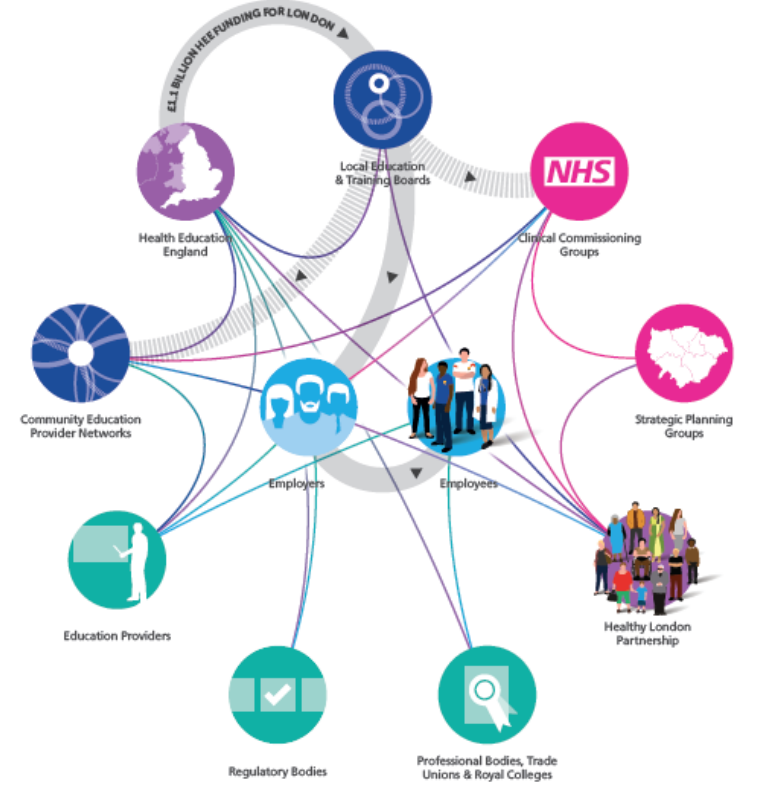
Case studies

Tower Hamlets Portsmouth Northumbria CWHHE	Tower Hamlets Portsmouth Northumbria Lambeth CWHHE	CWHHE Portsmouth Tower Hamlets

Section 3 | Enhancing and developing skills for diabetes

Broad principles

- Limited resources to deliver education for CPPD are available via structures on the next page.
- Aligning generic training and education for Diabetes with training for other long term conditions (eg motivational interviewing, coaching for long term conditions) provides access to wider resources (see Community Education Provider Networks [CEPN's]).
- Our example programmes also highlight that a lot can be achieved without specific resources for education but via ensuring commissioned diabetes services offer educational and training support within their service delivery mechanisms.
- Collaborative procurement and delivery of education with other organisations also offers other ways of providing training locally (eg universities, pharmaceutical companies, online resources, local and national networks).



Stakeholders involved in the workforce system have specific roles and interactions which as a whole will transform the workforce across the capital.

Image source: Healthy London Partnership strategic workforce framework

Section 3 | Enhancing and developing skills for diabetes

Structures to support implementation of this guide

There are many different groups with roles in developing services and education, within practices. Practice leads for diabetes or indeed any long term condition will need to consider how their staff are maintaining their core competencies and can consider implementing some of the above techniques to do this. They may benefit from working with some or all of these groups.

CCGs

CCGs should influence service design; ensuring education is built into commissioning plans and commissioning for outcomes that reflect maintenance of skills and expert support for primary care delivery.

CEPNs

Community education provider networks (CEPNs) are networked arrangements of community providers in a defined geography. Their purpose is to understand and develop the community-based workforce for now and into the future. They are ideally placed to assess local workforce development needs and to take a whole team approach, focusing not just on those directly involved in diabetes care so that every contact counts, also ensuring the equitable distribution of CPPD funding based on population need. In practice most CEPNs sit within or have close links with the local GP provider federation or CCG.

LETBs

Local Education and Training Boards (LETBs) are responsible for delivering CPPD for Health Education England. With changes in service delivery, education and training will need to reflect this with more undergraduate placements in community settings, multi professional education, and post-graduate training crossing the primary secondary care interface. The responsibility for CPPD is being shifted to other community providers, including CEPNs in some areas.

Royal Colleges and professional bodies

The Royal Colleges are an important source of expertise and resources for educational delivery as well as supporting curriculum and revalidation tools.

Service provider groups

These include GP federations, multispecialty community providers and primary and acute care systems.

When bidding for service delivery contracts provider groups should consider the educational needs and continuous development of the workforce.

In conclusion...

It is essential to develop and maintain a workforce to support effective diabetes care.

Education and training are vital in planning and developing a quality service that aligns with local need and reduces inequality of service provision, which will in turn impact on patient engagement and outcomes.

Traditional education courses, many provided by higher education institutions, remain an effective method of acquiring key skills. However, they can be time consuming, presenting barriers to attendance for many healthcare professionals. Moreover, they will not always possess the flexibility of delivery to make their content receptive to local population need. For maintenance of competency, such courses need to feed in to on-going continued professional development.

The use of competency frameworks is an attractive means of ensuring that teams and individuals are equipped with the required skills to deliver care commensurate with their respective role in a pathway. The introduction of competency based learning and assessment might be challenging in the current environment. In the future such an approach can offer a comprehensive yet flexible means of assuring that services are of quality and fit for purpose.

An innovative approach to education and training that aligns with service delivery offers the opportunity of acquiring skills in a more efficient manner. Such skills are also likely to be more relevant to the needs of the local population. Competency frameworks and assessment can be built into local education models in an unobtrusive fashion that allows better access to relevant education and training.

Recommendations

We believe the following should be considered for successful programmes in diabetes care.

- Any service where staff have contact with people with diabetes should ensure their workforce have access to appropriate education and training for diabetes care.
- Organisations should ensure that teams with responsibility for diabetes care should possess competencies and skills commensurate with the level of care being delivered. This should be underpinned by a robust service specification.
- It is the responsibility of individual healthcare professionals to acquire, as well as maintain, skills and competencies relevant to their role within a team.
- Local education and training programmes for diabetes and other long term conditions should be informed by an appropriate training needs assessment.
- Competency frameworks are an evolving and effective way to ensure that teams, and individual members of teams, possess the required levels of competency.
- Courses currently provided by higher education institutions, and other organisations, are a recognised way of acquiring skills. Such courses can be tailored to local need.
- Locally designed programmes can fit the needs of the local health economy. Learning can be aligned with the requirements of service delivery.
- When designing a programme ensure the key attributes of quality care are present to support the process involving all stakeholders and use a selection of the evidenced techniques to deliver local educational requirements.
- It is essential that solutions that are locally designed, or co-designed with higher education institutes, have engagement from organisations involved in commissioning and providing service delivery.

Future direction

Potentially under used resources (such as patient input and technology) should be evaluated and incorporated into education and training where appropriate.

While it is too early to get rigorous evaluation of many projects, evaluation methods to capture improvements in patients' care and ultimately patients' health will be crucial in building the evidence base for future development and improvement. In this way education and training can be properly included as an essential ingredient of population outcomes and value based commissioning.

Resources

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Abbreviations used in this guide

CCG	Clinical commissioning group
CDEP	Cambridge Diabetes Education Project
CEPN	Community education provider networks
CPD	Continuing professional development
CPPD	Continuing professional and personal development
EDEN	Effective Diabetes Education Now
HEE	Health Education England
LETB	Local education and training boards
MCPs	Multispecialty community providers
PACs	Primary and acute care systems
TNA	Training needs assessment

References

1. The Health and Social Care Information Centre. Quality and Outcomes Framework 2013/14, 2014 (viewed 2015 April 1) | Link
2. Health Committee, London Assembly (April 2014). Blood Sugar Rush; Diabetes time bomb in London, 2014 (viewed 2015 April 1) | Link
3. Diabetes UK. Diabetes Facts and Stats, 2014. (viewed 2015 April 1) | Link
4. Health and Social Care Information Centre. Health Survey for England 2004: health of ethnic minorities, 2006 (viewed 2015 April 1) | Link
5. Healthcare for London. Diabetes Guide for London, 2009 (viewed 2015 April 1) | Link
6. Health and Social Care Information Centre. National Diabetes Audit 2009/10: executive summary, 2011 (viewed 2015 Apr 1) | Link
7. London Strategic Clinical Networks. Improving the management of diabetes care: A toolkit for London clinical commissioning groups, 2015 (viewed 2015 August 7) | Link
8. NHS England. Transforming Primary Care in London, a Strategic Commissioning Framework, 2015 (viewed 2015 April 7) | Link
9. NHS England. Five Year Forward View, 2014 (viewed 2015 April 7) | Link
10. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study'. The Lancet, vol 380, no 9836, pp 37–43.
11 Department of Health (2012). Long term conditions compendium of information, 3rd ed. London: Department of Health (viewed 2015 Sept 14) | Link
12 The Kings Fund (2103) Delivering better services for people with long-term conditions, building the house of care, 2013 (viewed 2015 Sept 14) | Link
13. Hull S, Chowdhury TA, Mathur R, Robson J. Improving outcomes for patients with type 2 diabetes using general practice networks: a quality improvement project in east London, 2014. BMJ Qual Saf, 23(2): 171-176.
14. Kar, P. The 'Super Six' for the acute trust, all else under primary care, 2011. Practical Diabetes, 28(7): 308-309.
15. Health Education South London. Continued Personal and Professional Development Strategy, 2014 viewed 2015 April 7) | Link
16. Simmons D, Deakin T et al. Diabetes UK Position Statement. Competency Frameworks in Diabetes, 2015. Diabetic Medicine, 32: 576-584
17. TREND. An integrated career and competency framework for diabetes nursing, 2011 (viewed 2015 April 7) | Link
18. Deakin, T. An integrated career and competency framework for dietitians and frontline staff, 2011 (viewed 2015 April 7) | Link
19. TRIEPodD-UK. Podiatry competency framework for integrated diabetic foot care, 2011 (viewed 2015 April 7) | Link
20. NHS Diabetes. Lead midwife in diabetes: standards, roles and competencies, 2010 (viewed 2015 April 7) | Link
21. Skill for Health, Competences tools, 2010 (viewed 2015 August 10) | Link
22. Cambridge Diabetes Education Project (viewed 2015 August 10) | Link
23. The EDEN Project, Leicester Diabetes (viewed 2015 August 10) | Link
24. Royal College of General Practitioners. GP with special interest (GPwSI) accreditation. (Viewed 2015 May 23) | Link

Appendix 1 | Competencies by level

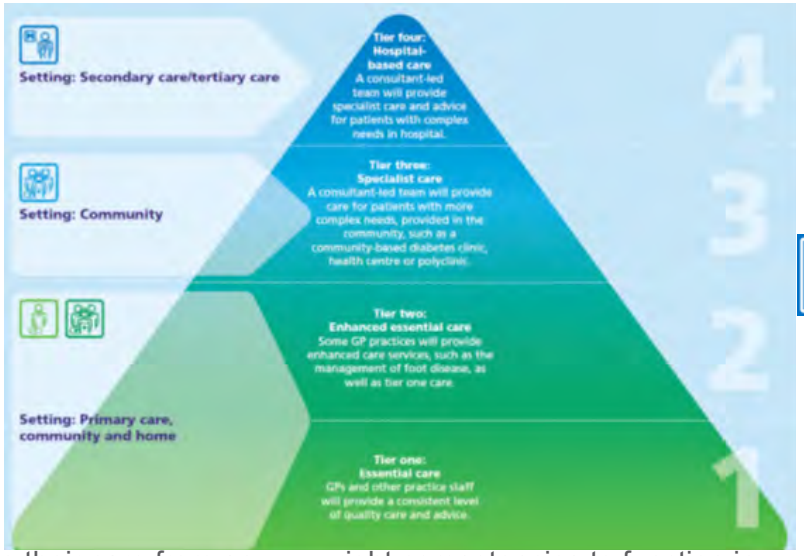
A model for diabetes care in London shows four tiers of care, from essential to hospital-based care.

Essential care

Enhanced essential care

Specialist care

Hospital-based care



With an increasing emphasis for out of hospital care, more care will be shifted to a closer to home setting.

As the care setting shifts, there is concern from patients and their advocates that this might compromise outcomes, with patient groups noting that it the quality of care is more important than the care setting[1]. Fortunately, ample examples illustrate that care close to home does not compromise the overall quality of care.

In general practice, nurses and doctors are required to ensure that they are fit to practice (via their professional registration) although this is not specifically focussed on the long term and acute management of diabetes. As care provision changes, patients may receive their care from any number of developing healthcare roles within general practice (eg healthcare assistants, pharmacists and physician's associates). Quality of care remains the key component.

There are a number of competency/ skills frameworks in existence that can be utilised to map team and individual skills to ensure that teams possess the right competencies to function in their role.

The table on the next page builds on existing frameworks with this in mind to give an indication of the competencies that might be necessary at differing tiers of care. The following is intended to give an indication only. The exact skills required will depend very much on the exact model of care in question.

Appendix 1 | Competencies by level

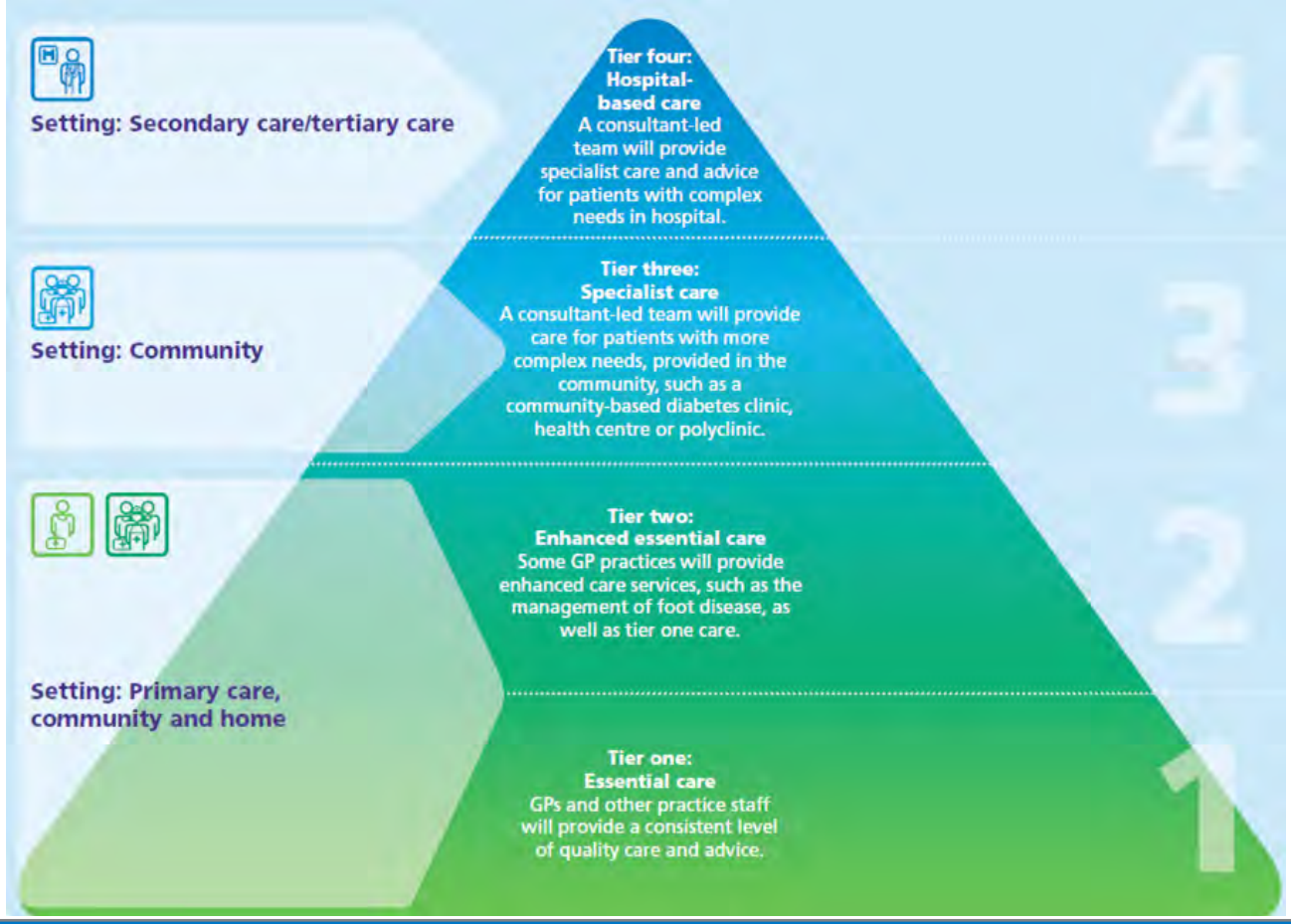
A model for diabetes care in London shows four tiers of care, from close to home to specialist care.

Essential care

Enhanced essential care

Specialist care

Hospital-based care



Appendix 1 | Competencies by level

Download mapped competencies

Common themes throughout all levels

Common theme throughout all levels

- Education programmes
- Information
- Support
- Signposting
- Prevention
- Awareness raising
- Care planning
- Retinal screening programme

Appendix 1 | Competencies by level - Essential care

Download mapped competencies

Delivered in primary care by general practices

Activity	Performed by	Competency reference
Diagnosis of diabetes	GP or practice nurse	Diab TT01
Annual diabetes review type 1 and 2 which includes care processes that require additional skills: • Nutritional assessment and advice • Foot check • Erectile dysfunction check • Psychological review	GP or practice nurse	Diab HA10 Diab HA5 Diab HA3 Diab ED01& ED02
Follow up of type 2	GP or practice nurse	Eden Insulin 1
Newly diagnosed diabetes	Practice nurse	Diab GA4
Medication review and titration of oral agents	GP or practice nurse	Diab HD2
Insulin administration, sharps disposal, insulin passport and sick day rules	GP or practice nurse	Trend 5.8 & Diab HD3
Assessment and management of the obeste patient	GP or practice nurse	Eden - Obesity
Teach self-monitoring of blood glucose	Practice nurse	Diab HA8 & HA9
Complication screening	GP or practice nurse	Diab GA1 & HA6
Chronic disease register and recall	Practice team	
Achieving QOF targets	Practice team	
Information exchange	Practice team	
Coordinate access to higher levels	GP or practice nurse	
Care planning	GP or practice nurse	Diab GA4
Prevention	GP or practice nurse	
Screening. NHS health check	Practice team	Trend 5.1
Referral and demand management	Practice team	

Diab - Skills for health https://tools.skillsforhealth.org.uk/competence_search/
Trend - Trend (Training, research and education for nurses U, 3rd Edition
Eden - Eden (Leicestershire Enhanced Diabetes Services)
D UK - Diabetes UK

Appendix 1 | Competencies by level - Enhanced essential care

Download mapped competencies

Delivered by specialist MDTs in primary care by general practices with appropriate support from specialist clinicians

Activity	Performed by	Competency reference
Assessing, initiating and monitoring newer agents: GLP1, DLP4, SGL2	CDSN or enhanced primary care clinician	Eden 4-7
Assessing and preparing for starting insulin	CDSN or enhanced primary care clinician	Diab Ha11
Follow up of type 2 patients on insulin	CDSN or enhanced primary care clinician	
Assessment and prevention of hypoglycaemia	CDSN or enhanced primary care clinician	Diab DF03
Trend 5.9	GP or practice nurse	Diab HD2
Support patients with learning difficulties	CDSN or enhanced primary care clinician	
Virtual clinics in practices	CDSN or enhanced primary care clinician	
Psychological support and counselling	Counselling/IAPS	
Dietetics	Dietitians	
Podiatry	Podiatry	
Pre-conception advice where control is good	CDSN or enhanced primary care clinician	Diab PD01&PD02
Professional education	CDSN	
Follow up post discharge from secondary care	CDSN or enhanced primary care clinician	
Follow up post tier 3	CDSN or enhanced primary care clinician	
Management plans for tier 1 follow up	CDSN	
Assessment for bariatric surgery	CDSN	Eden 9

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Trend - Trend (Training, research and education for nurses U, 3rd Edition
Eden - Eden (Leicestershire Enhanced Diabetes Services)
D UK - Diabetes UK

Appendix 1 | Competencies by level - Specialist care

Download mapped competencies

Delivered in the community by a consultant led specialist diabetes MDT

Activity	Performed by	Competency reference
Extended management of Type 2 patients on Insulin	MDT	
Group and Individual initiation for type 2 patients	CDSN	Diab HA12
Intensive individual intervention and management	MDT	
Dietetics and podiatry support to MDT	Dietician or Podiatrist	Trend 5.4
Psychological support	Counsellor with interest in diabetes	Trend 5.3
Routine follow up of type 1 (in some areas)	MDT	Eden Type 1,1
Preconception advice where control is poor (MDT approach)	MDT	
Housebound patients requiring extra intervention	CPSN	Eden Diabetes and Elderly 1
Care home Support for patients and staff	CPSN	Trend 5.19

Diab - Skills for health https://tools.skillsforhealth.org.uk/competence_search/
Trend - Trend (Training, research and education for nurses U, 3rd Edition
Eden - Eden (Leicestershire Enhanced Diabetes Services)
D UK - Diabetes UK

Appendix 1 | Competencies by level - Hospital based care

Download mapped competencies

Delivered in a hospital setting by a consultant led specialist diabetes MDT

Activity	Performed by	Competency reference
Newly diagnosed type 1	MDT	
Follow up of type 1 diabetes (all or just those with more complex co-morbidities)	MDT	
Insulin Pump	MDT	Diab IPT01-06
Acutely ill patients with diabetes	MDT	Eden 11
Neuropathy	Joint specialist clinic	Trend 5.14
Nephropathy	Joint specialist clinic	Trend 5.16
Heart failure/unstable angina	Joint specialist clinic	
Dietetic and podiatry support to MDT	Joint specialist clinic	
MDT foot clinic for ulcers, infection ischaemia	Specialist podiatrist supported by MDT and vascular	Diab DF03
In-patient management	MDT	Trend 5.12
Diabetes in pregnancy	MDT	Diab PD03
Trend 5.13		
Transitional care from paediatrics to adult services	MDT	

Diab - Skills for health https://tools.skillsforhealth.org.uk/competence_search/
Trend - Trend (Training, research and education for nurses U, 3rd Edition
Eden - Eden (Leicestershire Enhanced Diabetes Services)
D UK - Diabetes UK

Appendix 2 | Competencies - Essential care

Early detection and screening	Oral therapies	Hypoglycaemia	Retinopathy
Self care / management	Blood glucose monitoring	Intercurrent illness	Preconceptual care
Mental health / special groups	Injectable therapies	Nephropathy	Patients with type 1 diabetes
Diet / nutrition	Hyperglycaemia	Neuropathy	Process indicators

Appendix 2 | Competencies - Enhanced essential and specialist care

- Self care / management
- Injectable therapies
- Mental health / special groups
- Preconceptual care
- Diet / nutrition
- Patients with type 1 diabetes
- Blood glucose monitoring

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