Building the right workforce for diabetes care
A toolkit for healthcare professionals

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
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.

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.

<table>
<thead>
<tr>
<th><strong>ASSESSING SKILLS</strong></th>
<th>Section 1 considers the <strong>use of competency frameworks in assessing team and individual skills</strong>, although it is recognised that progression to the use of competency based learning and assessment is not inevitable and very much dependent on future service development.</th>
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</thead>
<tbody>
<tr>
<td><strong>ONGOING DEVELOPMENT</strong></td>
<td>Section 2 documents <strong>currently available education and training programmes for diabetes care</strong> 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.</td>
</tr>
<tr>
<td><strong>ENHANCING SKILLS</strong></td>
<td>Section 3 considers <strong>how skills and knowledge can be maintained</strong> 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.</td>
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</table>
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\(^4\).
Variation in care is one of the biggest problems in London. The *Diabetes Guide for London* 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:

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.

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.

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.

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

» 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\(^6\). 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 hospital
- 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. If done correctly, a workforce can be developed with competence and skills relevant to current and future need.
 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 outcomes¹³.

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 education¹⁴.

(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.
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.
Building the right workforce for diabetes care: A toolkit for healthcare professionals

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\(^2\). Given this gap, this guide considers the use of competency frameworks to guide service providers.

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

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.

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

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

<table>
<thead>
<tr>
<th>University of Warwick</th>
<th>University of Bradford</th>
<th>Cambridge Diabetes Education Programme</th>
<th>M &amp; K Update</th>
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<tbody>
<tr>
<td>University of South Wales</td>
<td>University of Greenwich</td>
<td>City University London</td>
<td>Practitioner Development UK</td>
</tr>
<tr>
<td>University of Cardiff</td>
<td>King’s College London</td>
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<td>Primary Care Diabetes Society</td>
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<tr>
<td>University of Highlands and Islands</td>
<td>AstraZeneca</td>
<td>Imperial College London</td>
<td>Primary Care Training Centre</td>
</tr>
<tr>
<td>University of Leicester</td>
<td>Lilly</td>
<td>London Southbank University</td>
<td>The Open University</td>
</tr>
<tr>
<td>University of Huddersfield</td>
<td>Novo-Nordisk</td>
<td>Sanofi Aventis</td>
<td>Virtual College</td>
</tr>
</tbody>
</table>
Section 2 | Continuing development | Focus areas

Courses designed for injectable therapies, including insulin

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

Behavioural change and psychological wellbeing 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.

Define the problem
Population need
Educational need

Engage the Network
Patients and staff
Who interacts with people with diabetes in the area?

Evaluate
Create a system for continual improvement and learning

Co-design the solution
Whole team approach with focus on self-management
Whole systems approach
Align with long term conditions strategy
Co-produce pathways with built-in education

Create support mechanisms for sustainability
Methods for communication and maintaining competencies

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
- Educational 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
Section 3 | Case studies

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

Rollover the themes to see each case study.

These case studies provide methods to deliver training in local healthcare environment.
Section 3 | Enhancing and developing skills for diabetes care

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.
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

Tower Hamlets
Camden
CWHEE
Cambridge
Leicester

Tower Hamlets
Portsmouth
Camden
Newham
Northumbria
Ealing
Cambridge
CWHHE
Leicester

Camden
Portsmouth
Leicester

Tower Hamlets
Portsmouth
Cambridge
Leicester

CWHHE
Leicester
## Section 3 | Enhancing and developing skills for diabetes

### Promoting patient involvement, self management and psychological wellbeing

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<tr>
<th>Case studies</th>
<th>Ealing</th>
<th>Lambeth Cambridge</th>
<th>Tower Hamlets Camden Northumbria CWHHE</th>
<th>See Education programmes Ealing Camden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-design and delivery of education to HCPs and patients</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>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</td>
</tr>
</tbody>
</table>

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.

**Clinical information systems**
Clinical information systems that:

- Enable determination of skills and support required for practices to enable pathways to work
- Provide alerts, messages, links to guidelines as reminders during patient consultation

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**Case studies**

- **Tower Hamlets**
- **Portsmouth**
- **Northumbria**
- **CWHHE**

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Overview

Techniques for use

Principles

Implementation
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).

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.
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

Acknowledgements

Abbreviations

References

Appendix 1 | Diabetes competencies by tier

Appendix 2 | Diabetes competencies for healthcare professionals
Acknowledgements

The London Diabetes SCN would like to thank all stakeholders and partners for their time and commitment resulting in this guide, *Building the right workforce for diabetes care*.

Bringing together complex ideas and previously quite separate approaches to improving the care provided to patients into a single source for providers and commissioners alike.

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We thank all those shared their case studies, allowing an in depth view of their services, in order to tease out the various attributes for successful upskilling and development of the work force. A huge thank you goes to Dr Charles Gostling for his literature and policy review work and chairing the working group.

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Finally, special thank you to Gemma Snell, senior project manager for the Diabetes SCN, whose tenacity and vision led to the development of the guide.
Abbreviations used in this guide

CCG  Clinical commissioning group  
CDEP  Cambridge Diabetes Education Project  
CEPN  Community education provider networks  
CPPD  Continuing professional 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

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

**Essential 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 setting¹. Fortunately, ample examples illustrate that care close to home does not compromise the overall quality of care.

**Enhanced essential 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.

**Specialist care**

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

Common themes throughout all levels

- Education programmes
- Information
- Support
- Signposting
- Prevention
- Awareness raising
- Care planning
- Retinal screening programme
### Appendix 1 | Competencies by level - Essential care

Delivered in primary care by general practices

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

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

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

Delivered in the community by a consultant led specialist diabetes MDT

<table>
<thead>
<tr>
<th>Activity</th>
<th>Performed by</th>
<th>Competency reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended management of Type 2 patients on Insulin</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Group and Individual initiation for type 2 patients</td>
<td>CDSN</td>
<td>Diab HA12</td>
</tr>
<tr>
<td>Intensive individual intervention and management</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Dietetics and podiatry support to MDT</td>
<td>Dietician or Podiatrist</td>
<td>Trend 5.4</td>
</tr>
<tr>
<td>Psychological support</td>
<td>Counsellor with interest in diabetes</td>
<td>Trend 5.3</td>
</tr>
<tr>
<td>Routine follow up of type 1 (in some areas)</td>
<td>MDT</td>
<td>Eden Type 1.1</td>
</tr>
<tr>
<td>Preconception advice where control is poor (MDT approach)</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Housebound patients requiring extra intervention</td>
<td>CPSN</td>
<td>Eden Diabetes and Elderly 1</td>
</tr>
<tr>
<td>Care home Support for patients and staff</td>
<td>CPSN</td>
<td>Trend 5.19</td>
</tr>
</tbody>
</table>
### Appendix 1 | Competencies by level - Hospital based care

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

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

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england.london-scn@nhs.net

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