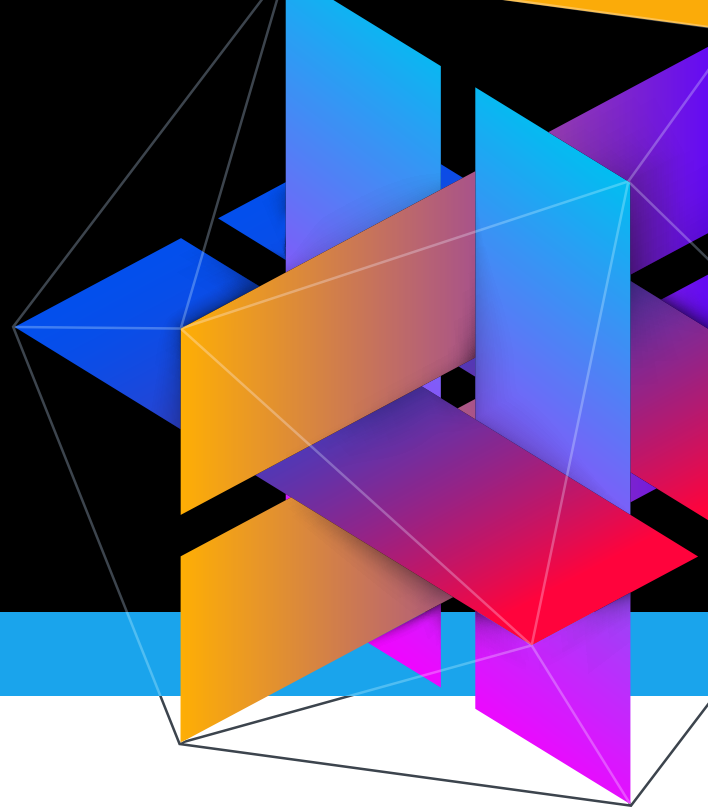


# The changing shape of diabetes care delivery:

## What the new Primary Care Networks mean for practice

### Question and Answers



#### **Q: Is this going to be mandatory?**

A: No this is not mandatory. It sets out the gold standard for diabetes care in the primary care network. It showcases how with current funding a lot of this can be achieved.

#### **Q Where will the dietitian come from?**

A: A diabetes specialist dietitian (DSD) has been included as a key member of the PCN Diabetes Support team (DiaST). We have asked for the BDA's document 'What does a Diabetes Specialist Dietitian do?' to be hosted on the [Diabetes on the Net website](#). The following are outcomes from DSD intervention:

- Dietetic intervention in newly-diagnosed Type 1 diabetes can offer an additional 8mmol/mol improvement in HbA1c.
- Reductions in HbA1c of up to 22mmol/mol have been reported in Type 2 Diabetes, with intensive diet interventions associated with improved glycaemic control.
- Dietetic intervention has shown to be cost effective and resulted in fewer visits to both physicians & health services, as well as reductions in the need for diabetes medication.

Diabetes UK suggests 4.0 WTE Adult DSD per 250,000 total population. However, according to a 2016 survey by the BDA the number of DSDs per team has not changed significantly since 2010 despite the number of people with diabetes increasing from 2.6 million to 3.8 million in the same period.

The additional roles reimbursement scheme (ARRS) offers an opportunity because it allows a PCN reimbursement for 1.0 WTE band 7 specialist dietitian; in some areas there has been great demand. There is the opportunity for a networked approach for the provision of dietetic support across local PCN's and between Tier 2 and Tier 3 Diabetes Care. PCN DiaST teams may wish to connect with local DSD services that work in the community, where available. The BDA is also working with Skills for Health and Health Education England to develop credentials for the Advanced Clinical Practitioner Dietitian in Primary Care, but we understand this would not be a diabetes specialist role.

***Q: Why have you not included a psychologist within the DiAST?***

A: It is expected that PCNs will use a wide range of approaches to meet the mental and emotional health needs of their localities, involving a wide range of mental health practitioners to deliver this.

The IAPT (Improving Access to Psychological Therapies) programme is world leading and the 'Five Year Forward View for Mental Health' clearly sets out an expansion of this service. Increasing access to IAPT services for adults and older adults with common mental health problems with a focus on those with long-term conditions are evolving and it is expected that primary care networks will work towards this type of integrated care for all people living with diabetes.

PCNs should work collaboratively with mental health practitioners to ensure that appropriate mental and emotional health screening is done for people with diabetes from the first point of contact and regularly thereafter with clear referral processes.

***Q: Why do you think structured education should be the main focus and why did you decide on the 2 week wait?***

A: The seriousness of a diagnosis of type 2 diabetes is often underestimated. Just as the two week wait for cancer has helped facilitate better outcomes because of earlier investigations and treatment, if applied to diabetes we think it could have the same results. The two week wait was recommended to ensure early access to the PCN diabetes specialist team and quality assured diabetes education, providing reliable and up to date information, which is culturally relevant, tailored to the health literacy requirements of the group, and providing access to peer support. The efficacy of structured education soon after diagnosis is well established, with demonstrable improvements in glycaemic control, reduction in cardiovascular risk and weight, and improved quality of life. It is hoped that by attending structured education within two weeks of diagnosis, there may be better clinical and psychological outcomes for people with type 2 diabetes.

***Q: I agree about the importance of structured education. Do you think the 2-week wait may be difficult to achieve unless more courses are set up?***

A: This depends on capacity of local education services. Where there is an increase in demand, investment may ideally be needed in order to increase the number of courses, and more educators may need to be trained to increase capacity. Due to funding restrictions alternatives should be considered. One option is to facilitate the use of non-clinical educators 'lay-educators', together with HCPs in order to retain their clinical expertise. In some regions with better attendance, the two week wait would not result in a large enough increase in referral numbers to exceed capacity. We also need to look to ways to improve non-attendance to courses which leaves spaces unfilled. Online education provides a more a flexible option for people with digital access. It provides neighbouring education services the opportunity to join up their programmes to provide more options for people with diabetes. There has been an increase in the provision of live virtual education with HCP's, which can incorporate peer support with interaction through video software and message boards. In addition online and app education options have advanced, with more pre-recorded and interactive content that can help to engage people during independent learning. All of

these can be incorporated into the local education pathway to help increase capacity and may support delivery of earlier education, particularly in hard to reach groups. Nevertheless, face to face education has the largest evidence base for clinical and psychological outcomes therefore should be considered first.

***Q: Re-education: Will there be a standardised education programme based on accredited programmes in order to ensure high standards across the board?***

A: Structured education programmes can be tailored e.g. to meet the needs of the local populations, but should always meet a set of nationally agreed criteria set out in NICE guidelines. This includes an evidence-based curriculum, the use of trained and competent educators, quality assurance of teaching standards, and regular audit and review. QISMET (the Quality Institute for Self-Management Education and Training) has developed the Diabetes Self-Management Education Quality Standard offering providers a means of demonstrating that they have met NICE criteria. We hope that a menu of options will be offered which will also enable a learning style to suit the individual with diabetes. There is currently little in the way of monitoring and quality assurance of clinical content of digital apps and online tools. PCNs are encouraged to individualise recommendations according to user requirements and preference, and to liaise with diabetes education services to ensure educational content is evidence-based and aligns with national guidelines regarding management of diabetes and diet, particularly when referring to an online self-management education programme in place of structured education.

***Q: Will structured education be offered in different languages and take into account different cultural needs/diet/lifestyle?***

A: This will depend on local needs. Culturally relevant health education has demonstrable short-term effects of improved glycaemic control and knowledge of diabetes and healthy lifestyles. Some examples have been included in the full document of how structured education can be adapted to local population needs, as well as Appendix 3, which lists some of the resources currently available to help deliver culturally relevant diabetes education. In some areas programmes have been adapted to have a HCP delivering education in another language and providing culturally relevant nutrition and lifestyle advice. It may be possible to use TV, radio or phone to ensure that language is not a barrier in delivering good care to all people living with diabetes.

***Q: Are you suggesting PCNs set up their own structured education programmes, rather than aim for better links with already locally available services? Just wondering where we are going to find enough Dieticians etc..?***

A: No the document recommends accessing established services locally. We would recommend that localities assess if their structured education offerings are fit for purpose and offer a menu of options for access. There are places in the country which have designed and deliver their own structured education programme based on their population needs, e.g. remission groups, but where possible these should be coordinated with local education services for consistency, to use available educators (including dietitians) expertise, and to ensure quality assurance measures are applied to the programmes such as internal and external peer review.

***Q: Should not we be using TV media more frequently to teach/ educate/ motivate people with diabetes ?***

A: The use of the above alternative sources was not explored in the document, but could potentially provide appropriate education. We would advocate the use of reliable sources of information which are regularly updated to reach out to people living with diabetes.

Health care professionals should encourage people that have digital access to link in with the diabetes online community on social media e.g. Twitter by following conversations via these hashtags: #DOC and #OurD. Social media platforms enable users to follow organisations, such as @DiabetesUK, individual professionals/diabetes services, or to join local diabetes peer support groups. Many people with diabetes have created blogs and vlogs as useful resources for peers, which can be found on the individual's profile. Forums such as the Diabetes UK Support Forum facilitate conversations for hundreds of thousands of peers.

***Q: We currently have no access to face to face education locally due to COVID restrictions. Is this likely to change anytime soon? What are the advantages of delivering education virtually?***

A: We would anticipate that when Covid-19 restrictions lift nationally there would be a return to safe face to face education however most of the major diabetes educators have been publishing outcome data on the virtual education that has taken place during Covid-19 restrictions and this preliminary outcome and qualitative data is very positive. Once available, face to face education should be considered first because of the body of evidence showing superior clinical and psychological outcomes. While virtual education is a less flexible option for different learning styles and some people with diabetes will not engage virtually, it is recommended we keep virtual education within the menu of options because some people prefer it, it is time and cost-efficient, and resolves transport matters.

***Q: Can you elaborate on the qualifying attributes of pharmacists; you have specifically referred to the RPS framework and this may put people off who are not RPS members.***

A: The RPS advanced level framework has been used as this is currently the only general pharmacist based national higher level framework available. This framework is available from: <https://www.rpharms.com/resources/frameworks/advanced-pharmacy-framework-apf>

Despite this being an RPS document it is available to all for free access. The RPS are currently doing a large piece of work on the advanced frameworks and the PCN document will be adjusted accordingly if any significant changes are made.

The RPS at this time have chosen to work on the advanced frameworks for mental health and intensive care and so there is no financial incentive to the RPS through any credentialing processes for inclusion of the RPS advanced framework in this document. We hope that in the future we will see lots of innovation from different organisations providing competency based education and this market competition will provide a good menu of choices to the varying needs of the PCN pharmacist population.

The UKCPA have a competency framework which dovetails into the RPS advanced level framework. This is focused mainly on the clinical requirements for advanced level practice. This is available from: <https://ukclinicalpharmacy.org/wp-content/uploads/2018/05/An-integrated-career-and-competency-framework-for-pharmacists-in-diabetes-First-Edition-2018.pdf>

This competency framework is due for renewal and the updated framework we hope will cater well to the needs of the new PCN pharmacists. This will be launched later this year, 2021.

***Q: Do you think that the lack of update of the NICE guidance is holding diabetes care back?***

A: The NICE guidance is eagerly awaited however we feel that the plethora of good practice examples in terms of anticipatory care may be testament that the lack of NICE guidance is not holding good care back. Numerous local pathways have been developed across the country, based on evidence based consensus (ADA/EASD) which can and have been used to promote better outcomes

***Q: Can you elaborate on what experience and/or qualifications the GPwER would be expected to have?***

A: There is no definitive answer on this, and we would recommend that you look to your local commissioner/providers/ICSs to set out their required standards. We would also guide you to the RCGP framework to support the governance of GPwERs available at <https://www.rcgp.org.uk/-/media/Files/CIRC/GPwSI/RCGP-framework-to-support-the-governance-of-GPwERs-2018.ashx?la=en>

***Q: If initial attendance at structured education does not engage someone, what additional support can be offered to people living with diabetes?***

A: This is covered in Appendix 2. Alternatives for people unable to attend structured or virtual education programmes. Options include carers attending structured education, 1-2-1 dietetic education, online education and self-management platforms and apps, peer support 'buddy ups', groups and linking in with the diabetes online community on social media, and alternative group options.

Evidence also suggests structured education needs to be repeated in order to sustain the improvements seen after attendance. Therefore, referral to a structured education programme should be considered at every annual review, and people who have missed education in the past should be identified by PCNs and diabetes education services. The capacity of local diabetes education services may not match the demand for annual structured education and funding of specialist dietitians through the Additional Roles Reimbursement Scheme would help to bridge the gap. Local attendance data should be interrogated to see if there are certain demographic characteristics which have lower attendance as well as whether certain modalities of delivery suit certain population groups.

**Q: How can we ensure this guidance is taken up universally? Will DHSC and NHSE be pushing it as well?**

A: We are initially focusing on the five main priorities however the document has been designed to provide next steps even for the most mature ICS. The five priorities which will be a focus for national stakeholders will be:

1. Recommendation for early 2-week referral on diagnosis of diabetes for structured education, dietary input, individual goal setting and the opportunity of exploring remission of type 2 diabetes.
2. Recommendation of holistic care with the long-term disease burden for people living with diabetes in mind as key values.
3. Development of a new PCN enhanced tier system with an MDT approach, specifically with the creation of the Diabetes Support Team (DiAST). This allows for the PCN to provide support, mentorship and clinical governance in diabetes to all practices in their locality
4. PCN DiAST clinics for special groups, including: people with a new diagnosis, young adults, women of childbearing potential, those struggling to meet individualised target levels for their diabetes, those with other co-morbidities and initiation/management of injectable therapies.
5. PCN DiAST led and monitored training/ upskilling of dedicated HCPs involved in the delivery of diabetes care.

**Q: How do the guidelines specifically mention/address people who are housebound patients (own home and nursing homes)?**

A: The document does address this and sets out 4 key recommendations for this population of people living with diabetes.

Recommendations:

- Frailty assessment at least annually
- Individualised care plans which incorporate individualised targets of care
- Structured medication reviews to include de-escalation of medications where indicated
- MDT working to include those in care homes, and those who are housebound

In addition to this Appendix 5 of the full document sets out the Standards for Good Diabetes Management in Care Homes

***Q: There is no mention of podiatrists in the DiAST team, where does this important member of the MDT fit?***

A: Podiatrists are key players in diabetes care and have been included in the document as a supporting role. Because of the focused role of the podiatrist it was necessary to take them away from the pyramid of care and discuss their essential role separately.

Once foot issues are identified, people with diabetes should be referred to existing secondary or community podiatrists with clear referral criteria and pathways. Community podiatrists and PCNS should have appropriate links to secondary and tertiary foot services. Podiatry services are often in great demand and it is essential to highlight urgent cases for appropriate, timely advice and management, virtual clinic platforms are an important consideration and are being trialled.

***Q: Does the NSF on diabetes (2001) have a key role to play as a tool?***

A: The NSF for Diabetes (2001) is a key document in setting out what good diabetes care should look like in the wider systems. 'Best Practice in the Delivery of Diabetes Care in the Primary Care Network' takes a more focused approach to some of the themes in this national document. The NSF can certainly be used as a tool to substantiate service development and innovation.

***Q: How do you intend to fund the different elements of the document? Will there be funding available to recruit to these posts?***

A: We do not see that there will be additional posts needing recruitment to as we propose that the PCN DiaST Team is formed from HCPs with an interest in diabetes already working within the PCN to give a level of focused care to more complex persons with diabetes. Each PCN can look to the document so look to what fits best for them in terms of service delivery and current funding levels/priorities.

The document also includes examples where efficiencies of finances have been made alongside care quality improvement.

The GIRFT Diabetes report has highlighted some recommendations around medicines optimisation where significant savings can be generated.

***Q: Is this approach generalised to the whole country? Will GP federations be involved?***

A: Yes this document sets out the gold standard of practice for the whole country. The GP Confederation have been working with us closely to ensure that the GP federations are involved.

***Q: How will this guideline affect the person living with diabetes? Will the document be promoted to people living with diabetes, it may be that people will have to change levels to get the care they require and they should be involved in these decisions?***

A: We absolutely agree that persons with diabetes should be involved in decisions in their care and the document has and will continued to be promoted to persons with diabetes with all feedback very welcome.

For the person living with diabetes, this guideline aims to ensure they receive appropriate early structured education and management input, with improved, early access to specialist services and the multidisciplinary team. By standardising the delivery of diabetes care, this should reduce variation in care. Furthermore, there should be a smooth flow of movement through the different levels of service depending on management needs at any one time point in their diabetes care journey.

***Q: Where does the DiAST team come from and where will they be appointment from?***

A: The PCN DiaST Team are not an additional team. The document is suggesting that they are HCPs already working within the PCN with a special interest in diabetes. By having diabetes leads within each PCN persons in need of more focused/complex care can be reviewed by someone at the appropriate competency level and this DiaST Team can look to ensure effective diabetes education for other HCPs within the PCN.

This is a model that will lend itself well to other areas of long term condition management.

***Q: How will the document affect secondary care?***

A: The document will hopefully encourage secondary care to look to providing integrated service where these are not currently offered. This should also ensure better continuity of care and communication across the various care sectors ultimately providing a seamless pathway for the person with diabetes and their families and carers. 'The right person will be seen in the right place, by the right person at the right time'.

***Q: What does the training for these tiers look like? How do you expect to upskill the workforce? How do you intend to do this especially in relation to injectable therapies? What sort of accredited training is available? Who will work to set this up?***

A: The full document does cover in detail the vision for training the staff in this tiered system as this will depend on individual PCN needs. This guideline supports a 'train the trainer' approach where at each level of care, practitioners participate in 'on the job' training, in addition to accredited training, provided by the level above. We advocate that levels should have dedicated time to deliver this training. This continuous education will ensure that all healthcare professionals are upskilled to provide up-to-date, high quality evidence-based diabetes care across the board.



***Q: Is there a useful resource for dietary advice for HCPs and patients?***

A: First line dietary advice for type 2 diabetes can be found on the Diabetes UK website. People with diabetes are recommended to follow a healthy balanced diet similar to the general population guidelines as per the national Eatwell Guide, which is similar to a heart-protective Mediterranean diet. A dietitian should guide the nutrition advice provided to people with diabetes in the PCN caseload and local referral criteria should be examined to understand how and when a dietitian can provide assessment and treatment to individuals. Weight loss diets should be individualised, sustainable and affordable.

***Q: Who will be responsible for driving this service and how will the funding be generated? How can people get involved in making this happen?***

A: The GP federations, ICS, PCNs and indeed ourselves as HCPs, will be responsible for driving the services. Funding will be generated through already identified funding streams within the PCNs e.g. DES (Direct Enhanced Service), ARRS (Additional Roles Reimbursement Scheme), IIF (Investment and Impact Fund) indicators. We would also expect that innovation would lead to cost savings and re-investment. Use of Transformation funds that have been allocated for diabetes care could also be explored

***Q: Are there any accessible documents to give people with diabetes and learning/literacy difficulties?***

A: The Diabetes UK website hosts a plethora of resources for HCPs and people living with learning difficulties and diabetes. These can be accessed: <https://www.diabetes.org.uk/professionals/resources/shared-practice/for-people-with-learning-disability>

We also hope that by highlighting the care needs of this population in the document more resources will be developed and can be shared.

***Q: How will this service be communicated to all PCNs who are not on this platform today? What are the time frames to set up this service?***

A: In terms of time frames, we understand that PCNs are all at various stages of development and thus some may already be providing a high proportion of what we have advocated, whilst other PCNs may be just starting on formulating their diabetes services and thus we have no pre-determined time scales and highlight that this document is not mandatory.

We have published articles relating to this document and will be presenting at various local and national conferences to highlight the document.

The NHS PCN Confederation has also disseminated a 'two page' version of the document in their May (2021) correspondence to PCNs with links to the full document.

Diabetes UK and the Primary Care Diabetes Society are also continuing to both host and disseminate the document to wider HCP audiences and commissioners.

***Q: Who will ensure that competencies have been met for the relevant levels of care?***

A: The teams are made up of registered practitioners who should be able to hold themselves to account for their level of competency. Frameworks have been included in the document to aid this self-reflective process. In time we hope there will be robust credentialing associated with competence levels however in the interim it may be that PCNs wish to develop their own systems of assessment.

***Q: How do you intend on building strong connections and collaboration between acute and community services to provide holistic care?***

A: There are lots of ways to go about delivering the integrated care described in this document and we would signpost you to reviewing the models of care described in the document.

***Q: How will PCNs cope with the increasing patient load due to 2 week wait referrals?***

A: By innovation with virtual platforms and group clinics this could actually mean that resource within the PCN to deliver those initial consultations with people could be reduced.

***Q: Does this mean that you are looking to phase out the current community teams? Tier 3 and 4 are both secondary care staff no? Could the 4 tiers of care be reduced to three levels for large practices with many GPs one of whom can be spared to train as diabetes with special interest would that not be more convenient for patients and more effective? Likewise will we actually need tier 2 if the PCNs are upskilled?***

A: Not at all. This document sets out a whole system approach to good care. The community teams will continue to be essential and make up both tier 3 and tier 4. There is a new DiAST who will hold expertise within the PCN team but rather than those expert professionals being based at one practice they will look to spread their expertise to areas in need across the PCN. There is a great need to provide standardised good care for all, but there is also a great need to intensify care in areas where there are large levels of inequality/variation.

***Q: Can a diabetologist be involved with the PCN team and deliver PCN clinics?***

A: Absolutely. The document sets out collaborative and seamless care. Tier 3 (Integrated Care from the Associated Secondary Care Trust) caters to this. It essential that the time of these highly skilled individuals is optimised and we would expect them to take referrals for complex cases unable to be managed at Tier2 Diabetes Care, examples to include:

- Targeted clinics e.g. post MI, technology (community-managed CBG and flash glucose monitoring devices), Frailty tailored to population needs, Renal: up to stable CKD 4, Type 1 needing community management (e.g. care home, learning disabilities)
- People with uncertain diagnosis e.g. suspected LADA or MODY.

**Q: What online course can health professionals do as 1st line education in practices? This would be not to replace structured education but to ensure we all work from the same page**

A: There are a wide variety of baseline HCP education resources available and in the first instance we would direct HCPs to both Diabetes UK and The Primary Care Diabetes Society who both provide excellent HCP learning opportunities/modules. Your locality may also provide baseline diabetes education so it would also be useful to reach out to your local education team.

<https://www.diabetesonthenet.com/course>

<https://www.diabetes.org.uk/professionals/training--competencies/courses>