Improving Diabetes in Primary Care for South West London

Discussions and next steps from event held on 26th March 2018

Start well, live well, age well
Contents

Introduction ........................................................................................................................................... 3
Summary ............................................................................................................................................... 5
What you said: Identifying people with diabetes ............................................................................ 8
What you said: Care planning and care processes .................................................................... 14
What you said: Achieving treatment targets ................................................................................. 21
What you said: Practice and staff development ......................................................................... 28
**Introduction**

On Monday 26th March 2018, the South West London Health and Care Partnership Diabetes Programme Team invited stakeholders from across the local healthcare system to come together and discuss how we can improve our care for people with diabetes in primary care.

In total 69 people attended including people with diabetes, practice nurses, community nurses, GPs, commissioners, and public health consultants.

The most recent NDA results show significant variation in performance in diabetes across South West London. There are some areas of excellent practice but on average we are below national average for treatment target achievement and care process completion. Our NDA results also show we have a recorded prevalence of 4.97% for diabetes, while estimates show our actual prevalence is likely to be significantly higher than that.

The aim of this workshop was to draw out ideas on what we can do to improve on the status quo. These ideas have been turned into a set of suggestions and actions for practices, CCGs, and the South West London Health and Care Partnership. Our intention is to use the outputs from the workshop launch a new project at South West London level to address some of the system-wide challenges and to support GP practices and CCGs to enact changes on a local level suggested in this workshop.

The event was split into two parts. The first part saw speakers from around South West London present their ideas on various themes relating to diabetes in primary care.

**Speakers**

<table>
<thead>
<tr>
<th>London context</th>
<th>Clinical Director, London Diabetes Clinical Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Stephen Thomas</td>
<td>Dr Stephen Thomas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care planning and care processes</th>
<th>Kingston GP and Clinical Lead for Diabetes at Kingston CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gareth Hull</td>
<td>Dr Gareth Hull</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff and practice development in diabetes</th>
<th>Nurse Practitioner and Clinical Lead for Long Term Conditions at Sutton CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karol Selvey</td>
<td>Karol Selvey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identifying people with diabetes and using PRIMIS</th>
<th>Consultant Diabetologist, St George’s University Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Roni Saha</td>
<td>Dr Roni Saha</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Deputy Chief Pharmacist, Wandsworth CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raj Dhir</td>
<td>Raj Dhir</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Project Manager, Battersea Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Tappenden</td>
<td>Sue Tappenden</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Wandsworth GP Federation Clinical Lead for Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Sachin Patel</td>
<td>Dr Sachin Patel</td>
</tr>
</tbody>
</table>
Workshop

For the second part of the event we held a workshop to explore four themes in more detail.

The four themes explored were:
1. **Identifying people with diabetes**
2. **Care planning and care processes**
3. **Achieving treatment targets**
4. **Staff and practice development in diabetes**

**Part one: The 4 L’s Exercise**

Firstly, all attendees were invited to give their thoughts on each of the four themes using post-it notes to capture the thoughts of everyone attending.

This exercise used a technique known as the “4 L’s”.

The 4 L’s are; **Liked, Learned, Lacked, and Longed for**.

- **Liked** is for ideas that we know work well, and that we are currently doing in some areas.
- **Learned** is for things we have tried in the past that worked well, or things that don’t work well. Also for things that have worked well in other areas that we may wish to try.
- **Lacked** is for anything that we don’t have now, but would help us to improve
- **Longed for** is for blue-sky thinking and establishing what ideas we think will really make a difference

**Part two: Group discussions**

After the 4 L’s exercise the workshop split into 4 groups, with each group looking at the ideas generated and holding a round table discussion. The ideas generated and discussions held are captured in this document.

A summary of the key themes, actions, and recommendations provides an overview of the outcomes from the workshop, with a more detailed round up of the group discussions and all of the post-it note ideas also included.
Summary

While over the course of the event there were a great many ideas shared, which are detailed later in this document, there were several cross-cutting themes which are summarised here. We hope to use these ideas as a launch pad for work across South West London, however we recognise that each CCG have their own strategy for diabetes, and each practice will have different priorities and resources available to them. We hope that the suggestions below can be considered by CCGs and practices when considering how they deliver diabetes care. The South West London Health and Care Partnership (SWL HCP) are committed to addressing the key suggestions made for the diabetes programme, and will undertake work on these over the coming year.

1 Coding and data

One of the key themes, mentioned by almost all speakers and groups, and for every theme, was inconsistencies in coding and data. This includes poor recording of people with diabetes, recording of the completion of education and care processes, and inadequate information about the local diabetes locally being available to clinicians and commissioners. The use of PRIMIS in Wandsworth was discussed at length and it was felt that all areas could benefit from this in the future.

SWL HCP will...

- Arrange a SWL-wide event for people to learn more about PRIMIS
- Implement work to standardise coding used across SWL
- Create a data dashboard to give primary care staff and commissioners better access to data about diabetes in South West London.

2 Care planning

The importance of personalised care planning came across in a number of the discussions, as did the variation in completion of care processes between practices. Some practices have exemplary approaches to patient recall that could be shared with other areas. Some practices use mandatory fields in their templates to ensure care processes are being completed at annual review, which was an idea that was popular.
Summary (continued)

SWL HCP will...
- Promote training in collaborative care planning for primary care staff in South West London.
- Develop a proposal for funding to pilot digital tools to support sharing of care plans with patients and across care settings.

3 Working together

Access to specialist advice for clinicians working in primary care was another of the most prominent themes. Several ways of delivering this were mentioned, including joint or virtual clinics, diabetes academies, and technology solutions which allow contact via e-mail.

SWL HCP will...
- Help to network people working in diabetes
- Launch work to improve integration of diabetes care in South West London

4 Using the whole team

Ensuring that all members of the practice team have a stake in diabetes care was a point that came up in all of the discussions. Using the skills of receptionists and healthcare assistants, as well as doctors and nurses, to help support people with diabetes could improve the experience for the patient and allow for more to be done. Standardised training was seen as a key part of this, as it would help ensure everyone involved in helping people with diabetes understand what they need to do.

SWL HCP will...
- Ensure that e-learning resources which are already available are shared with Primary Care teams
- Promote work to standardise training in diabetes in South West London
What you said

In this section we include a report of the group discussions held on each of the 4 topics, look at next steps for each topic, and include all of the ideas generated from the 4 L’s exercise for each topic.

For each topic we have included:

- A summary of the group discussion
- Key themes that came across from both the group discussion and the 4 L’s exercise
- Next steps
- All of the ideas captured in the 4 L’s exercise for each topic split by Liked, Learned, Lacked, and Longed For.

The Next Steps are split into actions that could be taken by Practices, CCGs, and by the South West London Health and Care Partnership Diabetes Programme team. The actions which are suggested for the Health and Care Partnership will be taken forward with the aim of launching a new project to work on them later this year. We have also included an explanation of where current work is already addressing some of the points raised in the workshop. CCGs and GP practices may wish to incorporate the ideas and actions generated from into their diabetes work.

For some of the ideas that came out of the workshop there are projects already underway in South West London which covers them. We have included a brief explanation of the work we are doing where this applies.

The post-it note ideas from the 4 L’s exercise have been grouped roughly into themes which were identified. These themes are shown in light blue, with ideas from that theme placed near the themes they represent.
What you said

1 Identifying people with diabetes

Start well, live well, age well
Identifying people with diabetes

Group Discussion

The discussion identified 3 main points to take away from the “4 L’s” exercise.

PRIMIS

Firstly, it was clear that the group felt that PRIMIS should be used regularly and routinely in Primary Care.

Engaging communities

Secondly, it was felt that more innovative ways of identifying and engaging people with diabetes could be used. There was a “big tent” event in Sutton which brought people together, and it was suggested that community and religious groups could be engaged in this regard. Other potential avenues for screening people included NHS Health Checks, mental health settings, and the National Diabetes Prevention Programme. It was recommended that we find a better way to align the screening of diabetes through these channels across the system.

The third main point raised was that additional resources for training, and services for diabetes prevention would be helpful.

Key Themes

- Use of PRIMIS more widely was strongly favoured
- NHS Health Checks are a useful avenue for identifying people with undiagnosed diabetes
- Community engagement is key
- Focus on wider screening for diabetes would help
- Poor quality of data and coding an issue currently
- Additional training and services for diabetes prevention

Next Steps

Practices consider...

- Working with CCGs to implement PRIMIS
- Identifying their “Prevalence Gap”

CCGs consider...

- Setting up PRIMIS training for GPs
- Deep dive sessions could be considered

SWL HCP

- Hold a SWL-wide PRIMIS event so CCGs and GP practices can learn more
Identifying people with diabetes

Health checks

- NHS Health Checks were great for identifying new diabetes patients
- Screening of patients
- Keeping new patient reviews to identify glycouria

Screening

- PRIMIS to update automatically with alerts to Practice Nurses and GPs
- Virtual dashboard from PRIMIS
- I love PRIMIS

PRIMIS

- Ability to identify areas for improvements—knowledge is power
- Time to go through ‘at risk’ groups
- Can PRIMIS be used to identify pre-diabetes patients?
- Liked to use PRIMIS

Liked

- NHS Health Checks
- Healthier You Programme
- Identifying high and low risk and making sure patients are called in

Liked

Identifying people with diabetes

Our NDA registers do not capture everyone with diabetes.

Other programmes like PriDia2, MSD Informatics etc.

Knowing the extent of the work can be overwhelming but PRIMIS makes it feel more manageable.

Learned

Working closely with multiple practices gives a better understanding of issues and solutions.

Better understanding of diabetes management.
Identifying people with diabetes

**Lacked**

- Knowledge of benefits of PRIMIS
- No training as yet
- More support in using the tool for practice nurses and CDSNs

**Time to go through ‘at risk’ groups**

**Time to review PRIMIS**

**PRIMIS**

- I’ve never heard of PRIMIS until today
- Knowledge in using PRIMIS

**Data and coding**

- Bad coding
- Data sharing agreement for EMIS so accessible by community and hospital teams
- Direct line to DSN—not via community provider

**Other systems**

- Link to SMI health checks for additional cohorts
- Diabetes champions are a good way of informing people about diabetes
- NDPP for all in different localities and evenings / weekends
- Robust system for annual recall for gestational diabetes

**Identifying people with diabetes**
Identifying people with diabetes

Screening
- Close working with mental health inpatient units for screening
- Check for diabetes when other checks completed
- Systematic way to embed into routine practice

Longed for
- Better screening options for people: HbA1c, psychology, pharmacy, community teams
- Peer groups help patients control their condition
- Using religious leaders in educating population
- Protected time within daily schedule for targeted admin
- More support in management

Data and coding
- Standardised coding
- Better coding e.g. gestational diabetes or family history of diabetes
- PRIMIS update

Community engagement
- Close working with mental health inpatient units for screening
- Systematic way to embed into routine practice

Workforce
- Close working with mental health inpatient units for screening
- Check for diabetes when other checks completed
- Systematic way to embed into routine practice

Resources to identify and provide follow up for people at risk of diabetes
- Alignment of opportunities for identifying people across health checks and community/voluntary sector
2 Care processes and care planning

Start well, live well, age well
Group Discussion

Collaborative care planning

The discussion focussed around care planning recognised that a “one size fits all” approach towards care planning would not be appropriate, but that if we can introduce a more streamlined system, with a better summary care record this could be managed. The discussion recognised that the constant in caring for a patient’s long term condition is primarily the patient themselves, and secondarily the GP practice and therefore having joint care plans with the patient engaged is a realistic target.

Practice processes for recall

The “4 L’s” exercise showed there is a feeling that a collaborative care process where there is more time for both newly diagnosed and annual review appointments, and where patients arrive pre-armed with the information they need and having had their blood tests would be an improvement. There was also a common suggestion that a more robust recall process was required to ensure patients attend their annual reviews, and that automatic alerts or prompts in the system for care processes would be useful as well. The recall system was highlighted by Dr Gareth Hull as one of the factors behind his practices success in achieving 80% completion of all 8 care processes. Gareth also highlighted that the template on his practice system for annual review does not allow the user to close it unless the care processes have been completed, which was an idea that garnered a lot of interest.

Access to specialist advice

As with the other topics, there was a significant emphasis in the “4 L’s” exercise on working together and access to advice from specialist colleagues across the healthcare system. Significant support was shown for MDT clinics or virtual clinics in primary care and for more joined up working with the diabetic eye screening programme and pharmacists for example.

Mental health

Mental health, which falls outside of the 8 key care processes, was also a common theme which came through the “4 L’s” exercise, with gaps in provision in this area. Closer integration of mental health screening and services within the annual review process would be an important step in improving this.

It was recognised that there were limited resources for additional workforce to implement these improvements and so providing more information to patients so that they can assume responsibility for their own care plan was especially important. This could involve either giving patients hard copy of the information or and electronic solution.
Key Themes
- Involve patients in care planning
- Develop robust systems for completing care processes
- Improved access to specialist advice would be helpful
- Working more closely together across the healthcare system including with mental health services

Next Steps
Practices consider...
- Implement robust systems for patient call / recall
- Working towards collaborative annual review
- Changing template so care processes are mandatory fields

CCGs consider...
- Supporting practices to reduce variation in care process completion

SWL HCP
- Work with Mental Health team to integrate service
- SWL level solution for collaborative care planning

SWL HCP plans for care planning

The South West London team agree that collaborative care planning should be a priority for improving care for people with diabetes in South West London. We are applying for funding as part of the NHS Test Bed programme to test digital solutions for collaborative care planning in South West London, if successful a project will launch in October 2018.

Our plan is to give GP practices a way of sharing annual review results and care plans with patients electronically, and for patients to be able to share their care plans with clinicians they see in different care settings. This will bring those who care for people with diabetes closer together, and ensure that care plans are consistent across the health system.

We also have worked with our colleagues in South East London to develop a diabetes education hub for patients, which will enable a wider choice of courses to patients. We hope this will support primary care to give patients the information they need to manage their own condition.
Collaborative care planning

Working together

- Working with a DSN in a tier 2 clinic
- Kinesis advice
- In-house dietician

Data

- PRIMIS data extraction
- Support from diabetes specialist in data findings discussions with GP practices

Liked

- Tower Hamlets Year of Care approach
- Patient involvement in their management and care
- DXS being updated

Practice systems and processes

- Support and update of medication information
- Admin / HCAs taking organisational responsibility

When recall process worked well
Collaborative care planning

Most important to involve patients in planning for their care and treatment

Patients who attend DESMOND are more proactive in discussing targets

Ensure the patient is able to understand the relevance of the care processes prior to their appointment

Leased

Collaborative care planning (e.g. Year of Care) has worked well elsewhere

Need to educate family members to help their relative

Sitting in on expert clinics

Some surgeries are relying on Diabetes Specialist Nurses to manage their patients

Strong clinical leadership in Primary Care is key

Practice systems and processes

Deep dive / virtual clinics are an opportunity to develop a management plan and can avoid /delay referral to secondary care

When the Practice Nurse or GP involved with a patient has an interest in diabetes management is much better

GPs not acting on blood test results when HbA1c above target
Care processes and care planning

Collaborative care planning

Lacked

Not all patients want this if it becomes a box-ticking exercise.

Uniformity of approach to care planning between practices, and some practices lack care planning altogether.

A streamlined, segmental process.

Care plans from GPs

Clear pathways for patients if they have problems so they can be their own safety net.

Greater peer support offered for different patient groups.

Greater engagement with GP and practice nurses regarding care management.

Time constraints in seeing diabetic patients in clinic.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Care processes and care planning

Collaborative care planning

Lacked

Not all patients want this if it becomes a box-ticking exercise.

Uniformity of approach to care planning between practices, and some practices lack care planning altogether.

A streamlined, segmental process.

Care plans from GPs

Clear pathways for patients if they have problems so they can be their own safety net.

Greater peer support offered for different patient groups.

Greater engagement with GP and practice nurses regarding care management.

Time constraints in seeing diabetic patients in clinic.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Care plans shared between clinicians and patients, and primary and secondary care.

Clear pathways for patients if they have problems so they can be their own safety net.

Greater peer support offered for different patient groups.

Greater engagement with GP and practice nurses regarding care management.

Time constraints in seeing diabetic patients in clinic.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Time constraints in seeing diabetic patients in clinic.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.

Inadequate time in practice—15 minute slot often to cover a multitude of issues of new patients.
What you said

3 Achieving treatment targets

Start well, live well, age well
Achieving treatment targets

Group Discussion

The table discussion about treatment targets focussed on three themes identified from the post it notes of the “4 L’s” exercise.

Targets and benchmarking

The first theme discussed was around setting targets. The group felt targets should be set at every level including South West London level, CCG level, locality level, practice level and for patients. Targets for patients need to be individualised, recognising the complexity of each individual’s care.

For improvement, whether at practice level or for individuals to meet their targets, a supportive approach needs to be taken, including peer support which isn’t currently widely offered. Better support for carers is also needed.

Whole team approach

The group also discussed the roles different people can have in helping people with diabetes to achieve their treatment targets. It was recognised that not all GP’s are specialists, and that access to specialist advice would be helpful. It was felt there would be a great benefit to have more dietitians and podiatrists in primary care. It was felt that clinicians who are not specialised in diabetes would benefit from clear and simple guidelines on how to help patients achieve treatment targets.

Involving HCAs and reception staff more in the care of people with diabetes could be a helpful way of supporting people with diabetes further by using existing staffing resources.

The need to ensure we are aligning incentives and targets across the healthcare system was also highlighted. Supporting team working across organisations and care settings could be a key improvement.

Collaborative care planning

The benefits of engaging patients in their own care were also discussed. It was raised that had Wandsworth arranged workshops on motivational interviewing for primary care clinicians which was helpful to support this approach a few years ago but this was not followed up. It was agreed that care planning and/or motivational interviewing training being delivered collectively across South West London would be very helpful.
Key Themes

- Working together across teams and the healthcare system (including mentors and champions)
- Care model design—ensuring incentives are aligned across the system
- Personalised care planning
- Access to specialist advice and skills in primary care (including dietitians and podiatrists)
- Better access to patient education needed

Next Steps

Practices

- Use Diabetes UK Information Prescriptions
- Engage receptionists and HCAs in diabetes care
- Move towards collaborative care planning

CCGs

- Work with GP federations to set targets & align incentives
- Collaborative care planning training

SWL HCP

- Look at standardising training and competencies across SWL

SWL HCP plans for treatment targets

Using the National Diabetes Audit results from last year, the SWL team have been looking at the data around treatment targets, and are hoping to create a live dashboard to help practices monitor the treatment target achievement of their patients more easily.

The data can also be used to highlight variation across the CCGs and will allow CCGs to work with the practices in their area requiring the most help. If you would like to see your practice’s data and how it compares to other similar practices, please contact the team.

As mentioned previously, there is also a diabetes education hub for South London planning to launch in October 2018 which will enable better access for patients, and we are bidding for funding from NHS England to work on a digital solution for collaborative care planning.
Working together

- Hounding patients works
- Local Enhanced Service

Communication

- Recall individually based
- Inviting patients routinely on their birthday month and follow up through the year

Education

- Educate patients on the importance of self care
- Using Diabetes Champions to support communication

Information prescriptions

- Well organised regular diabetes reviews, booked in advance, blood test forms provided and reminder calls / texts

Guidelines and frameworks

- Good achievement in my practice
- DSN and Practice Nurse reviewing patient cases together
- PITSTOP guidelines huge help in target setting
- Ability to have patient specific targets on EMIS

QOF

- Diabetes Champions can encourage patients to look after their health
- Addition of ACR to QOF again
- Sutton CCG are looking after diabetes patients
- NICE guidelines and local version

Liked

- Using Diabetes Champions to support communication
- Kineses
- Diabetes Champions can encourage patients to look after their health
Achieving treatment targets

Personalisation and communication

- Being vigilant with results
- Better targets
- Translator / family member very important to improve education

Education

- Type 1 education course helped with self-treatment (needed to be within 1 year of diagnosis)

Learned

- Deep dive
- Coding should be standardised across Wandsworth (e.g. retinal screening)
- One stop shop for patients
- Routinely perform new patient check, paying attention to urinalysis

Coding and data

- Get the coding right (retinopathy)

Practice systems and processes

- PRIMIS is a good tool
- Involve as many staff as possible to call / recall if notice any alerts aren’t completed
- ACR pop-up on EMIS as a reminder

Targets need to be individualised and not ‘one size fits all’

Recall system in place and patient expectation of annual bloods and review

Patients need to have talks by lay people to allay fears

Need clinical buy-in to use tools like PRIMIS and a strong clinical champion
Achieving treatment targets

**Communication**
- Access to easy data e.g. PRIMIS
- For me to have greater knowledge about some aspects
- Communication of care processes from secondary care
- Options for onward referral for stopping smoking and exercise
- GP practice team approach to diabetes prevention and care
- Whole team approach

**Education and knowledge**
- More knowledge among primary care staff of the symptoms of diabetes
- Education of patient at diagnosis around targets – i.e. engaging patients early

**Lacked**
- Immediate access to expert advice
- Resources of time and money
- More administration support to help with patient recall
- Cross sector team / specialist approach
- Joined up approach to system redesign
- Communication of care processes from secondary care
- Access to easy data e.g. PRIMIS

**Workforce**
- Patient engagement—need to chase them when not acting on advice
- GPs not acting on high / abnormal results
- Clinician engagement in escalating treatment
- Whole team approach

**Working together**
- Options for patients to self-refer to further support
3 Achieving treatment targets

Working together

Education

- Standardised training for clinicians being available and easy to access
- DESMOND not limited to 1 year of diagnosis—do it when patient is ready to engage
- Better communication / clinic letters from secondary care

Workforce

- More effective recall system for patients not achieving treatment targets
- Better resources to educate patients that isn’t just one off like DESMOND
- Access to technology (e.g. flash glucose monitoring) to encourage better glucose control

Communication

- More time with patients
- To achieve better results on HbA1c, blood pressure, and cholesterol
- More involvement with patient

Personalisation

- MDT diabetes community clinic—Consultant / DSN—rapid access—local
- Clinics that include social support as well as physical i.e. benefits / housing
- More dietitians and Community DSNs
- More dietitians in Primary Care
- Patients owning and taking responsibility for their diabetes

Reasonable targets that are patient specific

- Shared responsibility and incentives across the system (e.g. localities)
- Designing of processes to better fit the roles and potential of HCAs in practices
- More time with patients
- More involvement with patient
- Better resources to educate patients that isn’t just one off like DESMOND
- Access to technology (e.g. flash glucose monitoring) to encourage better glucose control

- Achieving treatment targets

- Longed for
What you said

4 Practice and staff development

Start well, live well, age well
Group Discussion

Two key common themes emerged from the “4 L’s exercise” which the discussion focussed around.

Training

It was felt that there should be standardisation and minimum standards of training in diabetes across primary care. It was felt this should be for all levels of staff from receptionist to GP, and that this would assist practices in developing robust processes for people with diabetes, as all staff would understand why what they were doing was important.

It was also discussed that increased support for staff learning and development in diabetes was an important message that came through.

Working together

The other key theme that was discussed was access to specialist advice and guidance and working more closely together across the healthcare system. The use of KINESIS (technology allowing Primary Care clinicians to access advice from specialists via e-mail) was seen as important for this. It was also mentioned that there could be telephone contact at set times with secondary and community care.
Key Themes

- **Standardised training available to everyone is needed**
- **Some clinicians have had difficulty accessing diabetes training**
- **Peer learning and providing staff in primary care with access to specialist advice are valuable (e.g. Kinesis system or virtual clinics).**

Next Steps

**Practices**

- **Support staff of all levels to attend diabetes training**
- **Use new e-learning resource**

**CCGs**

- **Look into providing CCG wide training in diabetes**

**SWL HCP**

- **Work on standardising competencies and training for diabetes across SWL**

---

**SWL HCP plans for practice development**

As part of the funding for the diabetes education hub we are introducing with our colleagues from South East London, an e-learning resource for all staff working in diabetes. The resource is available now, so if you wish to arrange access for your practice please contact your CCG diabetes lead.

We have had successful projects working with podiatry teams and inpatient nursing teams which we now hope to develop to support primary care.

Our inpatient nursing project focussed on developing and retaining diabetes specialist nurses, an issue which we know affects some of the community teams in South West London. Therefore we have started looking at how we can support community teams in a similar way to solve some of the existing workforce issues, and ensure all practices have better access to their valuable support.

We have also secured funding for ‘pathfinder’ podiatrists at our hospitals, to help patients with diabetic foot conditions navigate to the right care setting. We hope that through this work we will be able to provide training and information to support clinicians in primary care manage the foot health of people with diabetes.
Training

Recognising that people who have just been diagnosed with diabetes have a psychological response too

Working with the patients we are not reaching but can reach

Funding time for education

Peer learning

Local meetings and training

Call and recall system in place

Kinesis

Deep dive

Practice systems and processes

Practice and staff development

Liked

E-learning for staff in Diabetes

Community Diabetes Specialist Nurse involvement in primary care

Diabetes Academy

Community DSNs Diabetes Academy Wandsworth

Learning to facilitate peer workshops

Attendance of GPs as well as Practice Nurses to DSN appointments to learn from each other

MERIT course

Easy to access and affordable e-learning

Good team work with receptionists and IT
Practice and staff development

Learned

Coding and data

- Standardised coding

- Coding and informatics

- Kinesis

Practice systems and processes

- Diabetes UK
  - Clinical Champions

- Record any events so they can be shared with people who can’t attend

- Practice learning team

Training

- I did the diabetes diploma (distance learning) with little support from practice

- Paying GPs for attending education improves engagement

- Important to include HCAs and nurses in the education programme

- Individualised care

Personalised care

- Personalised care

Practice and staff development

- Practice and staff development

- Making staff sure all planning is in place for the patient’s care and treatment

- Designated lead nurse and GP to plan and guide care

- Recognise that patients have knowledge as well

- Opportunistic appointments— if the patient is in to collect a prescription, get them seen if possible
Practice systems and processes

- GP referral to local Diabetes UK support groups
- Poor follow-up of housebound and mental health patients
- GLP-1 initiation incentive scheme

Lacked

- Support from other clinicians

Working together

- Box-ticking exercise with QOF
- Patient attendance

Workforce

- Appropriate admin support

Training

- Better learning for all levels on diabetes. Especially on psycho-social care
- Education for whole practice team (e.g. receptionists) to understand why important
- Training for new staff and HCAs for foot checks

- Regular updates and training sessions
- Took a long time to get funding for diabetes course
- Funding for training (e.g. diabetes diploma)

Protected time to do courses

- No financial incentive to attend courses (no pay rises for Practice Nurses)
Practice and staff development

**Working together**

- Monthly diabetes forum locally
- Biannual updates
- Virtual clinics in primary care
- More practice nurses
- More Community Diabetes Specialist Nurses

**Longed for**

- Consistent levels of care
- Protected time for development
- Diabetes diploma run by CCG
- Type 1 Workshops
- More emphasis on GPs ensuring they are up-to-date as it is for nurses
- Standardisation of workforce to patient ratio and depth of targeted support/capacity
- Working with community groups on education

**Workforce**

- Telephone links to DSNs in Secondary Care
- Monthly diabetes forum locally
- DSNs in Secondary Care
- Biannual updates
- More practice nurses
- More Community Diabetes Specialist Nurses
- Link health checks to avoid duplication (e.g., serious mental illness health check)
- All clinicians to get involved in diabetes care
- Virtual clinics in primary care
- More Community Diabetes Specialist Nurses

**Training**

- Yearly updates for all staff
- More funding for diabetes courses for both GPs and Practice Nurses
- Mandatory diabetes training
- National developed competencies for clinicians working in diabetes
- Need more Type 1 educators - DAFNE central to relax rules on training new DAFNE educators
- Funded and free online or face-to-face training that is standardised