iDEAL
Insights for Diabetes Excellence, Access and Learning

iDEAL Group Position Statement

Invigorating Diabetes Health Professional Education to meet Service and Individualised Needs

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The iDEAL Group is an independent multi-disciplinary panel of diabetes specialists with expertise that spans across diabetes management, medicine, pharmacy, dietetics, technology, nursing, health professional and patient education, psychology, commissioning and the perspective of living with diabetes. Their focus is to build consensus, network, research, share knowledge and collectively seek to make things better; both for practitioners working in partnership with and for people living with diabetes.

iDEAL recognises the need for responsive and effective HCP education, coupled with educated HCPs, to meet the increasing needs for diversity, specialism, cultural competence, advancing practice and person centredness in diabetes care delivery.

KEY MESSAGES

- Health Care Professionals (HCPs) are facing a monumental opportunity, using person centred care approaches and enablement through collaborative partnerships and team working, to promote effective self management and see the best results for People with Diabetes (PwD).
- HCP vitality and resilience can survive current changes and increased pressures within the NHS.
- Enablement to create a core competency framework for HCPs working in primary care and PCNs to establish and affirm currency and evidence for effective diabetes care delivery.
- Recognition of the vivacity of the work of HCPs in diabetes care can support engaging others to succession plan and build an informed and current diabetes workforce in every area of practice.
- Campaign to increase access, availability and Health Education England (HEE) funding to support HCP diabetes education for all HCPs; and ensuring the foundations of effective and current diabetes care being fundamental in every HCP pre-registration programme.
- Access to Continuous Professional Development (CPD) by various means such as taught modules, through publications, digital resources, apps and e-learning should be evidenced by every HCP working with PwD to maintain safety and currency.
- It is imperative for HCPs working with PwD, to possess and acknowledge that they have core proficiencies and competencies in diabetes care to promote individualised education.
- Even if the known workforce shortages are addressed, particularly in primary and community based care, HCPs must have the training evidenced to be competent in delivering clinically safe and cost effective care.
- To use evidence and intuition to ensure safe practice and promote succession planning to develop the HCP diabetes focused multidisciplinary workforce in an ever changing healthcare landscape.
- To recognise individualised care and respecting choice as fundamental by all HCPs in diabetes care.
- To focus on the need for cultural competence, respect and education in diversity to disintegrate barriers and reduce inequalities in accessing diabetes care for all PwD.
- To appreciate traditional role boundaries between HCPs in diabetes care and acknowledge the need to deconstruct potential barriers and improve access for PwD.

This Position Statement was prepared with the support of an unrestricted educational grant from Ascensia Diabetes Care

INTRODUCTION

This position paper emphasizes the need for constant evidence-based educational opportunities to be available and accessible, via a variety of means, to ensure health care practitioners (HCPs) can maintain currency and deliver evidence-based diabetes care wherever they practice. Enabling partnership approaches to deliver individualised care while working with people with diabetes (PwD). This echoes a key aim of the White Paper published by iDEAL on World Diabetes Day 2018 (Grumitt et al, 2018).

THE NEED

Self management of diabetes can be challenging, due to the characteristics of diabetes, the potential unpredictability and variation over the life span. Diabetes can be psychologically demanding and requires informed choices, knowledge, personal application and health literacy. We recognise the need for ongoing education based on individualism, confidence, motivation and potential behavioural change to maintain optimum diabetes self management for every PwD (Swanson & Maltinsky, 2019). At the same time, diabetes care is becoming increasingly complex, with escalating HCPs sub-specialising in their knowledge and care delivery, to meet the intensifying complex and diverse requirements of PwD (Riordan et al, 2019).

PROFICIENCIES

Recognition of the importance of diabetes self management education, as being a key determinant in treatment outcomes, knowledge growth and adjustment for PwD (Vandenbosch et al, 2018). It is imperative for HCPs working with PwD to possess and acknowledge that they have core proficiencies and competencies in diabetes care to promote individualised education. Developing HCP knowledge to understand their role with PwD is elementary. Core competencies have been established through various national and international organisations (International Diabetes Federation, (IDF), 2015, American Association of Diabetes Educators, 2016, Australian Diabetes Educators Association, 2017, TREND UK, 2019). All these offer some commonality in approach to the development of HCPs. In 2019, Diabetes UK further published a core education framework for Diabetes Specialist Nursing (DSNs), aiming to clarify the educational planning to succession plan for the development of DSNs in the future and reduce the current variations in practice. The need for succession planning is emphasised by key national advisory boards in the UK in Diabetes Nursing such as TREND UK, Diabetes UK and The Welsh Academy of Nurses in Diabetes (WAND), and in Medicine by The Association of British Clinical Diabetologists (ABCD) and The Primary Care Diabetes Society (PCDS).

The Kings Fund (2018) recognised that the NHS has a lower than average number of staff for all professional groups. Shortages are apparent especially in general practice who are struggling to recruit and retain doctors. Allied HCPs and Nurses are rapidly developing their roles and removing traditional role boundaries. King et al (2019) recognise that each professional will bring a different perspective to their role in diabetes care, however, there are no recognised distinctions between HCPs from different professional backgrounds nor are there articulated differences in their scope of practice. Perceived role barriers can and do exist, however, apart from levels of prescribing rights and requiring recognised university education and registration to prescribe (Association for Prescribers, UK), there are no legislative boundaries between nursing and allied health practice in any aspect of diabetes management (King et al, 2019).

The increasing reliance on unregistered HCPs, especially in primary care, does require clear core proficiency and competency frameworks for safety and access to informed education for unregistered HCPs when working with PwD (Royal College of Nursing (RCN), 2019, TREND UK, 2019). Over reliance on unregistered HCPs with little or no access to ongoing diabetes education raises safety and quality of care concerns regarding information giving and knowledge gain for PwD. Therefore, access to ongoing learning and support is essential for safe care delivery for increasing numbers of Health Care Assistants and Assistant Practitioners (RCN, 2019). An example of this is Ruth Miller's Diabetes 10-Point Training Programme, endorsed by Diabetes UK.

ACCESS TO CPD

Building strong networks of engaged, active HCPs participating in continued professional development (CPD) across the health service lies at the heart of the educational practice. It is the essential link between transformative, reflective learning (Gardner, 2014); this is also core in revalidation for safety in practice, but can reduce HCPs' autonomy in practice and increase organisational accountability (Tazzyman et al, 2019, Fisher et al, 2019). However, restricted study leave and reliance on HCPs using their annual leave for their ongoing CPD does present significant challenges. The decision by Health Education England in April 2016 to streamline funded CPD activities for HCPs, other than in medicine, has caused difficulty for ongoing CPD access for many HCPs across England. Greatbatch (2016) on behalf of the Council of Deans of Health suggested that despite the NHS Five Year Forward View (NHS England, 2014) announcing the need for an educated workforce to deliver optimum care, this cannot become a reality without access to CPD to create the right skills, values and behaviours of an educated workforce to deliver effective care.

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Not investing in HCP education prevents ideal clinical practice being delivered with PwD, at a time when this requires optimisation. NHS England and GIRFT (2019) both demonstrate considerable variations in the delivery of diabetes care across CCGs in England, however also promote areas of good practice for other HCPs to model themselves on in their service improvement, especially with the advent of Primary Care Networks (PCNs).

ROLE DEVELOPMENT

In the UK, advice and guidance for generalised diabetes practice have been developed and published for hospital based pharmacists (UK Clinical Pharmacy Association, (UKCPA), 2018), and podiatrists (SLWG, 2019). A framework is being created currently for dietitians and will be published in the near future. Other HCPs, for example GPs, and psychologists are acknowledged in special interest groups and societies (PCDS), to support knowledge development and 'transferable skills' (The British Psychological Society, 2019) and availability of e-learning (RCGP, 2019).

Diabetes UK (2014) previously published their position statement regarding the recognition and need for 'core competencies' for every HCP working with PwD in response to The Francis Report (2013),with the need for all HCPs in either generalist or specialist practice to be able to demonstrate their knowledge and competency in safe practice. This is fundamental in succession planning for the next generation of diabetes aware HCPs to meet the growing needs and prevalence of PwD in the UK (TREND-UK, 2019, WAND, 2019, Scottish Public Health Observatory, (SCOTPHO), 2018, Northern Ireland Audit Office, 2018, DSN Forum).

PERSON CENTRED CARE AND RESPECTING CHOICE

Hudon et al (2012) described 'self-determination theory' as one of the key elements relating to person centred care. This represents eliciting and acknowledging an individual's perspectives and information giving in an individualised way, offering treatment options, avoiding medical control over each individual's decision making and recognising individual choice. An educated HCP can go beyond the delivery of diabetes care. They can facilitate the development of other HCPs to deliver excellent, informed, individualised diabetes care. This makes the real difference to individual personal experiences and develops abilities of HCPs, in particular by enabling practitioners to grow within their roles, supported by access to CPD.

Historically, preparation of educators focused more on teaching them the facts about diabetes rather than emphasising the principles of person centredness and choice (Dickinson et al, 2019). HCPs who offer education to PwD require a blend of art and science in diabetes care along with humility. Effective practice relates as much to the humanity of the HCP as it does to his/her technological knowledge or expertise. At the heart of the therapeutic relationship is person centred communication and the HCP's ability to fully engage with each individual and his/her needs (Phillips & Yates, 2017). Furthermore, Greenhalgh and Heath (2010) reported for The Kings Fund about the unique value of the therapeutic relationship, especially with practice nurses and PwD receiving care.

The dimension of appreciating the unique role practitioners have in diabetes care, whether working in generalist or specialist practice, where intuitive reason and appreciation of the individual within a consultation can often count for more than any conversation shared. The art of diabetes care can be articulated through recognising and appreciating the unique and unassuming role of practice nurses. As Fitzpatrick (2016) recognised, the therapeutic relationship formed 'oils the wheels' and facilitates any therapeutic intervention. The evolution of the practice nurse's role in diabetes care has been fundamental as practice nurses do work with the majority of people with type 2 diabetes and some with type 1. The distinctiveness and responsibilities of the role of practice nurses must be acknowledged, along with reason and intuition. Precision in practice, which is current, evidence-based and delivered in partnership reflecting 'making every contact count' (PHE England, NHS England, Health Education England, 2016), is efficient, effective and indubitably fiscally responsible.

MacDonald et al (2013) undertook an ethnographic survey of practice nurse consultations with people with type 2 diabetes. Their results illustrated that inexperienced practice nurses have a tendency to be checklist driven to meet all the criteria required within a diabetes consultation. More experienced practice nurses can more readily apply discernment and intuitive self reflectivity into their practice, which changes the focus of the consultation. Furthermore, PwD reported that the approach to promote self management and discuss their diabetes trajectory was very different and very welcome, as opposed to the usual problem-solving medical model (Silverman, Kurtz and Draper, 2013).

However, MacDonald et al's (2013) study suggested that discord between the HCP and PwD experience in diabetes consultations remains. Sharing good practice and evidence can motivate HCPs within their partnership working in diabetes care. However, recognition also of the needs of HCPs, who are isolated or who cannot attend CPD or diabetes updates, can be challenging to delivery of evidence-based currency in diabetes care. This is where digital access to online communities and education solutions can be useful.

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ROLE DIVERSITY

Diabetes teams are interdisciplinary which Engel and Prentice (2013) indicated can cause challenges to the delivery of person centred care. Even though each HCP in the team, might wholeheartedly agree with the general concept of person-centeredness; it calls back to an ethical narrative that is created by both the HCP and the PwD. Reeves (2012) suggested that the aims of care between HCPs and PwD, might create difficulties if 'common ground' (Stewart et al, 2013; Brown, Thornton and Stewart, 2011), and choice are not included as core in the care equation. This can cause misunderstandings about the complexity of diabetes treatment aims (MacDonald et al, 2013). As illustrated in Winkley et al's (2016) study, this can translate in the most needful of people not accessing the right care at the right time to promote their diabetes knowledge and self-management skills.

Delivery of individualised care and respecting the 'whole person' assumes that PwD are generally autonomous, therefore are equally capable of making their own decisions. A culture of caring and compassion is at the core of practice. This means sharing person-to-person communication that venerates and involves profound respect and concern for the unique humanity of each person the HCP works in partnership with (Phillips, 2013). An effective relationship between HCPs and PwD can be described as a relationship of trust, mutual respect and a therapeutic alliance. Reaching out to ensure diabetes care meets the needs of PwD with learning disabilities, (Smith & Phillips, 2018), PwD living with severe mental ill health (Taylor et al, 2019) and those who are experiencing social isolation or deprivation (Everest and Phillips, 2015) is essential.

Professional detachment can be coupled with a bond of commitment and understanding of the therapeutic relationship within diabetes care. Blame or judgments have no place in this relationship as communication barriers, whether perceived or actual, could be readily, if not intentionally, imposed on PwD (Language Matters, 2018). Failing to do this can create a relationship of mistrust or blame and can engender a lack of engagement (Speight et al, 2012, Language Matters, 2018). Therefore, careful and considered choice of the language used to describe a situation is valuable to alleviate this.

ENABLING A LEARNING ENVIRONMENT

HCPs in diabetes care can stimulate peer and student learner engagement in order to build learner enablement in succession planning (Christenson, Reschly and Wylie, 2012). This means investing in productive learning environments suited to learners' needs, in order to build HCPs' self efficacy and resilience in diabetes care provision for their future, and thus allowing less experienced HCPs to transform themselves, transform their practice and enhance their diabetes service delivery. This also accords to the changing needs of the practice environment. Pre-registration education for all HCPs is core to establishing person centred diabetes care approaches in HCPs and this is where initial knowledge, attitude and education about diabetes is established.

Developing HCPs can uncover their tacit knowledge and can be used to articulate the expert knowledge that experienced HCPs use. This is often difficult to enunciate other than HCPs 'just knowing' or using their 'sixth sense' in consultations. Furthermore, Pearson (2013) proposed that intuition is decision-making that is not based on scientific or evidence-based knowledge but relies more on an individual's discernment of the situation or consultation.

Giving the most current, effective, efficacious and appropriate advice to PwD enables the optimum delivery of diabetes care that HCPs should strive to deliver. Dowell et al (2018) in their longitudinal study of consultations with newly diagnosed PwD, highlighted the use of language to promote understanding differed between inexperienced and experienced HCPs, with checklist and technical language being applied far more frequently by inexperienced HCPs. A contentious element is that some HCPs who follow checklist type diabetes care can miss the nuances and potential needs of each individual. As such, treatment choices offered can be limited by inexperience, usual prescribing habits, pharmaceutical influence or familiarity of the practitioner. Krautscheid (2014) suggested that HCPs must be held to account if minimal practitioner education and failure to maintain current practice affects the delivery of optimum care with PwD.

Murrells et al (2013) suggested that there is a wide variation in accessibility to ongoing education and CPD for practitioners within diabetes care. Their conclusions are that access to up-to-date HCP education to target key issues in diabetes care is inconsistent. An example of this need is foot assessments for PwD, to prevent unavoidable and unnecessary amputations (Boulton, 2015, Phillips and Mehl, 2015, Edmonds, 2019). Up-to-date information is paramount to escalate care accordingly and help prevent complications occurring unnecessarily. This will be highlighted in an accompanying position statement about foot care for PwD by Edmonds et al (2019) for iDEAL.

Diabetes care can be delivered reactively rather than proactively, resulting in, as Zafar et al (2014), Barnett and Grice (2016) and Edmonds, (2019) identified, clinical inertia in timely treatment escalation, resulting in far too many unnecessary vascular and neuropathic complications. This is where community pharmacists have a key role in treatment escalation and early referral for PwD (Hughes et al, 2017). The substantial cost of avoidable complications to a financially austere NHS is considerable, with 80% of all funding allocated to treat avoidable complications (Hex et al, 2012, Baxter et al, 2016). The cost savings for modest improvements in risk factor reduction are substantial. When we have an NHS which is experiencing acute financial pressures, any financial savings from timely interventions seems practical. Additionally, accessible education for HCPs to enable them to deliver fiscally responsible care to meet individual needs is fundamental.

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Davis (2015) suggested that understanding of how diabetes weaves into the complexity of an individual's life is crucial to optimise self-management, in addition to the recognition of factors that might impede this. These may include health literacy, the experience of co-morbidities, employment/unemployment, psychological consequences of diabetes and, potentially, the age and cultural beliefs of the PwD. Understanding of these influences is a core skill of diabetes-aware HCPs and one that is also gained with working with PwD and through CPD.

CULTURAL COMPETENCE

Fourteen per cent of the UK population are identified as being from a minority background (Goff, 2019). Self-management education and engagement with HCPs can be less effective in PwD from non-white ethnic backgrounds (Creamer et al, 2016). This is often attributed to a lack of cultural competency amongst HCPs and a failure to account for cultural beliefs and practices in generic education programmes as recognised in a recent Cochrane Reviews by both Creamer et al, (2016) and Hovart et al (2014). Culturally tailored advice and education programmes that are respectful of and responsive to the health beliefs, practices, linguistic needs and culture of PwD from diverse communities are required (Creamer et al, 2016), as a principal way to reduce inequalities in diabetes care (Office of Minority Health, 2019). Furthermore, Attridge et al, (2014) suggested that diabetes care for PwD, that has been culturally tailored or is culturally appropriate can bring significant greater improvements in risk factor reduction, diabetes knowledge and self-efficacy. McGregor et al's (2019) work in the US demonstrates the growing appreciation for the need to have a culturally competent HCP workforce.

SUMMARY

The nature of diabetes care delivery and the need for growth in accessible diabetes HCP education for both generalist and specialist practice is vital. Educated HCPs enable knowledgeable PwD, so each is mutually inclusive to each other. This position statement has highlighted the key themes for consideration as detailed in the key messages.

KEY SUGGESTIONS FOR PRACTICE

For all HCPs at every level working in all areas of clinical practice, who work with PwD, to have a competency/proficiency education programme from induction that is recorded and can be evidenced for annual performance and revalidation purposes. The aim of this is to reduce variation in care delivery and raise standards of care received by PwD as highlighted by iDEAL Diabetes and Grumitt et al (2018).

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