APPROACHES TO DIABETES HEALTH PROFESSIONAL EDUCATION IN ENGLAND

A report from the Diabetes UK Healthcare Professional Education Task and Finish Group

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Introduction

This survey was undertaken at a time of substantial infrastructure change in the NHS, with the formation of Clinical Commissioning Groups where ‘front-line’ clinicians take on the strategic, leadership and managerial roles in the commissioning (purchasing) of services for patients.

Diabetes is a significant health concern, both in the UK and globally. In 2010/11 UK NHS spending on diabetes was estimated at nearly £10 billion – 10 per cent of the NHS budget. £1bn for Type 1 diabetes and £8.8bn for Type 2. Eighty per cent of NHS spending on diabetes goes into managing avoidable complications\(^1\). Better management of diabetes has great potential to reduce these costs and improve the care provided to people with diabetes.

Management of care can be complex, often requiring high levels of knowledge and skills in order to provide high quality and safe care. The provision of good, safe, quality care lies within the foundations of healthcare education, continuing professional development and evidence-based practice, which are inseparable and part of a continuum during the career of any health care practitioner. Sound education provides the launch pad for effective clinical management and positive patient experiences.

However, both the standard and standardisation of education and training in diabetes management remain a matter of concern. The varying standard of diabetes knowledge and practices across the NHS has a direct bearing on patient safety and well-being. Diabetes UK has had a Diabetes Health Professional Education working group for some time and identified that it was unclear how a framework to optimise diabetes skills and knowledge would be commissioned in the future.

The Cambridge Diabetes Education Programme, a Cambridgeshire and Peterborough HIEC funded initiative therefore agreed to undertake a survey to elicit the current perspectives of Clinical Commissioning Groups on diabetes health professional education. These data have then been used to provide a series of recommendations which promote high quality health professional education that, in part, significantly address on-going concerns of patient safety and well-being.

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Background

From April 2013, NHS England has taken on many of the functions of the former primary care trusts (PCTs) with regard to the commissioning of primary care health services, as well as some nationally-based functions previously undertaken by the Department of Health.

The new arrangements comprise a single operating model, using the £12.6bn the NHS spends on commissioning primary care. Through this new system, NHS England plans to develop the future strategy for primary care. The intended benefits include:

- Greater consistency and fairness in access and provision for patients, with an end to unjustifiable variations in services and a reduction in health inequalities;
- Better health outcomes for patients as primary care clinicians are empowered to focus on delivering high quality, clinically-effective, evidence-based services; and
- Greater efficiencies in the delivery of primary care health services through the introduction of standardised frameworks and operating procedures.\(^\text{2}\)

What are Clinical Commissioning Groups (CCGs)?

From April 2013, Clinical Commissioning Group Boards (groups of local GPs supported by managers, one nurse and one secondary care consultant from another area) have become responsible for the planning, design and commissioning of local health services in their catchment areas across England. The health and care services ‘bought’ include:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

Commissioning involves a range of functions, including assessing the health needs of a population, taking responsibility for ensuring that appropriate services are available to meet those needs and being accountable for the associated health results. Clinical Commissioning transfers these responsibilities to the GPs in the area.

To do this Clinical Commissioning Groups work with patients and health and social care organisations (e.g. local hospitals, local authorities, local community groups) to ensure services meet local needs. All GPs in England have to belong to a Clinical Commissioning Group.

Who are Clinical Commissioning Groups accountable too?

NHS England is the new body that will make sure Clinical Commissioning Groups meet their

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financial responsibilities, and have the capacity and capability to successfully commission services for their local population.

As well as overseeing Clinical Commissioning Groups, NHS England will commission some services itself. These are:

- General Practice
- Pharmacy
- Dentists
- Specialist services (i.e. those required by a limited number of people)

At a local level, Health and Wellbeing Boards have been set up in Local Authorities to ensure that Clinical Commissioning Groups meet the needs of local people. Health and Wellbeing Boards will bring together clinical commissioning groups and the local councils to understand the health, social and wellbeing needs of their community.

The underlying purpose is to use allocated public funding to buy health services that meet the needs of the population. CCGs must seek to improve the quality of services provided, and the experience of patients when using those services. Most importantly they must improve the health outcomes for patients within the financial constraints set by their budget (defined by a population based formula and legacy costs and debt).

To achieve this aim, CCGs are tasked to work in a new way that focuses on patients’ needs, is led by clinical commissioners and develops partnerships between patients, health care providers, social care, voluntary services and commissioners.

**Relevance of health professional education to CCGs**

Beyond the desire to maximise the quality of care through optimally trained staff, demonstration of health professional education is also of importance within the commissioning process. As CCGs strive to improve care within their budget, some services will be procured through a competitive process. Potentially, all services are open to competition by any qualified provider. Definition of any qualified provider is loose, however primary, community and secondary care staff will need to show that they have the knowledge and skills to deliver the service. Certification and credentialing of health professional education would help to demonstrate that staff are qualified and competent.

The attitude to health professional education in diabetes should therefore be of prime concern to CCGs, where they intend to enhance the care of those with diabetes either currently or in the future.
**Methodology**

The survey was conducted using an online questionnaire. A letter of introduction to the CCGs can be found in appendix 1. A database supplied by the NHS Commissioning Board\(^3\) was used as a baseline for the contact data with two hundred and nine English CCGs identified. This database was updated and email/telephone calls were made to every CCG to elicit the most appropriate clinical lead for correspondence.

An initial invitation and two follow up reminder emails were issued to every CCG with a closing date for submission. The survey was undertaken during the period April – mid June 2013.

**Return Rate**

A concerted attempt was made to elicit the most appropriate person (i.e. clinical lead) to contact in each CCG, in some instances the survey was directed to a general enquiry mailbox or to an online submission form; in a few instances the recommended email did not function. A conservative estimate to be used for the denominator in calculating the true response rate could be set at two hundred, with 86 responses yielding a response rate of 43%.

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\(^3\) The outline database supplied the most up to date information on the CCG website (see [http://www.england.nhs.uk/ccg-details/](http://www.england.nhs.uk/ccg-details/))
Findings

The findings cover four basic elements concerning diabetes education, namely policy, allocation of time (protected time), funding and evaluation. A fifth aspect provided the opportunity for respondents to provide general feedback on any aspect relating to the commissioning of diabetes education.

Policy on diabetes education

Two out of three CCGs do not have a formal (written) policy on diabetes education (see table 1).

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<td>Yes</td>
<td>28</td>
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3 responders did not specify

Allocation of time to undertake education, training and development

CCGs were asked if they specifically funded time to participate in diabetes related health professional educational events. Just over half the CCGs (56%) affirmed this (see table 2).

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<td>Yes</td>
<td>48</td>
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<td>No</td>
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1 responder did not specify

If the answer was yes to this question, CCGs were then asked for which groups this decision applied. Figure 1 shows that doctors and nurses remain the prominent beneficiaries of this decision; it is positive to note however that health care assistants nevertheless feature in this picture (54% of CCGs).

Figure 1 Funded time x staff groups

| If yes, for which staff groups does this opportunity apply (tick one or more)? |
|-----------------------------|---|
| Doctors                     | 98% (47) |
| Nurses                      | 96% (46) |
| Health care assistants      | 54% (26) |
| Dietitians                  | 25% (12) |
| Podiatrists                 | 27% (13) |
| Other                       | 17% (8) |

* 48 total responses, 36% of submissions
**Allocation of funding**

CCGs were then asked if they allocated specific funds to diabetes education for health professionals. Table three below shows that six out of ten CCGs do not fund such activity.

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<td>No</td>
<td>50</td>
<td>60</td>
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2 responders did not specify

**Allocation of funding and type of event**

If the answer was yes to this question, these CCGs were then asked for which groups this decision applied. Figure two shows that organised funded events were heavily favoured (n=32), individual health profession payments (n=20) and ten CCGs opting for contracted-out events.

**Evaluation of effectiveness**

CCGs were asked if they evaluated the effectiveness of their activities in diabetes education for health professionals; approximately four out of ten CCGs carry out some form of evaluation (see table 4).

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<td>42</td>
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<td>No</td>
<td>48</td>
<td>58</td>
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3 responders did not specify
General comments
CCGs were provided with the opportunity of giving feedback on any aspect of diabetes education for health professionals. These comments have been grouped into five main headings namely, strategy, standards, funding, provision and ‘position statements’. In this last category there are three sub-divisions: interest, operational issues and challenges.

Note: For cross reference a full citing of all comments can be found in appendix 2.

Strategy
It was clear that there exists a spectrum of preparedness by CCGs for the tasks in hand; to this end, many CCGs stated that they were in the process of developing a strategy for education.

‘The CCG have an integrated diabetes steering group which brings together multiple agencies and CCGs to review diabetes care. This steering group has formed a specific education and training working group which is currently developing a strategy for structured education for health care professionals. Key areas being reviewed to inform the strategy are the currently levels of training, the minimum training requirements to provide the level of care required and how the training levels will be increased, where appropriate, to meet the minimum standards.’

Many CCGs saw their role purely as commissioning whereby an ‘envelope’ of funding was agreed in which the providers would apportion (in the most appropriate way) some part of this overall funding to education; in a similar vein, some CCGs noted that they would look for it to be written in to a service specification of a provider. This ‘strategic’ position was summed up succinctly by one CCG:

‘CCGs don’t provide services and therefore wouldn’t provide training for health professionals. Commissioners specify the standards of provision that are expected from their providers within contracts they hold with an expectation that the providers would train their staff accordingly. Monitoring of outcome and process measures allow commissioners to ensure service standards are in line with those specified. Payments made to providers are implicit of the necessary cost associated with ensuring staff are suitably trained to deliver high-quality care’

One CCG noted the critical link between strategy and operational purpose:

‘We need to reduce variation and the CCG’s need to be proactive in developing the education strategy and funding protected time.’

Standards
The importance of having a standard of education and ensuring this standard is met was comprehensively described:
‘Diabetes, particularly type 2 should be part of the core competencies of all primary care. There should be an annual appraisal of the services offered and the provision delivered. The outcomes should be assessed and where the outcomes are not up to standard either more education is offered or contract withdrawn.’

Alongside the setting of standards, one CCG noted the value of having some form of standardisation of provision:

‘Standardisation would be the ideal across the UK and may help reduce the variation of care for people with diabetes’;

‘I would like to see competencies set for Practice Nurses in a number of LTC's including diabetes with primary care responsible for ensuring that these are met’.

**Funding**

Many CCGs noted that funding was available but at this stage it was a general ‘pot’ from which many topics would have a legitimate call,

‘we fund protected learning time for our member practices to meet together. These meetings will consider all clinical topics we do not target any particular condition’

Other comments did highlight specific funding for diabetes education

‘diabetes is high on our priority list with funding for courses, diploma's etc. from general education funding rather than specific diabetes education funding’;

‘This education is funded as an Enhanced service so available to practices who have signed up to do this’;

‘At present our funding for diabetes is being channelled through the networks but the need for individual funding is being reviewed’.

**Provision**

There is clearly a lot of planning activity around the provision element in relation to diabetes education for health professionals:

‘Currently no organised provision of structured education to HCPs, but we are in the process of implementing a new integrated diabetes service, which includes this’;

‘About every 2 years we have a protected learning time event for Drs and nurses about diabetes, with a plan to keep them up to date with developments. This will include medications, foot care, dietary issues etc’

‘for the last year we have run a series of Diabetes Master classes for local primary care professionals in our areas in partnership with our local secondary care trust and the pharmaceutical industry - 4x afternoons per year - free for staff to attend but we do not fund backfill into their practice’;
Position statements
As noted above, these statements have been grouped into three areas namely interest, operational issues and challenges.

A. Interest
There is considerable interest in diabetes education in the CCGs – the critical nature of education was summed up by one CCG:

‘Absolutely essential to provide education to HCPs or the tidal wave of diabetes related disease just can’t be tackled in the modern NHS’
‘we are in the development phase for much of the above and would welcome support’
‘At present there is no formalized education programme at all for diabetes and so any DM UK support would be very useful’

On the specific element of elearning:
‘The CCG is currently undertaking a review of diabetes services. As part of this review HCP diabetes education will be looked at. Online education has many advantages and we would welcome any developments in this area’.
‘There is need for much more diabetes education for all staff groups via e-learning, accredited courses and update sessions, but not always the time and capacity in CCGs to deliver. Any national support would be very welcome.’

B. Operational issues
Comments on operational issues were in essence a reflection on the state of general preparedness of the CCGs:

‘We are in the process of reviewing all Diabetes training and will work with the …. Local Implementation Team to ensure we implement this’;
‘CCG has not formally adopted the existing PCT policies so technical answer to Q1 is no although there has been a policy- now due for review’;
‘We are about to address all of these in a new diabetes LES, participation in which will require engagement in designated training. We still have to define what the designated training should be including who for’;
‘The CCGs have only been in place a month and the issue of training strategies and policy is currently being looked at’.

Education was operationalised through a contractual basis:
‘education is core specification in contract for DSNs locally’

C. Challenges
The challenges (and targets) that CCGs face within the early stages of operation are recognised:
‘Though we would like to be able to ring-fence ‘diabetes education’ the pressure on time, funding, clinical and administrative workload and lack of central NHSCB or DH funding for CCGs to ‘fund’ education means that - in the broad picture of the massive agenda which CCGs have been charged with, it is currently not possible to ‘ring fence’ diabetes education compared to other education needs across healthcare service workforce support

‘The CCG has to reduce referrals and acute admissions. Nothing else counts. Innovation is stifled by the crushing hand of the national commissioning board’

On prioritisation of activities, one CCG noted:

‘It is not one of CCG priorities at the moment’

On the challenge as to the specific nature of education:

‘educational activity has to be primary care focus and tailored made to individual practice . Otherwise it is unlikely to be effective. Since there is an increased emphasis on treating Type 2 diabetes in Primary care, Diabetes UK should campaign to make diabetes training compulsory for primary care’
**Recommendations**

The following recommendations are set within the context of significant NHS structural change and demands on CCGs. It is clear that there is a spectrum of preparedness (in relation to policy and strategy) across the two hundred plus organisations. It is also clear that there is significant interest in diabetes education and in the call for support.

**Strategic position**

Some CCGs take a ‘strict’ view in relation to their strategic role which could be summed up as “we commission, the providers provide”. This area of function is not simply one of semantics – it has a decisive impact on both policy and funding in diabetes education. The majority of respondents however were of the view that they could take a more active role in shaping both the nature and scope of diabetes education. Moreover, such pro-active CCGs realised that they had a leadership role to play in the promotion of diabetes education. Furthermore, CCGs do not commission primary care services and yet would be expected to have a policy on optimising primary care diabetes skills and knowledge to ensure that they can play their full role in any catchment-wide diabetes service framework.

**Opportunities exist to work and support these CCGs and NHS England; national diabetes organisations could take a lead role in this area. One of the key outputs from such support would be the emergence of statements by CCGs on policy with respect to diabetes education and of dedicated funding.**

**High quality provision of diabetes health professional education**

As one CCG noted that, in the face of a tidal wave of diabetes related disease, it was ‘absolutely essential’ to provide high quality diabetes education to health care professionals. Provision however is predicated on a number of key factors: existence (i.e. accredited, relevant educational programmes), availability (e.g. protected time) and opportunity (e.g. cost). Each of these factors in turn present significant challenges to individual CCGs.

**CCGs will require support in negotiating through the inter-related components of access, availability and opportunity for high quality diabetes health professional education.**

**Standards and standardisation of diabetes education**

Against this backdrop of provision, there is little national guidance on the implementation of standards and standardisation of diabetes education courses and programmes. There are varying standards of diabetes knowledge and practices across the NHS; this has a direct bearing on patient safety and well-being. There is as yet little or no guidance as to what constitutes a minimum standard in on-going education for health care professionals working in diabetic care. In the case of actual of standardisation, there are a series of peer reviewed
national competency frameworks already in operation e.g. a competency framework for nurses\(^4\), for dietitians\(^5\) and frontline staff and in podiatry\(^6\).

**National guidance is required as to a minimum standard of on-going education and to the adoption of a common approach to the implementation of competency frameworks in helping to standardise practice in education.**

**A common national framework for accreditation with endorsement of quality by Health Education England through the Local Education and Training Boards (LETBs) would allow the implementation of minimum standards in diabetes knowledge and skills across health service staff.**

**Educational mode of delivery**
Given the current state of flux in the NHS and the constraints on CCGs both in terms of opportunity cost (time) and access to funding, one solution lies in the promotion of elearning programmes.

**CCGs to be informed of the current availability of accredited diabetes elearning materials and programmes for health care professionals.**

**Dissemination**
It is recommended that there is widespread dissemination of this report to leading diabetes organisations and key stakeholders across the UK.


\(^5\) An Integrated Career and Competency Framework for Dietitians and Frontline Staff Diabetes UK 2011

\(^6\) Competency Framework for the prevention, treatment and management of diabetic foot disease The ‘Scottish Diabetes Foot Workforce Development Group 2012
References


Costing Care Pathways Understanding the cost of the diabetes care pathway: A briefing from ACCA and the Audit Commission. Audit Commission 2012

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Programme Budgeting Costing Methods, Department of Health, August 2010

Audit Commission Interpretation of Information and Data from Diabetes UK; Hospital Episode Statistics; Department of Health National Tariff; Department of Health NHS Atlas of Variation 2011

Prescribing for Diabetes in England: 2004/5 to 2009/10, The Health and Social Care Information Centre, July 2010
Acknowledgment

The authors would like to acknowledge the participation of clinical commissioning groups in this survey; the use of a DH dataset from the National Commissioning Board is also acknowledged.

A copy of this report will be sent to the respective clinical leads of the CCGs in due course.
Contact

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Dr Chris Loughlan
Director
Cambridge Institute for Research, Education and Management (CiREM)
Email: christopher@cirem.co.uk
Email invitation
To: Clinical Commissioning Groups (England)

Dear colleague,

**Review of diabetes education**
Diabetes UK is supporting the development of online educational materials for health care practitioners in primary and community service provision. These materials are comprehensive in nature and aimed to be of relevance to the unregistered health care assistant through to medical staff.

As part of this development, we are undertaking a brief review of education, training and development in diabetes management provided by clinical commissioning groups.

There are five questions in total; the survey is being administered online and can be accessed by clicking on the following link: [https://adobeformscentral.com/?f=KAPfntTiGq09iQt55QNfrQ](https://adobeformscentral.com/?f=KAPfntTiGq09iQt55QNfrQ)

All responses are anonymised and the final report will only detail aggregated findings. The final report will be sent out to all participating clinical commissioning groups when complete.

If you would like further information on this survey, please contact the programme manager:
Dr Chris Loughlan ([christopher@cirem.co.uk](mailto:christopher@cirem.co.uk))

Thanking you in anticipation.

**Dr David Simmons**
*Consultant*
Chair: Diabetes UK Health Profession Education Working Group
Appendix 2

General Comments

Note: these are unabridged comments from CCGs; all comments were automatically anonymised.

We are trying to formalise training as much as possible to link it to an accreditation process. We commission diabetes care, providers will be funding the education and development of their staff within their funding envelopes.

The CCG have an integrated diabetes steering group which brings together multiple agencies and CCGs to review diabetes care. This steering group has formed a specific education and training working group which is currently developing a strategy for structured education for health care professionals. Key areas being reviewed to inform the strategy are the currently levels of training, the minimum training requirements to provide the level of care required and how the training levels will be increased, where appropriate, to meet the minimum standards.

CCG is very young and has not developed policies for education of health professionals on ANY topic not just diabetes.

Diabetes particularly type 2 should be part of the core competencies of all primary care. There should be an annual appraisal of the services offered and the provision delivered. The outcomes should be assessed and where the outcomes are not up to standard either more education is offered or contract withdrawn.

Please note while the CCG does not yet have a specific policy on diabetes education and training the CCG is in process of developing an overall training and education strategy that will involve practice input.

Difficult to pitch it right for different professionals with diff levels of skill.

We are trying to pull together a Diabetes Program budget which would help facilitate education.

CCG do organise education events for GP's and Nurses but request the practices fund these themselves. Our Community Diabetes Service also provides Warwick training for XX GP's/PN's.

Educational funding available but not specifically for diabetes although it can be used for this.

There is need for much more diabetes education for all staff groups via e-learning, accredited courses and update sessions, but not always the time and capacity in CCGs to deliver. Any national support would be very welcome.

Though we would like to be able to ring-fence diabetes education the pressure on time,
funding, clinical and administrative workload and lack of central NHSCB or DH funding for CCGs to 'fund' education means that - in the broad picture of the massive agenda which CCGs have been charged with, it is currently not possible to ring fence diabetes education compared to other education needs across healthcare service workforce support.

*Diabetes education is one element of the CCG strategy for and commitment to professional education for which protected time is agreed and for which resources are made available.*  
*Diabetes is high on our priority list with funding for courses, diplomas etc from general education funding rather than specific diabetes education funding.*

we are currently developing education program for HCA and NURSES  
The more education the better the service will be.  
we need to reduce variation and the ccg's need to be proactive in developing the education strategy and funding protected time

*Provision of education is primarily a provider responsibility. This CCG dies provide education around QIPP priorities. We may well part-support diabetes education in the future*

We are in the development phase for much of the above and would welcome support  
It is not one of CCG priorities at the moment

*The CCG has to reduce referrals and acute admissions. Nothing else counts. Innovation is stifled by the crushing hand of the national commissioning board.*  
*We are in the process of reviewing all Diabetes training and will work with the Guildford and Waverley Local Implementation Team to ensure we implement this.*

Absolutely essential to provide education to HCPs or the tidal wave of diabetes related disease just can't be tackled in the modern NHS.  
At present there is no formalised education programme at all for diabetes and so any DM UK support would be very useful.  
Currently no organised provision of structured education to HCPs, but we are in the process of implementing a new integrated diabetes service, which includes this.

*About every 2 years we have a protected learning time event for Drs and nurses about diabetes, with a plan to keep them up to date with developments. This will include medications, foot care, dietary issues etc.*

Standardisation would be the ideal across the UK and may help reduce the variation of care for people with diabetes.

*This education is funded as an Enhanced service so available to practices who have signed up to do this.*  
*The CCG is currently undertaking a review of diabetes services. As part of this review HCP*
diabetes education will be looked at. Online education has many advantages and we would welcome any developments in this area.

I would like to see competencies set for Practice Nurses in a number of LTC’s including diabetes with primary care responsible for ensuring that these are met.

Educational activity has to be primary care focus and tailor made to individual practice. Otherwise it is unlikely to be effective. Since there is an increased emphasis on treating Type 2 diabetes in Primary care Diabetes UK should campaign to make diabetes training compulsory for primary care.

CCGs don’t provide services and therefore wouldn’t provide training for health professionals. Commissioners specify the standards of provision that are expected from their providers within contracts they hold with an expectation that the providers would train their staff accordingly. Monitoring of outcome and process measures allow commissioners to ensure service standards are in line with those specified. Payments made to providers are implicit of the necessary cost associated with ensuring staff are suitably trained to deliver high-quality care.

Written into service spec of Community Provider.

We need to develop a more coherent strategy.

Education is core specification in contract for DSNs locally.

At present our funding for diabetes is being channelled through the networks but the need for individual funding is being reviewed.

CCG has not formally adopted the existing PCT policies so technical answer to Q1 is no although there has been a policy- now due for review.

We are about to address all of these in a new diabetes LES, participation in which will require engagement in designated training. We still have to define what the designated training should be including who for.

The CCGs have only been in place a month and the issue of training strategies and policy is currently being looked at.

Re Q1 we are currently developing a policy and making sure out diabetes education is more structured than it was under the PCT.

For the last year we have run a series of Diabetes Master Classes for local primary care professionals in our areas in partnership without local secondary care trust and the pharmaceutical industry - 4x afternoons per year - free for staff to attend but we do not fund backfill into their practice.

We fund protected learning time for our member practices to meet together. These meetings will consider all clinical topics we do not target any particular condition.

Looking to develop education strategy with neighbouring CCG and trust hospital.