Workforce Matters
A guide to role redesign in diabetes care
Workforce Matters is a series of publications on role redesign. Other titles currently in this series include: A good practice guide to role redesign in primary care and a guide to role redesign for staff in the wider healthcare team. Other titles will be added to this series in the near future. If you would like to be kept informed of new titles please email effie.stevenson@doh.gsi.gov.uk

2002
First is the experience of people with diabetes themselves. Time and time again when we ask people what is wrong with their service they complain about the confusion created by the ‘procession of faces’

“I sometimes find the advice given at the hospital clinic differs from that given by the diabetes nurse attached to the hospital. This again sometimes differs from advice given by my doctor’s practice diabetes nurse. It is clear that different people do things in different ways but when advice is not consistent this can be problematic.”

Second is the epidemiology. Estimates vary but no-one disputes that we are facing a huge increase in the number of people diagnosed with Type 2 diabetes. Unless we do things differently services simply won’t cope.

Third is the increasing role of people with diabetes who, given the right support and training, will increasingly be able to self manage tasks which have been the traditional domain of the health care professional.

The Standards set out a vision of integrated and person-centred care. The Delivery Strategy lays the foundations for implementing that vision through, for example, a care plan, a personal diabetes record and a named contact. Redesigning roles to make best use of these new opportunities will be key to reaching the National Service Framework standards.

Diabetes services have long been exemplars of innovation in the workforce. This document highlights a practical approach to job redesign that will benefit people with diabetes and professionals as they struggle to provide improved services against a backdrop of rising demand.

If services are to cope, change will be needed within the specialist hospital team, within the primary care team and, perhaps most challenging of all, between the two, to provide the holy grail of ‘seamless care’ needed by people with diabetes. A creative approach to job redesign will also bring them to the fore as part of the care team.

When people with diabetes require care, however, they need to be reassured that the professional they see is qualified to do the job.

“Too few doctors know enough. I have often been seen by doctors who know considerably less than me about nearly all aspects of diabetes.”

Understandably many people with diabetes, and professionals, fear that re-examining who does what will lead to a ‘dumbing down’ of quality. Both need to be reassured that redesign will improve quality, not compromise it. For that reason job redesign needs to take place within a competency framework promised in the NSF. This will underpin new approaches to service delivery with appropriate education and training curricula giving confidence to patients and to clinical leads in acute and community settings.

Properly managed job redesign can help both to improve the experience of people who use diabetes services and address the growing demand. Equally important, it can enhance job satisfaction by enriching roles and freeing up professionals higher up the career ladder to do the jobs they have been trained for.

We commend the Changing Workforce Programme and the pilot projects involved in this work for helping to light the way.

Paul Streets
Chief Executive Diabetes UK.
Role redesign

Improving patient services and the working lives of staff is at the heart of the NHS Plan and the Diabetes National Service Framework (NSF) – and the aspiration of many working with people with diabetes.

One way of achieving both is introducing new ways of working with new or redesigned roles. The benefits that ensue will be considerable and the journey there enjoyable and enlightening. Managed diabetes networks (See the Diabetes NSF Delivery Strategy) can be a powerful vehicle for planning and implementing role redesign locally. Local clinical leads in the networks can help facilitate the implementation of new roles.

So what is role or job redesign, what are the benefits and how do you get started?

What is role redesign?

Role redesign involves four main types of change:

1. Moving tasks up or down a traditional unidisciplinary career ladder. For example, health care assistants performing regular review examinations e.g. diabetes care technician (See page 19)
2. Expanding the breadth of a role e.g. specialist foot health technician (See page 30)
3. Increasing the depth of a role e.g. diabetes nurse facilitators (See page 20)
4. Entirely new roles, which combine tasks differently from before e.g. diabetes practitioner (See page 21)
What are the benefits?

Some of the benefits of role redesign include:

**Reduction in waiting times** – more efficient use of staff skills in the right locations leads to efficiencies in service delivery, reducing waiting times and improving access

**Less ‘faces’, more personalised care** – service users will no longer have to endure a ‘procession of healthcare faces’ to obtain treatment or advice. This will not only help to reduce waiting times, it will also improve people’s experience of the system

**Managing an ever increasing workload** – better deployment of staff skills leads to improvements in the management of workloads, and as a result, to better services and less stress for staff

**Job satisfaction** – role redesign enables staff to benefit from making the best use of their training and applying all of their existing skills, helping them to develop in other areas, making jobs more satisfying and rewarding

**Development of special interests** – role redesign can help staff who wish to develop specialist interests, which in turn can reduce waits in primary and secondary care, provide more specialised care for those with complications of diabetes, and provide support for other non-specialist staff working in diabetes

**Reduced vacancies and staff turnover** – role redesign can produce a satisfying job mix, which takes account of continuing personal and professional development, and so can address the skills gap in diabetes by impacting on every stage of recruitment and retention

**Career development through the skills escalator** – role redesign can be used to encourage staff constantly to develop and renew their skills and knowledge through lifelong learning, enabling them to develop their careers by moving along the skills escalator

**A more flexible, more responsive workforce** – role redesign can also be used to develop a culture of continuous improvement and workforce flexibility, meaning that services will be better able to adapt to changes in demand or practice in the future

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**Tips for success**

- keep it simple and safe
- keep the change bite-sized – start small and build up
- There is no right or wrong answer – if it works for you then use it
- Copy and adapt other people’s ideas. Use this guide to find out what others are doing
- If the process is becoming too difficult or you need help to progress your ideas, get support from the organisations listed in the Getting Support section of this publication.
Assessing your needs

Changing the way we work and the way we think isn’t always easy, but there is much you can do to make role redesign a success.

There are some simple clues to finding out if job redesign is right for you. If you find yourself answering yes to any of the questions below, then you probably need to rethink the scope of some of your current job roles.

Are staff members sometimes so busy that they feel like they can’t stop to think?

Do your staff get bored with the same repetitive tasks?

Do they ask to be able to do more and learn new skills?

Do you find staff spontaneously offering to help each other out?

Is it difficult for staff to spend as much time as they would like providing one-to-one care?

Is it difficult to recruit enough registered professionals?

Do highly qualified staff members get frustrated that other staff could do more, but are prevented by ‘the rules’?

Are staff members frustrated that they could do more themselves, but are prevented by ‘the rules’?

Whilst some staff are very busy, do others have time on their hands?

If you answered Yes to any of these, then think on…
Training and development

Often we find staff in our teams whose potential for growth and development has not been fully explored, perhaps someone whose family circumstances meant that they could not stay in higher education, or who’d left school without many formal qualifications. Many organisations have found that developing their own staff to take on tasks beyond those traditionally considered to be part of the job is one of the greatest opportunities to help run services better. There are many part-time training courses, in support of in-house training programmes in which people are able to learn new skills whilst still working.

Questions to consider as you re-allocate tasks:

- What are the training and educational needs of the holders of new or amended posts?
- Can the training be accessed in-house or do you need external support?
- How will you tailor delivery to take account of an individual worker’s existing competencies?
- What further training and development can be provided in support of continuing professional development for the new post-holder?

Who does what?

Where a member of staff is very busy, think about their role and ask whether or not elements of it could be performed by someone else. You could ask them to keep a diary of activity for a week: noting the task, and whether or not it actually required someone with their level of skill to perform it. If you find a number of such tasks within the current role then consider if it would be more appropriate for another member of staff to take on these tasks. Very often you can add interest to another person’s job, by allocating tasks that relieve the pressure from others at busy times.

Questions to consider as you re-allocate tasks:

- Do staff understand the purpose of the role change and development?
- Who will manage the workload for the new or amended role and keep it under review?
- Is funding needed for the role and if so where will this come from?
- Have you taken into account patients’ views?
Protocols and guidelines

When re-allocating tasks to others it is important to have clear protocols and guidelines outlining who does what, what must be done, and what the limits of each person’s responsibility are. Protocols should include simple decision support systems, or make reference to more complex ones, with information on how to access them.

Written protocols should be readily available to be followed, ensuring quality and consistency of practice. For instance, if a health care assistant is allowed to refer people with diabetes direct to the dietitian, then the exact circumstances in which they can do this should be clearly written. Likewise, practice nurses holding nurse-led diabetes clinics should have clearly understood agreements about the limits of their responsibility, and when patients should be referred to the GP or specialist team. Local protocols should incorporate evidence-based, best practice and should take into account the National Service Framework for Diabetes Standards and Delivery Strategy, which identify important areas where protocols will help reach the standards, and NICE guidelines.

Help on developing protocols is available from the Changing Workforce Programme on 020 7210 5101.

Questions to consider as you re-allocate tasks:
- Does the new or amended role have clear boundaries?
- What are the main functions of the new or amended role?
- Have you considered the relevant clinical governance issues?
- How do you plan to monitor/performance manage this post?

Regulation and patient safety

Where roles have been designed, which cross traditional, professional boundaries, or which involve the wider healthcare team, e.g. diabetes specialist nurses and specialist diabetes dietitians taking on aspects of each other’s roles, or healthcare assistants performing regular review checks, it raises questions of regulated practice. For professional staff working outside their scope of practice, their current registrations and codes of conduct are sufficient to ensure proper accountability. There are ongoing discussions about extending regulation to clinical support staff. In the absence of a national scheme, each organisation needs to be sure that staff members working in new or amended roles are clearly aware of their responsibilities and accountability. This can be done through contracts and local codes of conduct. Local clinical accountability procedures, and care protocols should be reviewed regularly to ensure that the tasks allocated to the new diabetes team are covered sufficiently.

The organisation should also consider legal protection and support of the staff members as well as the limits of its own liability.

Questions to consider as you re-allocate tasks:
- Does the new or amended role involve regulated areas of practice?
- Are care protocols and accountability procedures sufficiently robust to ensure patient safety?
- What indemnity arrangements are being made for staff working in new or amended roles?
- Has appropriate clinical supervision been provided for the new post-holder?
Looking Ahead

Using the current flexibilities within your organisation and the wider healthcare workforce to create new or redesigned roles will ensure that they can evolve over time as change and needs dictate. Apart from career progression for individual post-holders, thought should also be given to how a role fits into the future planned developments of the diabetes care network and organisation.

Questions to consider as you re-allocate tasks:

- Is the post sustainable?
- What does the new or amended role mean for the configuration of the whole team?
- If the post-holder left, could someone else fill the new or amended role?
- How will you ensure that the new or amended role remains relevant?
- Are you planning for the future of the role and of the team?
The job description

Begin by describing what you want people to do to help support the service. Your solution may be to amend current jobs or design new ones.

With the NSF Standards and Delivery Strategy, it will be important to ‘think outside the box’ in writing a job description for a new or changed role. The managed diabetes network can be a helpful forum for thinking more holistically about job roles and descriptions.

Your HR department can also help with drafting a job description. When writing a job description you are trying to describe explicitly what you want a person to do at work. It is sometimes easier to write a job description by completing a typical week’s timetable. Do this first if it helps you.

Draft timetable

Thinking about what somebody in a new or different/expanded role would actually do hour by hour is a useful way of clarifying the job description, and identifying other practical problems.

Plan out a typical day. Would each day of the week be the same? Would each week be the same?

Patient safety

Consider the following when developing a new role:

- Education and training
- Assessment of competency
- Continuing staff development
- Protocols
- Accountability
- Regulation
- Performance review

Seven steps to role redesign

To help convert your initial ideas for a post into practical working reality, there is a seven-step process to developing your job description, person specification and education and training plan.
Education and training

Make reference to the typical week’s timetable you prepared in Step 2 and to the points raised in Step 3.

Analyse the skills needed for the post, the education and training needed to acquire those skills, and how this will be organised.

Person specification

The person specification is a tool to help you recruit the best person into the role you plan. Some skills or qualities will be essential to help someone do the job, others desirable. If a candidate does not meet one or more of the essential requirements, you cannot shortlist them.

The desirable requirements are used at the time of shortlisting or interview if you have a number of candidates who meet the essential requirements. Be careful not to put too much or too little into the essential category. If you are happy to recruit for potential in a category then be explicit about that, and remember that training can be provided to develop the appropriate skills.

Practical management issues

Think about those difficult practical matters that are often forgotten about prior to recruitment, but may present you with the most difficulties after a person is in the post. For example, who will manage the person, who will cover them during annual leave, what arrangements will be made for travelling around the patch?

Also think about:

- Whether the post is full time or part time
- Who should supervise the post-holder

The job description

Now, using all the information from steps 2 to 6, go back and complete all sections of the job description from Step 1 (above).
Support in role redesign is available in a number of ways. Accessing this resource is easy and designed to help you address your particular needs.

The Changing Workforce Programme

This is a national Programme set up to help all those involved in healthcare to redesign roles or tasks. The aim is to improve services to patients and the working lives of staff.

The Programme is currently working with 16 pilot sites to implement new or redesigned roles across a number of care group and workforce areas including stroke, older people, mental health, cancer, support workers, healthcare scientists and others.

The diabetes care pilot is being hosted by the health economies in Peterborough and Luton, working across primary and secondary care, and including as wide a selection of people involved in diabetes care as possible. A number of themes are being explored in this pilot to address the problems of inconsistency of care provided, lack of and inequality of access to education for patients and carers, the ‘procession of faces’ in diabetes care, and the lack of clinical career progression opportunities for many professionals. Roles are being developed at all levels, from support workers to advanced specialist practitioners.

In addition to the pilots, the Programme has developed the Toolkit for Local Change a workshop in which a series of practical steps help local staff to implement job redesign successfully within their own setting. The Toolkit provides a framework that can harness staff enthusiasm and ingenuity to tackle service problems. It uses a variety of activities and exercises that enable you to identify the cause of any problems, consider a new or redesigned role that may provide a solution and cover a wide range of issues to ensure successful implementation of the role.

Through the Toolkit you can explore the professional and management issues, staff and patient perspectives and possible barriers to implementation. By the end of the process, you will have developed a job description and person specification for the new role as well as an action plan for its implementation.

The Changing Workforce Programme Role Redesign Database is another source of help and ideas when thinking of introducing new roles. You can search the database by job type, geographical area or care group, and find numerous examples of new or amended roles, not only in diabetes care, but also in many other care areas.

If you are interested in using the Toolkit for Local Change or need support with job redesign you can:

telephone: 0113 254 6587
email: deborah.watson@doh.gsi.gov.uk
Visit: www.modern.nhs.uk/cwp for further information or to access the database
The Long Term Conditions Care Group Workforce Team (LTC CGWT)

The LTC CGWT is one of seven Care Group Workforce Teams that have been established to take a national view on the health and social care workforce pressures and priorities for a particular client group or condition.

The Care Group Workforce Teams are multi-disciplinary advisory bodies. They support the development of national strategies for producing the right workforce to deliver NHS Plan commitments for service improvements across health, social care and the independent and voluntary sectors. They look at how staff numbers can be increased and also at how job roles can be redesigned or new ones developed to meet service needs. They are the overarching body for workforce development issues within their particular areas and include representation from the Changing Workforce Programme.

The LTC CGWT in particular supports the development and implementation of this role for the NSFs for Diabetes, Renal Services and Long Term Conditions. It brings together key stakeholders to lead and enable change. These stakeholders include professional associations, education providers, royal colleges, patients and patient interest groups, social care providers and experts working in the area. A Diabetes specific sub-group leads on workforce assumptions, education and training issues and oversees the development of the skills and competency framework for all staff involved in diabetes care, which is being undertaken by Skills for Health.

Links with local service planning are made via Workforce Development Confederations (WDC), with the Devon and Cornwall WDC taking a national lead role.

The LTC CGWT, together with the Diabetes NSF Implementation Group, has considered the workforce implications of the Diabetes NSF and its Delivery Strategy.

Further information

Further information on the role and work programme of the LTC CGWT can be obtained from the website: www.doh.gov.uk/cgwt
Diabetes UK

Diabetes UK is a registered charity providing support and information to people with diabetes and their carers, as well as supporting research into diabetes and disseminating information to professionals about good practice in diabetes. They are currently compiling a Database of Good Practice in which information about new roles in diabetes, as well as the details of clinical practice, will be displayed. The database is not yet online, but examples of good practice in retinal screening delivery methods and physical activity programmes are currently being sought.

Further information
Further information can be obtained from Diabetes UK web-site: www.diabetes.org.uk

The Expert Patient Programme

The Expert Patient Programme helps people with long-term conditions, such as diabetes, to use their knowledge and experience of their condition and develop the skills, motivation and confidence to manage their condition, with the support of healthcare professionals and others. Pilot programmes, in which patients with long-term conditions undergo specific training to enable them to become expert in self-management, are underway in over fifty primary care trust sites. The programmes are planned to be mainstreamed throughout the NHS over the next few years.

Further information
Contact: mb-expert-patient@doh.gov.uk for more information

National Institute for Clinical Excellence (NICE)

The National Institute for Clinical Excellence (NICE) provides guidance on current best practice, covering health technologies and clinical management of specific conditions. NICE has already published guidelines on screening for renal and retinal complications of diabetes, as well as the use of a number of specific therapies. Further guidelines, on diagnosis and management of Type 1 and Type 2 diabetes, are currently under development.

Further information
For further information visit: www.nice.org.uk
Skills for Health

Skills for Health, the Sector Skills Council for Health, is undertaking a project to develop workforce competency frameworks for a number of long-term conditions, including diabetes. Competency frameworks can be used for development of new and changed roles, service development, team and organisation development, personal development planning and appraisal, career development planning, supporting development of qualifications, standards for work-based learning, and assessment of learners.

Working with the NHSU, the competence framework will be used to assess the gap between current training provision and what is needed and to devise education and training curricula for diabetes care and appropriate qualifications.

The competency framework for diabetes is due to be published in Autumn 2003, with guidance on how to put it to use.

Further information
telephone: 01179 221155

Workforce Development Confederations

Workforce Development Confederations (WDCs) lie at the centre of local workforce planning and development, and are critical to the delivery of the NHS Plan workforce targets and HR in the NHS strategy. They work closely with local education providers and Postgraduate Deaneries in developing innovative approaches to the delivery of integrated education and training, with particular responsibility for:

• Planning the future healthcare workforce
• Planning post registration and other training requirements
• Developing comprehensive plans for delivering workforce increases in their areas
• Contracting with local education providers

Working with Strategic Health Authorities, WDCs offer long-term support to NHS trusts and primary care trusts on related workforce issues such as recruitment and retention. WDCs are central to driving change both in the way in which staff are trained and educated and in the way in which they are employed. They will build on, develop, and share good ideas and ensure that education and training is sensitive to the needs of employers and increasingly undertaken on an interprofessional/multi-disciplinary basis.

Further information
Further information can be found at the WDCs web-site: www.wdconfeds.org, which provides links to each WDC.
Reducing waits

Reducing the ‘procession of faces’ will be crucial in reducing waiting times for people with diabetes. It is not uncommon for people with diabetes to see four or more different healthcare professionals during one clinic visit, when a change of treatment is required. At a general practice-based clinic, this will sometimes also involve several visits for the patients, often to more than one location. In Peterborough staff working in diabetes care are examining their roles and testing roles that work across traditional professional boundaries, e.g. the paediatric diabetes specialist nurse and dietitian are each taking on elements of each other’s role, so that individually they are each able to provide a fuller service to patients and reduce the number of handoffs. The diabetes practitioner role is also being tested in Peterborough. In this role, all the fundamental elements of diabetes care can be provided by a single practitioner, with support and guidance from other specialist staff. This will enable patients to receive nearly all the diabetes care that they require in a single visit.

Improving health and tackling health inequalities

There is an increasingly wide range of national and local policy priorities and programmes aimed at reducing health inequalities by reducing inequalities in access to and provision of healthcare. This has special relevance for diabetes, in which there is an increased burden of disease among people from minority ethnic communities.

Addressing these inequalities will involve cultural sensitivity and language and communication skills. It might, therefore, be useful to bring into the diabetes team people with different skills and experience, and special knowledge of ethnic communities. This could include people who know and live in the community, and who can communicate appropriately with people with diabetes and their families. In this way, a wider range of skills and qualities can be introduced into the workforce, people from ethnic communities can have greater access to healthcare and can achieve a greater understanding of their condition and individual’s skills are put to best use in the new and interesting posts that are developed. This can also identify a source for future recruitment into professional roles. A good example of this is the Ethnic Chronic Disease Assessment Outreach in North Peterborough.
Managing chronic conditions

Nurse-led clinics are leading the way in chronic disease management, not only in primary care, but also in hospitals.

Diabetes specialist nurses are also extending their roles in doctor-led clinics, providing regular review examinations and developing their management plans in the same way as the doctor would, limited only by current restrictions on their ability to prescribe medications. An example of this way of working is found in Peterborough, where the DSNs take a role in the diabetes clinic almost the same as that of the doctors. Also in this clinic they have developed the role of the Diabetes Care Technician, who provides the standard clinical assessment, preparation and recording involved in the annual review, saving time for more expert staff to engage in discussion with patients – planning treatment and motivating and educating them.

Enabling people with diabetes / working with empowered patients

In diabetes, as in many chronic conditions, the patient is most often the person best placed to manage their own disease. The Expert Patients Initiative encourages a shift in the way in which chronic diseases are managed, equipping and encouraging patients to take an active role in their own care. This means that staff working with people with diabetes will need to be equipped to form partnerships with the patients, which will have an impact on the skills required (especially communication, educational and psychological support skills) by all of them. Also, patients with in-depth experience of diabetes and the appropriate skill and aptitude can become part of the diabetes workforce, helping to educate and motivate other people with diabetes. One such expert patient educator role is currently being developed by the Changing Workforce Programme in Somerset.

Enabling primary care

Most of the care of people with diabetes and other chronic conditions is provided in primary care. Increasingly practitioners in primary care are providing comprehensive management for people with diabetes, reducing the need for patients to make regular trips to hospital, and enabling specialist hospital resources to be concentrated on more complex problems. Although this increases the workload in primary care, it also offers healthcare staff the opportunity to broaden their experience and develop their expertise.

Currently, diabetes care in general practice is often led by practice nurses, with the support of the GP. In other practices GPs with a special interest in diabetes are able to take referrals from neighbouring GP practices which are unable to make systematic provision for people with diabetes. There are a number of innovative roles, including lecturer-practitioners, who provide education and support to other healthcare professionals dealing with diabetes, as well as maintaining direct contact with patients. In some areas this type of support is provided by diabetes facilitators, who also help to strengthen the links between primary and secondary care.

Additionally, the Diabetes Delivery Strategy promotes the wider use of managed diabetes networks. Such networks could include people with diabetes, their families and carers, representatives of patient organisations, specialist diabetes staff, primary and community care staff together with senior management from PCTs, NHS Trusts, local authorities and others. Managed diabetes networks can provide the structure for service planning and delivery, promoting seamless care and supporting staff by targeting resources where they are most needed.
Current innovative practice

Diabetes care has had a head start with new ways of working in many respects, having a long history of extended roles and inter-professional team working. Below is a small selection of innovative roles.

Many of the roles will be familiar to you, but they are included to help those who haven’t yet implemented them in their areas. Equally, many of the job titles will be familiar, but there are people with the same job title working very differently from each other across the country, having extended their practice in a variety of directions. So even if you think you already know what it is, please take the time to read through the details that follow.

The details below are of necessity very brief and summarised. If you are interested in knowing more please approach the relevant contact. Always be careful to check that an idea from elsewhere can be safely applied in your area of work before putting it into practice.
Clinical Project Lead

Contact
Julie Winterbottom
North Bradford PCT

Telephone
01274 322174

Job content
A clinician with an interest in a particular field is identified to work alongside a manager from the PCT and jointly develop the relevant service. The PCT has project leads in a number of areas including diabetes, cancer, CHD, IM&T, prescribing, older people, mental health and children.

Benefits
Clinical issues are taken into consideration when redesigning planning or commissioning services. The system has worked well encouraging team working.

Clinical Governance Lead (Diabetes)

Contact
Melanie Alford
Reading PCT

Telephone
0118 947 2431

Job content
Lead clinician on NSF/Plan. Contributes to HimP development and implementation. Established close contact and liaison with GP/clinics. Lead for clinical governance for GP practices.

Benefits
The role is crucial to integrating clinical governance into everyday practice.

Berkshire Diabetic Eye Screening Service (Driver)

Contact
Stephanie Holland
Wokingham Hospital

Telephone
0118 949 2928

Job content
The postholder is responsible for the transportation of three digital camera systems across Berkshire. The role entails collecting the systems from GP practices and other locations and safely transporting them to pre-arranged locations.

Benefits
The role helps to provide better access to services for the local population and ensure maximum efficiency of equipment usage.

For more details, contact the Changing Workforce Programme Role Redesign Database on 020 7210 5832
### Clinical Psychologist / Organizational Development

**Contact**  
Yvonne Doherty  
Northumbria Diabetes Service  

**Telephone**  
0191 293 2708

**Job content**  
As well as providing direct clinical care, training and support to other diabetes team members, the post holder has a remit to ensure that all teaching, education, protocols, procedures and organization of the team and the service are psychologically informed to embed a patient centred ethos in all activities.

**Benefits**  
From induction, training and personal development plans, protocol development, training in consultation, team building and patient education, all aspects of the service are checked for best practice. This leads towards a supportive service for users and an innovative, stable and enthusiastic workforce.

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### Clinical Support Worker

**Contact**  
Alistair Stinson  
North West London Hospital NHS Trust  

**Telephone**  
0208 965 5733

**Job content**  
Pre-testing of diabetic patients using a protocol. Provides visual acuity tests and prescribes blood tests.

**Benefits**  
Provides one-stop specialist care to patients improving access and quality of care.

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### Community Diabetes Educator

**Contact**  
Mimi Hills  
Peterborough Hospital NHS Trust  

**Telephone**  
01733 875201

**Job Content**  
This role is being developed in Peterborough as part of the Changing Workforce Programme Pilot. The objective of this role is to provide community based education for people with diabetes and their carers. The educator will work in community centres and other locations providing group education sessions for patients and their carers. Educators are recruited from the community and trained in diabetes and education techniques and are then able to provide education to patients in their own language and appropriate to their culture.

**Benefits**  
Better access to education for people with English as a second language and reducing the waiting times for education sessions. Relieving pressure on Diabetes specialist staff.
DAFNE Educator

Contact
Jackie Rollinson
Northumbria Diabetes Service

Telephone
0191 293 2708

Job content
Member of a team of 4 DAFNE educators spending one quarter of their time providing DAFNE courses for people with Type 1 diabetes. Each has a basic teaching qualification, 1-year experience in diabetes and additional training to teach DAFNE courses. The post includes recruitment, assessment and specialist follow up.

Benefits
The service can provide DAFNE courses routinely, and more health professionals become ‘DAFNE aware’. Enhances teaching skills within the service and increases job satisfaction.

Diabetes Advisor

Contact
Lindsay Oliver
Northumbria Diabetes Service

Telephone
0191 293 2708

Job content
A specialist dietitian or nurse who has undergone additional career development and performs holistic assessment of someone with diabetes including physical and psychosocial aspects of care, within clinics, community settings or at home. Competent to manage all routine issues within a diabetes review including reviewing results, negotiating care plans, motivational interviewing, behaviour change and referral to other team members. Dietitian advisors work with Type 2 patients from primary or secondary care approaching insulin, helping them to review options, consequences and adapt to the new treatment.

Benefits
Releases medical time for complex cases. Enables more individual care to be provided. Reduces the number of professionals each patient needs to see.

Diabetes Care Technician

Contact
Mimi Hills
Peterborough Hospitals Trust

Telephone
01733 875201

Job content
Postholder works with registered professional, carrying out annual review examinations, including foot examinations, and inserting dilating eye drops for those patients requiring eye examinations. Completes annual review documentation. The postholder is receiving further training to enable them to give basic education and advice to patients, e.g. on blood glucose monitoring.

Benefits
Frees time for professional staff to spend with patient on listening, planning management, and giving advice and education. Patients feel as though they have had a more thorough examination and a more effective consultation.

For more details, contact the Changing Workforce Programme Role Redesign Database on 020 7210 5832

Diabetes Nurse Facilitator

**Contact**
Sue Robson  
Northumbria Diabetes Service

**Telephone**
01983 534570

**Job content**
Organizes results for clinic appointment and takes routine clinic measurements. Identifies each patient’s major concerns and brings these to the attention of clinicians to promote patient-centred consultation. Maintains and produces educational displays and ensures that all written information and protocols are available, and up to date. Administers renal screening, home HbA1c and BP self-monitoring programmes.

**Benefits**
Many clinically related administrative tasks are linked and readily available at the right time. The post provides enhanced professional satisfaction beyond traditional clinic nurse roles.

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Diabetes Clinic/centre Support Nurse

**Contact**
Sue Robson  
Northumbria Diabetes Service

**Telephone**
0191 293 2708

**Job content**
Organizes results for clinic appointment and takes routine clinic measurements. Identifies each patient’s major concerns and brings these to the attention of clinicians to promote patient-centred consultation. Maintains and produces educational displays and ensures that all written information and protocols are available, and up to date. Administers renal screening, home HbA1c and BP self-monitoring programmes.

**Benefits**
Many clinically related administrative tasks are linked and readily available at the right time. The post provides enhanced professional satisfaction beyond traditional clinic nurse roles.

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Diabetes Community Support Worker

**Contact**
Gillian Johnson  
Northumbria Diabetes Service

**Telephone**
0191 293 2708

**Job content**
Assists the Primary Care coordinator in supporting patient involvement in service development and establishing patient groups. Liaises between healthcare professionals, voluntary service workers and people with diabetes to facilitate two-way flow of information. The post holder has a background in work with community groups.

**Benefits**
Greater involvement by service users in developing the service and greater understanding of a culture where patient involvement is the new agenda.

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For more details, contact the Changing Workforce Programme  
Role Redesign Database on 020 7210 5832
Diabetes Practitioner

Contact
Maria Leveridge
North Peterborough PCT

Telephone
01733 875463

Job content
This is an extended role for dietitians, nurses, podiatrists and other healthcare professionals, which is currently being piloted by the Changing Workforce Programme. The postholder’s role predominantly involves clinical examination and diagnosis and all aspects of management of uncomplicated diabetes, including patient education and referring onto other specialists or within diabetes team.

Benefits
The role increases the job satisfaction of health care professionals, through better use of skills and increasing the scope of practice. The role improves monitoring of patients and reduces delays for patients in obtaining referral onto other specialities. It also reduces delays in receiving treatment and reduces the numbers of healthcare professionals involved with each patient.

Diabetes Roving Team

Contact
Bernie Stribling
University Hospitals Leicester

Telephone
0116 258 5971

Job content
The team comprises a specialist nurse, specialist dietitian and specialist podiatrist, and sees all in-patients referred to diabetes, giving specialist advice.

Benefits
This role provides improved care for in-patients with diabetes by providing quicker access to specialist advice. The key improvement is that patients are discharged on average two days earlier than before the role was introduced.

Diabetes Specialist Nurse

Contact
Francesca Arundel
Portsmouth City PCT

Telephone
023 9228 6260

Job content
Postholder provides education workshops based on behavioural change models to people with Type 2 diabetes in primary care. Supports primary care colleagues in the use of standards and guidelines for care of patients with diabetes. Postholder maps current services with a view to improving service provision to meet increasing demand for services in both primary and secondary care.

Benefits
The post offers expert educational input for patients as well as provide support to staff and service provision. Using behaviour change techniques to improve patient education, is more likely to result in positive outcomes.

For more details, contact the Changing Workforce Programme Role Redesign Database on 020 7210 5832
Diabetes Specialist Nurse

Contact
Lesley Hammond
Royal Berkshire Hospital

Telephone
0118 9877478

Job content
Education and support for patients with diabetes and those working with them. The role also provides support to staff on acute wards who work with inpatients with diabetes.

Benefits
The role provides opportunities for staff who want to work within a specialism or develop in-depth knowledge and expertise. The role provides a variety of tasks, approaches and locations and promotes multi-disciplinary working.

Diabetes Specialist Nurse

Contact
Julia Fisher
Dunstable Hospital

Telephone
01582 497152

Job content
Provides education and lifestyle advice for people with diabetes and those working with them. Patients visited at home to start insulin and newly referred patients are seen by the postholder very soon after referral especially for starting insulin.

Benefits
Seeing referred patients before medical outpatient appointment reduces delays and improves access for patients. Home insulin starts are convenient for patients and help to dispel fear of starting insulin.

Diabetes Specialist Nurse /Dietitian – Primary Care Support

Contact
Gillian Johnson
Northumbria Diabetes Service

Telephone
0191 293 2708

Job Content
This post provides strategic and day-to-day liaison between the specialist team and a group of GP practices. Direct clinical work within practices fosters credibility and understanding and allows dissemination of new ideas and good practice. Joining with the practice team the post holder is involved in clinic planning and redesign and facilitates the delivery of training based on individual practice needs.

Benefits
By providing operational links the specialist service can adapt to specific and changing primary care needs for support, and primary care can adopt and incorporate best practice quickly.

For more details, contact the Changing Workforce Programme Role Redesign Database on 020 7210 5832
**Diabetes Specialist Nurse – Primary and Secondary Care Joint Post**

**Contact**
Bernie Stribling  
University Hospitals Leicester

**Telephone**
0116 258 5971

**Job Content**
This role provides patient care and support for non-specialist staff in primary care (80% of role). The role is part of the Secondary Care Diabetes Team, spending 20% of time with them for continuing professional development and case review.

**Benefits**
The role maintains links to secondary care for the community Diabetes Specialist Nurse and builds strong relationships between primary and secondary care. The role enables the postholder to keep up-to-date with theory and practice. The variety and support provided helps to prevent burn-out.

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**Diabetes Specialist Nurse / Midwife**

**Contact**
Michelle Eastlake  
Northumbria Diabetes Service

**Telephone**
0191 293 2708

**Job Content**
This dually trained diabetes specialist nurse and midwife acts as a liaison between the services, leads protocol development, training and audit. Provides individual women with one to one care from preconception care through pregnancy, increasing continuity and reducing the need for multiple appointments and professionals.

**Benefits**
Consistent care for individual women, an expert resource and first point of contact for other primary and secondary care team members, and an opportunity for career development for a midwife.

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**Diabetes Specialist Nurse / Research & Development**

**Contact**
Bhupinder Pawar  
Wolverhampton Diabetes Centre

**Telephone**
01902 642858

**Job Content**
Provides diabetes education to patients, carers, community and staff. Around 50% of the role involves research.

**Benefits**
Improves patient access both for specific ethnic minority groups but also other parts of the community.
Diabetes Specialist Nurse with Special Interests

Job content

Each specialist nurse has an area of specialist responsibility in addition to clinical work. This involves a greater percentage of clinical or teaching time, implementation of good practice, keeping the rest of the service up to date, designing, service improvement and audit. Examples include:

- Inpatient care – ensuring multidisciplinary response, training and support to wards
- ‘DIGAMI’ support – ensuring individuals with glucose abnormalities and myocardial infarction have protocol driven care during and after the event
- Elderly care – liaising with primary, elderly and community care to ensure district policies are developed and followed for the frail elderly
- DAFNE (Dose Adjustment For Normal Eating) – ensuring that recruitment, assessment and delivery of DAFNE training programmes in Type 1 diabetes occurs to national standards, a range of follow up options are developed and that all professionals in primary and secondary services are ‘DAFNE aware’

Benefits

Each part of the service benefits from having a responsible lead. Provides job satisfaction, rotating experience and opportunities for career development.

Diabetes Specialist Nurse with Specialist Responsibility for Children

Job Content

This specialist nurse with additional children’s nurse training is lead for a multidisciplinary children’s diabetes team, carries a case load of children with newly diagnosed diabetes or specific problems seen mainly at home. Supports parents, liaises with schools, statutory and voluntary services, attends clinics, and ensuring smooth transition to young adult services.

Benefits

Children with diabetes and their carers have consistent care from a recognized and valued individual who can link all aspects of the service ensuring seamless expert care.
**Diabetes Team Assistant**

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<tr>
<th>Contact</th>
<th>Julia Fisher</th>
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**Job content**

Works with in-patients and out-patients as well as seeing patients in the community and on home visits. Organises young adult clinic including receiving and preparing patients, checking vital signs and weight, inserting eye drops etc. Provides education to patients in areas such as home blood glucose monitoring, use of pen devices, etc.

**Benefits**

The role frees up the time of other team members and provides expert advice to patients. This is an extended role for healthcare assistants and provides them with a high level of knowledge and technical expertise.

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**Education Linkworker**

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**Job content**

Sees patients before they see a professional team member in out-patients and on wards, helping them to formulate questions for the professionals. Also takes simple ward referrals eg to teach blood glucose monitoring.

**Benefits**

Simple ward referrals saves time of professional staff. Patients are given the opportunity to have more useful consultations.

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**Ethnic Chronic Disease Assessment Outreach Nurse**

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<tr>
<th>Contact</th>
<th>Hazel Ann Smith</th>
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**Job content**

Offers ethnic minority groups assessment, advice and support to combat diabetes, CHD and hypertension. Close liaison with community leaders, city council and local population to set up clinics and outreach that will meet the needs of the local community. Develops protocols and evaluation as well as roll out to other local practices.

**Benefits**

Proactive intervention and detection improves quality of life for patients and is of benefit to primary, secondary and social care in terms of developing current and future service provision for local needs.
Health Psychologist – Diabetes

Contact
Bernie Stribling
University Hospitals Leicester

Telephone
0116 258 5971

Job Content
Apart from the clinical caseload, a major part of role is in developing other health care professionals, training them in motivation, behaviour change and counselling skills. Also developing and introducing new approach to patient education, using the above skills. Teaches group patient education sessions.

Benefits
Improved communication between staff and patients. More effective patient education.

Health Care Assistant

Contact
Mary Burden
Heart of Birmingham Teaching PCT

Telephone
07870 632088

Job content
Support diabetes team in the community clinic and the practice nurse in surgery.

Benefits
Frees specialist use of time to allow better use of skills and provides development opportunities for health care assistants.

Group Education

Contact
Bernie Stribling
University Hospitals Leicester

Telephone
0116 258 5971

Job content
Providing education sessions for newly diagnosed people, enabling them to get access to education on living with diabetes within a week of diagnosis, even before being seen by a diabetologist. Multi-disciplinary group patient education provided through, dietitian, diabetes specialist nurse and health psychologist.

Benefits
Patients have quick access to education after diagnosis.
Nurse Consultant – Diabetes and Chronic Disease

Contact
Mark Wagstaff
Portsmouth City PCT

Telephone
023 9282 2444 ext. 4350

Job Content
This is a joint post funded by both primary and secondary care. This role involves direct clinical care to patients, research and audit, critical appraisal and implementation of good practice and education of other health care professionals.

Benefits
The role brings together primary and secondary care, reduces access times for patients and supports GPs in treating patients.

Patient Educator

Contact
Kate Andrews
Changing Workforce Programme

Telephone
0207 210 5852

Job Content
This role is being developed in Mendip as part of the Changing Workforce Programme Pilot. The objective of this role is to provide community based education for people with diabetes and their carers. The educator will work in GP Surgeries and other locations providing one-to-one education sessions for patients and their carers. An expert patient has been recruited as an educator and trained in diabetes and education techniques and is then able to provide education to other patients, supervised by a diabetes specialist nurse.

Benefits
Newer patients benefit from experience of people with longstanding diabetes. Provides a career opportunity for people with diabetes. Relieving pressure on specialist diabetes staff.

Mobile Screening Podiatrist linked to Retinal Screening Programme

Contact
Drs Mike Sampson or Richard Greenwood
Elsie Bertram Diabetes Centre
Norfolk and Norwich University Hospital
NHS Trust

Telephone
01603 287094

Job Content
The screening podiatrist travels with an existing retinal screening programme to see nearly 7000 Type 2 diabetic patients managed in 84 general practices at their local practice. The podiatrist examines patients for peripheral vascular disease, peripheral neuropathy, and foot condition, measures blood pressure and gives written dietary and foot care advice. In addition, patients cardiovascular history and use of aspirin/statins is recorded. This data is relayed to the practice on the day of screening. Patients with highest risk feet are triaged to a specialist secondary foot care clinic. This runs in parallel with the retinal screening programme which triages patients with sight threatening eye disease to secondary care for treatment.

Benefits
Reduced admission rates with diabetic foot disease. NSF targets for diabetic screening met for majority of primary care patients.

For more details, contact the Changing Workforce Programme Role Redesign Database on 020 7210 5832
**Practice Nurse – Diabetes & Asthma Clinics**

**Contact**
Prabha Lacey
Great Hollands Health Centre, Bracknell

**Telephone**
01344 786956

**Job content**
Management and review of patients who have asthma or diabetes. Call and recall of patients for regular checks to agreed protocols. The role also involves health promotion, lifestyle advice and medication management.

**Benefits**
This role enables nurses to run clinics and thereby release the time of GPs. Patients have more dedicated time with staff and there is a systematic approach to call/recall of patients providing more regular and standardised patient management.

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**Primary Care Coordinator / Facilitator of ‘user’ involvement**

**Contact**
Gillian Johnson
Northumbria Diabetes Service

**Telephone**
0191 293 2708

**Job content**
This senior member of the team has two strategic roles informed by ‘hands-on’ work and 1 clinical session.

- Works with PCOs to plan, resource and shape the diabetes service ‘patch-wide’
- Leads the development of user involvement. Facilitates the development of local groups, based round specific areas such as education, provides on-going support, liaises with voluntary organizations, and assesses need via questionnaires and focus groups. Supervises a community development worker.

**Benefits**
Comprehensive patch-wide services, tailored to local requirements and provided to uniform standards, are increasingly influenced by primary care and user priorities.

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**Practice Nurse – Diabetes & Asthma Clinics**

**Job content**
Tasks include diabetes, asthma and hypertension checks. Carries out blood tests, checks inhaler techniques and assesses patients for depression. The postholder runs clinics on their own.

**Benefits**
Better care for patients, specifically for translation purposes for ethnic minority patients. The tasks cover a wide range of skills and releases nurse time to focus on more complex cases.
For more details, contact the Changing Workforce Programme
Role Redesign Database on 020 7210 5832

Senior Practice Nurse

**Contact**
Jane Bean
Merchiston Surgery, Swindon

**Telephone**
01793 823307

**Job content**
This is a lead role for a number of areas including diabetes, asthma and CHD. Leads on protocol and patient care development and acts as a nurse tutor mentor.

**Benefits**
This role enables improved communication across the multi-disciplinary team to improve patient care through better cascading of information to GPs, patients, carers and other practice team members.

Retinal Photographer

**Contact**
Stephanie Holland
Wokingham Hospital

**Telephone**
0118 949 2928

**Job Content**
The postholder has been trained as a retinal photographer. Takes retinal photographs in a mobile unit as part of the annual eye screening programme for people with diabetes.

**Benefits**
To increase the uptake of eye screening, by providing better access to eye examination for people with diabetes. Relieves pressure from optometrists and doctors.

Reception Nurse Assistant

**Contact**
Judy Coates
Little Common Surgery, Bexhill on Sea

**Telephone**
01424 845477

**Job content**
Postholder carries out venepuncture, diabetes clinic, ECGs, runs appointment and annual reviews and carries out checks for those over 75 years of age.

**Benefits**
Releases nurse time. Provides career development opportunity for clinical as well as administrative support staff.
**Specialist Foothealth Technician**

**Contact**
David Clements  
Portsmouth City Council

**Telephone**
023 92434900

**Job content**
Assesses, monitors, educates and provides appropriate referral of high risk patients. Liaises with Diabetes Centre and vascular wards between patients and the diabetes nurse specialist. The role is essential in discharge policy.

**Benefits**
The role provides whole patient care ensuring continuity, reassurance to patients and reduced confusion. Encourages team working between Diabetes Centre, specialist podiatrist and the DSN.

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**Specialist Registrar Secondment to Primary Care**

**Contact**
Professor Brian Hurwitz  
Mitchison Road Practice, London  
& Department of Medicine, Royal Free University College Medical School

**Telephone**
0207 226 6016

**Job content**
The role provides general medical services to a registered population of patients in an inner London practice. The practitioner is also focused on stimulating research and teaching collaborations between the Schools of Humanities and Medicine at King's College, London.

**Benefits**
The Specialist Registrar benefits from this role for the knowledge of providing diabetes care in a GP clinic. A wider clinical focus of care can be given than is generally provided in hospital clinics. The Specialist also gains experience of how the referral process between primary and secondary care is planned and managed, the communication between hospital and GP and also contributing to audits of practice in diabetic care. The GP is less isolated and has the opportunity for face-to-face discussion in decision making. The GP also benefits from being updated in aspects of diabetes care including newer drugs, insulin regimens, risk factor management, monitoring assessments, complications screening and overall diabetes management.
If you have any new or amended roles which you would like to include on the Changing Workforce Programme Role Redesign Database, please fill in the form below.

Title of new job role created

Please summarise the tasks the new job role covers

Please summarise the benefits of the new role

Please state which care groups/services the role involves

Name

Title

Organisation name and address

Tel

Fax

Email

Thank you. Please return your completed form to the CWP at the address below:

Hazera Bibi
Changing Workforce Programme
Richmond House, Room G19A
79 Whitehall, London SW1A 2NS
Telephone 020 7210 5832
The NHS Modernisation Agency is part of the Department of Health