

Seeing where the action really is: experiences of a specialist training post in primary care

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Abstract

As the prevalence of diabetes, and the complexity of care increases, developing new models of care that cross the hospital boundary in to the community is of considerable importance. In order to improve training in community diabetes, and to help forge stronger links with primary care colleagues in Northumbria, this specialist training post was developed by the Health Education North-East Diabetes and Endocrinology training programme. This article describes the experience of the post, and the feedback gained from both the trainee and the healthcare professionals in primary care. This was a positive experience from a trainee and primary care perspective, promoting a better understanding for all of the challenges faced in both primary and secondary care, and facilitating supportive working relationships which ultimately should have a beneficial impact on patient care.

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Background

As healthcare professionals supporting people with diabetes, we are all too aware of the rising prevalence of diabetes and the increasing complexity of the care as people live longer and have multiple conditions. This complexity can impact on patient experience as a multitude of healthcare professionals may need to be involved with care; this can lead to fragmentation, duplication and inefficiency, with consequent impact on both health economics and, most importantly, on the person at the centre of this struggle. As a result, there has been increasing emphasis on the provision of an integrated approach to the commissioning

and design of diabetes services, focusing on improved communication and team working between specialties, and between primary and secondary care. This interface with primary care is hugely important, as a large proportion of the burden of diabetes care is based in general practice, and for that care to be delivered safely and effectively, it needs to be supported by specialists. For diabetes specialists in training, such support is likely to be a vital component of our future consultant careers, but exposure to diabetes services in primary care is often limited.

The Health Education North-East Diabetes and Endocrinology training programme has supported a training post with exposure to primary care for 5 years, but the previous post came to an end as local funding was withdrawn. The Specialist Training Committee recognised the post offered crucial and unique training opportunities that were valued by post-holders, and looked for other trusts to host the position. Northumbria Healthcare NHS Foundation Trust won a competitive process and the post started in September 2014. This article describes the experiences of the first post-holder (RJW) and some reflections on primary care support.

The post

The SpR post is entirely funded by the hosting trust. This is a considerable investment which reflects the organisation's commitment to integrated care and supporting primary care, but the trust also benefits from the post-holder participating in the General (Internal) Medicine specialty registrar on-call rota (presently 1 in 10). There is an expectation that senior trainees will usually fulfill the post as there is a significant degree of autonomous working, although the post is closely supervised clinically. Over a period of 6 months, one core hospital diabetes clinic per week maintains contact with the secondary care team, and a weekly session is dedicated to the trainee's other learning needs; the rest of each week is working with GP practices around the locality. Trainee assessment can be carried out by both hospital and community-based professionals, providing a holistic overview of progress.

GP practices were recruited through direct or opportunistic approaches, word of mouth and local educational events. Engagement with diabetes care and relationships with the local specialist service are very positive, and there was no difficulty in identifying practices with interest in offering training opportunities and receiving the additional support. The shape of the experience at, and the input to, each practice has been different,

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depending on the needs of the individual practice and team. As the trainee was working part-time, five practices were involved during this first 6 month post, with each receiving visits on a fortnightly to monthly basis depending on the shape of the input required and experience offered. A combination of joint clinics, allowing observation of working practices and sharing of ideas, and solo clinics for challenging cases were most well received, with input for community nurses also sought after.

Working with primary care

The post complements close working relationships between primary and community care and the local specialist diabetes service, working with a locality focus, which includes regular educational events, direct telephone and email contacts and a rolling programme of regular practice visits.

Practice visits

Members of the locality specialist team (preferably a consultant, nurse and the dietitian linked to the practice) visit the practice to discuss updates in diabetes management and practical issues on an annual basis. The practice may have identified a specific focus of the visit, but will also involve general discussions and consideration of difficult cases and scenarios. As preparation, the team also accesses the QOF outcomes of the practice through gpcontract.com, which are compared with national, regional and local averages. Used constructively, this can facilitate a productive discussion about practice successes and potential service developments and improvements.

Such visits were already taking place prior to this post, but the post-holder had a role in organising and potentially leading such visits with the supervision of the consultant.

Clinic observation

Observing the primary care diabetes clinic process can be very informative, especially the administrative processes of the recall systems, data collection by the healthcare assistants or practice nurses and the case mix. It is not often that you get to observe other health professionals in action, particularly in very different clinical settings, and this provides the opportunity to understand the challenges of diabetes management in primary care. It is remarkable how different patients' needs – as well as processes and systems – can be across GP practices, and how interested teams are in feedback about this and ideas and examples inspired from elsewhere.

Joint clinics

Participating in joint clinics alongside the practice nurse or the GP can be very rewarding. This may be their usual clinic cohort or a specifically selected group of people for whom they would like support and advice. These offer opportunities to share and discuss different approaches to a management conundrum, benefitting individual patient care and providing a very real learning experience for all involved.

Solo clinics

These provide the practices with an opportunity to get specialist input for patients closer to home, particularly those not keen to

attend secondary care clinics. Ideally, these are done in parallel to the practice diabetes team with team meeting/de-brief afterwards to optimise learning opportunities and ensure decisions and plans are agreed and appropriate.

Joint home visits with community staff

Linking with the community nursing team to arrange joint visits with complex housebound patients offered unique insights into the role of the community nurse and the challenges of this patient group. There are often specific management issues, a need to individualise targets and care and the ongoing issues of high risk of hospital admission due to hyperglycaemia or hypoglycaemia.

Practice/clinician feedback

The feedback from the five practices involved and from the district nursing team has been resoundingly positive. A questionnaire sent to the practice staff involved in the initiative asked for a rating of between 1 and 10 to ascertain the usefulness of the role. The mean score of the seven questionnaires returned was 9.5. There was also the opportunity for free text comments, and those findings are summarised in Box 1.

Box 1. Summary of feedback from primary care teams

"Extremely informative to both patients and myself"

"Very specific practical advice to help us cope with both difficult to manage patients and some with poor control"

"Regular input from secondary care seems very much to be the way forward – especially now when much importance is being given to admission avoidance"

"I have found the experience very rewarding – it has helped me look at my patients from a different perspective"

"Knowledge of current advances and newer treatments has been very helpful"

"Patient benefits by being reviewed by specialist at home"

"Educational, especially joint surgeries"

"Useful communication skills regarding stepping up to insulin therapy"

"A very useful resource that has prevented referrals back to secondary care...some patients prefer to come to the surgery for this support"

Trainee experience/reflection

The improved communication and collaboration through this innovative role has been a positive experience for both myself, improving my understanding of the primary care perspective, but also seems to have been rewarding for the primary care teams and for the patients themselves. In particular, the experience of time spent working with the community nurses, seeing patients in their home environment, has left a lasting impression – the insight into a patient's life, and into the challenges of the nursing team in keeping these patients well and at home cannot be underestimated. It was a privilege to be able to support this care



Key messages

- Much of the burden of diabetes sits beyond the hospital boundary, so integrated ways of working are needed
- This innovative training post based in primary care provides the trainee with a unique insight into the processes in the community
- Working towards integrated care, involving the next generation of consultants through posts such as this, would be a positive move

and to help formulate shared management strategies that may help to prevent morbidity caused by unstable glycaemic control and also prevent acute hospital admissions.

Conclusions

This innovative post demonstrates the potential value of training beyond the hospital boundaries, offering unique training opportunities for the specialist trainee, valuable support for primary care and generally fostering better relationships with primary care colleagues. Establishing similar posts around the UK on specialist training programmes would seem the logical next step, reflecting the changing NHS climate and developing the skills and attributes required to understand both sides of the fence for the next generation of consultants.

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