

Diabetes education in primary care: An opportunity for shaping the future medical workforce



Azhar Farooqi OBE

GP, East Leicester Medical Practice, and Honorary Professor of General Practice, University of Leicester, Leicester

“No longer should it be acceptable to invest in primary care only a fraction of the teaching tariff given to secondary care.”

GP Taskforce (2014) *Securing the Future GP Workforce: Delivering the Mandate on GP Expansion*. Health Education England, Leeds. Available at: <http://bit.ly/1Cy6bPe> (accessed 28.01.15)

NHS England (2014) *Five Year Forward View*. NHS England, London. Available at: <http://bit.ly/1rr78ja> (accessed 28.01.15)

Shape of Training (2013) *Securing the future of excellent patient care*. General Medical Council, London. Available at: <http://bit.ly/1Bnxqbj> (accessed 28.01.15)

The nature of our population and the disease burden it faces is rapidly changing. This change – characterised by a rising number of older people, with multiple long-term conditions (LTCs) – is increasingly well understood by health planners, clinicians and the population alike.

However, while the changing nature of the population has long been recognised, it has hitherto been largely ignored in major structural changes to the NHS, which still follows a largely 20th century acute model of healthcare delivery. The consequences of this are clear to see, with under-investment in prevention and inadequate community services. Lack of workforce planning is also apparent from the current crisis in recruitment of GPs and community-based staff. It should thus be no surprise to see an increasingly overwhelming burden on acute services, mainly from older people with LTCs.

The good news, however belated, is that we are now seeing signs that changes are on the way. The “Five-Year Forward View” (NHS England, 2014) led by Simon Stevens, CEO of NHS England, clearly signals an increased emphasis on prevention and enhanced management of LTCs in the community. Alongside this the implications for workforce planning are also being recognised. The Greenaway “Shape of Training” review (Shape of Training, 2013) recognises the importance of a medical workforce that is able to deliver broader and more holistic care for people with LTCs, and the “GP Taskforce” report (GP Taskforce, 2014) highlights the importance of undergraduate training in promoting primary care as a career choice.

So where does diabetes service delivery fit into this? I would argue that given the increasing delivery of diabetes care in the community, there is a real opportunity to “up the game” in terms of diabetes as a subject for teaching, resulting in benefit for both professionals and patients.

Diabetes is an exemplar LTC that can provide huge educational opportunities. It is a clinical

area which can help train the future workforce in the skills required to understand and deal with requirements of people with LTCs. The diabetes pathway clearly illustrates the need for effective prevention, self-management and integrated care delivery. Diabetes can illustrate the role of carers, and the impact of a range of health and social care professionals working collaboratively.

As a clinical condition it is attractive to academics and teachers as a subject deeply rooted in evidence-based practice, with direct links to learning from the basic sciences. Diabetes provides endless opportunity for clinical skills development. It clearly illustrates the physical, social and psychological aspects of disease. Medical schools will be looking to primary care increasingly to deliver teaching to their students. Training based on the management of LTCs such as diabetes has great merit as an important part of the undergraduate curriculum, delivered in primary care – the environment where integrated care can be observed first hand.

To enable such a programme to develop there are barriers that need to be overcome. Medical schools need to recognise the changes in population and services that have been described, they need to understand and accept their role in shaping the future workforce, and they need to equip primary care to deliver such teaching programmes to large cohorts of students. High standards of teaching and clear educational outcomes cannot be compromised, and quality assurance needs to be integral to this new approach to undergraduate training. Clearly, all this requires investment in primary care, such as in “teaching the teachers”, in IT and in teaching facilities and infrastructure. No longer should it be acceptable to invest in primary care only a fraction of the teaching tariff given to secondary care.

The opportunities to develop such programmes are immense and need to be grasped by medical schools, professional leaders and “grass root” clinicians alike. ■