

Analysing training needs Part 2: Questionnaire results

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ARTICLE POINTS

1 The training needs analysis (TNA) has helped the diabetes network to plan workforce skills.

2 Collaboration between clinical practice and education is vital for success.

3 Increasing partnership working between primary and specialist diabetes services should be strived for.

4 Education and clinical practice can work in tandem to support the workforce.

5 Support within primary care to develop effective teams is necessary.

6 The TNA has enabled the network to realistically goal set and support diabetes care delivery.

KEY WORDS

- Workforce skills planning
- Care planning
- Seamless care approach
- Collaborative working
- Diabetes network development

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Introduction

This article highlights the use of a training needs analysis (TNA) to plan appropriate workforce skills. As part of a sub-group of a diabetes network, a collaborative approach to assessing the training and educational needs of primary care practitioners was undertaken using a TNA questionnaire. This enabled the diabetes network to plan workforce skills and to collaboratively provide clinically relevant and educationally applicable education and training opportunities in diabetes care. This led to the publication of *Diabetes – Advancing clinical practice* (University of York et al, 2004), a portfolio for practitioners. This enabled them to access appropriate and timely education opportunities in diabetes care to support clinical practice development. This article is the second in a two part series.

The exploding prevalence of diabetes nationwide (Yorkshire and Humber Public Health Observatory, 2005), coupled with the evidence that the number of people with diabetes has tripled worldwide since 1985 (Bloomgarden, 2004), means that diabetes networks are facing a potential predicament in ensuring their workforces have the necessary skills, support and educational opportunities available to support effective and efficient care for the person with diabetes at the point of contact. In an insecure environment of change within current primary care trusts (PCTs) and an unfunded National Service Framework (NSF; Department of Health [DoH], 2001), despite having vision, the need to overcome constraints is paramount. The clinical education and workforce skills planning subgroup of the Selby and York PCT Diabetes Network fostered a partnership and collaborative approach in the education–care continuum in order to provide the skills needed by the primary care workforce to provide effective diabetes care on a sustained and supported basis (O’Neil and Krauel, 2004).

(TNA) were to seek practitioners’ thoughts regarding their requirements in diabetes education and support, in terms of not only subject but also delivery style.

As diabetes services are provided by multidisciplinary healthcare professionals it was essential to approach each professional group, and this was achieved using colour-coded TNA forms for ease of data sorting. As the clinical education and workforce skills planning subgroup was multi-professional in its make-up (Table 1), we were able to pilot the TNA to ensure its usability and applicability for each professional group.

Article one of this series described the formulation of the TNA (Phillips and Dromgoole, 2005). We were able to analyse some interesting aspects, which have since influenced workforce planning, including the concept of a theory–practice gap in diabetes care.

Where has diabetes knowledge come from?

Respondents to the TNA questionnaire were asked to assess where their knowledge and skills of diabetes had been acquired (i.e. from educational opportunities, clinical practice, or a combination of both). The potential for a

Aims of the TNA

The aims of the training needs analysis

Table 1. Members of the clinical education and workforce skills planning group for Selby and York Diabetes Network.

Group member	Role
Anne Phillips	Lecturer in Diabetes and Primary Care
Paul Dromgoole	Lecturer/Practitioner in Diabetes
Moria Carnazza	Practice Nurse
Carol Sucheski	Practice Nurse
Carey Trenchard	District Nurse
Jill O'Brien	Staff Nurse
Sarah Lomax	Diabetes Specialist Dietitian
Julie Thomas	Lead for Diabetes UK, Selby and York
Jim Khambatta	Health Planning Manager
John Reid	GP and Lead for Selby and York Diabetes Network

PAGE POINTS

1 Support in the practice environment is vital, and some of the practice and community nurses highlighted the difficulty in obtaining study leave to enable them to access education.

2 Each professional group demonstrated some similarities in educational needs but also some subtle differences worthy of further investigation.

gap between theory and its practical application (Gallagher, 2004), and the efforts employed to try to reduce this deficit, is recognised (Ekebergh et al, 2004).

Figure 1 demonstrates the relationship between where and how the respondents feel they acquired their knowledge about diabetes care. This was interesting, and demonstrated that education had influenced practice.

The notion that a gap between theory and practice exists has proven to be most fertile (Gallagher, 2004) and provides the opportunity for appropriate educational opportunities to be developed locally. This gave the subgroup reassurance that education and clinical practice can enhance diabetes care, but only if support and clinically relevant opportunities are made available. Support in the practice environment is vital, and some of the practice and community nurses highlighted the difficulty in obtaining study leave to enable them to access education.

Walsh and Jones (2004) stress that multi-faceted developments can facilitate learning in practice; these include partnership working, new modes of learning, supported learning and problem-based learning. The publication of the *Diabetes National Workforce Competence Framework* (Skills for Health, 2004) provided an ideal opportunity to tailor opportunities in order to meet practice needs and to develop individual teams.

Each professional group demonstrated some similarities in educational needs but also some subtle differences worthy of further investigation.

Self-reporting of education needs in diabetes care

The self-reporting and actual measurement of knowledge can be nebulous, so a more specific measure needed to be employed. Figure 2 highlights each individual group's self-reported diabetes knowledge. The TNA was designed to extract more depth and as such gave respondents opportunities to highlight and rate their perceived knowledge and also their need for further training/education opportunities. This reaffirmed the assumption that it

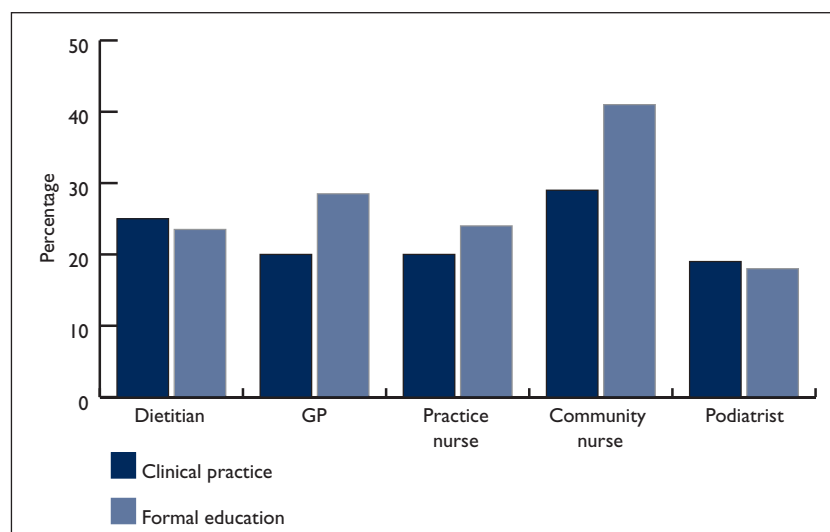


Figure 1. How diabetes knowledge was acquired by professional group.

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1 When asked if respondents wanted educational opportunities that were multidisciplinary or discipline specific, 88% of respondents replied that multidisciplinary opportunities would suit their needs better.

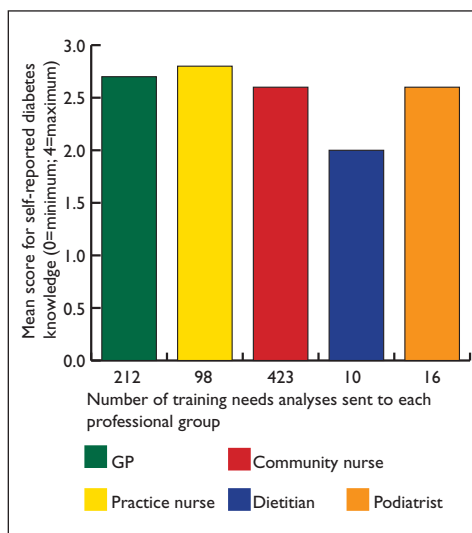


Figure 2. Mean self-reported overall diabetes knowledge by professional group.

is extremely difficult to make accurate self-assessments of knowledge (Tracey et al, 1997), particularly when the management of diabetes represents one of the most complex medical challenges in the treatment of any chronic condition. Effective management requires a robust healthcare system with enough support for people with diabetes to perform multiple complex behaviours over the short and long term to improve both biological and quality of life outcomes (Williams et al, 2004).

Future interest in diabetes-related training by profession

Each professional group indicated its overall need for educational opportunities (Figure

3). Six 'hot topics' were identified from specific educational requests (Figure 4).

When asked if respondents wanted educational opportunities that were multidisciplinary or discipline specific, 88% of respondents replied that multidisciplinary opportunities would suit their needs better. Of the 12% who expressed a preference for discipline-specific educational opportunities, all were GPs; this response was linked to the next question, which asked about whether there is any need for educational opportunities to assist in implementing all or parts of the National Service Framework for diabetes (DoH, 2001) or new General Medical Services contract targets. GPs also commented that despite them having a need for education in diabetes care, education/training was often attended by the lead GP for diabetes within the practice. Another element was the time needed to attend; there clearly was enthusiasm, but the time was a difficult hurdle to overcome. This highlights the need for a different type of educational provision for whole practice teams, and the concept of workplace-based skills education (Chapman and Howkins, 2003; Parboosingh, 2002).

Type 2 diabetes risk management strategies

The topic of management strategies for type 2 diabetes is timely and the request for education in risk management strategies was high on the agenda among all disciplines approached. This reflects the current multi-faceted interventions required in diabetes care (Olivarius et al, 2001); it also reflects evidence from the United Kingdom Prospective Diabetes Study regarding the need to recognise and effectively treat modifiable risk factors (Adler et al, 2002). Figure 5 identifies the rating from each discipline regarding its knowledge of type 2 diabetes risk management strategies.

Implementation of NSF Standard 3: Empowering people with diabetes

This aspect (the implementation of Standard 3 of the NSF) of the TNA reflects

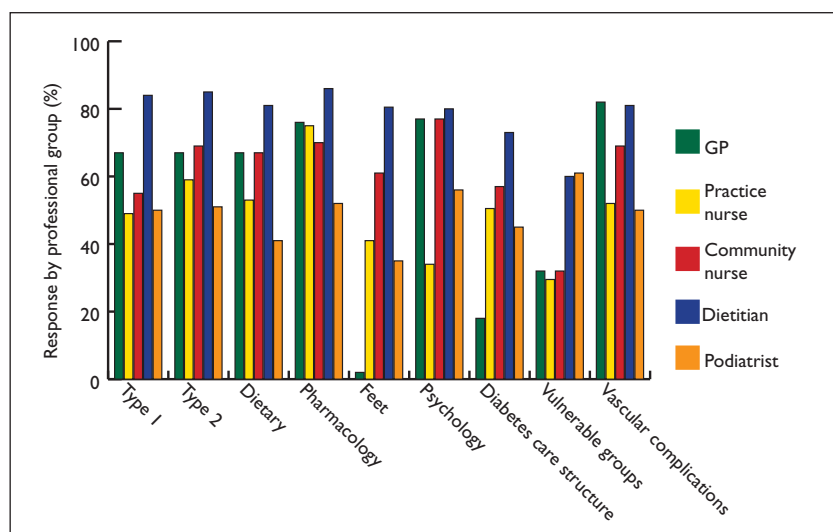


Figure 3. Future interest in diabetes-related training by professional group.

the national agenda of development of personal care plans (PCPs) for people with diabetes. Figure 6 illustrates TNA respondents' knowledge of developing PCPs.

Fifty per cent of practice nurses and almost 50% of GPs felt their knowledge of PCP development to be good. However, in a whole team approach incorporating dietitians, podiatrists and community nurses, all indicated a need for more knowledge of diabetes care delivery. This approach is more systematic and, according to Roberts (2003, personal communication):

'A care plan is at the heart of a partnership approach to care and a central part of effective care management. The process of agreeing a care plan offers people active involvement in deciding, agreeing and owning how their diabetes is to be managed.'

This need for a whole team approach to the use and implementation of PCPs is at the heart of the NSF (DoH, 2001) and the concept of effective management of chronic conditions.

Psychological implications of diabetes

While the long-term health consequences of diabetes are recognised, the effects of educational and psychological interventions in diabetes aimed at self-management are not well understood. According to Skinner and Hampson (2001), in people with diabetes, beliefs and personal understanding of the illness and its treatment are considered to be key factors influencing self-care, emotional well-being and glycaemic control.

Psychological problems such as depression and coping with eating disorders are common and are associated with suboptimal diabetes management and further complications (Ismail et al, 2004). As optimum diabetes management is desirable and respondents have indicated their needs in this vital area by low self-reporting of knowledge in most of the professional groups (Figure 7), this is an aspect of provision that needs to be in place to support clinical practice in its

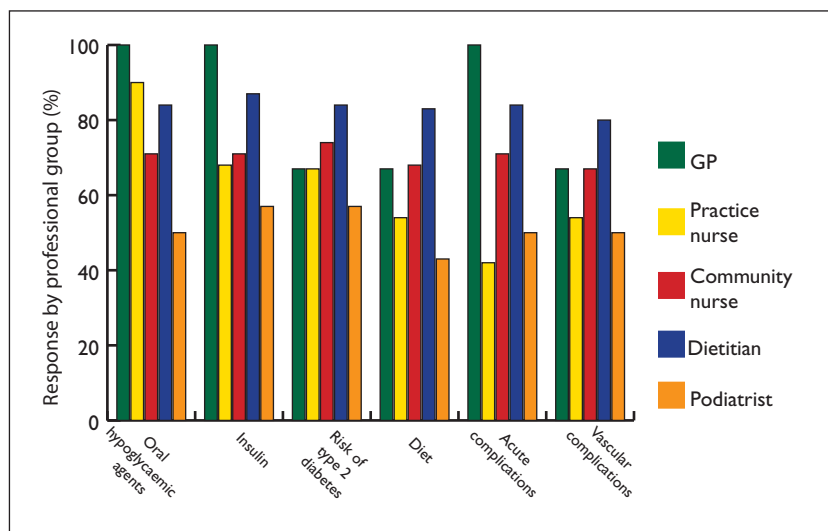


Figure 4. The six 'hot topics' as identified by professional group.

diabetes care skills. This is especially pertinent in respect of NSF standard 3 (DoH, 2001).

Pharmacological issues

All respondents indicated the need for continuous updates in the use of pharmacological agents, including insulin. This is highly relevant as it reflects the increasing role of primary care in insulin initiation, and the recognition of the importance of risk management strategies and effectively treating any potential vascular complications. This is highly reassuring, and supports evidence that primary care is very effective in managing diabetes as long as the necessary support is available from specialist care services

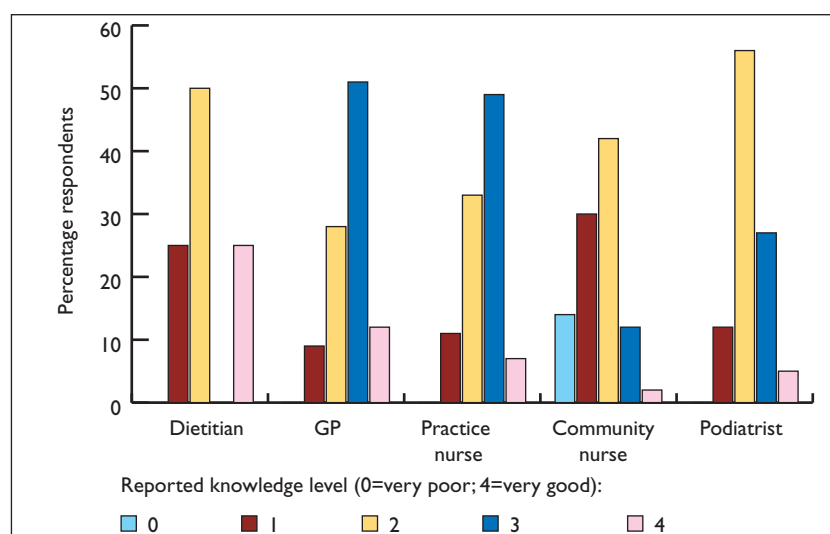


Figure 5. Self-reported knowledge of type 2 diabetes risk management strategies.

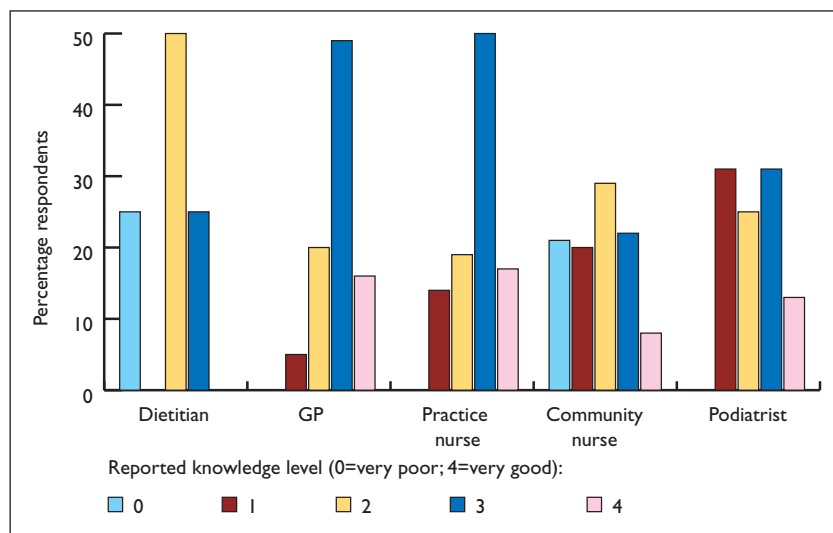


Figure 6. Self-reported knowledge of developing diabetes personal care plans.

as and when required (Williams and Farrar, 2005). Respondents did comment that time was presenting difficulty in accessing ongoing education, and that an impartial delivery by healthcare professionals regarding pharmacological issues was preferable to a pharmaceutical company-sponsored event.

Responding to the needs highlighted by the TNA

Use and value of the TNA

In delivering the NSF, the Selby and York Diabetes Network aims to ensure that effective diabetes care is available for all those with diabetes in the PCT, and as such the TNA has been immensely useful. It has highlighted areas for future

development, and has provided a valuable listening exercise to the practitioners who predominately provide the care. This exercise has enabled the subgroup (Table 1) to plan workforce skills, and to present its findings to the larger network.

The results of the TNA have also been presented to the clinical leads meeting at the strategic health authority, and the TNA template has been adopted by several neighbouring networks.

The next steps

The development and metamorphosis of the network is a fundamental principle in delivering the NSF and also accrediting local services with acknowledgement of the expertise already in place, and those areas to be further enhanced. In conjunction with the University of York, the network produced a portfolio of educational opportunities for healthcare practitioners entitled: *Diabetes – Advancing clinical practice* (University of York et al, 2004). This has enabled educational opportunities to be tailored to meet local need and to respond to NSF Standards 1–5 and 7–11.

Conclusion

Through the use of the TNA, the mapping of existing expertise and excellence in the delivery of diabetes care, and of areas where a need for support and education exists, has been highlighted. This has enabled the network to target, plan and focus support for healthcare professionals requesting it. This is an ongoing and productive venture, which also seeks to clarify the person with diabetes’ journey between primary and secondary care services along a continuum, and to break down the apparent divide between primary and specialist services, by recognising and supporting the growth of specialist services within primary care throughout the network. This type of approach, through the network members, is vital in order to sustain and establish a level of service at the point of contact for people with diabetes, whilst encompassing advancing clinical expertise, effective team-working and coping with the sustained epidemic of diabetes facing the UK. ■

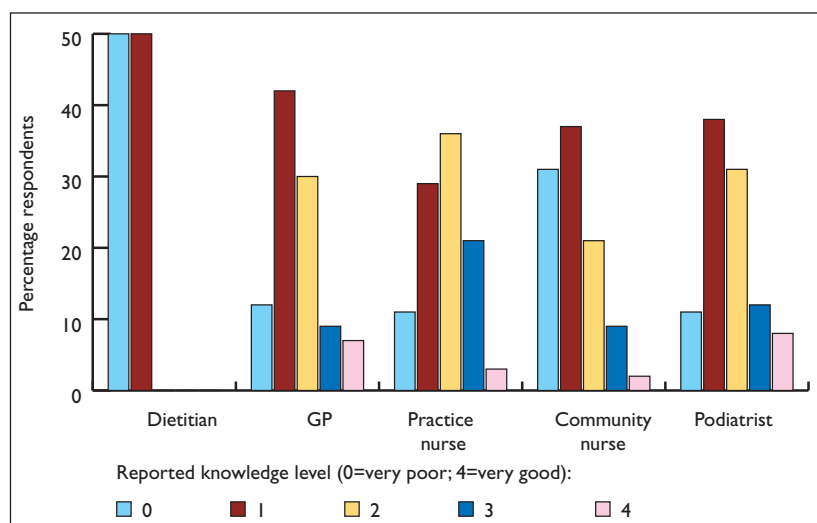


Figure 7. Self-reported knowledge of psychological implications of diabetes.

Adler AI, Stevens RJ, Neil A, Stratton IM, Boulton AJ, Holman RR (2002) UKPDS 59: hyperglycemia and other potentially modifiable risk factors for peripheral vascular disease in type 2 diabetes. *Diabetes Care* **25**(5): 894–9

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Skinner TC, Hampson SE (2001) Personal models of diabetes in relation to self-care, well-being, and glycaemic control. A prospective study in adolescence. *Diabetes Care* **24**(5): 828–33

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Williams GC, McGregor HA, King D, Nelson CC, Glasgow RE (2004) Variation in perceived competence, glycaemic control, and patient satisfaction: relationship to autonomy support from physicians. *Patient Education and Counseling* **57**(1): 39–45

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Yorkshire and Humber Public Health Observatory (2005) *Diabetes Population Prevalence Model*. University of York, York. Available at http://www.york.ac.uk/yhpho/resources_diabetes.htm (accessed 30.08.2005)

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