Diabetes and Diabetologists

A survey of the roles, responsibilities, working practices and job satisfaction of Consultant Diabetologists in England

Aims

- To describe Consultant Diabetologists
  - perceptions about there work
  - current concerns
  - elements contribute job satisfaction
  - aspirations
- To describe models of care as presently provided
- To identify key problems and present barriers to service development
- To consider potential solutions

Project Team

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Workplace of Consultant Diabetologists interviewed

92 interviews

Common themes:
Important aspects of the role of Consultant Diabetologist

- **Clinical specialist**
  - Highly clinically skilled in managing a complex chronic disease.
  - Special relationship with patients.
  - Long years of training & experience.
- **Leader of diabetes service**
  - Sets priorities & direction
  - Responsible for service development
- **Key educational role**
  - For patients
  - For multi-disciplinary staff
  - For primary and secondary care diabetes teams
  - For other non-diabetes secondary care health professionals
- **Responsibility for quality of diabetes care**
  - For patients directly under care
  - For all patients in the healthcare community

Common themes:
Interface with General (Internal) Medicine

- Increasing burden
  - other specialties withdrawing.

- Critical for maintaining currency of essential skills
- Diabetologists should champion G(I)M.

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- Barrier to fulfilling other important roles.
- Diabetologists should give up G(I)M.

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- Responsibility for G(I)M should vary according to different career stages or interests.

Common themes:
Interface with Endocrinology

- Usually satisfactorily resolved
- Some active and enjoying
- Others not doing any Endocrinology
- Usually personal choice
- Much less tension than with G(I)M

Common themes:
Issues around team working

- Multi-disciplinary
- Size of team important
- Extending to include primary care/community outreach

- Geographical considerations
- Physical considerations.
- Line management issues.

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- Worries about loss of team in community setting.
- Role of the Consultant within the team.

Common themes:
Issues affecting relationships with General Practices

- Mostly good, collegiate, co-operative.

- Concerns about minority.
- Concerns about expertise and capacity.
- Central role of practice nurses

- Educational programmes strengthen relationships.
- IT and information transfer/sharing improved.
- General Medical Services (GMS) contract & Quality & Outcomes Framework (QOF).

Common themes:

Issues affecting relationships with PCTs

- Different stages of organisational development.
- Differing cultures.

- Reorganisation and instability of PCT structures
- High turnover of staff with frequently changing roles and responsibilities.
- Staff attending meetings are not empowered to make decisions.
- Responsible PCT staff have poor understanding of diabetes.
- PCTs in poor financial situations.

- Diabetes Network Manager & engaged GP Lead have critical roles.

Common themes:
Training & recruitment

- Adverse effects of shift patterns & EWTD.
- Increasing pressure from Acute / General Medicine.
- Lack of exposure to out-patient diabetes.
- Limited opportunity for training and educating junior staff.
- Limited opportunities for private practice compared to procedural based specialties.
- Negative impact of poor Consultant morale
- Need for positive role models.

Summary

- Positives – clinical role and commitment to patient care
- Multi-faceted role
- Centrality team-working
- Relationships with primary care critical…..
- Time to develop, build and grow teams…..
- Negotiations with PCTs often problematic
- Present structure spawned competitive rather than collaborative culture……
- …..impedes true cross–boundary working
- Key tension: between the close collaborative working underpins excellent diabetes care and multiple unregulated providers
- Key critical role of high quality commissioning

Recommendations (1)

- Commissioners should recognise the importance of effective primary and secondary care collaboration in the provision of diabetes care…and commission for the extended role of the diabetes specialist.

- Better understanding of the need for flexibility in the development of local services to deliver national quality of care standards in a way that reflects local need.

- Greater recognition that to function effectively networks need to have consistent high-level PCT involvement and membership and be empowered

Recommendations (2)

- Development of locality based, multi-faceted teams of Consultant Diabetologists with complementary skills and expertise.
- Increasing flexibility around involvement in General (Internal) Medicine and Endocrinology.
- Protected time for:
  - creating, developing and supporting an effective multidisciplinary team.
  - developing strong partnerships and collaboration with primary care colleagues.
  - education and support of primary and secondary care teams.
- Training programmes for Consultant Diabetologists should recognise the core skills and expertise required by the diabetologist but also reflect the increasing diversity of the role.
- Increasing the awareness and exposure of junior doctors in training, to diabetes.
- Issues which lead to negative morale are actively addressed so that Diabetes becomes a positive choice for junior doctors.

Thank you

Questions…..?