LEADING ARTICLE

**Teaching and Learning at the primary - secondary care interface: work in progress?**

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**Abstract:** Teaching and learning across the primary -secondary care interface is more described than actually carried out. As such it could be said this mirrors patient care across the same interface. We argue that for very good reasons generalists and specialists could do a lot more learning together than they currently do. If they did patient care, particularly integrated care, would be significantly advanced. We describe some examples of how it can be done well and suggest ways in which such learning might be more generally achieved. We suggest not only that those who learn together work better together, but also that they innovate health care more.

**Introduction**

For all sorts of reasons, clinicians in primary and secondary care seem to find it difficult to learn together. They exist in different workplaces, learn their various crafts differently and probably see the world in separate paradigms. Such a state of affairs is not the most fertile soil in which to grow integrated care across the primary -secondary care interface [henceforward ‘the interface’] Overall there is a paucity of scholarship on interface learning. This may reflect clinicians’ comfort in their own silos.

**A few facts**

Here are few facts to conjure with: firstly, we know population health is better delivered where hospital and community co-operate together. Secondly those who learn together work better together; and thirdly, improving individual health care depends on innovative methods of delivery.

Putting all this together means that we need to improve clinical education at the interface [where traditionally it has not happened much]. We will offer, later on, some examples of where it is done well. To some extent this depends on good inter professional education, for which there is an evidence base of efficacy. In this context considering doctors who work in primary care as a different discipline from those who work in hospitals is practicable if novel, for the reasons given above. In reality we should consider all clinicians across the interface as part of that inter- professional nexus.

**Constraints:**

There are constraints of course. The National Health Service [NHS] in all four UK countries is under severe financial pressure [and has been so for at least 10 years]. The opportunity for educational innovation is limited by service pressure, traditional educational conservatism and the need to fulfil regulatory driven learning outcomes. Furthermore, we might argue that the workplace could, and should be, the primary venue for healthcare education delivery, or at least should aim to achieve a better balance with the classroom. Given the distributed nature of community-based service provision, compared to the hospital, this can be a challenge too. Historically for example, whilst General Practitioners [GPs] have conducted some of their training in the milieu of a hospital, the reverse is not generally true. The implication is that specialists should actually get out more![[1]](#endnote-2). Relationships across the interface do exist, both professional and personal. We suggest such relationship building is a necessary part of good care and good education too [[2]](#endnote-3). The success of the UK Foundation Programme since 2007, where early years generic training is conducted across the interface, is an example of this [[3]](#endnote-4)

**Collaborative competencies:**

This is of particular consideration as hospital clinicians tend to be specialists whereas community practitioners tend to be generalists. This is not always so but, given the preponderance of work styled in this fashion, it is an important issue for education planning and delivery. However, the NHS is essentially a monolithic provider where change can be fostered throughout the system. A generalised will to move to a system where clinicians learn together across the interface with the explicit aim of advancing integrated care, and thus patient outcomes, should, at least in theory, be more easily achievable at scale. Collaborative competencies, described often as a prerequisite of integrated care, are thus a necessary adjunct of interface education [[4]](#endnote-5). In fact, the very act of sharing education practice, when it is done well, should augment the development of such competencies.

When planning interface educational initiatives, desirable outcomes could include equipping our postgraduate medical workforce with skills to design and deliver innovative and seamless patient care across the sectors [[5]](#endnote-6). Therefore, it can be very helpful to plan to evaluate educational change and service redesign in tandem. [[6]](#endnote-7)

**Designing interface medical education**

In designing interface medical education thought can be given to a range of possible educational methods, and their suitability in terms of desired impact and scalability. By looking systematically at the parameters which can be changed in postgraduate medical education, one can design and evaluate a range of educational initiatives.[[7]](#endnote-8) Such parameters may include changing the disciplines of those forming a learning or clinical team, adapting the learning environment to cross interfaces, using innovative technologies to run interactive learning events between remote interface sites, utilising educational skills of the opposite discipline, and creating cross sector employment as a catalyst for learning and service transformation.

Changing the disciplines of learners who form a learning group or clinical team is exemplified in *Learning Together* [[8]](#endnote-9), and the care home educational ward round projects. Using the *Learning Together* model, pairs of learners sourced from a mixed background of primary and secondary care see patients together, under the guidance of the GP trainer in practice. Clear educational gain and health improvement at minimal cost has been demonstrated[[9]](#endnote-10). The care home project includes learners from general practice, care of the elderly, care of the elderly psychiatry, pharmacy, nursing and patients’ carers. Again, the learning team are under the supervision of the GP who has clinical responsibility for patients in the care home. A holistic care plan for the coming year is created with full involvement of the patient and their family who are invited in advance. In both these projects changes in agreed priorities, management plan and prescribing may occur. In addition, at the end of the session, a facilitated learning event occurs involving the wider practice or care home team, to spread learning and seek feedback from the wider team.

**Innovative technologies:**

Using innovative technologies to combine and connect learning across interfaces can have the advantage of utility, in that no additional learning events need to be created and learners or existing staff remain in their usual workplaces. Live streaming can allow combined meetings where for example medical conditions are explored by presenters and audiences from many venues, again spanning any traditional boundary in health and social care[[10]](#endnote-11) . In addition, wider reach can be obtained by recording and uploading such events on a learning platform, facilitating access for those who would otherwise have missed the event. Such learning events could be co- designed with service innovations, such as virtual clinics [[11]](#endnote-12)

Some educational projects have not mixed disciplines of learners but have sought to utilise educational techniques more commonly used by the opposite discipline. Examples include expanding simulation in primary care learning to include manikin-based simulation, virtual reality consultations as well as the commonly used simulated patient scenarios [[12]](#endnote-13) . Such events can benefit from the skills of simulation centre teams, and secondary care learners such as psychiatrists in the design and delivery of the event, alongside primary care physicians.[[13]](#endnote-14)

**Cross sector employment:**

Employment across sectors, exemplified by new NHS post qualification fellowships, has attracted much recent interest [[14]](#endnote-15). This offers the potential benefit of developing a flexible workforce. As these learners have been tasked with systems redesign across interfaces, NHS England have described the hope that such opportunities will become available to all newly qualified GPs and practice nurses from 2020 onwards[[15]](#endnote-16).

As yet, primary - secondary care joint education is rarely embedded fully [though reference is often made to integrated care] in Royal College curricula. This would be a very valuable next step if effectiveness and desired impact on educational outcomes and patient care can be demonstrated. Next steps should include formal evaluations of existing projects and consideration of any evident limitations [[16]](#endnote-17).

**Advancing interface education**

How then to proceed in advancing this agenda of interface education into the modern NHS?

We suggest it can be considered at three levels:

1 **Micro** – primary and secondary care practitioners should learn together in their practices and hospitals in the same room at the same time. Such planned [or even unplanned] events will enhance local relationships in the cause of learning. Local leadership may or may not be needed, but the support and encouragement of local management is probably a *sine qua non*. Such learning may add to that gained from consideration of Serious Untoward Incidents or other patient driven events for example. No doubt local neighbourhoods can establish interface learning needs centered on local priorities set by local health needs.

2 **Meso** – Hospital locations and groups of primary care clinicians are not always contiguous. This is usually because hospital locations are accidents of history rather than systematically planned. Nonetheless the community education provider networks [CEPNs] or training hub network [THs] forming across England offer an opportunity for primary and secondary care clinicians to come together across a defined placed based system. For example, London has 32 CEPN/THs covering each of the boroughs and encompassing all primary care practitioners of that area [[17]](#endnote-18). Some are linking up with their local hospitals to run interface events, and in the future should be able to formally foster such activity.

3- **Macro**- Integrated care has been built into many recent NHS policy documents. [[18]](#endnote-19) Our strong position is that service and education can, and should, run hand in hand. In this way the implementation of integrated care, and the collaboration that must underlie it, will positively develop population health outcomes. Central support for interface education must be in place for these gains to be realised.

**In summary**,

We have argued that this point in NHS transformation offers just the moment to correct a longstanding omission in the delivery of health care education in the UK. As integrated care advances so should health care education. Bridging the historical NHS divide between primary and secondary care and integrating teaching and learning across this interface is crucial, we claim, to achieving this.

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