New models of care: Mind the ~~Gap~~ GAPS

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Outline

Trainer Perspective

- What we're doing
- What we're missing

Trainee Perspective

- Dr Ben Houlford ST7
- Three month placement

Community Consultant: Typical Blueprint?

- Consultant Diabetologist, 0.6 WTE
- Appointed 2010 from SpR training (Flexi)
- Prior experience in QI
- First two years – no peer support
- Over seven years team has doubled and includes a research team.
- Leading new models of care work for diabetes across West Hampshire.


NHS

1. What is our community experience and why does it matter?

- WHCDS has been recognised nationally and locally (BMJ and HSJ award shortlists)
- GP trainees – two years (3m rotation)
- SpRs – since August (3m rotation). No OOH

Quality Improvement projects do not have the same recognition as Academic projects/ research and can be seen as a potential irritant to the status quo!

2. What feels different about working in a community service?

- In order to innovate we have to change
- Leadership skills are key: self awareness
- Constantly developing our workforce: new roles
- Culture change: new heuristics[1]

1. Recommissioning a sustainable model of care. Fayers, Price, Woodman; Practical Diabetes (33) December 2016

Financial incentives are not aligned across the locality and cause conflicting behaviours.
Service vs training?

3. What skills are we looking for?

- Ability to work effectively in MDT
- Self awareness and effective leadership
- Resilience & appetite for change
- Experience of managing budget/ resource

Registrars have little experience of service redesign.
Leadership skills are often under developed.
Understanding of the healthcare economy is poor.
The specialist training portfolio doesn't really measure what we offer.

4. What can we offer?

- A number of different QI projects
- Understanding of how these fit together through shared aims
- Exposure to external stakeholders

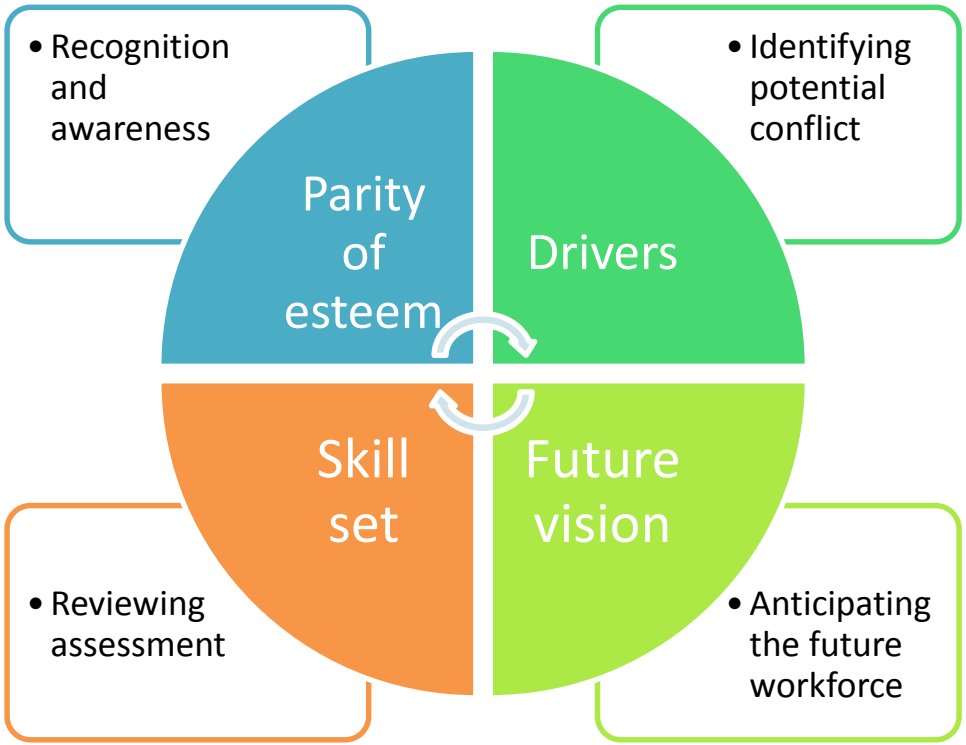
The current model of training encourages new consultants to “own” a subspeciality rather than their role in the wider system - are they conflicted from the start?

Inertia


JUST IN CASE THIS CARE MODEL SINKS.
NHS ENGLAND
HMS
VANGUARD
HMS
VANG
IAN BAKER..

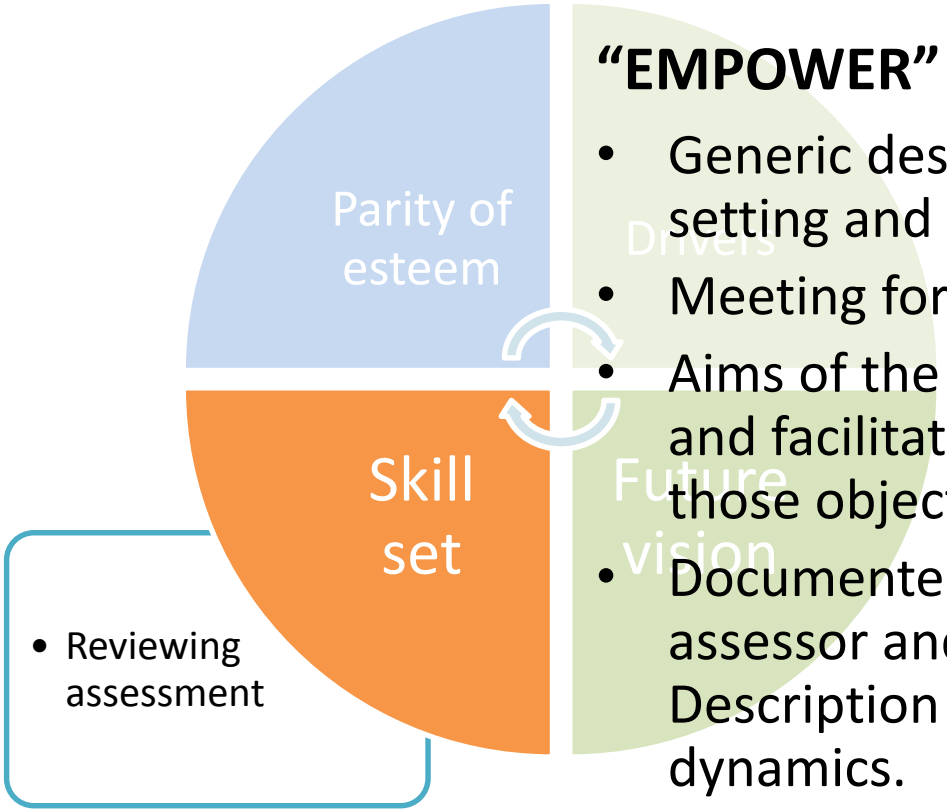
Summary

- Community training needs the same **parity of esteem**
- Our **drivers** are different care is improved
- The **skill set** of specialist registrars doesn't match our job description
- We can offer a **vision** of the future!



How we can help modernise training

Measuring missing skills – a tool



“EMPOWER”

- Generic description of the setting and stakeholders
- Meeting format and structure
- Aims of the meeting –barriers and facilitators to achieving those objectives.
- Documented debrief between assessor and trainees. Description of insights and dynamics.
- Self-directed trainee reflection

Exposure to management and participation in operational and external relationships

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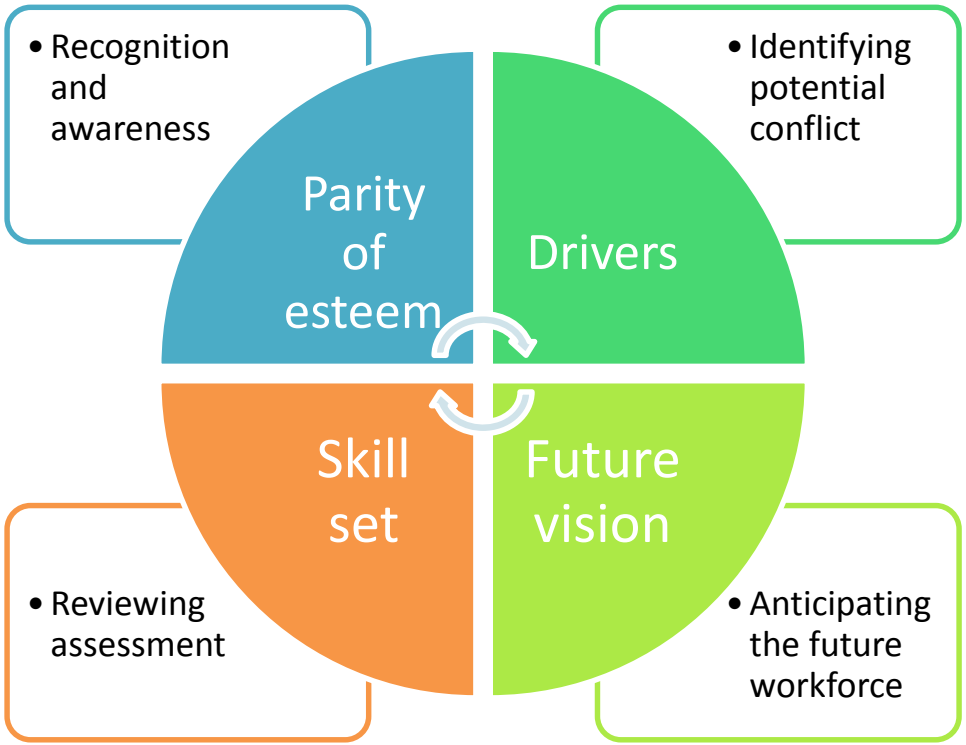

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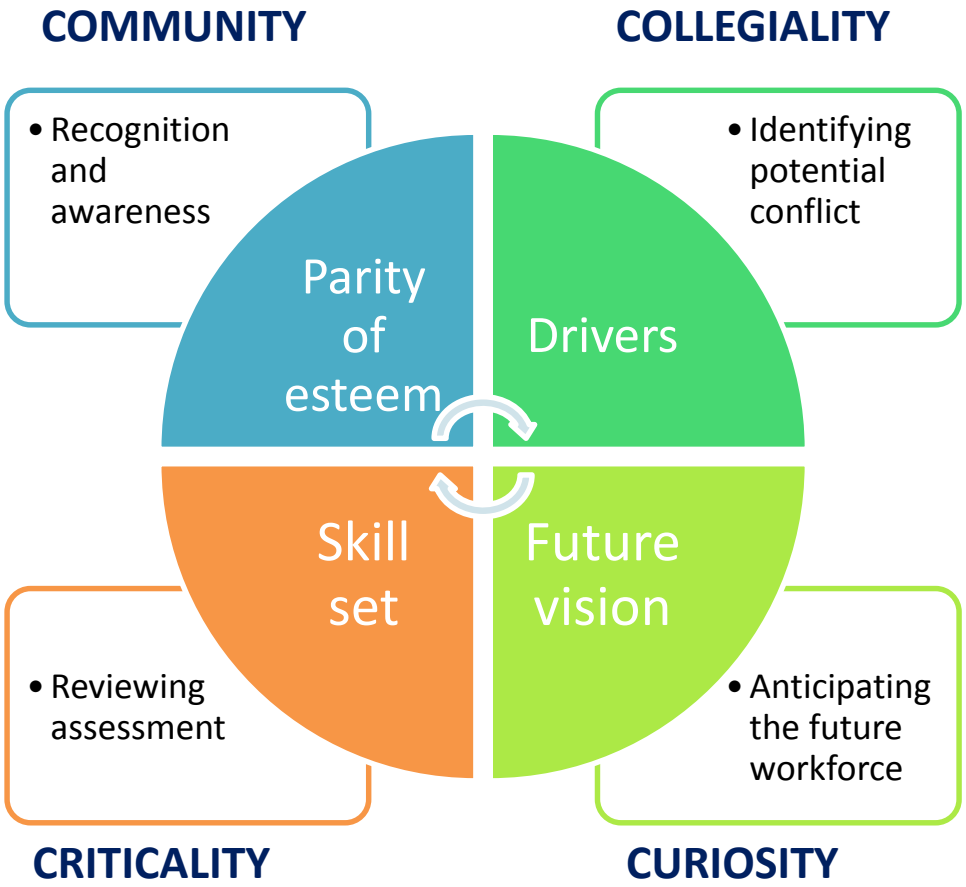

How we can help modernise training

The whole purpose of education is to turn mirrors into windows

Sydney Harris

COMMUNITY SERVICE!
DR BEN HOULFORD SPR

What have I been up to?

- Clinics – same as in hospital
- Patient education sessions
- Patient education project – Patchworks
- Phone clinic
- Triage – learning how to make best use of limited resources
- Work with GPs – seeing the interface

What have I got out of this?

- It’s been brief…
- …but valuable
- Community diabetes team – what they actually do
- How a service can work across a large area
- Building a team – types/traits
- Running a project
- Experience of community diabetes – jobs