MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

Written evidence submitted to the
National Assembly for Wales
Inquiry into Medical Recruitment, Feb 2017

Medical Recruitment:
Learning from Bangor ED

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Introduction

Whilst your inquiry today may be mostly focused upon GP recruitment, I wish to share with you the transferable lessons from the Bangor Emergency Department (ED) Clinical Fellow scheme: the most successful Emergency Medicine recruitment scheme in the UK.

Emergency Medicine middle-grade doctors are notoriously difficult to recruit and retain, and rural Wales is notoriously difficult to recruit doctors into. So Ysbyty Gwynedd in Bangor, the western-most Emergency Department (ED) in North Wales, might be expected to have a extremely severe recruitment problem.

And, historically, we did. Indeed, we faced the possibility of going into August 2011 with no middle grade doctors at all. Yet in the intervening six years, we have completely turned around the staffing and recruitment situation.

Bangor ED is now - quite literally - the *only* ED in the UK that has more doctors than posts. We have doctors queueing for posts at all levels (junior, middle-grade and consultant) some of whom are doctors lining up to *return* to Bangor for the next stage of their career.

This has been achieved without recourse to recruitment agencies, golden handshakes, or expensive "doctor hunting safari trips" to India.

It has been achieved by designing posts that doctors actually *want*, treating our doctors *well*, and connecting with potential recruits via their preferred forum (i.e. social media) in a scheme that is 100% clinician-designed and led.

The fundamentals of the strategy underpinning the Clinical Fellow scheme are 100% transferable to other settings in medical recruitment. I hope this summary will be helpful.

This report in the context of the Terms of Reference/scope of your inquiry

This report concentrates on the last three of the five areas of reference for this inquiry, as indicated below. I would, however, be happy to comment upon any of these areas when I give evidence to the Committee in person on Feb 8th 2017.

- ❌ The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care [although with my EM/GP/WAST/Community Care of the Elderly experience I have an interest in this this)
- ❌ The implications of Brexit for the medical workforce.
- ✅ The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.
- ✅ The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.
- ✅ The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

Where we were, and where we are now

Prior to August 2012, the Bangor ED middle-grade doctor tier consisted of only five SAS doctor posts ("staff grades"). They worked a tough rota with 2-in-5 weekends. Night cover was non-resident on-call. Agency locums were used for all annual and study leave, and were also required to top-up cover every weekend, making it an extremely expensive staffing model. Some years, we also had a Wales Deanery Specialty Trainee in ST4-6 (i.e. registrars in their final three years of Emergency Medicine training) but due to failure to fill all the Wales Deanery posts, we were often left without. Hence, as the combined effects of "Modernising Medical Careers" and UK visa/ immigration policy kicked in, like most UK Emergency Departments, we were left with a dearth of middle grades.

By early 2011, we had only one substantive staff grade left (and he was trying to secure a place on radiology training and wanting to leave) and few aced going into August 2011 with no substantive middle-grade doctors at all. This, of course, threatened the supervision we were able to give our *junior* doctors (mainly provided by deanery-approved training posts) placing the viability of the entire ED at risk.

Hence, in late 2011 I proposed and launched the **Bangor ED Clinical Fellow Scheme**. By the 2012/13 recruitment year it had both increased our cover *and* saved more than £250k compared to continuing reliance on agency locums for 4 out of 5 middle-grade posts.

Since then, our middle-grade recruitment has steadily increased, with the number of high quality candidates now at - or surpassing - the (much-increased) number of available posts. This is despite a background trend of major recruitment and retention problems in UK Emergency Medicine, with the well-documented failure in patient flow producing ED/system gridlock and "crowding",

What are Clinical Fellows?

The Bangor ED posts were specifically designed for trainees wishing to take a "year out" of training posts following completion of the three-year Acute Care Common Stem (ACCS) programme and prior to applying for Higher Speciality Training. The headline feature of the posts is the "20% playtime" - 2 sessions a week (plus an admin session) working in pre-hospital emergency medicine (in partnership with WAST), Medical Education, or Management/ Quality Improvement, or a bespoke mixture.

ACCS trainees may have a parent specialty of either EM, Acute Medicine (AM) or anaesthetics, and all have followed a prescribed training programme consisting of 6 months of EM, AM, anaesthetics and Intensive Care, plus one further year of training in their parent speciality.

Our posts were, therefore, designed to dovetail with deanery training posts, but are not educationally approved for training themselves.

Since our posts were designed, most EM trainees are now on "run through" training (i.e. they no longer needing to re-apply for training posts after completion of ACCS) and come to us with the permission of their host deanery on "Out Of Programme Experience" (OOPE).

an extremely stressful and unpleasant working environment for staff. The speciality has been "haemorrhaging" trainees across the whole UK.

Bucking this national trend, we now have 13 Clinical Fellow posts, plus two 100%-HB funded posts allocated to Wales Deanery trainees (one for an ST3 and one for an ST4-6) and most/all are usually filled. This does not equate to 15 Whole Time Equivalents (WTEs) - fully one third of our current middle-grade tier have taken advantage of the options to be less than full time (LTFT), take a break mid year (either as traditional unpaid leave or by annualising their hours), or both.

Our advertising for Aug 17-Aug18 posts has, for the first time, been conducted entirely by social media and following interviews last week, our middle grade tier is secure until August 2018 at least.

How this was achieved: the Bangor 6-step recruitment strategy

Our position as the UK's most successful Emergency Department in terms of recruitment and staffing has not been reached by chance, and did not occur as a result of following traditional NHS HR recruitment practices. A combination of extremely hard work, the willingness of our management teams to allow clinicians take ownership of the problem and "get on with solving it" with minimal interference, and - crucially - a knack for understanding the motivations of the doctors who are our potential recruits have all been required. These following six steps summarise the approach I devised and we have successfully utilised. I believe the principles outlined here are applicable to all medical recruitment scenarios.

Step One: Take a good hard look at what you are offering

In a tough recruitment market, mediocre jobs will get nowhere

At the start of 2011, we took a dispassionate view of our existing staff grade posts and it wasn't too difficult to see why we had lost 4 out of 5, with the last man standing preparing to go. The posts were, to put to bluntly, dreadful.

The rota was horrific, the work intensity high, the pastoral and professional-development support zero (apart from the 10 days of funded study leave), and the status of the doctors was poor. The posts were 100% service provision, regarded by all as work-horses.

Acknowledging that no amount of being "near Snowdonia" or "friendly department" makes up for fundamentally bad posts was the Eureka moment that set us on the road to finding a successful solution .

Before this, we had been convinced that "all we needed was a better advert" and, as is so often seen, we resorted to full-page colour adverts in the BMJ extolling the scenery. What few applicants we did have could certainly be described as "scraping the barrel".

Who are the Bangor ED Clinical Fellows?

Real life examples at a reunion

Nick Brazel, post-ACCS anaesthetics. Came to us from East Midlands. Aug 2014-Aug 2015. Returned to anaesthetic training afterwards.

Andy Muirhead-Smith, post-ACCS anaesthetics in London. In Bangor Feb 2014-Aug 2015 Still working in BCUHB

Rio Talbot , Cardiff graduate. CF Aug 2012-Aug 2013 after ACCS in London. Then EM higher training in Wales. Interviewing for Bangor consultant post later this month

Linda Dykes Clinical Fellow programme director

Dafydd Williams. From Anglesey, first language Welsh. Trained in England, moved home Aug 2014-Aug 2015 for CF post. Now Wales' ICM trainee.

Rich Griffiths. From Sheffield. Clinical Fellow Aug 2012-Aug 2013. Returned to Bangor for final six months of EM training. Currently locum consultant in Bangor ED, interviewing for substantive post later this month

Step Two: What are the "push" and "pull" factors for your target recruits?

What makes your target recruits tick?

We initially designed our Clinical Fellow posts by asking our star ACCS trainee "what would make you take a year out and work here before going into ST4?" - which is how we ended up offering a post with front-line ambulance sessions in partnership with Welsh Ambulance.

We have since refined our approach, and realised that in order to successfully recruit, you must have an in-depth understanding of what factors are likely to be acting as "push" and "pull" factors on your target market.

For Bangor ED Clinical Fellow posts, this wasn't difficult to deduce. Generally, EM trainees are finishing ACCS are experiencing significant burnout: many are thinking of leaving. The promise of a civilised rota (ideally, the best they have every worked) and time away from the "hot-zone" of the ED shop floor is appealing. The "playtime" - especially Pre-Hospital EM *in work time and* without having to wait until completion of ST4 (4th year of specialist training) and throwing oneself into sub-speciality training - is a key attraction.

Our typical recruits are around 30 years old, mostly single or in a relationship, with only a few being married. Hardly any of them have yet had children. They are still used to the concept of moving around the country for work - their roots are not too deep and some can still move their possessions in a hired self-drive van.

Most are from England. In our experience they are universally angry with the current Westminster government, loathe Jeremy Hunt, feel let down by the BMA, resent the contract imposition in England and (unsurprising in those choosing to take a post offering a "year out") often cynical and disengaged with the training system.

They are almost all Generation Y. Hence, they are less likely to be motivated by money, and more likely to be motivated by posts offering support, coaching, a better work-life balance, a feeling of "belonging to something that matters" and excellent pastoral support.

By knowing our target recruits, we can target our advertising - see Appendix 2.

Doctors and recruits (and their life-stages)

The "push" and "pull" factors are different at different stages of a medical career and life stages. Some "push" and "pull" factors are professional, but domestic circumstances are vital (and yet too often forgotten).

The most mobile doctors are those in the **first few years after qualification** - by five years in, as per our Fellows, partners/spouses (and their jobs) may be starting to restrict their mobility. The last chance for easy relocation (single and divorced doctors excepted) is **before any kids go to school.**

By the time they are in their late 30s and 40s, many doctors are **parents of school-age kids:** few will be prepared to move across the country without other significant push/pull factors.

However, as **kids get older & leave school**, some doctors may have itchy feet after many years in one place, and financial incentives may be more attractive (older Generation X and younger Baby Boomer doctors often face a double-squeeze of university costs for kids and potential care-home fees for their own parents).

Later-career doctors would be a prime target for many GP posts, with plenty of experience yet no longer tied by the kids (however, elderly parents may influence relocation decisions) and any **last-few-years-before-retirement** doctors may be attracted by pensionable perks if they are still under protected final salary pension arrangements.

- *See Appendix 1 (a rural GP recruitment proposal) for a discussion regarding influence of Welsh language and education policies on decisions to move.*

Step Three: Fix everything you can in the posts you offer

… and be scrupulously honest about what you cannot fix

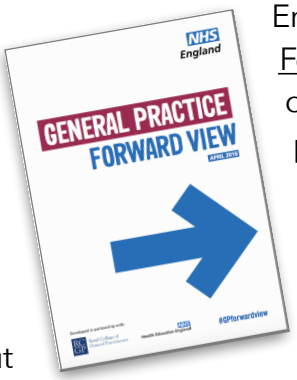
Everyone is wary about job adverts that promise the world, and yet do not deliver the package in full.

This is so endemic in medicine it is a running joke: when I was appointed to Bangor in early 2005 I was promised the rebuild of the ED would be commencing within months, and here we are nearly 12 years later and it still has not happened.

When it comes to designing any post for **junior doctors**, it really isn't difficult to work out what your recruits want sorted out - if it was mentioned in the English Junior Doctors dispute, it is a problem that needs fixing.

Into this category comes rotas (e.g. fixed annual leave allocations, being unable to take time off for important things like family - or one's own - wedding), paltry study leave budgets, covering rota gaps, and not knowing rotations or rotas till the last minute.

Designing posts for **consultants** or **GPs** have some things in common with junior doctors, but others are specific to specialty and post.



England's 2016 "General Practice Forward View" (GPFV) contains a comprehensive analysis and set of proposed solutions to the problems facing Primary Care. Wales will need to meet or surpass the commitments made in England's GPFV if we hope to attract qualified (and trainee) GPs from across the border.

That said, we have advantages in Wales too, and should not be afraid to point these out. Despite the shared problems with underfunding of health and social care with England, we are free of the scourge of CCGs, internal competition, and STPs. We are also free of Jeremy Hunt, a fact that we fully exploit in our "guerrilla" social-media recruitment campaigns (see Appendix 2). For doctors in England bruised and demoralised by battles within the CCG system, the simplicity of NHS Wales structure is a potential bonus. Like scenery, it's not enough to sell a post in isolation, but it could certainly help clinch a deal.

Step Four: Work out your USP (but *don't* copy)

What is it about your job that is unique?

Whilst it is tempting to attempt to carbon-copy formats that have worked well elsewhere, successful jobs are a product of their environment, the workplace culture and the people running them and cannot be replicated exactly.

Several schemes have attempted to copy the Bangor ED Clinical Fellow posts and failed, as they were unable to offer a replicate the full package we offer with the posts, only the headline "playtime" - which isn't enough.

New posts, especially novel ones, benefit from a USP and it is worth taking the time to work out what the should be.

The next page demonstrates the features of our Clinical Fellow posts, in a format we used to advertise the posts.

Autumn 2016 Bangor ED Clinical Fellow advert incorporating the key features of Steps 1-4

Applications for the Bangor Clinical Fellow posts OPEN NOW on NHS Jobs: 050-ED-CF-11-16

MENU

A La carte menu for the perfect year out after ACCS ST/CT3 (any specialty)

STARTER

Included in all packages

- Fantastic quality of life
- Snowdonia on the doorstep
- Fabulous beaches on Anglesey
- Amazing surfing on the Llyn Peninsula
- Hill-walking, mountain-biking, rock-climbing & wonderful road cycling
- Sailing, kite-surfing, horse-riding
- Affordable house rental prices
- Flexible, annualised rota (LTFT very easily arranged)

MAIN COURSE

Emergency Medicine the way it should be

- Rural EM in a friendly, small ED
- Well staffed with loads of middle grades: no #mindtherotagap here
- Enthusiastic Educational Supervisors who have time to look after you
- Structured activity programme to enhance your CV
- Full range of cases (very little bypasses) including STEMIs, strokes, and major trauma

DESSERT

A day a week (two sessions) of playtime, plus a paid-but-not-timetabled SPA session

The icing on the cake of your year out: combining fantastic opportunities and burnout prevention

Pre-Hospital Emergency Medicine

- Shifts with Welsh Ambulance (ambulances and RRVs) plus Helimed
- Gain a unique appreciation of SAR: we are the mountain medicine experts!

Medical Education

- Teaching practice with medical students, paramedic students, MSc students and junior colleagues
- Help develop our simulation programme
- PGCertMedEd fully funded for 12-month posts starting Aug/September

Management/Quality Improvement

- Dreading trying to populate your management portfolio whilst battling with FRCEM & the demands of ST4-6?
- Enjoy the luxury of 2 sessions a week (plus your SPA session) of tailor-made, supported activities and projects

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www.mountainmedicine.co.uk

Step Five: Build up your brand

Who are you and what do you stand for?

One of the four key roots of employee engagement is that "everyone wants to belong to something bigger then they are". It is also true that most people like to belong to something they perceive as successful. Hence, in Bangor ED we have worked very hard to establish our "brand".

We do not advertise ourselves as the ED in "Ysbyty Gwynedd, Betsi Cadwaladr University Health Board". For most of our target recruits, this means nothing (we have only ever recruited one Clinical Fellow from inside of Wales, though several have subsequently chosen to remain in Wales for higher training) and we may as well be advertising a job in Timbuktu. For those who *are* already aware of BCUHB, a struggling health board in special measures is hardly an attraction - and for a junior doctor, a health board is too big a unit to imagine feeling the impact of one's personal contribution (the 4th "root of engagement")

Non-geographical health board names are significant handicap when it comes to recruitment, and, given the scarcity of Welsh-speaking doctors, we also need to ensure our advertising does not project the impression that speaking Welsh is essential to work as a doctor in Bangor. Hence, we stick to "Bangor ED" or "Snowdonia's ER".

We also use "Mountain Medicine Bangor", our longstanding research and teaching collaborative project with local Mountain Rescue Teams and SAR helicopter partners. We are also known as "Mountain Medicine Bangor" (Facebook group, Twitter handle) and we use the project logo (right) to reinforce our visual identity.

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Many of the Bangor ED consultants and Middle Grades - past & present - assist with building the "Team Bangor ED" brand via social media and in person.

(right)

Summary of the efforts Team Bangor ED go to in order to build, and maintain, the "brand".

Most of this is discretionary effort, completely unfunded by the NHS, costing considerable amounts of our own time - and money.

However, the reward for the team is that we can now recruit, and take pride in running what is arguably one of the best small DGH EDs in the UK.

Links:

www.mountainmedicine.co.uk
(our unofficial ED website)

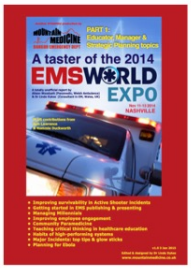
www.scribd.com/BangorED
(our unofficial filesharing site)

We attend conferences in polo shirts featuring the ED Mountain Medicine logo. We pay for these ourselves.

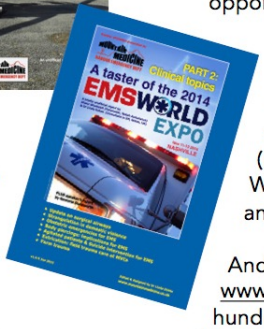
We also **produce and print flyers and leaflet the toilets at some conferences**. We pay for these ourselves, too.

We are active on Twitter, both on individual accounts (followers range from around 250 to over 3500) and with the @YGEDBangor account (653 followers)

We produce conference reports after going on Study Leave. There are further used to promote the ED and we try to release them at times when we are recruiting to make use of a free advertising opportunity.



We **organise CPD events**: these provide speaking opportunities for our Fellows, and reflect very well on our ED when we promote then via Social Media.



These get between 1000-3000 views on our file-sharing website www.scribd.com/BangorED (needs non-NHS computer to view). We also upload our conference posters and other educational material there.

We **accept speaking engagements**: Linda and Rob both speak at national events in the UK, and Linda is regularly invited abroad, too. If we can't attend, we delegate any Mountain Medicine speaking invitations to our HSTs and Fellows who've been involved with the scheme.

And finally, **we run our unofficial website**, www.mountainmedicine.co.uk which gets hundreds of hits a week. We maintain and pay for this ourselves.

Step Six: Advertise your wares

Attractive adverts come last, not first!

There seems to be an almost universal belief held by clinicians, managers and politicians that the scenic, recreational and cultural delights of Wales are all that is required to attract doctors to move here, and so all we need are slick and sexy adverts pointing out how lovely it is to work close to mountains/beach/Cardiff.

Sadly, this is complete nonsense, as should be evident from the fact that Wales is short of doctors, still struggling to recruit, to the extent that you are having to hold this government-level inquiry into it.

Advertising is important - see how we do it in Bangor ED in Appendix 2 - but is is the final icing on the cake when tackling a recruiting problem. In Emergency Medicine, General Practice and many other shortage specialities, our potential recruits are "customers", who can walk into a job wherever they like. No business in their right mind would spend their entire budget on an advertising campaign when they know the "product" is sub-standard, and yet this is what continues to occur in the NHS in Wales. Too many of our posts are the equivalent of a 1980s Skoda - basic, old fashioned, outdated, unfashionable and undesirable.

Skoda did not reach it's current market position and award-winning cars merely by sexing up its adverts. It had to completely re-engineer its products, whilst also providing superlative customer service from dealers, in order to overcome the handicaps of its past.

Treating your recruits well

Never underestimate the importance of treating your doctors well. Quite apart from improving one's own job satisfaction, in these days of social media, a kind or harsh word to a trainee could well be relayed across the UK medical community in minutes, particularly in very connected specialities like EM who have many doctors actively using Twitter.

"Feeling like a VIP in Bangor, rather than a useful though ultimately inconsequential person in xxxx deanery"

Pre-2011, although I worked alongside my staff grade colleagues, I knew nothing about them. I didn't know their backgrounds, hopes or dreams. I had no idea of their marital status or kids or hobbies. I didn't know what their learning goals were because I never asked. Looking back, I am ashamed of how poorly we treated them.

In contrast, with my Clinical Fellows today, I know what makes them tick. I know if they have a parent undergoing cancer treatment, an exam looming, or a career dilemma. I know if they worry about running a trauma call. Our educational supervision meetings are usually 2-3 hours for a first meeting and 1.5-2 thereafter (*cf.* average for a new deanery trainee of 30 minutes) usually in a cafe, over food. We know this effort is noted and appreciated by our Clinical Fellows, and is in particular contrast to their feeling of disillusionment in their (usually English) training posts. It is also what makes them recommend our posts to their friends and junior colleagues, even though we are falling behind our competitors in terms of the proportion of "playtime" in our Clinical Fellow job plans.

A word about recruitment practices and HR support

It shouldn't feel like wading through treacle

This eclectic mix of observations are purely from a personal perspective. Like the rest of this paper, they reflect my personal opinions and are not necessarily those of the rest of the ED team.

1. Timescales of unfilled deanery posts being released to health boards for local recruitment

- National problem

The timing of release of unfilled Deanery junior-tier posts (F2, GPST, ACCS-ST1/2) for local recruitment is extremely unhelpful, occurring as it does only weeks before commencement of posts. This results in need to hire agency locums at short notice at extortionate expense, when a few months earlier we have had to send away multiple young doctors wishing to work in Bangor ED for an "F3" year as we've had no posts released back to us at that time. These willing applicants have long gone by the time the Deanery release posts back to us.

2. GPs returning to the UK

- National problem

There have now been two UK-trained GPs wishing to work in North Wales (both of whom had been working in similar primary care environments, one in New Zealand and another in Holland) who have been completely let down by Wales' apparent inability to handle returners to the Performers List in a coherent and responsive way. One gave up and returned to NZ; the other we managed to find a 12-month Speciality Doctor in Care Home medicine post for.

The English GPFV document carries specific provision for returners to GP including decently-funded placements.

Wales must address this as a matter of urgency or risk never being able to recruit returners to practice, who will just leak to England instead.

An experienced GP, even if requiring an element of supervision/conversion to UK practice, is unlikely to be a "net generator of extra workload" to host primary care settings.

3. Delays creating consultant posts for shortage specialties when candidates come forward

- Problem noted in BCUHB, but may be widespread

Consultants in Emergency Medicine are scarce and good ones need to be secured whenever the opportunity presents itself.

In years gone by, regardless of the financial position, if good candidates arose then posts would be created with a "make hay whilst the sun shines" philosophy. However, in BCUHB today, it has taken almost a year to create two new posts for Bangor ED (even in the face of looming retirements on the same tier) primarily due to concerns about budgetary constraints in the current financial pressures.

This is short-termism at its worst, and having worked so hard to fix EM recruitment in Bangor it is also soul-destroying to see our efforts near-sabotaged because the organisation is so desperate to meet short-term financial constraints that it seems willing to sacrifice long-term financial prudence.

The government needs to indicate clearly to Health Boards that recruitment of high-quality consultants, especially in shortage specialties, is an acceptable reason to overspend, especially when there would be foreseeable agency locum usage on the horizon otherwise.

A word about recruitment practices and HR support

4. Policies for overseas doctors commencing posts

- Problem noted in BCUHB, but may be widespread

With the recent arrival of a Dutch doctor completely new to the UK, we have just been made aware that current BCUHB policies compel overseas doctors (and UK doctors returning from abroad) to turn up at work for their paperwork and occupational health assessments/blood tests, *but they are not then added to payroll until these results are back*. In the intervening time, without a payroll number, they are also unable to access on-line mandatory training.

Clearly this is not acceptable: a doctor's first day at work is when they should expect to be paid from and it looks amateurish and exploitative to suggest otherwise: not a good recruitment tool in these days of social media. It would also be a far better use (of days that would otherwise be wasted) for doctors to be able to undertake their mandatory training in this time window before their occupational health blood results are back.

This may be a local policy, but I also understand that for doctors who require their TB status to be ascertained as part of the visa-obtaining process, our local Health Board policy is to re-check this, subjecting these doctors to another delay of several days.

We were also unaware of some of the logistical difficulties faced by doctors new to the UK . For example, UK car insurance companies require UK-registered credit cards be used for payment (I had to pay for my new Dutch doctor's car insurance).

Whilst Bangor ED has very few doctors completely new to the UK, colleagues in other health boards and specialties have made much more use of overseas doctors coming to Wales for their first NHS post. Adequate supporting packages and fair pay-from-day-of-starting-work policies should be required from Welsh Health Boards.

A poor "customer experience" from the point of view of the new recruit will very likely result in adverse gossip on social media, hampering further recruitment.

Appendix One

In Appendix One, I present a four-page proposal as a suggested solution to the dual challenge of recruitment to rural General Practice now, and the need to encourage Welsh-speaking medical students to pick general practice (and in particular rural General Practice) in the future.

Recruitment of rural GPs in mainly Welsh-speaking areas of Wales: an integrated proposal

Dr Linda Dykes, Consultant in EM, Ysbyty Gwynedd and GP - Jan 2017 *v1.1*

Introduction

Like everywhere else in the UK, Wales is struggling to recruit sufficient GPs to meet the healthcare needs of an ageing population and soaring demand. However, the overall difficulty recruiting GPs is compounded in our rural areas: recruitment of doctors to rural settings is a worldwide problem.

These challenges are further compounded by Wales' need to optimise access to Welsh-speaking HCPs, particularly in areas (e.g. the Llŷn Peninsula, Carmarthenshire) where elderly residents may not be balanced bilinguals, and consultations conducted in English may impact upon the safety and quality of care.

"Do what you've always done and you'll get what you've always gotten..." - Bolger

Quite rightly, the need to increase the number of Welsh-speaking students going to medical school has been recognised.

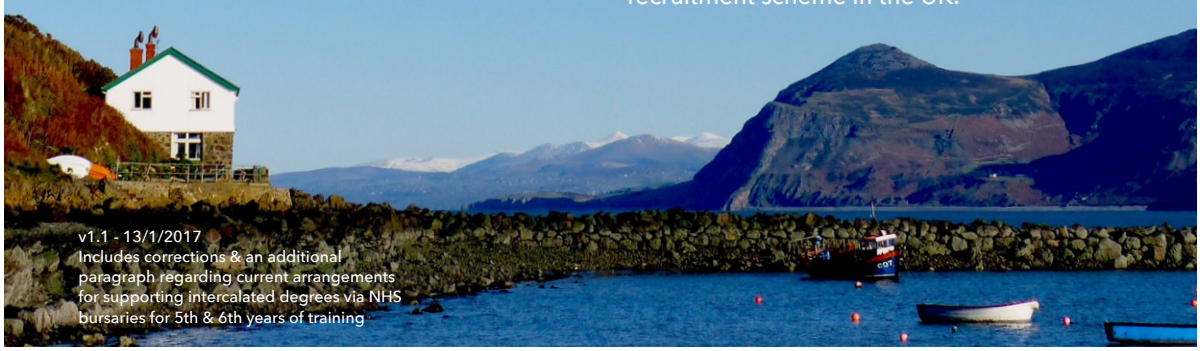
But it takes more than decade to train a GP from scratch, and we are desperately short of GPs *now*. Furthermore, only about half of UK medical graduates choose to enter General Practice.

We know that settled choices regarding eventual specialty are often made early in medical school, and we know that early exposure to rural practice settings increases the chance of Healthcare Practitioner students later working in a rural area.

This proposal suggests a combined solution, which would simultaneously address:

- tackling the serious challenge of GP recruitment to rural areas
- the need to provide optimal exposure to rural practice early in medical school
- support provision of bilingual primary care

The suggestions in this document incorporate the evidence regarding medical students' specialty choices and rural healthcare recruitment, plus the experience I have gained running both a hugely popular medical student programme in Ysbyty Gwynedd Emergency Department and the most successful Emergency Medicine doctor recruitment scheme in the UK.



v1.1 - 13/1/2017
Includes corrections & an additional paragraph regarding current arrangements for supporting intercalated degrees via NHS bursaries for 5th & 6th years of training

Step 1a: Recruit your GP

There are two likely sources of GPs for this scheme:
- already working in Wales who fancy a move
- those considering a complete lifestyle change

Identifying target recruits in the latter group requires pragmatism. Many (if not most) GPs have children. English-speaking families with school-age children are rarely prepared to consider relocating to an area where all the local schools are Welsh-medium*. Hence, the targets would be those with children under 4/5 years of age, or who don't currently have children, or whose children have left school.

Spouse/partner profession is also important. Doctors married to teachers or social workers are unlikely to consider relocation to an area where their spouse/ partner will be unable to gain employment within commutable distance**. However, many doctors are married to other doctors: dual-GP couples would be ideal.

Given that "lifestyle change" is the most likely factor "pushing" someone to contemplate a move to rural practice, post design must include features appealing to GPs feeling unfulfilled or burned-out in their current urban posts. It is also important to recognise that younger recruits (up to their mid-30s) are "Generation Y" and have different motivating factors and behavioural characteristics to older Generation X and Baby Boomer doctors.

Posts should be developed with features such as:

- Flexible job plans with features such as annualised hours and generous funded study leave
- Experienced rural GP mentor/support available
- Sabbatical options after several years' service
- Encourage portfolio careers: offer options within the HBs (e.g. within Enhanced Care schemes)
- Funded Medical Education training (e.g. PGCertMedEd)
- Choice of salaried or partnership options, but with partnerships underwritten by HB (e.g. freedom from "last man standing" financial obligations) & incentivised with indemnity costs covered etc
- Excellent relocation expenses package

** the RAF address this issue by offering support for private/ boarding school fees to all personnel at RAF Valley. This is an option that may require consideration (perhaps for the situation of sixth-form children). Young children immersed in a Welsh-speaking environment do quickly become bilingual - schools in some areas have extra support for such children - but there is no point in pretending that this option is palatable to most English-speaking parents: they are much more likely to decide to opt for another rural part of the UK where it is no consideration (right)*

*** In private industry requiring work abroad, spousal support packages are sometimes offered*

**** Traditional five-year course assumed; suitable equivalent for four-year Graduate-Entry programmes*

Step 1b: Recruit your medical student

The primary goal is to provide an experience of rural healthcare that is the "highlight of medical school", in the hope that this will translate into intention to become a GP, preferably in a rural area, after graduation.

A fully-funded intercalated BSc in Rural Healthcare for students who have completed their third year*** at medical school, combined with a placement to a rural practice or practices for a whole academic year - with good-quality accommodation and a car provided - should prove a *highly* attractive proposition for Welsh-speaking medical students studying at *any* UK university.

The Welsh-speaking Medical Students are then assets. Deployed to a GP surgery to be "buddied" with a non-Welsh speaking GP, or Welsh learner, the student can be utilised as a language tutor, translator, and health-care assistant… all whilst learning medicine. Students used in this way should receive a HCA salary.

Obviously, we would be foolish to limit our long-term efforts to recruit Welsh-speaking doctors to those who have opted to undertake their medical degree in Wales.

Caveat: stunning scenery is not enough

Whilst our amazing scenic and outdoor leisure areas such as Snowdonia, the Llyn and Pembrokeshire are great assets to those who live and visit, it would be folly to think that fabulous scenery alone will motivate doctors to relocate to rural parts of Wales. This is patently not true!

From the perspective of recruiting, GPs wishing to have a lifestyle change to "go rural" have their pick of rural areas of the UK, e.g. Cornwall, Peak District, Lake District, and Scotland. None of these areas have to overcome the twin challenge of language issues from the perspective of childrens' schooling *plus* poor spousal employment prospects (which are worse probably only in the more remote parts of Scotland).

It is only by developing posts *better* than anywhere else in the UK that we can possibly hope to make the idea of moving to rural Wales more attractive than our competitors. This does *not* necessarily mean "Golden Handshakes", but by investing in the areas identified by GPs and doctors in general as their "wish lists", plus making the daunting idea of relocating as hassle-free as possible (e.g. providing accommodation - good quality family homes that could be rented as holiday cottages when not occupied by doctors - or perhaps even providing business set-up grants to spouses**).

Step 2: Does the GP wish to learn Welsh?

It is said to take approximately 1000 hours, using modern language educational techniques and conversational practice, to become sufficiently proficient in a new language for everyday conversation (not technical-level communication). This enables us to quantify the financial cost of training a doctor to learn Welsh.

With rural GP posts already relatively undesirable in the current UK market, it would be unwise to *insist* that willingness to learn Welsh is a pre-requisite for the posts, and patently ridiculous to suggest that applicants should undertake to do so in their own time. We could, however, *incentivise* learning Welsh:

- Offer to send the doctor - in paid work time - on an intensive Welsh-language course. This will of course require locum backfill, which increases the cost substantially (see page 4)
- Introduce step-wise pay premia to reflect Welsh language competency, in *addition* to an already-competitive salary. Speaking Welsh is a skill that doctors moving from elsewhere in the UK are likely to perceive as "only required for the job" (although they may well soon realise that speaking Welsh is of great benefit socially in the rural Welsh communities). See also "The Hiraeth Strategy", right.
- Funded intensive Welsh courses should be offered, in addition to standard study leave, *at any point during the rural GP's stay in Welsh-speaking parts of Wales*.

Offering a month off clinical medicine to do an intensive Welsh language course in paid work time may be a surprisingly attractive "decompression" proposition for a newly-arrived, burned-out doctor seeking a change in lifestyle.

Combined with the reassurance of on-the-spot translation support from a Welsh-speaking medical student, it may well be possible to recruit individuals who are willing to learn Welsh.

The "Hiraeth" Strategy

There are probably more Welsh-speaking doctors *outside* of Wales than *inside*: offering a pay premium to Welsh-speakers **over and above a nationally-competitive salary** may be effective in persuading some to consider answering the hiraeth (yearning for home). Welsh-speaking doctors may be specifically attracted home *because* they want their children to be educated bilingually.

Step 3: Make use of the Medical Student

Unless/until a doctor becomes conversationally proficient in Welsh, other staff will need to support provision of a bilingual service. Welsh-speaking medical students, working with the GP in an "apprentice" model, would provide this facility at the same cost as a HCA (i.e. A4C Band 3) as a maximum, and yet with far greater underpinning medical knowledge, as they would have already completed about half of their pre-registration medical training.

The relationship would be symbiotic: the doctor teaches the student medicine, and the student teaches the doctor Welsh, helping to provide an immersive Welsh-language environment which will in turn speed up the doctor's language acquisition.

Another option: using other HCPs instead of Medical Students

This scheme could also be run using other HCPs (nurse, paramedic, pharmacist or physiotherapists) who are undertaking their Advanced Practitioner training & MSc, during which time they require supervised clinical placements together with time and teaching from a mentor. GPs are ideally suited to this role.

Utilising already-qualified, registered HCPs within the primary care team (instead of a medical student) might be a more flexible addition to the Primary Care Team, and would be faster to set up faster than a new intercalated BSc.

However, It would cost more in pay (i.e. Band 5 or 6, rather than Band 3).

Most importantly, using HCPs instead of medical students would do *nothing* to help encourage medical students into rural primary care, which is likely to be the only way to sustainably tackle rural GP recruitment in Wales.

The ideal solution might well be to utilise **both** - medical students and student Advanced Practitioners.

What would it cost?

Intensive Welsh Courses

- Nant Gwrtheyrn in Pwllheli charge £395 for five-day courses full board, or £255 for daily attendance.
- Completion of their first five levels of course (Pre-entry, Entry, Foundation, Intermediate, Higher 1) would take approx five weeks and cost about £2000
- + locum backfill during the course (c£350/session = £14-18k to backfill five weeks of Welsh course)

Training the medical students to support the learning of Welsh as a foreign language

- I have been unable to find any direct equivalent of the English TEFL (teaching English as a foreign language) courses, which are 4-week long intensive courses.
- Cardiff University offer a 2-year part time National Tutors Qualification which would *not* be suitable - students may need to apply competitively for places on an intercalated BSc and then need a short, swift course to provide them with strategies to assist novice Welsh learners. A bespoke short course may be required.

Paying Medical Students during the intercalated year

- Bangor 3 A4C salary approx £17,000 + on costs: budget as £22,000.
- Use of a vehicle and accommodation (estimate £7000 for 9-month placement) could be included as part of salary package, but the aim is to make the whole rural placement the "highlight of medical school" . This is much more likely if the year is characterised by a well supported placement; enthusiastic GPs; quality accommodation; having more disposable income than the other years of medical school; and not racking up more debt.
- Course Fees of an intercalated BSc plus travel/ subsistence for any associated contact days
- **NB** *intercalated degrees are currently supported by NHS bursaries for courses involving 5th/6th years of training and already carry a cost to the NHS, covering fees and some contribution to living expenses. The current arrangement for intercalated degrees might possibly be enough to attract students to the scheme, especially if combined with decent accommodation and use of a vehicle.*

What would it save?

About £40,000 per post, per year

Reduced locum costs - each post recruited to produces recurring savings in region of £40k+/year

- Vacant GP posts require locum cover - if you can get them - but many remain empty, increasing the pressure on a shrinking number of substantive GPs in the area.
- Locum cover is expensive: based on locum fees of c£350/ session & a typical 8-session GP job plan (cost c£80k including on-costs for substantive post), filling 8 sessions x 44 weeks with a locum would cost about £123k/year.

Saved lives and better healthcare outcomes

- Inequalities in access to primary healthcare are well-recognised as serious problems leading to poorer health outcomes and wellbeing for rural communities.

Summary of anticipated benefits

Supports future GP recruitment to rural areas

A highly attractive intercalated BSc package will encourage students to experience the rural primary care environment early enough in their training to influence their future specialty choice.

Supports provision of healthcare bilingually

Utilising Welsh-speaking medical students in this way would be the most cost-effective way of providing on-the-spot translators *with a clinical background*.

Providing training to participating Welsh-Speaking students in how to support Welsh learners would, in time, help produce a rural NHS workforce capable of nurturing Welsh learners.

Provides a mechanism to improve GP recruitment

Only a tiny minority of doctors will ever be attracted by a move to rural general practice in a remote part of Wales. However, even recruitment of one or two individuals each year would help to alleviate what is currently a problem approaching crisis proportions.

Each post that transitions from locum to substantive filled produces a *recurring* saving of approx £40k/ year… easily half a million pounds in the course of a 10-15 year career in Wales. Part of these savings can be used to support world-class post design. It may also be possible, using the savings, to extend the scheme to all Cardiff/Swansea medical students who wish to participate, whether Welsh-speaking or not.

Appendix Two

Appendix Two contains examples of our unofficial, "Guerilla" adverts/flyers for the Bangor Clinical Fellow posts. Created in my own time without the involvement of HR, these informal, sometimes-provocative and hopefully entertaining adverts are widely shared on social media, and generate many shares and comments *because* they are so different from standard medical adverts.

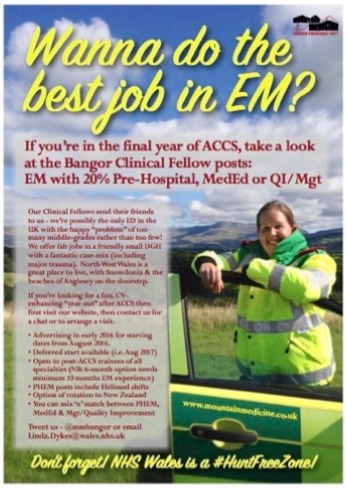
Our recruitment round for 2017/18 has just completed. We attracted a record number of applicants with only social media advertising - more than a dozen flyers over a 12-week campaign - producing a saving of more than £7000 on the customary full-page colour BMJ advert.

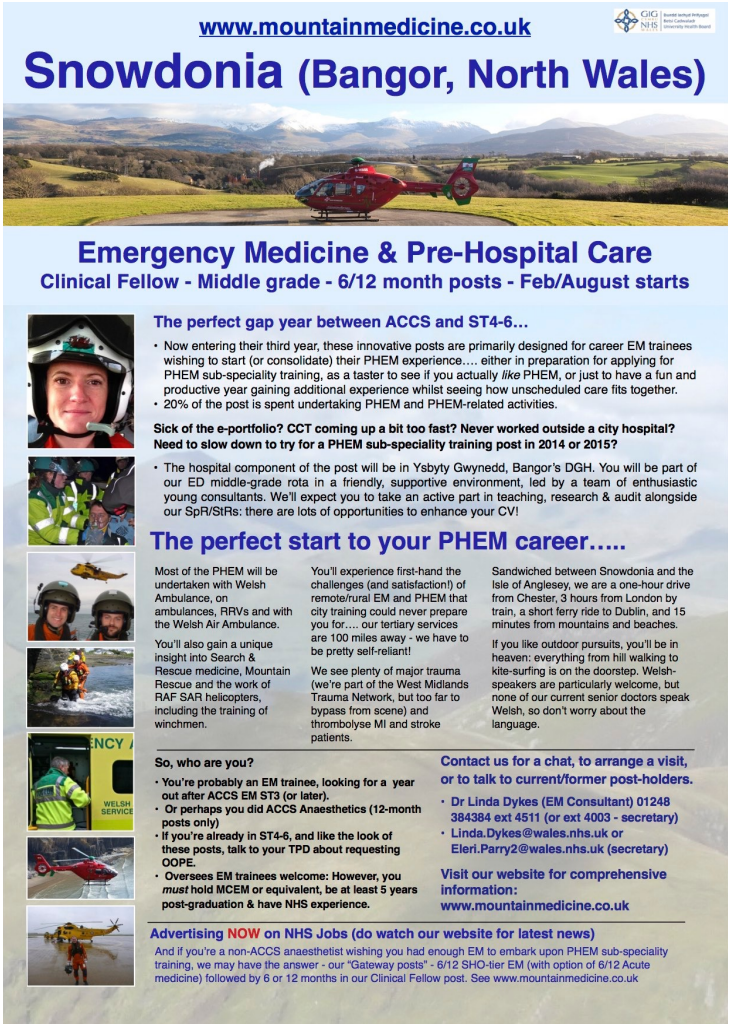
(right)

Selection of unofficial flyers from the 2016/17 recruitment campaign, which emphasised some of the benefits of our Clinical Fellow posts compared to the flash-point topics in the English Junior Doctors dispute during the autumn and winter of 2015/16.

Note in particular the centre-top and bottom-left: by using these "guerilla flyers", we can rapidly respond to the Zeitgeist prevalent amongst our target recruits at the time.

When Lonely Planet recently declared North Wales the 4th best place to visit in the world, we had a new flyer out circulating social media outlets frequented by our target recruits within six hours.





(left)

Early flyer from 2013: the posts at that time were still new and unfamiliar to our target audience.

Today, they are discussed on social media, and doctors we have had no direct contact with recommend them on the Junior Doctors Contract Forum.

(below)

Final flyer of our 2017/18 recruitment campaign: very simple but with the essentials still there.

Signposting to our unofficial website is always included: after each flyer we typically see a spike of about 800 extra hits than normal.

Thought you'd missed your chance to come to our famous post-ACCS Clinical Fellow posts in August? Fantastic jobs with Snowdonia & Anglesey on the doorstep? You're in luck!

Thanks to a couple of deferred starts, one or two opting for LTFT job plans, and creation of additional posts, we can squeeze another one in for a year (plus *possibly* another Aug-Feb) - despite us having more doctors from August than ever before.

Bangor ED

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

Clinical Fellows 2016/17

20% PHEM, MedEd or Mgt/QI

With enthusiastic supervisors, a very friendly department, civilised rota (annualised & LTFT options), playtime of your choice and all the Bangor extras (from pub quiz team to the Mountain Medicine database) then if you're finishing ACCS CT/ST3 (any speciality) why not come to us *this* August? We can't guarantee having many spare places in Aug 2017 - it's half full already from deferred starts.

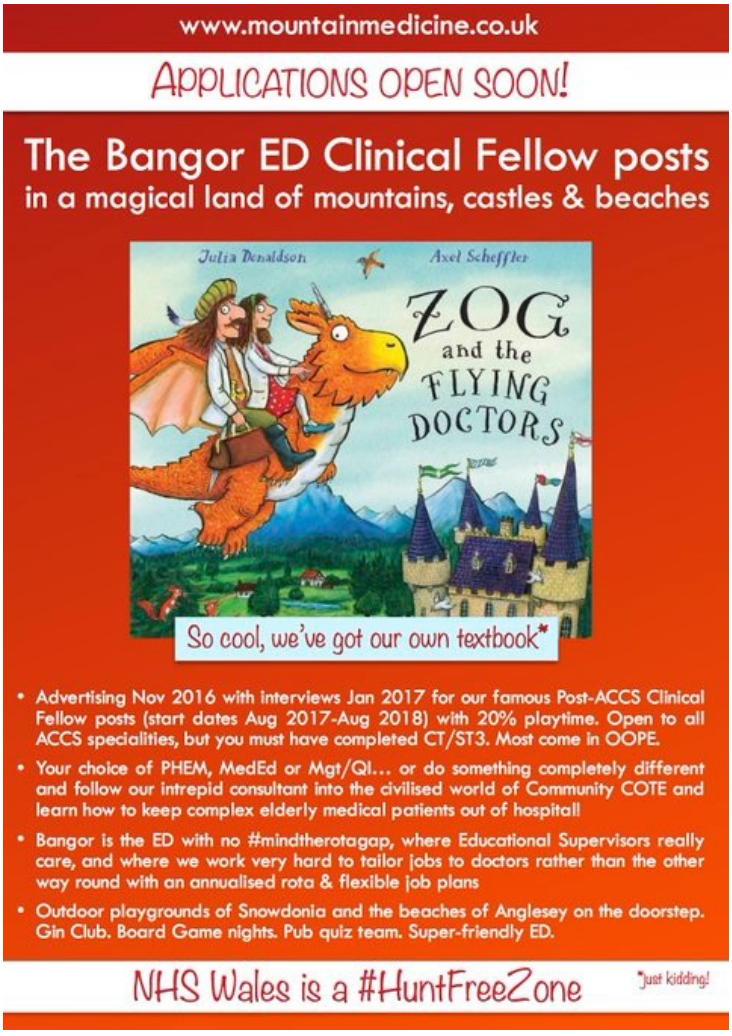
We'd particularly welcome applicants wanting to do MedEd (we'll fund your PGCertMedEd) but could accept another PHEM person!

Contact us: @mmbangor @HelenSalter5 @NoS_EMPhysician

www.mountainmedicine.co.uk

(above)

Catch-up flyer from late Spring 2016 - trying to avoid the "oops we have a space" feeling by emphasising the flexible nature of the posts (e.g. LTFT options) as a reason for having spaces at short notice - which was perfectly true.

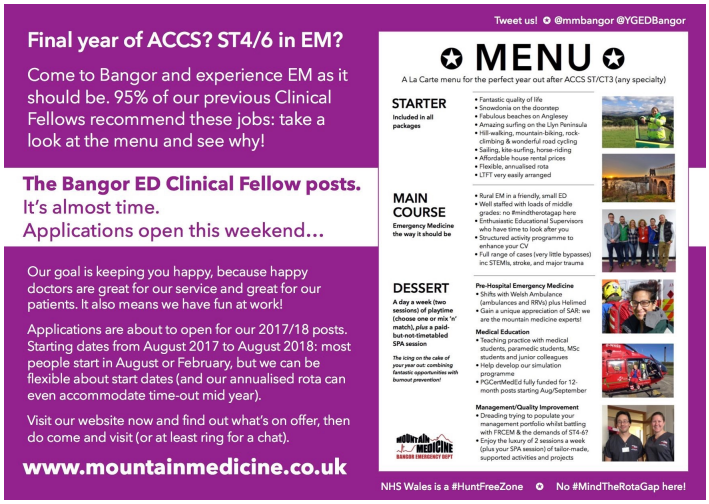


(left)

Early pre-recruitment flyer for 2017/18.

Our adverts for 2017/18 because distinctly more assured and ironically cocky for the current recruitment round. By using flyers such as these as "warm-ups", enquiries are generated and new Twitter followers gained, all of which help to maximise the impact and reach of the later adverts

Medical Recruitment: Learning from Bangor ED



More unofficial flyers from the 2017/18 recruitment campaign.

Above left & right: emphasise that, in contrast to most EDs, our doctors are happy, recommend their posts, and we do not have any problems with rota gaps (the #mindtherotagap hash tag was in wide use at the time).

Right - the most widely viewed flyer of 2017/18 campaign - more than 84,000 views on Twitter.

Below - following the "Zog" warm-up flyer we had toyed with the idea of running a movie-themed campaign, but quickly realised they can alienate potential recruits if they didn't like that movie.

Appendix Three

In Appendix Three, I present for your information page 1-11 (minus appendices which can be supplied upon request) of the Welsh Acute Community Care Scheme (WACCS) proposal document prepared by myself, Welsh Ambulance's Assistant Medical Director and Dr Suman Mitra, a consultant colleague in Ysbyty Gwynedd, in 2015.

We believe this scheme would be of great benefit to Wales, attracting trainees here, supporting Welsh Ambulance, and with likely longer-term benefits for GP recruitment.

We obtained agreement in principle almost two years ago from both Welsh medical schools, the Postgraduate Dean, and WAST. Progress has been slow since, as we have been developing the associated curriculum, and none of us have any time in our job plan for this work.

Thanks to Dr Mitra, the curriculum mapping is now almost complete and we are hopeful that we can start to make progress with WACCS in 2017.

The caveat is the scheme can only progress with the blessing of the Health Boards in order to ensure cover by the Welsh Risk Pool for participating trainees (unless NHS Wales overall were able to construct a national solution). Realistically, the scheme will also require some pump-priming funding support to provide the required administration and consultant time.

10 July 2015

All-Wales Acute Community Care Training Scheme (WACCS): an expanded proposal

Dr Linda Dykes (Consultant EM, Bangor)
Dr Jon Whelan (Assistant Medical Director, WAST)
Dr Suman Mitra (Deputy Training Programme Director, PHEM Wales)

From medical school to PHEM sub-specialty training

contents

from the project instigator

This document has been revised from our original proposal document, following feedback from stakeholders. It expands the scope of our initial proposals at their suggestion. Both of the Medical Schools in Wales, and the Postgraduate Dean, have indicated their support and offered invaluable and insightful suggestions. In the meantime, the Medical Student Pre-Hospital EM societies at Cardiff & Swansea universities have joined forces.

All the pre-requisite ingredients to make this scheme viable are now in place. It is now time to examine the logistics required to make it a reality. I would welcome feedback on this expanded and revised proposal - l.dykes@btinternet.com or Linda.Dykes@wales.nhs.uk

Dr Linda Dykes
10th July 2015

summary & recommendations

- Many medical students and junior postgraduate trainees are keen to gain experience in Pre-hospital Emergency Medicine (PHEM), but the headline “blue light” jobs are only a small part of the work undertaken by ambulance services.
- In other parts of the UK, undergraduate PHEM programmes (which are optional and selective) are extremely popular: Wales is falling behind the curve
- We propose developing an optional structured all-Wales “Acute Community Care Training Scheme”, that students and trainees could apply to opt into, complementing their existing training and helping to prepare them for later application to PHEM sub-specialty training, and/or as clinicians who are comfortably providing acute care in a community setting.
- We believe the proposed scheme would be advantageous for participating individuals, the two Medical Schools in Wales, Health Boards, Welsh Ambulance Service Trust (WAST), patients, and the Welsh health community in general
- Adverse consequences are likely if such a scheme is not created:
  - ✳ Medical students and junior doctors attracted to PHEM will increasingly shun Wales in favour of regions perceived as more accommodating to those interested in gaining PHEM experience.
  - ✳ As more and more medical students wish to copy their counterparts in England and access shifts with WAST, then unless a formal framework is in place, there is a risk of uncontrolled multiple requests to access observer shifts which will overwhelm the current arrangements for hosting observers
- The proposed scheme would catapult Wales to being a UK leader in providing a structured, developmental curriculum with carefully graded PHEM experience for all levels of trainee from medical student to PHEM sub-specialty training
- The proposed scheme would enable students and junior doctors to actively participate in audit & (potentially) research, crossing the boundaries between pre-hospital, community & in-hospital medicine and raising awareness and understanding of how healthcare provision fits together
- The proposed scheme, once established, has potential to become a platform for the delivery of both undergraduate and postgraduate (probably F1) acute community care.

background

Pre-hospital Emergency Medicine is coming of age. Instead of being a minority pursuit of a tiny handful of doctors, it is now a recognised sub-specialty that is generating huge enthusiasm from medical students & junior doctors.

Several areas of the UK have already embraced medical student involvement in early PHEM training - see page 4 - and there are growing calls for formal exposure to PHEM as a routine part of undergraduate training (Antrum & Ho, 2015).

Whilst some medical schools offer formal schemes in partnership with their local NHS Ambulance Trust, in other areas - including Wales - keen medical students have organised their own PHEM student societies typically concentrating on education events, although most of them are also keen to gain access to pre-hospital experience

At junior doctor level, access to PHEM experience is particularly difficult, as there are logistical and governance barriers to ambulance trusts carrying trainee doctors on shifts in anything other than a purely observer role.

Unfortunately, this makes acquisition of PHEM experience even more difficult for those who could not or did not gain any exposure at undergraduate level and this lack of experience may seriously hamper the chances of these doctors when applying for PHEM sub-specialty training.

The Person Specification for PHEM sub-specialty training lists prior experience as “desirable”, as is possession of the Diploma in Immediate Medical Care... but a pre-requisite of sitting this exam is significant PHEM experience.

Access to PHEM experience is so highly prized by medical students & junior doctors that we believe that developing an all-Wales pre-PHEM training scheme - running from medical student to ST3+ - will help aid recruitment of high quality medical students, and junior doctors, into Wales. It will be the first scheme in the UK to include junior postgraduate trainees as well as medical students.

Conversely, if Wales does *not* develop such a scheme, we will become uncompetitive in the UK market and unable to attract medical students or junior doctors who think they may be interested in PHEM.

Meanwhile, we are struggling to recruit GPs. Medical training, despite efforts to the contrary, is still dominated by hospital placements. Given that we know many medical students make a settled choice of the future specialty quite early in medical school, this remains a worry, and we believe that additional exposure to community-based acute care could help enthuse students to consider general practice for a career... or could enthuse those heading into hospital specialties to find a way to have continued access to community-based sessions via the GMC’s incoming credentialing scheme.

Finally, without a coherent scheme to cater for them, the various medical student PHEM groups that have already sprung up in South Wales are likely to make repeated individual approaches to WAST, which has potential for unfairness in terms of access to this experience, and confusion by paramedics as to the role and remit of medical student and junior doctor involvement.

what there is already (in Wales & beyond)

Undergraduate PHEM schemes elsewhere in the UK:

- The **Barts & Royal London Pre Hospital Programme** - the first formal scheme in the UK - involves the medical school & London Ambulance Service (LAS) as well as the London HEMS clinicians. As well as pre-hospital experience with LAS assets, the scheme features monthly open academic sessions, and PHEM-related Student Selected Components (SSCs). This PCP began as a student-initiated scheme. Participation is (highly) competitive and optional.
- **Barts and the London** also offer an intercalated PHEM BSc option for undergraduates.
- **All London medical schools** include the opportunity for students to undertake shifts with LAS.
- **Oxford medical students** have access to a pre-hospital & trauma extracurricular scheme, and their local ambulance service has provided a car for student volunteer first-responders.
- **Birmingham medical students** have had pre-hospital training and exposure as part of their courses since 1991 and were probably the first in the UK to do so.
- **Other affiliates** of the London schemes (Hull/York, Peninsula, Southampton).

PHEM schemes in Wales: Postgraduate

Ysbyty Gwynedd's Clinical Fellow Programme began in 2011 as a scheme to support recruitment of EM middle-grades. Post-ACCS doctors (i.e. ST4 equivalent) spend 20% of their job plan on PHEM and related activities, including with WAST assets.

PHEM Sub-specialty training for ST5+ trainees in EM & anaesthetics began in Wales in 2012, with two places per year available.

PHEM schemes in Wales: Undergraduate

PEMS (Pre-Hospital & Emergency Medicine Scheme) began as a Cardiff medical student society, run with the support of Dr Katja Empson in UHW. The PEMS scheme, like FPHC Student group, is keen to gain access to WAST shifts, but established activities are assisting interested students access ED placements extra to their normal curricula, and regular teaching sessions on EM and PHEM-related topics. See Appendix 2 (page 12).

Since the production in early 2015 of our original proposal document, the fledgling FPHC group at Swansea medical school has been incorporated into a co-ordinated PEMS structure with Cardiff. The FPHC Wales student lead and the FPHC Wales postgraduate lead [Dr Linda Dykes] intend to propose that the FPHC student lead has a seat on the PEMS committee, but will not seek to duplicate activity.

Some students are accessing PHEM experience by standalone SSCs, but without any co-ordination by WAST or control of content beyond scrutiny by the relevant Medical School.

Swansea medical students do already participate in a limited "ride out" programme.

proposed scheme: outline/components

1. Curriculum

The foundation of the scheme will be an all-Wales PHEM curriculum.

Based upon the syllabus for the DipIMC, the content of Phase 1A of PHEM sub-specialty training, the FPHC's "PHEM Skills Framework", and possibly the FP curriculum, the WACCS curriculum will help participating students and junior doctors to undertake activities to gain useful, practical, cross-transferable skills and clinical knowledge, at the same time as optimising their experience for later application for PHEM sub-specialty training.

2. WAST Placements

Carefully supervised WAST placements in RRVs or Emergency Ambulances will be undertaken with specially selected paramedics - likely to be Advanced Paramedic Practitioners (APPs) or Trainee Advanced Paramedic Practitioners (TAPPs) - who will be fully briefed in the different levels of students and doctors participating in the scheme, and what each is allowed to do. See next page for *provisional* proposals.

3. Participation in Community First Responder Scheme

Medical Students participating in the programme will be required to participate in the WAST CFR scheme wherever they are on placement in Wales.

Qualified doctors will also be encouraged to continue as a CFR.

4. Training sessions/CPD

Participants in the scheme will be required to organise a programme of PHEM-related training sessions, and will be invited to participate in any suitable training opportunities being run by WAST (and hopefully other PHEM providers in Wales, e.g. WAA/EMRTS & Bristow SAR helicopters), such as the North Wales monthly PHEM simulation training.

The intention would be to increase the number of multi-professional CPD opportunities so students & junior doctors can learn, and WAST paramedics attend as CPD.

5. Mentorship

All scheme participants will have a named mentor both within WAST *and* a named supervisor in their participating Health Board, who will help to guide placements, supervise and projects or skill acquisition and decide who is showing satisfactory progress.

6. Assessment

Scheme participants would be assessed regularly, both for acquisition of practical skills and for evidence if participation in the education & CFR elements of the scheme. A failure to demonstrate minimum levels of skill acquisition and/or scheme participation would result in withdrawn access to WAST placements.

WAST placements (provisional)

Trainee	WAST access	Clinical Scope of Practice	Indemnifying organisation	Other activities
Medical Student	Block placement (SSC or elective) + Participation in Community First Responder scheme + Optional shifts with paramedic mentor	Observer-only. Possibility of adding specific skills once competency assessed in pre-hospital environment (e.g. chest compressions in cardiac arrest, 12-lead ECG acquisition)	TBC - ?WAST NB - Hosting SSCs has potential to generate income stream for WAST	Participation in regular teaching sessions (structured around the curriculum), to be organised by student PHEM group affiliated to the pre-PHEM training scheme
F1/F2	Block placement in "Taster weeks" + Optional shifts with paramedic mentor (own time) + Participation in Community First Responder scheme	Paramedic makes all decisions; trainee may assist with practical tasks e.g. cannulation, drawing up drugs, physical examination, "scribing" for the paramedic NB - Postgrad dean has raised possibility of future FP placements within WAST	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme
ACCS trainees CT/ST1-3 **GPST 1-3**	Shifts with paramedic mentor (own time) or other paramedics approved to host doctors participating in the scheme	As F1/2 until trainee has completed at least 4 months in supervised practice seeing unselected patients (i.e. EM or GP) **and** Scheme Educational Supervisor/TPD **and** paramedic mentor believes trainee suitable to undertake clinical decision-making appropriate to "SHO" tier. Paramedic retains right of veto in event of dispute.	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme. Possibility of mentoring TAPP for their MSc modules
ST1-7 (*without* EM or GP experience) *[i.e. no formal training in setting with unselected patients]*	Shifts with paramedic mentor (own time) or other paramedics approved to host doctors participating in the scheme	Paramedic makes all major decisions; trainee may assist with practical tasks e.g. cannulation, drawing up drugs, physical examination, scribing. May only discharge IAW Paramedic Pathfinder.	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme.
Post-ACCS (Bangor Clinical Fellow)	WAST shifts as part of BCUHB-funded job plan. Shifts may be undertaken with any WAST asset but should include all platforms: max 50% Helimed	Doctor likely to lead on many clinical decisions, but paramedic retains right of veto in event of dispute. Allowed APP drugs & external FP10s. Additional competencies (e.g. ketamine analgesia or sedation) may be "earned".	WAST	Leading teaching session programme. Mentor for WAST TAPPs. Running CSGs/ training for paramedics
Post ACCS trainees (ST4-7 in EM, AM, anaes or ICM)	Shifts with any WAST asset in own time	Doctor likely to lead on many clinical decisions, but paramedic retains right of veto in event of dispute. Allowed APP drugs & external FP10s. Additional competencies (e.g. ketamine analgesia or sedation) may be "earned".	WAST	Assists with teaching session programme. Optional - mentor for WAST TAPPs. Optional - running CSGs/training for paramedics

what's in it for WAST?

1. Steady supply of Community First Responders, particularly in Cardiff & Swansea but potentially also elsewhere in Wales

2. More interaction between paramedics and medical students & young doctors, that will eventually translate into more doctors understanding how paramedics train, think and work, and who are comfortable working in community settings

3. Increased access to CPD opportunities for WAST paramedics

4. Easier access to physician mentors for WAST paramedics undertaking MSc programmes, or topping up their vocational qualification to BSc

5. Supporting the transformation of WAST's culture into that of a clinical service first & foremost

6. Avoidance of an uncontrolled proliferation of medical students & junior doctors requesting WAST ride-outs.

what's in it for the Medical Schools?

1. An attractive option to offer potential medical students in a competitive market

2. Demonstrable commitment to promoting multi-professional working & education, plus exposure to community care in the wider sense

3. Assures the quality of student-led initiatives and ensures controlled access to appropriately supervised and structured PHEM placements.

4. Placements providing medical students with first-hand experience of the superb communication skills common to many paramedics: for example, jargon free discussions with patients, persuading & cajoling the unwilling, firm but fair humour with intoxicated patients, and all much close to a worrying or upsetting event than students will ever see in hospital or general practice.

5. For Welsh-speaking medical students, who sometimes report reticence to consult in Welsh (some will cite concerns that they "don't know medical words in Welsh"), the opportunity to work with Welsh speaking WAST crews/patients (especially in NW Wales) and gain confidence in the fact that patients aren't bothered about clinicians using "everyday" Welsh to take a history - they prefer it that way, it builds rapport much more quickly.

what's in it for the Health Boards?

1. Access to PHEM experience is highly prized by trainees, and health boards supporting the scheme via ED consultant participation will be attract trainees

2. As the scheme develops, the use of doctors on WAST assets will result in reductions in ED attendances, admission-avoidance, and more appropriate use of primary care

3. Long term benefits include a cohort of doctors who fully understand the unscheduled care system, and are better able to work across the current artificial boundaries between hospital and the community.

logistical challenges

- All participants in the scheme will be expected to join the Intensive Care Society in order to acquire personal injury & life insurance when working in ambulances. Funding TBC: it may be possible to utilise SIFT money from hosting student SSCs to pay for this cover
- EWTD rest requirements must be respected
- Trainees must have access to supervision/advice (by phone): this would need to be provided by the ED consultants of participating Health Boards where the trainee works. If Health Boards do not wish to participate (and/or ED consultants do not agree to provide cover) then scheme participants (of any grade) will be limited to same level as F1/F2 doctors where the risk of trainee-related litigation is negligible
- Although Welsh Risk Pool covers claims exceeding £100k, in event of litigation, claims less than this would be borne by the employing Health Board for more junior doctors
- For junior trainees to take an active part in WAST shifts, their employing Health Boards will need to agree to participate in the scheme both in terms of supplying supervision (typically ED consultant on-call, by phone) but also accepting *there could be a litigation risk which might include treating patients in another HB area*: WAST assets in South Wales regularly move between HB areas in the course of a single shift. This is less of an issue in North Wales, but a policy regarding patients treated across the English border will also be required. Should HBs not wish to take on this risk, clinical practice will need to be restricted to that of a medical student, or could be capped at the level suggested for an F1/F2 doctor (see table, page 7)
- Provision of PPE & how this will be funded
- Provision of Violence & Aggression training for all scheme participants
- Development of assessment tools for use on the scheme
- Willingness of the student-led PEMS societies to participate in organisation of a training programme based around the all-Wales PHEM curriculum (see Appendix) and provision of consultant/senior trainee supervision of their sessions
- Willingness of EM consultants in providing telephone advice and being part of the governance chain of this scheme - however, some very keen and able trainees would preferentially choose placements in participating departments
- Work required to map levels of scheme participant against the FPHC PHEM provider skills levels
- Work required to expand existing draft pre-PHEM curriculum (currently with activities & skills designed for post-ACCS Clinical fellows) to cover all grades of scheme participants
- Work required to map scheme participation against Foundation Programme curriculum
- Resourcing of time for WAST mentors, HB Educational/scheme supervisors - *NB expected to be minor, as WAST mentors would be undertaking shifts with their mentees and the HB scheme supervisor would often be the trainee's Educational or Clinical Supervisor and hence meeting with them regularly anyway*

the strategic fit

The need for more UK doctors to be "generalists", and less confined to traditional specialty boundaries, is widely recognised, most recently by the Greenaway "Shape of Training" review.

Whilst it is not yet clear how much of "Shape of Training" will be adopted - the recommendations having attracted much negative comment from both specialty Colleges and the BMA - it is abundantly clear that our current "silo" model of hospital versus community/GP medical care is failing to deliver for patients and completely unsustainable given the demographic changes the UK is facing.

Medical students and junior doctors going into many specialties would benefit from a much wider view of health care in the community, and we believe work with the ambulance service would be an excellent way of introducing this.

At present, with few exceptions, the only doctors who routinely see patients in their own homes are GPs, and only GPs and Emergency Physicians see "unselected" patients.

The forthcoming "credentialing" system - currently in preparation with the GMC - may provide a way to break this stranglehold and produce a more flexible workforce with generalist abilities - potentially aded to their specialist training as a "top up".

For example, consider if it were possible for Emergency Physicians, Acute Physicians and Geriatricians (COTE) specialists to undertake "top up" training and credential in Acute Community Medicine - i.e. the component of general practice that isn't chronic disease management. The result would be a cadre of doctors able to seamlessly work between hospital and community, well equipped to support GP with the relentlessly increasing onslaught of complex frail elderly patients - and the ability to create bespoke portfolio careers, promoting sustainability and a creative, vibrant and productive medical workforce.

"Interface Medicine" is a term that we are likely to see the WACCS scheme will be able to promote the concept in Wales.

training opportunities with WAST at medical school & beyond

Following discussions with both Swansea & Cardiff medical schools, and the Wales Postgraduate Dean, it became apparent that our initial proposal had perhaps been less ambitious than it might have been.

Whilst all agreed that a slow, steady launch to the proposed scheme is sensible, they saw future possibilities that we had not. Should these initial proposals prove to be a success, they could pave the way for a new shared relationship between WAST & UG/PG medical training in Wales:

1. Potential to use WAST placements to deliver some core undergraduate content to medical students

2. Potential for a full 4-month Foundation Programme rotation with WAST (probably F1, as 100% deanery funded and never expected to independently discharge patients)

Hosting **medical student placements** has the potential to generate a useful income stream for WAST - around £500 per week per student. Clearly there is potential for a station to host three students and fun an additional shift per day.

Hosting **Foundation Programme** junior trainees - all of whom should have practical skills probably in excess of a newly-qualified paramedic - should mean that WAST would have less requirement for EAs to be crewed by two *paramedics* whilst hosting these doctors, as a lower-banded clinician assisting/driving could be used whilst still maintaining two highly skilled patient attendants.

what happens next?

STAGE ONE - Spring 2015

- WAST to be registered as an Approved Practice Setting with the GMC
- Approach Swansea & Cardiff Medical School and invite their approval for the scheme (highly desirable, not essential) & request admin assistance for running the student phase of the scheme
- Approach Wales Postgraduate Deanery and invite their approval for the scheme - *particularly the use of WAST placements as suitable for FP1/2 "tasters"* & to request admin assistance for running the postgraduate phase of the scheme
- Encourage the existing Welsh undergraduate PHEM groups to unite in order to affiliate with this scheme

STAGE TWO - July-October 2015

- Confirm name of the scheme - Welsh Acute Community Care Scheme or Welsh Interface Medicine Scheme - "WACCS" or "WIMS"?
- Approach Health Board Medical Directors
- Approach EM consultants in each Health Board to determine which would indicate willingness to support the scheme
- Finalise table on page 7 of this report & arrange logistics of booking shifts etc.
- Invite expressions of interest from experienced WAST paramedics
- Complete mapping PHEM curriculum against competencies/levels/assessments
- Plan SSC educational descriptors
- Collate list of potential projects for medical students to undertake on WAST SSCs

STAGE THREE - 2015/16 Academic Year

- Launch in Medical Schools
- Launch postgraduate scheme in BCUHB area initially (no cross-boundary issues with other health boards, supportive consultants on hand & BCUHB Medical Director has already indicated he is fully supportive of the proposed scheme)

STAGE FOUR - when ready: likely 2016/17 or 2017/18 Academic Year

- Roll out to all Health Boards who wish to participate

references

Antrum J & Ho J, Prehospital emergency care: why training should be compulsory for medical undergraduates. EMJ 2015;32:171-172

Websites of other schemes

- London PHP http://prehospitalcareprogramme.org
- Oxford major trauma and PHEM society (student response car) http://studentoxtrauma.org/student-section/student-first-responder-scheme/
- http://pems.doctorsacademy.org/Home/Index
- Affiliates of the Barts & the London PCP scheme http://prehospitalcareprogramme.org/affliates/
- Interesting report from a UCL PCP scheme participant http://www.fphc.co.uk/content/Portals/0/Documents/Pre-hospital%20end%20of%20year%20report%20pdf.pdf