Discussion table 1 – Bfam/SG 15/05/17. Rough notes

Table discussion

Redacted

Feel – all open and polite to challenge and ideas

Why undersupply

Insight as to why crossborder flow deficit

: Things that influence career choice, geography most important - number one, closeness to family/friends. Speculation non - Scottish domiciled med students, especially overseas DO NOT stay but DO NOT have accurate up to date data to sat that RUK dom less likely to stay in Scotland.

- aim is to increase proportion staying and coming to scotland cross border at interface: what can we do?
- outreach in regions exists, can only go so far in that number of schools engaged with outreach programmes is minimal and this is a big challenge, all would like to engage more schools. agrees

- young people at school orientate what they. may want to do quite early because science.

Ie – need to impact before they have even thought about medicine potentially, at S3.

Keeping sciences for those able EARLY is key because dropping these closes doors and teenagers frequently and reasonably change mind about potential career choice. Subject choices at 3rd year very important and need to be targeting students at S3

- do we need these subjects?
- Yes, chemistry etc develops their thinking and gives basic skills and if don't have this then don't have fertile grounds for base of medicine or many other disciplines

Data around subject choice?

- most require chemistry + another science or thereabouts. (In response to SI), you would need to provide a case to change entry requirements. At moment status quo produces competent doctors. - are there other ways of nurturing this thinking and demonstrate this.

- there is data that you need this baseline invested prior to start. Same is for IT and other specialists careers. There are fewer students in Scotland going into STEM subjects and this is a problem

– why is this happening ?

: shortage of science teachers, especially to provide subject at higher level, or at least it not being a norm (eg having to go to a different school for shared class, makes it "not normal")

Agreement all –school is a big challenge in this and long before application

- is this a self fulfilling proficy?

– we do allow non science graduates, a few, but these are graduates eg good primary degree in non-science do fine.

– agree but there is a difference between a graduate in non-science and a school leaver without the science, accept that if a bit older without science and with good arts degree may be ok
Pre med is mostly widening access schools leavers but 3-4 each year are arts graduates.

- guidance teachers overwhelmed: universities bombarding with them
School students think that they haven't got any chance of getting in

– teenagers need to be able to project themselves to a place in life they can relate to. Need to help them vision this, they are taking a risk - different from family, away from their safe local environment, need to make them realise why it's worthwhile and why its a safe choice - is talk of bonding a risk to this (medicine would be perceived as an even bigger risk)?

- Lots of professional excellence that can be shared to balance the negatives/disputes. Role modelling. Showing what life will look like, balancing up negatitivety around NHS collapsing.
All agreed.

- 2 ways to increase. Increase numbers at base or increase conversation, feel both need to be attended.

: Have we ever done better in Scotland historically in terms of social mobility in medicine and why?

All – Not in last 20 years, bu beyond we don't know but interesting question because it may gives us clues on what works

- what data you have. : each institution has data on which secondary schools kids come from but by definition not which secondary schools they don't come from though this could be derived. All agree as a

project could put this data together and identify those places that aren't getting folk in to and target address why falling numbers Scottish domiciled applicants.

Getting in the right spaces

outreach programmes good but can only go so far, need to better identify targets and to engage much earlier.

Barrier - resource and ability of people to do above

- could we have some role models on a Scottish wide problem.

So - optimise outreach (currently only reach a minority, probably have capacity to go to a few more schools but don't because many schools don't engage) so getting schools to engage is part of this as well as identifying these schools.

It is a Scottish wide systematic problem, can we have a Scottish wide solution rather than institution by institution - Brexit is a risk to retention of EU graduates from Scottish medical schools

Other barriers to Scottish domiciled medical school entry:

Redacted

- Actually we don't absolutely know that scot does are more likely to stick and would have to establish this before major policy – all agreed

- issues with our St Andrews students not enough clinical places for them in Scotland, this may mean less likely to work in Scotland

- working somewhere different as a junior is not negative, some of these doctors may return at CCT.

All agreement cross border flows both ways but net away from Scotland ie not as many come back, but moving isn't bad in its own right and need to be mindful of this.

- a collabarative bit of work around careers advice could be a way foward

- why different entry criteria different med schools? Would harmonisation help?- they are very similar and largely harmonised, further harmonisation wouldn't help

Role models - med student from widening access background as role models VC, all agreed helpful

What would a different system look like?

- discussion on English system: increased in UK places and lifting international cap: will be a vaccum cleaner to Scottish medical schools SI - even with the 1500 they will still have fewer medical students per head of population in England than in Scotland

- BEST candidates may be vacuumed away. SI will this just vaccum RoUK doms? Discussion – but some of these (quite a lot) will stay in Scotland so even if it is RoUK doms still a risk?

- in defence of RUK doms: why can't we retain them.

Are Scotdoms more likely to stay in Scotland: probably but how much. All agree must know this and investigate?

So
- widen pool that we get medical students in from
- Are Scotdoms more likely to stay and practice medicine in Scotland?
- Don't know for certain how many good scotdoms could recruit,

Should we go to marketisation like England? - depends what you want to achieve?

What can we do before youn people get to med school, applicants, in med school, after, employer. Innovation?

How can we be what it's going to be?

Within delivery of curriculum

GP recruitment challenge:

- longitudinal clerkships: early days, seems one potential approach, but need to measure. ER - scotgem may tell us this because they spend more time. ER perception thing: more time in positive practice understanding the difference in peoples lives to balance the negativity

- more UG and FP into GP.

Ability to deliver more UG and PG curriculum in general practice, can it and should it?
Would universities be open to being directed?

- if direct too much centrally you **reduce innovative** ways to get there, actually you want different ways. Suggests **setting outcome** and support and nurture a variety ways of achieving it. Incentivising fine as long as journey there is not directive.
- How would you incentivise. - would you link funding to output eg if. X% of your output applies to GP . - if did that it would work and would encourage innovation. good but must be aware of unintended consequences. All agree. at moment only incentivise input not output – all agree is a problem.

Medical licencing is this a good way to control output? - less so cos what are you wanting to achieve, more GPs or higher mark?

What may universities do internally? SSC development to community.

Room feedback/discussion

Redacted

What is the problem that we actually are trying to solve?

Don't loose sight of time lag, who will be delivering service in ten years, multi prof nature, PAs
Being thoughtful around this when shaping policy

Provision higher chemistry - broader, being able to timetable enough higher, one med school will dumb down entry

Redacted
? Oversupply, deregulate, redacted.
If deregulated may help can't be certain.

Knowing very little about those schools who don't send (med schools know about those who do)
Message about less competitive med schools needs to spread

Stella - challenging grade entry requirements more broadly outwith widening access, and then can rely on UKcat.
- better to look at more wider pool of entry to medicine

NHS Lothian - as an employer. Wants to train people in local areas to be employed in local area to do local jobs. Wants it to be more like nursing. Nurses are more often a bit older graduates with other career background. Agrees working around needs of current cohort but keen to recruit a less assertive more compliant future cohorts. (*AP note ? wants more narrow pool of people who won't challenge/less autonomous in who are more tightly trained to do the job – risk with this is as the job/needs change this group of people may be less adaptive/versatile to change and innovate*)

SR - triangulation of school giving you academic requirements needed for H&S care, need to be aware of this13% of employed in Scotland in H&S care, huge resource. Do we need to invest some of this in schools.

- thinking of nurses and others getting into medicine (or is this robbing peter to pay paul) can they skip bits *(note – my limited experience with doctors who have previously been nurse practitioners isn't always positive, may work sometimes but can't be assumed to work)*

Should we pay kids to go to med school? SR - kids get very worried about cost of this and the group that they would be moving into and what they'd be expected to have. The more of a challenge that is the more of a risk an oversupply is perceived as.

Redacted

Bypassing overwhelmed guidance teachers and communicating directly with pupils with regional expert available.

Role models

If could afford oversupply, risk is not having job at end and risk to input. But people still do other industries, but only if that training could take them to other ways. Having acknowledgement to pupils that medical training could take them in other ways could actually be more reassuring (interesting nuance) and make them more likely to make commitment knowing that it wouldn't workout could do something else - very interesting point.

- their table disagree that quantity of exposure alone does not dictate what specialty (eg 10 weeks with burnt out GP, won't do GP!). Could increase proportion of course done by GPs if keep quality. SR - communities, good or bad experience shared very quickly. Glossy broshures not that helpful. They know way ahead of data. Odd bit of publicity - video sharing story good experience most important.
Canary in coal mine is junior training for hospital in difficulty.
Videos and stories being saved in library. Building network. Could making this network available to GPs

Keeping people in their own locality - open university model.

What kind of employer are we? Key bits, humaneish rota etc.

Importance of not loosing innovation around some groups

- HC data versus WTE is a real real issue. SR - if presume whole time equivalent will fail.

Lothian - medical unemployment so small a risk, because will see increasing number wanting to work PT/career gaps and because of good pay and common marriages they can manage on PT policy.
SR - could give a commitment that costs us nothing: if you come out appropriate standard you could be guaranteed job in NHS Scotland

Redacted

- throw it back to GMC: article 13 very difficult puts people off and there is a real issue with the SAS workforce, if could look after these well and retain and progress them this would be really positive

- how easy is it to innovate?

SR - how do we make ourself an employer he type someone wants to work for people.
Encourage people to be leaders within their organisation even if not called that
Taking highly intelligent part of workforce and forcing into square (interesting Lothian wouldn't take a highly intelligent)
(AP - A lot is made about millenials and tech, perhaps overrated compared with the "simple" things)

Importance of feedback, looking after people
People don't respond well to bullying

How we reward excellence moving foward.
Universities could offer design, technology and service expertise.

Careers advise BEFORE deciding medicine

Conversations over coffee comments

Importance of recognising that those not in training are not all a "lost tribe" and not actually a negative thing but actually some of them are quite a happy and "want to do what you did boss" ie try some different jobs, have a bit of flexibility to move about etc Still need to make training attractive so that they re enter but it's not a problem that they are out for some time. A bonus of this is that whilst they are doing this their input can support rotas.