

Guidelines for the Standard Rural GP Fellowship – Jan 2025

BACKGROUND

The 'standard' rural fellowship has been in operation since around 2000 and is based within rural and remote general practice. It provides extra training and support for GPs who wish further experience in rural practice and is based on the curriculum for rural practice developed by the Remote and Rural Training Pathways Group (GP sub-group Final Report Sept 2007)

AIMS

1. To promote rural general practice as a distinct career choice.
2. To help GPs to acquire the knowledge and skills required for rural general practice
3. To help those GPs who wish to develop skills to provide acute care in remote hospitals develop these competencies
4. To provide the opportunity for GPs to experience rural community living.

The fellowship is aimed at recently qualified GPs who are offered a further year of training in, and exposure to rural medicine. Part time fellowships will be considered. Two distinct fellowship options will be included in August 2025:

- The 'standard' GP Rural Fellowship option based on the curriculum for rural practice developed by the *Remote and Rural Training Pathways Group (GP sub-group Final Report Sept 2007)*.
- The GP Acute Care Rural Fellowship option based on the GP Acute Care Competencies work following from the agreement of the *Framework for the Sustainability of Services and the Medical Workforce in Remote Acute Care Community Hospitals*

More information relating to both these options can be obtained by e-mailing Debbie Miller, the fellowship coordinator at Debbie.miller@nhs.scot

As fully qualified GPs fellows are expected to organise their own professional development (attend courses, arrange clinical attachments etc) based on a PDP derived from needs assessment mapped to the relevant curriculum and agreed with the fellowship coordinator. Individual PDPs are supported by three meetings that are organised by the coordinator during the year to help fellows meet learning needs that cannot be easily met by personal study.

STRUCTURE

The fellowship is currently run as a cooperative venture between the rural Health Boards in Scotland and NES with the funding being provided on an approximately 50:50 basis (local variations to this do

occur but are subject to prior negotiation and agreement). This joint funding arrangement is organised as follows: -

1. Health Boards provide their funding share from Board Administered Funds or other funds. Boards' investment in the fellowship is returned through the service commitment that the fellows provide. It is a condition of the fellowship that such service commitment should be in rural environments; rural practices (for instance providing locum cover to remote practices) or rural out of hours services for the 'standard' Rural Fellowships, or in Rural Hospitals for the Acute Care Rural Fellowships. The objective is that the service commitment contributes to the training aspects of the fellowship and provides experience of rural practice. Fellows are expected to spend approximately a half of their time working in these environments.

2. The funding share from NES allows fellows to have protected educational time to meet their educational needs in relation to rural medicine. They are allocated a base practice in the area in which they will be working and are expected to spend approximately a quarter of their year working in this practice. This relates both to 'standard' Rural Fellowships and also to Acute Care Rural Fellowships; it is crucial that the latter group maintain their general practice competencies and experience through the year despite a focus on gaining acute care competencies. Base practices should be chosen for their proven record of good organisation, of teamwork and of supporting educational initiatives (see annex 2). They do not have to be training practices. They should be sited in or within reasonable travelling distance of the area in which the fellows are expected to fulfil their service commitments. The remaining educational time is spent attending courses, clinical attachments (both in hospital and in primary care) and study, depending on the needs of the individual (see annex 1). All fellows are expected to undertake a project during their fellowship year on a relevant topic of their choice.

3. Each fellow is allocated a contact/mentor in their area of work to help with any local difficulties that may arise (problems with local duty rosters, timetable clashes etc). This contact person should normally be a GP in their base practice for the Standard Fellowship option or a GP or Consultant in the acute care service for the Acute Care option, but if this is not possible this function would normally default to the Rural fellowship coordinator. Base practices and mentors should be determined and arranged before the recruitment cycle begins so that job descriptions are clear and specific.

4. Apart from overseeing the general administration of the fellowship the role of the fellowship coordinator is to ensure that all fellows have a relevant and achievable PDP for the year, to liaise with fellows during the year to monitor progress and to organise the three fellows' meetings during the year. The meetings provide an opportunity for the fellows to discuss and share experiences, to fulfil those learning needs that are best met by group study and to meet rural medical specialists and others who have a special interest in remote and rural medicine.

ADMINISTRATION AND MANAGEMENT.

1. Recruitment is organised by NES with representatives from the participating Health Boards included in the interview panel. The cost of the recruitment process is met by NES.

2. Contracts are issued by the Health Board in the area the fellows are working. There is a nominated administration officer in each employing board whose task it is to make sure that contracts are issued and signed timeously. Contractual and administrative arrangements, including the nomination of responsible administrators, should be determined in advance of the recruitment process so that once appointed the fellows will know who to contact should difficulties arise.

3. Contracts should be standardised with Health Board specific job descriptions. Job descriptions will vary depending on current circumstances in a given Health Board area but contracts should not vary between Boards.

4. Employment issues such as sick leave, poor attendance and unauthorised absence. The resolution of contractual issues such as these should be led by the NHS Board officer responsible for the employment of the rural fellow concerned. It would be expected that the board officer would discuss such issues with the local mentor, the fellowship coordinator, Dr Debbie Miller or Lead Dean Director, as appropriate and that decisions should, if at all possible, be agreed by all concerned.

5. Clinical performance issues should be reported to the fellowship coordinator who would be expected to discuss any possible action with the local mentor, Dr Debbie Miller and the Lead Dean Director, in collaboration with the employing Health Board.

6. Travel and subsistence expenses incurred during periods of service commitment should be met by the employing Health Board but educational expenses (T&S and course fees) will be met by NES subject to an agreed budget maximum (currently £2500 per fellow).

7. Removal expenses are met by the employing Health Board subject to the NHS terms and conditions of employment.

8. Medical defence fees are met by NES.

TIMELINE

A typical year is as follows:

1. The recruitment process: –

- a) Discussion re budgets for the coming year and invitations to NHS Boards to participate in the coming recruitment round –January/ February.
- b) Job descriptions and working arrangements (base practices, mentors, contracts etc) agreed February/ March.
- c) Advertisement –March.
- d) Interviews – May.
- e) Appointments agreed, contracts issued, needs assessment interviews arranged – June/July.

2. The fellowship year: -

- a) PDPs agreed prior to starting the fellowship in July
- b) Start work at the base practice in August.
- c) Attend the first fellows' meeting of the year in August or September.
- d) BASICS PHEC (pre-hospital emergency care) course in September/October.
- e) Second meeting of the year in January.
- f) Third meeting of the year in May.
- f) Fellows' annual review in May, June or early July.
- g) Assessment of project work in May
- h) Feedback by questionnaire.

APPENDIX 1 – THE STRUCTURE OF A FELLOWSHIP YEAR.

1. Leave and public holiday commitment – 6 weeks plus 10 statutory holidays – leaves 44 weeks out of the year.
2. Service commitment – 50% = 22 weeks +/- 2 weeks to allow Health Boards to recoup their costs.
3. Educational component – 50% = 22 weeks divided into: -
 - a) 11 weeks minimum working in the base practice – leaves 11 weeks
 - b) Up to 4 weeks spent experiencing remote practice(s) preferably in areas other than that of the host Health Board.
 - c) 7 weeks to attend courses, arrange clinical attachments (hospital or primary care) or undertake study as agreed with the coordinator.

Notes: –

1. There has to be flexibility in these arrangements to allow for the circumstances of individual fellows and the needs of Health Boards. For instance, service commitment could continue beyond 22 weeks if the fellow was working in remote practices that satisfied the educational needs of the scheme and if such an extension were compatible with the individual fellow's PDP for the year.
2. Potential conflicts between service commitment and educational need should be discussed between the coordinator of the scheme and the nominated officer of the Health Board. Experience has shown that such conflicts can be avoided by careful planning and negotiation at the start of the year.
3. Fellows are salaried employees, and their contracts are subject to the provisions of the Working Time Directive. In the past there has been considerable variation in the out of hours work that fellows have been asked to perform and the question of what is reasonable has been raised on several occasions. The following are suggestions to guide local discussion: -
 - a) If a fellowship involves regular out of hours work provision should be made for sufficient time off in lieu so that the WTD is not breached.
 - b) If a fellowship does not involve any out of hours work then a fellow can be asked to undertake a minimum of 2 out of hour's shifts per month at a PCEC in the area to help them maintain their emergency treatment skills. The cost of these shifts can be included in the service commitment part of the fellowship.

- c) When on attachment to very remote practices that are still obliged to do their own out of hour's care fellows should take part in the on-call rota so that they experience the peculiar stresses and strains of working alone in remote areas. They should not be asked to take part in an on-call rota that is more onerous than that worked by the resident general practitioners.

- d) In single handed practices where the fellow will be required to work on a 24/7 basis provision will be made for the fellow to have "compensation" in the form of 2 days recovery time for every 7 days of 24/7 cover provided. No additional payments will be made to fellows for providing 24/7 cover under these arrangements.

APPENDIX 2 – THE ATTRIBUTES OF A BASE PRACTICE.

We would expect that all the base practices used to host GP Rural Fellows will be rural but not necessarily remote practices who have the following attributes:

1. Knowledge of, support for and a willingness to actively participate in the GP Rural Fellowship
2. A supportive environment with a strong educational ethos as exemplified by training practice status, active interest in service development or research work or proven track record of good quality education of previous rural fellows. Host practices do not necessarily have to be training practices.
3. Ability to nominate a GP in the practice who is willing and able to act as a mentor for a rural fellow.
4. Willing to facilitate and encourage rural fellows to participate in all areas of practice activity including partnership meetings, management, administrative and educational activities. Host practices must enable rural fellows to access the resources that they require for assessment purposes (for example administrative support for audit).
5. Willing to facilitate educational activities in the practice such as time spent with the practice manager learning about practice management issues. Host practices are not expected to provide regular tutorials in the manner that is required for trainees but are asked to make sure that rural fellows have access to all areas of practice activity for educational purposes.
6. Willing to provide support for the project that must be completed during the fellowship year.
7. Willing to provide a structured reference at the end of the year.

In return for this commitment base practices will have the services of a rural fellow provided free of charge in the practice for up to 13 weeks in the fellowship year. Rural fellows should be included in the practice rota with a workload equivalent to but no greater than that of a partner in the practice. They can be used to provide cover for holidays and study leave. Details of working arrangements should be discussed on an individual basis between the practice and the rural fellow bearing in mind that the demands of service provision and of education take precedence.

