GP Fellowships in Nottinghamshire

Sarah Chalmers-Page
Chalmers-Page Consultancy
sarahelainechalmers@yahoo.co.uk

Summary 3
The Nottinghamshire Fellowship 4
Intentions of the Fellowship 4
Before 2018 4
From 2018 Onwards 4
Impact of Funding 6
Retaining and developing talent 9
Reducing the risk of burnout 11
Why General Practice? 13
Appropriate support and supervision for fellows 14
New Ways of Working 17
Benefits for Patients and Providers 19
Impact on Medical Education 21
The Future 22
Economic benefits 23
Conclusions 24
Recommendations 25
Appendix One: Methodology 27
Appendix 2 Fellowship alignment with policy 28
A2.1 By Choice Not Chance 28
A2.2 GP Contract 28
A3: The Long Term Plan 29
References 30

Summary

GP Fellowships offer an opportunity to improve recruitment, retention, training and job quality for new GPs. They allow a progression between training and independent practice, encourage academic and service improvement skills and provide career planning time. Lessons have been learned from the Nottinghamshire scheme.

This paper is based on semi structured interviews, and literature search. The University of Nottingham Medical School funded the evaluation. It was written in May and June of 2019 by Sarah Chalmers-Page of Chalmers-Page Consultancy, an independent consultancy working on behalf of the Chair of the Nottinghamshire Primary Care Workforce Group.

This study will inform the design and delivery of future fellowship schemes, by outlining the main challenges, benefits and unexpected factors influencing the success of the Nottinghamshire fellowships.

Fellows valued new skills gained in communication, teaching, management, leadership, curriculum design, project management, understanding of the wider health and care system, networking opportunities, and multi-professional working. Findings on retention were mixed, and highlighted the role of wider work-life factors in career choice, but the role of a portfolio career in reducing burnout was clear.

Recommendations are made around

- Supervision of fellows, including the need to tailor it to the project and individual
- Managing the fellowship, including the expectations of host organisations.
- The role of individual supervisors and action learning sets in successful fellowships
- The importance of idiosyncratic factors, such as a Fellow's family circumstances, in their career planning
- The need for project management training, reflection and networking time.
- The impact of who is finding project sessions on the types of projects done
- Risks for scaling the fellowships up.

Clear communication, funding and supervision arrangements must be in place for successful fellowship programmes. The fellowship has been positive overall, encouraged GP trainees to remain in the NHS and provided them with valuable educational and leadership skills. The fellows enjoyed the programme, and in some cases credit it with helping inform their future career and with accelerating moves into teaching, training or leadership.

The Nottinghamshire Fellowship

Intentions of the Fellowship

The idea of a GP Fellowship scheme had been discussed for some time, notably by the chair of the RCGP, Claire Gerada. The initial funding for the Nottinghamshire fellowship was from under-recruitment to trainee GP posts in 2014. Of 280 posts across the East Midlands, around 160 had been filled. This was a concern for the region's ability to retain and recruit enough GPs for the future, but the under spend associated with it also provided an opportunity for a new approach; a funded fellowship.

The main goal of the programme was therefore to boost recruitment and retention of GPs post CCT. It also aimed to improve training for early career GPs to become fully independent, through providing an additional year of support.. This would ease the transition from training to independent practice, allow time for career planning and to develop new skills, not covered in the medical curriculum, around education, leadership, management and understanding the wider NHS and care context.

Before 2018

Originally, the fellowship was managed by Health Education England in the East Midlands and enabled and supported by Nottinghamshire Local Medical Committee. Funding was identified for four sessions of project work, two of education (including course and exam fees for one post graduate qualification). People were eligible for two years post CCT, and had to be working in a Nottinghamshire GP practice for 4 sessions a week, and most people who were interested were successful in applying. The types of projects were left deliberately wide [NF1], with "no constraints", to maximise the opportunities for people to follow their own career interests or opportunities that presented themselves whilst talking to colleagues.

The majority of fellows chose a certificate in medical education (PGCME), which was felt to be a high quality course, with good transferable skills [NF3]. This was also felt to be positive for the future talent pathway, because it would accelerate new GPs into roles as lecturers and GP trainers, which would in turn encourage more medical students into primary medicine (through providing role models), and allow more practices to become training practices. However, some other postgraduate certificates were available, in areas such as palliative care, and management and leadership.

From 2018 Onwards

In 2018, the fellowships in East and West Midlands, which had been locally determined, were aligned under the same system across the Midlands... Recruitment and selection was coordinated by Health Education England working in the Midlands. Health Education England funded two sessions of education, plus an Education Supervision Grant of up to £5000 per fellow.

The four sessions for the project had to be funded by the host organisation. In Nottinghamshire, this was a combination of GP Forward view retention funds, and workforce development funding allocated via the local workforce action board against priority project areas. GPs would be eligible for the scheme for two years after completion of training; in 2019 it has been extended to five years after their CCT. In 2018, the training hubs were also given responsibility for mediating between HEE and employing practices (or employ the fellows), and for providing the action learning sets. There was also more constraint around the types of projects that could be supported. This coincided with changes at the Nottinghamshire training hubs, where they formed an alliance with a single back office function, pooling their management, education and administrative capacity. For a period of time there was no dedicated resource in Health Education England for communicating changes with the candidates for fellowships [NF3; NF4]. No upfront funding was provided to training hubs for their role, but in Nottinghamshire there were small amounts of around £5k funding available from the Primary Care Development Centre and the University of Nottingham Medical School to support setting up the fellowship scheme and action learning sets, until funding became available.

Communication around the transition was described as chaotic, disappointing and unclear by several of the Fellows [GPF4; GPF5]. This could have been a major risk to the programme; one fellow [GPF10] mentioned that they were "lucky" that their practice could be flexible with how many sessions they worked for clinically as the fellowship was uncertain and they may have had to back out without that assurance. When asked if there was anything that they would do differently, one respondent [NF4] said that the biggest area was communicating better with applicants around the transition to the new system.

During 2018/19, the Nottinghamshire Alliance of training hubs (hosted by NEMS Community Benefit Partners) was essential in maintaining a fellowship scheme The training hub interviewees noted that initially there had been no confirmation of funding, despite an expectation that the fellowship would go ahead, and that there was no team in place and they were "working out of borrowed space [NF3]." Interviewees from the university and Health Education East Midlands, as well as the Fellows, were very complementary about the training hub stepping into the gap. They identified projects for fellows, and managed the fellowship until the new system was formalised. Although the training hub was enthusiastic to be involved, felt that the fellowship was a good platform for them and they were positive about this, this resulted in "*working a lot of extra evenings and weekends through the summer*" in addition to an already heavy portfolio of work [NF3] and another respondent felt that the hub must have been working close to full capacity for two months [NF2]. The quality of placements at NEMS Partners was seen as excellent, with one fellow [GPF4] mentioning that they had not intended to be at NEMS Partners initially but that they were glad they had been allocated a placement there because it had "*broadened [their] horizons massively and [they] wouldn't have got that elsewhere*", including national level exposure and working with some of the national education bodies. Another medical

educator [NF1] said "*without them, I don't know how much of a fellowship we would have had*."

Some of the fellows have criticised the interview and application process in 2018/19. From having been run locally, with spaces for most interested candidates, the process was now more competitive and managed regionally. The process felt "*sketchy*" [GPF7] and this was stressful.

This reliance on individuals working to support the fellowship scheme at this intensity in addition to their main roles is unstable, and unsustainable. Future fellowships should have dedicated administrative, project and supervision resources allocated in advance, to ensure stability.

Recommendation 1: Allocate administrative, project leadership and supervision resources to fellowships in advance and at the appropriate level.

One interviewee [NF1] expressed continued concerns that during the transition between systems there was no clear national strategy and that fellowships may not be being valued sufficiently to make a success of them if they were to be scaled up. This is no longer the case; GP Fellowships have been endorsed in the GP Partnership Review and the NHS Long Term Plan [7; 9], and in the Interim People Plan [12]. Communication has been improved as the new arrangements have become more settled, and the interview process has been made more local again [NF4]. Providers are now more heavily involved in the interview process, which is boosting engagement [NF4]. From 2019, the scheme will be moved to the LMC supported Phoenix Programme based on the model developed by the Training Hubs and with their support. The involvement of the training hubs has also resulted in Action Learning Sets, a form of peer led learning that allows fellows to problem solve together and form professional friendships. All the fellows from 2018/19 mentioned that this was supportive, helped them problem solve, and provided them with an important sense of community.

Impact of Funding

When they first started, the aim of the fellowship was to be as open as possible for people to choose their own projects. With an underspend to fund the sessions, there was no reason to narrow choices down. Initially, there were a wide range of projects, including screening services, paediatrics, support for children with special needs, diabetes, end of life and palliative care, and rheumatology [NF1]. With the transition to a new process in 2018, funding had to be found for the four project sessions in Nottinghamshire. Not all providers were able to pay, and this narrowed choices. The training hub aligned fellowships to existing priority projects within the Local Workforce Action Board (LWAB), which has reinforced an emphasis on training, new role and curriculum development and within advanced emergency practice and frailty. This is needed, but it would also be good to build skills in service

improvement or research [NF4]. This contrasts with other Fellowships. For example, one programme in the West Midlands [1] had funding for urgent care fellowships, and focused many learning experiences there.

The transition from local to national GP Forward View funding also may also have had an impact on expectation management for providers. Prior to 2018, project funding was in place for the fellows and organisations did not have to pay them for this time; they now must be funded by the host organisation. When the fellow was funded externally, there was no pressure to view them as delivering good value for money at the provider level, leaving them free to develop projects as they saw fit. When the provider is funding a project, this changes the balance of power and creates a need to demonstrate outputs. This creates two problems. The first is that although the fellows were fully qualified doctors, they were novice project managers; where a project was around service development or event management, they were slower and less efficient than an experienced non medical project manager would have been [NF2], which could put providers off. The second is that this created a pressure for projects to meet the provider's short-term needs,. Outputs and activities were therefore more constrained. There will be a need in the future to make sure that the advantages and disadvantages of appointing a fellow rather than a project manager are well understood amongst potential hosts.

Recommendation 2: Work with hosts to understand what outputs and activities they would value, and how this can also meet the specifications of a suitable project for a fellow.

Three fellows mentioned being treated as an "extra pair of hands" or having to explain that they were not there to be a specialty registrar, and that the time they had for innovative work could be constrained by inaccurate understanding of their role. In a similar fellowship in the West Midlands and LASE [1], some people reported feeling that they had been "used" as a "commodity" and that this had left them unable to meet their training goals. There is a recurrent tension between fellows' training and development needs and the need to deliver a service, which should be an explicit conversation amongst fellows, supervisors and host organisations.

Recommendation 3: Supervisors should ensure that they discuss managing the tension between service delivery and personal development with their fellows, and if necessary with their contacts in host organisations, on a regular basis.

One area for improvement would be to enhance provider understanding of what fellows are and what benefits they can bring. One respondent [NF4] felt that providers had become used to the proof of concept funding and were taking time to understand why they should have to fund projects now the concept was established and they were expected to help with funding.

Split funding arrangements may pose managerial challenges when the fellowship scheme is scaled up. A similar scheme in the West Midland and London and the South East (LASE) [1] found that considerable time and effort could be spent on working out and publicising which employers were responsible for what aspects of the fellowship. Learning from elsewhere suggests that this could complicate fellows tax arrangements, pensions, liability, sickness and holiday entitlements, and supervision arrangements. It was particularly acute if fellows were working across primary, secondary, and community care over a range of provider organisations.

As discussed above, the managerial support for the fellowship can be underestimated, but is important for its success. In LASE, a CCG or Federation was asked to host the fellow rather than an individual GP practice; this is also likely to be an appropriate role for training hubs and emergent primary care networks. Even so, resource is still required to manage cross charging for clinical aspects.

Recommendation 4: Work with providers to ensure that the managerial aspects of the fellowship role are in place, including how this will differ from a training role, how to manage across sites and employers, and additional supervision requirements.

Retaining and developing talent

The main goal of the fellowship was to retain talented GPs within Nottinghamshire. According to the National GP Survey (2017) [2], 34% of GPs are planning to retire in the next five years, a further 28% of full time GPs plan to reduce their clinical contact time, 19% of GP trainees (including two of the fellows before their fellowships) are considering moving abroad, and 35% would not recommend a career as a GP. A review of papers on addressing recruitment and retention in GPs [3] found that the most significant factors in primary care retention included portfolio careers and job satisfaction, and highlighted internal motivators like recognition rather than extrinsic factors such as income in people's decisions. One fellow specifically stated that they would rather earn less, and see more of their family and have a more interesting job [GPF12]. Of course, this paper does not look into why more GP trainees did not seek fellowships, and it may be that the sort of GP who became a fellow is less interested in income than others.

Some fellows had been considering emigration [GPF2, GPF4]. Several had also been considering other areas of the UK, in particular London and Manchester. All those who were in a position to make career commitments were now hoping to stay in Nottinghamshire, although three were waiting for their partners to complete CCTs and find permanent posts before long term decisions could be made. This highlights how GPs completing training have to consider the needs of their partners and families. However, in the context of a National Health Service, it should not be viewed as a waste if GPs then take partnership roles in other regions, if the alternative was leaving general practice. One mentioned that their doctor significant other was now looking for work in Nottinghamshire rather than moving region, which is a net benefit to the Midlands region.

Recommendation 5: Do not adopt too narrow a definition of retention when assessing GP Fellowships. Include doctors working on a portfolio basis or reducing their working hours a week and remaining in primary care but moving regions as categories in analysis.

The fellowship can support retention in a range of ways. One is in providing new challenges and a potential route into academia or teaching. There is a perception that there are fewer research or teaching opportunities as a GP [4], compared to secondary care; around 1% of GPs held an academic post compared to 7% of secondary care consultants in 2014 [4]. However, there are opportunities for more research in primary care, and there are a wide range of teaching opportunities (for example as GP trainers); the issue may be more in the power of the "Hidden Curriculum" [6] to cause people to miss-perceive the opportunities. The existence of Fellowships and support for taking post graduate certificates is the first step towards a masters; two fellows have gone on to Masters, with at least one self funding the course. Two other fellows [GPF12 and GPF13] specifically stated that they would not have had experience of academic writing without the fellowship, and that this

had had a significant impact on their abilities to get clinical teaching posts after the fellowship was over.

The role of the GP has evolved, with GPs managing complexity and work that has previously been part of secondary care. At the same time, the primary care team has expanded, and more same day presentations are seen by nurses and other health and care professionals. GP training has not addressed these changes [NF4], and the increased need to manage leading a team. This means that newly qualified GPs are learning multiple new skills at once, and leaves little time for trainees with little time to think about their own talents and ambitions either during their training or immediately after it [NF2, NF4], and no training in the complex wider primary and community care ecosystem (for example no chance to shadow in social care) NF4]. The Fellowship allows thinking time and exposure to academia, Commissioning Organisations and other bodies, which several fellows had valued, mentioning the importance of networking. This can be the first step toward primary care leadership.

This can support someone's decision to stay in the region; GPF13 mentioned it would be *"hard for me to leave now, having built my network up; the training hub know me.*"

The Fellows valued a chance to build portfolio careers, earlier than might otherwise have been possible [e.g. GPF1]. One mentioned how important it was to them that they "*did not want to stagnate*" [GPF4]. There was a feeling that it was good to "*know what else was out there*", and gain a wider understanding of the NHS, and this enabled people in looking for teaching, research or leadership opportunities. Fellows mentioned that the fellowship had been a "*stepping stone*" [GPF2]. One of the first fellows to go through the scheme [GPF2] talked about how they had gone from wanting to emigrate to being a senior leader, running three managed practices, doing further leadership courses and that this had been in part due to the reflection time, mentorship and support from the fellowship. They mentioned that there was "*no way to have a KPI*[1]" for a scheme like this, but that it had been an important experience for them. Another [GPF4] had led national engagement on a project, which would not normally have been possible.

Recommendation 6: Provide leadership and person management training for GP Fellows, even if that is not a core part of their project and they are not doing a post-graduate certificate in management. There are existing materials to support this.

The GP Partnership Review referenced this when it talked about extending postgraduate GP training [7]. It mentioned that historically, this has involved creating GPs with Extended Roles (GPwER, formerly GPs with Special Interests or GPwSIs), but that this should now be broadened out to include leadership, management and quality improvement; all skills that the Fellows

[1] Key Performance Indicator

emphasised they had valued acquiring on the programme. The Partnership Review also notes that in secondary care, doctors have a training budget, both as a specialist trainee and as a consultant, but GPs are expected to self-fund. Offering to fund training is helpful both to the GP, and in establishing that the nation values training enough to pay for it.

Reducing the risk of burnout

Around half the fellows mentioned a fear of burnout if they had to work in a solely clinical role full time.

Many newly qualified GPs have been closely focused on passing their MRCGP and gaining their CCT[2], and have not had a chance to consider a portfolio career, or to practice teaching or research [NF2]. This, coupled with the pressure of the role, can lead them to consider working as a locum or leaving the NHS; two fellows mentioned considering emigration, and three mentioned that they had been planning to locum until they started the fellowship. By contrast, fellows on the scheme mentioned that they felt more relaxed, engaged, and "passionate" [GPF13] about GP practice, and therefore happier to promote it to other medical professionals, and more able to help their patients.

There was a consensus that the Fellowship had allowed "headspace". On a short-term level, education days had allowed reflection on practice, patients and an opportunity to "catch yourself up". One Fellow said that **"***I can switch off…I can get stuff done, work from home sometimes and get things off my to do list – I couldn't do GP practice full time, you'd burnout."* [GPF10]. Another stated that they had been an "*anxious over thinker*" [GPF13] and that they were a better doctor because of the chance to become more confident. On a longer-term basis, the fellowship allowed people the opportunity to think about career direction and also about major life decisions like where to live, and whether to buy a house. This was highly valued.

> Recommendation 7: Be aware, when designing programmes, that there are external factors such as home buying, marriages and personal partnerships, and childcare, which will impact on people's career choices and fellowships.

The participants also reported feeling valued by the fellowship, in particular by being paid to train. One [GPF3] pointed out that they could have volunteered to gain experience in other health settings, but that they were already working full time, trying to make time for their family and exercise, and that equivalent continuing professional development was paid for in secondary care. Being paid to develop made them feel more valued as a professional. This feeling

[2] Certificate of Completion of training.

of being valued will be important as the fellowships are scaled up and with newer models not necessarily including a post graduate certificate.

The structure of the Nottinghamshire Fellowship included clinical and non-clinical time running in parallel. This contrasts with other fellowship programmes in secondary care. One study [8] found that 59% of their participants felt somewhat or significantly isolated from clinical peers while undertaking research, and this was slightly less acute in those who continued in clinical work (although this was not statistically significant). Participants who undertook clinical work during research training were also significantly less likely to struggle transitioning back to clinical work. It makes sense to retain a clinical component to the training rather than moving to full time project or research work.

Time to have fun and engage in wider interests is also important. One Fellow [GLF4] explicitly mentioned amateur dramatics, sport and travel, and another spoke of the importance of having a wider circle of friends "*from outside GP land*" [GP10] in deciding to stay in the area.

Recommendation 8: Retain a mix of clinical and non-clinical work in the Fellowship structure, and run this in parallel (i.e. x sessions per week) rather than series (i.e. x week blocks). This will allow fellows the headspace that they value, and maintain them in feeling connected to clinical work.

Why General Practice?

For a fellowship to be successful, it must support the reasons that GPs chose general practice in the first place.

Six fellows had intended to become GPs from medical school, or before, it was "*always in the back of my mind*" [GPF9] and "*no other speciality grabbed me*" [GPF1]. Key themes included that General Practice offered a broad range of patient ages ("*you treat a UTI in a seven year old really differently from in a 70 year old, and I like that*" [GPF8]), a broad range of conditions ("*I'm not a specialist by nature*" [GPF7]; "*I like a bit of everything*" [GPF12]) that there were more predictable and controllable working hours and that the work was interesting. There was also a sense of valuing the traditional, whole person focus of general practice: *"I like people more than conditions"* [GPF9]. In some cases, fellows discussed changing their minds away from general practice, towards paediatrics, anaesthesia or palliative care, and then changing their mind back again. Some had initially intended to be secondary care doctors, but disliked the hospital environment and rota pressures and came to primary care for a combination of interesting work and "*some control over my hours*" [e.g. GPF13].

Work life balance was important to the Fellows. Some fellows mentioned that they wanted evenings and weekends free for family or hobbies, and one who had started another specialty training path discussed feeling "miserable" without seeing their partner [GPF10]. This could be a potential concern for some; one mentioned that they knew established GPs and *"I didn't feel I had the same sense of vocation as people did in the 1970s."* [GPF7]. This is important in terms of the fellowship because several fellows discussed being able to set up a working week with clinical days and non-clinical days, with the non-clinical days being more predictable in length and less emotionally demanding than clinical days. This can also support childcare arrangements.

Several specifically said that they believed that a full time GP role would have led to burnout, and that the fellowship had helped them see how to avoid that. An evaluation in 2017 found one fellow who stated that *"For me the Fellowship was career saving and without it would I would have probably have left the profession."* [5]

One respondent [NF4] felt that one of the factors in improving recruitment to GP training posts since the start of the fellowship was people feeling "bruised" by the new hospital junior doctor contract, and the increased out of hours working for hospital consultants, making being a GP more attractive. He also felt that there had been considerable work marketing the GP career path to students (e.g. the Discover General Practice Programme at the RCGP [10]). This was supported by comments by fellows about the training rota in hospital being "brutal," and one respondent stating they had always wanted to be a GP because they "*didn't want to be a slave to a rota for ten years*" [GPF9].

Appropriate support and supervision for fellows

The fellows required different amounts of supervision and support at different points in the fellowship. They also needed clinical supervision, management on their fellowships and educational supervision. Several mentioned "imposter syndrome", where an individual does not feel good enough for their post and is waiting to be "found out", or mentioned being a bit *"daunted"* by the idea of moving straight into independent practice. As projects advanced, people's confidence and familiarity with tasks varied.

It should be noted that people are not all starting from the same level of experience and confidence. One fellow had been practicing as a GP for two years, and pointed out that they were new to project work but not to independent clinical practice, where other colleagues were learning both skills at once; they felt that this reduced their need for supervision and that they were glad that their supervisors were able to tailor supervision to their needs [GPF13]. Another fellow observed that they had not expected how open ended project work could be, having progressed straight from medical school though GP training to independent practice in a more structured environment, and that if "someone really needed more structure, they would need the right supervisor" [GPF12]. This will be even more important as fellowships are made accessible to everyone from very newly independent GPs to people who have been in practice for five years.

Recommendation 9: Tailor bespoke supervision and support to the level of experience that suits the individual fellow.

In general, all the fellows were positive about the support they received. A theme emerged that people did not have regular supervisory meetings, but that this was not missed; several stated that the support was there and that they knew who to ask if needed, and that it was OK to ask for help. In a programme dedicated to the transition to independent practice, this is absolutely appropriate.

Recommendation 10: Provide fellows with clear lines for asking for support when needed, and occasional formally scheduled reviews.

None of the fellows mentioned mentorship or preceptorship explicitly. Mentorship is available in Nottinghamshire through the GP-S scheme, and may have been accessed by fellows through this scheme [NF2].

Preceptorship is a relatively new concept for many medical students, trainee doctors and GPs, and there may be a need to publicise the concept better.

Several talked about the importance of individuals who they had contact with; the most frequently mentioned were the programme manager, training hub leads and programme director at the training hub, GP supervisors, and senior GPs. They were credited with providing the initial support and encouragement to apply, with reassurance through the difficult communication gaps during application, with support choosing projects and on-going support as projects went forward. When prompted about how they decided to start a fellowship, fellows did mention formal mechanisms such as road shows and emails, but the majority said this was secondary to personal contact. It is not clear whether this will continue to be as important as fellowships are scaled up and become more common, or if there will always be a need for personal contacts in encouraging applications.

Project colleagues and hosts were mentioned as supportive less often, although four fellows mentioned nurses on wards and the third sector as instrumental in helping introduce them to the right people to make projects work, supporting shadowing and so on. One fellow mentioned that there was a "*difference between visions*" [GPF11] between the hub and project colleagues and that managing this difference could become stressful. However, managing the difference in expectations between different bodies is a key skill in health leadership and this experience may well be very useful in the future.

HEE was not mentioned as a source of support, with fellows stating that they were "*not that involved*" [GPF1], or not mentioning them at all. Amongst other professionals, there was a general feeling that communication could have been improved and that as the programme scales up, this would be important.

Scaling up, fellows will need approachable, available mentors or supervisors. One potential source of this will be the Clinical Directors in the Primary Care Networks. Others may be programme directors or educational supervisors. In the course of this study, it appears that the job title is less relevant than the individual's own qualities as a supervisor; several of the people mentioned as particularly supportive were nurses or managers.

Recommendation 11; Provide fellows with enthusiastic, approachable mentors. Ensure that there are clear lines of communication and that people are confident to approach mentors between formal contacts.

The fellows, particularly more recently, also highly valued contact with other fellows. The Action Learning Set was well received, and fellows talked about

Recommendation 12: Provide action learning sets or similar peer led learning, and allow time for this to include social interaction. Formalise the funding for action learning sets.

the importance of being able to form friendships and work together to solve problems.

The value placed on the fellowship is reflected in the fact at least three of the fellows are now looking for further development under the Nottinghamshire General Practice Phoenix Programme (known as the Phoenix Programme). The Phoenix scheme offers a fellowship-lite programme (clinical sessions in an alternative setting to gain specialist skills such as community gynaecology or urgent care, but no postgraduate certificate), a GP transition scheme, and support for mid career GPs looking for portfolio opportunities or special interest training. The Phoenix Programme has a number of schemes that mirror aspects of the fellowship, including GPwER training and qualifications, and management and leadership development.

Another potential way of supporting the transition to independent GP from trainee is to offer Preceptorships, also being developed under the Phoenix Programme. This would offer access to advice on portfolio development, access to coaching and mentoring, brokering conversations with potential employers, and opportunities for further skills development. Preceptorships will be introduced under the long-term plan [10], and are better established amongst nursing careers than GPs. There may not be time to pilot Preceptorships fully, but learning from nursing Preceptorships is likely to be useful.

Recommendation 13: Use learning from nursing to establish Preceptorships. Evaluate the new Preceptorships in primary care GPs with a clear set of success criteria built in from the start of the programme.

New Ways of Working

When GPs progress from trainee to independent practice, they also have to learn staff management, leadership and project management skills. Those who are interesting in a partnership will also find themselves managing a business. The trainee workflow and tasks are clearly defined, if extremely demanding; patients come to clinic and are diagnosed, treated and referred on where needed. This is different from the demands of running a practice business, working in systems and commissioning, influencing the wider health economy and managing quality improvement. Fellows talked about feeling "*daunted*" and that they had "*imposter syndrome*" [GPF1] prior to their fellowship, and [NF2] felt that they initially "*floundered*" but then quickly gained skills and did well.

Managing fellowship projects may be especially good preparation for this transition. Fellows talked about challenges and stressors around people not returning messages or providing information, project lags, and delays. They also mentioned that influencing skills, such as presenting ideas to boards and CCGs, how to best chair a meeting and how to explain what you needed to colleagues with different priorities were new. The tension between service development and personal development, is also a tension in many professional lives. Being able to manage that boundary and still free time for reflection and development is a skill that will be invaluable in future GPs. One fellow [GPF2] discussed how not having a clear objective had been both freeing and stressful, with the advice that they should focus on enjoying their time as a fellow supportive but hard to follow initially.

One fellow [GPF12] advised that it was important for fellows to be "*clear what you want to get out of the fellowship*", not so much in terms of specific projects but "the skills and exposure", as there were a lot of directions that you could go in and being clear what your goals were would help maximise what you could learn; "*it would be a mistake to view this as a break*." However, that fellow had been a practicing GP for two years and may have had a clearer view than some of their colleagues about the skills they were seeking.

Recommendation 14: Offer fellows some basic project management training, either in person or as an e-module, if they are not undergoing formal management training as part of their fellowship.

Whilst fellows were positive about these new skills, several suggested that it would have been helpful to have been warned about issues like time lags in project management and that this would have reduced their stress. One said that they felt it shouldn't be "*too easy*" and that the effort put in was a big part of the education [GPF4], and another [GPF13] acknowledged that this learning was an important part of the fellowship. This issue could be covered through project management training, or through discussion at action learning sets.

One area that was highly valued was having the time to shadow clinical leaders to board, CCG, network and MDT meetings. This allowed fellows to reflect on influencing skills, what chairing styles worked and what was less successful, and how to get points across to different professional groups. Fellows also talked about having time and the chance to network amongst senior colleagues, making connections that had improved their projects and allowed them more of a sense of the health landscape in the midlands and where they might want to work in the future. One fellow pointed out that practices are businesses, and that they were not sure how the business could have justified giving them so much time for meetings, [GPF3] but that this had been essential in setting up their career. Familiarity with working across organisational boundaries will also support the drive for integration across health and social care.

Alongside networking and shadowing, fellows mentioned having a better understanding of the wider health economy, and increased respect for nurses, third sector partners (e.g. MacMillan, hospices) and other health and care professionals. This is supported by literature from other fellowship programmes [1], which mentioned multi-professional working as a benefit. This understanding grew over time, with some fellows stating that when they began they had not been sure of the role of some organisations that became key to their projects later, and others discussing how they had changed projects significantly on discussion with colleagues they met during networking or shadowing time. This organic growth of knowledge and partnerships should be seen as an advantage, and a good reason not to be too structured or prescriptive around the details of projects at the beginning of fellowships.

Recommendation 15: Design fellowships to allow time and scope for networking, shadowing, and for projects to change and develop over the course of the fellowship as fellows become more confident and knowledgeable.

Fellows reported growing in confidence, in a range of areas, but particularly in stating cases and presenting ideas to colleagues, both in board meeting environments and one on one. One mentioned that they felt “much more able to manage my workload with the practice manager now,” which was another factor in reducing their stress and the risk of burnout. Fellows also reported feeling increasingly creative, and able to use creative ideas, throughout the fellowship. One respondent [NF1] stated that one of their hopes for the programme was the creation of “*sensible free thinkers,”* able to problem solve flexibly and implement ideas pragmatically; the fellowship seems to be a good training ground for people with these skills.

Benefits for Patients and Providers

With the shift to requiring providers to fund the placement, it is important to emphasise the fellowship's benefits to patients and providers.

The fellows felt that the fellowship had led them to become better doctors. The fellows talked about teaching improving their clinical knowledge and communication skills, through practice in conveying information and opportunities to study. One respondent [GPF8] described the impact of training as a consultation trainer on their medical practice as one of the greatest advantages of the fellowship. They also talked about how contact with the wider NHS had led to a better understanding of what other help was available for patients, and some of the wider social contexts for health.

All the non-fellow respondents felt that the Fellows provided enthusiasm, fresh eyes and time for getting projects running, especially if they did not fall directly into anyone's core responsibilities or if they had been shelved for lack of resource. The fellows achieved major success in workforce development roles, including running national engagement for the development of tools for implementing new roles across primary care, developing postgraduate certificates and masters modules for skilling up staff in a range of specialities, improving care for people with mental health needs or learning disabilities, improving understanding of palliative care in primary care and working to improve care in care homes. Having Fellows in these roles replaced the need to recruit either a manager, who would have lacked the clinical insights, or to recruit a GP who may not have been attracted to a four session, short fixed term role given the current recruitment issues. Where the host organisation has to pay for the project sessions, the Fellows are paid a different rate from the clinical contact rate. This is an area that may need to be explored as fellowships scale up; which projects are patient facing, and paid at a clinical contact rate, and how are other projects analysed for the correct pay band?

One respondent did note that a fellow was not a trained project manager [NF2], and that an experienced project manager may be better at getting a project set up and running to a timeline and budget until the fellow had learned those skills; this is an expectation that would need to be managed, with fellows offered support with these skills as needed. The Nottinghamshire programme provided a suite of project management templates, in response to this need. It also provided a manager to offer project management support to fellows.

The benefits of the fellowship have not been fully explored with providers, and this would be worth further research.

Recommendation 16: Commission research into the benefits of fellowships to providers.

Impact on Medical Education

Throughout the development of the scheme, projects based in medical education have been popular choices. The majority of Fellows took the postgraduate certificate (PGC) in medical education, with one [GPF7] self-funding a conversion to a Masters degree. This was partly due to the influence of HEEM and the local medical school, but also reflected long-standing ambitions in the fellows; four mentioned that they had always wanted to be GP trainers and that the scheme had allowed them to achieve this ambition sooner. The PGC in Medical Education was seen as a good course, with a wide range of transferrable skills that would be useful in future careers.

Fellows were involved in a wide range of educational activities, from teaching medical students, through supporting foundation year placements and up-skilling the nursing, AHP and non-registered workforce through training events and curriculum design. This extended to developing training and standards for brand new roles like the GP Assistant, a mixed clinical and administrative non-registered support role.

Several policy papers in general practice have emphasised the need for more role models from primary care for medical students (e.g. 6; 7) to provide representation, prevent prospective GPs from being put off by negativity from other specialities and mentor new students. There is also a need for enthusiastic trainees and a continued pipeline for clinical leaders to inspire the next cohort of students. The Fellows are particularly well placed to do this, as many of them have worked creatively with a range of medical and care professionals, and several mentioned a strengthened respect for nurses; they are well placed to encourage multi-professional working and learning.

Curriculum development has been described as difficult, but enjoyable, by the fellows involved in this. It has also been a major source of increased confidence: "*I would never have thought I could develop a whole curriculum*" [GP10]

The Future

The fellowships are five years old, and the first cohorts are still early in their careers. In the NHS Long Term Plan [10] it was announced that there would be a national fellowship scheme for GPs and practice nurses, which will be two years long; this is also in the GP contract [11], partly funded by NHS England. This will be tailored where possible to the needs of the individual and the primary care system, and offer a secure contract during this time. This will change the fellowship offer in Nottinghamshire and nationally.

Early indications are that the fellows have become GP trainers and in one case senior leaders earlier than they had expected, but follow up research will be needed to track the careers of fellows. Similarly, this is a small sample of people, many of whom were already enthusiastic about portfolio roles and going into GP trainer roles before the fellowship. More research into the sorts of projects that support retention career advancement, and what sorts of GP trainees benefit most, could be very helpful as the schemes expand.

Recommendation 17: Conduct more research into the long-term impact of fellowship, and which sorts of projects and trainees are most benefitted.

The scheme is due to expand. The fellowships in their current form placed a high burden on individual supervisors; scaling up will require a dedicated resource for setting up projects and mentoring fellows. This role seems a good fit for the primary care networks, which would have scope for identifying projects, and where clinical directors could take an active role in supervision.

Recommendation 18: Consider the role of primary care networks and clinical directors in identifying projects for new fellows, and supervising and mentoring them.

The majority of recent fellowship projects have been in educational fields. These have been successful in creating new curriculums and new roles, but there is also a need to boost primary care research and develop out of hospital services in primary care [NF4]. In the light of the Choice not Chance [citation needed] paper comments on the lack of input in these areas in medical school, it is not clear if new fellows would know enough about these areas to identify their own projects. Information in these areas should therefore be considered when informing new fellows about potential project areas.

Recommendation 19: Inform prospective fellows about potential projects in education, service delivery and primary care research.

Economic benefits

The fellowship was not designed with an intention to make savings. However, it is theoretically possible that the reduction in medical errors due to exhaustion or burnout, the reduction in locum costs due to retention improvements, a reduction in sick leave costs and the benefits of general improvements to patient care may be economically beneficial to the system. More research would be needed, with a larger cohort. On-going evaluation in this area could be useful.

Recommendation 20: Build economic measures into on-going evaluation of fellowships

Conclusions

The fellows were overwhelmingly positive about their experiences, despite the most recent cohort having frustrations around the organisation of their fellowships initially. One told NF2 that " I was going to go abroad to work but since being a fellow, and being supported, I now feel happier and more content and am actually enjoying working," and another that they felt “very blessed” [GPF2]. This contrasts sharply with the picture from [2] of stressed and distressed GPs.

Fellowships reduce the risk of burnout, allow fellows to gain experience and confidence that allows them to become GP trainers earlier in their careers, and has encouraged some to stay in British primary care who may otherwise have left the country. Despite the 20 recommendations below, the fellowship scheme has been a positive influence on individual GPs careers, and has also benefited patients through better training for medical students, trainee GPs and other primary care health professionals.

Recommendations

1	Allocate administrative, project leadership and supervision resources to fellowships in advance.
2	Work with hosts to understand what outputs and activities they would value, and how this can also meet the specifications of a suitable project for a fellow.
3	Supervisors should ensure that they discuss managing the tension between service delivery and personal development with their fellows, and if necessary with their contacts in host organisations, on a regular basis.
4	Work with providers to ensure that the managerial aspects of the fellowship role are in place, including how this will differ from a training role, how to manage across sites and employers, and additional supervision requirements.
5	Do not adopt too narrow a definition of retention when assessing GP Fellowships. Include doctors working on a portfolio basis or reducing their working hours a week and remaining in primary care but moving regions as categories in analysis.
6	Provide leadership and person management training for GP Fellows, even if that is not a core part of their project and they are not doing a post-graduate certificate in management. There are existing materials to support this..
7	Be aware, when designing programmes, that there are external factors such as home buying, marriages and personal partnerships, and childcare, which will impact on people's career choices and fellowships.
8	Retain a mix of clinical and non-clinical work in the Fellowship structure, and run this in parallel (ie x sessions per week) rather than series (ie x week blocks). This will allow fellows the headspace that they value, and maintain them in feeling connected to clinical work.
9	Be prepared to tailor supervision and support to the level of experience that suits the individual fellow.
10	Provide fellows with clear lines for asking for support when needed, and occasional formally scheduled reviews.
11	Provide fellows with enthusiastic, approachable mentors. Ensure that there are clear lines of communication and that people are confident to approach mentors between formal contacts.
12	Provide action learning sets or similar peer led learning, and allow time for this to include social interaction. Formalise the funding for action learning sets.
13	Use learning from nursing to establish Preceptorships. Evaluate the new Preceptorships in primary care GPs with a clear set of success criteria built in from the start of the programme.

14	Offer fellows some basic project management training, either in person or as an e-module, if they are not undergoing formal management training as part of their fellowship.
15	Design fellowships to allow time and scope for networking, shadowing, and for projects to change and develop over the course of the fellowship as fellows become more confident and knowledgeable.
16	Commission research into the benefits of fellowships to providers.
17	Conduct more research into the long-term impact of fellowship, and which sorts of projects and trainees are most benefitted.
18	Consider the role of primary care networks and clinical directors in identifying projects for new fellows, and supervising and mentoring them.
19	Inform prospective fellows about potential projects in education, service delivery and primary care research.
20	Build economic measures into ongoing evaluation of fellowships

Appendix One: This Paper

The University of Nottingham Medical School funded this evaluation. The paper has been written based on semi-structured interviews conducted with 13 fellows and 4 senior leaders working with the Nottinghamshire Fellowship scheme. This was supported by a literature search for policy and literature relating to fellowships. It was written between May and June 2019.

The author is an independent consultant, working on behalf of the Chair of the Primary Care Workforce Board and in association with the Nottingham Alliance of Training Hubs. Sarah Chalmers-Page is an experienced independent consultant with a background in NHS and Social Care management. There are no conflicts of interest, financial or otherwise.

The address for correspondence is sarahelainechalmers@yahoo.co.uk

Thanks are due to Simon Browes, Programme Director, and his team, for his support of the fellowship programme and the drafting of this evaluation. His name came up frequently during the evaluation as someone who had been essential in keeping the fellowship running, at considerable effort, and his team have been very supportive in terms of information and support throughout.

Appendix 2 Fellowship alignment with policy

A2.1 By Choice Not Chance

This section aligns the fellowship programme to the recommendations in By Choice not Chance [6]; please note the recommendation numbers here refer to Choice not Chance, not the recommendations in the body of this paper.

The Fellowship can contribute to providing a cohort of early career, enthusiastic GPs with training in medical education or recent research experience, who can then:

- contribute to selection processes in medical schools, through recent involvement in medical education (recommendation iv)
- influence the formal curriculum as lecturers and curriculum developers (recommendation v)
- highlight the range of potential career options to students, as role models with non-traditional and portfolio careers, and support the understanding of the breadth and complexity of general practice and practice at the primary and secondary interface (recommendation vi; recommendation xvi)
- be positive, supportive and enthusiastic role models who can become more visible in medical schools (recommendation ix)

Several of the fellows had further advanced as GP trainers and assessors, supporting an increase in training placements (recommendation viii).

The fellowship could also potentially become more involved in research and publishing results, especially given the non-clinical sessions in a fellowship which could allow time to write up results from studies, although a one year fellowship may be too brief to fully support this (recommendation xiii).

A2.2 GP Contract (2019)

The GP contract (2019) contains explicit details of a new national fellowship programme. It states:

"As recommended by the *GP Partnership Review* , **NHS England will also now introduce a new voluntary two-year *primary care fellowship programme* for newly qualified nurses and doctors entering general practice.** This will offer a secure contract of employment alongside a portfolio role tailored, where possible, to the aims of the individual and the needs of the primary care system. This will enable newly qualified nurses to consider primary care as a first destination role, in the knowledge that they will receive support in their early years to become confident in practice and work in supportive multi- disciplinary teams across Primary Care Networks. There is emerging evidence that such approaches will also for example increase the number of GP trainees taking up substantive roles in primary care. On

completing their fellowship, these clinicians may be more encouraged to become full partners. The arrangements will be designed in 2019.

Working with Health Education England, NHS England will establish primary care training hubs from 2020/21. These will enable more consistent provision of training and continuing professional development for primary care staff in the community.

A3: The Long Term Plan and the NHS Interim People Plan.

The Long Term Plan mirrors the GP contract, in introducing new, partially funded voluntary fellowships for all newly qualified GPs and GP Practice nurses. The Interim People Plan also supports the formation of a two-year voluntary fellowship.

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