

Rural & Remote Psychiatry

One proposed model

(Alternate proposals e.g. Credentials/Dual training are options)

Run-Through Training Scheme

A complete pathway from entry into specialty training to consultant level, designed for rural and remote workforce needs.

This programme would be a **prestigious, competitive, supported run-through scheme**, designed specifically for doctors who are committed (or open) to working in rural, remote or dispersed communities.

It offers structure, identity, protection, and continuity – things rural trainees often miss.

1. Overall Design: What Kind of Scheme Is This?

This run-through programme is:

- **ST1–ST6 (or CT1–ST6)** continuous training
- With optional **extended modules** in years 4–6
- With **rural-optimised placements**
- With **bespoke curriculum elements**
- With **enhanced consultant-preparation components**
- With priority access to **consultant posts in rural areas, co-working with CMOs**

It parallels GP's Rural Fellowship model

2. Who Is It For?

- Doctors with interest in community psychiatry, integrated care, small systems work, and generalist leadership
- IMGs seeking a structured, highly supported pathway
- LTFT doctors who value continuity and stability
- Regions with workforce gaps (Highlands, islands, Cumbria, North Wales, Cornwall, Borders, remote Midlands areas, etc.)

Entry could be via Oriel as a distinct track.

3. Structure of Training (ST1–ST6)

ST1–ST3 (Core Training Component)

Trainees complete all usual core psychiatry elements **plus rural-enhanced modules:**

Core Rotations (standard):

- Acute adult
- Older adult
- Liaison
- Community
- CAMHS or LD
- Addictions as available

Rural Enhancements:

- Exposure to **small MDT working**
- Understanding **geography-driven service design**
- Local voluntary sector collaborations
- Crisis support when transport is limited
- Experience with digital-first mental health pathways
- Risk management where admission is distant
- Working across boundaries (primary care, ambulance, police, crisis teams)

CT1–CT3 Support Elements:

- Dedicated rural mentor
- Virtual national rural teaching programme?
- Peer group “North–South Rural Community”
- Extra simulation on risk, lone worker challenges, emergency care without nearby beds

ST4–ST6

Trainees specialise as per any other higher trainee, but with **rural-specific options.**

Additional Rural Rotations Could Include:

- Remote community mental health hubs
- Crisis services without local inpatient units
- Telepsychiatry and hybrid teams
- Rural perinatal or older adult services
- Outreach to dispersed communities
- Prison and forensic outreach in remote regions
- Joint roles with voluntary and community partners

Rural Leadership Modules:

- Managing services with limited staff
- Developing crisis alternatives
- Creating community partnerships
- Writing and leading business cases for rural services
- Working with local authority or ICS leadership
- Leading across geography and digital platforms

Governance & Medico-Legal Training:

- Incident management in areas with reduced local onsite support
- Writing reports for serious incidents, safeguarding, coroner's
- Conducting QI in small teams
- Working safely with ambulance delays or police reliance
- Managing lone working and health & safety issues unique to remote areas

Consultant Preparation:

- Rural job planning
- "Generalist-plus" skill set to handle broad case mixes
- Advanced digital psychiatry
- Managing burnout risks in isolated settings
- Building peer networks remotely

4. Curriculum Themes Unique to Rural & Remote Scheme

1. Digital & Hybrid Care Proficiency

- Virtual clinics
- Digital triage
- Remote supervision
- Remote MDT meetings
- Online crisis review pathways

2. High Professional Autonomy Training

In rural settings, psychiatrists often make decisions without immediate peer availability.

Trainees learn:

- Self-protective decision-making
- Appropriate escalation
- Using virtual peer groups for advice
- Balancing risk with geography

3. Community Transformation From a Rural Perspective

- Building care in places with no crisis houses

- Working with non-NHS community groups
- Rural transport challenges
- Designing services with sparse populations

4. Cultural and Community Competence

Including working with:

- Farming communities
- Traveller communities
- Island populations
- Remote coastal groups
- Strong-identity localities

5. Emergency & Crisis Skills

Tailored to:

- Long ambulance response times
- Police reliance
- Community risk containment
- Access issues for inpatient care

5. Teaching Model

A. Monthly National Rural Teaching Sessions

Delivered virtually, including:

- Case-based learning
- Guest consultants from rural posts
- Rural governance scenarios
- Population health approaches

B. Twice-Yearly In-Person “Rural Intensives”

2–3 day gatherings covering:

- Leadership
- Simulation
- Networking
- Wellbeing
- Workshop on SUIs, coroners, complaints

C. Quarterly Rural Leadership Workshops

Run jointly with NHS regional bodies or ICSs.

6. Mentoring, Coaching, and Peer Support

Mentoring

- One rural clinical mentor
- One systems/leadership mentor

Peer Network

- Assigned “Rural Cohort Group” entering at ST1
- Continues through ST6
- Evolves into a new consultant network

Coaching

Optional coaching in:

- Negotiating job plans
- Managing boundaries
- Handling isolation safely
- Maintaining confidence and wellbeing

7. Incentives & Opportunities

A. Preferred access to rural consultant posts

Trusts involved in the scheme can offer:

- Priority shortlisting
- Guaranteed interview
- Fellowship-style add-on year
- Golden handshakes
- Rural housing or relocation grants (where available locally)

B. Academic Opportunities

Because rural research is underdeveloped:

- Trainees can lead QI or research on rural models
- Partner with universities with rural health research groups

C. Pathway Recognition

Completing the scheme earns:

- “RCPsych Rural Psychiatry Qualification” or
- “Certificate in Rural & Remote Practice”

8. How Successful Would This Be?

High probability of success IF:

- ✓ College/ GMC formally backs it as a recognised pathway
- ✓ ICSs/Health Boards commit to creating rural placements
- ✓ Trusts offer incentives for rural posts
- ✓ Digital infrastructure is robust (most rural areas already rely on this)
- ✓ Mentoring & national teaching reduce isolation (already proven effective in other fields)
- ✓ Residents feel a sense of identity and belonging as part of a Rural Cohort

Why it works:

- Rural workforce gaps are persistent and well-known
- Trainees often avoid rural posts due to fear of isolation – this removes that fear
- Run-through stability appeals to IMGs and LTFT doctors
- It creates a “tribe” and a “brand” – key to long-term loyalty

Potential impact:

- Improved recruitment into rural posts
- Better retention of new consultants
- Safer care through better governance training
- Stronger rural leadership
- Reduced burnout from structured support