NHS Education for Scotland
GP Fellowship Posts 2022
Rural Fellowships in General Practice – Job Information
Job Reference 8860 BR

Background

Rural Fellowships in General Practice were established by NES in 2002. A maximum of 10 Rural Fellowships will be available for the year commencing August 2022, organised in partnership with local NHS organisations. Each Fellowship will last up to one year. Both 'standard' and 'acute care' rural GP fellowships are available from August 2022 in a variety of rural locations across Scotland; details of locations and post descriptors at: http://www.scotlanddeanery.nhs.scot/your-development/gp-fellowships/

Local post descriptions vary between the different geographical locations. The detailed guidelines for the Rural Fellowship are appended.

Purpose & Structure of Fellowships

See attached Guidelines

Terms and Conditions

Salary

Salary will be £**63,374 pa** This figure is based on the trainee base salary point 03 on the salary scale £43,706 plus 45%. This arrangement reflects the unique educational nature of the post. Superannuation is payable on the base part of the salary only. Any 2022/2023 salary uplift will be applied.

If the post holder does not hold a valid UK driving licence, the ability to travel and organise suitable alternative transport will be necessary. Travel expenses incurred as a result of the need to travel will be reimbursed.

Subsistence and Removal Expenses

It is anticipated that each Fellow will declare a home base at the beginning of the Fellowship. Relocation expenses from previous locus to base will be paid in accordance with employing Health Board relocation policy

Study Leave

See attached Guidelines

Disclosure

Pre-employment checks may be undertaken and all appointments will be subject to satisfactory clearance according to the employing Health Board Arrangements.

Health Screening

All appointments will be subject to satisfactory health clearance and pre employment health checks may be required according to the employing Health Board Arrangements.

Maternity Leave and Pay
Any maternity pay that may become applicable will be paid according to the employing Health Board Maternity Arrangements.

Medical Defence
The fellow will be responsible for notifying their Medical Defence Organisation (MDO) of the expected programme to ensure that there is a good understanding of the programme on which to base membership fees. Most MDOs have dealt with Rural Fellows' subscription needs in the past. Advice can be sought from Dr Gill Clarke, Rural Fellowship Coordinator and subscription fees will be reimbursed by NES.

Holidays
Annual leave and public/local holidays will be in line with the employer's contractual terms and conditions.

Sick Pay
The contractual employer's policies and procedures will apply.

Discipline, Grievance and Complaints Procedures
The contractual employer's policies and procedures will apply.

Supervision
Fellows will be accountable to the Fellowship Co-ordinator.

Fellows' Personal Development Plans for the fellowship year will be determined in negotiation with the Fellowship Coordinator. The Fellows will be required to attend the Fellows' meetings held during the year that will be organised by the co-ordinator and will undergo an appraisal according to the Scottish GP Appraisal system performed by the Fellowship Co-ordinator.

The Terms and Conditions above are for information purposes only and may be subject to variation. They do not form the basis of a legal contract.

Support and Accountability of Fellowship
See attached Guidelines

Further Information
For further information please contact the Rural Fellowship Co-ordinator, Dr Debbie Miller Debbie.miller@nhs.scot

Discussion with current post-holder(s) and mentors can be arranged if desired.

NHS Education for Scotland

Rural Fellowships in General Practice – Person Specification

Ref. 7337BR

FACTORS		CRITERIA	MEANS OF ASSESSMENT		
			Application	Interview	Other e.g. presentation
Education and Professional Qualifications	Essential	• An appropriate range of previous experience in hospital posts; • Anticipated completion of General Practice Specialty Training by August 2022	√ √		
	Desirable	• Previous experience of rural/remote practice	√	√	
Experience/Training (including research if appropriate)	Essential	• Certificate of Completion of training (CCT or CEGPR) prior to commencing Fellowship • Experience of working in UK NHS	√		
Specific aptitude and abilities	Essential	• Evidence / demonstration of self directed learning • Good communication skills • Is able to articulate the core values of general practice • Evidence of personal initiative in achieving educational objectives	√ √	√ √ √ √	 √
	Desirable	• Insight into areas requiring further training • Evidence of exceptional achievement personal/professional		√ √	

Interpersonal skills	Essential	• Flexible approach to working arrangements • Willing to travel to various locations • Some understanding of the range of problems facing a remote and rural CHP or general practice • Commitment to collaborative and partnership working • Commitment to working in rural/remote practice	√ √ √	√ √ √ √ √	√
	Desirable	• Adaptable to working in a variety of workplaces over the fellowship period • Affinity for "rural or remote way of life" • Evidence of delivery of core values in general practice • Evidence of awareness of own development needs		√ √ √ √	
Other factors		• This post involves travel to areas which may not be served by public transport. If the post holder does not hold a valid UK driving licence, it will be necessary to organise travel arrangements and suitable alternative transport. Reimbursement will be available for necessary travel as per employer guidelines.			

Doctors from overseas wishing to be considered for these fellowships will need to achieve an overall score of 7.5 out of 9 in the International English Language Testing System (IELTS) test.

GUIDELINES FOR THE OPERATION OF THE GP REMOTE AND RURAL FELLOWSHIP (Feb 2022)

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 2021:

- 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 Gill Clarke, the fellowship coordinator at gillian.clarke1@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 course of the year to help fellows meet learning needs that cannot be easily met by personal study. This year we are uncertain of the way we will deliver the courses but will do our best to provide you with a structure which meets your needs.

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 make the arrangements for and conduct the annual appraisal of the fellows, 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 other 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 lead 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 Gill Clarke or Dr Amjad Khan, GP 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 and Dr Amjad Khan, GP 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.

9. The cost of the three annual meetings is met by NES. These costs include fellows' subsistence costs, speakers' fees and speakers' travelling expenses. Travelling expenses incurred by the fellows in travelling to and from the meetings are reimbursed from their individual educational budget.

TIMETABLE

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 appraisal in May, June or early July.
g) Assessment of project work and portfolio of evidence and issuing of certificates in July.
h) Feedback by questionnaire.

APPENDIX 1 – THE STRUCTURE OF A FELLOWSHIP YEAR.

1. Leave and public holiday commitment – 6 weeks plus 10 statuary 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 was 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. Past 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 European 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 <u>regular</u> out of hours work provision should be made for sufficient time off in lieu so that the EWTD 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. 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 as part of the assessment process.

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.

Guidelines for the Standard Rural GP Fellowship – Jan 2023

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.

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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.

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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 course of 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.

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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.

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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 Director of GP Postgraduate Education, 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 Director of Post Graduate GP Education, 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.

9. The cost of the three annual meetings is met by NES. These costs include fellows' subsistence costs, speakers' fees and speakers' travelling expenses. Travelling expenses incurred by the fellows in travelling to and from the meetings are reimbursed from their individual educational budget.

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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 appraisal in May, June or early July.

g) Assessment of project work in July

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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 <u>regular</u> 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.

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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.

Guidelines for the Operation of the Acute Care Rural GP Fellowship.
Updated Jan 2023.

Background to the Fellowship: -

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*).

The Acute Care Rural GP Fellowship allows extra training and support for GPs who wish to work in a more intermediate care setting, including no-bypass hospitals and small district general hospitals. The GP Acute Care Rural Fellowship option was developed based on the agreement of a list of GP Acute Care Competencies (Annex 1) following from the agreement of the *Framework for the Sustainability of Services and the Medical Workforce in Remote Acute Care Community Hospitals*(ref).

The agreed aims of these fellowship options are

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 GP Acute Care Competencies assume that GPs working in no-bypass hospitals provide some or all of the following core activities:

1. Care of acutely ill adults and children including in-patient care
2. Stabilisation for transfer of patients to other facilities within Scotland
3. Initial management of major trauma
4. Basic orthopaedic procedures such as reduction of fractures and dislocations
5. Anaesthetic care including rapid sequence induction and Advanced airway care
6. Support of midwives providing intra-partum care
7. Management of psychiatric emergencies
8. Administration of chemotherapy

9. Police surgeon duties

The drivers for change include

- The Scottish Government's 2020 vision and Quality Strategy with a commitment to care as close to home as possible and the need for equitable access to high quality healthcare services for all patients regardless of personal characteristics such as gender, ethnicity, geographic location or socio-economic status (ref x 2)
- The 'Greenaway Report', on the shape of training in the UK with an increased emphasis on training for more generalist roles and blurring the boundaries of care provision from the traditional primary /secondary care, and social care interfaces (ref)
- An increasing elderly frail population, particularly in rural areas (ref)
- The Accounts Commission report 'Reshaping Care for Older People', which emphasises the need to focus on avoiding hospital admissions and transfer of care into community settings (ref)
- The National Audit Office's report on managing admissions to hospital with the emphasis on making sure patients are treated in the most appropriate setting and in a timely manner to take the pressure off emergency hospital admissions (ref)
- A need to provide a clinical governance structure to manage risk in 'no-bypass hospitals' (ref)
- The potential to develop an acute care credential for GPs working in remote and rural setting as fore grounded in the GMC's recent consultation (ref)
- A recognition of the need for team drills and training solutions provided in localities to enhance resilience and reduce skills decay (ref)
- New training resources such as BASICS e-resources, the mobile skills unit, the newly implemented 'no-bypass hospital course' for GPs
- The vulnerability of remote and rural services requiring novel and integrated options for service delivery using a team approach
- The under-used potential of the community hospital as a training environment
- Recruitment and retention challenges for medical and other clinical staff

The fellowship is aimed at recently qualified GPs who are offered a further year of training in rural medicine. As a hospital based rural fellow, the frequent exposure to acute situations and managing the first few hours of acute illness in a supportive, yet isolated, environment allows for hands-on involvement and responsibility to allow skills and confidence in managing such cases to evolve at a rapid rate.

Such a training opportunity enables the rural fellow to be confident to work thereafter in hospital based GP-led intermediate care posts, and provides an excellent opportunity to gain acute skills that would be transferable to working in general practice in any isolated rural location within Scotland.

The acute care fellowship has been offered in Skye (Broadford), Orkney (Balfour Hospital), Moray (Dr Gray's Hospital, Elgin), Caithness, Galloway (Stranraer) and the Western Isles (Stornoway). There is a hybrid scheme in Cowal (Dunoon).

Structure of the Fellowship

The fellowship is currently run as a cooperative venture between the rural Health Boards in Scotland and NHS Education for Scotland (NES) with the funding being provided on an approximately 50:50 basis. There is scope for other funding arrangements as the need arises.

The joint funding arrangement is organised as follows: -

1. Health Boards provide their 50% from Board Administered Funds or other funds. The Boards' investment is returned through the service provision that the fellows provide in Rural Hospitals so that the service commitment contributes to the training aspects of the fellowship.

2. The 50% contribution from NES allows fellows to have protected educational time to meet their educational needs in relation to rural medicine. Educational time is spent attending courses, undertaking clinical attachments and personal study depending on the needs of the individual (see annex 2).

   Acute care fellows may wish or be required to undertake a basic anaesthetic placement of up to 3 months to obtain the necessary competencies in critical care, airways management and rapid sequence induction. This will clearly impact on other training needs if all their time is spent on one activity of learning. A flexible approach is therefore required. Anaesthetic placements should ideally be provided as locally as possible both to allow for team working and educational alliances to develop.

   A set of Acute Care Competencies (Annex 1) has been developed to enable fellows to structure their training needs and act as an aide to recording them

   It is crucial that fellows maintain their general practice experience through the year despite a focus on gaining acute care competencies and for this reason they must spend 9-10 weeks in a local base general practice. Base practices are chosen for their proven record of good organisation, of teamwork and of supporting educational initiatives but do not have to be training practices (Annex 4). They should be sited in or within reasonable travelling distance of the area in which the fellows are expected to fulfil their service commitments.

   All fellows are expected to undertake a project during their fellowship year on a subject 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 would normally be a supportive specialist within the local hospital or a consultant providing tertiary support. It may be a lead emergency care nurse with the requisite skills. If this is not possible this function would normally default to the Fellowship Coordinator. Allocation of base mentors should be 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

    a. to market the fellowship and support recruitment
    b. to ensure that all fellows have a relevant and achievable Personal Development Plan (PDP) for the year
    c. to make the arrangements for, and undertake annual appraisal of the fellow
    d. to liaise with fellows during the year to check progress
    e. to liaise with and support base mentors, local mentors, and participating Health Boards
    f. to organise the three fellowship meetings of 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 other who have a special interest in 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. Fellows are employed by participating Health Boards and a contract will be issued by the Board in which area the fellow is working. There is a nominated individual 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 individuals, 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 according to the NHS Highland model contract with Health Board specific job descriptions. Job descriptions (see annex 3) will vary depending on current circumstances in a given Health Board area but contracts should not vary between Boards. Salary placement will be at the level of StR4 on the StR pay scale (pro-rata), including a supplement of basic salary in line with current GPStR training grade salary. The fellow will be responsible for notifying their medical defence organization of the expected programme to ensure that there is a clear balance between crown indemnity and personal indemnity cover.

4. The resolution of contractual issues such as sick leave, poor attendance and unauthorised absence 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 and the Director of Postgraduate GP training 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 action with the local mentor and lead professional at NES 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.

9. The cost of the three annual meetings is met by NES. These costs include food and accommodation, speakers' fees and speakers' travelling expenses. Travelling expenses incurred by the fellows in travelling to and from the meetings are reimbursed from their individual educational budget.

Timetable for the year.

A typical year is as follows: -

1. The recruitment process (Feb – June)
    a. Discussion re budgets for the coming year and invitations to NHS Boards to participate in the coming recruitment round
    b. Agreement on job descriptions and working arrangements (base practices, mentors, contracts etc) agreed
    c. Advertisement
    d. Interviews
    e. Appointments agreed, contracts issued, needs assessment interviews arranged.

2. The fellowship year (August – July)

a. PDPs agreed prior to starting the fellowship shared with mentor and Fellowship Coordinator. The plan for educational activities then shapes the service provision for the year (for e.g. if Anaesthetics induction is chosen this may need to be arranged for the beginning of the year)
b. Induction into hospital work with planned and documented package of initial support
c. First fellows' meeting of the year in August or September (administrative arrangements, networking, introduction to appraisal and the educational programme)
d. BASICS PHEC (pre-hospital emergency care),ATLS, ALS, PALS, SCOTTIE course booked and planned out
e. Second meeting of the year in January (feedback, networking, project work)
f. Third meeting of the year in May (feedback, networking, appraisal issues, submission of project)
g. Annual appraisal towards the end of the year.
h. Assessment of project work and portfolio of evidence completed by July.
i. Evaluation/ feedback by questionnaire.

Annex 1

Competencies for the Acute Care Rural Fellowships

Cardiovascular		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate.	Chest pain - using appropriate departmental pathways			
	Acute coronary syndrome			
	Pulmonary embolus			
	Aortic dissection			
	Cardiac arrest			
	Cardiogenic shock (secondary to MI, Massive PE, Aortic Dissection etc)			
	Arrhythmias, left ventricular failure/ pulmonary oedema and hypotension			
	Syncope (including differential diagnosis)			
Cardiovascular - Additional Skills				
Interpret ECGs: Rhythm recognition, ACS changes and treatment (inc. Right ventricular and posterior infarcts)				
ECGS: recognise and treat narrow and broad complex tachycardias and bradycardias				
Anti-arrhythmic drugs: know indications, contraindications and side effects				
Thrombolysis / angioplasty / surgery: know indications, contraindications and complications				
Implantable cardiac devices: indications, function and malfunction				
Safe use of DC electrical cardioversion				

Indications for and use of external pacing equipment			
Inotropes and vasopressors: understand appropriate use			
Cardiac enzymes: understand indications and limitations			

Respiratory		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Pneumonia (community and hospital acquired)			
	Aspiration pneumonia			
	Sore throat epiglottitis			
	Pulmonary thromboembolic disease & DVT			
	Systemic features of pulmonary disease			
	COPD & Cor Pulmonale			
	Asthma			
	Respiratory failure			
	Pulmonary hypertension			
Respiratory - Additional Skills				
Safe prescribing and use of short- and long-term oxygen				
Appropriate use of non-invasive ventilation (inc. CPAP, BiPAP)				
D-dimer analysis: understand indications and limitations				

Gastroenterology		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Bleeding oesophageal varices			
	Non-variceal haemorrhage			
Gastroenterology - Additional Skills				
Appropriate use of pharmacological agents in GI haemorrhage				
Be able to use balloon tamponade				

Neurology		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Acute confusion			
	Stroke & TIA			
	Cerebral oedema			
	Subarachnoid haemorrhage			
	Extradural, subdural and intracerebral haematoma			
	Venous sinus thrombosis			
	Seizures and pseudo-seizures			

	Encephalopathy			
	The head injured patient (including raised intracranial pressure)			
	Post concussion syndrome			
	Diffuse axonal injury			
	Neurogenic shock / spinal shock (and recognise masking effect of spinal injury)			
	The comatose patient (including protection using log roll and urinary catheterisation etc)			
Neurology - Additional Skills				
Interpretation of EEG report				
Request appropriate CNS imaging and identify and optimise joint team working (inc. ED and Critical Care) for those requiring neurosurgical referral				
Interpretation of imaging of the central nervous system				

Endocrine, Renal & Metabolic		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Diabetic ketoacidosis (including delivering a sliding scale of insulin)			
	Adrenocortical insufficiency			
	Hyperosmolar non-ketotic Coma			
	Thyroid storm			
	Acute and Chronic renal failure			
	Malnutrition			

	Dehydration (including its life-threatening complications)			
	Electrolyte Disturbance (Na+, K+, Ca++, Mg++, PO4-, Cl-)			
Endocrine, Renal & Metabolic - Additional Skills				
Be able to administer Glucagon and manage hypoglycaemia				
Have understanding of fluid homeostasis mechanisms				
Understand the principles of renal replacement therapy				
Be able to interpret Blood Gas results and understand Acid-Base balance				

Haematology & Oncology		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Neutropenic sepsis			
	Coagulopathy & Bleeding (including DIC)			
	Transfusion reactions			
	SVC obstruction			
	Spinal cord compression			
	Malignant pericardial, pleural and peritoneal effusion			
Haematology & Oncology - Additional Skills				
Have knowledge of safe blood and blood product transfusion practice				

Infectious Disease and Dermatology		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Sepsis (and define severe sepsis, septic shock, SIRS)			
	Meningitis (and other life threatening causes of Purpura)			
	Toxic shock syndrome			
	Toxic epidermal necrolysis			
	Stevens Johnson's Syndrome			
	Bullous disorders			
Infectious Disease and Dermatology - Additional Skills				
Recognise and appropriately investigate skin manifestations of systemic disease				

Toxicology and Other		Date	Relevant Case?	Where else might this competency be achieved?
Be able to provide assessment, initial management and after-care as appropriate	Hyperthermia (including heat stroke and drug related)			
	Hypothermia			
	Adverse drugs reactions			
	Decompression illness			

	Burns (including special cases - face, joints, perineum, electric burns, lightening)			
	Drowning / Near drowning			
Toxicology and Other - Additional Skills				
Have knowledge of the diagnosis and specific management of poisoning with common substances such as paracetamol, tricyclic antidepressants, beta-adrenoceptor blockers, carbon monoxide, opiates, digoxin, benzodiazepines, SSRI, ethanol and methanol				
Provide treatment with cooling and warming				
Manage analgesia				
Be able to assess size, depth and fluid loss of a burn				

Airway & Breathing		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Appreciate the urgency of providing a patent airway, and the importance of basic airway manoeuvres in optimising the patient's position for airway management			
	Initiate therapy, including oxygen and bag valve mask ventilation / Mapleson C-circuit if needed.			
	Be able to identify the difficult or potentially difficult airway and summon expertise (physiological, burns, anaphylaxis, foreign body obstruction etc			
	Be able to assess, establish and maintain a patent airway, using both Basic Life Support and Advanced Life Support techniques.			
	Know the principles of invasive and non-invasive ventilation.			
	Identify those patients who will need intubation and ventilation.			

	Choose and pass appropriate tracheal tubes using appropriate laryngoscope blades.			
	Be aware of complications of tracheal intubation.			
	Identify correct/incorrect placement of tube (oesophagus, right main bronchus).			
	Be able to use techniques for difficult intubation (bougies, introducers and alternative laryngoscopes)			
	Be able to undertake failed airway drill, including LMA, needle & surgical cricothyroidotomy			
	Be able to deliver safe conscious sedation to selected patients			
	Be able to deliver rapid sequence induction (not in children)			
	Understand the appropriate use of pharmacological agents in induction and maintenance of anaesthesia and be aware of their complications and side effects			
	Recognise the difficulties of rapid sequence induction and ventilation in asthmatics			
	Be able to deliver the Heimlich / Abdominal thrust manoeuvre			
	Know the indications and contraindications for a surgical airway			
	Perform needle/surgical cricothyroidotomy and percutaneous transtracheal ventilation			
	Understand different Oxygen delivery systems			
	Be able to introduce and checking correct placement of laryngeal mask airway.			
	Understand the principles of simple ventilators			

	Be able to identify and treat life threatening chest trauma, i.e. tension, pneumothorax, open pneumothorax, flail chest, massive haemothorax, and cardiac tamponade.			
	Understand the likely chest injuries through different age groups			
	Be able to undertake a needle thoracocentesis, intercostal chest drain insertion and pericardiocentesis.			
	Be able to manage tracheostomy tube complications			
	Be able to manage Endotracheal drug administration			
	Interpret a capnograph trace.			
	Understand the prognostic features of the outcome of respiratory arrest			

Circulation		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Be able to manage haemodynamically compromised patients			
	Understand management of haemorrhagic shock including uterine displacement.			
	Be able to obtain appropriate peripheral venous and arterial access including intra-osseous and cut down techniques			
	Be able to gain central access: Subclavian / internal jugular / femoral (inc. ultrasound guided)			
	Understand invasive monitoring			
	Be able to calculate and prescribe fluid replacement, maintenance fluids and replacement for ongoing losses as per EPLS/ APLS etc...			

	Know Indications for blood administration, central venous pressure monitoring, urgent endoscopy and surgical involvement			
	Be able to use high flow infusion techniques			
	Understand judicious use of fluids especially in the elderly and the trauma patient.			
	Understand management of the exsanguinating pelvic fracture including the role of external fixation and arteriography/embolisation.			

Trauma, Orthopaedic and Musculoskeletal		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Apply the A, B, C, D, E approach to stabilise and manage the patient			
	Know APLS, ATLS, BASICS IMC algorithms and be able to apply them			
	Understand how spinal injury affects assessment			
	Safe initial care of the potential spinally injured patient (spinal immobilisation & log rolling).			
	Be able to examine the spine and apply the indications for being able to clinically ‘clear’ the spine			
	Be able to undertake Pelvic Stabilisation Techniques & apply a splint			
	Understand how to manage acute spinal cord compression (Cauda Equina syndrome).			
	Understand fracture and dislocation reduction techniques			
	Manage supracondylar fracture with limb threatening vascular compromise			

	Be able to reduce a patella dislocation and knee dislocation with limb threatening vascular compromise.			
	Recognise those patients who need urgent reduction of a dislocation ankle, and to be able to reduce it.			
	Be able to manage a compartment syndrome			
	Be able to splint appropriately, using Donway/ Hare /Thomas splint			
	Have some experience of plastering technique			
	Understand the components of a “Trauma series”			
	Know the indications for investigation using plain radiology, CT, ultrasound and blood tests.			
	Be able to administer a Femoral block			

Surgical		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Recognise when a patient’s presentation heralds a surgical cause and refer appropriately			
	Recognise and manage common acute abdominal pathologies such as pancreatitis, cholecystitis and appendicitis			
	Know symptoms, signs, presentation, causes and treatment of peripheral ischaemia, abdominal and thoracic aortic aneurysms and aortic dissection.			
	Recognise the influence of injuries elsewhere on abdominal assessment.			
	Recognise patients who have sustained significant abdominal trauma by thorough history and examination and appropriate investigation.			

	Be able to assess and reassess the traumatic abdomen, initiate treatment and investigation and involve appropriate specialists.			
	Have specific knowledge of blunt splenic, hepatic, renal pancreatic trauma, hollow viscus injury, penetrating abdominal injury, urethral / bladder / testicular trauma and bowel ischaemia			
	Be able to identify those patients with a potential aortic injury, diaphragmatic rupture, pulmonary contusion, myocardial contusion, oesophageal rupture, tracheo-bronchial injury, rib fracture and sternal fracture and to appreciate the plain radiology and CT appearances of these injuries.			

Obstetrics & Gynaecology		Date	Relevant Case?	Where else might this competency be achieved/ identified?
Knowledge and Skills	Understand the principles of emergency delivery (normal delivery, complications of labour and delivery e.g. cord prolapse)			
	Understand management of Abnormal delivery			
	Be aware of how trauma and pregnancy impact on one another; Obstetric complications associated with trauma			
	Be able to manage bleeding in pregnancy (inevitable abortion, missed abortion, threatened abortion,ectopic pregnancy, abruptio placentae, placenta praevia)			
	Have an awareness of the more unusual presentations of ectopic pregnancy			
	Be able to manage Eclampsia / HELLP syndrome			http://www.rcog.org.uk/
	Be able to manage resuscitation of the newborn LP			

	Know the differential diagnosis, diagnostic features, investigation and management of gynaecological abdominal pain (ectopic pregnancy, endometriosis, complications of ovarian/corpus uteum cysts, pelvic inflammatory disease, ovarian torsion, complications of fibroids,dysmenorrhoea)			
	Be aware of the role of anti-D immunoglobin			http://www.rcog.org.uk/

Paediatrics		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Be able to assess, establish and maintain a patent airway in a child			
	Be able to follow age-appropriate algorithms for obstructed airway including choking.			
	Understand the differential diagnosis of the well looking infant presenting with apparent life threatening events (ALTE) e.g. apnoea, cyanosis, floppy baby.			
	Know the differential diagnosis of seizures including febrile convulsions and their management (inc status epilepticus)			
	Understand specific aspects of the management of cardiac arrest in children			
	Understand the indications, pharmacology, contraindications, dose calculation and routes of administration of drugs used in resuscitation and in the stabilization of children in cardiac arrest or failure			
	Understand the presentation, complications and management of children with blocked shunts			
	Recognise and manage life threatening complications of Kawasaki Disease			

	Manage the child with a spinal injury			
	Recognise the need for intubation in life-threatening asthma			
	Be able to examine a child in a way which localises injuries			
	Understand the prognostic factors for outcome of cardiac resuscitation for children			
	Be able to manage major trauma in children.			
	Manage the child with burns (including % surface area calculation)			
	Understand the outcomes of cardiac arrest in children in a sympathetic and caring manner with patients and their families			

ENT & Ophthalmology		Date	Relevant Case?	Where else might this competency be achieved?
Knowledge and Skills	Be able to control epistaxis			
	Be able to undertake anterior nasal packing / use nasal tampon.			
	Be able to undertake posterior nasal packing with Foley catheter and balloon placement			
	Know the management of a Pre-tonsillar abscess			
	Know the management of a post tonsillectomy bleed			
	Be able to manage torrential nasopharyngeal bleeding			
	Be able to use the slit lamp to compete the eye examination			
	Be able to remove Foreign bodies and rust rings at the slit lamp			

Teamwork, Leadership & Communication Skills		Date	Relevant Case?	Where else might this competency be achieved?
Specific Skills	Be able to lead a resuscitation team in line with appropriate guidelines			APLS, ATLS, ALS, EPLS, NLS, BASICS
	Be able to triage and identify those patients requiring transfer			
	Be able to take a senior coordinating and command role in the reception phase of a major incident in the ED			
Teamwork, Leadership & Communication Skills - Additional Skills				
Understand the role of the Medical Incident Officer, the definition of a major incident and a major incident plan				
Know the equipment and documentation required to manage a major incident				
Participate in major incident exercises.				
Understand the organisation of pre-hospital services, scene safety, patient care and transport				
Know when to discontinue resuscitation				
Understand the indications and procedures for transport to a definitive facility following stabilisation				
Have experience of tele-medicine				
Be able to provide effective and sensitive support to patients and relatives of those involved in trauma and major incidents				
Be aware of forensic medicine issues for the non specialist GP				

Using the Competency Guidance etc....You should aim to write up one case every 2 months (6 for the year) which is reflected on in your SOAR entries. Cases can (and will ideally) cover multiple competencies from different areas of the list.

Annex 2

The structure of a fellowship year

1. Leave and public holiday commitment – 5-6 weeks depending on StR grade plus 10 statuary 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. 9-10 weeks working in general practice
    b. 12 weeks to attend courses, arrange clinical attachments (hospital or primary care) or undertake study as agreed with the Fellowship Coordinator.

Notes

1. Flexibility in these arrangements is paramount 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 hospitals that satisfied the educational needs of the fellowship and if such an extension was compatible with the individual fellow's PDP for the year.
2. Potential conflicts between service commitment and educational need should be discussed between the Fellowship Coordinator and the nominated individual in the Health Board. Past 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 European 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 <u>regular</u> out of hours work provision should be made for sufficient time off in lieu so that the EWTD 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 relevant 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 hours care fellows should take part in the on-call rota so that they experience the particular issues related to 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. 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

Annex 3

Sample Job Description (from NHS Highland)

NHS Highland
North CHP
Acute Rural Fellows Job Description

Location: Caithness/ (X posts available)

The rural fellow would spend at least 22 weeks working in a hospital setting across the North Community Health Partnership (CHP). The expectation will be that the base hospital will be Caithness General Hospital. There will be opportunities to be involved in smaller community hospitals service provision.

As part of the General Practice component 9-10 weeks would be spent working in a practice within the North CHP , and would be arranged in agreement between the North CHP, and NHS Education for Scotland.

Duties: Duties will include:-

- monitoring and providing general care to patients in Casualty, ward settings and out-patient clinics. This is likely to include the care of children and may include Obstetrics depending on the unit. There will be a need to be involved in Palliative care.
- stabilising and transferring patients from Casualty into wards and tertiary hospital settings via the air ambulance team
- liaison with other teams, patients and relatives in a timely fashion
- carrying out specialist procedures such as lumbar punctures and chest drains and interpretation of emergency scanning and Xrays where available
- keeping adequate and timely paperwork
- effective inter-professional team work
- promoting health education and personal responsibility
- undertaking managerial responsibilities such as planning the workload and staffing of the department when necessary
- teaching junior doctors and medical students, as well as auditing and review of activity to enable robust patient safety

OOHs Element: Fellows are expected as part of their educational programme to gain experience in Out of Hours Care. All Fellows will be subject to the European Working Time Directive.

Supervision in practice: A suitable person will be identified as a mentor/supervisor and will be available to the Fellow within a reasonable time frame.

Education in practice: Fellows will be expected to join in with the educational activities available within the hospital and practices that they are working. During the year they will be required to fulfill the requirements for GP appraisal including audit, at least 2 Significant Event Analyses and Practice/ Service improvement activity (see SOAR for full details).

Local Educational Opportunities: A variety of regional educational activities are available including courses such as Advanced Life Support and attachment potential in Highland i.e. Raigmore Hospital, the hospice, etc.

Protected educational time: This will be organised in conjunction with the service elements of the posts and with the Rural Fellowship Co-coordinator. Fellows will have the opportunity to negotiate additional experience in secondary care, remote practices and to undertake specific course activity as available. Fellows will also be expected to attend the 3 meetings of the Scottish Rural Fellows that are provided during the year.

This Job Description is not definitive and may be subject to change in discussion with the Fellow, North Highland Community Health Partnership and the Fellowship Coordinator.

Annex 4

The attributes of a Base Practice

All base practices used to host GP Rural Fellows will be rural but not necessarily remote, and will 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 an educational ethos as exemplified by training practice status, approved practice for undergraduate attachments, 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. Commitment to identify a GP in the practice who is willing and able to act as a mentor for a rural fellow whilst within the general practice setting.
4. A willingness 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. A willingness to 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. A willingness to to provide support for the project that must be completed during the fellowship year.
7. A willingness to to provide a structured reference at the end of the year as part of the assessment process.

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 9 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.

Leadership Behaviours

NHS Education for Scotland (NES) assesses and selects employees based on our leadership behaviours which are expected at all levels in the organisations. These leadership behaviours support the NES ways of working and NHS Scotland values.

These leadership behaviours describe how we work, and what is expected of everyone who works in NES. A number of methods may be used to assess these behaviours as part of our recruitment and selection processes. Our leadership behaviours are:

Inspiring	Passionate about our strategic mission and about excellence; communicating purpose and vision with enthusiasm; innovative, and learning from success as well as setbacks
Empowering	Giving our teams space and authority to deliver outcomes; investing in learning and development; expecting top performance & dealing with occasions where this is not delivered; being approachable and open to constructive challenge
Adaptive	Respond flexibly to changing requirements and help others to do the same, recognising that required leadership and expertise may not always sit at the top of the hierarchy and actively encouraging good ideas/input from all levels.
Collaborative	Committed to working together, and across professional, clinical and organisational boundaries, internally and externally to achieve our objectives
Engaged & Engaging	Committed to our values, agreed ways of working and our strategic and operational direction; visible to stakeholders and to our teams; straightforward and honest in our communications