Guidelines for the Operation of the Acute Care Rural GP Fellowship.
Updated Jan 2024.

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). From 2025 the Acute Care Rural Fellowship Curriculum mirrors that of the GMC-approved Credential in Rural and Remote Health (Unscheduled and Urgent care) the Credential in Rural and Remote Health | Turas | Learn , allowing an opportunity for the Acute Care Rural Fellow to work towards securing the award of a Credential in Rural and Remote Health (Unscheduled and Urgent Care) via the Learner route

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 competencies suitable for GPs working in Rural Hospitals.
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 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 development of the GMC Credential in Rural and Remote Health (Unscheduled and Urgent Care)
- Shaping the future together: remote and rural GP working group 2020
- 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).
- The development of the GMC Credential in Rural and Remote Health (Unscheduled and Urgent Care)
- Shaping the future together: remote and rural GP working group 2020

- 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)
- Training resources such as BASICS e-resources, the mobile skills unit,
- 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 also 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 have 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. These should also be provided at no extra cost to the fellowship other than the cost of bed and board to be met by the fellow's educational allowance.

- An Acute Care Competencies logbook (Annex 1) has been developed to enable fellows to structure their training needs and act as an aide to recording them. It is advised that the fellow writes up 6 cases which can be linked to this logbook, but there is no minimum requirement. All sections of the log do not need to be completed but this logbook is a useful resource as it documents experience throughout the fellowship year. T

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 liaise with fellows during the year to check progress
    d. to liaise with and support base mentors, local mentors and participating Health Boards
    e. to organise three fellowship meetings a 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 organisation 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 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 Debbie Miller and Lead Dean Director as appropriate and that decisions should, if at all possible, be agreed by all concerned.

5. Clinical performance issues should be reported to the Fellowship Coordinator who would be expected to discuss any possible action with the local mentor 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.

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) Usually booked for early October in Nairn . ,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 review towards the end of the year.
    h. Assessment of project work and portfolio of evidence (log book) completed by July.
    i. Evaluation/ feedback by questionnaire.

Annex 1- Log of competencies

Annex 2 – Structure of fellowship year

Annex 3 – Job description example

Annex 4 – Attributes of a GP Base Practice

Log of competencies for Acute Rural Fellowship

Name	
Reviewer	
Signature and Date	
Comments	

Cardiovascular			
Be able to provide assessment, initial management, and after-care as appropriate.			
	Date	Relevant case	Where else might this competency be achieved
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			
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			
Interpret ECGs: Rhythm recognition, ACS changes and treatment (inc. Right ventricular and posterior infarcts			
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			
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			

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			
Be able to provide assessment, initial management, and after-care as appropriate			
Bleeding esophageal varices			
Non-variceal hemorrhage			
Gastroenterology- additional skills			
Appropriate use of pharmacological agents in GI hemorrhage			
Be able to use balloon tamponade			
Neurology			
Be able to provide assessment, initial management, and after-care as appropriate			
Acute confusion			
Stroke & TIA			
Cerebral oedema			
Subarachnoid hemorrhage			
Extradural, subdural and intracerebral hematoma			
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 recognize masking effect of spinal injury)			
The comatose patient (including protection using log roll and urinary catheterization etc)			
Neurology – additional skills			
Interpretation of EEG report			
Request appropriate CNS imaging and identify and optimize joint team working (inc. ED and Critical Care) for those requiring neurosurgical referral			
Interpretation of imaging of the central nervous system			
Endocrine, Renal and Metabolic			
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 and Metabolic- additional Skills			
Be able to administer Glucagon and manage hypoglycemia			
Understand the principles of renal replacement therapy			
Be able to interpret Blood Gas results and understand Acid-Base balance			
Haematology and Oncology			
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			
Hematology and Oncology -Additional skills			
Have knowledge of safe blood and blood product transfusion practice			
Infectious disease and dermatology			
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			
Recognize and appropriately investigate skin manifestations of systemic disease			
Toxicology and Other			
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 and Breathing			
Knowledge and skills			
Appreciate the urgency of providing a patent airway, and the importance of basic airway maneuvers in optimizing 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.			r
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 (esophagus, 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			

anesthesia and be aware of their complications and side effects			
Recognize the difficulties of rapid sequence induction and ventilation in asthmatics			
Be able to deliver the Heimlich / Abdominal thrust maneuver			
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 hemothorax, 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.			
Circulation			
Knowledge and skills			
Be able to manage hemodynamically compromised patients			
Understand management of hemorrhagic 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/embolization.			
Trauma Orthopeadic and Musculoskeletal			
Knowledge and skills			
Apply the A, B, C, D, E approach to stabilize 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 immobilization & 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 Stabilization 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.			
Recognize 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			
Knowledge and skills			
Recognize when a patient's presentation heralds a surgical cause and refer appropriately			
Recognize and manage common acute abdominal pathologies such as pancreatitis, cholecystitis and appendicitis			
Know symptoms, signs, presentation, causes and treatment of peripheral ischemia, abdominal and thoracic aortic aneurysms and aortic dissection.			
Recognize the influence of injuries elsewhere on abdominal assessment.			
Recognize 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 ischemia			
Be able to identify those patients with a potential aortic injury, diaphragmatic rupture, pulmonary contusion, myocardial contusion, esophageal rupture, trachea-bronchial injury, rib fracture and sternal fracture and to appreciate the plain radiology and CT appearances of these injuries.			
Obstetrics and Gynaecology			
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 previa)			
Have an awareness of the more unusual presentations of ectopic pregnancy			
Be able to manage Eclampsia / HELLP syndrome			
Be able to manage resuscitation of the newborn LP			
Know the differential diagnosis, diagnostic features, investigation and management of gynecological abdominal pain (ectopic pregnancy, endometriosis, complications of ovarian/corpus luteum cysts, pelvic inflammatory disease, ovarian torsion, complications of fibroids,dysmenorrhoea)			
Be aware of the role of anti-D immunoglobin			
Paediatrics			
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			
Recognize and manage life threatening complications of Kawasaki Disease			

Manage the child with a spinal injury			
Recognize the need for intubation in life-threatening asthma			
Be able to examine a child in a way which localizes 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 and Ophthalmology			
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 and communication			
Specific skills			
Be able to lead a resuscitation team in line with appropriate guidelines			
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 and communication- 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 organization 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 stabilization			
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			
Any additional competencies			

Fellow should aim to write up 6 cases in 12 months which should link to a number of competencies

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 teamwork
- 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

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 organized 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.