GP Fellowship in Urgent and Acute Care

2016-17 Manual

September 2016
Foreword

Sir Keith Pearson,
Chair, Health Education England

There is a greater need than ever before for joined up working within our national health service. Our GP workforce must be capable of providing comprehensive care and access to community care pathways for an increasingly aged population of patients, who present with an ever-wider range of complex health issues. The Health Education England - West Midlands GP Fellowship programme addresses this need by providing enhanced skills training for the GP of the future. This innovative scheme demonstrates that training can continue to occur across sectors, enabling patients to be seen by the right professional, in a timely manner.

Professor Elizabeth Hughes,
Director of Education and Quality,
Health Education London and Southeast

Health Education England – West Midlands collectively feel that, with an increasing emphasis on admission avoidance and reconfigurations resulting in minor injury units and step-down care units where GPs would be involved, additional training is necessary to meet such service requirements and provide comprehensive patient care. The Fellowship program will aim to address this need, by providing a platform for GPs to gain enhanced skills in the provision of Urgent and Acute care. The end result will be a GP capable of practicing effectively and with confidence in new roles in primary and community care, whilst continuing to use their skills in managing complex co-morbidity within the acute setting in emergency departments and medical assessment units. The Fellowship will enable the retention of generalist skills and the development of specific and enhanced skills to fit new settings of urgent care.

Professor Veronica Wilkie,
Professor of Primary Care,
University of Worcester

The role of the General Practitioner is changing and becoming ever more complex. The training of GPs is therefore evolving and it is becoming clear that in some cases there needs to be increased clinical experience and accredited learning to reflect the role of the generalist medical practitioner in urgent care. This innovative programme is pioneering the way that 21st century medical practice in the community is evolving. The Fellowship will act as a blueprint for other schemes, to integrate the role of the future primary care physician within 21st century community care.
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Executive Summary: The GP Fellowship in Urgent and Acute Care

Introduction

General Practice is evolving….

As UK healthcare service continues to evolve, the demand for generalist practitioners has never been greater or more varied. Generalist practitioners are needed in traditional office-based family practice, as out-of-hours acute practitioners, as medical practitioners working within intermediate care teams, or specialising with the care and rehabilitation of an increasingly frail population; all in addition to the delivery of timely and effective community healthcare.

Individual practices are merging into super-partnerships or Federations (RCGP 2008) and model GP contracts have been published to reflect this (DH 2016). At-scale primary care offers a greater range of services, increasingly integrated with other parts of the health and social care system, provided by a more diverse workforce, with patients accessing care through alternative pathways.

The evolution of general practice is essential to meet the aspirations of the NHS ‘Five Year Forward View’ - To centre care on the needs of patients and populations and blur the boundaries between primary and secondary care, health and social care, physical and mental health. The King’s Fund suggest that achieving such ambitions will “require a workforce that reflects the centrality of primary and community care and the need for more generalism; is able to deliver increased co-ordination across organisational boundaries; and can address inequalities in treatment and outcomes across physical and mental health services.”

1. **Why is GP workforce transformation needed? Programme Justification**

General practitioners have been fortunate to have remained generalists, but it is clear that there needs to be a re-evaluation of 21st century training pathways, to reflect the needs of an aging population and a changing healthcare organisation. The Royal College of General Practitioners (RCGP) argued the case for enhanced and extended training for GPs (Rughani, Riley, Rendal 2012). The educational case for enhanced and extended training was accepted, but has not progressed for reasons outlined by Riley and Howe (2015).

The emergence of Sustainability and Transformation Plans (STPs) are a significant opportunity - through the Local Workforce Action Boards (LWABs) - to influence the development of a workforce capable of providing a level of care that local populations should expect from a 21st century healthcare system. The RCGP has already announced regional ambassadors, who will work with STPs to promote the voice of primary care. In addition, primary care educators are engaging with the STPs to shape the nature of training pathways for a primary care workforce.

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1 See also Appendix 1
New models of care and closer inter-agency service delivery are creating new opportunities for professional development for the GP workforce. The need for generalist practitioners with the ability to lead and change services across sectors and professional groups is fundamentally important.

The Shape of Training Report (2013) recommended greater workforce flexibility through the development of credentialing, defined as “a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area...” The General Medical Council (GMC) has been working on developing pilots to define how credentialing will work. Credentialing opens the doors for the development of enhanced competencies through educational programmes (such as Fellowships), based on service need.

Finally, collective action that connects local innovation and best practice within a national framework is required if the NHS is to meet the aspirations of a fit-for-purpose workforce for primary care and achieve the aspirations of the RCGP for enhanced and extended training.

The tools for such action are already available through organisations such as the Conference of GP Educators (COGPED), RCGP, and other arms-length bodies. The GP 5 Year Forward View (2016) and Primary Care Workforce Commission (2015) provide the relevant policy framework. Despite this, it is recognised that relying on joint investment across a multitude of sites and stakeholders is often the greatest barrier to successful adoption.

In 2013, a Post-CCT GP Fellowship programme commenced in the West Midlands, with a focus on urgent and acute care. The programme enjoyed a successful pilot and was quickly scaled to extend across London and the South-East of England. A Midlands-wide programme is currently in development. The Fellowship has enabled newly qualified GPs to continue to undertake a structured, placement-based experience, with a supporting educational framework.

The evaluation of the West Midlands Fellowship pilot by the University of Warwick was favourable, albeit with only a small cohort to consider. The Fellowship model was shown to provide a defined framework for wide-skilling GPs to work in an enhanced manner across primary, urgent and emergency care settings; supporting admission avoidance and making greater use of community-based alternative care pathways.

The Fellowship successfully challenged traditional barriers, which may have previously resulted in patients receiving fragmented, inappropriate and costly care.

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2 See Chapter 6 (Page 30) for Evaluation Summary
Complex challenges facing the NHS with an ageing population with multiple co-morbidities require a "cross fertilisation" of knowledge, practices and ideas; the Fellowship scheme demonstrated an ability to catalyse this at a system-wide level.

2. **GP Fellowship in Urgent and Acute Care: Programme Content**

During the twelve-month, full-time Fellowship, the GP Fellow will undertake a programme of clinical and academic training, to gain experience in the providing of care for step-down patients in the community.

The Fellowship programme is divided into three, four-month phases, requiring a *weekly* commitment of ten (10) Programme Activities [PAs] to include:

i) **4 PAs Trust commitment:**
   - **1st Phase:** Spent within the **Emergency Department** of the nominated Trust.
   - **2nd Phase:** Spent within the **Acute Medical Unit** of the nominated Trust.
   - **3rd Phase:** Undertaking a range of strategic and operational placements within the West Midlands Ambulance Service.

ii) **4 PAs** within a nominated GP practice. Here, the Fellow will work with their GP mentor to develop ways of transferring skills, experience and innovative working (gained during each of their Fellowship phases) between primary and secondary care settings.

iii) **2 PAs**, during which the Fellow will complete a bespoke **Post-Graduate Certificate [PGCert]** in **Urgent and Acute Care**, delivered by Worcester University. The Certificate, delivered as part of the academic day (Thursdays) every week (for the life of the Fellowship), will develop in its students a deeper understanding of and increased confidence in dealing with the pathophysiological changes that underpin presentations of urgent and acute illness.

The week was set out in this manner to encourage each Fellow to enhance their cross-practice strategic and operational thinking, while also allowing for maximum opportunity to innovate.

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3 See Chapter 8 (Page 49) for Fellowship Role Description and competency matrix.
4 See Chapter 7 (Page 40) for PGCert course structure and content.
3. **Quality Assurance: Mentoring and Evaluation**

Once the Fellow’s individual GP Practice is nominated, an experienced GP mentor will be allocated. The GP mentors will undertake to provide weekly 1:1 meetings with their Fellow. Additionally, contact between the HEE-WM programme team and the nominated Trust Clinical Supervisor, the Fellow and their GP mentor will take place at the end of each Trust phase and at locally agreed intervals throughout.

As they rotate through their Fellowship phases, the pilot Fellows will record feedback and learning outcomes from and within their GP and Trust teams. They will continue their involvement post-pilot as Associate Lecturers, assisting in delivery of the PGCert to future cohorts.

4. **Expectations and Deliverables**

The PGCert was designed and influenced by its practitioners, with the aim of blending clinical and academic learning. With the future joined-up workforce model in mind, the PGCert modules were designed to be relevant to a multidisciplinary intake (eg. Nursing / Pharmacists / Physician Associates), rather than being exclusive to GPs.

Upon successful completion of the twelve month programme, Fellows will be able to confidently:

- Demonstrate the ability to diagnose and assess urgent presentations in long term illnesses.
- Formulate, implement and evaluate current pathways of care according to best evidence.
- Show understanding of frail and elderly complex co-morbidities and how such patients are appropriately managed.
- Demonstrate competence in the interpretation and evaluation of evidence and the application of appropriate treatment and assessment.
- Apply knowledge and skills to the management of urgent care.
- Critically interpret and evaluate the current evidence behind urgent care.

**Discussion**

In June 2015, the UK Government set out the first steps in a new deal for GPs. The Health Secretary made specific reference to the HEE-WM Post-CCT GP Fellowship in Urgent and Acute Care, as an exemplar for developing specific skills in future GPs.

“…Building on the success of a Health Education England pilot in the West Midlands, we will incentivise a number of newly qualified GPs with an extra year of training and support to develop specific skills needed in areas such as paediatrics, mental health and emergency medicine…”

The world is changing… and patient needs with it... to the point where traditional models of clinical workforce planning are no longer sustainable. New models of care and care delivery need to be developed to allow for safe, effective and sustainable patient care in the 21st century.
In particular, there is a need for a medical primary care input to an increasingly diverse multi-professional team, across the urgent, acute and EM healthcare economies. Some of this need to change is driven by the demands of geographical location, family or a partner's non-medical career aspirations, as well as a real enthusiasm and drive to make a difference in a particular clinical area.

The 2013-15 pilot and subsequent October 2015 West Midlands and Pan-London cohorts have proven the Fellowship model as fit for purpose, demonstrative of workforce transformation, demand-led, sustainable and capable of scale and spread. As such, it is proposed that a cohort of the GP Fellowship in Urgent and Acute Care be launched across the West Midlands in 2016-17, to support government mandate, HEE strategic drivers and the national imperative to drive primary care redesign across the Urgent and Acute Healthcare economies.

It is further proposed that the West Midlands cohort be launched in January 2017, to complement the pan-London GP Fellowship cohort and allow for cross-region learning and collaboration between the two programmes where appropriate.

While preparing to launch the 2017 cohort of the Urgent and Acute Fellowship, HEE-WM are also expanding their portfolio. At the time of drafting, Fellowship variations in Primary Care Paediatrics, Frailty, Geriatrics and Mental Health (to include Veteran’s Health) are under development.

Through the Urgent Care Fellowship and future variants, HEE-WM and its partners aim to influence a change in cultural thinking and assist in the evolution of the future medical workforce.

This manual will provide the reader with an overview of the programme; its structure, deliverables, content and evaluation processes.

A list of programme contacts can be found at the end of this document.
Chapter 2

Emergency Department Phase
A. Overview: Emergency Department Phase

Author: Dr Chris Hetherington, Consultant in Emergency Medicine.

The main aims of the Emergency Department (ED) attachment as part of the fellowship are:

- To up-skill the general practitioner (GP) Fellow in modern emergency care, in a secondary care setting.
- To use the GPs primary care skills and knowledge of community services to disseminate and share knowledge with the Emergency Department (ED) team and
- To reduce the number of avoidable admissions presenting at the Emergency Department.

Such an approach inevitably requires significant understanding and knowledge of community-based solutions, particularly for the frail and elderly population.

The GP Fellow must also possess an ability to work within a team of doctors and other health care professionals, who carry varying levels of competence and skill mix.

The GP Fellow may also use their primary care skills to help educate junior doctors in Emergency Medicine, regarding the non-urgent conditions that inevitably arrive in the ED and of course help educate doctors in terms of what facilities may be available to avoid admissions through the ED.

If the Fellow has had previous experience working as a junior doctor in Emergency Medicine, then clearly there will be a period of relearning and reusing old skills; updating knowledge regarding the new elements of emergency care options that are currently at the disposal of ED clinicians.

The Fellowship programme will also allow the GP Fellow to experience the type of case mix that comes through a modern ED, where there is an emphasis now on the sicker, frailer, elderly patients with multiple co-morbidities, who will very often find themselves in an MAU or acute inpatient setting.

Perhaps one of the great values of the placement is that the Fellow will be able to analyse this case mix and start to identify areas where interventions in the pre-hospital setting or during their attendance at ED will enable discharge and support through enhanced care teams, community-based services, social care and the utilisation of the patient's own GPs and district nursing teams.

How this develops during the four-month attachment will vary depending upon the previous knowledge and experience of the Fellow and the role they play within the department.

The first 1–2 months of the EM Phase may involve a period of familiarisation of the systems used in the ED and developing an understanding of the team structure and the case mix that is seen on a daily basis. This will inevitably vary between departments. It is useful for the Fellow to see undifferentiated patients both in the majors and minors setting, in order to experience the work streams that occur and are utilised in Emergency Medicine.
Once comfortably embedded in the department, the Fellow can then progress in the final two months of the phase, using their primary care skills and enhanced knowledge of other services, to try to identify those particular patients where they can have a greater input and perhaps influence the admission and discharge decision to a greater degree.

It is important that the Fellow does not get “bogged down” trying to address one agenda or the other, because this will gradually evolve over the period of the attachment. Also, as they become more confident in seeing emergency type cases, they will start to get a feel and understanding for the levels of case that they will be able to provide greater and more specific input to.

As part of the ED phase, the Fellow should be involved in teaching and education. Usually this takes the form of departmental teaching activities both at middle grade and junior doctor levels.

There will also be ample opportunity for the Fellow to teach and support junior members of the ED team on the shop floor. This is where a significant opportunity for sharing knowledge and shared learning is to be achieved.

In addition the more formal teaching arrangements should be used as an opportunity by the Fellow to help educate the juniors about more specific issues relating to primary care and also learn more about Emergency Medicine from a junior doctor prospective.

It is useful if the Fellow is already a recipient of the life support courses [ATLS / APLS / ALS], as this will perhaps give them a broader scope of patients that they can see and be involved in the care of. However, if they have not completed these courses, it should not be viewed as a barrier as there will be opportunities throughout the Fellowship for up-skilling in such areas (particularly during the West Midlands Ambulance Service phase PHEM (Pre-Hospital Emergency Medicine) Course).

Finally, urgent and emergency care should be viewed as a continuum. The ED attachment of the Fellowship Programme provides an excellent opportunity for the GPs to experience modern emergency care being delivered in a secondary care setting, but with ample scope for primary care input and intervention within that environment. This will result in patients’ needs being addressed more appropriately in the right place, at the right time, in the future.

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5 See Ch.7 - PHEM COURSE
A. Example EM Phase Induction Program:

<table>
<thead>
<tr>
<th>Time</th>
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<th>Supervisor</th>
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<td>Introduction to the ED</td>
<td>Mr Hetherington</td>
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<td>09:45</td>
<td><strong>ED Orientation:</strong></td>
<td>Mr Hetherington</td>
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<td></td>
<td>- Resus Kit</td>
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<td>- Paeds Trolley</td>
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<td></td>
<td>- Ultrasound</td>
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<tr>
<td>10:00</td>
<td><strong>Departmental Basics:</strong></td>
<td>Mr Hetherington</td>
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<td></td>
<td>- Bloods, Cannulae, Forms</td>
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<td>- Paeds Minors Streaming</td>
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<td>- Speciality Referrals</td>
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<td>- The Middle Grade</td>
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<td>- Radiology ordering / out of hours</td>
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<td>- Rapid Response / Virtual Ward</td>
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<td><strong>Clinics:</strong></td>
<td>Dr Crawford</td>
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<td></td>
<td>- ED Review Clinic</td>
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<td>- Fracture Clinic</td>
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<td>- Falls Clinic - forms</td>
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<td>- TIA Clinic - forms</td>
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<td>- EPAU Clinic</td>
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<td>- Eye Clinic / ENT / Maxfax</td>
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<td>- HITS</td>
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<tr>
<td>11:00</td>
<td><strong>ACS / Myocardial Infarction:</strong></td>
<td>Dr Crawford</td>
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<td>- ECGs</td>
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<td>- Treatment guidelines</td>
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<td></td>
<td>- PPCI / Thrombolysis</td>
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<td>11:30</td>
<td><strong>Psychiatric Cover / DSH CR/HTT</strong></td>
<td>Su Madden</td>
</tr>
<tr>
<td>12:30</td>
<td><strong>Computer System</strong></td>
<td>Maria Hall</td>
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<tr>
<td>13:00</td>
<td>Lunch</td>
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<td>Dr Hartley</td>
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<td>- New Renal Colic protocol</td>
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<td>- Fax forms available on Patient First</td>
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<td>- Co-morbidities checklist</td>
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<td>14:00</td>
<td><strong>Protocols / ED Guidelines:</strong></td>
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<td>- TIA / NOF / antibiotics / LVF / DVT etc.</td>
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<td>- Toxbase / Intranet</td>
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<td>- Trust Guidelines</td>
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<td>- STROKE Thrombolysis</td>
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<td>- NICE C.Spine &amp; Head Injury</td>
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<td>- Urinary Retention / Renal Colic</td>
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<td>- Trauma Unit</td>
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<tr>
<td>14:30</td>
<td><strong>Child Protection</strong></td>
<td>Anne Crohill</td>
</tr>
<tr>
<td>15:30 – 16:30</td>
<td><strong>SHOP FLOOR</strong></td>
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B. Fellows’ Reflections

i. Dr Michael Clements (2014-15 cohort)

The ED rotation of the pilot programme has undoubtedly been a success story. There are a number of factors which have had to align in order to achieve this. This document will attempt to identify some of the aspects and drivers which have contributed to this with the anticipation that ‘lessons learned’ can be applied to future rotations within and without the ED.

- **An ‘on board’ consultant team.**
  - The ED consultant body were involved in an early stage of the development of the Fellowship and this understanding of the requirements within it has been critical in a successful rotation.

- **Flexibility within learning outcomes.**
  - Each of the Fellows coming through the department will have different learning objectives. While a degree of ‘bedding in’ to the department is likely to be necessary, the opportunity to then develop specific competencies while there is vital to plug those skill gaps which may exist.

- **Enthusiastic Fellows.**
  - Self-evidently, being self-motivated within the department results in greater opportunistic learning.

- **A Functional Department.**
  - The Alexandra ED has a stable and functional middle-grade tier who are keen to share their experience and provide educational supervision. The same can be said for the department’s EMPs, who are keen to share their experience if asked.

- **A Departmental Commitment to Education and Training.**
  - As above, but also evident in weekly middle-grade teaching and ‘lessons of the week’ supplied by the junior clinical tier. This makes education a cultural norm.

- **A Small and Adequately Resourced Department.**
  - The size of the Alexandra Hospital means that networks can be developed quickly and keeps the Fellow visible to colleagues. It is difficult to ‘get lost’ in the same manner that might exist in larger units.
ii. Dr Janki Patel (2015-16 cohort):

I applied for this fellowship because I had always had a great interest in acute medicine, after qualifying as a GP I undertook locum work in both general practice and hospital settings and enjoyed them immensely. My friend and previous colleague who was undertaking the fellowship at the time, recommended it to me and I knew I just had to get involved.

At the beginning I expected to gain some more experience in ED and CDU as well as general practice but I have been overwhelmed with what I have learned and experienced this year. The whole programme has allowed me to gain a better understanding of our health care system and where some of the challenges lie as well as teaching me to think in a more critical way in all aspects of my career. I have previously been someone who does not challenge and very much accepts systems and practice for how they are but this fellowship has succeeded in increasing my maturity of thinking as a general practitioner. Once it is complete, I hope to embark into new and previously unchartered roles that have emphasis on acute care.

**ED and CDU placements**

Unlike the previous cycles, this phase involved some of the fellows working at the University hospital in Birmingham. Being a tertiary centre with extremely well organised and well-staffed units, our roles within the departments were initially a little uncertain. However this gave us a blank canvas for us to demonstrate what we could do. Fortunately within a matter of a few shifts, I personally felt far more confident in seeing patients in this role, than I ever had as an SHO. As a qualified GP, my approach was completely different; it was no longer about turnover and satisfying seniors but more focused on assessing patients and their concerns efficiently as well as proactively advising and educating about the most suitable places for their concerns to be addressed. The majority of consultants were engaging and were impressed at our initiative and low admission rates; their feedback was positive.

We also had the opportunity to spend time with the older person liaison team which also helped us gain insight into community geriatrics, once again an area I had not had the privilege of experiencing. One of the highlights of my ED placement was a lovely thank you card with some chocolates left for me by a lady whom I had actually discharged. The reason she was so grateful was that I had assessed her symptoms and initiated a management plan in the same way that I would have done in a GP setting. This cemented the fact that one of fundamental skills that GPs should have in abundance - communication - can have an important impact in other medical settings.

I have only recently commenced my placement with West Midlands Ambulance service and already it has been invaluable. I genuinely had no idea about the complexities of the service and had not truly realised how the system was run and the pressures that they have to face on a daily basis. Effective health care provision today requires collaborative work between different arms of the health service rather than each system working in silos. During this placement there have been countless potential admissions that my colleagues and I have managed to avoid by being present with the paramedics and all parties have appreciated this outcome.

The urgent and acute care fellowship has challenged me ways that I could not have even anticipated, I am a better doctor and a better person having undertaken it and I recommend it wholeheartedly.
C. Example: Introductory Poster for GP Fellows in the ED:

Created by Dr Michael Clements - Urgent and Emergency Care Clinical Fellow.

“Introducing the GP Clinical Fellows in Alexandra Hospital ED”

Hello.

For 2 days a week a GP will be in the department, as part of a Clinical Fellowship in Urgent and Emergency Care.

The Fellowship is part of a wider drive to move urgent care from a hospital setting to the community.

As GPs we are used to seeing acutely unwell patients in surgery/at home/residential care facilities and community hospitals. Often these patients do not require review in an ED or admission and GPs are generally comfortable with managing these types of patient.

However, a degree of ‘up-skilling’ is desirable for those GPs who may wish to pursue this focussed area of primary (or pre-hospital, in this context) care.

The aims of having GPs in the department include: updating old skills, learning new skills and understanding the ED system in 2014, while also getting a feel for the types of cases in the department.

The rest of our week is spent in General Practice and at the University of Worcester, working towards a Postgraduate Certificate in Urgent and Emergency Primary Care (and not on the golf course, as some of my ED colleagues have suggested!).

Our role in the department is supernumerary, meaning that while we are on the rota, the department will be fully resourced without our presence. Of course, if the department is busy, we are happy to get ‘stuck in’ and see patients. As experienced GPs we are also happy to provide reviews of patients to Foundation doctors and offer our expertise where we can. We tend to be quite good with complex / frail / elderly / mental health and dermatology for instance.

Different GPs coming through the rotations will have different skills sets and you may find that some of us are actually quite experienced in an ED setting. Others may have backgrounds in surgery or anaesthetics. Some of us may have done something completely different before training in medicine. We will work within our competency and will probably be asking for advice as much as trainees.

As GPs we are a pretty approachable bunch so don’t hesitate to ask us anything clinical or otherwise. We are expert at drinking tea and exploring your ideas, concerns and expectations….
Chapter 3

Acute Medical Unit Phase
A. Overview: Acute Medical Unit (AMU) Phase

i) Introduction.

The GP Fellowship program is designed to enable colleagues trained in primary care to undertake training in acute medicine, gaining competencies and experience by working alongside colleagues in secondary care and the ambulance trust.

It is hoped that such training will enable successful candidates to support initiatives such as primary care diagnostic units, integrated acute medical units and hospital admission avoidance schemes.

ii) The Acute Medical Unit (AMU) Placement.

The AMU placement provides an opportunity for highly motivated candidates to gain experience in the short-term management of common conditions.

Patients are referred to the AMU from the emergency department and primary care. They are assessed, have investigations and, where appropriate, the initiation of treatment. Many are discharged following senior review. Others remain on the unit, undertaking senior review on a daily basis and are typically discharged in less than three days. Discharge is supported by access to clinics led by the AMU team.

During the AMU placement, the GP Fellows should become familiar with the diagnosis and treatment of common medical conditions. The placement provides an opportunity to consolidate diagnostic skills, the interpretation of investigations, standard treatment protocols and discharge planning.

iii) Related Attachments.

Aside from working alongside colleagues on the AMU, the GP Fellows should also be given the opportunity to undertake attachments with specialist nursing teams. These specialist teams provide further learning opportunities, concentrating on specific diseases, and also work closely with clinical teams in the community, supporting early discharge planning and insight into the management of chronic diseases.

In addition to experiencing these clinical skills, GP Fellows will have the opportunity to reflect upon the management of patients referred to an AMU and contrast the patient experience with patients seen and managed in the community whilst working in primary care.
iv) Summary.

The acute medical experience, combined with insight from primary care, provides candidates with a unique oversight of healthcare and the ability to reflect upon patient pathways and the configuration of services.

Upon completion of an attachment on AMU, the GP Fellow should be familiar with the diagnosis and management of common medical conditions and the management of chronic medical conditions that often result in hospital admission.

B. Example content of an appropriate GP Fellowship AMU Attachment:

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Placement Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous fluids</td>
<td>Intensive Care Outreach Team</td>
</tr>
<tr>
<td>Diabetes Care</td>
<td>Diabetes Specialist Nurses</td>
</tr>
<tr>
<td>Alcohol withdrawal and Health promotion</td>
<td>Alcohol Specialist Nurses</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Liaison Psychiatry Nurses</td>
</tr>
<tr>
<td>Heart Failure and Acute MI</td>
<td>Coronary Care Nurses</td>
</tr>
<tr>
<td>COPD and Asthma</td>
<td>Respiratory Nurses</td>
</tr>
<tr>
<td>End of Care</td>
<td>Palliative Care Nurses</td>
</tr>
<tr>
<td>Safe Discharge</td>
<td>Discharge Liaison Team</td>
</tr>
</tbody>
</table>

C. Fellows’ Reflection: Acute Medical Unit Rotation.

Dr Oluwatosin Oladini - Urgent and Emergency Care Clinical Fellow.

The posting started on February 10th 2014, at the Worcester Royal Hospital acute medical unit. The first day was an introduction to the triage nurses (from whom I ultimately learnt a range of pathways), followed by a walk through the AMU and introduction by James Young (mentor consultant and clinical supervisor) to the staff on the wards. The first day was spent with the triage nurses, familiarising myself with the referral pathways that exist. This including improving my knowledge of the community services available in Worcestershire. I had the opportunity to make copies of the referral pathways which would be useful in developing a simple referral pathway / smartphone app; an app that could be readily available to the urgent care fellows in their community work.

On February 11th, I undertook a visit to the Wardon Community Clinic, where I met with the community matrons, physiotherapists and occupational therapists. I was given the opportunity to carry out home visits with the lead nurse for the day.
I was able to more fully appreciate the work that the nurses undertake and how nursing and matron staff are so intricately intertwined in their job roles with physiotherapists and occupational therapists. I was also able to gain skills in assessing patients in their homes for their mobility and independence.

I spent the afternoon visiting the Malvern Community Hospital; a modern twenty-four bed unit which acts as both a step down and step up unit taking patients both from primary and secondary care.

Since then my two days a week have been spent on the AMU, conducting morning ward rounds with the consultant and joining the Ambulatory Emergency Clinic (AEC) in the afternoon. The AEC runs five days a week, with referrals from GPs being seen by the acute consultants and finalised on the same day. They are able to request and complete investigations in most cases on the same day, with results available for decision-making by the end of the day.

Examples of cases that commonly present to the AEC are:

- Pulmonary embolism
- Severe headaches
- Transient global amnesia (as uncommon as this diagnosis is, I have seen two cases so far in the AEC),
- Bronco pneumonia.

The time spent on the ward allowed me the opportunity to meet with other GPs, who were running a pilot of discharge facilitation. I also had the opportunity to meet with one of the community matrons, who was similarly tasked with the mission of facilitating early discharge of patients into the community. She had the experience of working in a multidisciplinary team in the community and was familiar with pathways for referrals. Working with her opened my eyes to a range of issues regarding discharge liaison and social work in the hospital, as well as roles and responsibilities in relation to discharge planning.

A visit to the Wyre Forest Admission Prevention team was also very useful as it enabled me to understand systems working in that area of Worcestershire. I was able to visit the Kidderminster community hospital / GP unit and meet with the team members. As previously mentioned, working on the AEC was my opportunity to pick up clinical skills in managing patients on an outpatient basis, evaluating the types of patient who are typically referred in by GPs and having access to diagnostics.
Chapter 4

Ambulance Service Phase
A. West Midlands Ambulance Service (WMAS) Phase: Structure

i) Introduction

“We are looking forward to developing this educational course further and have already received positive feedback from the attending fellows, who have each shown a great deal of passion for developing their knowledge of pre-hospital medicine.”

Richard Gough, Post Qualification Manager, WMAS.

To support ongoing plans to assist NHS A&E departments through winter pressures, the Department of Health have identified a need for long-term assistance.

The initial stages will focus on care for vulnerable older patients with complex health problems. The objective will be to reduce the need to convey patients repeatedly to A&E; releasing clinical staff and consequently improving diagnosis, treatment and discharge times when patients are required to attend hospital. The aim of the Fellowship programme will be to enable GPs to bridge the gap between primary and secondary care, enhancing their scope of community service.

ii) What can be expected?

When commencing the Fellowship Programme with West Midlands Ambulance Service, there will be set structured allocations during the planned four-month rotation, which will enable the GP to gather an in-depth view of how the Trust functions and operates on a day-to-day basis.

GP Fellows will also gain experience working on specialised vehicles with allocated crews, i.e. RRV, Mental Health Car, MERIT and HART; thus providing diversity of eventualities when “on the road.”

To gain the most from the placements, it would be beneficial for the GP Fellow to negotiate weekend work and liaise with the WMAS facilitator for Clinical Placements.

The WMAS facilitator will assess the GP Fellows placements on an individual basis and will be in contact with each of them from the early stages; taking into account preferred base, training venues and weekend allocations.

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6 For Acronym assistance, please see Appendix 2
### B. GP Fellowship: Sample West Midlands Ambulance Phase Timetable.\(^7\)

<table>
<thead>
<tr>
<th>Topic/Session</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td>Induction</td>
<td>Clinically and Educational Developments – NEOC</td>
<td>EOC</td>
<td>DCA</td>
<td>DCA</td>
<td>RRV</td>
</tr>
<tr>
<td><strong>PA’s</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic/Session</th>
<th>Week 7</th>
<th>Week 8</th>
<th>Week 9</th>
<th>Week 10</th>
<th>Week 11</th>
<th>Week 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td>RRV</td>
<td>RRV/Mental Health Car</td>
<td>Special Ops MERIT/MAA</td>
<td>Special Operations MAA – HART</td>
<td>Reflective discussions and Clinical Heads</td>
<td>Education Team</td>
</tr>
<tr>
<td><strong>PA’s</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic/Session</th>
<th>Week 13</th>
<th>Week 14</th>
<th>Week 15</th>
<th>Week 16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td>Education</td>
<td>Self-directed Placement</td>
<td>Self-directed Placement</td>
<td>Presentation, evaluation and feedback</td>
</tr>
<tr>
<td><strong>PA’s</strong></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

\(^7\) For Acronym assistance, please see Appendix 2
### C. Placement Contacts

<table>
<thead>
<tr>
<th>Name/Lead</th>
<th>Topic/Session</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julian Rhodes</td>
<td>FT Induction</td>
<td><a href="mailto:Julian.rhodes@wmas.nhs.uk">Julian.rhodes@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Matthew Ward</td>
<td></td>
<td><a href="mailto:Matthew.ward@wmas.nhs.uk">Matthew.ward@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Victoria Cooper</td>
<td></td>
<td><a href="mailto:victoria.cooper@wmas.nhs.uk">victoria.cooper@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>ETO (Education Training Officer)</td>
<td></td>
<td>As per personal programme</td>
</tr>
<tr>
<td>Sara Peck</td>
<td>PTS</td>
<td><a href="mailto:sara.peck@wmas.nhs.uk">sara.peck@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Liz Parker</td>
<td>EOC</td>
<td><a href="mailto:Liz.parker@wmas.nhs.uk">Liz.parker@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>As per personal programme</td>
<td>OPS Manager</td>
<td>As per personal programme</td>
</tr>
<tr>
<td>Ian Roberts</td>
<td>MAA/MERIT</td>
<td><a href="mailto:ian.roberts@midlandsairambulance.com">ian.roberts@midlandsairambulance.com</a></td>
</tr>
<tr>
<td>James Price</td>
<td>HART</td>
<td><a href="mailto:james.price@wmas.nhs.uk">james.price@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Aaron Martin</td>
<td>NEOC</td>
<td><a href="mailto:aaron.martin@wmas.nhs.uk">aaron.martin@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Aimee Trimbee</td>
<td>Education (development)</td>
<td><a href="mailto:aimee.trimbee@wmas.nhs.uk">aimee.trimbee@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>John Wright</td>
<td>Performance Cell</td>
<td><a href="mailto:John.wright@wmas.nhs.uk">John.wright@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Tracy Rayment-Bishop</td>
<td>Performance Cell</td>
<td><a href="mailto:tracy.rayment-bishop@wmas.nhs.uk">tracy.rayment-bishop@wmas.nhs.uk</a></td>
</tr>
<tr>
<td>Leanne Chapman</td>
<td>Mental Health</td>
<td>Via <a href="mailto:victoria.cooper@wmas.nhs.uk">victoria.cooper@wmas.nhs.uk</a></td>
</tr>
</tbody>
</table>

**Please note:** Fellows’ personalised programmes will detail specific locations and contacts for each week. The main point of contact will be Victoria Cooper – WMAS Facilitator for Clinical Placements.

During the early stages of the placements it will be crucial to highlight any concerns with the programme schedule, so that amendments can be made on an individual basis.

Individual programmes and supporting timetables will be provided prior to commencing the placement. This will detail specific dates and venues for each week of the programme.

**Due to topics/sessions covered in weeks 11 – 13, there may be occasions where these weeks can be interchanged. Fellows may discuss their requirements with the WMAS Facilitator for Clinical Placements.**
D. Fellows’ Reflection: West Midlands Ambulance Service Rotation.

Dr Alwin Mascarenhas - Urgent and Emergency Care Clinical Fellow.

My employment as Urgent Care Fellow (UCF) commenced from 3rd March 2014, with Rother House Medical Centre (RHMC) as the base surgery. I was given my WMAS induction on 17th March 2014 at the Baggaridge training centre by Julian Rhodes (Head of Training, WMAS) and Matthew Ward (Clinical Lead, WMAS). Both were enthusiastic about the project and the subsequent interactions that the project could develop between Paramedics and General Practitioners. We discussed the aims of the placement.

We discussed the mandatory training which WMAS staff must undertake and whether it was practical for the UCF to follow suit.

I was given a tour of the WMAS HQ at the Millennium point, Dudley. I was introduced by Matt and was very well received in all the departments. The department leads explained their roles and we discussed the time allocation for each of these departments over the four month phase. I was pleased to meet Paramedics with whom I had worked in my previous year of practice.

On subsequent days I started to work with the Clinical Support Desk (CSD), listening to and later making call backs to patients who were triaged as G4 priority calls. The computer system seemed too complex to learn within a short period of time. I also learnt about the Manchester Triage Tool and how the CSD use it to give advice. I sat in with the call handler and listened into incoming 999 calls. It was quite exhilarating to see how efficiently these calls were handled, especially the target to match the address within thirty seconds of answering the call. I gained experience in how the NHS pathways allocate priorities and send them to dispatch.

I also observed how the trauma desk, air ambulance, hospital desk are managed. It was interesting to see how the staff anticipate the resources needed and co-ordinate various personnel.

Following this, I started work on the Double Crew Ambulance (DCA). The Responsible Station Officer (RSO) kindly accommodated me on one of the DCAs for that day. The staff were welcoming and keen to have a GP with them. After a few sessions I started working on a Rapid Response Vehicle (RRV). I favoured the RRV experience to DCA as on a DCA more time is spent conveying patients to hospital and waiting for handover. DCA can be used to transport patients who do not need any assessment or intervention (Eg: GP referral to AMU, inter-hospital transfer for 24-week-pregnant lady with ante partum haemorrhage).

During the final two weeks of the phase, I was posted to the Mental Health Car (Street Triage), based at Oleaster Unit, Birmingham. This was a positive experience, which allowed me to work with three different professional bodies: Police, Paramedic and Community Psychiatric Nurse (CPN).

Through this experience I gained a better understanding of Section 136/135, Mental Health Act assessment, and treating patients with lack of capacity and the practical aspects of implementing them. The nature of the job means the patient contact can be varied from 2 to 10 patients per shift.
Chapter 5

The General Practice Phase
A. Overview: General Practice Placement.

Placement Aims:

To maintain primary care focus and skills.

To develop transferrable capabilities, informed by the other Phases of the Fellowship Programme.

Throughout the Fellowship, participating GP Fellows are based in a GP practice for two days (four sessions) per week, where they are mentored by a GP trainer.

The role of the trainer is to support and facilitate learning across the project, with regular informal reviews and a formal appraisal after six months and again at the end of the twelve month programme.

The host practices are chosen based on a profile and demographics appropriate to the project.

Examples from the pilot include involvement with:

- Step down care.
- Admission prevention projects.
- Community beds.

It is expected that the Fellows will be proactive in seeking out opportunities for innovation and practice development; this may include leading or supporting work on:

- Risk stratification relating to unplanned admissions,
- Reducing A+E attendances,
- Improving care in nursing homes,
- Reviews of out of hours contacts and reviews of acute access.

There should also be the opportunity to work with local Clinical Commissioning Groups (CCGs) on local projects and initiatives.

It is recommended that the four GP practice sessions each week should include at least one:

- Duty doctor session,
- Telephone triage,
- “Normal” surgery” and
- Patient visiting - see sample timetable.
B. Suggested Profile For Primary Care Phase of the GP Fellowship in Urgent and Acute Care.

i) Practice Requirements:

- Training practice with experienced Clinical / Educational Supervisor
- Full range of General Medical Services.
- Provision of acute care within hours
- Full range of emergency and diagnostic equipment – ECG, nebulisers, oximeters, spirometry.
- Participation in OOH and A&E unscheduled care management LES.
- Provision of ‘advanced access arrangements’ – extended hours, triage.
- Full range of chronic disease management clinics
- Enhanced primary care teams – including intermediate care, virtual ward, palliative care and GSF
- Access to specialist community nurse services – CCF; diabetes; respiratory;
- Provides unrestricted home visiting.
- Provides nursing home cover
- Good liaison with local secondary care services

ii) Employment Terms:

- Honorary contract
- 12 month contract
- Expectation of protected teaching time and mentoring
- Annual and Study leave pro-rata

Suggested Activities in Practice:

iii) Educational Activities:

- Professional development planning to identify learning needs and outcomes of attachment
- Portfolio of achievements and reflective practice
- Educational feedback from supervisor
- Support during the undertaking of a quality improvement project
- Attendance at Clinical Governance meetings
- Protected teaching time and mentoring opportunities.
- Membership of RCGP First5 peer group where appropriate
iv) Clinical and professional activities:

- Telephone and in-house triage
- Routine surgery
- Acute surgery appointments and in-hours on call emergency duty
- Acute home visits, including Nursing Home visits and anticipatory care, Experience working with PHCT:
- Supervised quality improvement project

Other projects that may be encompassed:

- Audit,
- Assessment and follow-up of OOH contacts and A&E attendances,
- Follow-up of acute mental health assessments,
- Work with mental health crisis team and alcohol services,
- Post-discharge assessments of patients admitted due to exacerbations of LTCs – eg. asthma, COPD, Diabetes, CCF

v) Exclusions

- QOF, LES, DES, or QP responsibility
- Routine administrative work eg. PMAs, insurance reports etc.
- Cover for regular clinical staff
- Fellows will not be expected to routinely supervise trainees, but may choose to be involved in teaching and supervision, by mutual agreement with their practice leads.

vi) Example Case Record Proforma:
C. GP Fellowship: General Practice Phase: Suggested Appraisal Format

Discussion topics and evidence:

i) Revalidation activities:

- Significant Events or Patient Safety issues
- Multi-source feedback
- Patient Satisfaction feedback
- Summary of educational activities

ii) Clinical Placement feedback:

- Looking at the guidelines for suggested clinical activities how has your clinical experience compared?
- What has gone well?
- What has not gone so well?
- Suggestions for improvement.

iii) GP Placement feedback:

- Looking at the guidelines for suggested practice activities how has your practice experience compared?
- What has gone well?
- What has not gone so well?
- Suggestions for improvement.

iv) University and Academic activities:

- Looking at the suggested curriculum areas, how far has your teaching and academic work provided you with the opportunity to explore these?
- What has gone well?
- What has not gone so well?
- Suggestions for improvement.

v) Personal Professional Development:

- Looking at the suggested curriculum areas and person specification, how far has your experience given you the opportunity to develop personally?
- What specific competencies / capabilities have you developed through this post?
- What is your PDP for the next 4/12?
- Give any examples of innovation or sharing of best practice that you have been involved in through this project.
D. Example Timetable for the GP Practice Phase: Dr Alwin Mascarenhas.

i) Wednesdays:

8.30 – 11.30: Triage / Acute surgery; duties to include:

- Handling phone calls from patients
- Self-booked appointments
- Triaging and booking HVs
- Liaison with community nurses
- Liaison with partners

11.30 – 13.00: Acute HVs OR Risk management visits:

- Long term conditions
- Risk stratified patients
- End of life care
- Community nurse referrals
- Acute follow ups
- Nursing home care

13.00 – 14.00: Referrals meeting.
14.30 – 15.00: Liaison with supervisor.

15.00 – 17.30: Surgery:
- Triaged
- Self-booked
- Long-term condition reviews

ii) Fridays:

08.30 – 11.30: Triage / Acute Surgery (as above)
11.30 – 13.00: Acute HVs as above OR Risk Management Visits.
14.30 – 16.00: Acute access review of:
- OOH contacts
- A&E attendances
- Hospital discharges
- Nursing home visits
- Stratified risk data

16.30 – 18.00: Surgery (as above)

SEE ALSO APPENDIX 3 – Timetable is based on 4 sessions per week, throughout the 12 month Fellowship Period.
Chapter 6

Fellowship Evidence Base:

2014-15 Pilot Evaluation
Fellowship Evidence Base: Evaluation of the West Midlands Pilot of GP Fellowship in Urgent and Acute Care

A. Evaluation Methodology

The evaluation of the 2014-15 pilot commenced in September 2014, with the Phase 1 pilot report released in March 2015. The final report to cover the full pilot study – Phase’ 1 and 2 – was released in January 2016. The evaluation was led by Prof Jeremy Dale, Professor of Primary Care at Warwick Medical School.

In view of the relatively small numbers of key stakeholders, a qualitative interview design was proposed, as self-completed questionnaires were considered unlikely to produce data of sufficient depth.

B. Key Questions:

- To what extent is the scheme addressing the aims, expectations and aspirations of its key stakeholders (the trainee fellows, the clinical supervisors, staff within the settings in which they work, HEE, Worcester University, AHSN etc)
- How is the scheme enhancing the function of the GP within the ED, AMU and Ambulance Service teams?
- How is the scheme supporting GPs to develop ways in which enhanced urgent and acute skills can be applied to support the identification, introduction and maintenance of community-based alternative care pathways?
- In what ways is the scheme improving “joined up care, spanning GPs, social care, and A&E departments”?
- How can the scheme be improved?
- What are the key lessons for national strategy and policy?

C. Pilot Project Evaluation

This section summarises the interim evaluation covering the two phase 2014-15 pilot

Overall, the evaluation demonstrated that the fellowship was enthusiastically received by those involved in its delivery and successfully addressed the aims and aspirations of key stakeholders.

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9 The reader should consult the January 2016 evaluation report for full detail.
D. Evaluation Design

The Fellowship aims:

- To enhance the function of the GP within the ED, AMU and Ambulance Service teams.
- To develop ways in which the GP can apply enhanced urgent and acute skills to support the identification, introduction and maintenance of community-based alternative care pathways.
- To raise GP interest in emergency medicine and urgent care career paths.
- To support the national policy drive for improving "joined-up care, spanning GPs, social care, and EDs - overseen by a named GP."

From July 2014, Warwick Medical School was commissioned to undertake an evaluation of the pilot. Data was collected from telephone and face to face stakeholder interviews supplemented by direct observation of each fellow's work. The fellows, clinical placement supervisors and the project advisors were interviewed at various time-points, with views sought on how the programme was meeting its aims and any difficulties encountered. Colleagues with whom the fellows worked (paramedics, staff nurse, junior doctors etc.) were also interviewed opportunistically for their perceptions about the fellowship. In total, 156 interviews were undertaken with 125 individuals; each was recorded, transcribed verbatim and analysed using a framework approach.

In addition, the fellows from the first cohort were re-interviewed eight months after completing the fellowship to explore their reflections on the scheme and its impact on their career intentions. Observations were undertaken of the fellows in the host GP practices and their placements in ED, AMU and WMAS, and at the academic day at Worcester University.

A researcher discreetly observed the fellows using an observation checklist to record activity and interactions. Workload data was gathered via an activity planner. The aim was to capture evidence of workload and how the fellows applied their skills and knowledge in the various settings.

E. Key Findings

The overall view that emerged was that the fellowship is successfully meeting its aims. Key outcomes that were achieved included developing early career doctors with the skills and knowledge relevant to integrated care, admission avoidance, ambulatory care and supporting patients to access alternative community-based pathways; disseminating such skills and knowledge to colleagues with whom the fellows interacted with in each clinical placement; evidence of sustained learning, retention and capacity building in practice. The fellows’ primary care experience and ability to manage risk was viewed as being particularly relevant within the emergency department and ambulance settings. It was felt that the fellowship was contributing towards making general practice a more exciting and attractive career choice for newly trained doctors.

In terms of the process of implementing the scheme, most potential barriers had been addressed through careful planning and efforts to ensure that all those involved in delivering the scheme had a shared understanding of its objectives and processes.
F. Relevance to Regional and National Policy

The pilot has demonstrated the feasibility and potential impact of the fellowship scheme. It offers a model of advanced training to prepare doctors for an enhanced role that spans primary care and secondary settings, supporting admission avoidance through relationships with other services and greater use of community-based alternative care pathways. It provides an entry point for an emerging aspect of general practice that requires GPs who have the leadership, clinical and academic skills to drive forward implementation of more integrated services across the NHS. It is also relevant to the current need to attract medical students and newly qualified doctors to a career in primary care. A clinical career in a sub-specialty that spans primary, urgent, and emergency care provides a portfolio opportunity that could attract individuals who might otherwise not be retained in either general practice or emergency care.

G. Discussion

It was evident that some challenges remained in relation to maintaining a clear sense of shared purpose across the organisational boundaries and varied teams with whom the fellows worked. For example, staff within some of the placements appeared unclear about how the placements were intended to differ from ST1 and ST2 training that they were familiar with, and the specific training, professional development and service requirements that the fellowship was intended to meet. There were some organisational issues, such as lack of agreement about the extent to which fellows were intended to be supernumerary, and the extent to which time should be ring-fenced for their training. Some fellows felt they would benefit from more structured and timetabled clinical supervision, suggesting a need for clarity over training expectations. The fellows appeared to be better integrated within the AMU and ED placements towards the end of each year, than during the early placements, suggesting that it took some time for these departments to understand and accommodate the fellows. During Phase 2 pilot, there seemed to be more noticeable problems in team communication on placements; the fellows not being on shift enough for integration to happen or being placed on sub-rotations that prevented integration. Sometimes, this led to a lack of awareness that a fellow was present in the department, with fellows being mistaken for GP trainees and confusion around the purpose of their presence. Factors that may have contributed to this were the different attributes of the fellows across the two years, with some displaying more self-confidence than others. A contributing factor could also have been the ED in Phase 2 being a larger and busier department.

The fellows’ employment contracts being held with a hospital trust (Phase 2) was viewed more favourably than when they were held by GP practices (Phase 1), in terms of addressing HR requirements. However, the fellows felt that this ran the risk that the hospital’s service requirements might supersede fellowship training requirements, particularly in placements such as ED where the workload is significant.

The three fellows who completed the Phase 1 pilot, when interviewed eight months later, were all employed for at least part of the week in roles requiring urgent care skills; two of the three continue to work concurrently in general practice with the third intending to return in some capacity.
This confirms the scheme’s potential to support retention and capacity building in urgent/emergency care, as well as general practice. The fellows all felt that the fellowship had prepared them successfully to apply their skills and work across care sectors, so maximising the benefit to patients and the NHS.

**H. Enhancing the Function of the GP**

- The ED, AMU, WMAS and GP clinical placements have enabled the fellows to develop a broad range of knowledge and skills related to urgent care.
- The scheme not only improved knowledge, skills and confidence in urgent primary care, but enabled those taking part to improve joined-up management of care, between secondary and primary care.
- GP supervisors noted that the fellowship allowed for additional skills training opportunities in community-based patient management; significantly more than for GPs who were not involved in the scheme.

**I. Promoting Community Based Pathways**

The fellows were able to share knowledge of community-based patient management with GP host practices and ED-based colleagues.

Fellows also assisted paramedics in making clinical decisions to support patient referral to community services, as an alternative to ED admission.

**J. Improving Joined-Up Care**

- Fellows were able to discuss with staff, which patients could be managed most effectively in primary care; also, how to develop an understanding of each sector’s priorities and methods.
- Fellows were ideally placed to cascade this knowledge across the General Practice and secondary care placements.

**Note:** Care should be taken to ensure that clear objectives are set and communicated prior to the secondary placements, with respect to the role and function of the fellows.

**K. ED / Admission avoidance**

The pilot cohort was too small to enable any quantitative evaluation on admission avoidance, although the full report cites qualitative evidence to support a positive impact.
L. Conclusion

The complex challenges facing the NHS of an ageing population, presenting with multiple co-morbidities, requires a “cross fertilisation” of knowledge, practice and ideas. The Fellowship scheme is well-placed to catalyse this at local level.

The success of the pilot (to date) provides evidence that can inform future NHS strategy and policy. The Fellowship has proven feasibility and provides a model for up-skilling GPs to work in an enhanced way across primary care, urgent care and emergency care settings. GP Fellows can and will support admission avoidance and make greater use of community-based alternative care pathways.

The programme has successfully challenged traditional barriers, which may result in patients receiving fragmented, inappropriate and costly care.

M. Suggested measures to improve future programme delivery

- Use simple measures to raise awareness of this new scheme e.g. by a picture and role description in staff areas.

- Project leads should engage stakeholders to generate robust marketing strategies, to aid the recruitment of candidates. A single point of contact, locally, should be identified – a “comms hub” – to maintain internal and external communication channels between stakeholders and user groups.

- Identify the host GP practice and clarify requirements, work patterns and role description of fellows, prior to commencement.

- Expectation with service improvement projects need to be negotiated with the host practice prior to commencement.

- Important to align academic training to fit with clinical placements e.g. Pre Hospital Emergency Medicine Course

- Any ALS skills training should be undertaken prior to commencement of clinical phases.

- Where possible, ensure that the community and secondary care placements fall within the same geographic area, to enhance integration and knowledge sharing locally.
### N. Summary Checklist: Requirements for a Successful Fellowship (suggested)

#### The Fellow:

| Clinical Experience: General Practice with previous emergency care experience |
| Academic Ability: |
|   | Strong academic record |
|   | Ability to manage academic work alongside daily placements |

| Personal Qualities: |
|   | Emotionally intelligent |
|   | Team player |
|   | Confident and self-directed |
|   | Supportive of peers |
|   | Flexible and able to manage multiple work placements and responsibilities |
|   | Personal resources to manage mental and physical requirement of fellowship |
|   | High professional standards (e.g. mindful of colleagues’ needs, reliable, communicates and integrates with team) |
|   | Commitment to living in the locality of Trust and GP host (desirable) |

#### Clinical Placement Settings:

| Clear statement about how the clinical attachment fits with the overall objectives of the fellowships, as well as the expectations on the clinical teams and the fellow |
| Clearly defined scope of practice for the fellow |
| Clear training objectives, with the placement designed to address them |
| Profile-raising strategy (e.g. introductory event; fellowship poster / newsletter explaining the aims of the scheme and introducing the fellow to staff; introductory staff email whenever new fellow commences a placement, with regular emails reminding staff to make use of their fellowship resource) |
| Educational sessions for fellows to share fellowship knowledge and skills with colleagues |

Fellowship champion at each setting to enthusiastically drive fellowship and provide assurance that clinical teams understand:

| Fellowship aims, role, expectations of setting |
| Training requirements of fellow |
| Placement requirements of fellow |
**Host GP practice:**

Should be situated in the same locality as NHS Trust, with a designated practice fellowship champion identified.

**The GP supervisor should:**

- be aware of the training and education that the fellow is receiving throughout the fellowship
- ensure that the GP placement is designed to enhance learning, to meet the fellowship aims
- ensure that all staff are aware of supernumerary nature of GP fellowship
- support service improvement projects that the fellow will undertake

**Formalise:**

- Service development project, with presentation to the practice leads at fixed points
- Liaison with secondary care placements and academic setting to agree timetable for the entire fellowship: GP sessions, administration time, secondary placements, training days, academic days, GP supervision times.

**Academic Setting:**

The current academic programme, including the accredited learning, worked very well and should inform learning and development of future cohorts.

Learning objectives and training timetable should be formalised and disseminated to each setting in order that clinical experience, training needs and learning within placements are as closely matched as possible

The sequence of workshops / taught modules to be appropriately timetabled, to benefit clinical learning eg; pre hospital emergency medicine training undertaken early in the fellowship

Match the academic learning to fellow's competencies and needs

Pre-programme academic skills training, to strengthen essay writing, literature searching and other skills necessary to complete the academic element of the programme.

Frequent discussion sessions between fellows and academic supervisors to air any challenges at an early stage; to ensure that learning needs and objectives are being met.
O. Data Collection Instruments: Interview And Observation Schedules

i) Interview schedule for stakeholders

- To what extent has the scheme addressed the aims, expectations and aspirations of its key stakeholders such as clinical supervisors and the GP fellows?
- How has the scheme supported GPs to develop ways in which enhanced urgent and acute skills can be applied to support the identification, introduction and maintenance of community-based alternative care pathways?
- How has the scheme enhanced the function of the GP within the EM, AMU and Ambulance Service teams?
- In what ways has the scheme improved “joined up care, spanning GPs, social care, and A&E departments”?
- From the pilot scheme, what are the key improvements that you think should be made, to improve delivery of the programme?
- How do you see the Fellows being deployed post-Fellowship?

ii) Interview schedule for observation day

- What has been / is your professional relationship to the fellow?
- Has it been useful having a GP fellow on placement with you? If so, why?
- Has hosting the GP fellow caused you any difficulties? If yes, please elaborate.
- Were you briefed about the programme before the fellow arrived? To what extent? Was communication sufficient to fully inform you about the role of the fellow?
- Do you think that a GP fellow being present encourages better communication and understanding between primary and secondary care?
- Would you encourage more GPs to undertake this fellowship?
- What do you think is the most important thing that you / your team have learnt from having a GP fellow present?

iii) Generic placement observation criteria

- **Space analysis**: Where is the fellow physically located in relation to others? Does the fellow have an allocated desk or area?
- **Integration**: How is the fellow introduced to patients? What are the attitudes of staff toward the fellow? Is the fellow included in general discussion?
- **Knowledge transfer**: Is the fellow asked for a primary care perspective on particular cases? Does the fellow ever volunteer a primary care based view on a situation? Are there ever phone calls between primary care and the secondary setting?
- **Skills**: Are the fellows confident dealing with patients outside of general practice? Do they use the skills learnt on their academic days in the setting?
- **Issues**: Are there any practical issues that arise because of the fellows’ GP status?
iv) **Key considerations:**

- Examples of when a primary care contribution is offered.
- Examples of when a primary care contribution is sought.
- Communication between staff members and the fellow.
- Any example of primary and secondary care integration.

v) **Specific service setting-related observation criteria**

**WMAS:**
- When the fellow is called out to see a patient with a paramedic, does the fellow have active involvement in the encounter? (e.g., consultation, physical observation).
- Do the paramedics and the fellow discuss the case and is there a primary care perspective offered?
- Does the fellow prescribe medication?
- Is the presence of the GP fellow a help or hindrance?

**ED / AMU:**
- Is the fellow allocated patients, or are they just called to assist other doctors when primary care issues arise?
- Is the fellow involved in case discussions?

**General Practice:**
- Does the fellow use their secondary care experience in the primary care environment?
- Does the fellow consider referrals to secondary care from a different perspective?
- How do other members of the primary care team respond to the fellow? Is there any acknowledgement of an enhanced role?

**Academic Training Day:**
- Are the fellows actively engaged in teaching?
- Is the teaching from a primary or secondary care perspective?
- What are the aims of the academic course?
Chapter 7

Fellowship Academic Programme:

Postgraduate Certificate In Urgent and Acute Care
A. Fellowship Academic Phase: Course Structure and Content.

One day per week (Thursday) of the Fellowship will be spent at The University of Worcester, with the following objectives:

i) The Completion of a Post-Graduate Certificate in Urgent and Acute Clinical Care

The Post Graduate Certificate in Urgent and Acute Clinical Care aims to develop the skills and confidence of the UGFs in their ability to assess and treat urgent cases in primary care. The course will increase their understanding of the pathophysiological changes that underpin presentations of urgent and acute illness and develop their knowledge and confidence in assessing and managing this.

Urgent care is changing and the National Health Service is having to adapt, to take in to account increasing demand and the increasing complexity of the care required by its population.

Traditional urgent care by accident and emergency departments and General Practitioners is making way for a plurality of urgent care providers and settings, caring for an increasingly frail and older population.

Completion of the Post Graduate Certificate will significantly increase the Fellows’ understanding of the pathophysiological changes that lead to the symptoms in urgent and acute presentations. This will ensure that the investigations and treatments used are understood and managed appropriately.

The Post Graduate Certificate involves the attendance at, and completion of, the taught days and the summative assessment requirements for all three modules.

All prospective students on the Post Graduate Certificate in Urgent and Acute Care will apply for this according to the Universities’ application process. As part of this process, they will need to ensure that they meet the admission criteria for postgraduate study.
The course consists of three modules:

1. **Urgent care for adults with long term conditions**
2. **Urgent care and the frail elderly**
3. **Acute and life threatening care**

**Sample content:** each module includes (but is not necessarily limited to):

<table>
<thead>
<tr>
<th>MODULE TITLE</th>
<th>MODULE CODE</th>
<th>SAMPLE CONTENT</th>
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</thead>
<tbody>
<tr>
<td>Urgent care for adults with long term conditions</td>
<td>UACC4001</td>
<td>Urgent care and:</td>
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<td>- Cardiology</td>
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<td>- Health psychology</td>
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<td>- Acute mental health</td>
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<td>- Diabetes and endocrinology</td>
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<td>- Neurology</td>
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<td>- Musculoskeletal</td>
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<td></td>
<td></td>
<td>- Sepsis and antibiotic stewardship</td>
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<tr>
<td>Urgent Care and the Frail Elderly</td>
<td>UACC4002</td>
<td>Urgent care and:</td>
</tr>
<tr>
<td></td>
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<td>- Risk stratification</td>
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<td>- Commissioning for urgent care</td>
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<td>- Stroke</td>
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<td></td>
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<td>- Falls and the frail elderly</td>
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<td></td>
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<td>- Complex multi-morbidity and pharmacotherapy</td>
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<td></td>
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<td>- Palliative care</td>
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<td></td>
<td></td>
<td>- Managing acute care in dementia</td>
</tr>
<tr>
<td>Acute and Life Threatening Care</td>
<td>UACC4003</td>
<td>Life threatening care and:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Advanced assessment in adults and children</td>
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<tr>
<td></td>
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<td>- Assessment and initial management of severe trauma</td>
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</tbody>
</table>
ii) Participation in an Action Learning Set.

The main objectives of the Action Learning Set are:

- To support the learning in urgent care settings and general practice
- To develop skills in leadership and service improvement methodology
- To develop skills in education, lectures, small group facilitation
- To increase skills in Evidence Based Practice
- To develop skills in presenting material either through lectures or written documentations
- To support the learning in urgent care settings and general practice.

When the taught sessions are not running, there is a weekly meeting which is run as an action learning set. This involves case-based discussions based on clinical and management and leadership scenarios.

The UGF’s will consider the learning and preparation that may be needed before the next action learning set. This might include preparation of teaching slides, preparation of material for small group facilitation, or identification and critical appraisal of clinical and management evidence. Examples could include an executive summary for the project, or a paper for submission to BMJ careers.

Where other external urgent care experience is required, this will be undertaken following negotiation in the time set aside for the academic day. Such experience has previously included:

- Attendance for a day at Ophthalmology A&E,
- A day with the palliative care team,
- A day spent learning about joint injections.
- Attendances at winter pressures planning, or other related organisational meetings are also included, with the expectation that learning will be fed back to and shared with the Fellowship group.

iii) To Develop Skills in Leadership and Service Improvement Methodology.

The Fellow should expect that their personal leadership skills will be extensively tested within the Fellowship programme.

Leadership skills learning is based around discussion and enabling the UGFs to address their own leadership and management problems, with time allotted to experience-based reflection around the organisations they are working within. The leadership competences are taken from the Leadership Framework and the Medical leadership Competency Framework.

Opportunities to consider and reflect on management experiences (eg. relating to winter pressures, tri-service experience days, or commissioning) are actively encouraged.

At present, there is no portfolio required, but this is anticipated to be a future Fellowship development.
iv) To Undertake Quality Improvement Projects (QIP).

Each of the fellows is expected to work on a Quality Improvement Project. Ideally one project will be undertaken within primary and another within one of the urgent care placements.

As part of the fellowship, each fellow is enrolled on the BMJ Quality Improvement Program (http://qir.bmj.com/). This learning resource supports clinicians through a step-by-step process on a designated project, which in turn is supported by evidence and learning materials.

The QIP requires and implants within Fellows the ability to:

- Work within a team,
- Carry out effective baseline research as well as surveys
- Demonstrate awareness of the importance of understanding the Process Flow before designing the intervention.

The projects are discussed within the Action Learning Set part of the Academic days.

The primary care projects can be undertaken as individuals or GP practice teams, while the secondary care projects will be undertaken by one or more fellow as they rotate through a particular placement.

Once completed the QIP should result in a published paper as part of the electronic journal BMJ Quality Reports.

v) To Develop Skills In Education, Lectures and Small Group Facilitation.

UGFs are supported in developing their skills as educators.

All GP Fellows will be made Associate Lecturers at the University of Worcester during their fellowship year.

Urgent Care fellows will be given the opportunity to facilitate small group learning and lecture to audiences including:

- GP Vocational Training Schemes (VTS)
- Non-medical prescribing courses,
- Advanced nursing students,
- Paramedic students
- Physicians Associates.

They are supported in the development of presentation and small group skills and will gain experience in planning, preparing and observing lectures, as well as chairing conference workshops, educational events, or facilitating small group sessions - including, for example, minor illness courses - as well as presentations in the workplace.
vi) To Increase Skills in Evidence-Based Practice.

Formal teaching and learning in evidence-based practice is undertaken; both of the more traditional evidence-based medicine, as well as considering how the principles can be used in service improvement and management and leadership literature.

The teaching is based on Evidence-Based Practice or Urgent Care, with each teaching session being planned and practiced in the group. Fellows will have the opportunity to observe their colleagues as they deliver each teaching role.

Skills are demonstrated through the written assessment in the certificate and the teaching observation.

The current cohort have developed the curriculum and content of the Certificate in Urgent Primary care based on a portfolio review of the first 2 months of learning in all settings. The 2014-15 cohort will develop a web-based portfolio, to reflect experiential learning for the whole Fellowship year.

Time is also spent in practical learning sessions, covering topics such as report and academic drafting and preparing urgent care documents for publication.

vii) To Develop Skills In Presenting Material; Through Lectures & Written Documentation.

We anticipate that the UGFs will be pioneers in their careers and are very likely to become involved in service delivery management and leadership.

The Action Learning set will assist the Fellows in developing their skills in written documentation and presentation of ideas; working in a team and as a group; and understanding when a leader needs to follow.

Fellows are actively encouraged to involve themselves in commissioning projects in the community and to share their individual learning with their colleagues.

viii) To complete the required Pre-Hospital Emergency Medicine training.

Module 3 of the Post-Graduate Certificate in Urgent and Acute Care will be complimented by elements of the Pre-Hospital Emergency Medicine (PHEM) course offered by the West Midlands Ambulance Service (WMAS).

To maximise the Fellows’ preparedness for the Fellowship programme, this training will be offered prior to commencement of the “live” phases, at the outset of the programme.

For reference, the WMAS “PHEM” Course Structure and example timetable are described at (B).
B. PHEM Course Content:

**Theme 1: Working in Emergency Medical Systems:**

1.3.2 - Compare the differences in training of pre-hospital healthcare personnel.

1.4.1 - Describe the process of ambulance service emergency:
   - a) Call handling
   - b) Call prioritisation
   - c) Dispatch
   - d) Resource activation
   - e) Resource management

1.6.1 - Differentiate lawful consent to treatment between adults and children.

1.6.2 - Differentiate lawful refusal of treatment between adults and children.

1.6.3 - Explain the legal basis for the emergency treatment of the incapacitated patient.

1.6.4 - Describe the emergency provisions in legislation for:
   - a) Protecting and safeguarding patients with mental illness
   - b) Protecting and safeguarding children
   - c) Protecting and safeguarding vulnerable adults

1.6.5 - Describe the emergency provisions in legislation for:
   - a) Emergency driving procedure
   - b) Helicopter emergency medical services
   - c) Air ambulance services

1.6.6 - Cite examples where confidentiality may lawfully be breached in pre-hospital emergency medical practice.

1.6.7 - Describe the legal requirements related to deaths outside of hospital.

1.7.2 - Compare the incident command structures of:
   - a) Medical services
   - b) Ambulance services
   - c) Police services
   - d) Fire services
   - e) Rescue services
**Theme 2: Providing Pre-Hospital Emergency Medical Care:**

2.1.1 - Describe how interpretation of an incident scene may influence a patient assessment.

2.5.8 - Describe the immediate pre-hospital management of the following:

   a) Injuries to the head.
   b) Injuries to the face.
   c) Injuries to the neck.
   d) Injuries to the thorax.
   e) Injuries to the abdomen.
   f) Injuries to the spine.

2.6.8 - Describe the management of the difficult airway in the pre-hospital environment.

2.9.10 - Recognise signs of physical abuse suggestive of non-accidental injury.

**Theme 3: Using Pre-Hospital Equipment:**

3.4.1 - Describe the operation of common pre-hospital:
   a) Communications equipment
   b) Audio-visual recording equipment
   c) Incident management equipment
   d) Navigation equipment
   e) Information management equipment

3.5.1 - Describe the principles of good pre-hospital medicines management.

3.5.3 - Categorise medicines used in Pre-hospital Emergency Medicine.

3.5.6 - List medical gases in common pre-hospital use.

3.5.7 - Describe the dangers of medical gases used in pre-hospital care and the precautions that ensure safety during administration.

3.5.10 - Demonstrate preparation of medicines for parenteral use.

3.5.11 - Demonstrate safe and effective administration of medicines by all routes.

3.5.12 - Demonstrate compliance with legislation related to Controlled Drugs.

**Theme 5: Supporting Safe Patient Transfer:**

5.3.2 - Describe the principles determining destination hospital selection.
C. Example PHEM Course Timetable:

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-Sep-13</td>
<td>Course Introduction, Objectives &amp; Ambulance Service Overview (1.3.2)</td>
</tr>
<tr>
<td>24-Sep-13</td>
<td>Incident Command Structure (Guest Speaker) (1.7.2)</td>
</tr>
<tr>
<td>17-Oct-13</td>
<td>Scene Assessment and Triage (2.1.1)</td>
</tr>
<tr>
<td>18-Oct-13</td>
<td>West Midlands Trauma Network Overview</td>
</tr>
<tr>
<td>25-Nov-13</td>
<td>Recognition of Life Extinct (AACE &amp; Trust Policy)</td>
</tr>
</tbody>
</table>

**P.H.E.M. Induction Week 1**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>0800-0815</td>
<td>Law and ambulance staff (including duty of care)</td>
</tr>
<tr>
<td>0815-0900</td>
<td>Consent (including incapacitated pts) (1.6.1 - 1.6.3)</td>
</tr>
<tr>
<td>0900-1000</td>
<td>Incident Command Structure (Guest Speaker) (1.7.2)</td>
</tr>
<tr>
<td>1000-1015</td>
<td>Scene Assessment and Triage (2.1.1)</td>
</tr>
<tr>
<td>1015-1100</td>
<td>WMAS Trauma Pack</td>
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<tr>
<td>1100-1200</td>
<td>WMAS Trauma Pack</td>
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<td>1200-1230</td>
<td>WMAS Trauma Pack</td>
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<td>1230-1330</td>
<td>WMAS Trauma Pack</td>
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<td>1330-1415</td>
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<tr>
<td>1545-1600</td>
<td>WMAS Trauma Pack</td>
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**Break**

**Lunch**

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<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>23-Sep-13</td>
<td>Incident Command Structure (Guest Speaker) (1.7.2)</td>
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**Recognition of Life Extinct**

<table>
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<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800-0815</td>
<td>The Difficult Airway (2.6.8)</td>
</tr>
<tr>
<td>0815-0900</td>
<td>Spinal Trauma (2.5.8)</td>
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<tr>
<td>0900-1000</td>
<td>Thoracic Trauma (2.5.8)</td>
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<tr>
<td>1000-1015</td>
<td>Abdo. Trauma (2.5.8)</td>
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<tr>
<td>1015-1100</td>
<td>Pelvic Trauma (2.5.8)</td>
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<tr>
<td>1100-1200</td>
<td>Limb Trauma (2.5.8)</td>
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**Safeguarding**

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<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>0800-0815</td>
<td>Safeguarding (Legal issues, NHS and Trust procedures) (1.6.4)</td>
</tr>
<tr>
<td>0815-0900</td>
<td>Safeguarding (Abuse - Types, signs &amp; symptoms) (2.9.10)</td>
</tr>
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</table>

**Reflection on the day / questions / clarifications / signing of paperwork**

**Scene Assessment and Triage**
Chapter 8

Fellowship Role Description

&

Competency Framework
**Role Description:** GP Fellow in Urgent and Acute Care.

**Primary Employer:** A West Midlands Acute Trust; either:

University Hospitals of North Midlands NHS Trust

**Or:**

South Warwickshire NHS Foundation Trust

Additionally, the post holder will hold honorary contracts with:

1) A nominated GP Practice (local to the employing Trust).

2) West Midlands Ambulance Service.

**Responsible / Accountable to:**

1) Medical Director, employing Trust.

2) Line Manager, GP practice (local to the employing Trust).

3) Medical Director, West Midlands Ambulance Service.

**Remuneration:** £75,249 pa

**Duration:** Full-Time, 12 month post (fixed term contract).

*(Please note: This post will require a commitment to out-of-hours working; remuneration reflects this requirement)*

**Commencement Date:** January 2017
A. The GP Fellowship.

Health Education England - West Midlands are pleased to announce the January 2017 launch of the first cohort of their GP Fellowship in Urgent and Acute Care. Recruitment to the posts will allow GPs to develop a special interest in Urgent and Acute care.

During the 12 month Fellowship program, the GP Fellow will spend time on Emergency Medicine and Acute Medicine units, to gain experience in the providing of care for step-down patients in the community. There will also be time spent training within their nominated GP Practice and with the West Midlands Ambulance Service, as well as other training including ALS and First Person on Scene (FPOS) training. Key features of the curriculum include: Paediatrics, care of acutely ill patients, frail and elderly care and end-of-life care.  

B. Fellowship Aims.

- To enhance the function of the GP within the EM, AMU and Ambulance Service teams.
- To develop ways in which the GP can apply enhanced urgent and acute skills to support the identification, introduction and maintenance of community-based alternative care pathways.
- To raise GP interest in Emergency Medicine career paths.
- To support and follow the Hunt recommendations for improving “joined up care, spanning GPs, social care, and A&E departments - overseen by a named GP.”

C. Learning Outcomes.

- To better understand the needs of patients, why they are attending A&E and how the GPs role could be adapted to improve A&E avoidance.
- To develop innovative ideas / share best practice of meeting the EM agenda in Primary care.

Learning outcomes will be developed between the GP, their GP mentor and Trust clinical supervisor, consistent with the operational requirements of their host and RCGP Curriculum guidelines.  

- Care of acutely ill people.
- Care of older adults.
- Care of children and young people.
- Care of people with Mental Health problems.
- Cardiovascular health.
- End of life care.
- Healthy People: Promoting health and preventing disease.

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10 See Page 60 – “Core Competencies”
11 See Page 60 – “Core Competencies”
In addition to their personal learning and development, fellowship trainees will be expected to:

- Work with their host Practice and Health Education England - West Midlands to encourage other areas (regionally and nationally) to commission the Fellowship.
- Develop their enhanced service locally, following the Fellowship.
- Develop ways in which a GP may respond to Emergency and Acute presentations.
- Establish a working relationship with the ‘Virtual Ward’ model and explore models of care that offer viable alternatives to A&E admission.
- During practice attachments, offer direct contact by A&E staff. When patients of the host practice present at A&E with ambulatory or long-term care conditions, they will provide an assessment and management advice.
- Learn / enhance practical skills and interventions including: chest drains, reducing dislocations, suturing, cannulation and ultrasound use, as well as advanced life support courses and acute illness management in resuscitation.

D. Duration.

The 12 month fellowship will be divided into three, four-month periods. Each period will include a weekly commitment of:

- 4 Programme Activities [PAs] per week within their GP mentor’s practice. During this phase, the GP Fellow will work with their mentor to develop ways of transferring skills, experience and innovative working gained during each of their Fellowship phases, with the aim of demonstrating a commitment to joined-up primary, community and secondary care working.

- 2 PAs study time, where the Fellow will be expected to complete the Worcester University Postgraduate Certificate in Urgent and Acute Care (see below).

- 4 PAs Trust commitment, to include:
  - 1st phase: Spent within the Emergency Department of their nominated Trust.
  - 2nd phase: Experiencing acute medicine, within the Acute Medical Unit of their nominated Trust.
  - Final phase: Spent within the West Midlands Ambulance Service in a variety of strategic and operational placements.\(^{12}\)

The week is apportioned in this manner to encourage the Fellow to develop cross-practice thinking and innovative strategic planning and operational processes - capable of bridging the gap between primary and secondary care.

\(^{12}\) Placements will not necessarily be carried out in this order.
The clinical Fellowship phases are framed by a bespoke Postgraduate Certificate in Urgent and Acute Primary Care delivered by Worcester University.

Upon successful completion of the certificate and linked Fellowship phases, students will be able to:

- Demonstrate the ability to diagnose and assess urgent presentations in long term illnesses.
- Formulate, implement and evaluate current pathways of care according to best evidence.
- Show understanding of frail and elderly complex co-morbidities and how such patients are appropriately managed.
- Demonstrate competence in the interpretation and evaluation of evidence and the application of appropriate treatment and assessment.
- Apply knowledge and skills to the competence in management of urgent care.
- Critically interpret and evaluate the current evidence behind urgent care.

E. Remuneration.

The GP Fellow will be employed in a supernumerary capacity through their host Trust, with honorary contracts during their GP practice and Ambulance Service placements.

Remuneration for the 12 month fellowship will be £75,249 pa

F. Mentoring.

- An experienced GP trainer will be provided as mentor to each GP.
- The Fellow will be allocated a dedicated clinical supervisor during each of their Trust phases.
- The frequency of mentor / supervisor contact will be determined at the outset.
- A mandatory appraisal will be conducted at the 6-month mark and again at the conclusion of the fellowship. Ad hoc appraisals will be conducted where appropriate. The Fellow will be expected to cooperate fully with all reasonable requests, in relation to appraisal.
- The Fellow will be expected to produce an appropriate portfolio of learning, which will complement their academic studies on the (PGCert) Urgent and Acute Care.

G. Fellowship Evaluation.

GP Fellows will be expected to contribute to evaluation processes, as and when reasonably required.

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13 The PGCert is a requirement of the Fellowship Programme; As such, there is an expectation that all Fellows attend 100% of class sessions and satisfactorily complete all course requirements, as specified by Worcester University.
14 NOTE: The GP will arrange their own indemnity cover, in accordance with requirements of their regulating body.
15 Dependent on the additional consideration discussed in Para.5.
H. Quality and Governance.\textsuperscript{16}

As an employee, the GP Fellow will assume a position as a member of organisations which endeavour to provide the highest quality of service to their patients. Particularly in light of the high-profile nature of this programme, the GP Fellow will be an ambassador for both the programme and their host employer. As such, they will be expected to ensure that suitably high standards are maintained at all times.

As an employee, the GP Fellow will have a responsibility for data quality. All employees are accountable for the quality of data they input into employer’s systems and/or documents in paper-based records and must ensure that it is accurate, complete and valid at all times.

Risk Management.

The GP Fellow will have a responsibility for the identification of all risk which could have a potentially adverse effect on the employer’s ability to maintain quality of care and the safety of patients, staff and visitors. The GP Fellow will be responsible for recording the risk, escalating to their line manager and for assisting (where appropriate) in the taking of positive action to eliminate or reduce risk.

I. Health & Safety.

The GP Fellow will be expected to:

- Adhere to & promote employers personnel department policies & procedures, including health & safety.
- Identify any risks & undertake relevant assessments, in line with employer’s policies.
- Be responsible for reporting any defects, in accordance with the Health & Safety at Work Act.
- Have knowledge of employer’s fire procedures, location of fire exits, alarms & equipment.
- Understand how to complete incident forms in accordance with employer’s guidelines.

As an employee, the GP Fellow will have a responsibility to abide by all of the safety practices and codes provided by their employer and have an equal responsibility with management for maintaining safe working practices, both for their health and safety and that of others.

J. Professional Conduct.

The GP Fellow will be expected to:

- Be aware of and maintain professional standards, in accordance with their regulating body’s code of conduct.
- Be accountable for their own actions and responsible for their clinical area.
- Be aware of responsibility of confidentiality & Caldicott principles.

\textsuperscript{16}NOTE: Paras H-M are subject to change, based on locally agreed contractual variations, to be determined by the host employer and communicated to the Fellow ahead of commencement.
K. Additional Information.

i) Infection control.
Where relevant, the GP Fellow will work to minimise any risk to clients, the public and other staff from Healthcare Associated Infection including MRSA and C difficile by ensuring that they are compliant with the Health Act 2006 – Code of Practice For The Prevention and Control of Healthcare Associated Infections (the Hygiene Code), as well as the employer's Infection Control Policies. All employees must comply with the relevant Infection Control Policies and attend infection control training as required within their department, or as directed by their line manager.

ii) Confidentiality.
As an employee, the GP Fellow will have a responsibility to maintain the confidentiality of any confidential information which comes into their possession regarding patients, employees or any other business relating to their employer. In accordance with the Public Interest Disclosure Act 1998, protected disclosures are exempt from this express duty of confidentiality.

iii) Equal Opportunities.
As an employee, the GP Fellow will have a responsibility to ensure that all people with whom they have contact during the course of the Fellowship - including patients, relatives and staff - are treated equally, in line with the employer’s Equal Opportunities Policy.

This post is subject to an exception order under the provisions of the Rehabilitation of Offenders Act 1974. This stipulates that all previous convictions, including those that are ‘spent’ must be declared. Previous convictions will not necessarily preclude an individual from employment within the Trust but must be declared in writing at the appropriate stage during the recruitment process.

i) DBS Checks.
The employer has a responsibility to safeguard and promote the welfare of children, young people and vulnerable adults who use their services. The employer expects all staff and volunteers to share this responsibility. As part of the selection process for this post, the GP Fellow may be required to undergo a "Disclosure and Barring Service" (DBS) criminal records check (previously known as Criminal Records Bureau / ISA checks). If successfully appointed, the GP Fellow will receive confirmation of which checks and / or registration they are required to have.
M. General Information

This job description is not intended to be an exhaustive list of duties, but it aims to highlight typical responsibilities of the post. It may be reviewed from time to time in agreement with the post holder.

The post holder will be required to comply with all policies and procedures issued by and on behalf of their employer.

The employer is an Equal Opportunities employer and the post holder is expected to promote this in all aspects of their work.
### Person Specification: Post CCT Emergency Medicine Fellowship

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| **Qualifications** | Basic Medical Degree.  
MRCGP.  
Safeguarding Level 3.  
Basic Life Support.  
Equality and Diversity Training. | | Application Form |
| **Experience** | Working a minimum of 4 PAs as a GP. | GP based in the West Midlands.  
Nursing home, end of life and OOH experience.  
Proven interest in development of primary care / Emergency Medicine. | | Application Form  
Interview  
References |
| **Knowledge** | To be able to comprehend, plan and prioritise work.  
To have innovative ideas and develop into reality.  
Up to date knowledge of:  
- Acute illness in adults and children.  
- Mental health.  
- Health Promotion.  
- End of Life Care.  
- Cardiovascular Disease.  
Awareness of NHS provision and legislation.  
To know when to ask for help. | Experience in OOH or emergency care. | Interview  
Application Form |
| **Skills** | Coping with pressure.  
Resilient and pro-active attitude.  
Ability to work on own initiative.  
Organising and prioritising own work.  
Excellent verbal & written communication skills.  
Basic IT competence (word processing / email).  
Report writing. | Developed protocols/guidelines. | Application Form  
Interview |
## Person Specification: Post CCT Emergency Medicine Fellowship

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People Skills</strong></td>
<td>Evidence of managing people and projects. Ability to listen to the needs of others / active listening. Ability to work as part of an integrated multi-skilled team.</td>
<td></td>
<td>Interview</td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Enthusiasm for Primary Care and Emergency Medicine. Commitment to lifelong learning and willingness to learn from others. Willingness to change in response to feedback.</td>
<td></td>
<td>Interview</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Registered on the Medical Performers List. As part of the selection process for this post, applicants may be required to undergo a &quot;Disclosure and Barring Service&quot; (DBS) criminal records check (previously known as Criminal Records Bureau / ISA checks). If successfully appointed, the applicant will receive confirmation of which checks and/or registration they are required to have. The applicant will confirm whether they are under investigation for fitness to practice or outstanding criminal proceedings. Applicant must have access to a road legal vehicle with fully comprehensive insurance for business use. Applicant must have a full UK driving licence. Any endorsements must be disclosed.</td>
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</tbody>
</table>
## Practice Requirements and Suggested Activities While in Practice.

(See end of document for Exclusions)

<table>
<thead>
<tr>
<th>Practice Requirements</th>
<th>Suggested Activities In Practice</th>
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</thead>
<tbody>
<tr>
<td>Act as the Practice lead for Emergency Medicine referrals, to provide an audit of admissions to EM Departments:</td>
<td></td>
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<tr>
<td>- In the last 12 months.</td>
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<tr>
<td>- Of those readmitted after 1 month into ED.</td>
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<tr>
<td>Collaborate with GP Practice on the audit scope/remit to inform EM discussions.</td>
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<tr>
<td>Training practice with experienced Clinical / Educational Supervisor</td>
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<tr>
<td>Full range of General Medical Services.</td>
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<tr>
<td>Provision of acute care within hours</td>
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<tr>
<td>Full range of emergency and diagnostic equipment – ECG, nebulisers, oximeters, spirometry.</td>
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<tr>
<td>Participation in OOH and A&amp;E unscheduled care management LES.</td>
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<tr>
<td>Provision of ‘advanced access arrangements’ – extended hours, triage.</td>
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<tr>
<td>Full range of chronic disease management clinics</td>
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<tr>
<td>Enhanced primary care teams – including intermediate care, virtual ward, palliative care and GSF</td>
<td></td>
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<tr>
<td>Access to specialist community nurse services – CCF; diabetes; respiratory; neuro.</td>
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<tr>
<td>Provides unrestricted home visiting.</td>
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<tr>
<td>Provides nursing home cover</td>
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<tr>
<td>Liaison with local secondary care services</td>
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<tr>
<td><strong>Educational activities:</strong></td>
<td></td>
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<tr>
<td>Professional development planning to identify learning needs and outcomes of attachment</td>
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<tr>
<td>Portfolio of achievements and reflective practice</td>
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<tr>
<td>Educational feedback from supervisor</td>
<td></td>
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<tr>
<td>Participation in audit and development of care pathways</td>
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<tr>
<td>Attendance at Clinical Governance meetings</td>
<td></td>
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<tr>
<td>Protected teaching time and mentoring opportunities.</td>
<td></td>
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<tr>
<td>Membership of RCGP First5 peer group</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical and professional activities:</strong></td>
<td></td>
</tr>
<tr>
<td>Acute surgery appointments and In-hours on call emergency duty</td>
<td></td>
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<tr>
<td>Acute home visits</td>
<td></td>
</tr>
<tr>
<td>Audit, Assessment and follow-up of OOH contacts and A&amp;E attendances</td>
<td></td>
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<tr>
<td>Follow–up of acute mental health assessments</td>
<td></td>
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<tr>
<td>Work with mental health crisis team &amp; alcohol services.</td>
<td></td>
</tr>
<tr>
<td>Post-discharge assessment of patients admitted due to exacerbations of LTCs, eg. asthma, COPD, Diabetes, CCF</td>
<td></td>
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<tr>
<td>Nursing Home visits and anticipatory care</td>
<td></td>
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<tr>
<td>Experience working with Primary Health Care Team (PHCT)</td>
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<tr>
<td>Virtual Ward</td>
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<tr>
<td>Intermediate Care</td>
<td></td>
</tr>
<tr>
<td>MacMillan / Hospice at Home service</td>
<td></td>
</tr>
<tr>
<td>Specialist nurses: heart failure; respiratory; diabetic; neuro.</td>
<td></td>
</tr>
</tbody>
</table>
GP Fellowship in Urgent and Acute Care – Core Competencies.

As a general practitioner (GP) you must:

- Recognise the signs of illnesses and conditions that require urgent intervention
- Work effectively in teams and co-ordinate care
- Prioritise problems and establish a differential diagnosis
- Make the patient’s safety a priority
- Consider the appropriateness of interventions according to the patient’s wishes, the severity of the illness and any chronic or comorbid diseases
- Be able to make mental state assessments and ensure the safety of others
- Accept responsibility for your actions, at the same time recognising any need for involving more experienced personnel
- Keep your resuscitation skills up to date – a yearly certified resuscitation course
- Act calmly in emergency situations and follow agreed protocols
- Know the processes and arrangements for commissioning and delivering urgent and unscheduled care in your community
- Be aware of how the management of patients with continuing conditions affects the need to give urgent and unscheduled care

A. CARE OF ACUTELY ILL PEOPLE: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT

- Recognition and management of life-threatening illness
- Symptoms signs and presentation of common severe illnesses
- Differentiation between early severe and less severe illness
- Recognition of age, gender and ethnicity on presentation
- Diagnosis and certification of death. Legal obligations.
- Knowledge and coordination of team approach to care
- Ability to accept responsibility for appropriate decision-making
- Understanding of influence of pre-existing LTCs
- Awareness of IT, recording and communications systems
- Promoting continuity of care with colleagues

Management of specific acute illnesses, including:

- Cardiovascular – chest pain, haemorrhage, shock
- Respiratory – wheeze, breathlessness, stridor, choking
- Central nervous system – convulsions, reduced conscious level, confusion, unconsciousness
- Mental health – threatened self-harm, delusional states, violent patients
- Severe pain
- Acute coronary syndromes
• Anaphylaxis
• Appendicitis
• Arrhythmias
• Asthma
• Bowel obstruction and perforation
• Dissecting aneurysms
• Ectopic pregnancy and antenatal emergencies
• Haemorrhage (revealed or concealed)
• Ischaemia
• Malignant hypertension
• Meningitis and septicaemia
• Parasuicide and suicide attempts
• Pulmonary embolus and Pulmonary oedema (severe)
• Shock (including no cardiac output)
• Status epilepticus
• Understand the principles of managing dangerous diagnoses

ii) PERSON-CENTRED CARE

• Good communication skills in an acute situation
• Appropriate recognition of patient autonomy
• Awareness of needs of carers / relatives
• Ethical awareness

iii) SPECIFIC PROBLEM-SOLVING SKILLS

• Differential diagnostic knowledge and skills
• Accurate assessment of urgency and timely management
• Share decision-making with patient appropriately
• Telephone triage and safety netting
• Self-awareness, organisational skills and prioritisation of work
• Decision between social and medical care needs

iv) COMPREHENSIVE APPROACH

• Understanding of exacerbations of chronic LTCs
• Recognition of co-morbidities
• Appreciation of relevance psycho-social factors

v) COMMUNITY ORIENTATION

• Understanding of rural/urban/ethnicity/ social mobility / demographics
• Knowledge of available community healthcare resources
• Dealing with inappropriate demands on healthcare services
vi) HOLISTIC APPROACH

- Understanding the impact of illness on future needs
- Recognition of emotional causes and consequences of acute illness
- Awareness of wide spectrum of health beliefs
- Awareness of pastoral needs in times of crisis

B. RESPIRATORY HEALTH: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT:

- Good diagnostic skills in acute respiratory distress

Knowledge of relevant diagnostic and treatment guidelines for:

- Asthma
- COPD
- Lung cancer
- Pneumonia

- Understand boundaries between primary care and specialist management

ii) PERSON-CENTRED CARE:

- Communication skills with a breathless patient
- Support for appropriate self-management strategies

iii) SPECIFIC PROBLEM-SOLVING SKILLS:

- Knowledge and interpretation of diagnostic tests eg. PEFR, pO2
- Understand appropriate use of inhaled therapy and O2
- Ability to provide relevant information to professional colleagues

iv) COMPREHENSIVE APPROACH:

- Recognise the impact of relevant co-morbidities on diagnosis and management

v) COMMUNITY ORIENTATION:

- Understand services and support available in the community
vi) **HOLISTIC APPROACH:**

- Understand the varying factors on the nature and timing of presentation
- Non-judgemental approach to patients eg. smokers
- Choose management appropriate to age and culture

C. **END OF LIFE CARE: Areas Of Competence:**

i) **PRIMARY CARE MANAGEMENT** Understand the principles of palliation in:

- Cancer
- Cardiovascular disease
- Respiratory disease
- Neurological disease
- Infectious disease

- Differentiate between treatable and untreatable symptoms in end of life care
- Knowledge of Gold Standards framework and community EOL teamwork

ii) **PERSON-CENTRED CARE:**

- Recognise & address full range of physical, social, psychological & spiritual needs of patients
- Understand the 24-hour continuity of care framework of services
- Communicate effectively about management options and prognosis

iii) **SPECIFIC PROBLEM-SOLVING SKILLS:** Manage symptoms causing distress:

- Pain
- Nausea and vomiting
- Shortness of breath
- Confusion
- Intestinal obstruction
- Emotional distress
- Retained secretions
- Understanding of appropriate treatment modalities - eg. syringe drivers
- Appropriate and effective drug prescribing and dose calculations

**Manage palliative care emergencies, including:**

- Haemorrhage
- Spinal cord compression
- Intestinal obstruction
iv) COMPREHENSIVE APPROACH:

- Counselling regarding symptom control
- Knowledge of processes around death
- Role of DNAR and care planning
- Understanding and managing bereavement reactions

v) COMMUNITY ORIENTATION:

- Understand the social care services available to dying patients
- Liaise with community services eg. MacMillan and hospice services

vi) HOLISTIC APPROACH:

- Awareness of psychological, emotional & spiritual needs of dying patients and their families.

D. CARDIOVASCULAR PROBLEMS: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT:

Correctly diagnose signs and symptoms to identify cardiac and non-cardiac disease:

- Chest pain
- Breathlessness
- Palpitations and arrhythmias
- Syncope and collapse
- Cerebrovascular symptoms

Appropriately manage:

- Ischaemic heart disease
- Heart failure
- Arrhythmias
- TIA and CVA
- Thromboembolic disease

ii) PERSON-CENTRED CARE:

- Take account of health beliefs and autonomy in managing acute illness
- Involve the patient in self-monitoring, self-management, and safety-netting
iii) SPECIFIC PROBLEM-SOLVING SKILLS:

- Intervene urgently in MI, CVA and critical ischaemia
- Demonstrate understanding of likely co-morbidities eg. renal impairment
- Utilise correct investigations and interventions eg. ECG

iv) COMPREHENSIVE APPROACH:

- Prioritise interventions for multiple risk factors according to severity and prognostic risk

v) COMMUNITY ORIENTATION:

- Recognise social determinants of acute illness and presentation
- Assess and modify immediate risk factors eg. driving

vi) HOLISTIC APPROACH:

- Appreciate the importance of the psychosocial & emotional impact of cardiovascular disease
- Recognise cultural significance of heart disease.

E. DRUG AND ALCOHOL MISUSE: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT:

- Appreciate that drug and alcohol use is common in the community and often unrecognised.
- Awareness of range of forms - excessive use, binges, risk-taking behaviours, dependency.
- Recognise special needs of patients with complex lives and those marginalised by society.
- Understand presenting signs of drug / alcohol misuse and withdrawal.
- Work in partnership with other professional colleagues in the team.
- Recognise that older adults can have unrecognised alcohol / drug problems.

ii) PERSON-CENTRED CARE:

- Treat each person as individual and do not stereotype.
- Assess each person's awareness of their problem and the consequences.
- Do not attach blame.
- Understand the stress associated - in both patient and doctor.

iii) SPECIFIC PROBLEM-SOLVING SKILLS:

- Always be alert to the possibility that problems may be alcohol or drug related.
- History-taking skills - physical, mental, social, and forensic and assess severity.
- Awareness of long term sequelae and causes of drug-related death.
- Awareness of safety and risk management to self and others and seek urgent help.
iv) **COMPREHENSIVE APPROACH:**

- Perform brief interventions when possible
- Recognise co-morbidities especially mental and physical
- Be aware of associated infectious illness eg. Hepatitis
- Understand the home situation and assess vulnerability of patient or family
- Refer to local specialist and social services if appropriate for comprehensive treatment planning

v) **COMMUNITY ORIENTATION:**

- Know available services for acute crises locally.
- An awareness of prejudice which prevents seeking help.
- Appreciate their vulnerability.
- Know and appreciate that you might be the first person to try and help them.

vi) **HOLISTIC APPROACH:**

- Recognise they have chaotic lives and conflicting pressures.
- Understand the problems which are multi-factorial.
- Beware of hidden risks of neglect and abuse in the family.

**F. MENTAL HEALTH: Areas Of Competence.**

i) **PRIMARY CARE MANAGEMENT:**

- Understand the importance of emotions in the context of wellbeing and stress
- Understand and empathise with people who are distressed and fully assess them
- Fully explore and integrate physical, psychological, family, social and cultural factors
- Understand primary care management of common mental health problems
- Understand the initial management of a patient with suspected acute psychosis
- Understand how to access local organisations for managing patients with mental health problems

ii) **PERSON-CENTRED CARE:**

- Use communication skills to enable distressed patients to discuss their concerns.
- Provide opportunities for continuity of care for people with mental health problems.

iii) **SPECIFIC PROBLEM-SOLVING SKILLS:**

- Understand the difference between depression and emotional distress and avoid medicalising
- Be able to assess and manage risk / suicidal ideation
iv) COMPREHENSIVE APPROACH:

- Understand importance of recognising mental health problems in long term physical illness
- Understand the common mental health problems in the elderly and with complex comorbidities
- Understand the range of mental health problems experienced by people with learning difficulties

v) COMMUNITY ORIENTATION:

- Understand why some people find it difficult to access primary care and mental health services
- Be able to work in partnership with other agencies to offer appropriate interventions

vi) HOLISTIC APPROACH:

- Understand the disadvantage of a dualist approach to mental and physical health
- Understand that mental illness is culturally determined and the need to be sensitive to this

G. CHILDREN AND YOUNG PEOPLE: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT:

Treat common and rare but important paediatric conditions, such as:

- Neonatal problems - feeding, heart murmurs, abdominal pain, gastroenteritis.
- Management of fever and febrile convulsions, rashes.
- Respiratory tract disease - croup, bronchiolitis, asthma, earache, tonsillitis.
- Meningitis.
- UTI.
- Safeguarding in mistreatment or neglect, working with other agencies.
- Support parents in enabling patients to manage minor illness and access service appropriately.
- Prescribe & advise appropriately - dosing, risk/benefit and cultural dimensions of prescribing.
- Awareness of welfare of unborn children - domestic abuse, substance misuse, and mental health problems.

ii) PERSON-CENTRED CARE:

- Effective communication and engagement with children, young people, parents, and families
- Support to parents and involve them in making informed decisions
- Awareness of child 'hidden' behind parent’s illnesses
- Achieve concordance and understanding of medication
iii) SPECIFIC PROBLEM-SOLVING SKILLS:

- Use a decision-making process determined by prevalence and incidence in the community
- Manage conditions that may present early and in an undifferentiated way
- Recognise a seriously ill child

iv) A COMPREHENSIVE APPROACH:

- Simultaneously manage acute and chronic problems in children
- Being aware of the GP role in promoting immunisation and prevention of accidents
- Provide access for young people who require sexual health advice

v) COMMUNITY ORIENTATION:

- Understand the legal and political context of child and adolescent care
- Understand organisation of care pathways and local systems of care

vi) HOLISTIC APPROACH:

- Understand the way that values, culture, and beliefs affect illness and health

H. OLDER ADULTS: Areas Of Competence:

i) PRIMARY CARE MANAGEMENT:

- Know epidemiology of older people’s problems presenting in primary care and management
- Recognise early “red flag” symptoms which can be non-specific in isolation
- Know local rapid-access referral pathways and common treatment options
- Understand physical, psychological and social changes occurring with ageing
- Understand the special factors associated with drug treatments and risk / benefit
- Understand the effect of physical factors such as diet, temperature and sleep, which may affect health in the elderly.
- Know how to access support services for older patients
- Know how to use statutory and voluntary organisations for supporting older patients in the community
- Ensure that care promotes identity, dignity and is non-discriminatory

ii) PERSON-CENTRED CARE:

- Know the special dimensions of prognosis of diseases in the elderly and plan care appropriately
- Understand End-of-Life care planning
- Consider the influence of the psychological state and social situation on health and disease
- Have appropriate communication skills
iii) SPECIFIC PROBLEM-SOLVING SKILLS:

- Understand prevalence of disease and demography
- Understand the difference in laboratory and diagnostic measurements / values in elderly
- Recognise the importance of a problem-based approach based on the 'big picture'

iv) A COMPREHENSIVE APPROACH:

- Understand the complex nature of health problems in older patients
- Understand the special features of psychiatric disease
- Understand the influence of comorbidity on the presentation of illness and how it may delay diagnosis
- Be able to coordinate teamwork and involve the family

v) COMMUNITY ORIENTATION:

- Be aware of inequalities in healthcare provision in older people
- Consider how socio-economic and health factors inter-relate

vi) HOLISTIC APPROACH:

- Be aware of carer issues
- Be aware of possibly outdated social and health beliefs and cultural traditions
- Be wary of neglect or abuse in the elderly.

I. Exclusions.

- LES, DES, or QP responsibility
- Routine administrative work eg. PMAs, insurance reports
- Cover for regular clinical staff
- Supervision of trainees
Appendices

&

References
Appendix 1:

West Midlands Urgent and Immediate Care Fellowship: Meeting the Challenges of 21st Century Healthcare Provision.

Authors:

Urgent Care Fellows:

- Dr Michael Clements;
- Dr Alwin Mascarenhas;
- Dr Oluwatosin Oladini

Matthew Aiello, Project Manager, Health Education England - West Midlands
Professor Veronica Wilkie, Professor of Primary Care, Worcester University

Introduction.

To cite a key message from a September 2013 “Blog for GP,” by Professor Keri Thomas (National Clinical Lead of the GSF Centre CIC for End of Life Care):

“The importance of the holistic role of the family doctor is poised to come into its own in a way never previously encountered. These words come not from Jeremy Hunt but the RCGP’s 2009 End of Life Care Strategy. Mr Hunt’s proposals can be achieved for our most frail elderly patients and GPs are ideally placed to fulfill this important role. With an aging population and the need to make best use of scarce resources, I would urge my GP colleagues to meet this challenge and to ‘go for gold’ for our most vulnerable patients; especially those nearing the end of life.”

There has been a significant demand for urgent and emergency care from Emergency departments and general practice. This coupled with poor recruitment in emergency departments has raised concerns within Emergency Medicine. There is also falling recruitment to General Practice training as discussed in an occasional paper by the RCGP. This qualitative analysis states that “a cultural change amongst medical educationalists is needed to promote general practice as a career choice that is equally attractive as hospital practice” and also the lack of more flexible working arrangements for newly qualified doctors means getting into partnerships is less attractive to them.

Health Education England - West Midlands (HEE-WM) has developed a pilot to investigate the feasibility of enhanced skills training for qualified GPs in Urgent and Immediate Care, to care for patients both in the community and health care settings.

A. Emergency Medicine.

Ongoing challenges around recruitment and retention within the medical profession, while a perennial challenge, are reaching what is often referred to as crisis levels across a number of specialties. The College of Emergency Medicine Taskforce recognises this as detailed in their interim report both at consultant and trainee level.\(^3\)

- The model of care recommended by the College of Emergency Medicine (CEM) is for Consultant presence 16 hours per day, seven days per week. This requires 10 Whole Time Equivalent (WTE) Consultants per Emergency Department (ED), compared to the current average of 4.5 WTEs.

- The Centre for Workforce Intelligence (CfWI) predicts it will take until 2020 to secure sufficient numbers of consultants. This is based on maintaining the number of training posts at current levels and ensuring 100% fill rates for such posts and programmes. However, this is unlikely to occur given current attrition rates, which will inevitably lead to a significant revision towards 2030\(^4\).

- For core training, recruitment is to the Acute Care Common Stem (ACCS), of which Emergency Medicine (EM) is one constituent specialty. In 2011, 96% of the 192 posts were filled– but retention in ED training is poor. For example, many ACCS trainees migrate to another specialty rather than progressing to ST4 (EM). In 2012, 94% of posts were filled.

- For ST4 (first year of higher training) in 2011 there were 135 posts vacant in England but only 45 (41%) were filled. In 2012, there were 196 posts vacant in England and 86 (44%) were filled.

- Based on the GMC Trainee Survey there were 169 CT3 trainees in post on the 30 April 2012. Of these trainees, only 84 applied to the national EM recruitment ST4 recruitment round. 92% (77) were considered appointable and were offered a post, with 85% (71) accepting a post.

- Recruiting doctors from overseas represents a possible short-term solution but will not provide longer-term recruitment and retention solutions given there were significant immigration obstacles to this recruitment option during 2011-12. This route is now open and there is still significant scope for the UK to recruit non-UK/EEA doctors into EM posts in 2012. In practice, despite intensive recruitment efforts, this initiative has proved disappointing. It may be that the issues of quality of support and supervision of trainees are impacting on overseas recruitment.
B. Demands on General Practice, and how this affects availability for urgent care.

General Practice, as the other key provider of front line healthcare is also facing challenges around recruitment and retention. Against the increasing complexity of patients presenting to general practice is the additional problem of an overstretched workforce, spread across a number of access points, meaning that GPs of today are finding it increasingly hard to deliver continuous care.

The number of full time equivalent (FTE) GPs in England increased from 28,854 in 2001 to 35,319 in 2011. This represents an average annual change of 2.0%. Between 2010 and 2011, the increase was only 0.2%.

In Wales, the number of FTE GPs increased from 1775 in 2006 to 1867 in 2011, a total of 5.2%.

In Scotland, the headcount number of GPs (but not the number of FTE GPs) increased by 8.8% between 2005 and 2010, and in Northern Ireland over the same period the headcount number of GPs rose by 7%.

In the 12 months to September 2011, the number of consultants rose by 3.5%: GP numbers rose by 0.2% FTE in the same period.

Figure 1: Health Education England. Workforce Plan for England
The graph above (Figure 1) shows how the number of GP’s has not increased, compared with a significant increase in the number of consultants. GP’s are responsible for 91% of all medical contacts in the NHS, because of a greater amount of chronic disease monitoring, as well as urgent care. GPs are often working on a more part time basis, not only because of family commitments but also because of the need for GPs to become involved in commissioning, taking some experienced GPs away from the front line.

GPs are reporting that the intensity of their work is significantly increasing, as well as the number of reasons people access primary care - all of which compete for urgent care access.

There is a significant increase in the demand for appointments; an increase which is not only due to an older population but present at all age ranges (see graph below):

**C. Factors affecting attendance in A&E.**

There are many reasons why people attend A&E. The evidence falls into the following categories:

- A service that is immediately available and known to most people.

ED departments are open 24 hours a day and have walk-in entry, which obviates the need for individuals to make an appointment enabling them to come in and access medical advice at a time that suits them.
A National audit office 2013 document on emergency admissions to hospital states that "a system such as the NHS needs simple, easily understood pathways guiding patients to the most appropriate treatment. Without this, some patients may end up in the more easily available and visible elements of the system inappropriately."8

- **Genuine need.**

A number of patients end up in A&E by virtue of the nature of their injuries, while some are referred because of decisions by medical professionals (including paramedics as well as general practitioners and nurses).

- **Perception of need.**

There are many studies from the UK and internationally, showing that people access Emergency Care because of a genuine fear that their illness is serious (although the diagnosis at the end of the contact is often one of minor illness)9. Evidence here suggests that patients will continue to present with minor illnesses to the ED because of the perceptions of the urgency of their treatment and also the availability and capacity of alternative services. This mismatch is further exaggerated by social deprivation.10

- **Use of statistics which drive the data.**

John Appleby, chief economist, the kings fund,11,12 has argued that the increase in numbers attending A&E may be related to the change in the way data has been collected. He found that, starting from 2003/2004 onwards when Type 2 and Type 3 (specialist A&E units, minor injury units and walk in centres) ED data was added to existing A&E access data, the numbers increased significantly i.e. that the increase is due to a change in how the data was collected not the actual numbers accessing emergency care (see graph below). However there is little doubt that ED’s are struggling to meet the demands placed on them.
Demographics

The population is getting older, and those with long term conditions are living longer. This collection of factors has led to an increase in number of the very old and the very frail with multiple co-morbidities. A study published in the British Journal of General Practice\textsuperscript{13} showed that social isolation increases the demand on emergency services, leading to higher A&E attendances.

Other factors

An initial evaluation of the 111 emergency service concluded that the service did not deliver a "hoped for" reduction in ED attendances. A review titled "NHS 111" led to more ambulance dispatches, with study finds\textsuperscript{14} indicating that this service may in fact have led to an increase in demand because of the way calls are triaged and handled and the need to "safety net" calls which are dealt with at a distance.
D. The GP Fellowship in Urgent and Acute Care.

From April 2013, Health Education England - West Midlands (HEE-WM) developed a pilot to investigate the training and experience needed to enable GPs to work across all aspects of frontline care. A pilot for a twelve month fellowship programme was developed to test whether a bespoke package of enhanced skills training is practicable and viable.

A working party was set up by HEEWM to explore the development of a fellowship post to enhance the skills of newly qualified GPs in the management of acutely unwell patients at the interface between primary and secondary care. It was recognised that there was a need for additional knowledge and skills above those required for everyday general practice that the MRCGP was designed for. South Worcestershire CCG agreed to work as a pilot site for this because of their experience of tasking GPs innovatively – eg. as part of the “GP With Ambulance” scheme and within the Acute Medical Unit.

One A&E and one of the Medical Admissions Units in Worcestershire volunteered to host the pilot project, along with three General Practices. West Midlands Ambulance Services also agreed to support the programme, with a capability to place Fellows throughout the West Midlands.

Three Urgent Care Fellows (UCFs) were appointed in early 2014. Their work pattern involves three urgent care placements of 2 days a week for 4 months, in each of:

1. Emergency Department
2. West Midlands Ambulance Service
3. Medical Admissions Unit

Two further days are spent in General practice, looking at the organisation and provision of urgent primary care appointments and a day spent in an action learning set to develop professional skills, leadership, Evidence-Based Practice, system improvement methodology, and the achievement of a post-graduate Certificate in Urgent and Immediate Primary Care.

Four-monthly reviews of all of the placements and the experiences of the pioneer UCFs are carried out in order to further refine the placements as the scheme is rolled out.
### Appendix 2: WMAS Curriculum: Acronyms:

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCA</td>
<td><strong>Double Crew Ambulance:</strong> The recognisable wagon with two people in it that can convey patients to hospital.</td>
</tr>
<tr>
<td>HART</td>
<td><strong>Hazardous Area Response Team:</strong> Used recently for severely flooded areas. HART is for all hazardous areas so they also will do CBRN (Chemical, Biological, Radiological, Nuclear) as well as access other hazardous areas in PPE (personal protective equipment).</td>
</tr>
<tr>
<td>MAA</td>
<td>Midlands Air Ambulance</td>
</tr>
<tr>
<td>MERIT</td>
<td><strong>Medical Emergency Response Incident Team:</strong> Critical care and trauma paramedics and doctors</td>
</tr>
<tr>
<td>NEOC</td>
<td><strong>Non-Emergency Operations Centre:</strong> Forward planning of ambulance journeys</td>
</tr>
<tr>
<td>PTS</td>
<td><strong>Patient Transport Services:</strong> For example booked ambulances for outpatients or taking patients back home from hospital</td>
</tr>
<tr>
<td>RRV</td>
<td><strong>Rapid Response Vehicle:</strong> Conveys the Paramedic and emergency equipment to the patient rapidly, but not able to convey a patient to hospital (usually a 4x4)</td>
</tr>
<tr>
<td>SOC</td>
<td>Strategic Operations Cell</td>
</tr>
<tr>
<td>VNR</td>
<td>Vehicle Not Required</td>
</tr>
<tr>
<td>VOR</td>
<td>Vehicle Off Road</td>
</tr>
</tbody>
</table>
### Appendix 3:

#### Sample Timetable for GP Practice Phase:

**EM Fellow**

**Weekly timetable - initial**

<table>
<thead>
<tr>
<th>Time</th>
<th>Weekday</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30hrs</td>
<td></td>
<td><strong>Meeting</strong></td>
</tr>
<tr>
<td>09.00hrs</td>
<td></td>
<td>Phone calls from patients</td>
</tr>
<tr>
<td>09.30hrs</td>
<td></td>
<td>Monthly meeting</td>
</tr>
<tr>
<td>10.30hrs</td>
<td></td>
<td>Acute home visits</td>
</tr>
<tr>
<td>13.00hrs</td>
<td></td>
<td>Triaged (HD)</td>
</tr>
<tr>
<td>14.00hrs</td>
<td></td>
<td>By rota</td>
</tr>
<tr>
<td>16.00hrs</td>
<td></td>
<td><strong>Self booked</strong></td>
</tr>
<tr>
<td>18.30hrs</td>
<td></td>
<td><strong>LTC reviews</strong></td>
</tr>
<tr>
<td>08.30hrs</td>
<td>Friday</td>
<td><strong>Acute Access review</strong></td>
</tr>
<tr>
<td>09.00hrs</td>
<td></td>
<td>Phone calls from patients</td>
</tr>
<tr>
<td>09.30hrs</td>
<td></td>
<td>Weekly review</td>
</tr>
<tr>
<td>10.30hrs</td>
<td></td>
<td>Discuss</td>
</tr>
<tr>
<td>13.00hrs</td>
<td></td>
<td><strong>LTCs</strong></td>
</tr>
<tr>
<td>14.00hrs</td>
<td></td>
<td><strong>Risk management</strong></td>
</tr>
<tr>
<td>16.00hrs</td>
<td></td>
<td><strong>Visits</strong></td>
</tr>
</tbody>
</table>

**Wednesday**

- **COM**
- **Triage / acute surgery**
- **PHCT**
- **Visits**
- **Acute surgery**
- **Extended hours**

**Friday**

- **Triage / acute surgery**
- **Weekly Access review**
- **Referrals meeting**
- **Risk management**
- **Visits**

**CGM**

- **Meeting**
- **Triage / acute surgery**
- **Self booked appts.**
- **Triaging and booking home visits**
- **Liaison with Community Nurses**
- **Liaison with partners**

**Referrals**

- **Monthly**
- **Acute**
- **Extended**
- **Self booked**
- **LTC reviews**

**Self-booked appts.**

- **Hospital attendees**
- **A&E attendees**
- **2WWs**
- **EoL**
- **Community nurse referrals**
- **Nursing home**
- **Acute follow-ups**
- **Nursing home**
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### GP Fellowship Key Contacts

<table>
<thead>
<tr>
<th>NAME</th>
<th>ROLE</th>
<th>Organisation</th>
<th>Project Team Position</th>
<th>Contact Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professor Elizabeth Hughes</strong></td>
<td>Director of Education and Quality</td>
<td>Health Education England - London and Southeast</td>
<td>Project Board Chair</td>
<td></td>
</tr>
<tr>
<td><strong>Dr Martin Wilkinson</strong></td>
<td>Director of GP Education</td>
<td>HEE-WM</td>
<td>Project Advisor</td>
<td></td>
</tr>
<tr>
<td><strong>Prof Veronica Wilkie</strong></td>
<td>Course Lead – Fellowship Accreditation &amp; GP Mentor</td>
<td>Worcester University</td>
<td>Fellowship Academic and Clinical lead</td>
<td><a href="mailto:v.wilkie@worc.ac.uk">v.wilkie@worc.ac.uk</a></td>
</tr>
<tr>
<td><strong>Dr Steve Walter</strong></td>
<td>Associate Dean Post-Graduate GP Education</td>
<td>HEE-WM</td>
<td>GP Mentor / host practice</td>
<td><a href="mailto:Steve.Walter@wm.hee.nhs.uk">Steve.Walter@wm.hee.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Dr Sanjiv Ahluwalia</strong></td>
<td>Postgraduate Dean</td>
<td>HEE North, Central and East London</td>
<td>Project Lead, Pan-London GP Fellowship</td>
<td></td>
</tr>
<tr>
<td><strong>Mr Matt Aiello</strong></td>
<td>Programme Manager</td>
<td>HEE-WM</td>
<td>Project Manager</td>
<td><a href="mailto:Matthew.aiello@wm.hee.nhs.uk">Matthew.aiello@wm.hee.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Mr Julian Rhodes</strong></td>
<td>Head of Education and Training</td>
<td>West Midlands Ambulance Service</td>
<td>Project Lead (WMAS Phase)</td>
<td><a href="mailto:julian.rhodes@wmas.nhs.uk">julian.rhodes@wmas.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Mr Matthew Ward</strong></td>
<td>Head of Clinical Practice</td>
<td>West Midlands Ambulance Service</td>
<td>Training Lead (WMAS Phase)</td>
<td><a href="mailto:matthew.ward@wmas.nhs.uk">matthew.ward@wmas.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Mr Rob Cole</strong></td>
<td>Head of Clinical Practice</td>
<td>West Midlands Ambulance Service</td>
<td>Training Lead (WMAS Phase)</td>
<td><a href="mailto:robert.cole@wmas.nhs.uk">robert.cole@wmas.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Ms Victoria Cooper</strong></td>
<td>WMAS Facilitator for Clinical Placements</td>
<td>West Midlands Ambulance Service</td>
<td>WMAS Facilitator for Clinical Placements</td>
<td><a href="mailto:victoria.cooper@wmas.nhs.uk">victoria.cooper@wmas.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Dr Jonathan Leach</strong></td>
<td>Associate Medical Director (Revalidation)</td>
<td>Arden Herefordshire &amp; Worcestershire</td>
<td>Project Advisor</td>
<td><a href="mailto:Jonathan.leach@nhs.net">Jonathan.leach@nhs.net</a></td>
</tr>
<tr>
<td><strong>Dr Tim Kilner</strong></td>
<td>Course Director</td>
<td>University of Worcester</td>
<td>Certificate/University Queries</td>
<td><a href="mailto:t.kilner@worc.ac.uk">t.kilner@worc.ac.uk</a></td>
</tr>
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</table>