

Out of Hours (OOH) Training for GP Registrars Position Paper

Introduction

This paper sets out COGPED's position on the way in which GP registrars are to continue to obtain experience in out of hour's care where their GP trainers' practices have opted-out of providing out OOH services

The Committee of General Practice Education Directors (COGPED) has consulted with the main stakeholders in this process, including the General Practitioners Committee (GPC), Royal College of General Practitioners (RCGP), The Joint Committee on Postgraduate Training for General Practice (JCPTGP), National Association of GP Cooperatives and the Department of Health (DH), to seek their views throughout the development of this paper. The preliminary response has been very positive and we have received extensive constructive comments from the GPC and RCGP, GP Postgraduate Deaneries and others, which are reflected in this draft with the intention of modifying it further in the light of experience and development of the OOH services in the months and years ahead.

The JCPTGP (the Joint Committee) as the Competent Authority has approved the content of the revised paper for training of GP Registrars in OOH care and stated that the content of this position paper should be implemented.

COGPED will continue to liaise with representatives from the GPC, GPR's subcommittee of GPC, RCGP, providers of OOH Organisations, JCPTGP, DH and PCOs to review and consider all issues of importance in the future for OOH training of GPRs.

Background

The delivery of OOH services, and the nature of the work, has changed over the past few years. As the nGMS contract comes into place, many GP trainers will choose not to take on the responsibility for OOH work, and thus put their GPRs at a disadvantage. The strong view of COGPED is that the generalist role of the GP should be maintained, and newly accredited GPs will be expected to have demonstrated their ability to perform competently in OOH primary care. It is still the GP Postgraduate Deaneries' responsibility to ensure that OOH experience occurs in training and for the JCPTGP/PMETB to be satisfied that all generalist competencies have been successfully assessed in order for a certificate of completion to be issued.

There is general agreement that the OOH changes in the new GMS contract are the first in a line of probable radical changes for general practice services. The OOH position itself is likely to alter rapidly over the next five years, and with the

development of emergency care pathways in the NHS, this will have a significant impact on the primary care OOH services.

The new GP contract defines core services, and when implemented will allow practices to opt out of OOH. Between 1 April 2004 and 31 December 2004, practices can opt out of OOH where this is part of the PCO strategy. From 31 December 2004, PCOs will take full responsibility for making sure there is effective OOH provision. Some PCOs are organising this to take place from April 1st 2004, which is the earliest possible date. The UK Health Departments are currently working with the Strategic Health Authorities (SHAs) and PCOs **[NB: "PCO" is the generic term that covers English and Scottish Health Boards, Welsh LHBs and the NI equivalent]** to scope alternative arrangements for OOH provision, with an expectation that most practices will be able to opt out of the responsibility from January 1st 2005. It is important to clarify that whilst most GPs wish to give up the responsibility for OOH work, they are not giving up the option of being able to do it. It is likely that for a period of time, there will be significant variability in the arrangements for providing OOH in the UK.

Early indications are that at least 90% of practices will opt out initially and that the responsibility will pass to the PCOs who may contract for the delivery of this care from a range of agencies including reconstituted co-operatives and commercial services, or provide this directly themselves.

It is anticipated that with the progressive development of various patient care pathways, including emergency care in the NHS over the next five years, we will need to review the provision of the OOH training delivery for GPRs regularly. In addition, we are mindful of the implication of the European Working Times Directive that will be in place from August 2004, for GPRs' working times, though it is unlikely initially that this will impact significantly on the training for GPRs

The ideas and competencies presented in this paper are based upon the recently published article, which is fully endorsed by COGPED. We support the position of the generalist role and define the competencies that should be in place. In order to develop the OOH training programme, COGPED has facilitated the involvement and agreement of all the appropriate organisations and stakeholders in the provision of OOH primary care.

Definitions

Out of Hours service: The new contract (nGMS) has defined the normal working day for general practice to be between 08.00 and 18.30. Thus, OOH is defined as that work undertaken between 18.30-08.00 and all day at weekends and on public holidays. However, for the purpose of this paper, OOH is also taken to mean the type and style of working that takes place in this time. This recognises that the processes for providing general practice and primary care, both during the normal working day, and outside that, have changed over the last decade, and these processes provide different models of working, with the need for possession of different knowledge and competencies by GPs. It is important to make clear that these do not just refer to the management of emergencies, but also to the experience of dealing with patient contacts in a different quantity and context to the general normal working day.

Educational supervision of the GPR is usually undertaken by the GP Trainer. They undertake overall supervision of the individual's learning experiences, manage the process, commission learning opportunities, and are responsible for the delivery of the formative and summative assessment processes. Others may provide the educational supervisor with data to inform formative assessments, appraisal, and the completion of the Structured Trainers Report.

Clinical supervision may vary according to the learning situation. At its most basic, clinical supervision is a clinical governance issue, ensuring the quality of care and patients' safety. In this context it is taken to mean this, as well as the supervision of a GP Registrar's learning and experience. In some areas the clinical supervisor is called an associate or assistant trainer (and in secondary care, a consultant trainer). It is likely that Postgraduate GP Deaneries will need to develop and monitor the competencies of the clinical supervisors for this role, as well as clarifying the requirements of the job for the OOH provider organisation.

It is desirable for the clinical supervisor to have additional skills to that of being a proficient professional, and these will include the ability to teach observation and feedback to learners. The clinical supervisor could be a clinician who is beginning the process of becoming a trainer. Clinical supervisors need not be GPs.

Those doctors already approved as GP Trainers by their Postgraduate GP Deaneries will be automatically deemed qualified to supervise GPRs.

The Assessment Systems must be fit for a range of purposes. The methods used within the programme will be selected in the light of the purpose and content of that component of the assessment framework. Methods will be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning. For example, work-based assessment must be subject to reliability and validity measures. Evidence must be collected and documented systematically. This paper indicates that the assessment of the GPR will remain the responsibility of the Trainer, supported by evidence supplied by the GPR, which will include their own self-assessments.

JCPTGP View

The Joint Committee has debated this issue and has noted that their certificate licenses the holder to work in any capacity unsupervised in UK general practice. They therefore concluded that GP training should continue to be designed to equip GP Registrars to deal with all work that currently forms part of UK general practice. The opinion of the Joint Committee is that GP Registrars should continue to be trained in OOH work, as this remains a core part of the GP's role. Moreover, completion of the Structured Trainer's Report and the signing of the VTR1, and thus the overall educational supervision, would still be the responsibility of the GP Trainer, even if their service responsibility changes. In effect, the GP Registrar would be trained in OOH competencies, but under the supervision of a trained clinical supervisor in the local OOH organisation. The GP trainer would be in receipt of written evidence and formative feedback from clinical supervisors in the OOH Organisation that would allow the trainer to monitor and assess the GPR's competencies in this aspect of the training, and eventually sign off the registrar as appropriately competent. In some instances, the demonstration of some of the skills

and competencies needed for OOH care could also take place during the normal working day, and could be signed off by the GP trainer from personal assessment. The quality assurance of this aspect of training would remain the responsibility of the JCPTGP via the GP Postgraduate Deaneries.

Expectation of GP Postgraduate Deaneries

The Postgraduate GP Deaneries would expect all GP registrars to obtain the necessary OOH experience and training. Where the practice has not opted out of responsibility for OOH services the responsibility for providing the experience and supervision of OOH training for the GPR would remain with that practice, but where training practices have opted-out of responsibility for OOH services delegated arrangements for supervision would be made with the OOH service providers, who would develop locally agreed criteria with the Directors of Postgraduate GP Education for training and the appointment of clinical supervisors. In some circumstances, this could be the GP Registrar's usual GP trainer. A formal feedback of each GP Registrar in their OOH competencies would be made on a regular basis (at least three times during the year) and this evidence would inform the GP Trainer's decision-making in signing off the trainer's report. The aim of the training is to enable GPRs to learn, develop, practice and maintain their competencies in OOH working. It is likely that one session, at a certain clinical intensity, per month will be necessary or the equivalent in another appropriate and negotiated combination of sessions. In some instances, the GP Trainer, in agreement with the GP Registrar, may indicate that additional time in this experience is required so that the competencies can be signed off. GP Registrars will be responsible to keep completed records of experience and feedback on all sessions that they attend in a workbook as evidence of their competencies in OOH training.

Assessment of out of hour's competencies

GP Registrars would have to demonstrate competency in the provision of OOH care. The overall responsibility for assessment of competency is with the GP Trainer but GPRs have duty to keep the record of their self-assessment, feedback and their experience in the competency domains. The five generic competencies are defined:

1. Ability to manage common medical, surgical and psychiatric emergencies in the out of hours setting.
2. Understanding of the organisational aspects of NHS out of hours care.
3. Ability to make appropriate referrals to hospitals and other professionals in the out of hours setting.
4. Demonstration of communication skills required for out of hours care.
5. Individual personal time and stress management.

Provision of Out of Hours Services

There are a number of organisations involved in the delivery of OOH services, including NHS Direct, GP Co-ops, Commercial Deputising Services, Nurse Triage, minor injury centres, Primary Care walk-in centres, and A&E departments. The model of service provided will be of necessity varied, but there will be a need for partnership and collaboration between all agencies at the local level. This will be driven and shaped by a national quality standards process. It is expected that the service will follow care pathways and patient journey/s, delivered in multi-professional settings, which will include GPs, nurses, paramedics, and A&E staff etc.

There will be a strong likelihood of consortia forming to serve this need. We need to encourage collaboration, and co-operation to ensure the success of the service.

Every model of service will have a place and thus should be able to offer training for GPRs.

The attached pictorial images demonstrate possible routes for the provision of services for patients out of hours, drawing on models of likely patient pathways (appendices - [appendix 1](#), and [appendix 2](#)).

The role of Primary Care Organisations

The PCOs will be required to secure the OOH services, either from appropriate organisations or consortia of organisations, or by direct provision. The PCOs will also have responsibility for the recruitment of competent GPs (as generalists who have adequate experience in the provision of OOH services) to serve in this area. Although the consensus opinion at present is that OOH services provided by GPs is that they are there as generalists, it is inevitable that changes and developments will occur, and PCOs might consider the development of Practitioners with Special Interest including GPwSI in the area of OOH provision, not only to enhance the quality of the service, but also as part of the overlying strategy for the retention of GPs. PCOs will need to ensure that the OOH service includes the provision of appropriate training for GPs in training. The PCOs are encouraged to work closely with the GP Postgraduate Deaneries in assuring the quality of training in the OOH organisations.

The role of GP Postgraduate Deaneries

When commissioning services, PCTs will need to reassure themselves that the provider will not only deliver high quality OOH care, but also has the capacity and capability to deliver the required training for GPRs. They will also need to ensure that the provider complies with the quality assurance processes of the GP training programme delivered by each Deanery.

The quality assurance of the GP training programme in OOH will include the assessment of:

- The post holder's educational plan, progress report, and monitoring processes, and the process for assessment of competencies (all to be documented).
- The post's level of workload, educational facilities and the overall quality of the learning environment.
- The clinical supervisor's ability (which must include skills in observation and the ability to give feedback).
- The capability and capacity of the OOH organisation in delivery of the clinical supervisory process.

It is essential that GPRs keep documented evidence of achieved competencies and experience, which will include their own self-assessment, the clinical supervisor's feedback, and any formal or informal comments made by others appropriately involved in the process. In order to support the skills of the OOH clinical supervisors, the GP Postgraduate Deaneries will provide programmes of training and skills development for them. The GP Postgraduate Deanery, in consultation with PCOs, may provide an ongoing development programme as part of professional development of clinical supervisors.

Educational Materials

The workbook and record of sessions are suggested as a model, and will not be compulsory. However, a nationally agreed model could be available electronically which could operate similarly to that for GP appraisal, and allow both GPRs and GP Trainers to access records easily.

The role of GP Trainers

The GP Trainers would be expected to sign off the Trainer's report using the written evidence provided by the workbook and to provide the assessment of their GPRs in the competencies that have been recorded with the help of OOH clinical supervisors. It may be useful for trainers to use other assessment methods from a variety of sources, as they feel appropriate.

GP Trainers should make arrangements, as part of their initial educational planning with the GPR, for their sessions with the OOH service. This should take place at a time agreed by the trainer and GPR, following a clear evaluation of the GPR's level of skill and competency and their learning needs. The Trainer should also ensure that the GPR gets exposure to community based emergency and OOH care, as part of their negotiated sessions.

The Responsibility of GP Registrars

GPRs would work in the OOH services, under supervision, in order to gain competence and confidence in delivery of these services, as required as a necessary

part of becoming registered as GPs. Therefore, GPRs would work in OOH services as part of their normal contract of employment.

The Role of the OOH Service

The OOH service would gain a contribution to service work from the GPR and would have the opportunity to promote OOH working to the future workforce. OOH providers will need to continue to have service input from doctors trained in, and certified for general practice work, and thus have a vital interest in maintaining their capacity. In addition, as the service will gain a contribution to service work in return, the OOH organisation would provide the clinical supervision and written and oral feedback to both GPR and GP Trainer. In order to support this, the OOH clinical supervisors will receive appropriate training commissioned or provided by the GP Postgraduate Deaneries. It will also be important to ensure that clinical supervisors have adequate time after a session in order to debrief the GPR.

The role of the PCO

The PCO would need to ensure that each OOH provider is able to provide the necessary training opportunities, has a sufficient number of trained clinical supervisors in their organisation, and that these supervisors are appropriately trained and supported. The PCOs are encouraged to consult with their GP Postgraduate Deaneries in advance of commissioning the OOH services.

Sessions in Out of Hours

The number of sessions worked by a GP Registrar will vary according to the number of patients covered but, in an urban setting, normally a six hour session every four weeks would seem appropriate, and in other settings on a pro rata basis. It is likely that organisations will form to provide cover for similar numbers of the population, but as variations will occur, each GP Trainer and each GP Postgraduate Deanery will need to assess the provision of experience for each individual GPR. The purpose of having a minimum number of sessions worked by GPRs, even if they can demonstrate the competencies, is that these sessions would increase the experience and exposure to different aspects of OOH work, particularly if they are undertaken in a wide variety of OOH settings. The negotiation of this is an issue for all involved organisations and GP Trainers.

With the inclusion of a necessary period of induction into general practice and primary care for GPRs, a minimum of twelve sessions would be expected over the (normal) GPR year. The number of hours worked in any week, would also have to comply with the appropriate European Working Time Directive. Furthermore, OOH work should not be undertaken the night before any organised educational activity, and Trainers will need to be aware of this. It is desirable that GPRs have experience of different models and shift times of the OOH service, but a GPR who works an overnight session should have the following day off. Although this would more commonly be worked as a session per month, it would also be possible for the GPR

to have two separate weeks, for example, one week in the first six month period and one week in the last part of their GP training year.

Exposure to a variety of community based emergency and OOH cover should be provided for GPRs as part of their training programme. This should be acknowledged and negotiated with the GP Trainer, as part of the GPR's PDP.

Medico-Legal

The GPRs will be subject to the normal processes of clinical governance, GMC regulations and civil law. Their contract is likely, in the near future, to remain with the training practice or their GP Trainer, but they will be supervised by a clinician who may not be from that practice, or, on occasion, a professional who may not be a doctor (but who will be an approved clinical supervisor in OOH care). When working directly for a PCT, GPRs are likely to be covered by NHS indemnity arrangements. Other OOH providers will need to ensure that their insurance is adequate to cover liabilities in connection with the work done for them by GPRs.

Review

COGPED recognise that the process and structures for delivering OOH care are going through rapid and fragmentary change; thus the processes for delivering the training for OOH care for GPRs will require to be formally reviewed regularly and further consultation after the first year. To this end, the steering group of appropriate stakeholders should continue to exist and meet regularly.

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 April 2004