

FAQs for Urgent and Unscheduled Care

The guidance on urgent and unscheduled care (UUSC - formerly OOH) training requirements for GP trainees has been updated as of 1.8.2019.

The new guidance moves away from 'counting hours' of UUSC work completed. Instead it puts the responsibility onto the trainee to ensure full and comprehensive learning has been undertaken. It asks them to demonstrate this against six UUSC statements.

To aide trainees, educational supervisors, UUSC clinical supervisors and others working with this new guidance we have produced the following 'FAQ's'.

With thanks to the RCGP AiT Committee and colleagues, Alison Hutchings and Andy Eaton, OOH Fellows from Severn for creating these FAQ's.

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Why have these changes been brought about?

OOH is changing. With ordinary GP surgeries being able to offer evening & weekend appointments, the lines between "in" and "out" of hours practice are blurring. In addition, the OOH workforce is diversifying. Our OOH training needs to adapt to these changes. Trainees need exposure to these changes.

What are the key changes to OOH training?

- A move away from counting the number of hours worked OOH, to an approach that looks at the number of competencies trainees have reached whilst working in a variety of OOH locations
- Where general practitioners are not available on site, allowing the use of allied care practitioners to contribute towards trainee supervision as part of an effort to learn from and appreciate the skills held by these colleagues, considering their increased presence within OOH services with safeguards to ensure there is a qualified GP to whom issues can be escalated
- Allowing senior trainees now the option of completing unsupervised ("solo") OOHs shifts, moving away from these being a mandatory requirement, but ensuring the opportunity is there prior to CCT if the trainee feels it will add value to training.

Do I still need to do OOH training?

Absolutely. All trainees will still have to complete OOH training. They still need to use the OOH setting to sign off appropriate competencies and all trainees must have the opportunity to experience delivery of OOH primary care in settings away from their usual place of practice.

Why has the USSC guidance changed from 'counting hours' to competencies?

The guidance reflects an overall move towards individual training designed around individual trainees and their personal educational and training needs. It is recognized that trainees have different learning needs and can meet them in a variety of ways and at variable paces. Accordingly, it follows that simply counting hours may not correlate with the actual clinical experience and subsequent knowledge and competencies that are demonstrated. It is the intention that the new guidance will be more robust at ensuring all trainees are fully competent in UUSC by CCT.

How many hours of UUSC do ST3 trainees now need to complete during their training?

There is no longer a minimum required number of hours of urgent and unscheduled care work trainees must complete prior to CCT. In rolling out this new guidance for trainees, the GP School considers that the nature of work GPs do in the urgent care setting has not fundamentally changed.

The emphasis in the new guidance is on achieving competence, and whilst there is clear national guidance that we cannot stipulate a minimum number of hours worked outside the practice setting, we do know that it used to take most trainees around 72 hours in ST3 to achieve competence in all aspects of UUSC. In all cases a sign off as "competent" will need to be justified by the evidence provided.

What if a trainee has demonstrated competence in UUSC but wants to continue to do more UUSC shifts to gain more experience and confidence?

GP training is varied and individual with underlying key competencies that must be demonstrated. This is to allow trainees to take advantage of a broad range of educational experiences to prepare them to work as generalists, but also to enable them to adapt their training to meet their individual learning needs, special interests and future career plans. If a trainee feels the need to develop their UUSC experience and confidence further this should be documented in their PDP and would be supported by the GP School. To do this they would be expected to be on track with demonstrating competency in all other areas of training in time for their scheduled CCT date.

Is there a maximum number of hours trainees can work in the UUSC setting?

There is no upper limit on the number of hours trainees can work in the UUSC setting so long as they adhere to the limits of safe working practice as detailed in their Contract of Employment.

Is there a minimum number of hours trainees can work in the UUSC setting?

There is no lower limit on the number of hours trainees must work in the UUSC setting as noted above. Full UUSC competencies must be demonstrated however and it would be considered difficult to achieve this without reasonable work in the UUSC setting. For guidance, approximately 48 hours of experience should be regarded as a minimum figure that should allow a GPST to demonstrate that they are capable.

Time spent working in UUSC is taken out of the trainees clinical working week in the training practice and can be hard to accommodate on the practice's clinical rota and can lead to the practice being short of appointments. Can you suggest how a practice can facilitate the trainee gaining enough experience while balancing the administrative and clinical needs of the practice?

This only applies to England.

The GP School expects educational supervisors, and their training practices, to support trainees learning in UUSC. It is however recognised that practices need to plan rotas, rooms and other logistics and therefore need to know when a trainee will be working. The GP School would encourage trainees to give a reasonable amount (to be agreed in each practice but usually of the order of 4-6 weeks) of notice for clinical time off in lieu (TOIL) due to urgent care shifts worked. If reasonable notice is given, we would expect practices to be able to accommodate this.

When the previous guidance was in place many practices scheduled six hours of time off in lieu per month into timetables to assist forward planning and to balance out time worked in UUSC outside the practice. A comparable system could be agreed between the trainee and practice if preferable.

Is the guidance different for less than full time (LTFT) trainees?

LTFT trainees need to demonstrate competence in all six UUSC care competencies by the end of ST3 as full time trainees do. It is up to the trainee to decide how they can achieve this. There is no need to consider 'pro rata' UUSC work given there is no specified minimum or maximum number of hours any trainee must complete.

Do ST1/2s need to do UUSC work?

The new guidance does not make a formal stipulation as to what should happen over each of the three years of training but expects all trainees to have achieved competence by the end of ST3. In order to achieve this we would suggest trainees start to familiarise themselves with the breadth of UUSC in their area during their GP placements in ST1 or 2. This could include observation of others (which will count towards weekly educational time - see below) or experience working in urgent care providers (which may count towards weekly clinical time - see below). We would expect trainees to arrange enough exposure such that they are ready to work with an UUSC provider in a patient facing capacity from the start of ST3 at the latest.

Can a trainee spend time with paramedics, the crisis team or other allied healthcare professionals as they used to in ST1/2?

The DOOHL group considers time observing colleagues and teams who support GPs in offering UUSC a valuable element of training, particularly for trainees who feel they haven't covered these areas in other aspects of their training. Observation, including sitting in with a GP and watching them consult, is considered educational and therefore counts towards this element of their working week. In England time off in lieu should be taken out of educational time.

It is expected that the vast majority will be undertaken via your designated OOH provider; sign posted by your GP training programme. The following are examples, but other opportunities are likely to exist depending on models of service delivery in your local area.

Additional opportunities exist:

- “In-hours” practice
 - Duty doctor experience
 - Extended access appointments during evenings/weekends at your training practice
- “Out of Hours” practice
 - Regional ambulance services
 - Local psychiatric “crisis teams”
- Secondary care rotations

- Emergency medicine, Paediatrics and Psychiatry

Is a trainee working under direct supervision (with a qualified GP in the room whilst consulting) doing clinical or educational work?

If the trainee is taking clinical responsibility for patient contact, regardless of the level of supervision, this is deemed clinical contact and should count towards this element of their working week. In England i.e. TOIL should be taken out of clinical time.

What has happened to the red/amber/green supervision categories? Do trainees still need to do a certain amount of each?

The new guidance focuses on demonstration of competencies and purposefully doesn't specify the type, level or supervision required to achieve this. Pragmatically it would be anticipated that trainees start with direct supervision (GP and trainee in the same room while consulting) and move onto near supervision (GP in another room but same location as trainee while consulting). It would be expected that a trainee is confident, and has experience of, working in the UUSC setting independently without another clinician in the room during consultations prior to CCT.

Further to this it remains acceptable for trainees to work with remote supervision (GP and trainee in different locations i.e. one on visit and one at base) if the supervisor and the trainee agree that the trainee is experienced enough to work with this level of supervision. With the new guidance however there is no expectation, or requirement, that this is necessary to achieve competency and therefore CCT.

How does a supervisor and their trainee decide what level of supervision they should be working at on each shift?

At the start of each shift the supervisor and trainee should sit down to discuss the supervision level they both feel is appropriate. It is expected that the trainee will provide the supervisor with an updated copy of their training passport preferably before but at the latest at the start of each shift to support this conversation.

Following discussion, the supervisor and trainee will agree on a level of supervision. If there is any discrepancy between their wishes it would generally be expected that they would start the shift at the highest level of supervision requested, but then consider progressing to less supervision if both parties were happy following further discussions.

Factors to consider are previous UUSC experience, level of supervision at in hours work at that time, familiarity with the provider set up/shift type/IT etc. The workload on the shift should not directly impact on the decision regarding supervision level given to the trainee i.e. if it is busy this is NOT a reason to relax supervision if it would not otherwise have been felt to be appropriate for that trainee.

Can COTs and audio COTs be completed during an UUSC shift?

Workplace based assessments should reflect the full scope of training. As a result, we would encourage trainees to complete a proportion of these assessment in the UUSC setting if the CS is trained in use of the WPBA tools.

If hours are not being counted do trainees need to keep a record all UUSC work completed and if so how and where?

An UUSC log sheet should still be completed by a trainee at the end of each UUSC shift. This form should then be signed by the UUSC clinical supervisor. The completed form should then ideally be uploaded to the eportfolio as an OOH log entry.

How will a trainee demonstrate competency in UUSC?

There are six UUSC competencies that need to be demonstrated.

1. Ability to manage common medical, surgical and psychiatric emergencies
2. Understanding the organisational aspects of NHS out of hours care, nationally and at local level
3. The ability to make appropriate referral to hospitals and other professionals
4. The demonstration of communication and consultation skills required for out of hours care
5. Individual personal time and stress management
6. Maintenance of personal security, and awareness and management of security risks to others

Some elements of these could be achieved through duty doctor sessions in the practice, but it is anticipated that others will only be fully achieved through working shifts for an UUSC provider outside the practice.

It would be expected that to achieve competence trainees will have experienced working in all shift types including face to face (base shifts), telephone triage and visits. In most cases they will have experienced this in settings with access to patient records. If their Out of Hours provider doesn't always provide this access, then they should demonstrate training experience of working without access to GP records. We recommend that evidence is collated in the form of assessments and learning log entries, collated in a competency record.

What does a trainee do if they have already done some OOH shifts under the previous guidance but will be assessed, and obtain CCT, after the new guidance is in place?

It is likely that any hours worked under the 'old' system will help trainees demonstrate the newly defined competencies anyway. We suggest that trainees midway through their ST3 year at the time of change-over discuss with their CS/ES what competencies they both feel have already been achieved and document this, perhaps with a note of hours worked to that point. After this the trainees would continue to document competencies, but no longer count hours.

Anyone entering ST3 after the introduction of the new guidance would be expected to follow new guidance and fully complete their competency log.

Who will decide if a trainee is competent?

The educational supervisor will review the passport and competency record, alongside discussion with the trainee regarding their experience in UUSC settings. Once satisfied the educational supervisor will sign off competence through the eportfolio/educational supervisors report (as they do currently).

What does a trainee do with the competency record once it is completed?

Once a competency record is complete it should be uploaded to the eportfolio and linked to a reflective learning log entry under the OOH heading so that it is easily visible by the ARCP panel (and your educational supervisor).

If an educational supervisor (ES) doesn't themselves work in the UUSC setting, how will they be confident that the trainee is competent?

The competence record will detail the evidence which the trainee feels demonstrates attainment of each competency. If there is concern or uncertainty, then we would encourage dialogue between the trainee and ES. If further clarification is sought, we would encourage the ES to speak to the clinical supervisors working with the trainee or seek further advice from the GP School via their local TPD team.