North East Primary Care Services Agency

Doctors in Training

within Out of Hours services

ADDENDUM - VERSION 1
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1. THIS AGREEMENT IS BETWEEN:

AND
**Introduction**

This document outlines the requirements of Out of Hours (OoH) Providers in the provision of GP training and acknowledges the expectations identified within the revised position paper provided by the Committee of General Practice Education Directors (COGPED) 2010 as to the further development of the training of Doctor in Training and the OoH service.

As defined within this document:

‘OoH continues to be taken to mean the type and style of working that takes place outside normal surgery hours for urgent and unscheduled patient contacts, and does not include any experience gained in the GP Training Practice during extended hours’ (p3).

It is acknowledged within this document that processes involving both general practice and primary care are evolving during and outside of normal working hours and that this is reflected within the varying levels of knowledge, skills and competencies required by GPs. Level of competency does not simply refer to the management of emergencies as in and out of hours work but to the management of cases by a practitioner often in isolation within the out of hours period. It is suggested that this therefore, requires a special educational focus. Whilst it is acknowledged that some of these skills can be gained within ‘day’ working through for instance, telephone triage it is recommended that Doctor in Training experience a range of shift working involving out of hours working.

On ‘Care of acutely ill people’ the six generic competencies described within the RCGP Curriculum Statement are:

1. The ability to manage common medical, surgical and psychiatric emergencies in the out-of-hours setting.
2. Understanding of the organisational aspects of the NHS out of hours care.
3. The 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.
6. Maintenance of personal security and awareness and management of the security risk to others.

It is also identified that collaboration between all organisations involved in ensuring GP training is required if compliance with national recommendations is to be met.

In 2009 the implementation of the Working Time Regulation (WTR) required doctors to work a maximum of 40 hours in any one week.
1. Out of Hours Provider

1.1 Shift allocation

As a result of recent changes to the Junior Doctors contracts, time spent in OOH training by doctor in training is deducted from their work ‘in hours’. Therefore the following approach is now in operation;

First GP post (generally ST1);

Doctor in Training will not usually undertake any OOH work. Instead they should be prepared for later work in this field by:

- Experience gathered through educational interventions which could include telephone triage, consulting skills in hours
- Observation of urgent / unscheduled care provision within hours
- In Hours experiential work in the practice

Second and third GP posts (generally ST3):

The precise arrangements will vary across areas in accordance with local negotiations. However, in general terms, doctor in training will address their learning needs in this field through the following:

- At the beginning of ST3 at least 1 educational session on delivering unscheduled care should be delivered in house by the in-hours GP trainer (clinical supervisor), and one day should be spent delivering such care under close supervision

- At the beginning of ST3 1 or 2 induction session(s) should be delivered by an OOH provider in-hours as study leave (see above); this would cover basic induction to the work, the provider’s systems and specific training in telephone triage. It may cover a range of other subjects. Attendance is mandatory, and in addition to the current regional teaching programme

- During OOH training doctor in training are supervised either by a Trainer, or by a GP who has been trained and approved by the School of Primary Care to act as a Clinical Supervisor

- Doctor in training’s competence for remote supervision is confirmed by the trainer using the OOH3 and OOH4 forms (see below).

The traffic light system is used i.e.

Red = Not ready for own OOH caseload (OOH5)
Amber = Can manage own shift, with supervisor present (OOH3)
Green = Can manage own shift with remote supervision (supervisor on the phone, actively supervising and available to attend centre if needed) (OOH4)

Green shifts might be solo (at quiet more rural centres) or alongside a non-supervising doctor in a more urban centre (with the supervisor typically at home or nearby). All green and amber shifts should have protected time for feedback.
• Once certified amber or above by the trainer, the doctor in training will undertake *(insert individual session number, or number of hours, per provider here – will be 4-6)* sessions of OOH work in each 6m post with a local provider, working within their normal shift pattern where possible, but with **no overnight shifts**. The time will be deducted from in-house clinical sessions. The precise arrangements will depend upon what the OOH provider has undertaken to deliver and will vary slightly from one Training Programme to another.

• Occasionally the clinical needs of a patient or an unusually timed shift might mean that hours are worked in excess of this norm, but this excess time would normally be taken back from a later OOH shift rather than in house clinical work, with a tolerance of no more than two hours in total for any one doctor in training per 6m WTE work.

• When practice extended working is added to the doctor in training’s work with the OOH provider, the doctor in training will not work on more than 3 weekends per 6m WTE post. Such work is complementary to and does not replace OOH shifts

• Any doctor in training in an extension or receiving targeted training would have a decision made on a case by case basis by their support TPD, entirely governed by their educational needs and where they would best be addressed, which might involve no OOH work, or that of, but not usually exceeding, an ST3 post. Such doctor in training should, by the end of their training, have completed, at a minimum, the same number of sessions as a standard doctor in training.

• Any doctor in training rated red should be actively withdrawn from their OOH commitments and the matter referred to their support TPD / the Training Programme

1.2 Details of the documentary process

The supervisor creates a record of the shift (OOH1) which the doctor in training takes back to the trainer, for debriefing and for recording in the educational record of that doctor in training. The session record should include the shift duration in the title and OOH1 be scanned onto the learning log entry for that date.

A trainer may wish to record additional information onto the form which may help to inform the OOH provider and supervisor eg the doctor in training consults at X minutes.

1.3 Safeguarding and CPR competence when working OOH

It is a requirement for Doctor in Training to have a current ALS certificate on joining the GP Training Programme.

It is a CCT requirement for all Doctor in Training to have a current (within 3 years) BLS certificate at final ARCP

OOH providers require evidence of CPR competence to align with their operational requirements. It is the OOH organisation’s responsibility to ensure that each doctor in training has an ‘in date’ Life Support certificate that aligns with those requirements.
Updates can be obtained either during GP posts (as part of the practice training, and therefore free), in hospital posts (where it should be provided F.O.C if a pre-requisite of the post) or self-sourced and claimed back via the Study Leave process. There are recognised providers for this e.g. NE Ambulance.

Doctor in training need to pay for these themselves and claim through the Study Leave arrangements.

Doctor in training working green shifts also need evidence of level 3 safeguarding training. Level 2 training needs to be done prior to level 3. This can be achieved either through an appropriate course or other equivalent learning. If a course certificate is not available, the trainer needs ensure that adequate evidence is logged on e-portfolio and sign the OOH4 form if the requirements have been met.

Responsibilities

2. Primary Care Organisations

Primary Care Organisations have, since 31 December 2004 taken responsibility for ensuring effective OoH provision with the majority of general practitioners no longer undertaking OoH work. A number of GP Trainers continue to provide clinical supervision for GP Registrars in out-of-hours sessions. It has been agreed across those organisations involved in the development of the COGPED position paper (2010) that the generalist role of the GP should be maintained and that there would be an expectation that newly accredited GPs would perform competently in an OoH setting.

*Primary Care Organisations will enter into discussions with the GP Postgraduate Postgraduate School of Primary Care to identify OoH opportunities for Doctor in Training.*

- PCTs will ensure that the opportunities identified are delivered within current OoH service arrangements.

- Primary Care Organisations will work with the Postgraduate School of Primary Care to establish clinical and educational governance standards for Doctor in Training

- Primary Care Organisations will work closely with the Postgraduate School of Primary Care to quality control GP training within OoH organisations.

- The PCT / PCSA will monitor provision via contracts and evidence will be examined within quarterly performance meetings.
3. The Postgraduate School of Primary Care

The Postgraduate School of Primary Care will provide a GP training programme supported by a quality assurance framework to include assessment of:

- The capability and capacity of the OoH organisation in delivery of the Clinical Supervisory process.
- The induction processes within the OoH setting for Doctor in Training.
- The criteria against which providers will be required to evidence compliance.
- An annual QC visit to the OOH provider
- Initial and ongoing training and accreditation of OOH Clinical Supervisors

The Postgraduate School of Primary Care will be responsible for the initial training for OoH Clinical Supervisors who are not current trainers.

The Postgraduate School of Primary Care will maintain a system of ongoing training and reaccreditation for OOH CS at least every 5 years.

The Postgraduate School of Primary Care quality control mechanisms will encompass the Clinical Supervisor’s ability (including observational and feedback skills).

The Postgraduate School of Primary Care will keep a list of Doctor in Training and their GP trainers for the OOH provider at least every 6 months.

3.1 Out of Hours Provider

The Out of Hours provider will work with the Postgraduate School of Primary Care and Primary Care Organisations to develop training opportunities for Doctor in Training. It is the role of the Out of Hours provider to:

- Ensure that Doctor in Training provide all required supporting information as identified in Item 6.
- Inform the Doctor in Training that they will not be able to commence training in the OoH service if this evidence is not received as directed.
- Have in place an induction policy which will be submitted to the Training Programme. Subsequent updates to this will be provided to the PCT. The policy is required to reflect the needs of the organisation and the local NHS Community the service is operating within.
- The Provider will ensure that the Doctor in Training operates within the training scheme area supported by the OoH Clinical Supervisor so ensuring a hands on second opinion is available if required.
- The OoH Provider is responsible for ensuring that Doctor in Training are exposed to a range of shifts as discussed and agreed with the Training Programme. This should include evening shifts and weekend day shifts, but no overnight shifts. Doctor in Training should gain experience in OoH centres, visits and telephone triage.
• The detail of how Doctor in Training gain the knowledge required to move through the ‘traffic light stages’ should be left with the OoH organisation and monitored via QC visits.

• Ensure at least one standalone induction session before a Doctor in Training works an OoH shift. This is in addition to the clinical sessions. It should include:
  ▪ Aims and objectives for the session
  ▪ IT systems
  ▪ Formal teaching on telephone triage
  ▪ Description of the organisation
  ▪ How to make referrals
  ▪ Maintenance of personal security and awareness and management of the security risks to others.
  ▪ In house protocols and prescribing policy
  ▪ Shadowing / Mentoring
  ▪ Local NHS Service Information
  ▪ Confirmation of GPRs competencies

• The Provider organisation is required to ensure that all OoH Clinical Supervisors achieve the minimum standard and will provide evidence when required to Commissioners and the Postgraduate School of Primary Care that this has been monitored and where not achieved rectification action taken.

• The Provider will recommend doctors who may be suitable as OoH supervisors but not withhold recommendation without a documented reason.

• The Provider to support the use of an approved feedback form from the Clinical Supervisor to the Doctor in Training after each session and collate the feedback. Electronic or paper methods may be used. The OoH Provider is responsible for developing a mechanism for the collection, assessment and transfer of all feedback relevant to the individual doctor in training and sharing this information with the Postgraduate School of Primary Care on an annual basis prior to the QC visit.

• The Provider will ensure that time is allocated within the session for feedback from the GP trainer to Doctor in Training.

The OoH Supervisor will highlight any concerns to both the Provider and Postgraduate School of Primary Care regarding Doctor in Training ability to move through the ‘traffic light’ sessions.

• The detail of the feedback mechanism is to be agreed between each provider and scheme.

• If a patient safety issue is identified, both the GP trainer and the scheme are to be notified within one working day.

• The Provider will participate in an annual QC visit with the training programme and provide access to relevant documentation.
• The Provider will maintain an up to date list of accredited OOH Clinical Supervisors and send this updated list to the Postgraduate School of Primary Care on a 6-monthly basis

• Liaise with the School of Primary Care in ensuring that OOH Clinical Supervisors maintain their accreditation

• The provider will ensure a mechanism for feedback by doctor in training on supervisors. This will be a form completed by each doctor in training after each OOH session. This form will be:

  - made available to the supervisor shortly afterwards, for purposes of professional development and requirements of appraisal and reaccreditation in the role

  - be screened by the provider organization to ensure there are no major concerns about the supervisor in either their clinical or educational roles, and that recurrent issues that might need addressing are identified. These should be escalated to the School of Primary care at annual QA review or sooner if deemed sufficiently concerning.

4. GP trainer with direct responsibility for the day to day work of the doctor in training must:

• Ensure that the doctor in training’s hours are EWTD compliant
• Allow attendance at OoH induction
• Determine when the doctor in training is at **amber** and therefore able to begin OOH work, and complete form OOH3 (see below)
• Determine when the doctor in training is at **green** and therefore able to begin working under remote supervision, and complete form OOH4 (see below)
• Inform the doctor in training’s educational supervisor and the OoH provider about any concerns with regard to the doctor in training’s performance and competence
• Work with the Doctor in Training to evaluate the individual’s level of competency and skill in order to establish learning needs. This would usually be completed within one month.
• Ensure that a debrief takes place following completion of OoH sessions and that areas of learning and further development are identified.
• Regularly re-evaluate the level of supervision required by the Doctor in Training and to agree this with the OoH Provider.
• Make the OoH Provider aware of any relevant occupational health issues concerning the Doctor in Training.

The GP Educational Supervisor must:

• Ensure that a doctor in training has done the required number of OoH sessions and total number of hours AND that there is evidence in the portfolio that demonstrates attainment of the OoH competencies. Simply doing the shifts does not provide the necessary evidence. The trainer should see the OoH supervisor’s feedback form for each shift.

• The easiest way to demonstrate the competencies is to get the doctor in training to complete an **ST3 final ARCP checklist** form detailing where the evidence sits within the e-
portfolio and to attach this to the e-portfolio under OOH. The same form can be used to
total up the number of OOH done and recorded on e-portfolio. This should be done for the
final ARCP.

- If a trainer or doctor in training has any queries or concerns regarding OoH certification or
requirements they should contact their training programme director.

- Keep a star rating form for each Doctor in Training prior to allocation of a shift. This will
include confirmation that the GPR has completed level one safeguarding training before
any sessions and a level 2 safeguarding course prior to green sessions.

5. GP OoH Supervisors

COGPED advise that there will be an ongoing need for the delivery of educational packages in order
to maintain the pool of Clinical Supervisors. Whilst acknowledged that clinical supervision should be
provided by GPs it is noted that clinical supervision can be carried out by healthcare professionals
who have undertaken a Postgraduate School of Primary Care approved Supervisors course during
an OoH shift when appropriate. These include nurse practitioners, retained doctor educational
supervisors and undergraduate medical student teachers.

Teaching, observation, assessment and feedback skills are required in addition to being a proficient
professional. The OoH Clinical Supervisor, if undertaking the roles and responsibilities of a doctor
must be qualified as a Medical Practitioner on the Medical Performers List. A GP Registrar working
under the supervision of a Deanery approved Clinical Supervisor will undertake tasks to a level no
greater than that to which the Clinical Supervisor is responsible.

The Clinical Supervisor:

- Must be recommended by their OoH provider as being suitable for OoH supervision prior
to acceptance on the initial training course. Consent should not be unreasonably withheld.

- Must have up to date training in equality and diversity.

- Must include their supervision role in their annual appraisal in the education/training
section.

- Must undertake an update on the role at least every 5 years. The training will be provided
by the Postgraduate School of Primary Care but should be monitored by the OOH provider.

- Must supervise a Doctor in Training in OOH work at least 6 times per year to maintain
accreditation.

- Must contact the Doctor in Training at least 3 times during a remotely supervised shift

- Will provide feedback to each Doctor in Training within a week after each session using the
approved Postgraduate School of Primary Care form. This will be emailed to the Doctor in
Training after remote supervision.
• Will provide verbal and documented feedback to both the Doctor in Training and the GP trainer.

• Out of Hours Clinical Supervisors will receive the appropriate training provided by the Postgraduate School of Primary Care.

6. Doctor in Training

• The GP Registrar will work under the supervision of a Postgraduate School of Primary Care approved Clinical Supervisor and undertake tasks to a level no greater than the supervisors skills allow.

• It is the responsibility of the Doctor in Training to provide evidence of all relevant documents required to demonstrate competency when asked. To include:
  
  • DBS
  • Safeguarding training
  • Equality & Diversity

• Doctor in Training will not undertake practice within the OoH service until an evaluation by the GP trainer has been completed and written form completed.

• Doctor in Training will record each of their OoH sessions in the e-portfolio.

• Doctor in Training will share and discuss all OoH sessions entered into the e-portfolio with their educational supervisor.

• The Doctor in Training will ensure that the OoH provider has an up to date traffic light rating form before a shift is allocated to them. This will be sent by email to the provider.

• Work the required shifts under appropriate supervision

• Attend all the sessions that they have agreed to.

• Supply the OoH provider with form OOH4 or OOH5 which informs the provider of the level of supervision that they need.

• Give adequate notice if unable to attend. Late notice of non-attendance puts patient safety at risk. Non-attendance without notice will be regarded as a negative probity indicator and may result in referral to the GMC.

• Demonstrate their competence to the level expected of the GP curriculum, and be prepared to undertake additional training should that be deemed necessary at their annual review.

• Honour any commitment to undertake out of hours sessions still outstanding when their ARCP is signed off

• Provide feedback on OoH supervision when asked. Form OOH2 can be used.
7. A note about the European Working Time Directive

Please note that this still applies, and any OOH schedule will need to maintain the necessary breaks / maximum shift lengths. The maximum shift is 13 hours and there has to be an 11-hour break. So, for example, if a doctor in training does a 6.30pm-12.30am shift they can only start work at 11.30am on the day of the shift and 11.30 the day after the shift. If that then results in them working less than 40 hours that week, they will need to add the “missing” hours elsewhere (not necessarily in the same week).