

FAQs for Urgent and Unscheduled Care (UUC) including OOHs training

The guidance on UUC training requirements for GP trainees has been updated and implemented since 1.8.2019 (COGPED position paper [found here](#)).

The new guidance moves away from 'counting hours' of OOH work completed. Instead it puts responsibility onto the trainee to ensure full and comprehensive learning has been undertaken. This should be demonstrated against the core capabilities for 'Being a GP' with reference to the Curriculum Topic Guide on 'Urgent and Unscheduled Care'. The college have provided a [document](#) that suggests how UUC links to the relevant capability areas.

To aid trainees, educational supervisors, UUC clinical supervisors and others working with this new guidance we have produced the following 'FAQ's':

Why has the UUC guidance changed from 'counting hours' to capabilities?

The guidance reflects an overall move towards personalized training designed around individual trainees and their specific educational and training needs. It recognizes 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 capabilities that are demonstrated. It is the intention that the new guidance will be more robust at ensuring all trainees are fully capable in UUC by CCT.

Do trainees still need to do OOH training?

Absolutely. All trainees will still have to complete OOH training. They still need to use OOH settings to develop and demonstrate appropriate capabilities and all trainees must have experience delivering UUC in primary care settings away from their usual place of practice.

How many hours of UUC/OOH do ST3 trainees now need to complete during their training?

There is no longer a minimum required number of hours of OOH work trainees must complete prior to CCT. The emphasis in the new guidance is on achieving capability rather than counting hours. However, the [national guidance](#) is clear that trainees '**will need significant opportunities to develop these capabilities in Out of Hours Services / primary care based urgent /unscheduled care provider organisations.**'

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

GP training is varied and individual with underlying key capabilities 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 UUC 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 capability 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 UUC setting?

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

Time spent working in UUC 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?

The GP School expects Educational Supervisors (ES), and their training practices, to support trainees learning in UUC. 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 of notice (usually of the order of 4-6 weeks) for clinical time off in lieu (TOIL) due to urgent care shifts worked outside the practice. 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 UUC 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 capability by the end of ST3, just 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' UUC work given there is no specified minimum or maximum number of hours any trainee must complete.

Do ST1/2s need to do UUC/OOHs 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 capability by the end of ST3. In order to achieve this, trainees should familiarise themselves with the breadth of UUC in their area during their GP placements in ST1 or 2. In addition to UUC work within their training practice, GP trainees should organize observational sessions with other services that provide urgent and emergency health and social care in the community, including OOHs. Examples might include Crisis Mental Health, Community Palliative Care, Social Services, District Nursing Team, Ambulance service and 111/999. Time observing colleagues and teams who support GPs in providing UUC can be a valuable element of training, particularly for trainees who haven't covered these areas sufficiently in other parts of their training. Observational sessions and the learning resulting from these can be captured in the [UUC observational session record](#) form, uploaded to the trainee's ePortfolio and expanded on in an 'Out of Hours session' learning log entry (linked to Clinical Experience Group 6: 'Urgent and unscheduled care').

Trainees should not provide **any** clinical care during these observational sessions which therefore count towards the educational component of their working week (TOIL should be taken out of educational sessions). Trainees should ensure that they are ready to work with UUC provider(s) in a patient facing capacity from the start of ST3.

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. 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 capabilities and purposefully doesn't specify the type or level of supervision required to achieve this. Trainees will start with direct supervision (UUC Clinical Supervisor and trainee in the same room while consulting) and would be expected to move rapidly onto near supervision (UUC CS in another room but same location as trainee while consulting). A trainee should be confident, and have experience of, working in the UUC setting independently without another clinician in the room prior to CCT.

It remains acceptable for trainees to work with remote supervision (UUC CS and trainee in different locations i.e. one on visit and one at base) if the CS 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 capability and therefore CCT.

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

At the start of each shift the UUC Clinical Supervisor and trainee should discuss the level of supervision they both feel is appropriate. If there is any discrepancy between their wishes it would generally be expected that they start the shift at the highest level of supervision requested (by either CS or trainee), and then consider progressing to less supervision if both parties were happy following further discussions.

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

Can CbdDs, COTs and audio COTs be completed from an UUC shift?

Workplace based assessments should reflect the full scope of training. We encourage trainees to complete a proportion of these assessment in the UUC setting (if an UUC Clinical Supervisor conducts an assessment then they should be trained in use of the WPBA tools).

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

An [UUC session record form](#) should still be completed by a trainee and their CS for each UUC session outside the training practice. The completed form should then be uploaded to the eportfolio and attached to an accompanying OOH session log entry (linked to Clinical Experience Group 6: 'Urgent and unscheduled care'). An example of a [completed UUC session record](#) is provided.

How will a trainee demonstrate capability in UUC including OOHs?

Trainees should have experience working in all shift types including face to face (base shifts), telephone triage and home visits. In many cases they will be working in settings with access to patient records. If their UUC providers don't always have this access, then they should demonstrate experience of working without access to patient records.

Evidence should take the form of WPBA and learning log entries. Trainees in GP posts should identify their strongest pieces of evidence across different UUC settings, using the [UUC Evidence for ARCP](#) document. This document is then reviewed with their ES prior to ARCP, uploaded to the trainee's ePortfolio and attached to a Professional Conversation log entry (titled 'Review of UUC evidence') that describes progress made and any future learning needs. It may be helpful to refer to the RCGP [mapping document](#) linking UUC to the RCGP curriculum capabilities'.

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 appropriate capabilities anyway. We suggest that trainees part way through their ST3 year at the time of change-over discuss with their ES what capabilities 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 capabilities, but no longer count hours.

During the transition period, accommodation may be made for trainees who have completed the majority of their training under the previous 'hours based' system to continue with this if appropriate.

Anyone who entered ST3 after 1st August 2019 should follow the new guidance and present their evidence as per the preceding section.

Who will decide if a trainee is capable in UUC?

The Educational Supervisor is responsible for assessing their trainee's capability across all areas of 'Being a GP', including UUC/OOHs. This will be guided by reviewing and discussing the evidence selected in the 'UUC Evidence for ARCP' document, as described above. From August 2020 there will no longer be a requirement for the Educational Supervisor to sign a statement that the trainee "has met [their] out of hours session requirements"¹

If an Educational Supervisor doesn't themselves work in the UUC setting/OOHs, how will they be confident that their trainee is capable?

They should base their judgement on the evidence chosen by the trainee to demonstrate their capability. Each UUC session record form should contain summary comments from the clinical supervisor for that session and confirmation of the level of supervision required. 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 supervisor(s) working with the trainee or seek further advice from the GP School via their local TPD team.

1. 'Urgent and Unscheduled Care – Trainee and ES Guidance', [WBPA section of RCGP website](#)

[Adapted from national DOOHLs and HEE Severn FAQs by Olie Morris, HEE Wessex OOH lead, July 2019. Updated to reflect new RCGP Curriculum in November 2019. For further queries, please see linked documents above. If these do not resolve the issue then please email omorris@doctors.org.uk]