ICGP Policy on Out of Hours experience for GP Registrars

Adopted by the Postgraduate Training Committee – May 2017

Updated PGTC September 2019.

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Consultation Process

The draft report prepared by the NCCT Task Group was circulated to all stakeholders including Trainees, Trainers, Programme Directors and Steering Committees for feedback. The report was then submitted and adopted by:

- The National Co-ordinating Committee for Training – April 2017
- The Postgraduate Training Committee – May 2017
- Document was reviewed by NCCT September 2019 and updated by PGTC September 2019

Index

Out of Hours experience for GP Registrars.

Aim:

That GP Registrars (GPRs) gain sufficient and appropriate out of hours (OOH) experience to be able to safely practise in this respect, independently, when they leave training programmes. This experience should be gained without unreasonable stress being placed on the registrar.

Objective:

To produce a document that will enable GPRs and GP training programmes to meet the aim.

Background:

The Medical Council, the regulatory body for medicine, expects the ICGP, the training overseeing body, to ensure that GPR experiences in all aspects of training, including OOH, do not vary substantially from site to site.

Some GPRs have expressed concerns about some of their OOH duties exceeding what is allowable under the NCHD contract and working time directives. This seems particularly to be an issue in training practices not covered by a co-op.

On the other hand some involved in GP training have concerns that some GPRs do not gain sufficient and/or appropriate experience in OOH activities – some do not appear to reach the stated ICGP minimum of 120 hours per year, while the OOH experience that other GPRs gain in their training may not sufficiently mirror what they might be expected to meet as GP principals.

As per the Criteria for Postgraduate Training Programmes 2016, the current minimum OOH requirement for Certification of Satisfactory Completion of Specialist Training (CSCST) is 120 hours in each of the GP Registrar years ..

The Postgraduate Training Committee in 2012 issued guidelines on OOH requirements these are at Appendix 1.

There remains variation in how GPRs reach the minimum figure of 120 hours. Some GP Registrars only make this requirement by including e.g. Saturday morning surgeries, by counting half days when the surgery is closed and they are on duty, or by counting lunchtime and/or "shoulder" periods between when the surgery closes and a co-op opens, in the tallying of hours. Some GPRs count evening surgeries also, which are run by the practice or run in a rota fashion. Learning and therefore the time spent during the routine day, of a registrar does not count towards OOH.

In addition, some GPRs gain no OOH experience in house calls, visits to nursing homes or visits to patients in other places, e.g. garda stations, homeless situations.

There is variation in the OOH commitment of GP trainers, from 40 to more than 150 hours per year in co-ops, with a bigger variation in non co-op situations. A small number of trainers do no out of hours work apart from evening and/or Saturday morning surgeries, switching to a "deputising service" at a certain time, with which GPRs usually have no relationship.

It is recognised that, because of their inexperience in GP OOH work, such work may be particularly stressful for GPRs.

For all these reasons, it is desirable that agreed statements are made with regard to GPRs' OOH experience, to ensure that there is balance of exposure to OOH learning and that that this experience in general, mirrors what GPRs might experience as GP principals.

The PGTC in January 2017 recommended a move towards a competency based assessment of the OOH learning experience.

In the interim period, it was agreed that the 120 hours requirement will remain in place until this issue has been reviewed by the Accreditation Sub-Committee.

The PGTC wishes to outline the following general principles on OOH experience these are as follows:

General Principles:

1. The aim is to eliminate unreasonable stress in OOH for GPRs. NCHD contracts and working time directives should be adhered to.

2. Principles and regulations concerning GPR OOH training are the remit of training programmes, the ICGP and the employer of GPRs, the HSE. There should be consistency between programmes and training practices in the experiences in OOH that GPRs receive, in so far as that is reasonable.

3. OOH experience should not include lunchtime, "shoulder periods" between when a surgery closes and a co-op or other OOH arrangements start, or half days when a practice is closed.

4. An induction process in OOH is necessary at the start of each GPR attachment, to include details of documenting consultations, ambulance and hospital contacts, and times to be worked etc. This should be performed by the trainer.

   Specific times to be worked in OOH by the GPR can be altered with the agreement of both parties – flexibility is an important part of all GP work.

5. Supervision should always be available, either by a trainer or a nominated suitably qualified GP (on the general practice division of the specialist register of the Irish Medical Council) being physically with the GPR, or being available by telephone. Debriefing should routinely happen on the next working day or soon thereafter.

6. GPRs should not be required to do day time, evening and night time (overnight) duty, followed by day time work again, this is not the norm for GPs and this does not fit with contracts or working time directives.

7. It is desirable that registrars gain most, if not all their OOH experience with their training practices, i.e. within their training practices' usual OOH arrangements. Any particular arrangements that some programmes have, in order for GPRs to get some of their OOH experience in other ways e.g. mobile health units, should be subject to scrutiny by programmes' steering committees, to ensure such training remains appropriate.

8. A log should be maintained by the Trainee of the number and site of patient contacts in the GPR's learning record, for each OOH period worked, so that a judgement can be made by training programme staff as to the appropriateness of the experience. The form attached at appendix II should be utilised in this regard.

9. It is in the interest of GPRs' OOH professional development that they progress from directly supervised to indirectly supervised (in this case telephone contact) training. This transition should be done at an agreed time between trainers and GPR, depending on the confidence of both parties in the GPR's readiness.

10. The concept of being "second on call", meaning being in reserve for OOH duties in case things get busy, is of no educational value to GPRs, they should not be asked to do this.

11. The steering committee or equivalent governance structure of each programme will be the adjudicator in matters of dispute as regards OOH experience of GPRs.

12. Trainers should be acutely aware that OOH experience for GPRs is usually more stressful than for trainers, due to lack of experience. Trainers **may** give time off in lieu for GPRs, where their OOH experience seems excessively stressful for whatever reason. This should **not be given on a routine basis.**

13. GPRs should routinely participate in practice arrangements regarding OOH experiences which do not "count" in the addition of hours e.g. carrying the phone at lunchtime, "shoulder" periods etc. It is reasonable to expect GPRs to do some of this work, as it represents a different kind of OOH experience, with which they will need to be familiar as GP principals. Goodwill is essential in this regard, with both parties.

14. Trainers, GPRs and schemes' steering committees should ensure the OOH arrangements agreed in this paper become normal practice.
15. This document will be subject to yearly review.

Specific principles to govern co-op situations

1. The concept of busy / less busy co-op work is hard to define. Because of this, there will be no attempt to differentiate between the busyness of different co-ops. GPRs should only see patients at a pace at which they are comfortable. They are learning and in training.

2. In some co-ops, in order to complete the minimum requirements per year, GPRs will need to work in most, or even all, their trainers' allocated shifts. In this situation they will need to spend anything from some to all of this time in the company of their trainer. In such a situation the GPR and trainer should see patients together, or alternately, on the same shift. In these situations learning can be swift and rich.

3. In some co-ops, even if the GPR works in all of their trainers' co-op shifts, they will not attain the minimum requirement per year. The additional hours can be made up by the GPR working other shifts in the co-op, supervised by their trainer or another GP principal, with the agreement of all concerned.

4. Any arrangements between training practices / programmes and individual co-ops will have to be consistent with these principles.

5. It is highly desirable, within co-ops, for all GPRs to gain enough experience outside the base, e.g. by being on duty for visits to patients' houses, nursing homes, garda stations, visiting the homeless etc., so that if faced with these responsibilities after graduating, they will have an acceptable proficiency in them.

Specific principles to govern non-co-op rota situations

a) Rota Situations:

1. While it is recognised that these situations are uncommon (around 5% of GPRs get their OOH experience in this way), it is important to make some statements about them.

2. GPRs on rotas, compared to those working in co-ops, will spend a greater amount of time not having any patient contact, but being available. The learning yield from time spent should be reviewed by the Trainee and Trainer in association with the Programme Directing Team.

3. The purpose of GPRs doing out of hours work is to learn from their experiences, in order to prepare them for life after training. It is important that arrangements in this respect maximise learning opportunities, and that GPRs do not find themselves being on duty for long periods, while learning little.

4. In this respect it is important that a balanced approach is taken, thus ensuring applicants to GP training will be attracted equally to programmes where these OOH arrangements exist.

5. There is also a service commitment (as there has been throughout GP trainees' training), which must be factored in, when considering appropriate arrangements.

6. As a consequence of 3, it is thought that all GPRs who get their OOH experience outside co-ops should still routinely follow their training practice arrangements, but with a ceiling applied.

7. It seems reasonable that all GPRs should experience the following:

   a) A maximum of four weekends per year (which should be no longer than a 24 hour shift). If this 24 hours includes Sunday night, the GPR should not have to work on a Monday.
   b) A maximum of one bank holiday per year (24 hours).
   c) As regards weekdays (Monday – Friday) – no more than one day per fortnight and this should not be overnight, in order to comply with the European Working Time Directive.

   Leave will not impact on the experiences detailed above.

8. If there is a OOH period within a training practice rota arrangement, that is recognised as presenting a large number of learning experiences, then a GPR's OOH arrangements can be skewed to gain from this, while adhering to the "ceiling" outlined in 7.

b) Other non co-op situations:

In a small number of training practices, which are not members of co-ops, the only OOH experience that GPRs gain is in evening or Saturday morning surgeries.

In such situations GPRs must, as with co-ops, gain at least sufficient OOH experience outside surgeries, to ensure they become proficient in visiting nursing homes, garda stations, patients in their homes etc. Trainers must in these situations to arrange such experience for their GPRs, and to ensure appropriate supervision is in place. Steering committees must monitor these arrangements.

Lead in time:

It is deemed reasonable that one year from the date of the document becoming "live" (May 2017) is a sufficient lead in time for the new guidelines to be fully effective.

Appendix 1

Out of Hours Learning

Summary conclusions regarding Out of Hours (OOH) Learning, arising from Post Graduate Training Committee (PGTC) meeting 1/5/2012:

1) Time:

- 120 hours of GP training activity is confirmed by majority as a minimum amount of time a trainee should spend, during the Registrar years, in OOH activity.

- Learning and therefore the time spent during the routine day, of a registrar, does not count towards OOH. Examples such as onsite 'holding the phone' at lunchtime or dealing with house-calls are not included.

- Working on-site after 17:00 is outside of routine working hours with regard to HSE contract, but is not recognised towards OOH learning time

- Guidance regarding OOH time for a trainee; as per the Criteria Document 5.6.6 stands. (see extract below)

- Maximum hours: a trainee must meet their minimum requirements. If their Trainer's OOH commitment exceeds this, they may be expected to spend more time in OOH but no greater than that of their Trainer.

- "active Hours": further discussion is required as regards this entity for those Trainees that are involved in OOH outside of the Co-operative structure. Interpretation of European Working Time Directive identifies active time as that spent in contact with patients and in transit to and from patients and the recognised on-call base. The learning yield from time spent should be reviewed by Trainee and Trainer in association with the Programme Directing Team.

2) Breadth of Experience:

- The merits of offering each trainee exposure to a variety of OOH arrangements is recognised by PGTC and encouraged. It is desirable that each trainee be afforded the opportunity to work at some point in a formal co-operative OOH facility

- This can be organised within but also among GP training programmes under the guidance of the Programme Director.

- Each trainee should feel confident and competent to work in any recognised OOH arrangement in Republic of Ireland. The determination of their learning needs should take account of this.

- Any activities that may or may not be classified as OOH should be clarified with the Programme Director. If the Director feels a particular activity qualifies as OOH time, then this should be submitted for discussion to the National Director of GP Training. The outcome of any necessary consultation with Assessors or other relevant committees or members of the PGTC will then be co-ordinated by the National Director and recorded centrally. Thus additional OOH activities can be collated and shared with GP trainees, Trainers, Programme Directing team members to preserve continuity nationally. PGTC will have the final decision making on all such issues

Extract from Criteria for Postgraduate Training Programmes Document 2009:

5.6.*6* *The Trainer must make provision for the Trainee/Registrar to have experience of out of hours work under the supervision of a nominated Trainer. This out of hours experience should be not less than 120 hours per annum during each of the years spent in general practice and it must adhere to current European Working Time Directives. In the case of GP rotas/co-operatives, Trainee/Registrars on call require designated back-up cover by a Trainer, or a nominated principal, at all times. Registrars should not work alongside each other in a co-op situation without on-site supervision by a nominated Principal.*

May 2012.

Appendix II

SAMPLE OUT OF HOURS LOG Year _____

(an absolute minimum of 120 hours per year out of hours work is one of the CSCT elements)

Fill this in each time you complete a session of out of hours work.
Have your trainer sign it at your debriefing session.

Date of call	Co-op or Rota C / R	Number of hours on call	No. of patients seen in surgery	Number of Domiciliary Visits	Trainers Signature	Date

OUT OF HOURS LOG

Fill this in each time you complete a session of out of hours work.
Have your trainer sign it at your debriefing session.

Date of call	Co-op or Rota C / R	Number of hours on call	No. of patients seen in surgery	Number of Domiciliary Visits	Trainers Signature	Date
Total number of hours on call Year						