



# Care of Acutely Ill People

*One in a series of curriculum statements produced by the Royal College of General Practitioners:*

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# Acknowledgements

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## Key messages

General practitioners must:

- Be able to work effectively in teams and coordinate care
- Be able to prioritise problems and establish a differential diagnosis
- Make the patient's safety a priority
- Consider the appropriateness of interventions according to patients' wishes, the severity of the illness and any chronic or co-morbid diseases
- Be able to make mental state assessments and ensure patient safety
- Accept responsibility for action, at the same time recognising any need for involvement of more experienced personnel
- Keep their resuscitation skills up to date – this would normally involve a yearly certified resuscitation course
- Act calmly in emergency situations and follow agreed protocols.

# Introduction

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## Rationale for this curriculum statement

Acutely ill people of all ages present unpredictably, interrupting work and routines, and requiring an urgent response. They may be seen in familiar contexts such as the surgery, on home visits and in out-of-hours centres; the general practitioner (GP) may be asked to give assistance in unfamiliar and unsupported surroundings such as at the roadside.

While the *new* GP contract (nGMS)<sup>1</sup> defined the normal working day for GPs to be between 08.00 and 18.30 on all weekdays except public holidays, many GPs will continue to be involved in the provision of care outside those hours. The Out of Hours Service is defined as that work undertaken between 18.30–08.00 and all day at weekends and on public holidays. The sort of care provided out of hours, however, does not just refer to the management of emergencies, but also to the experience of dealing with patient contacts in a different quantity and context from the normal working day. Emergency care, therefore, is a feature of both in-hours and out-of-hours work, but there are particular features of the out-of-hours period, such as isolation, the relative lack of supporting services and the need for proper self-care, that require a specific educational focus.

The Committee of Postgraduate General Practice Education Directors (COGPED) set out its position that specialty registrars (GP) should continue to obtain experience in out-of-hours care irrespective of whether their trainer had opted out of providing out-of-hours care in their guidance on *Out of Hours (OOH) Training for GP Registrars in 2004* (Appendix 1).<sup>2</sup> The publication followed a period of consultation with stakeholders including patients and concluded that the generalist role of the GP should be maintained and that newly accredited GPs should be expected to have demonstrated their ability to perform competently in out-of-hours primary care. Based on the work of Mclean and Houghton,<sup>3</sup> they defined six core competences, which are incorporated into this curriculum statement.

Although emergency care support (e.g. through paramedics) is increasingly available across the UK, it is not universal and there may be significant delays before help arrives. Nevertheless, the public, through the General Medical Council and other legal frameworks, expects a level of expertise in its medical practitioners that includes the ability to manage acute situations despite variable access to equipment and support.

GPs should be able to recognise that a person is acutely ill and take timely and appropriate action. These situations are relatively infrequent, making it difficult for the doctor to maintain the appropriate skills, some of which may be complex. Realisation of this fact along with periodic emergency care training in realistic situations will help doctors to maintain an effective response.

## UK health priorities

Some 10–15% of patients consult a GP for serious illness.<sup>4</sup> A proportion of these will be acutely ill. Recent changes to educational frameworks sponsored by the Department of Health have emphasised the care of acutely ill patients.<sup>5</sup> The importance of early coordinated intervention is stressed in the English National Service Framework (NSF) on *Coronary Heart Disease*.<sup>6</sup> The role of primary care is discussed in *Improving the Management of Patients with Mental Ill Health in Emergency Settings*.<sup>7</sup> Strategies have been developed in all of the United Kingdom's home countries.

## Learning Outcomes

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The following learning objectives relate specifically to the care of acutely ill people and include the care of patients in ‘out of hours’ primary care. Because of the nature of acute illness presenting to the GP, this curriculum statement should be read in conjunction with the other RCGP curriculum statements in the series. The full range of generic competences is described in the *core* RCGP curriculum statement 1, *Being a General Practitioner*.

The effective management of an acutely ill person will include recognition and immediate management. A wide range of (primarily) medical knowledge and skills will support these two areas. Of equal importance, however, in the management of these patients, is organisation, teamwork, communication and situational awareness. Poor performance in these four attributes predicts a poor outcome in the management of emergencies.<sup>i</sup>

The learning objectives for the specialty registrar (GP) reflect this. The most common immediately life-threatening emergencies are covered. The specialty registrar should be aware of how a response may change across a range of situations.

When selected to a general practice training programme in the United Kingdom, specialty registrars will have demonstrated that they had acquired the acute care competences described in *The Curriculum for the Foundation Years in Postgraduate Education and Training* published by the Departments of Health of the United Kingdom in 2005.<sup>8</sup> A list of the acute care competences described in the Foundation Curriculum can be found in Appendix 2; it is assumed, therefore, that specialty registrars will have acquired those competences in addition to those in this curriculum statement.

In order to demonstrate the core competences in the area of acutely ill people, by the end of their general practice training programme, specialty registrars should have acquired knowledge, skills and appropriate attitudes in the following areas.

### Primary care management

- Recognise and evaluate acutely ill patients.
- Describe how the presentation may be changed by age and other factors such as gender, ethnicity, pregnancy and previous health.
- Recognise death.
- Demonstrate an ability to make complex ethical decisions demonstrating sensitivity to a patient’s wishes in the planning of care.
- Provide clear leadership, demonstrating an understanding of the team approach to care of the acutely ill and the roles of the practice staff in managing patients and relatives.
- Coordinate care with other professionals in primary care and with other specialists.
- Take responsibility for a decision to admit an acutely ill person and not be unduly influenced by others, such as secondary care doctors who have not assessed the patient.

<sup>i</sup> up to 70–80% of errors are due to poor performance in these areas

## **The GP must be competent to provide out of hours care by demonstrating:**

- Ability to manage common medical, surgical and psychiatric emergencies in the out-of-hours setting
- Understanding of the organisational aspects of NHS out-of-hours care
- Ability to make appropriate referrals to hospitals and other professionals in the out-of-hours setting
- Appropriate communication skills required for out-of-hours care
- Individual personal time and stress management
- Maintenance of personal security and awareness and management of the security risks to others.

## **Person-centred care**

- Describe ways in which the acute illness itself and the anxiety caused by it can impair communication between doctor and patient, and make the patient's safety a priority.
- Demonstrate a person-centred approach, respecting patients' autonomy whilst recognising that acutely ill patients often have a diminished capacity for autonomy.
- Describe the challenges of maintaining continuity of care in acute illness and taking steps to minimise this by making suitable handover and follow-up arrangements.
- Describe the needs of carers involved at the time of the acutely ill person's presentation.
- Demonstrate an awareness of any conflict regarding management that may exist between patients and their relatives, and act in the best interests of the patient.

## **Specific problem-solving skills**

- Describe differential diagnoses for each presenting symptom.
- Decide whether urgent action is necessary, thus protecting patients with non-urgent and self-limiting problems from the potentially detrimental consequences of being over-investigated, over-treated or deprived of their liberty.
- Demonstrate an ability to deal sensitively and in line with professional codes of practice with people who may have a serious diagnosis and refuse admission.
- Demonstrate an ability to use telephone triage:
  - ◆ to decide to use ambulance where speed of referral to secondary care or paramedic intervention is paramount
  - ◆ to make appropriate arrangements to see the patient
  - ◆ to give advice where appropriate.
- Demonstrate the use of time as a tool and to use iterative review and safety-netting as appropriate.

## **A comprehensive approach**

- Recognise that an acute illness may be an acute exacerbation of a chronic disease.
- Describe the increased risk of acute events in patients with chronic and co-morbid disease.
- Identify co-morbid diseases.
- Describe the modifying effect of chronic or co-morbid disease and its treatment on the presentation of acute illness.
- Recognise patients who are likely to need acute care and offer them advice on prevention, effective self-management and when and who to call for help.

## **Community orientation**

- Demonstrate an ability to use knowledge of patient and family, and the availability of specialist community

resources, to decide whether a patient should be referred for acute care or less acute assessment or rehabilitation, thus using resources appropriately.

- Deal with situational crises and manipulative patients, avoiding the inappropriate use of healthcare resources.

## A holistic approach

- Demonstrate an awareness of the important technical and pastoral support that a GP needs to provide to patients and carers at times of crisis or bereavement including certification of illness or death.
- Demonstrate an awareness of cultural and other factors that might affect patient management.

## Contextual aspects

- Demonstrate an awareness of legal frameworks affecting acute healthcare provision especially regarding compulsory admission and treatment.
- Demonstrate an awareness of the tensions between acute and routine care and impact of workload on the care given to the individual patients.
- Demonstrate an awareness of the impact of the doctor's working environment and resources on the care provided.
- Demonstrate an understanding of the local arrangements for the provision of out-of-hours care.

## Attitudinal aspects

- Demonstrate an awareness of their personal values and attitudes to ensure that they do not influence their professional decisions or the equality of patients' access to acute care.
- Identify patients for whom resuscitation or intensive care might be inappropriate and take advice from carers and colleagues.
- Demonstrate a balanced view of benefits and harms of medical treatment.
- Demonstrate an awareness of the emotional and stressful aspects of providing acute care and an awareness that they need to have strategies for dealing with personal stress to ensure that it does not impair the provision of care to patients.

## Scientific aspects

- Describe how to use decision support to make their interventions evidence-based, e.g. Cochrane, PRODIGY, etc.
- Demonstrate an understanding of written protocols that are available from national bodies and how these may be adapted to unusual circumstances.
- Evaluate their performance in regard to the care of the acutely ill person; including an ability to conduct significant event analyses and take appropriate action.

## Psychomotor skills

- Performing and interpreting an electrocardiogram.
- Cardiopulmonary resuscitation of children and adults including use of a defibrillator.
- Controlling a haemorrhage and suturing a wound.
- Passing a urinary catheter.
- Using a nebuliser.

## The knowledge base

### Symptoms

- Cardiovascular – chest pain, haemorrhage, shock.
- Respiratory – wheeze, breathlessness, stridor, choking.
- Central nervous system – convulsions, reduced conscious level, confusion.
- Mental health – threatened self-harm, delusional states, violent patients.
- Severe pain.

### Common and/or important conditions

- Shock (including no cardiac output), acute coronary syndromes, haemorrhage (revealed or concealed), ischaemia, pulmonary embolus, asthma.
- Dangerous diagnoses (see Appendix 3).
- Common problems that may be expected with certain practice activities: anaphylaxis after immunisation, local anaesthetic toxicity and vaso-vagal attacks with, for example, minor surgery or intra-uterine contraceptive device insertion.
- Parasuicide and suicide attempts.

### Investigation

- Blood glucose.
- Other investigations are rare in primary care because acutely ill patients needing investigation are usually referred to secondary care.

### Treatment

- Pre-hospital management of convulsions and acute dyspnoea.

### Emergency care

- The 'ABC' principles in initial management.
- Appreciate the response time required in order to optimise the outcome.
- Understand the organisational aspects of NHS out-of-hours care.
- Understand the importance of maintaining personal security and awareness and management of the security risks to others.

### Resources

- Appropriate use of emergency services, including logistics of how to obtain an ambulance/paramedic crew.
- Familiarity with available equipment in own car/bag and that carried by emergency services.
- Selection and maintenance of appropriate equipment and un-expired drugs that should be carried by GPs.
- Being able to organise and lead a response when required, which may include participation by staff, members of the public or qualified responders.
- Knowledge of training required for practice staff and others as a team in the appropriate responses to an acutely ill person.

### Prevention

- Advice to patients on prevention, e.g. with a patient with known heart disease, advice on how to manage ischaemic pain including use of glyceryl trinitrate (GTN), aspirin and appropriate first-line use of paramedic ambulance.

## Further Reading

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### Examples of relevant texts and resources

BRITISH MEDICAL ASSOCIATION AND THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN. *The British National Formulary* London: Pharmaceutical Press, updated regularly

BRITISH MEDICAL ASSOCIATION, ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN, ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH, THE NEONATAL AND PAEDIATRIC PHARMACISTS GROUP. *BNF for Children* London: BMA, 2005

COMMITTEE OF GENERAL PRACTICE EDUCATION DIRECTORS. *Out of Hours (OOH) Training for GP Specialty Registrars* London: COGPEd, 2007

HAMPTON JR. *The ECG Made Easy (6th edn)* London: Churchill Livingstone, 2003

JONES R, BRITTEN N, CULPEPPER L, *et al.* (eds). *Oxford Textbook of Primary Medical Care* Oxford: Oxford University Press, 2004

MORTON RJ AND PHILLIPS BM. *Accidents and Emergencies in Children (Oxford Handbooks in Emergency Medicine)* Oxford: Oxford University Press, 1996

SKINNER D AND DRISCOLL P. *ABC of Major Trauma (4th edn)* Oxford: Blackwell Publishing & BMJ Books, 2006

SPRIGINGS DC AND CHAMBERS JB. *Acute Medicine: a practical guide to the management of medical emergencies* Oxford: Oxford University Press, 2001

WARRELL D, COX TM, FIRTH JD, BENZ EJ (eds). *Oxford Textbook of Medicine (4th edn)* Oxford: Oxford University Press, 2004

WYATT JP, ILLINGWORTH RN, CLANCY MJ, MUNRO P, ROBERTSON CE. *Oxford Handbook of Accident and Emergency Medicine* Oxford: Oxford University Press, 2005

### Web resources

#### National Library for Health and Public Health Specialist Library

The aim of the National Library for Health (NLH) is to provide clinicians with access to the best current know-how and knowledge to support health care-related decisions. Patients, carers and the public are also welcome to use the site, because the NLH is open to all. The ultimate aim is for the Library to be a resource for the widest range of people both directly and indirectly.

The main priority for the NLH is to help the NHS achieve its objectives. However, it is also aimed at those healthcare professionals who are working in the private sector where common standards should apply. For example, the National Screening Committee is not only an NHS advisory committee, but its mission is also to promote the health of the whole population and its recommendations are relevant to the private sector. Part of the content of the NLH such as Clinical Evidence and Cochrane Library is licensed from commercial providers. There are two other groups of health and care professionals whose needs will also be met by the NLH – those working in public health and in social care. The Public Health Specialist Library is intended for all public health professionals, many of whom work in local government. It has been developed by the Health Development Agency.

[www.library.nhs.uk](http://www.library.nhs.uk)

[www.library.nhs.uk/publichealth/](http://www.library.nhs.uk/publichealth/)

# Promoting Learning about Acutely Ill People

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## Work-based learning – in primary care

Specialty registrars must gain experience in emergency care, which is a feature of both in-hours and out-of-hours work. Because there are particular features of the out-of-hours period that require a specific educational focus, such as isolation, the relative lack of supporting services and the need for proper self-care, it is important that they spend time in the out-of-hours primary care work environment.

The specialty registrar should work in the local out-of-hours service, under supervision, in order to gain competence and confidence in delivery of these services. They should be supported by their GP trainer, who should make arrangements, as part of their initial educational planning with the specialty registrar, for their sessions with the out-of-hours service provider. This should follow an evaluation of the specialty registrar's level of knowledge, skill and learning needs.

There are a number of organisations involved in the delivery of primary care out-of-hours services, including GP co-ops, commercial deputising services, NHS Direct, NHS 24, nurse triage, minor injury centres, primary care walk-in centres, accident and emergency departments and some remaining individual practices and practitioners. The model of service provided is varied, but there will be a need for partnership and collaboration between all agencies at the local level. Exposure to a variety of community-based emergency and out-of-hours models should be provided for specialty registrars as part of their training programme.

## Work-based learning – in secondary care

The hospital environment is ideal for seeing concentrated groups of acutely ill children and adults. All doctors entering general practice training programmes will have acquired the competences in acute care laid down in the *Curriculum for Foundation Programmes*.

Many doctors will have acquired additional competences during their hospital training before entering GP training. Some GP training programmes will contain placements of varying length in acute medicine and in accident and emergency departments that are ideal environments for learning about acutely ill people and their management. While cardiopulmonary resuscitation skills will have been taught in the Foundation Programme or equivalent, it is important to maintain those skills once in practice. Hospital resuscitation departments are excellent learning resources for keeping up to date with those skills.

## Non-work-based learning

All specialty registrars should have access to cardiopulmonary resuscitation courses and learning resources to help them address their learning needs.

## Learning with other healthcare professionals

Teamwork is essential for the effective management of acutely ill patients in primary and secondary care. In primary care, it is vital that all members of the primary healthcare team understand their roles in managing acutely ill patients and contribute to the development of practice guidelines.

Acute events are an important source of material for significant event analyses and team members should be encouraged to participate in these and learn from them at both the individual and team level. Working in the out-of-hours environment will help the specialty registrar gain valuable experience of working and learning in multiprofessional settings, which will include GPs, nurses, paramedics, accident and emergency staff, etc.

# Appendix 1

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## COGPED position paper on out-of-hours training for GP specialty registrars, 2007

### Introduction

This revised document updates the position paper issued by COGPED in December 2004, which provided guidance on the way in which general practice specialty registrars (GPStRs) gain experience in out-of-hours (OOH) care. This update reflects the changes in regulation of GP training, the development of the GP curriculum, the new membership examination of the Royal College of General Practitioners (MRCGP), and GPStR portfolio, the increasing time spent in the general practice component of training programmes and the differing structures and pathways in OOH and unscheduled care.

COGPED has consulted with the main stakeholders in this process, including the General Practitioners Committee (GPC), the RCGP, provider and commissioning organisations, to seek and incorporate their views throughout the development of this paper.

In the months and years ahead COGPED will continue to liaise with representatives from the GPC, the registrar subcommittee of the GPC, the RCGP, providers of OOH services, NHS Employers, Primary Care Organisations (PCOs) and others to review and consider issues of importance in the future for OOH training of GPStRs in the light of experience and further development of the OOH services

### Background

Following the introduction of the new General Medical Services (GMS) contract (nGMS) GPs were able to transfer their responsibility for OOH work. From 31 December 2004 PCOs took full responsibility for ensuring effective OOH provision, except in very exceptional circumstances. A substantial majority of doctors no longer undertake OOH work. However, many GP trainers and their colleagues from training practices continue to provide clinical supervision OOH, and additionally other doctors working for OOH providers have received training to fulfil this role.

The strong view of all the organisations contributing to this document remains that the generalist role of the GP should be maintained and that newly accredited GPs will be expected to have demonstrated their ability to perform competently in OOH primary care.

It is the responsibility of the postgraduate deaneries to ensure that GP specialty training provides the experience and assessment of generalist competences, and for the competent authority to be satisfied that all generalist competences have been successfully assessed in order for a Certificate of Completion of Training (CCT) to be issued.

The way in which GMS are delivered continues to evolve. The development of emergency care pathways and services for both OOH and unscheduled care provides a variety of learning opportunities and environments for GPStRs to gain experience and competence in the care of acutely ill people.

Whilst further restrictions on working hours under the European Working Time Directive (EWTD) will come into effect in 2009, it is unlikely that this will impact significantly on the training for GPStRs.

The ideas and competences presented in this paper were initially espoused by McLean and Houghton and sub-

sequently incorporated into the GP curriculum. These are fully endorsed by COGPED. 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**

### *OOH service*

The nGMS has defined the normal working day for general practice to be between 08.00 and 18.30 on all weekdays except public holidays. 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 paper recognises that the processes for providing general practice and primary care, both during the normal working day and outside, are continuing to evolve and these processes provide different models of working, requiring different knowledge and competences by GPs. The ability to undertake efficient yet safe telephone triage is one example.

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 from the normal working day. In other words, emergency care is a feature of both in-hours and OOH work but there are particular features of the OOH period, such as isolation, the relative lack of supporting services and the need for proper self-care, which require a specific educational focus.

### *Educational supervision of the GPStR*

This is usually undertaken by the GP trainer who undertakes overall supervision of the individual's learning experiences, manages the process, commissions learning opportunities and is responsible for the delivery of formative assessment, Workplace-Based Assessment and preparing the GPStR for the other elements of the MRCGP examination. Others may provide the educational supervisor with data to inform these processes.

### *Clinical supervision*

This 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 GPStR's learning and experience. In some areas the clinical supervisor is termed an associate or assistant trainer (and in secondary care a consultant trainer).

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, observe, assess and feed back to learners. The clinical supervisor could be a GP who is beginning the process of becoming a GP trainer, or one who has recently retired, or a suitable GP who has had appropriate training or a suitable GP who has had previous educational experience or who has received specific training as a supervisor. When it comes to the delivery of training in specific skills in particular, clinical supervisors need not necessarily always be GPs. However, with the overall context of the GPStR's training firmly in mind, postgraduate deaneries will want to ensure that experienced GPs retain an appropriate and significant input into OOH training for GPStRs. Those doctors already approved as GP trainers by their postgraduate deaneries will be automatically deemed qualified to supervise GPStRs.

Postgraduate deaneries and some OOH providers have delivered educational packages or courses to enable GPs to develop the skills required for effective clinical supervision. There will be an ongoing need for such interventions to maintain the pool of clinical supervisors. Deaneries as well as clarifying the requirements of the job for the OOH provider organisation have a quality assurance function and should monitor the competences of the clinical supervisors for this role.

Formal lines of communication between GP trainers, OOH clinical supervisors and others involved in clinical skills training are necessary to deliver continuity of information and feedback to ensure the validity of the trainer's assessment of each GPStR.

### *The assessment system*

The formal assessment of the GPStR remains the responsibility of the trainer, supported by evidence supplied by the GPStR, documented systematically in their portfolio as well as feedback from the clinical supervisor. Such evidence should include their own reflections on clinical encounters, professional conversations with their clinical supervisor or other naturally occurring evidence. GPStRs may choose to use an OOH encounter to submit for formal case-based discussion.

### **The RCGP's view**

The RCGP has reiterated the previous Joint Committee for Postgraduate Training in General Practice (JCPT-GP) opinion that CCTs license the holder to work in any capacity, unsupervised, in UK general practice and that GP training programmes 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 College is that GPStRs should continue to be trained in OOH work, as this remains a core part of the GP's role.

The GP trainer should evaluate the portfolio evidence and formative feedback from clinical supervisors in the OOH organisation, validating competences when satisfied that these have been achieved, and confirming that the GPStR has undertaken the required level of exposure commensurate with the length of the GP component of their training programme.

In some instances the demonstration of some of the skills and competences needed for OOH care, for example those exhibited in undertaking telephone triage, could also take place during the normal working day, and could be validated by the GP trainer from personal assessment.

### **Expectation of GP postgraduate deaneries**

The aim of the training is to enable GPStRs to learn, develop, practise and maintain their competences in OOH working

The postgraduate deaneries will expect all GP registrars to obtain the necessary OOH experience and training to achieve the competences both as described in the GP curriculum and required for the MRCGP examination. Where the practice has not transferred responsibility for OOH services, responsibility for providing the experience and supervision of OOH training for the GPStR remains with that practice. However, where training practices have no longer responsibility for OOH services, delegated arrangements for supervision should be made with the OOH service providers, with locally agreed criteria with the Directors of Postgraduate GP Education for training and the appointment of clinical supervisors. An approved trainer providing services for an OOH provider could supervise his or her own and/or other GPStRs.

The evidence gathered by the GPStR in their portfolio and competences achieved should be formally reviewed by their educational supervisor on a 6-monthly basis, and form part of the Annual Review of Competence Progression process.

As an indicative benchmark of the time required to achieve, and maintain, the competences, it is likely that at least one session, at a suitable clinical intensity, per month will be necessary in an appropriate and negotiated combination of learning environments. In some instances, the GP trainer, in agreement with the GPStR, may indicate that additional time in this experience is required so that the competences can be signed off. However, as training becomes increasingly focused on the acquisition of competences, arbitrary definitions of time as markers of completion of any part of training will become less reliable and relevant, although it is likely that a defined period of training in OOH will be retained for the foreseeable future.

GPStRs will be responsible for keeping completed their portfolio of experience and reflection on all sessions that they attend as evidence of their competences in OOH training.

### **The key OOH competences and their assessment**

GPStRs should demonstrate competence in the provision of OOH care. The overall responsibility for assessment of competence is with the GP trainer but GPStRs have a duty to keep the record of their experience, reflection and feedback in the competence domains.

The six generic competences, embedded within the RCGP curriculum statement on *Care of Acutely Ill People*,

are defined as the:

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

### **Provision of OOH services**

There is a number of organisations involved in the delivery of OOH and unscheduled care services, including GP cooperatives, commercial services, NHS Direct, NHS 24, nurse triage, urgent care centres, minor injury centres, primary care walk-in centres, GPs embedded within A&E departments and some remaining individual practices and practitioners. The model of service provided is of necessity varied; however, there is a need for partnership and collaboration between all agencies at the local level. This will continue to be driven and shaped by national quality standards processes. It is expected that services will follow care pathways and patient journey/ies, delivered in multi-professional settings, which will include GPs, nurses, paramedics, A&E staff, etc.

The various organisations provide a range of learning environments for GPStRs to gain experience and achieve competences, and should be expected and able to offer training for GPStRs.

### **The role of PCOs**

PCOs are required to secure OOH services, either by commissioning from appropriate organisations or consortia of organisations or, although less frequently following recent reorganisation, by direct provision. The PCOs 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 the element of the OOH service best provided by GPs is that derived from their training and experience as clinical generalists it is inevitable that future developments will occur and PCOs might consider the development of practitioners with special interests, including GPwSIs, 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 should ensure that the OOH service includes the provision of appropriate training for GPs in training. This was clarified in explicit guidance from the Department of Health to Chief Executives of PCOs and SHAs:

*PCTs will need to discuss with their local GP Postgraduate Deanery the OOH training opportunities that are needed for GPRs and take steps to ensure they can be delivered through the new arrangements they are putting in place to provide OOH services. Arrangements need to be in place as soon as training practices opt-out. Advice and help will be provided by Deaneries.*

The PCOs are encouraged to work closely with the postgraduate deaneries in establishing clinical and educational governance standards for training in OOH and assuring the quality of training in the OOH organisations.

### **The role of postgraduate deaneries**

When commissioning services, PCOs must 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 GPStRs. They will also need to ensure that the provider complies with the quality assurance processes of the GP training programme delivered by each deanery. Appendix 1 to this paper provides guidance on standards for clinical and educational governance for training in OOH.

The deanery will need to work with PCOs and providers to develop mechanisms to ensure that suitable quality training is available and that incentives are in place to encourage and support the provider in delivering and monitoring the training.

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

- The induction processes for the initial exposure of GPStRs training in the OOH setting

- The placement'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 mandatory that GPStRs maintain a portfolio of evidence of achieved competences and experience that will include their own reflection on clinical encounters, professional conversations with and feedback from clinical supervisors 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 postgraduate deaneries should provide programmes of training and skills development for them. The postgraduate deanery, in consultation with PCOs, may provide an ongoing development programme as part of professional development of clinical supervisors.

### Documenting OOH experience in the e-portfolio

GPStRs are asked to record each of their OOH sessions in the e-portfolio. The portfolio necessitates that each entry must be tagged before filing against, at least, one curriculum statement heading. Normally, in the case of an OOH session, this would be curriculum statement 7: *Care of Acutely Ill People*. The 'OOH session' learning log entry in the e-portfolio will prompt the GPStR with a number of set entry fields.

Clinical supervisors in OOH will complete a session feedback sheet (see Appendix 3), which the trainee must share with the trainer/educational supervisor as evidence of attendance.

All OOH sessions entered into the e-portfolio must be 'shared' with the educational supervisor. In particular circumstances, the supervisor may choose to 'validate' some of these as contributing to Workplace-Based Assessment. In this case, the entry will also be tagged against one of the 12 professional competence areas.

At the end of the training programme, the educational supervisor will search for all OOH sessions in the 'shared entries' in the e-portfolio (there exists a filter facility for this) ensuring that the requisite number have been completed. A declaration by the educational supervisor is then completed that will appear in the 'progress to CCT' section of the e-portfolio.

Failure to complete the requisite number of sessions will lead to a face-to-face deanery ARCP panel review.

### The role of GP trainers

GP trainers should make arrangements, as part of their initial educational planning with the GPStR, for their sessions with the OOH service. The trainer should consider the range of learning environments and opportunities locally that could deliver the required competences. Examples might include:

- Observation of NHS Direct
- Undertaking a course in telephone triage
- Updating CPR skills
- Participating in a shift with a team of paramedics
- Working with a GP in A&E
- Working in an OOH/walk-in centre
- Undertaking home visits for an OOH service.

Sessions should take place at a time agreed by the trainer and GPStR, following a clear evaluation of the GPR's level of skill and competence and their learning needs.

GP trainers should ensure that they debrief their GPR following their OOH session and assess not only the learning made, and further areas for development, but also the quality of the experience of the OOH session provided to the GPR.

GP trainers should regularly re-evaluate the level of supervision required by the GPStR and confirm this with the OOH provider. This will be dependent on the learning environment but the following structure is suggested:

- Direct supervision    the GPStR is supervised directly by the clinical supervisor and takes no [red] clinical responsibility
- Close supervision    the GPStR consults independently but with the clinical supervisor close [amber] at hand, e.g. in the same building.

Remote supervision the GPStR consults independently and remotely from the clinical [green] supervisor, who is available by telephone. An example of such a session would include a session 'in the car' supervised by another GP 'at base'.

GP trainers should, with the GPStR, review the portfolio on a regular basis and, taking into consideration other feedback from clinical supervisors, validate competences that have been achieved.

### **The responsibilities of GPStRs**

GPStRs are responsible for organising their sessions with OOH providers and should ensure that the required number of hours are achieved commensurate with the duration of the GP component of their training programme.

GPStRs should work in the OOH services, under supervision, in order to gain competence and confidence in the delivery of these services as a necessary part of becoming registered as GPs. The work of GPStRs in acquiring OOH competences will be as part of their normal contract of employment.

GPStRs are responsible for maintaining a portfolio of evidence. For OOH such evidence should include their own reflections on clinical encounters, professional conversations with their clinical supervisor, relevant courses or reading and other naturally occurring evidence. GPStRs may choose to use an OOH encounter to submit for formal case-based discussion

### **The role of the OOH service**

OOH providers will continue to require service input from doctors trained in, and certified for, general practice work. Each OOH provider is different and faces different challenges that impact on their ability to support and deliver OOH training. One example is the differences between urban and rural settings. It is essential that the deaneries and PCOs work with the providers to understand the challenges that face them all. The OOH provider is in a good position to provide a range of training opportunities and the deaneries must work with them to develop this resource.

OOH providers should offer appropriate induction to the service including use of the computer system and any specific in-house protocols. Clinical supervisors should be trained and provide the appropriate level of supervision for the GPStRs' level of experience, competence and confidence. OOH providers should also ensure that clinical supervisors have adequate time to debrief the GPStR. Appropriate documentary and oral feedback should be provided to both GPStR and GP trainer. In order to support this, the OOH clinical supervisors will receive appropriate training commissioned or provided by the postgraduate deaneries.

Whilst it is recognised that there are financial implications to OOH providers in delivering appropriate induction, training and clinical supervision, the more experienced GPStR can make a significant contribution to service at no cost to the provider. The OOH provider in delivering a high-quality learning experience has an opportunity of promoting participation in OOH work to the future workforce.

### **The role of the PCO**

In commissioning and quality assuring OOH services the PCO needs 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. These provisions should be reflected in service-level agreement with the provider. The PCOs are encouraged to consult with their GP postgraduate deaneries on standards for clinical and educational governance in OOH training.

### **Sessions in OOH**

The number of sessions worked by a GPStR to acquire the necessary competences will vary according to the number of patients covered but, in an urban setting, is likely to require an indicative benchmark of a 4 to 6 hour session every 4 weeks adjusted in other settings on a pro rata basis. There are variations in the population numbers and patient demographics served by any one OOH organisation, therefore each GP trainer and each postgraduate deanery should, focusing on the learning needs and acquisition of the required competences,

assess the provision of experience for each individual GPStR.

The educational value of experience gained in putting acquired competences into practice is recognised and the purpose of having an indicative number of sessions worked by GPStRs, even if they can demonstrate the competences, is that these sessions would increase the experience and exposure to different aspects of OOH work, particularly if they are undertaken in a variety of OOH settings. The negotiation of this is an issue for all involved organisations and GP trainers.

However, allowing for a necessary period of induction into general practice and primary care for GPStRs, the indicative benchmark of 12 sessions is likely to be necessary over a practice year. For GPStRs undertaking more than 12 months of their programme in a general practice setting the number of sessions should be increased pro rata, ensuring that competences that are achieved in the ST1 or ST2 years are maintained throughout training. It is expected that GPStRs in integrated training posts (ITPs) based in general practice should gain similar OOH experience to those colleagues undertaking traditional general practice placements. Those doctors who undertake training on a less than full-time basis should undertake the same number of sessions as their full-time colleagues but these would be attained over a longer timeframe.

The number of hours worked in any week and the rest achieved should also comply with the EWTD. In order to experience a broad range of clinical presentations it is desirable that GPStRs have experience of different models and shift times of the OOH service, and GP trainers should be aware that a GPStR will need to be properly rested both before and after an overnight session.

Whilst it is preferable that OOH training should be distributed throughout the time as a GPStR in order that competences acquired can be consistently demonstrated, local circumstances may dictate the need for 'block release' options to deliver the required OOH experience. However, there are serious potential disadvantages to this pattern that risk distorting the overall training experience and such an option should be regarded as the exception chosen for compelling reasons.

Exposure to a variety of community-based emergency and OOH models, as described earlier, should be provided for GPStRs as part of their training programme. This should be acknowledged and negotiated with the GP trainer, as part of the GPStR's PDP.

### **Medico-legal**

The GPStRs will be subject to the normal processes of clinical governance, General Medical Council (GMC) regulations and civil law. Their contract of employment is likely, for the foreseeable near future, to remain with the training practice or their GP trainer, but they may be supervised by a clinician who may not be from that practice or, on occasions, a professional who may not be a doctor but who will be an approved clinical supervisor in OOH care.

In the context of OOH training, medical indemnity organisations have indicated that a GPStR's standard membership will provide them with indemnity for the work they undertake as part of OOH training.

As the situation continues to evolve and as new models are developed there will be an ongoing need to keep the situation regarding medical indemnity under review and OOH providers will need to ensure that their insurance is adequate to cover their own liabilities in connection with the work done for them by GPStRs.

### **Review**

COGPED recognise that the process and structures for delivering OOH care will continue to evolve, thus the processes for delivering training for OOH care for GPStRs will require regular formal review and further consultation. To this end, the steering group of appropriate stakeholders should continue to exist and meet regularly.

The following individuals and organisations have contributed in writing this position paper:

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Professor A Tavabie, GP Dean & Deputy Dean Director (Chairman) KSS  
Dr A Thompson, GP Registrar Subcommittee, BMA.

## Appendix 2

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### Acute care competences from Foundation Years 1 and 2

#### 1 Promptly assesses the acutely ill or collapsed patient:

- Assesses conscious level, responsiveness
- Ensures airway is supported and cleared
- Observes respiratory pattern and rate, identifies inadequate ventilation
- Assesses pulse rate, rhythm, volume
- Measures blood pressure using automated methods or sphygmomanometer
- Completes initial assessment within 2–3 minutes
- Identifies and attempts to correct circulatory failure appropriately
- Identifies oliguria, checks for common causes, intervenes appropriately
- Administers oxygen safely, monitors efficacy
- Attempts to ensure a clear airway
- Calls for help early.

#### 2 Identifies and responds to acutely abnormal physiology:

- Interprets abnormal vital signs correctly in context
- Anticipates and prevents deterioration in vital signs
- Recognises patients at risk including those with chronic and co-morbid disease
- Investigates causes of abnormal vital signs
- Makes a clinical assessment of adequacy of cardiac output and oxygen delivery
- Capable of leading multidisciplinary team
- Helps others stay calm
- Considers and ensures relatives (if present) are being supported.

#### 3 Where appropriate, delivers a fluid challenge safely to an acutely ill patient:

- Selects an appropriate fluid for intravenous resuscitation
- Sets up fluid administration giving-set correctly
- Administers fluid bolus(es), observes response, ensures continued administration with monitoring of effect to desired end points
- Identifies hypokalaemia and chooses a safe and effective method of potassium supplementation with monitoring of response

- Reviews impact of fluid administration on organ system function
- Considers additional electrolyte replacement requirements
- Considers the restraints of volume in young people, based on weight.

#### **4 Reassesses ill patients appropriately after initiation of treatment:**

- Implements a system of regular checking of unstable patients
- Calls for help if patient does not respond to initial measures
- Makes patient safety a priority
- Provides clear guidance to colleagues about monitoring
- Supports nursing staff in designing and implementing monitoring or calling criteria
- Ensures communications to relatives, if not present, are carried out by someone competent to advise on progress.

#### **5 Requests senior or more experienced help when appropriate:**

- Analyses clinical problems, considers possible causes and solutions
- Calls for help or advice appropriately
- Demonstrates understanding of the team approach to care of the acutely ill
- Prioritises problems
- Puts the patient first
- Demonstrates to seniors appropriate judgement in handling acute medical situations.

#### **6 Undertakes a secondary survey to establish differential diagnosis:**

- Demonstrates recognitions of the importance of iterative review
- Demonstrates competent history-taking and clinical examination in acute clinical situations
- Arranges appropriate basic laboratory tests, interprets results
- Recognises that the acute illness may be an acute exacerbation of a chronic disease
- Identifies co-morbid diseases
- Undertakes further focused history-taking in difficult circumstances and/or when patient unable to cooperate
- Rapidly identifies clinical signs, links them to the history to form a differential diagnosis
- Plans appropriate investigations to confirm or refute a diagnosis and considers alternative diagnostic scenarios as they emerge
- Recognises the modifying effect of chronic or co-morbid disease and its treatment on the presentation of acute illness.

#### **7 Obtains an arterial blood gas sample safely, interprets results correctly:**

- Takes an arterial sample in an adult safely using a heparinised syringe
- Describes common causes of abnormal values
- Interprets results in context
- Documents results clearly in the case record
- Takes appropriate initial action to correct abnormalities in acid-base balance and blood gas results
- Communicates significant acid-base disturbances to others in the team

- Directs corrective measures appropriately.

#### **8 Manages patients with impaired consciousness including convulsions:**

- Appreciates urgency of the situation
- Administers oxygen, protects airway in unconscious patient
- Places unconscious patient in recovery position
- Calls for help if fitting does not respond to immediate measures
- Follows local protocols reliably
- Seeks and corrects abnormalities of physiological signs, particularly hypoxaemia, hypotension, hypoglycaemia and electrolyte disturbances
- Questions and discusses scientific content of protocols in use
- Warns patients about the legal implications regarding fitness to drive.

#### **9 Safely and effectively uses common analgesic drugs:**

- Evaluates the patient in pain
- Makes patient comfort a priority
- Prescribes opioid and non-opioid analgesic drugs safely
- Re-evaluates the efficacy of analgesia in a timely manner
- Monitors patients for common side effects of analgesic drugs
- Safely uses anti-emetic drugs to treat or prevent nausea and vomiting
- Aware of the risk of addiction to pain-relieving medication
- Considers the effect of hepatic and renal dysfunction on analgesic pharmacology
- Assesses the effect of prescribed analgesia in a timely manner
- Considers that analgesia may temporarily mask the severity of illness.

#### **10 Understands and applies the principles of managing a patient following self-harm:**

- Undertakes a focused history, including psychosocial causes requiring social services or police intervention
- Knows how to access Toxbase and does so when necessary
- Recognises the need for involvement of mental health or more experienced personnel
- Demonstrates tolerance and understanding
- Performs a mental state assessment
- Demonstrates an awareness of child protection concerns where appropriate
- Protects and supports colleagues where appropriate
- Anticipates necessary steps to minimise risks to patient
- Initiates referral to mental health services where appropriate.

#### **11 Understands and applies the principles of management of a patient with an acute confusional state or psychosis:**

- Recognises diagnostic features of psychosis and acute confusional states
- Summons experienced help promptly
- Discusses safe administration of anti-psychotic drugs including the risks of sedation
- Knows the provisions of the Mental Health Act and can apply them appropriately

- Protects patient, self and colleagues from harm
- Safely administers anti-psychotic drugs
- Considers underlying causes of acute confusional state or psychosis.

**12 Ensures safe continuing care of patients on handover between shifts, on call staff or with ‘hospital at night’ team by meticulous attention to detail and reflection on performance:**

- Accurately summarises the main points of patients’ diagnoses, active problems and management plans
- Provides clear information to colleagues
- Attends handovers punctually and accepts directions and allocation of tasks from seniors
- Focuses on teamwork and reflects on the team performance
- Supports colleagues in forward planning at handover
- Can and sometimes does organise handover, briefing and task allocation
- Anticipates potential problems for next shift and takes pre-emptive action.

**13 Considers appropriateness of interventions according to patients’ wishes, severity of illness and chronic or co-morbid diseases:**

- Efficiently extracts information from history and examination that would influence treatment decisions
- Seeks information from relatives if appropriate
- Discusses factors influencing the use of do not attempt resuscitation (DNAR) decisions
- Has balanced view of benefits and harms of medical treatment
- Identifies patients for whom resuscitation or advanced care might be inappropriate and takes advice from senior colleagues
- Demonstrates sensitivity in the planning of complex ethical decisions
- Negotiates management plan with patient
- Respects patients’ wishes when dealing with relatives.

**14 Has completed appropriate level of resuscitation training:**

- Successfully trained to the standard of Advanced Life Support (ALS).

**15 Discusses DNAR orders/advance directives appropriately:**

- Understands the criteria for issuing orders, and the level of experience required to issue them
- Can discuss with colleagues, including nurses, and observes or participates in discussions with relatives
- Facilitates the regular review of DNAR decisions and understands actions required if decision is challenged
- Discusses the DNAR criteria and their legal framework with colleagues, including nurses, and relatives
- Encourages regular review of the order and takes appropriate action if challenged
- Is aware of any conflict that may exist between patients and their relatives, and of cultural and other factors that might be at work
- Describes the impact of chronic or co-morbid disease on patient outcomes.

## **16 Requests and deals with common investigations appropriately:**

- Requests common investigations appropriately for patients' needs
- Discusses risks, possible outcomes and later results with patients<sup>ii</sup> appropriately to level of expertise
- Recognises normal and abnormal results
- Prioritises importance of results and asks for help appropriately
- Ensures results are available in a timely fashion
- Supports F1 trainees or students in making appropriate requests for, interpretation of, and action on normal and abnormal results, for common investigations
- Understands local systems and asks for help appropriately from the relevant individuals.

<sup>ii</sup> carers, relatives, supporters or advocates

## Appendix 3

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### ‘Dangerous’ diagnoses

There are certain conditions that demand urgent action when the merest suspicion of them crosses a doctor’s mind. Problems occur where a doctor has correctly suspected such a diagnosis, recorded the fact, but then not acted on the possibility.

Diagnoses that fall into this category include:

- myocardial infarction
- pulmonary embolus
- subarachnoid haemorrhage
- appendicitis
- limb ischaemia
- intestinal obstruction or perforation
- meningitis
- aneurysms
- ectopic pregnancy
- acute psychosis/mania
- visual problems that could lead to blindness including retinal detachment and haemorrhage as well as systemic disease such as temporal arteritis, which if not recognised has serious complications.

If you suspect a potentially life-threatening diagnosis in a primary care setting, then *act as if the diagnosis were certain* and send the patient rapidly to his or her nearest secondary care centre. You may well get it wrong and appear to be over-cautious, but this is a call it’s often impossible to make without the benefit of investigations and close observation.

*Source:* Medical Protection Society<sup>9</sup>

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