

**North West Office**

**GP Specialty Training School**

**TRAINER**

**And**

**LEARNING ENVIRONMENT**

**ACCREDITATION**

*(Please complete and email back in word format )*

**Trainer Name :** …………………………………………………..

**Date:**………………………….

Lead visitor:

Co-visitor:

Date:

**Visitors Report – Trainer**

*(for GP School use only)*

**Summary of findings:**

**Key Strengths:**

**Key areas for development:**

**Recommendation to GP Director:**

**Lead visitor:**

**Co-visitor:**

**Visitors Report – Learning Environment**

*(for GP School use only)*

**Summary of findings:**

**Key Strengths:**

**Key areas for development:**

**Recommendation to GP Director:**

**Lead visitor:**

**Co-visitor:**

**GMC Framework areas for trainer quality assurance**

1. *Ensuring safe and effective patient care through training*
2. *Establishing and maintaining an environment for learning*
3. *Teaching and facilitating learning*
4. *Enhancing learning through assessment*
5. *Supporting and monitoring educational progress*
6. *Guiding personal and professional development*
7. *Continuing professional development as an educator*

**Mandatory Trainer Declarations**

**I declare that I have satisfactorily completed Equality and Diversity Training/update**

Date of Training:

**I confirm that I am not under any on-going investigations or restrictions to practice from the GMC or any other Regulatory or Contracting body and that I will inform the Deputy Dean at HEE immediately of any such investigations/restrictions**

**I can confirm that I am progressing satisfactorily through my appraisal/revalidation cycle**

(*If you have answered NO to any of the above, contact your Associate Dean before the review)*

**I can confirm that the following evidence is included with the submission:**

* Learner Feedback Questionnaire Yes/No
* Learning Environment Review Yes/No
* Recording of Educational Encounter Yes/No

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Trainer**

**Trainer Details**

Name:

GMC No:

Date of Birth:

Sex:

Surgery Name:

Home address:

Home Tel:

Mobile No:

Email Address:

Date of Registration:

Qualification with Dates:

Summary of Hospital Experience:

General Practice Experience:

Registrar:

Assistant:

Principal:

Please list all medical appointments outside the practice with the hours spent on these:

Voluntary and professional organisations:

Please list research interests:

Please list publications:

Please list relevant teaching/assessment courses you have attended:

**Trainer as Doctor**

How long have you been in a substantive GP post?

Are you full time/part time? (if part time, indicate how many sessions)

How long have you been with the current practice?

Have you passed the MRCGP? (if yes, indicate date)

Have you been subject to any fitness to practice investigations? (if yes please give details)

Have you participated in the annual appraisal process satisfactorily?

Are you free of health problems that may hinder your commitments as a trainer?

**Trainer as Teacher**

When did you complete the Basic Trainers Course?

What other relevant courses have you attended?

Which Trainers Group do you attend?

How many Trainers group meetings have you attended in the past year?

Are there any educational activities you lead on in practice?

Are there any educational activities you lead on in the locality/region?

Does your personal development plan include teaching and training domains? (please specify)

**Trainer**

*(for GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Trainer as Doctor**  (GP experience, MRCGP, probity, health) |  |
| **Trainer as Teacher**  (own learning, PDP, developing skills, plans for future) |  |
| **Areas of Good Practice** |  |
| **Areas to Develop** |  |
| **GPST School Criteria Met** | Yes/No |

The Learning Environment

**Practice Details**

Practice name for database:

Surgery address:

Surgery Tel: Fax:

Practice ID number:

PCT:

Branch Surgery:

Branch Surgery Tel: Fax:

Practice Manager

Name:

Direct Tel: Mobile Number:

Email address:

Number of years in practice:

Education Manager (if different from above)

Name:

Direct Tel: Mobile Number:

Email address:

Number of years in practice:

**The Clinicians (Doctors/ Nurses)**

Please underline who will supervise in your absence ( nominated deputy). Indicate if they any of them are involved in teaching, teaching related roles and/or if they have done teaching/supervision courses

|  |  |  |
| --- | --- | --- |
| Name of Doctor | Hours contracted | Special Interests |
|  |  |  |
|  |  |  |
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|  |  |  |

**Practice Staff**

Please list the numbers and total hours for the staff employed by the practice.

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Grade** | **Number of staff** | **Total Hours** | **Relevant Experience/Qualifications in teaching** |
| Practice Manager(s): |  |  |  |
| Receptionist(s)/secretarial staff/IT/data entry: |  |  |  |
|  |  |  |  |
| Others: | | | |

Do the all the staff have PDP and educational portfolio? Yes/No *(please delete accordingly)*

Do all the staff undergo annual appraisal? Yes/No *(please delete accordingly)*

**Practice Attached Staff**

Please list the members of the primary health care team that are attached to the practice

Please list any teaching qualifications members of the PHCT have or teaching courses they have attended

What team meetings take place?

What other teaching/training occurs in the practice? e.g. medical students, foundation year trainees, nurses, other PHCT members

**The Premises**

Total list size:

Trainer’s list size (if personal lists):

Are the premises

Health centre 🞏

Rented 🞏

Practice owned 🞏

LIFT 🞏

Number of consulting rooms:

Does the GPST have own consulting room? Yes/No

Is there video recording equipment in the room? Yes/No

If not in the same building are there services accessible nearby? Yes/No

What other services are housed in the same building? (please list)

**Learning Environment: Premises and services**

*(For GP School use only: Visitors report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Premises**  (room, branch surgery, facilities and equipment) |  |
| **Personnel**  (partners with teaching skills, nominated deputy PHCT, multi-professional input) |  |
| **Services**  (variety of services available and accessibility) |  |
| **Areas of good practice** |  |
| **Areas to develop** |  |
| **GPST School criteria met** | Yes/No |

**IT Systems**

What is the practice computer system?

List aspects of clinical practice the computer system is used for-

Do you use an electronic appointment system? If yes, how will this aid teaching and supervision?

Are results investigations accessible through Path-links? If not what method is there to access and record lab results?

Are all hospital letters/discharge summaries/OOH sheets scanned? If not what method is there to access and record lab results?

What is the practice policy for summarising and keeping records up to date? (if there is a written policy, please enclose)

Does the practice have a website? Yes/No

If yes, what is the web address?

Are there any patient services available online? (prescription ordering etc)

Are there any other aspects of the IT system in your practice that you feel will aid teaching and supervision?

Write a few lines on induction into the IT systems for the GPST-

Are paper records used? Yes/No

If yes what for?

Does the practice have a branch surgery? Yes/No

Is the GPST expected to consult from the branch surgery?

**(If yes fill in the following sheet – one for each branch surgery)**

**The Branch Surgery**

*(Please complete one sheet for each branch surgery)*

Address:

Does the registrar ever consult from this surgery? Yes/No

How many consulting rooms are there?

Is there a computer terminal? Yes/No

Is the computer connected to the main surgery? Yes/No

Does the branch surgery have an appointment system? Yes/No

How many patients are booked to the hour?

**Learning Environment: Records and IT**

*(For GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **IT Systems**  (ease of use, process of care, paper light) |  |
| **Introduction to systems**  (structured induction) |  |
| **Monitoring of activities**  (monitoring of GPST case mix, use of system prescribing, workload etc) |  |
| **Areas of good practice** |  |
| **Areas to develop** |  |
| **GPST School criteria met** | Yes/No |

**Workload**

Does the practice have an appointment system? Yes/No

If yes is this electronic?

Do you provide ‘advanced access’? Yes/No

Is there an in-house on call rota for cover during working hours? Yes/No

**Trainer**

How many patients are booked per hour?

How many extras are added to the session on average?

**Partners**

How many patients are booked per hour?

How many extras are added to the session on average?

**GP Specialty Trainee**

How many patients are booked per hour?

How many extras are/will be added to the session on average?

**Out of Hours**

Which organisation provides OOH on behalf of your PCT?

What are the arrangements for OOH experience for Registrars in your area?

Do you personally undertake OOH sessions? Yes/No

If yes how often?

**Learning Environment: Workload**

*(for GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Trainer’s Workload:**  (consultation rate, extras etc) |  |
| **GPR case load:**  (consultation rate, case-mix, monitoring) |  |
| **Out of hours:**  (experience in OOH, triage, teaching of such skills) |  |
| **Areas of good practice:** |  |
| **Areas to develop:** |  |
| **GPST School criteria met?** | Yes/No |

**Library and Educational Resources**

Does the practice have a quiet reading room/library on site? Yes/No

If no, are there alternatives?

Please highlight broad areas/categories in which books are available-

|  |  |  |  |
| --- | --- | --- | --- |
| Clinical | Yes/No | Medico Legal | Yes/No |
| Clinical Governance | Yes/No | Practice Management | Yes/No |
| IT | Yes/No | NMRCGP | Yes/No |
| Consultation/Communication skills | Yes/No | Teaching | Yes/No |
| Medical Ethics | Yes/No |  | Yes/No |

Is there a policy for updating and cataloguing the library?

What policy is there for purchasing books for the GPST?

Which Journals/occasional papers are available in-house?

Is there access to electronic resources at workspace? Yes/No

If yes are they listed?

Do you use an online mentoring system for clinical practice? Yes/No

Does the GPST have access to this?

Is there a practice *intranet* for local resources/induction packs/protocols? Yes/No

**Learning Environment: Library and Educational Resources**

*(for GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Library:**  (site and maintenance) |  |
| **Content:**  (areas covered, journals, other resources, how organised) |  |
| **Purchase policies and maintenance:**  (access to new resources, updated lists) |  |
| **Areas of good practice:** |  |
| **Areas to develop:** |  |
| **GPST School Criteria met?** | Yes/No |

**Process of Care**

What was your QOF achievement in the last financial year?

Please attach QOF summary sheet if available

Does the practice provide the following services and if yes who is the lead partner?

|  |  |
| --- | --- |
| **Service** | **Lead** |
| Child Health Surveillance |  |
| Minor Surgery |  |
| Family Planning |  |

If the above services are not provided what arrangements are/will be made for the GPST to experience them?

|  |  |
| --- | --- |
| **Other allied services (please list)** | **Provider** |
|  |  |
|  |  |
|  |  |
|  |  |

Is there a practice formulary? Yes/No

**Audit and Performance Review**

List recent audits (please underline rolling audits with completed cycles):

Clinical

Management

List significant events audits completed in the past 12 months:

Please list any of the above audits you’ve personally undertaken or led:

**Learning Environment: Audit and performance review**

*(for GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Audits & SEAs:**  (topics, cycle completion, team involvement, culture of QA) |  |
| **Audit and SEA as teaching tools:**  (understanding of/use of audit and SEA as teaching tools) |  |
| **Protocols and Guidelines:**  (availability, accessibility and update mechanisms) |  |
| **Areas of good practice:** |  |
| **Areas to develop:** |  |
| **GPST School criteria met:** | Yes/No |

The Educational Programme

**Plan for the GP Specialty Trainee**

Is there a structured induction to the practice?

Is there an employment contract in place?

Is there an educational contract in place?

**Workload**

What is the appointment rate for the GPST?

1-3 months:

4-6 months:

7-12 months:

Will extras be added to this list and if so how many on average?

How will you monitor the GPST case mix, workload and utilisation of services?

How often will the GPST be on-call in the practice (day time)?

Please detail what areas they would cover and what supervision they would have-

**Organisation of Teaching**

Please list which teaching methods would be used in the practice in order of preference (e.g. RCA, PCA, joint surgeries)-

How many hours of formal, protected teaching are allocated to teaching?

Is there additional informal teaching time? Yes/No

If yes, how is this organised?

How will chronic disease management be taught?

Do partners or staff have specific fields of expertise and how is this integrated into teaching?

**Organisation of Assessment**

Is the practice team familiar with the new assessment methodologies in the e-portfolio?

**Assessment of the Registrar**

Apart from the mandatory assessment tools (CBD/Mini CEX, COT, DOPS), please indicate the other tools which you intend to use with your registrar-

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessment method** | **Never Use** | **Use Sometimes** | **Use Regularly** |
| 1. MCQ |  |  |  |
| 1. MEQ |  |  |  |
| 1. Random Case Analysis |  |  |  |
| 1. Video Recording |  |  |  |
| 1. Record Review |  |  |  |
| 1. Joint Surgeries |  |  |  |
| 1. Project Work |  |  |  |
| 1. Patient Satisfaction Questionnaire |  |  |  |
| 1. 360 degree Assessments (all staff) |  |  |  |
| Other (please specify): | | | |

Which of the above methods will you use?

*(Please enter numbers corresponding to methods given above: 1-9)*

At the start of the training period: …………………………………..

At the mid-point of the training period: ……………………………..

At the end of the training period: ……………………………………

If ‘other’ please give details:

**Educational Programme**

*(for GP School use only: Visitors Report)*

|  |  |
| --- | --- |
| **Criteria** | **Comments** |
| **Organisation of teaching:**  (time, workload, multiplicity of input, variety of skilled teachers, familiarity with the GP curriculum) |  |
| **Organisation of assessment:**  (e-portfolio, familiarity with assessment tools, team involvement, OOH assessments) |  |
| **Recording of assessments:**  (personal records, learning log- GPST, trainers records, how multiple supervisors can input records) |  |
| **Areas of good practice:** |  |
| **Areas to develop:** |  |
| **GPST School criteria met:** | Yes/No |

**Practice Development**

Please outline (or enclose) key points of your practice development plan:

Please outline plans to develop (learning environment, expansion, succession planning of trainers etc):

**I understand that the information provided in the application form will be processed in accordance with the Data Protection Act. Personal data relating to doctors, such as that contained in the application form, is stored in Deaneries both on computer and manual systems. Where appropriate, information is shared with those who have a responsibility for the organisation, management and delivery of training, to help them execute their function in the planning and delivery of doctors’ training.**

**Prospective Trainer’s Signature: Date:**

**Proposed Practice Timetable Proforma (new training practice)**

Please indicate, using a letter from the key below, the activity of the practice during the week-

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Time (e.g. 9am – 10.30am)** | **Trainer (1)**  **Name** | **Registrar (1)** | **Comments e.g. cover/teaching by partners (please specify)** |
| **MON AM 1** |  |  |  |  |
| **MON AM 2** |  |  |  |  |
| **LUNCH** |  |  |  |  |
| **MON PM 1** |  |  |  |  |
| **MON PM 2** |  |  |  |  |
| **EVENING** |  |  |  |  |
| **TUES AM 1** |  |  |  |  |
| **TUES AM 2** |  |  |  |  |
| **LUNCH** |  |  |  |  |
| **TUES PM 1** |  |  |  |  |
| **TUES PM 2** |  |  |  |  |
| **EVENING** |  |  |  |  |
| **WED AM 1** |  |  |  |  |
| **WED AM 2** |  |  |  |  |
| **LUNCH** |  |  |  |  |
| **WED PM 1** |  |  |  |  |
| **WED PM 2** |  |  |  |  |
| **EVENING** |  |  |  |  |
| **THURS AM 1** |  |  |  |  |
| **THURS AM 2** |  |  |  |  |
| **LUNCH** |  |  |  |  |
| **THURS PM 1** |  |  |  |  |
| **THURS PM 2** |  |  |  |  |
| **EVENING** |  |  |  |  |
| **FRI AM 1** |  |  |  |  |
| **FRI AM 2** |  |  |  |  |
| **LUNCH** |  |  |  |  |
| **FRI PM 1** |  |  |  |  |
| **FRI PM 2** |  |  |  |  |
| **EVENING** |  |  |  |  |
| **SAT AM 1** |  |  |  |  |
| **SAT AM 2** |  |  |  |  |

**Key**

**T**eaching **A**dministration **H**alf Day (out of practice activities etc) **V**isits **C**linics

**S**urgery **T**eam Meetings **D**ay Release **O**ut of Practice

**Practice Timetable Proforma (new trainer in existing training practice)**

Please indicate, using a letter from the key below, the activity of the practice during the week

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Time (e.g. 9am – 10.30am)** | **Trainer (1)**  **Name** | **Registrar (1)**  **Name** | **Trainer (2)**  **Name** | **Reg (2) PRHO/stem cell/general professional training** | **Comments e.g. cover/teaching by partners** |
| **MON AM 1** |  |  |  |  |  |  |
| **MON AM 2** |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |
| **MON PM 1** |  |  |  |  |  |  |
| **MON PM 2** |  |  |  |  |  |  |
| **EVENING** |  |  |  |  |  |  |
| **TUES AM 1** |  |  |  |  |  |  |
| **TUES AM 2** |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |
| **TUES PM 1** |  |  |  |  |  |  |
| **TUES PM 2** |  |  |  |  |  |  |
| **EVENING** |  |  |  |  |  |  |
| **WED AM 1** |  |  |  |  |  |  |
| **WED AM 2** |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |
| **WED PM 1** |  |  |  |  |  |  |
| **WED PM 2** |  |  |  |  |  |  |
| **EVENING** |  |  |  |  |  |  |
| **THURS AM 1** |  |  |  |  |  |  |
| **THURS AM 2** |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |
| **THURS PM 1** |  |  |  |  |  |  |
| **THURS PM 2** |  |  |  |  |  |  |
| **EVENING** |  |  |  |  |  |  |
| **FRI AM 1** |  |  |  |  |  |  |
| **FRI AM 2** |  |  |  |  |  |  |
| **LUNCH** |  |  |  |  |  |  |
| **FRI PM 1** |  |  |  |  |  |  |
| **FRI PM 2** |  |  |  |  |  |  |
| **EVENING** |  |  |  |  |  |  |
| **SAT AM 1** |  |  |  |  |  |  |
| **SAT AM 2** |  |  |  |  |  |  |

**Key**

**T**eaching **A**dministration **H**alf Day (out of practice activities etc) **V**isits **C**linics

**S**urgery **T**eam Meetings **D**ay Release **O**ut of Practice