

**NHS Education for Scotland**

The Scotland GP Enhanced Induction Programme

2016

Updated 2018**The Scotland GP Enhanced Induction Programme**

**Context**

The Scotland GP Enhanced Induction Programme is for GPs who have never worked in NHS GP but who wish to live and work in NHS General Practice in Scotland. This programme is funded by Scottish Government and operated by NHS Education for Scotland, providing applicants with a salary to support them whilst on the programme.

Details and frequently asked questions in relation to the Scotland GP Enhanced Induction Programme can be found at: <http://www.scotlanddeanery.nhs.scot/your-development/gp-induction-and-returner-programmes/>

This programme provides an induction to working in NHS General Practice in a supported way. The programme will be tailored around you following an individual learning needs assessment. You will be allocated a practice-based supervisor who will provide feedback to support your integration as an independent general medical practitioner in the NHS in Scotland.

An interview with a GP Advisor from NHS Education Scotland (NES) will establish eligibility and suitability for the programme. A suitable placement in an approved GP practice for an attachment of **up to** six months will be identified.

To be eligible for the programme, doctors must successfully sit the national MCQ/SJT and Simulated Surgery. Anyone who scores band 4 or 5 of the MCQ with a pass in professional dilemmas will be exempted from the Simulated Surgery but will be expected to submit a video of their consultations during their time on the programme and will not be signed off until that meets a satisfactory standard. Those scoring a band 3 MCQ with a pass in professional dilemmas will require to sit the Simulated surgery. Those with a band 1 or 2 in the MCQ or a fail in professional dilemmas will require to re-sit the MCQ.

At the end of the programme, the supervisor will make a summative recommendation to the Medical Director of the Health Board in relation to suitability for independent practice and inclusion on the Health Board’s Performers’ List.

**Aims**

The aims of the GP Enhanced Induction Programme are to:

1. Provide a supportive and clinically relevant educational environment in which GPs can become familiar with patient expectations and NHS systems and organization.
2. Provide a formative assessment for the GP during the practice attachment
3. Provide a clinical reference through an Educational Review Document (ERD) supported by evidence to those managing the Performer List
4. Enable GPs who are committed to live and work in Scotland, to join the GP work force.

**Eligibility Criteria**

To be eligible for the programme, the following criteria must be met:

1. Certification of completion of GP Training (CEGPR) by a competent authority
2. On the GMC GP Register, without GMC [conditions or undertakings](http://www.gmc-uk.org/DC6535_Information_for_doctors_who_have_undertakings_or_conditions_that_affect_their_practice_58388105.pdf) (except those relating solely to health matters) and hold a current licence to practice as a GP
3. The doctor has never worked in NHS GP (for those who have but who have been out of clinical practice for more than 2 years, the GP Returner Programme may be suitable.)
4. Eligible to be included on Performers’ List on completion of the programme as confirmed by Health Board.
5. Passed both the national MCQ and simulated surgery (if required) before entry.
6. Eligibility for Medical Defence Organisation membership.
7. Committed to live and work in NHS General Practice in Scotland on completion of the programme.

 **The Scotland GP Enhanced Induction Programme**

**Process**

NES Responsibility

GP registered with GMC on GP Register with licence to work in GP

Health Board Responsibility

The doctor accesses the NES website

Application to join local NHS Board Performers’ List considered by administrator & Medical Director of relevant Health Board

Advice sought from relevant NES regional office of Scotland Deanery

Direct Entry to Performers List without conditions or career advice

Recommendation to Health Board Medical Director

That doctor eligible for EI Programme provided successfully passes national assessments

NES arranges assessments through NRO

NHS Board Medical Director confirms eligibility for entry onto performers’ list provided EI programme successfully completed. Health Board include doctor on performers list under appropriate category

NHS Education employs doctor and arranges placement in approved practice familiar with assessment methodology

At end of placement, Deanery conveys outcome and recommendation to NHS Board Medical Director

NHS Board Medical Director either agrees full inclusion onto Performers’ List without conditions or provides career advice in consultation with Deanery educational lead

If included on performers’ list, early appraisal and revalidation as scheduled

**Teaching and learning**

The GP will be supervised by a named Educational Supervisor (ES) who will have overarching clinical and educational responsibility for the doctor. The ES will:

* arrange a thorough induction to the practice and any recent changes to the NHS in Scotland before the EI GP embarks on the formal agreed timetable.
* facilitate a learning needs assessment using self-rating scale such as Lanarkshire checklist
* learning needs will be discussed during the first mentoring session with the ES, and a plan designed to meet these needs will be agreed.
* tailor the weekly timetable to the learning needs of the EI GP.
* provide an educational contract in the first week for mutual signature (modelled on the timetable suggested below)
* send a copy of the timetable to the Deanery Lead (who will be happy to advise re content and suitability), for approval.
* provide regular educational supervision meetings
* give regular formative feedback to the EI GP with explicit documented comments about progress
* advise about PDP & evidence required for appraisal and revalidation

**Suggested weekly timetable**

|  |  |  |
| --- | --- | --- |
| Day | Morning | Afternoon |
| Monday | Surgery  | Surgery |
| Tuesday | Surgery | Surgery  |
| Wednesday | Surgery  | A face to face session with the Educational Supervisor |
| Thursday | Surgery | Surgery |
| Friday | Surgery | Self directed learning to address areas identified as weak through educational needs assessment ORPlanned Educational Session as suggested by ES for example:* combined surgery
* appraisal preparation
* reflective log entries (see appendix 1)
* CDM Clinic with nurse
 |

* A session is defined as four hours

* A ‘surgery’ is to include direct patient contact, telephone advice, on-call responsibilities, home visits, and administration as timetabled by the practice.
* Initially each surgery will require close supervision appropriate to the experience, competence and confidence of the GP.
* The consultation rate should be graduated so that by end of the attachment, the doctor has achieved the standard of an independent general practitioner with an average of 10 minute appointments to include documentation in line with other clinicians working in the practice.
* Combined surgeries should be offered on a regular basis to allow observation of an experienced practitioner’s management of patients, time management and other strategies.
* We recommend a maximum of eight general surgeries per week but this should be negotiated in line with the educational needs of each EI GP.
* The ES will be encouraged to contact the Deanery Lead for any advice needed or with any concerns at an early stage.
* There is no requirement for the EI GP to work in Out of Hours (OOH) but if the EI GP anticipates applying to do OOH sessions in the future, then this must be discussed at the placement interview with the GP AA. Provided the local OOH service can accommodate the request and once the ES is satisfied that he or she is ready to do this then if the EI GP is willing to do two sessions in OOH per month, then a pay supplement will be available.

**Assessment**

**Minimum requirements:**

You will be required to do a specified number of formative assessments during your practice attachment.

* **Work place based assessments** should be recorded in a logbook. These assessments include assessments of clinical skills, communication skills & teamwork and are based around observed consultations, case based discussions, 360 degree feedback from patients (Patient Satisfaction Questionnaire) and colleagues (Multisource Feedback MSF) and observations of clinical procedures. PSQ and MSF can both be used towards appraisal and revalidation; it is thus in the EI GP’s interests to complete these during a stable funded post. Details of all of these requirements can be found on the RCGP website [RCGPAppraisal](https://gpeportfolio.rcgp.org.uk/Login.aspx) and through the Scottish Online Appraisal Resource [SOAR](http://www.scottishappraisal.scot.nhs.uk/)

Normally this will be **at least** one Case Based Discussion (CBD) assessment per month (pro-rata) and all 5 RCGP mandatory Clinical Exam & Procedural Skills (CEPS) satisfactorily observed by the end of the programme.

* Reflective educational diary to be shared with the ES (see appendix 1)
* The EI GP is not required to do the RCGP GP SelfTest or the WoS video consultation analysis if they have already sat the national assessments but are encouraged to share the feedback documents with their supervisor. The only exception is for those who have scored within the top two bands (4&5) of the MCQ/SJT who are exempt from sitting the Simulated Surgery but are required to submit a video for analysis to the WoS. The cost of the first two attempts of the MCQ and first attempt of the Simulated Surgery is funded by the programme but any subsequent attempts borne by the EI Doctor. Exceptionally 4 attempts at the MCQ may be funded.
* As part of the programme GP Returner doctors are allocated a £200 allowance towards educational activities available through CPD Connect https://www.cpdconnect.nhs.scot/

**Review of progress**

There will be a review of progress at the beginning, midpoint and end of the attachment with a summative conclusion being reached at the end of the programme, using the Educational Review Document (see Appendix 2). This will be shared with the EI GP.

This should demonstrate satisfactory and incremental progress throughout the Programme and continuing ability to reflect and learn from the EI GP’s own and colleagues’ practices.

The Deanery Lead will make contact at the midpoint of the attachment to help with any problems

1. The overall time allotted to the EI Programme will not normally be extended.
2. A failure to progress in achieving the agreed objectives (reaching the standard of an independent General Practitioner) may result in non-inclusion in the Performers’ List.
3. If a failure to progress raises concerns in relation to patient safety or professional probity, the Deanery Responsible Officer may make a referral to the GMC, after having discussed the situation with the Health Board’s Medical Director.
4. If a failure to progress is related to sickness absence, it may be appropriate to defer the completion date of the Programme. The normal quota of annual leave may be taken during the attachment, and this should be pro-rata. Any period of sickness absence greater than that covered by self-certification must be supported by a doctor’s certificate. A cumulative absence due to illness of more than four weeks in six months will trigger a referral to the Occupational Health Service unless seen as unnecessary in the opinion of the ES. Reasons for not making an OH referral will be given.
5. On completion of the programme, the ES will make an evidence based recommendation on the basis of the Educational Review Document, and this will be made available to the Deanery. This is not subject to appeal.
6. The Deanery will provide a report to the Medical Director of the Performers’ List with possible recommendations as follows:
* No concerns
* Needs further developments

Further developments will be evidenced in the Educational Review Document. This report should be considered equivalent to a recent, and detailed clinical reference, and a decision can be made by the Medical Director with responsibility for the Performer List whether to approve inclusion on the list.

NES is responsible through the Deanery for the delivery of the educational assessment and the provision of the Scotland EII GP Programme. Applicants who wish to complain or appeal against the outcome of any assessment or recommendation would do so through an appeal process with NES. If the EI GP feels that the GP Enhanced Induction Programme has not been compliant with the terms of their educational contract, they will be expected to have registered their concerns contemporaneously with documented evidence during the course of their post rather than after receiving their educational supervisor’s assessment. In the absence of valid grounds for appeal, the educational supervisor’s assessment is final.

1. Admission to the Performers’ List is the decision of the individual Health Board’s Medical Director. A decision to refuse an application or to apply conditions on a registration is taken by the Medical Director. Any appeal regarding the outcome of this decision should be made to the Health Board.

Further details around terms & conditions can be found at <http://www.scotlanddeanery.nhs.scot/your-development/gp-induction-and-returner-programmes/scotland-enhanced-induction-programme/>

Appendix 1

**Example of a Reflective Educational Diary**

## For completion by EI GP

*Specimen*

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| --- | --- | --- | --- |
| *Date and activity* | *Learning points* | *Impact/change in practice* | *What further do I need to know?* |
| *01/01/2000****Directed reading following consultation with patient suffering from Heart failure***  | *-HF commonest cause of hospital admission >65yrs**-Average age diagnosis 76yrs and 2/3rds have IHD**-NYHA system based on symptoms and guides treatment not echo or Ix findings. ( NYHA1-4 see page 8 re**treatments)* | *-Understand need for referral for urgent assessment* *-Would now consider classification as guide to treatment**-High risk condition with very poor prognosis* | *- Clarification on lipid testing and when to fast**- Confirm target of BP treatment 140/90 in HF /IHD* |

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| Date and activity | Learning points | Impact/change in practice | What further do I need to know? |
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**Add further rows as required**

**Appendix 2**

**NHS EDUCATION SCOTLAND**

**EDUCATIONAL REVIEW**

**LOGBOOK**



Name of Doctor:

Supervisor:

Acknowledgement: to North Western Deanery Department of Postgraduate General Practice and Dr Julian Page for developing the outline of this logbook.

*Developed from the 9 Point Rating Scale, it incorporates the GMC’s 14 “Duties of a Doctor”*

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| **1** | **History taking and examination** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Incomplete, inaccurate, confusing history taking, cannot get patient co- operation for examination, technique poor | Clear history taking, appreciates the importance of clinical, psychological and social factors, performs adequate and appropriate examinations | Accomplished and concise history taker; including clinical, psychological and social factors. Skilled examination technique, effective listener |
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| **2** | **Investigations** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Inappropriate, random, unnecessary investigations no thought given. Oftenfails to perform investigations requested | Investigates appropriately, ensures all investigations requested by the team are completed, knows what to do with abnormal results | Arranges, completes and acts on investigations intelligently, economically and diligently |
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| **3** | **Record Keeping** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Poor, confusing records. Inadequate, illegible | Clear records made in notes, medico-legally sound, others are able to understand | Records his/her information accurately and efficiently. Easy for others to follow |
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| **4** | **Problem solving / Making a diagnosis** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Unable to make decisions, or even make a working diagnosis. Fails to involve patients in decision making. Unaware of own limits | Can make a sound diagnosis, and produce safe, appropriate management plans. Involves patients in decision making. Good recognition of own limits | Plus – shows intelligent interpretation of available data to form an effective hypothesis, understands the importance of probability in diagnosis |
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| **5** | **Multimorbidity and medical complexity** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Manages health problems separately, without considering implications of multimorbidity. Maintains positive approach to patient’s health. | Simultaneously manages both acute and chronic health problems. Can tolerate uncertainty, including that of the patient where appropriate. Communicates risk effectively to patients. Encourages patient involvement in health promotion and disease prevention. | Accepts a key role in co-ordination and management of acute and chronic problems. Anticipates and uses strategies to manage uncertainty. Co-ordinates team-based approach to health promotion, prevention, cure, care and palliation and rehabilitation. |
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| **6** | **Emergency care** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Does not respond to emergency calls, chaos and panic in emergency situations | Responds quickly to emergency calls, works well within team, appropriate management of situation | Shows ability in evaluating the emergency situation calmly and intelligently, establishes priorities correctly, organises assistance and treatment promptly. |
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| **7** | **Attitude to and relationship with patients** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Discourteous, inconsiderate of patients views, dignity & privacy. Unable to reassure, subject of repeated complaints | Courteous & polite, communicates well with patients, shows appropriate level of emotional involvement in the patient and family. Respects privacy & dignity | Excellent bedside manner, able to anticipate patients’ emotional and physical needs and plans to meet them. Explains clearly andChecks understanding. |
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| **8** | **Team working / relationship with colleagues** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Unable / refuses to communicate with colleagues. Can’t work to common goal, selfish, inflexible | Listens to colleagues – accepts the views of others. Flexible – ability to change in the face of valid argument | Able to bring together views for a common goal. Team goal is put before personal agenda |
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| **9** | **Lifelong learning / Involvement in Teaching** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Does not see the need for learning, does not learn from mistakes. Fixed blinkered approach, poor attendance at teaching sessions | Positive approach to learning, participated in teaching, learns from mistakes, > 50% attendance at teaching sessions | Enthusiastic approach to learning, reports own errors unhesitatingly and shows ability to learn fromthe experience, good attendance(> 75%) |
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| **10** | **Has a responsible and professional attitude and approach to their work, in the following areas:-****• Manners • Ethics****• Dress code • Honesty****• Time management • Trustworthiness****• Punctuality • Confidentiality****• Safeguarding (Children and Vulnerable Adults)** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Poor attitude/ approach in above areas, possible concerns. Fails to make care of patient first concern, own beliefs prejudice care, abuses position as a doctor | Reasonable attitude/ approach in above areas, a good doctor | Excellent attitude / approach in above areas, a credit to the profession. Patient care is the priority |
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| **11** | **Verbal Communication - Understanding** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Poor comprehension of even simple sentences, unable to follow a conversation, no understanding of medical terminology and abbreviations | Good comprehension of English, can follow a conversation, few misunderstandings, understands most medical terminology and abbreviations | Can understand all that is said, can cope with “difficult” accents. |
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| **12** | **Verbal Communication – Being Understood** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Such a difficult accent that patients are unable to understand. Unable to construct sentences. Liable to be misunderstood | Has a good command of spoken English, may have some accent, can use appropriate medical terminology | Clear speech, little or no accent, n misunderstandings |
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| **13** | **Written Communication - Comprehension** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Cannot understand a simple typed medical letter. Frequent misunderstandings | Can read typed letters, can mostly understand written notes of others, and may have some difficulty with doctors’ handwriting. | Can easily comprehend both type hand written text |
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| **14** | **Written Communication – Being Understood** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Cannot dictate or write a simple letter, cannot make suitable records that are understandable. Misuses medical terminology. Illegible | Can dictate or write clear letters, notes in records understandable. Legible. Uses appropriate medical terminology. | Good clear letters, able to deliver complex messages |
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| **15** | Social Integration and/or AdjustmentFor this section a score was felt to be inappropriate, a simple discussion on how the doctor and family are settling in to;a. their new life (e.g. making friends, accommodation, children’s schooling etc.) orb. coping with their return to clinical work |
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| **16** | **Integration/Re-Integration with the National Health Service** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| No awareness of the NHS systems, unable to adapt to new ways of working | Coping well with the NHS systems, can overcome teething problems and is learning the new ways of working | Working well within the confines of the NHS, aware and correct use of its systems. Good awareness on professional etiquette |
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| **17** | **Case-based discussion (CBD)** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Significant concerns/learning needs identified | Some concerns/learning needs noted | Good reflection, no concerns no |
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| **18** | **Clinical Examination & Procedural Skills Assessment (CEP)** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Significant concerns/learning needs identified | Some concerns/learning needs noted | No concerns noted |
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|  | **Mandatory CEPS** | **Satisfactory** | **Unsatisfactory** |
|  | Male genital |  |  |
|  | Prostate |  |  |
|  | Rectal |  |  |
|  | Female genital + speculum |  |  |
|  | Breast |  |  |
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| **19** | **Multi-source feedback (MSF)** |
| Please use a recommended tool for detailed feedback as no specific tool is mandatory. Expectation is one per six month placement (i.e. if part-time over 12 months then two MSFs expected) |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Significant concerns/learning needs identified | Some concerns/learning needs noted | No concerns noted |
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| **20** | **Patient satisfaction questionnaire (PSQ)** |
| Please use a recommended tool for detailed feedback as no specific tool is mandatory. Expectation is one per six month placement (i.e. if part-time over 12 months then two PSQs expected) |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Significant concerns/learning needs identified | Some concerns/learning needs noted | No concerns noted |
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| **21** | **Out-of-hours Experience (OOH) - This is an optional field only if OOH sessions have been included within the programme** |
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**COMMENTS/ LEARNING OBJECTIVES AFTER FIRST REVIEW**

Date of feedback:

Date of discussion:

Comments:

Signed: Date:

**COMMENTS/ LEARNING OBJECTIVES AFTER SECOND REVIEW**

Date of discussion in relation to Simulated Surgery or WoS video of consultations(whichever apply)

Date of feedback:

Date of discussion:

Comments:

Signed: Date:

**COMMENTS/ LEARNING OBJECTIVES AFTER THIRD REVIEW**

Date of feedback:

Date of discussion:

Comments:

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| **22** | **Programme exit discussion must cover the following topics** |

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| **Date** | **Topic** | **Confirm Discussed** |
|  | **Performers List application** |  |
|  | **Appraisal and Revalidation Obligations** |  |
|  | **Medical Practice Indemnity** |  |
|  | **Resilience and Maintaining Health** |  |
|  | **Work plans on completion** |  |

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| **Practice Address** | **Educational Supervisor** |
|  | Name: GMC Number:Signed:Date : |

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| **Final Conclusion** (please tick as appropriate) |
| No concerns |  |
| Needs further development in areas identified above |  |

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| **Signed** |
| Director of Postgraduate GP Training or Nominated Deputy |
| Name: |
| Date: |

26th February 2016

Updated 20th September 2018