

GP Educator Self-Declaration Guidance



Introduction

The following guidance has been produced to help current GP educators when completing the online self-declaration form for their ongoing recognition as an educator. Please note that this is guidance only and that educators should use their own professional judgement when completing the declaration. Failure to complete the self-declaration honestly is considered a probity issue and will be escalated as a quality concern.

Risk Assessment Process

The revised processes for the ongoing quality assurance (re-approval) and monitoring of Tiered Educators within the EoE will be via the submission of a Self-Declaration Form that will be risk assessed by the relevant ICS Training Hub (TH).

The risk assessment will take the form of a 'desk-top' review by a panel comprising of the TH:

- Quality Administrator
- GP and GPN Leads
- TH Quality Lead
- Learner representatives if possible

The panel will review the submitted Self-Declaration Form and consider other sources of information e.g., learner and TPD feedback and use a standard 5x5 risk scoring metric to determine the Likelihood (L) and Severity (S) of poor-quality learner experience.

In order to ensure that the THs apply a consistent and equitable approach to scoring, a RA scoring guide has been produced. The guide has been created by testing scenarios with senior educators i.e., AD's and TPDs.

Once the TH have reviewed and risk assessed a submission, the possible outcomes are:

- **LOW** risk – i.e., there are no areas of risk – the TH will recommend the educator is recognised for a further 4 years.
- **MODERATE** risk – i.e., there are some actions the panel would like the applicant to progress – this could be the provision of additional evidence. In this case the panel will review again in 3 months' time.
- **HIGH** risk – i.e., the panel have significant concerns about the applicant and will immediately refer to the HEE Primary Care Quality Team.

Self-Declaration Guidance

The following guidance provides some examples as to how the self-declaration should be completed but by no means is comprehensive. Self-declarations will be sent in an online format by your local training hub and upon completion will be automatically returned to them. Please note that you are unable to save the declaration and it should be completed in one sitting. However, indications are that this should not take longer than 15 minutes.

There is no need to supply additional documentary evidence but where relevant this should be maintained in case any quality concern alerts are raised.

Section 1 – Personal Information

This section collects demographic data and is important in matching your details to that of the learning organisation in which you work. The training hubs need this information for triangulation when undertaking their risk assessment.

Section 2 – Ongoing Quality Management as an Educator

This section asks you to consider the requirements for ongoing recognition as an educator and whether you are continuing to meet those standards.

Equality and Diversity – Must be completed every 3 years. You should keep a certificate of this training should it be required.

Cultural Competency and Bystander Training – This is currently in development and once available all educators will be expected to complete this every 3 years.

GMC Revalidation Date – Please specify the date of revalidation not the date of renewal.

Health Issues – If there are any health issues that may affect your ability to provide consistently high-quality education these should be declared. Short-term health issues (up to 3 months), for example, time off due to an operation should be declared but should not affect the risk assessment. Longer-term health issues should have already been discussed with the local training programme directors or patch associate dean and there should be some narrative regarding this.

Convictions, Cautions or GMC Conditions/Investigations – There may be examples that have been resolved but should still be declared if they were within the past 5 years. Ongoing issues will need to be declared with some reflection on how this impacts on training and any action plans that are being adhered to. It is likely that this will have been discussed with the TPDs/AD and, as above, there should be narrative regarding this.

Changes in Future Personal Circumstances – This would include moving to part-time working, retirement or relocation and should be discussed with the TPDs/AD. It is important that the training hub is also aware of your plans as this allows them to undertake their role in workforce planning.

Requirements for Ongoing Recognition – The following table indicates the current requirements for the ongoing recognition of educators, depending upon length of time since initial recognition. Please note that the newly qualified educator workshop and workshop on improving exam success for GP trainees are still in development.

Tier	Requirements
Tier 2A initial 2 years	Attended 50% of OOH CS meetings, Attended newly qualified educator workshop
Tier 2A after 2 years	Attended 50% of OOH CS meetings, benchmarked COTs and audio-COTs, attended at the equivalent of at least one GP school educator day, attended the equivalent of at least one Autumn Seminar or Spring Symposium*, peer review of teaching
Tier 2B initial 2 years	Attended 50% of trainer workshop meetings, Attended newly qualified educator workshop
Tier 2B after 2 years	Attended one local ARCP panel as an observer, Attended 50% of local trainer workshops, Benchmarking a COT and CBD, Attended the equivalent of at least one GP School Educator Day and the equivalent of one Autumn Seminar or Spring Symposium*, Peer review of teaching, Attended a workshop on improving exam success for GP trainees.
Tier 3 initial 2 years	Attended 50% of trainer workshop meetings, Attended newly qualified educator workshop
Tier 3 after 2 years	Participated as a panel member in a local/central ARCP panel, Attended 50% of local trainer workshops, Benchmarking a COT and CBD**, Attended the equivalent of at least two GP School Educator Days and the equivalent of one Autumn Seminar* or Spring Symposium, Peer review of teaching***, Attended a workshop on improving exam success for GP trainees, Reflection on ESR feedback.

*It is recognised that with online conferencing educators may now choose to attend some sessions as opposed to entire days. For ongoing recognition one day equates to four sessions and two days to eight sessions. Educators may also choose to undertake asynchronous learning for HEE organised events and should keep a record of those sessions in case evidence is requested.

**Some educators at tiers 4 and 5 may be undertaking sessions within their local programmes or running sessions regionally for HEE. These educators can use those sessions as evidence of benchmarking.

***Educators who have delivered teaching centrally for HEE may use their feedback from those sessions as their peer review.

Additional Recommendations – Please list any recommendations following your last assessment and the progress you have made towards them. There is no need to supply any documents, a simple declaration that they have been completed will suffice.

Quality Concerns – If any quality concerns have been brought to your attention it is important to declare these and any learning that has occurred from them. Quality concerns that are either not declared, or where there is no tangible learning, may lead to an adverse risk assessment.

Educational Objectives in Appraisal – Appraisal should cover all the aspects of your work as a health professional. Learning objectives should reflect your developmental need as an educator rather than as a clinician. For example, “understanding the ARCP process by attending a central ARCP panel as an observer” is preferable to “attending a course on dermoscopy so that learners may benefit from the knowledge gained”.

Self-Declarations – The following table provides guidance on self-rating. Each of the headings relates to different domains within the National Quality Standards Framework. Please consider the word pictures below, within the context of your current tier and educational role to identify where you sit within the guidance. Where the self-rating is below green it is important that reasons for this are provided and that there is an action plan in place as this will influence the risk assessment by the training hub.

Requirement	Green	Amber	Red
Mitigates risks to patient safety due to any factors affecting learners	Isolated patient safety incidents involving learners. Ability to identify learners in difficulty and resources for supporting them, for example,	A few patient safety incidents involving learners. Knows how to identify learners in difficulty and awareness of resources for supporting them.	Multiple patient safety incidents involving learners. Minimal understanding of how to identify and support learners in difficulty.

	<p>use of Milton Keynes Traffic Light System. Systems in place to gather patient feedback about learners. Evidence of graduated responsibility of learners based on experience and stage of training. Early identification of individual learning needs and support in continuing professional development. Accommodates the individual personal needs of learners within their job plan.</p>	<p>Less formalised systems for gathering feedback about learners. Identification of learner needs primarily in response to patient safety incidents. Some flexibility in job plans but learners not considered to be supernumerary.</p>	<p>Graduated responsibility and job plans based on the needs of the organisation and not learners.</p>
<p>Ensures the welfare of learners</p>	<p>No learner complaints received in this regard. Bullying and harassment policies in place. Regular catch-up with learners on a 1-2-1 basis (at least 1 hour every two weeks for tier 3). Early identification of learners in difficulty and understanding of how to support them, including who to contact and how and when to involve PSW. Some understanding of the stipulations of less than full-time training. Does not place learners in dangerous situations, for example, sending them on visits by themselves to unsafe areas or</p>	<p>Isolated complaints received in this regard. Knows how to identify learners in difficulty but limited awareness of what to do in those situations. Meets with learners on a 1-2-1 basis on a reduced frequency. Awareness of less than full time training but not when this should be considered an option. Informal processes for handling racism and aggression towards NHS staff.</p>	<p>Multiple complaints received by learners in this regard. No opportunities for meeting with learners on a 1-2-1 basis or only happens at the beginning and end of a placement. Learners have been subjected to aggression or racist attacks by patients and offered little support. Learners have difficulty accessing appropriate clinical and pastoral support.</p>

	consulting patients with a history of violence and aggression. Robust policies and procedures for handling racism.		
Assessment of initial learning needs	Always done at the beginning of a placement or OOH shift. Use of various methods to assess – Clinical scenarios, use of the portfolio, structured learning needs assessments, direct observation during induction/OOH shifts.	An odd assessment has been delayed until later in the placement but there are good reasons as to why. Assessment of learning needs is more informal and relies on the learner identifying their own weaknesses.	No assessment of initial learning needs.
Planned approach to individual learner induction	Recognises the difference between personal and organisational induction. Provides opportunities for learners to be observed in a safe environment before seeing patients by themselves. Consideration given to the level of support needed when seeing patients at the beginning of the placement, for example, whether to discuss each patient during each contact. Discussion around pastoral support and identification of any factors that may impede learner performance. Discussion of the individual job plan and any amendments required. Use of individual training maps.	Lesser understanding of the difference between organisational and individual induction. Lacks understanding that the initial job plan needs to be revised to meet the needs of individual learners. Pastoral support available but not made explicit to learners. The induction may be excessive or insufficient to be able to identify individual learning needs.	Only undertakes organisational induction. No formal processes for identifying learning needs. Level of initial support to learners is based on service rather than individual learner needs.

	The induction period is neither too long nor too short.		
Clear approach to clinical supervision	<p>Written clinical supervision policy in place.</p> <p>Arrangements for when ES/CS not around to clinically supervise learners.</p> <p>Awareness of deanery remote supervision policy.</p> <p>Available at timely intervals for clinic debriefs.</p> <p>Protected time to be able to fulfil clinical supervision duties.</p> <p>Awareness of when learners may require greater clinical supervision.</p>	<p>Learners aware of who has the responsibility for clinical supervision but lacking a formal policy.</p> <p>Debriefs happening but less regularly meaning that learners may have to hold onto cases for longer (no more than a couple of days).</p> <p>Clinical supervision considered in addition to clinical work and no protected time to be able to do this.</p>	<p>Clinical supervision is intermittent and ad hoc.</p> <p>Learners have to request clinical supervision/debriefs.</p> <p>It is often not clear who is supervising learners.</p>
Understand the principles of giving feedback to learners	<p>Employs a variety of feedback methods – Verbal, written</p> <p>Understanding and use of different feedback models e.g., Pendleton.</p> <p>Ensures that feedback is timely and relevant to the needs of learners.</p> <p>Understands that feedback should be based on observable behaviours and constructive with tangible developmental points.</p> <p>Provides regular opportunities for learners to seek feedback on specific areas they are concerned about.</p>	<p>Feedback is provided regularly but is often verbal and not recorded.</p> <p>Feedback may be provided but at a point in time which is less relevant to learner development.</p> <p>There are few opportunities for 1-2-1 feedback.</p> <p>Feedback is driven by the educator rather than the learner (excluding where learners lack insight).</p> <p>Regular suggestions for learner development are made but these lack specificity.</p>	<p>Feedback is rarely given to learners and when it is tends to be based on generalisations or related to attitudes and preconceptions.</p> <p>Few, if any suggestions for development are offered.</p>

	<p>If providing feedback amongst a group, ensures that this is done in a safe way. Identifies when feeding back within a group may not be appropriate or wanted. Uses the educator notes within the e-portfolio on a regular basis to document any feedback that has been given.</p>		
<p>Seeking regular feedback from learners</p>	<p>Seeks feedback from learners on their educational performance throughout their placement. Asks learners to provide written feedback on tutorials. Identifies when learners may have reservations about providing feedback and encourage them to do this in a safe way. Utilises any feedback received to improve educational performance. Considers learning outcomes as a means of indirect feedback, for example, learning logs within the e-portfolio following teaching. Encourages learners to complete placement feedback forms.</p>	<p>Seeks feedback from learners at the end of a placement but fewer opportunities for this during the placement. Asks for verbal feedback only.</p>	<p>Rarely seeks any feedback on performance, either written or verbal. Defensive towards feedback rather than considering it as being developmental.</p>
<p>Supporting learners to gain a wide range of learning opportunities</p>	<p>Encourages learners to interact and learn from the wider health professions. Ensures that learners have opportunities for audit/QIP and</p>	<p>A wide range of learning opportunities is available, but the educator relies on the learner requesting to access those rather than actively promoting them.</p>	<p>Learning opportunities are limited and little consideration has been given to how the potential gaps in the learner's curriculum will be addressed.</p>

	<p>can attend significant event meetings. Encourages learners to attend safeguarding meetings, frailty meetings, MDTs etc. Ensures that learners are exposed to a wide range of clinical conditions, identifies when this is not happening and takes steps to address this. Suggests opportunities for learners to do child health checks, minor surgery, contraceptive services etc. Encourages learners to attend PCN meetings and provide opportunities for leadership activities, including teaching. Regularly suggests personal development points and signpost them to resources available to achieve these.</p>	<p>Learners are encouraged to attend different clinical meetings, but learners are expected to do this purely during their educational portion of the week. The wider health professions are involved during induction but thereafter have limited interaction with learners.</p>	<p>There are minimal opportunities for learners to learn from other health professionals. The work plan is so restrictive that it does not consider learners attending clinical meetings. The educator relies on the variety of general practice to provide the full range of learning opportunities. Few suggestions or resources are suggested for personal development and learning.</p>
<p>Use of weekly educational time to support learners</p>	<p>Tier 2A educators provide learners with feedback on their performance and complete a shift sheet. Tier 2B and tier 3 educators have a full understanding of the educational part of the working week – 1 Session structured education in the practice, 1 Session half-day release, 1 Session protected learning (pro rata).</p>	<p>Full understanding of the educational parts of the working week. Does not always provide suggestions for how protected learning time should be used. Learners can attend HDR but often delayed due to late clinics/home visits. Structured educational sessions are limited in scope or follow a set curriculum that fails to</p>	<p>Limited knowledge of the learner working week. Educational time is poorly protected. Educators not providing any structured education. Learners unable to attend HDR on a regular basis due to service commitments. Tier 2A educators fail to complete shift sheets with learners at the end of sessions.</p>

	<p>Supports learners to use the protected learning time constructively.</p> <p>Ensures that learners can attend HDR regularly and on time i.e., clinical responsibilities should not impact upon this.</p> <p>Employs a variety of structured learning methods in the practice – Tutorials (both learner and educator/wider professional led), 1-2-1 feedback, completion of WPBA, observed clinics, etc.</p> <p>Plans educational sessions in response to individual learner needs.</p>	<p>encompass individual learner needs.</p>	
<p>Full understanding of UUC capabilities and role in assessment</p>	<p>Full understanding of role in assessment of UUC capability</p> <ul style="list-style-type: none"> - Tier 2A provide feedback and complete shift sheets - Tier 2B (when no ES on site) discusses the shift and suggests developmental objectives - Tier 3 as above. Ensures that learners have documented a range of experiences that demonstrate capability and advise whether there is sufficient curriculum experience group coverage <p>Releases learners from clinical duties when undertaking direct,</p>	<p>Understands UUC capabilities but more limited understanding of how learners can fully demonstrate these.</p> <p>Lacks full understanding of when learners should receive time off in lieu in relation to working in OOH.</p> <p>Limited understanding of the implications of the European Working Time Directive in relation to working in OOH.</p> <p>Does not always review the shift sheets from OOH.</p>	<p>Little or no understanding of the UUC capabilities and role in assessment.</p> <p>Incorrect assessment of learners in relation to UUC, for example, deeming purely observational shifts or personal study as fulfilling the capability requirements.</p> <p>Failure to release learners so that they may undertake shifts in OOH.</p>

	<p>near and remote sessions in OOH. Ensures that learners are not breaching European Working Time Directives. Knows that there are no set number of hours that must be worked in OOH but that none would not be acceptable. Understands the types of UUC session and how these relate to the previous RAG rating. Promotes other opportunities for learners to address their UUC capabilities, such as, telephone triage and duty days at the practice. Awareness that UUC may be demonstrated within secondary care placements.</p>		
<p>Promotion of employment opportunities within the local primary care system</p>	<p>Regularly discusses career planning with learners. Highlights opportunity for working within the local OOH/learning organisation (including PCNs). Awareness of initiatives such as New to Practice Programmes and providing information to learners about these. Encourages learners to join the local First 5 group.</p>	<p>Regularly discusses career planning with learners but this is more generalised and lacks specifics regarding working within the local system.</p>	<p>Rarely discusses life after CCT or provides any opportunities for working within the local system.</p>

Additional Comments – This will not be used as part of the risk assessment but is an opportunity to feedback to the Primary Care School if there are systematic issues that need addressing to enhance your educational role.