**Educational Supervisor’s Structured Report - Occupational Medicine**

The Educational Supervisor (ES) must complete this report for the Annual Review of Competence Progression panel, summarising the trainees learning portfolio and Workplace Based Assessments (WPBAs) since the previous assessment. Handwritten forms will **not** be accepted.

Please note that if the trainee could not fulfil all training requirements (mapped against FOM curriculum/ARCP decision aide), the ES should additionally complete **‘COVID-19 ARCP Educational statement 2021**’.

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| **Trainee details** | **Educational Supervisor details****(Only the named ES can complete this report)** |
| **Names:** | **Name:** |
| **Employing Organisation:** | **Employing Organisation:** |
| **Main location of training:** | **Main location of work:** |

|  |  |  |
| --- | --- | --- |
| **Employer** | **Named clinical supervisor(s)** | **Dates (from-to)** |
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**Placements in OM programme (start with the current)**

**Previous ARCP**

|  |  |  |  |
| --- | --- | --- | --- |
| **Dates (from-to)** | **Grade reviewed** | **Outcome**  | **For outcomes 2&3, have the objectives been met (Y/N)** |
|  | ST\_ |  |  |
|  | ST\_ |  |  |
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**Please confirm the Mandatory evidence for this ARCP has been submitted in accordance with Appendix 1.**

|  |  |  |
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| **Evidence required**  | **Signed off by ES/CS (Y/N)** | **Minimum numbers (Y/N)** |
| Workplace risk assessment |  |  |
| First Aid assessments |  |  |
| Health surveillance programme |  |  |
| Environmental impact assessments |  |  |
| Health promotion programme  |  |  |
| Clinical audits |  |  |
| Mini CEXs |  |  |
| SLEs- DOPS |  |  |
| MSFs |  |  |
| CBDs |  |  |
| Sail OH 1 |  |  |
| Sail OH 2 |  |  |
| Teaching |  |  |
| Management and clinical governance  |  |  |
| Dissertation passed by FOM  |  |  |
| MFOM part 1 passed or Dip Occ Med |  |  |
| MFOM part 2 passed\*\* |  |  |
| Educational supervisor’s report |  |  |
| GMC anonymous Trainee survey |  |  |
| Form R (A&B)- Reflection on practice if needed |  |  |
| CCT Calculator |  |  |

**Please confirm if any Additional evidence for this ARCP has been submitted in accordance with Appendix 1.**

|  |  |  |
| --- | --- | --- |
| **Evidence required**  | **Signed off by ES/CS (Y/N)** | **Minimum numbers (Y/N)** |
| Educational plan  |  |  |
| Dissertation plan |  |  |
| Patient survey |  |  |
| CPD return and associated evidence |  |  |
| Reflection on CPD / educational events attended |  |  |
| Training to be a Trainer |  |  |

**Achievement of core competencies**

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| --- | --- | --- |
| **Core competencies commensurate to stage of training ST3/4/5/6** | **Achieved (Y/N)** | **If not achieved, provide the details including the reason and the action plan to rectify** |
| **1 Good Occupational Medical Practice**  |  |  |
| 1.1 Good Clinical Care including (i) History, Examination, Investigation & Record Keeping Skills and (ii) Managing Chronic Disease |  |  |
| 1.2 Time Management & Decision making |  |  |
| 1.3 Information including (i) Education & Disease Prevention, (ii) Health promotion and (iii) Information Management |  |  |
| 1.4 General Principles of Assessment & Management of Occupational Hazards to Health |  |  |
| 1.5 Assessment of Disability and Fitness for Work |  |  |
| 1.6 Environmental Issues Related to Work Practice |  |  |
| **2 MAINTAINING GOOD CLINICAL PRACTICE**  |  |  |
| 2.1 Learning Competency |  |  |
| 2.2 Research |  |  |
| 2.3 Clinical Governance |  |  |
| 2.4 Role specific competencies |  |  |
| 2.5 Occupational health in a global market |  |  |
| 2.6 Teaching  |  |  |
| **3 RELATIONSHIPS WITH PATIENTS AND COMMUNICATION**  |  |  |
| 3.1 Ethical/legal issues |  |  |
| 3.2 Maintaining Trust including Professional behaviour |  |  |
| 3.3 Communication Skills |  |  |
| **4 WORKING WITH COLLEAGUES**  |  |  |
| 4.1 Team Working & Leadership Skills  |  |  |
| 4.2 Management |  |  |

**Summary of Trainee’s Assessment**

**In your opinion has the trainee’s overall progression been satisfactory and therefore they can progress to the next level of training? Yes / No (delete as appropriate)**

**Comments** (You must provide feedback to explain the reason for your opinion including positive feedback and areas to improve both for satisfactory or unsatisfactory progression)

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| --- |
| Reason for opinion  |
| Positives  |
| Areas to improve  |

### Trainee’s comments:

|  |
| --- |
| Reflection on ES opinion  |
| Reflection on positives and areas to improve |
| Mitigating factors if relevant  |

**Please record the agreed CCT date based on the CCT calculator and previous outcome 3 DD/MM/YYYY.**

|  |  |
| --- | --- |
| **ES** I confirm that this is an accurate description/ summary of this trainee’s progression from DD/MM/YYYY to DD/MM/YYYY. | **Trainee** I confirm the content of this report has been discussed with me prior to submission.  |
| **Names:** | **Name:** |
| **Signature (initials are acceptable as electronic signature)** | **Signature (initials are acceptable as electronic signature)** |
| **Date:** | **Date:** |