NHS
North East & North Cumbria

EVALUATION FORM
PROTECTED LEARNING TIME 2025
PCN & Practice Returns

PCN Name:

Practice Name:

Date of Session:

Staff in attendance:

_____**GPs out of total number of GPs**

_____**Nurses out of total number of Nurses**

_____**Other staff out of total number of staff**

Subject: (Please provide a brief description of the topic covered**)**	
Aim: (Please provide brief details on the aim of the session and break down by staff group if appropriate)	
Outcome: (Did this training fulfil the aims/objectives of the practice)	
Was an outside trainer involved? (If so, please provide name and contact details) **If an outside trainer was involved, would you recommend this person to other practices?**	
Were other practices involved or invited to attend? (If so, please provide name)	
Any other comments	

Signed:
Date:
Please return this form to Primary Care. nencicb-cu.primarycare@nhs.net