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# RCGP Example Portfolio: Locum GP

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## Introduction

The RCGP has developed a range of example portfolios to demonstrate how GPs in a variety of professional contexts can demonstrate that they are meeting revalidation standards set by the GMC. The portfolios have been authored by RCGP Specialty Advisers, clinical experts on revalidation with specialist areas of knowledge. The documents should be treated as ‘hypothetical’ portfolios in that the supporting information contained, the GP and the GP’s working environment are fictional.

These are not full portfolios, but instead contain samples of supporting information, with emphasis on items which are of particular relevance to the GP’s role. Neither are they ‘exemplar’ portfolios. The Specialty Adviser, who provides commentary throughout, identifies where there is opportunity for the GP to develop their supporting information. The portfolios take a ‘snapshot’ of a portfolio at the end of the fourth year in a five-year cycle, enabling the Specialty Adviser to suggest any areas for the GP to concentrate on in the final year of their cycle.

Although the portfolios have been written by the RCGP Specialty Advisers, they do not represent the method by which advisers will give advice to Responsible Officers and others. Advisers will not comment on individual portfolios, and requests for advice will be made through the RCGP central helpdesk.

If there are specialty elements to the role, the RCGP would strongly advise that the GP refers to the guidance produced by the relevant College or Faculty.

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# General information

This area is blank unless there is information specifically relevant to the subject GP.

## 1. Personal details

Title: Dr First Name: A Surname: Locum

GMC Reference Number:

## 2. Qualifications

Primary medical degree:

Qualifications:

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### 3. Scope of your work

This area is blank unless there is information specifically relevant to the subject GP.

Please list the organisations and locations where you have undertaken work as a doctor.

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<i>Organisation</i>	<i>Location</i>
Sunnyhill Medical Centre	Sunnyhill Avenue, Newtown Magna
Appleby Health Centre	Pippin Hill, Bramley, Crumbleton
Sawrize practice	Sighthill place, Sighthill, Keynesville
The Bleak House practice	Charles Dickens Road, Worthyome
Nightjar Out of Hours Centre	Jupiter Centre, Constellation Road, Crumbleton

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Please provide a comprehensive description of the scope and nature of your practice.

I work as a peripatetic locum doing short time placements in different surgeries – over the past year I have worked mainly in about six surgeries, with the odd day at about another four surgeries. Naturally this makes follow up difficult. Having several different workplaces requires me to be organised and keep my weekly/daily timetable up to date. Each day is potentially different, though sometimes I work the whole week in one practice. I feel I can approach patients and situations with a fresh eye and can bring skills and knowledge from experience in one practice to the next.

At Appleby Health Centre there are a total of eight doctors at the practice (five full time equivalents) and a GP registrar. The Appleby practice is located in the Orchard Area, a suburb of Crumbleton providing general medical services to a list size of approximately 12,000 patients. There is a regular minor surgery list provided by two of the partners.

Sunnyhill Medical Centre is a purpose-built health centre in shared premises with two other practices. Sunnyhill serves a 10,000 patient population, which has a fair proportion of affluent middle-class patients, and also an area with patients of a different ethnic mix. This surgery provides all the usual services, and local district nursing, health visitor, counselling and physiotherapy services also operate within the building.

Sawrize practice is a practice of three GPs who own the premises. The surgery is in need of renovation and runs daily ‘sit and wait’ surgeries as well as a limited number of pre-bookable appointments. There are a higher proportion of social class 4/5 patients, with a recent increase in the proportion of immigrant patients from Eastern Europe, and a fair amount of deprivation.

The Bleak House surgery is located in a large commuter village in a semi-rural area, with a mixed population of around 8000 patients, and is attached to the local day hospital. A visiting consultant in elderly medicine attends the day hospital once a fortnight to provide secondary care outpatient services there.

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Nightjar Out of Hours Centre is located adjacent to Crumbleton Gen Hospital. As well as the OOH GPs it is staffed by a range of experienced nurses, paramedics and triage staff, with two drivers on each shift for the cars.

Working a little for several practices can sometimes be difficult in that each employing practice can forget that I have other commitments and involvements, and I am not always available to them. Frustratingly, I am rarely informed of latest developments and involved in audit and current projects. This means that I have to work alone a lot of the time, and do not enjoy the admin support that others have in the surgery for audit and SEA. I enjoy being part of a team and have had most continuity in the Appleby Health Centre, where I did a maternity locum for three months (previous locum left halfway through). Working in different locations in general practice also means lack of continuity of care. I may be losing my skills in chronic disease management and emergency medicine in particular. I am seldom involved in the care of the frail elderly at home. My OOH work enables me to use and refresh skills in acute disease management and emergency medicine.

I would like to restart doing minor surgery but find this infeasible as a locum. I no longer do any child health surveillance or maternity services. As a male GP, I relatively rarely provide contraception services, and I never do coil and contraceptive implant fitting.

*Specialty Adviser comments:*

A peripatetic locum preparing for appraisal and revalidation faces a number of additional challenges compared with a GP working as a principal or salaried doctor in a single practice. It is important to try to engage the cooperation and support of practices for locums in this situation, particularly with patient surveys, colleague feedback, audit/quality improvement activity, and Significant Event analysis. On the other hand, the locum working in different practices has a variety of patient populations and practice setups – this can sometimes work to the locum’s advantage, and the evidence required for appraisal can be gathered from different sites. Many OOH organisations can also offer support to GPs working solely or primarily in OOH. Professional isolation can be a problem, and local sessional GP groups, private study groups, and Balint groups can go some way to address this.

Although a description of each of the appraisee’s four main practices is given here, it is not strictly necessary. While the detail may be useful to give the context of the doctor’s work, giving an overview of the working environment would suffice. Including the average number of sessions worked per week or month, and where, might also be helpful.

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## 4. Record of annual appraisals

This area is blank unless there is information specifically relevant to the subject GP.

## 5. Probity declaration

This area is blank unless there is information specifically relevant to the subject GP.

I have met the probity requirements as defined by either the GMC or the Academy of Medical Royal Colleges.	<input type="checkbox"/>	Date <input type="text"/>
I have met the health requirements as defined by either the GMC or the Academy of Medical Royal Colleges.	<input type="checkbox"/>	Date <input type="text"/>
I have met the insurance requirements as defined by either the GMC or the Academy of Medical Royal Colleges.	<input type="checkbox"/>	Date <input type="text"/>

## Pre-appraisal documentation

One example of a pre-appraisal document is provided.

*In preparation for your appraisal you should consider how you are meeting the requirements of the domains of Good Medical Practice. This reflection will help you and your appraiser to prepare for your appraisal and will help your appraiser summarise the appraisal discussion.*

### General background/context

I like to think of myself as an experienced GP with good all round skills. I have particular interests in cardiology, dermatology and IT. As a locum I get given full patient lists each day so the focus is on getting through the patients, rather than any practice management or teaching. There is no time for meetings and educational events and any opportunities for this have to be found and funded by me. I usually do not get to hear about local courses and meetings, or if I do then they are incompatible with the clinical commitment. However, I enjoy the variety and challenge of managing different patient populations in a variety of settings.

### Aspirations/achievements/challenges

I have many years of GP experience and therefore a sound base of clinical knowledge and skills. I feel I have good organisational skills, in that I generally keep to time and pass on information to others when necessary. I find it easy to establish rapport with most patients. I take pride in my work and try to make sure I don't leave referrals etc. for others to do at the end of the day.

The nature of locum work and everyday time pressures is always challenged. Working sessions in different locations as a locum, coupled with increasing pressure on appointments, means that my days could be quite stressful. I find there is increasing complexity of cases managed in primary care and not enough time to deal with these in one ten-minute appointment – this tends to reduce satisfaction in the consultation both for me and for individual patients. Often just finding out where forms and specimen bottles are, the different setup in each surgery, and different IT systems take that much more time on an everyday basis.

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## Specific areas for discussion with your appraiser

As a locum, there is always difficulty with following up patients, so I am unable to review my diagnosis and management. As I work in several practices, as well as out of hours, I find it difficult to keep a record of referrals and follow up. This restricts my ability to do audit and learn from any letters back from hospital etc.

## Have you been requested to bring specific information to your appraisal by your organisation or RO?

No.

## Knowledge, skills and performance

I tried to keep up to date and spend approximately 1–2 hours per week reading medical literature and using internet sources. *GP* magazine, GP related articles in *BMJ*, some guidelines online etc. Also newsletters on clinical developments, which I sometimes receive by e-mail or pick up in one or two of the surgeries that I visit. I try to keep up with both clinical and medico-political aspects of GP practice. I have not managed to attend any substantial CME courses over the past year, because I have to take into account the cost of going and the loss of earnings if I take a day out of practice to go out to a distant centre of excellence for a course. Some of the practices that I locum in have regular educational meetings, but I'm not invited to these, and sometimes and specifically to cover the practice Protected Learning Time half days.

## Safety and quality

I have found doing an audit very challenging. I suppose I could make a note of my hospital referrals and check back on them if I go back to that surgery within a year, but I doubt if the numbers involved in any one surgery would make this a significant piece of work. I don't go to any Significant Events meetings in the practices that I work in, and I don't think there's a mechanism for reviewing these in a group in the out-of-hours centre. I've written up a couple of Significant Events, but haven't already discussed them with anybody – hoping to do this in my appraisal.

I submitted a patient survey as part of my evidence last year, but again this was really difficult to arrange and eventually I did get enough to satisfy the requirements of the particular survey that I carried out, and I've also done some more learning on consultation skills as a consequence of the results.

This year I found the multisource feedback was easier to do as I managed to get the number of responses needed according to the survey, though again this took time chasing people up to respond. Not all of them felt they were really able to comment on my clinical performance, leadership skills etc., and this is because they have limited contact with me as a locum. I used the four main practices where I locum, and found that I had enough people between the four sites.

## Communication, partnership and teamwork

One of my strengths is the ability to build rapport with wide variety of patients. I feel I am approachable and I try to allow patients time to talk. After reading a book and watching a DVD on consultation skills, I am more conscious about trying to share decision making with the

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patient. I use a variety of patient information leaflets, and try to explain results and proposed investigations where possible. Unfortunately, one of the consequences of this is a tendency to run over time in surgery. I started doing locums in an area where there is a high proportion of ethnic minority patients, and I find communicating with them quite challenging as many of them do not speak much English.

I would like to feel a bit more of a team, and the degree to which this happens depends on the surgery I am working in. Sometimes I am just an extra pair of hands and apart from the patients I hardly get to speak to anybody in surgery at all. At other times, I am made to feel quite welcome and have coffee with the others during the (short) breaks. Unfortunately the contact I have with the other doctors is often limited due to workload, and in many of the practices I work, several of the doctors remaining in the practice work part-time. I feel more of a team in the out of hours situation – we have a stable nursing and reception team, with a rotating number of drivers, and I get on well with all of these. There are quite a few doctors working out of hours, so it's difficult to get to know anybody really well particularly as we are working quite hard, but we all try to help each other out. For example, if we are not sure about what to do with results that are coming outside the normal range, we consult one another and share any guidance that we know of, so that we are all doing the same thing. I hope that my behaviour shows appreciation of others' skills and consideration, and that people realise that I try to support others in the practice and out-of-hours teams. I try to be flexible in that, if some visits come in, I will offer to go out if the other GP is not keen on doing visits, or nearing the end of his/her shift.

## Maintaining trust

*Complaints and compliments – required every appraisal cycle.*

I don't really get any cards or gifts as a locum, but some patients say very nice things to me, or about me to the receptionists. I haven't had any formal complaints that I know of over the past year. I did have a patient who said she was going to complain about me because I saw her 45 mins after her appointment time, and didn't deal with all the things that she wanted to talk about. But I don't really know whether she did complain because the practice manager deals with these complaints herself, and I don't get told about them. I suppose if it was really serious, then I would get to hear.

My health is fine, and I have had no reason to go and see my GP over this past year.

I have no concerns about my personal probity. I do not handle money, and have an accountant for my business and tax affairs.

### *Specialty Adviser comments:*

A locum GP may often experience a very fragmented working pattern, with relatively little contact with colleagues and teams in the surgeries he/she works in. A greater degree of flexibility may be needed when reviewing a locum's appraisal portfolio. The GMC questionnaires recommend 20 colleagues and a minimum of 34 patients for the colleague and patient survey respectively, but the appropriate number of responses required are dependent on the validated questionnaire. There will generally be more constraints and obstacles to overcome than a doctor based in one practice. Even so, it is important to try to obtain evidence



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to back up one's statements, otherwise they are simply expressions of opinion. A view on the sufficiency of evidence must take into account the context of the working environment. The appraiser can guide the locum appraisee on this, and advise on areas of professional support.

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## Keeping up to date

### Continuing Professional Development (CPD)

*Some key points about the RCGP credit-based system for CPD:*

- The expectation is that GPs will collect at least 50 credits per year covering the full scope of their practice.
- Credits are self assessed and verified at appraisal.
- At its simplest, each recorded hour spent on a CPD activity, which can include planning, accompanied by a reflective record will count as a credit.
- A GP can double their points if they can demonstrate impact, i.e. that learning has resulted in positive change for patients, the service or others e.g. NHS locally or nationally.
- The RCGP Impact Toolkit describes the ways in which impact can be evidenced.
- The RCGP Revalidation ePortfolio contains a field in which GPs are required to record a comment if they have claimed impact credits. If no impact comments have been claimed in the examples below, this field will be marked N/A.
- A common query around conferences is whether these should be recorded as a single learning episode. We would suggest that GPs record the parts of the conference that they consider useful learning separately with the appropriate time factor, reflections and evidence. This will enable them to allocate impact credits to the relevant CPD entries.

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Four or five examples of key learning activities are provided in each year (Years 1 to 4).

## YEAR 1

### CPD Activity 1

Type:  Start date:  End date:

#### Brief description of the activity

Update in cardiology for GP – management of AF, heart failure, and MI.

Time: 3 hours Impact: No Credit claimed: 3

#### Impact comment

N/A.

#### Learning need addressed

Keeping me up to date as a GP in this area.

#### Method used

Three lectures within a half-day course.

#### Outcome of activity

Interesting to know about controversies in therapeutic management.

#### Outline any further learning or development needs highlighted by the activity

None.

### CPD Activity 2

Type:  Start date:  End date:

#### Brief description of the activity

Attended a good resuscitation course run by the local hospital. This covered both paediatric and adult life support, and the Heimlich manoeuvre.

Time: 2 hours Impact: No Credit claimed: 2

#### Impact comment

N/A.

#### Learning need addressed

I need to keep up to date in this area for both in-hours and OOH work.

#### Method used

Hands-on teaching, practice on dummies for 'kiss of life' and cardiac massage, use of the defibrillator machine.

#### Outcome of activity

Refreshed vital skills in this area, new guidelines on BLS. Gained certificate of satisfactory performance.

#### Outline any further learning or development needs highlighted by the activity

Find out where the defibrillator machines are kept in all the practices I work in.

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### CPD Activity 3

Type: [ ] Start date: [ ] End date: [ ]

#### Brief description of the activity

Asthma management-new therapeutic agents.

Time: 2 hours Impact: No Credit claimed: 2

#### Impact comment

N/A.

#### Learning need addressed

I see a lot of asthmatics in practice and out of hours.

#### Method used

Consultant-led lecture, sponsored by pharmaceutical company.

#### Outcome of activity

I'm now aware of a new inhaler for Step 2 asthma treatment.

#### Outline any further learning or development needs highlighted by the activity

Find out whether this is available on formulary.

### CPD Activity 4

Type: [ ] Start date: [ ] End date: [ ]

#### Brief description of the activity

The impact of hypotension in elderly patients.

Time: 1 hours Impact: No Credit claimed: 1

#### Impact comment

N/A.

#### Learning need addressed

A common complaint in the elderly.

#### Method used

Online learning module.

#### Outcome of activity

Hypotension can be costly to the NHS and cause severe disruption to some patients.

#### Outline any further learning or development needs highlighted by the activity

Need to consider this when assessing a falls patient.

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*Specialty Adviser comments:*

Although all topics are relevant to general practice, within this sample there is a disproportionate focus on cardiology. The appraiser could be guided as to how to be more reflective on the learning activities described.

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## YEAR 2

### CPD Activity 1

Type:  Start date:  End date:

#### Brief description of the activity

Pharma module: Fungal infections and their treatment.

Time: 1 hour Impact: No Credit claimed: 1

#### Impact comment

N/A.

#### Learning need addressed

A common presenting complaint in general practice.

#### Method used

Online learning module.

#### Outcome of activity

Feel better informed on topical treatments for fungal nail infections.

#### Outline any further learning or development needs highlighted by the activity

Will give relevant advice to patients presenting with these problems.

### CPD Activity 2

Type:  Start date:  End date:

#### Brief description of the activity

Doctors.net e-Learning.

Time: 1 hour Impact: No Credit claimed: 1

#### Impact comment

N/A.

#### Learning need addressed

Update on colorectal cancer.

#### Method used

Online learning module.

#### Outcome of activity

Revised staging and treatment, dependent on the site of the tumour.

#### Outline any further learning or development needs highlighted by the activity

None.

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### CPD Activity 3

Type:  Start date:  End date:

#### Brief description of the activity

Doctors.net e-Learning.

**Time:** 1 hour **Impact:** No **Credit claimed:** 1

#### Impact comment

N/A.

#### Learning need addressed

Update on dealing with aggressive and violent patients.

#### Method used

Online learning module.

#### Outcome of activity

Now know there is a DES on aggressive patients, legislation to protect doctors and patients, yellow and red cards system.

#### Outline any further learning or development needs highlighted by the activity

More aware.

### CPD Activity 4

Type:  Start date:  End date:

#### Brief description of the activity

Reading articles on drug treatment of cardiovascular conditions; looking at the local formulary to update myself on first-line drugs.

**Time:** 3 hours **Impact:** No **Credit claimed:** 3

#### Impact comment

N/A.

#### Learning need addressed

Update on cardiovascular drugs.

#### Method used

Journal reading: GP Cardiovascular Update, and local formulary guidelines.

#### Outcome of activity

ACEI – use lisinopril or ramipril, but if ARB, then candesartan / losarten for BP or heart failure; also good for diabetic nephropathy. Calcium channel blockers: start with amlodipine for high BP or angina on b-blockers. Angina not on b-blockers – treat with diltiazem or verapamil.

#### Outline any further learning or development needs highlighted by the activity

I will remember to only use ARBs for ACEI-intolerant patients because of price.

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### CPD Activity 5

Type:  Start date:  End date:

#### Brief description of the activity

Doctors.net e-learning.

**Time:** 1 hour **Impact:** No **Credit claimed:** 1

#### Impact comment

N/A.

#### Learning need addressed

Update on the acute abdomen.

#### Method used

Online learning module.

#### Outcome of activity

Revised use of investigations and abdominal pain, when to use AXR, US, CT.

More able to advise patients as to what expect in hospital.

#### Outline any further learning or development needs highlighted by the activity

Find out if we have direct referral access to CT scans.

#### *Specialty Adviser comments:*

Online learning can be a convenient way of accessing education for locums, but using a variety of methods may be more interesting and effective. The appraiser has described some of the outcomes and intended further learning related to the topic. The learning log is more descriptive, and could be more reflective.



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## YEAR 3

### CPD Activity 1

Type:  Start date:  End date:

#### Brief description of the activity

I found an e-learning module, and revised the definition of terms, looked at retinal photographs, and related this to the progression of diabetes. I also found another module on the impact of eye health, which I thought would be relevant. I discussed how we interact with the optometrist with a GP colleague.

**Time:** 4 hours **Impact:** No **Credit claimed:** 4

#### Impact comment

N/A.

#### Learning need addressed

Diabetes and eye disease and its implications.

#### Method used

Doctors.net e-learning modules; additional reading on the Internet.

#### Outcome of activity

I now have a better idea of when to refer to an ophthalmologist, and also what the optometrist can do. I have also got a much better understanding of the impact of blindness and reduced vision, and the screening procedure for different groups of patients.

#### Outline any further learning or development needs highlighted by the activity

I read that there are liaison officers for the blind and would like to find out whether these exist in our area, and what other support services for the blind are available in the community.

### CPD Activity 2

Type:  Start date:  End date:

#### Brief description of the activity

OOH centre has changed its computer system. They put on a half-hour training session, and I also spent time practising what I'd learnt for another half hour.

**Time:** 1 hour **Impact:** No **Credit claimed:** 1

#### Impact comment

N/A.

#### Learning need addressed

Learning about the new computer system.

#### Method used

Software trainer came to give us a group talk and demonstration.

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**Outcome of activity**

In fact I found this quite easy to understand, and practising it straight after the session gave me extra confidence.

**Outline any further learning or development needs highlighted by the activity**

I realise that there is now a different method of logging drug use for stock control and will need to be careful about inputting batch numbers.

**CPD Activity 3**

Type:  Start date:  End date:

**Brief description of the activity**

Reading up on emergency contraception; discussion with an OOH colleague.

Time: 2 hours Impact: No Credit claimed: 2

**Impact comment**

N/A.

**Learning need addressed**

Contraception is an area that I feel less confident with, because these patients often go to my female colleagues in the surgery. However, I still need to see them in the OOH centre, particularly for the morning after pill.

**Method used**

I found some local guidelines, and also looked on the FSRH website about missed pills: [www.fsrh.org/pdfs/CEUStatementMissedPills.pdf](http://www.fsrh.org/pdfs/CEUStatementMissedPills.pdf).

**Outcome of activity**

I now feel much more clear on what to use and when, the greatest risk times for pregnancy with respect to OPSI, and the side effects of morning after pills.

**Outline any further learning or development needs highlighted by the activity**

I still feel a bit confused as to whether I can continue to use the seven-day rule safely, as the revised guidelines seem very complicated. I must also find out more about Ulipristal as I have never prescribed this.

**CPD Activity 4**

Type:  Start date:  End date:

**Brief description of the activity**

DEN (Doctor's Educational Need): Update on the guidance around fitness to drive. I went onto the DVLA website, and also completed an e-learning module.

Time: 3 hours Impact: No Credit claimed: 3

**Impact comment**

N/A.

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**Learning need addressed**

DVLA guidance on fitness to drive – this is an area that I do not address in OOH at all (but maybe I should!). Nor do I see many of these patients in the surgery. It was only when I overheard the GP in the training practice discussing this with the GP registrar that I realised I don't really feel confident in this area.

**Method used**

Online learning.

**Outcome of activity**

I updated myself and regulations surrounding angina, loss of consciousness, seizures, and diabetes.

**Outline any further learning or development needs highlighted by the activity**

I am now more confident in advising patients on fitness to drive, and will try to be more proactive when I see somebody with an acute event, e.g. TIA in the OOH centre.

*Specialty Adviser comments:*

The appraisee has made efforts to cover areas of the GP curriculum outside his current comfort zone and experience. Learning is relevant to both in hours and OOH practice. The entries have become more reflective.

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## YEAR 4

### CPD Activity 1

Type:  Start date:  End date:

#### Brief description of the activity

Improving my consultation skills through reading a book on consultation models and watching a consultation skills DVD with a variety of examples.

Time: 6 hours Impact: No Credit claimed: 6

#### Impact comment

N/A.

#### Learning need addressed

I was particularly keen to address how I covered the area flagged up in the patient survey that I carried out this year, which showed that although I was friendly and welcoming, patients were not always sure of the treatment plan. I was also keen to address my anxiety that I'm not always understood by patients, perhaps by speaking too fast. I concentrated on communication, and also the last bit of the consultation, as this is where the explanation of management plan and safety netting occurs.

#### Method used

I read this classic book on consultation models and picked up some useful tips on getting the message across clearly. I also watched the DVD, and looked at how management was explained to the patient in a clear way, with follow-up.

#### Outcome of activity

I feel more confident now that I have got a much better idea of how to get my message across, shared decision making with the patient, and make sure they know exactly what the plan is when they leave the consulting room.

#### Outline any further learning or development needs highlighted by the activity

None as yet, but when I do my next patient survey I hope that I will show some improvement in this area.

### CPD Activity 2

Type:  Start date:  End date:

#### Brief description of the activity

I found a book on soft tissue injuries and their management, and read the relevant chapter. I also went on YouTube and looked at the video clips of examinations of shoulder, elbow and wrist. I practised these on one of my locum colleagues!

Time: 4 hours Impact: No Credit claimed: 4

#### Impact comment

N/A.

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**Learning need addressed**

Management and rehabilitation of upper limb injuries.

**Method used**

E-learning, reading. Practical session on limit examination.

**Outcome of activity**

I'm much more structured in the way I approach upper limb injuries now, and much more slick in terms of joint examination. I also realise that timing is really important regarding referral for orthopaedic opinion, and am more aware of the role of the physio in managing these problems. I realise that some of my referrals could have been done earlier, and I am also more cautious about recommending steroid injections to patients because of the evidence.

**Outline any further learning or development needs highlighted by the activity**

This has made such a difference to my efficiency in examining the upper limb that I'm going to go on to look at similar joint examination techniques for the knee. I will try and touch base with the physio in the health centre and get her views as to how I use in practice.

**CPD Activity 3**

Type:  Start date:  End date:

**Brief description of the activity**

Finding out about the diagnosis and management of bacterial meningitis in the community. I went to an educational talk organised by the OOH centre.

**Time:** 2 hours **Impact:** Yes **Credit claimed:** 4

**Impact comment**

I felt strongly that this should not happen again and so decided to compile a checklist for red flags in meningitis, covering infants, children, adults, the elderly, and pregnant women. I discussed this at my locum GP study group, and refined the checklist after their advice. After speaking to the OOH organisation, the GP OOH educational lead and the OOH manager agreed that it would be useful if we could share this with all of the OOH GPs and it was therefore circulated as an e-mail reminder to all OOH clinical staff, and put up on the OOH secure website under 'educational resources'. I have subsequently had a couple of e-mails from colleagues reporting back to me that they found these helpful. (My evidence includes the final version of the checklist, minutes of the meeting of my GP study group where it was discussed, e-mails from the OOH organisation confirming it will be disseminated, and the e-mails giving positive feedback to me.)

**Learning need addressed**

SEA. There had been a recent death of a young person in the OOH centre due to delay in diagnosis and inappropriate triage. We all felt very shocked by this and the OOH centre decided to put on an educational meeting to update us all.

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**Method used**

Presentation and group discussion.

**Outcome of activity**

I was also interested to hear about the difficulties in diagnosing meningitis in pregnancy. This is a high-risk area and deaths have occurred because the symptoms can be easily confused with other pregnancy symptoms (tachycardia, increased respiratory rate, vasodilatation etc.). I realise I need to be more aware that signs of sepsis can be more difficult to identify in pregnant women, and they needed to be treated with antibiotics as early as possible.

**Outline any further learning or development needs highlighted by the activity**

I felt quite unnerved by this recent death and I'm going to revise the guidelines for treatment of children also, and make sure I know where the parenteral antibiotics are in the OOH centre and in the drugs bags in the cars.

**CPD Activity 4**

Type:  Start date:  End date:

**Brief description of the activity**

I was fortunate to be in the medical centre when the lunchtime educational meeting was on, and I was free to attend it. They had invited a local ENT consultant to give a talk.

**Time:** 1 hours **Impact:** No **Credit claimed:** 1

**Impact comment**

N/A.

**Learning need addressed**

Diagnosis and management of dizziness, an area I often feel at sea with.

**Method used**

A local ENT consultant gave a very informative talk including a question and answer session on common problems. He also went through demonstrations of ENT procedures to cure dizziness.

**Outcome of activity**

Covered ENT problems other than dizziness. I'm now much more aware of what the new audiology services do in terms of managing dizziness, vertigo and tinnitus, and will refer directly to them in the future. Even common problems like otitis externa, I realise I'm not treating them optimally, and this makes me aware that I should not be overconfident in areas that are common, without updating my knowledge on a regular basis.

**Outline any further learning or development needs highlighted by the activity**

See if I can revise the Epley manoeuvre and practise it – I don't feel confident in this yet!

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*Specialty Adviser comments:*

The appraisee has managed to attend a wide variety of educational events, with different learning methods attached to each. The reasons for some of these learning events are clearly justified. Write-up has been more reflective, with further learning or development needs outlined. This appraisee has claimed CPD credits for impact – these can be claimed if the doctor can show implementation of that learning. The evidence demonstrating impact should be brought along to the appraisal discussion. Where continuity, and therefore follow up, is not possible, impact could also be shown through several case reviews, e.g. a series of individual consultations where the appraisee demonstrates that learning has been used in patient care.

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## Personal development plans

Two examples of PDP objectives are provided for each year (Years 1 to 4).

### YEAR 1

<i>Current PDP objective</i>	<i>Learning / development need</i>	<i>Anticipated outcome</i>	<i>Achievement method</i>	<i>Anticipated achievement date</i>	<i>Achievement evidence</i>
To continue to improve my knowledge in clinical cardiology	General update in recent cardiology advances	Feel more confident	Reading GP journals	1 year	List of articles read
<i>Current PDP objective</i>	<i>Learning / development need</i>	<i>Anticipated outcome</i>	<i>Achievement method</i>	<i>Anticipated achievement date</i>	<i>Achievement evidence</i>
Refresh and update existing skills	Part of my professional development	Be a more effective GP	Various	1 year	Patient and colleague satisfaction in me

#### *Specialty Adviser comments:*

Both of these PDP objectives could be made much more SMART (specific, measurable, attainable, relevant and time-bounded). In addition to this, the appraisee needs to consider and justify why cardiology features once more in the PDP, as it was a key part of the previous year's PDP.



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## YEAR 2

<i>Current PDP objective</i>	<i>Learning / development need</i>	<i>Anticipated outcome</i>	<i>Achievement method</i>	<i>Anticipated achievement date</i>	<i>Achievement evidence</i>
Understand the nature of diabetic eye disease	This is an increasingly common problem, and I do not feel confident about what I might see through the ophthalmoscope	Being able to detect and categorise the types of diabetic eye disease	Online (electronic) CME tutorials	1 year	Referring patients appropriately and having my suspicions confirmed by the hospital opinion
Improve my knowledge of psychiatry	We have a lot of patients with mental illness contacting the OOH services	Be able to detect depression more effectively	Attend a course	1 year	Attendance certificate for course

### *Specialty Adviser comments:*

The appraisee has justified the learning objectives, and specified the desired outcomes. Online tutorials are appropriate learning methods, and another achievement method might be sitting in on a practice/hospital diabetic clinic. Limiting the achievement method to attending a course is risky if it is impossible to get on such a course during the year – other learning methods may be appropriate here.

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## YEAR 3

<i>Current PDP objective</i>	<i>Learning / development need</i>	<i>Anticipated outcome</i>	<i>Achievement method</i>	<i>Anticipated achievement date</i>	<i>Achievement evidence</i>
Improve consultation skills	Feedback from the patient satisfaction survey indicates there is some room for improvement in some areas	Better explanation and safety netting at the end of the consultation	Online (electronic) CME tutorials	1 year	Patients having a clear idea of the management plan – I can check their understanding on this
Learn about management and rehabilitation of upper limb Injuries	I had some feedback (regarding a shoulder problem in the patient) from the practice physiotherapist that my referrals could be more timely	Improved care of patients with shoulder/arm injury	Personal reading, discussion with specialist colleagues in community and secondary care	1 year	Appropriate referrals to physiotherapy

*Specialty Adviser comments:*

In this PDP learning needs are clearly related to feedback received on the appraisee's personal practice. Communication as well as clinical skills have been included.

## YEAR 4

<i>Current PDP objective</i>	<i>Learning / development need</i>	<i>Anticipated outcome</i>	<i>Achievement method</i>	<i>Anticipated achievement date</i>	<i>Achievement evidence</i>
Understand the role of the prescribing adviser	I know of the existence of this person, but I am not at all clear what she does	Finding out how prescribing advisers interact with GP surgeries, and understanding the bigger picture about prescribing issues	Asking colleagues in the surgery; meeting with the prescribing adviser to find out who she is and what she does; attending a prescribing meeting in the practice	1 year	I would like to think I'm keeping in touch with what's going on outside my consulting room, and aware of the wider members of the primary care team
Update on dementia management	With our ageing population, I feel this is an important area to know about. I would also feel more confident in treating patients in our residential and nursing homes	Understanding more about the types of dementia, how they are diagnosed, the services available in the community, and pros and cons of any drug treatment	Online learning, looking at national guidelines; BNF for dementia drugs; asking colleagues about community services	1 year	Being able to prescribe appropriately; also when to refer to the Medicine for the Elderly Services for diagnosis and management

### *Specialty Adviser comments:*

In this PDP sample the appraisee is expressing an interest in issues outside the consulting room as well as within. A variety of intended achievement methods are listed. Clinical areas, communication and working with colleagues appear to be included in both these listed PDP objectives.

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# Review of practice

## Significant Event Audits

Two examples of Significant Event Audit are provided.

### Significant Event 1

**Date the event was discussed:** four months before appraisal date.

#### Description of the event

I was doing a one-day locum at Sunnyhill Medical Centre. A 35-year-old female patient came to see me for smoking cessation therapy. She didn't wish to go through any relevant advice, she just wanted me to give her Champix tablets straightaway. I was running late and couldn't remember much about the criteria for patients taking these, or how to prescribe them. Also, I noticed that she had tried to give up smoking about nine months ago and had lapsed after a couple of months so I felt that she should see the Quit Smoking nurse practitioner. I informed her that we would not prescribe medication without her seeing the Quit Smoking practitioner first. She wasn't very happy and apparently went back to the reception and asked to see another doctor. She was given an appointment with a GP colleague in the practice on another day. I subsequently discussed this with the Quit Smoking nurse who told me that she feels it is okay for some patients to be started on medication by the GP and then to see her for a consultation after that. I happened to see the other Dr in the after-hours centre next week, and said that I was sorry the patient was not happy with my advice and that she had to make another appointment with the doctor concerned. He also informed me that some pharmacists can do smoking cessation treatment, so that is another route that patients can take.

#### What went well or not?

I felt that I at least went through the reasons for giving up smoking and tried to motivate the patient myself as well, rather than just giving her tablets or other smoking cessation treatments.

#### What could have been done differently?

I did not know that Quit Smoking nurse practitioner was happy for us to prescribe first, and might now handle the situation differently.

#### Roles present

Myself, other GP in practice, smoking cessation clinic nurse, receptionist.

#### Reflections on the event in terms of knowledge skills and performance; safety and quality; communication, partnership and teamwork; maintaining trust

I realise I don't know quite enough about the management of smoking cessation therapy and I don't feel confident enough to initiate prescribing. I feel it would be helpful to have some information on smoking cessation services in a locum pack in the surgery, and I have suggested this to them. Fortunately, the patient doesn't make a formal complaint.

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## **What changes have been agreed for me personally; for the team?**

I have now photocopied the smoking cessation leaflet. The practice says that they are going to try and put a leaflet and some contact numbers in a locum pack for future reference.

## **Changes carried out, and their effect**

I've not yet updated myself on smoking cessation therapy, but I'm going to put it in my PDP for next year. I don't have any control over whether the practice make up a locum pack taking advice from people like myself, but I hope so.

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## Significant Event 2

**Date the event was discussed:** 1 month before appraisal.

### Description of the event

Tannoy did not work in reception. I was in the Sawrize practice one day, and one of the other partners told me that he had had an incident with the Tannoy not working, so that he was unable to call patients into his room using this. His room is right down the far end of the corridor, so he is reluctant to walk down to the reception every time to call his patients in. Apparently he was pressing the button and lifting the receiver several times and it did not seem to work, so he had to go and get the patient from the reception himself and was a bit irritated. When he returned, he started off the consultation but had not put the receiver down properly so the first few sentences of the consultation were heard in the reception area. He was quite grumpy, and all the patients heard this. The receptionist rushed down to inform him about this straightaway, and he replaced the receiver immediately. All the doctors and nurses happened to be together in the meeting room over lunch, and we discussed this and all agreed that we need to be really sure that the receiver was properly replaced every time we used the Tannoy.

### What went well or not?

Fortunately it was a routine consultation about a blood pressure check so the information was not that sensitive. However, it was still a breach of confidentiality. The patient was very understanding and did not wish to make anything of it. However, other patients in the waiting room might have felt that they did not have confidence that their consultations were being held totally confidentially.

### What could have been done differently?

The practice manager wants to call a subsequent meeting with the partners to discuss whether the tannoy system should be changed. I guess if we all just went to the waiting room to call the patients then this wouldn't happen.

### Roles present

GPs, receptionist, practice manager.

### Reflections on the event in terms of knowledge skills and performance; safety and quality; communication, partnership and teamwork; maintaining trust

Obviously this could be a serious breach of confidentiality. I don't tend to use the Tannoy anyway, but this is further put me off using it.

### What changes have been agreed for me personally; for the team?

If I use the Tannoy, which is rare, I will try to make sure the receiver is replaced. The practice may look at changing the system, but this doesn't really involve me.

Changes carried out, and their effect

Not yet known.

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*Specialty Adviser comments:*

Significant Event 1 is an appropriate one to submit for appraisal/revalidation. It is personal to the appraiser, and there is plenty of scope for reflection. The appraiser has reflected appropriately on this, and it has generated a relevant learning need for the PDP.

Significant Event 2 is not especially appropriate for this appraiser to submit for appraisal/revalidation. This is because there was no personal involvement, although there was discussion of the event in the practice that involved the appraiser. The potential for reflection and learning is limited, and the appraiser will have little influence on any future practice decisions to change the situation.

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## Quality Improvement

An example of a Quality Improvement Activity is provided.

### **Reason for the choice of topic**

In the out-of-hours centre in which I work we have guidance folders in the rooms and in the out-of-hours cars. I noticed that there were marked differences between the folders in terms of content and how they were laid out. This was particularly brought to my attention when I was trying to find guidelines on issuing controlled drugs, and also the protocol for pronouncing life extinct. On both these occasions, the folder that I had with me did not have the relevant guidance sheet in it. This meant that there was a potential for error, and also wasting time as the doctor concerned will either have to go to another room in the out-of-hours centre to try and locate the sheet in another folder, or ring back to the centre if on visits in the car.

### **The standards set and their justification (reference to guidelines etc.)**

I could not find any journal articles or local guidelines on this subject, but I spoke to all the out-of-hours doctors that I came across in one month and asked them whether they felt that the folders should be standardised. The response was a unanimous yes. I then went to the out-of-hours management team and asked them if they felt that was a reasonable thing to expect, and whether they agreed with it. They did agree and I therefore went ahead with the quality improvement activity.

### **The criteria used**

All folders used by out-of-hours clinical staff, whether in the rooms in our centre, or in the out-of-hours cars, should contain the same essential guidance sheets. I set the standard at 100%, because the guidance was deemed essential, and without them the risk of error was high. Also, my OOH colleagues felt that it should not be that difficult to keep all folders with the same 20 sheets in them.

### **The results of the first data collection and in comparison with the standards set**

I looked at six folders in the six rooms at base, and two folders in the two OOH cars. Looking at all the possible guidance sheets, a full folder should have contained 20 guidance sheets. None of the folders contained all 20 guidance sheets, so the standard was not met.

### **A summary of the discussion and changes agreed, including and changes to the agreed standards**

I sent an e-mail to the OOH management team explaining my study and the findings. They were surprised that no folders were complete, and agreed that it would be useful thing to address.

### **The changes implemented by the GP**

I drew up a list of all 20 guidance sheets, and all eight folders, listing which folders lacked which sheets. I then sent this to the OOH management team, and they forwarded it to the OOH site administrator who agreed to gather in all the folders and organise them.



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**Dates of first data collection:** month 1 **Re-audit:** month 3

**The results of the second data collection in comparison with the standards set**

I repeated the exercise eight weeks later, and found that six of the folders were complete. Two folders (one in the car, one at base) lacked one document each.

**Quality improvement achieved**

The guidance folders are now standardised and have a list of documents included at the front of the folder. Clinicians working in OOH are now able to feel more confident they can access essential information whether working in the OOH room, or in the car on visits.

**Reflections on the event in terms of knowledge skills and performance; safety and quality; communication, partnership and teamwork; maintaining trust**

I felt slightly anxious about being seen to criticise the OOH management/admin teams, but in the end I think they felt it was a helpful exercise, and it gave a greater sense of us working together as a team.

*Specialty Adviser comments:*

It is often going to be more difficult for a peripatetic locum to perform the traditional eight-point audit cycle that should be achievable to most doctors working long term in a practice. Locums and doctors working purely in OOH are more likely to lack administrative and organisational support. Success with both audits and quality improvement projects is more likely if the topic is simple and the numbers manageable. However, there are nearly always opportunities for audit and quality improvement activities to be demonstrated, subject to discussion with and support of the practice/OOH organisation/employing body. The appraisee should be able to write something under each heading, and reflect on the event appropriately. If the appraisee wishes to know how the write-up of the quality improvement activity could be improved, the reflections could be broadened to include safety and quality. The results of the second data collection could be expressed as a percentage for easier comparison but, as the results are clearly stated and easy to interpret in this example, this would not be essential.

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## Feedback on your practice

One example of both colleague and patient feedback is provided.

### Colleague feedback (Multi Source Feedback)

#### Colleague feedback 1

##### Colleague feedback ref

MSF with 15 participants.

##### What were the key points arising from the survey from your colleagues?

Generally approachable and pleasant to work with.

Good at inputting information onto the computer.

Often has time for a cheery hello in reception even when in a hurry, treats us as human beings.

Illegible handwriting when in a hurry.

Could be less hesitant to ask colleagues for a second opinion when not sure.

Can sometimes be a bit blunt.

##### What changed as a result of the feedback? What were the outcomes/actions?

I was glad that people appreciated that I spend time keeping good records, and categorising conditions appropriately on the electronic summary sheet. I also feel it's worthwhile having a friendly chat with all members of the surgery team and will continue to do this.

I have felt inhibited about disturbing other colleagues when at work, but maybe it's better to do this than risk getting something wrong, or just spending time trying to search for the info on the internet, which can slow me up considerably. I will try to write my notes to people more legibly.

##### Record your personal key learning points

That it's important to foster good working relationships with all members of the PHCT. That maybe others don't mind being disturbed if it's not too often. I didn't find the other GPs in the Sawrize practice welcomed discussion when I detected mistakes that needed correcting and the practice manager also turned down or ignored my suggestions for improving services in the practice. This has put me off making further suggestions – it may be they are just not ready for change.

##### How has the experience affected patient care in practice?

I think writing more legibly will improve safety as I quite often have to write a note to the nurse/district nurse or another GP, and there is obviously a potential for error if my writing is illegible.

I also think that it seems better to ask rather than to guess about referral pathways and whether we can prescribe this or that drug – save the patient getting wrong info and having to come back or suffer a delay in referral.

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**Record your next steps in this area**

I will ask for feedback on my handwriting in a few months time after making efforts to improve it. I will try to ask the practice managers in each of my surgeries how I can best ask for help and information when I do not know something.

*Specialty Adviser comments:*

There are both risks and benefits to MSF and the results of the MSF should be discussed with a trusted GP colleague, including his appraiser. This appraisee has reflected appropriately on parts of the MSF feedback, but omitted other areas. Appraisees can feel hurt and suffer a dent to confidence by focusing disproportionately on (or fail to consider) a negative aspect of the MSF, and this needs to be handled sensitively and professionally. Appraisees who are locums may find this more difficult, and a support group can help here. Timing the MSF so that it is carried out within a reasonably short time before the scheduled appraisal means that the appraiser is in place to manage the feedback received.

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## Patient feedback

### Patient feedback (PSQ) 1

#### Patient feedback ref

Electronic survey benchmarked against UK colleagues, 42 participants.

#### What were the key points arising from the patient survey?

Good listener – patients say that I am easy to talk to.

Have the ability to put patients at ease, they find me friendly and cheerful.

Explanations to patients are not full enough or not always clear. Sometimes I speak too fast.

#### With whom and when did you discuss the patient survey results?

I discussed this with my wife, she is a nurse. I am hoping to discuss this with my appraiser also.

#### What was the focus of the discussion?

We looked at the results and how they compared with peers, and the good and not so good points raised in the free text comments.

#### What changed as a result of this feedback? Were there any outcomes/actions?

I realise that we all have strengths and weaknesses and I will try to remember I have both as well as address my weaknesses.

#### Record your personal key learning points

What patients say about me is a reflection of my personality. I will continue to maintain a good professional relationship with them. I believe I am on course regarding this as I have found some learning resources that could help me here.

#### How has this affected patient care in practice

I would like to further improve my consultation techniques in order to improve my efficacy in everyday clinical care. I need to think how to explain medical problems in easy to understand language, maybe by drawing diagrams, or speaking slowly. Also, if their first language isn't English I have found this difficult in the past, and I haven't tried accessing language line so far – maybe this would be helpful.

#### Record your next steps in this area

Maybe find a consultation skills course?

Find out about language line so I can use this when needed.

With increasing experience, I think all things will improve.

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*Specialty Adviser comments:*

Whilst discussing the results of the patient survey with one's spouse is convenient and presumably the spouse is regarded as a trusted friend, the appraisee would be better off discussing the results of the patient survey with a trusted GP colleague. This could be someone in the workplace, in a study group, or the GP's appraiser. This GP has reflected appropriately on the survey results, has commenced a relevant learning activity (reading a book on consultation skills and watching a DVD on the consultation), and has an idea for a subsequent learning activity for this year's PDP (finding out about language line and translation services).

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## Other feedback

No example is provided.

## Complaints/compliments

No example is provided.

### *Specialty Adviser comments:*

Although the appraisee is not aware of any complaints that he has received over the past year, it is important to him to be aware of any complaints relating to him that might have been received by the practice. This could be a relevant PDP objective, as practices do not always have a method of informing their locums about complaints received, or including them in Significant Event analysis relating to these.

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## Post-appraisal summary

One example of a post appraisal summary is provided.

### 1. Background/scope of work/relevant context

Dr A Locum works as a peripatetic locum, on average 5–7 sessions per week. Continuity of care is generally a challenge, but Dr L reported that he had experienced more continuity than usual by doing a maternity leave locum in Appleby Health Centre, a teaching practice with a list size of 12,000 patients. He continues to do four OOH shifts per month for the Nightjar Out of Hours service. Two shifts a month are weekday nights, two are weekend shifts which tend to be very busy. The OOH centre had changed its computer system at the start of the year, but Dr L stated that he had attended the training provided and had had few problems adapting to the new system.

He felt that this winter the norovirus outbreaks had made a major impact on the workload year for the practices, and for OOH. Dr L expressed the view that he had learnt more about infection control procedures as a result of this, but had also felt quite stressed with the extra workload in OOH.

### 2. Knowledge, skills and performance

Dr L stated that he felt very comfortable with IT systems and had been able to act as resource for the GP registrar in one of the practices on a couple of occasions. He also felt he was up to speed with the new OOH computer system, and that it was working well. Within the practices he works in, he feels he has relatively little contact with women's health problems as these tend to be directed by reception to the female doctors. He also expressed the view that he would like to refresh his minor op skills, but saw little opportunity to do so as a locum. He is developing an interest in dermatology, and having looked into courses on dermatoscopy, he is now wondering whether to take this further. We discussed how feasible this was, and whether this might be useful to his patients.

Over the past year he has kept a detailed learning log with appropriate reflections and action points. He has begun to regularly attend the quarterly educational meetings run by the OOH provider. From his log it could be seen that he regularly reads journals such as the BMJ and GP magazine, and uses online resources to aid his learning. He keeps a paper reflective clinical diary with PUNs and DENs that he submitted for inspection/discussion and we discussed how some of this could come into his e-learning log.

He does not attend many outside lectures and courses, but stated he finds e-learning most accessible. During the surgery he stated he uses electronic resources such as EMIS-mentor or GP notebook, and also web-based patient information. He stated that he tries to keep up to date with guidelines by accessing them online, though had not recorded this in his learning log. At home or during OOH he completes online learning modules (see list of certificates provided in learning log). We discussed how he might meet with peers to review significant

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events and discuss other points of educational interest. We talked briefly about the impact aspect of the CPD points system for revalidation. Last year's learning objectives in his PDP have all been addressed and included in his learning log. He has achieved just over the 50 CPD points required for revalidation; none of these were included as impact points.

### **3. Safety and quality**

He had written up and submitted a Significant Event in practice where he had personal involvement and a more general Significant Event discussed in a practice. Dr L was able to reflect appropriately on the personal Significant Event, but admitted it was not easy to reflect on or draw learning needs from the one where he had had little involvement. I was agreed that he would try to submit three personal Significant Events for the next appraisal, or reflective case reviews if he had not experienced personal Significant Events during that time.

Over the past year he had conducted a quality improvement project on standardisation of clinician guidance folders in OOH, both at base and in the out-of-hours cars. Dr L was pleased he had been able to do this, and that the OOH organisation appeared to appreciate and act on his findings. We discussed the positive changes that had resulted from this project.

Dr L expressed some interest in following up the outcomes of his clinical referrals and we discussed how this might be feasible, either in the practices he works in or in the OOH centre.

### **4. Communication, partnership and team work**

We discussed at some length the pitfalls of 360-multisource feedback questionnaires as Dr L commented that he had taken one or two relatively minor bits of constructive criticism to heart. During the appraisal we looked through some of the sections of the peer review questionnaire in detail. This showed that he tended to underrate himself to some extent, but that his colleagues and staff within the practice generally rated him highly on approachability, computer skills, clinical acumen and organisation. There were a few negative comments regarding his forthright approach to giving his colleagues advice and feedback, and a tendency not to ask others for advice if he was unsure about a referral pathway of other aspect of patient management. Dr L expressed the view that he was relatively isolated as a locum. We discussed how joining one of the local sessional GP groups might help in this respect.

He stated that he felt that relationships with patients remain good, and that he had had no problems in this area. He had done a personalised patient satisfaction survey at the end of the previous year, and had written up some reflections on this for this appraisal. Dr L feels that it focuses more on consultation skills, but there were also some affirming comments relating to clinical care. He expressed concern that he might not be understandable to all patients, as a colleague had commented that he spoke very fast at times, but this was not borne out by the



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results of the patient survey and comments. We discussed some of the issues raised by the questionnaire and actions he could take. Dr L reflected that he could try to spend more time at the end of the consultation explaining his management plan to the patient – he has done some learning in this respect and found watching the consultation skills DVD very helpful. One of the practices is developing their patient website and he has inputted into the website with respect to OOH cover.

#### **5. Maintaining trust**

He has no knowledge of any personal complaints from patients, but we also discussed the fact that he was unsure as to whether the practices he works in had a method of feeding this back to him. Dr L felt that it might be possible to approach the different practice managers to check that there was a method of contacting him if the complaint claiming that involved him, and keeping him updated about it.

Dr L did not feel that there were any probity issues that we need to address. We talked briefly about the ethics of recommending specific alternative therapists, and Dr L agreed that it would be better if he was not seen to promote any particular private agency over another.

Dr L has no health issues that impact on patients, and is registered in a practice that he does not work in as a locum.

#### **6. Summary of discussion around any material required by the RO/organisation to have been brought to the appraisal**

#### **7. General comment not covered above**

Dr L has had a stressful year with an unusually high workload over the winter period, which unfortunately coincided with his house move. However, he has coped well and provided all the required evidence for his appraisal. Over the next year he is intending to take a period of extended leave lasting three months, to go travelling across the Pacific Islands.

#### *Specialty Adviser comments:*

With three months out of the UK it may be more difficult for the appraisee to meet the requirements of appraisal. The appraiser needs to feed this information back to the organisation so that it can be taken into account if a request for exceptional circumstances to be noted is received.