
RCGP Example Portfolio: Private Practice



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Royal College of General Practitioners
30 Euston Square, London NW1 2FB

RCGP Revalidation Helpdesk: revalidation@rcgp.org.uk

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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 of 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.

General information

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

1. Personal details

Title: First name: Surname:

GMC Reference Number:

2. Qualifications

Primary medical degree: MB BS

Qualifications: MRCGP

Specialty Adviser comments:

MRCGP is not a necessary qualification for GPs in private or NHS practice who became GPs before vocational training and before MRCGP was the entry qualification to the generalist register. However, if the doctor is on the generalist register his appraisal should be a GP appraisal.

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.

<i>Organisation</i>	<i>Location</i>
The Roundel Hospital	Truebridge Spa, 2 sessions
The Private Medical Clinic	Central London, 3 sessions
The Wishing Well Surgery	Little Spalding Village Clinic, 3 sessions
My Home The Grange Greater Spalding Highfield East Sussex	I tend to spend Fridays writing up my reports or undertaking CPD

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

The Roundel is a private hospital in Truebridge, where they have GP clinics designed primarily around the needs of the London commuter who finds it difficult to access a GP. I do two evening clinics (6–9pm) where I have 15- and 30-minute appointments a week. Although commuters are the main patients, I have also a developing patient base of mothers and children, and older women who are not working. The more relaxed atmosphere here in the Tower contrasts to the hurly-burly of regular general practice – where a common system of ring on the day does make life quite difficult for the patient. At The Roundel we have been developing a Monday morning clinic for these situations. I have a prescribed connection with the Responsible Officer of the Independent Doctors Federation through which I receive my appraisals.

The Private Medical Clinic is in Harley Street, London. Patients here tend to be foreign visitors to the UK, who are referred by central London hotels. Some patients who have come to the UK specifically for treatment come here. Quite often Middle Eastern or more recently Russian patients come to the UK for assessment and treatment. I do clinics all day Wednesday and Thursday. At the Central Medical Clinic I have access to the whole range of investigations, from blood tests to MRI scans. We have a team of specialist visiting and I can refer for a same-day specialist opinion.

Rarely, I will visit patients at a hotel or at home.

The Wishing Well Health Centre is an NHS surgery where I have for many years used their facilities on a Saturday morning and some evenings to conduct my insurance practice. These patients are usually referred by insurance companies in relation to road traffic accidents, or occasionally I will do a life insurance medical. The area team are aware of the arrangements and have approved the rental payments.

Specialty Adviser comments:

Like many doctors who work in different locations Dr S has correctly provided sufficient details of the three areas of his practice. Dr S has not previously been part of a managed GP system as he has been working in different locations. He has now engaged with appraisals through the IPA (Independent Doctors Federation) to which he has a prescribed connection. He is now in a

‘managed system’. As in NHS primary care, the Responsible Officer will consider any additional information, such as serious complaints, ongoing GMC investigations, or performance issues when making a recommendation to the GMC.

4. Record of annual appraisals

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

Appraisal year Appraisal status

2008

2009

2010 Independent Doctors Federation Appraisal

2011 Independent Doctors Federation Appraisal

2012 Independent Doctors Federation Appraisal

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 checked="" type="checkbox"/>	Date 13/12/12
I have met the health requirements as defined by either the GMC or the Academy of Medical Royal Colleges.	<input checked="" type="checkbox"/>	Date 13/12/12
I have met the insurance requirements as defined by either the GMC or the Academy of Medical Royal Colleges.	<input checked="" type="checkbox"/>	Date 13/12/12

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. Sections 1–4 and the declaration at the bottom are mandatory and sections 5–8 can be optional.

General background/context

I have been a private GP for ten years having been previously an NHS principal in South Hadden. My work is in three centres.

My work at The Roundel in Truebridge is two evening clinics a week. This work is a combination of acute illnesses, presentation of non-acute illnesses, health promotion, and emotional and stress related problems. I have the facility to undertake minor surgery here and regularly remove lipomas, sebaceous cysts, BCCs and SCCs.

My work at the London Medical Clinic is in the West End where I see people who are usually visiting the UK from abroad. We have several large hotels who make appointments for their clients who may become unwell, or would like a British opinion while they are in London.

I undertake my insurance work, usually RTAs, in the Wishing Well Health Centre, which is a private clinic specialising in beauty therapy and plastic surgery. I have six half-hour appointments at each session. Much of this work is now facilitated by a computer template and is primarily the assessment of musculoskeletal injuries.

Aspirations/achievements/challenges

Private practice brings its challenges and rewards. Financially, I find that I am not quite billing what I would aim for but this is due to a decrease in patients when I was on sick leave.

Specific areas for discussion with your appraiser

I have undertaken colleague feedback that was quite challenging. But now I have the results I find that the comments are quite supportive. I would like to discuss the issue raised about my treatment of women requesting HRT: 'Dr S still prescribes HRT which seems inappropriate in view of the current evidence.'

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

No.

Knowledge, skills and performance

I do find it quite difficult to access CPD and as such the mainstay of my CPD has been the annual week's course at St Francis Hospital in London. This was my teaching hospital and I meet up with colleagues there each year. I am aware that, for revalidation, a doctor should cover the full spectrum of their professional work over five years and to a certain extent the course at St Francis helps achieve this.

I have undertaken regular CPD credits over the last five years These have been self assessed and agreed at my various appraisals by my appraiser.

I have over the years developed meetings with my colleagues at The Roundel Hospital and with guidance from my appraiser have suggested making these meetings more interactive rather than in lecture format. This has enabled me to discuss cases and SEAs.

Safety and quality

I have attached two audits: the first is on the treatment of urinary tract infections and the other is in relation to interpreting services. They are both eight-point audits. I am planning a HRT audit as a result of the comments I have received from colleague feedback.

I have also included two SEAs that have been discussed at our monthly Roundel Hospital meetings.

I do have several case reports going back over the last few appraisals – some of which I have discussed in previous appraisals. I find audits rather time consuming and although I appreciate that sometimes the learning from them is useful, writing up challenging and interesting cases fulfils my leaning needs more effectively.

Communication, partnership and teamwork

I would say that I have excellent relationships with my patients and colleagues. I have included colleague and patient feedback.

I have undertaken a patient survey using the CARE questionnaire. I managed to get 50 patients to fill these in. The responses were generally favourable although there were some comments about feeling rushed, which I think were unjustified. I think some foreign patients do not understand that I do book patients every 1/2 hour.

Maintaining trust

I have an interest in the London Medical Clinic Imaging Centre. I find it a bit tiresome to have to explain to patients who frequently speak little English that there is a potential conflict of interest here. However, I still do this.

I am careful to write or email the NHS GPs of patients whom I see to explain the presentation and management. This is not usually possible for foreign patients.

I have a clear rental arrangement at the Wishing Well Centre and this has been approved by the NHS.

I can confirm:

I have no restrictions on my driving licence
No financial probity issues
No current GMC issues
No current MDO issues – my MDO is MDDUS.

I discuss and agree my fees at the beginning of each consultation.

Duty/continuation of care

All patients receive a confidential letter following a consultation. If a referral is required, I then write to the appropriate consultant; a copy of my letter is sent to the patient's NHS GP and other consultants involved in the case. Patients are asked to sign a statement stating whether or not they want copies of my letters and investigation results to be sent to their NHS GP.

Permission is obtained from the patient if they wish letters sent to them by email or fax. These documents contain an appropriate legal disclaimer regarding protection of personal data.

Specialty Adviser comments:

The doctor has provided sufficient pre-appraisal reflection on the setting and nature of his work, and the CPD he has undertaken. The QIA includes two eight-point audits (one would be sufficient for revalidation purposes). There is colleague and patient feedback (only one of each is required every five years for revalidation purposes, unless the appraiser requests they should be repeated).

There is reflection as well as statements on probity. There are a number of probity issues, which the appraiser could raise for discussion at appraisal, for example: consent and confidentiality with people with linguistic barriers; probity regarding billing and handling of money; and possible conflicts of interest in terms of referral to other agencies etc.

Dr S has been obtaining his appraisal through the Independent Doctors Federation (www.idf.uk.net/), which can offer advice on appraisal to its members. There is also a useful synopsis of the requirements for appraisal and revalidation on its website. This is a designated body with its own Responsible Officer.

The doctor has declared he has been undertaking regular and approved CPD.

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.

Four to 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

General practice update. St Francis Hospital, Central London.

Time: 30 hours Impact: No Credit claimed: 0

Impact comment

NA.

Learning need addressed

I have been to this course every year since 2001 and find it addresses the updating I need for my private practice. I also meet some of my old friends and it is excellent for networking. I trained at St Francis in the 70s and feel an affinity to the old place.

Method used

Lectures. I have always felt comfortable with getting my CPD through lectures. I take notes, but nowadays there are excellent handouts, so I can just annotate the key learning points relevant to my practice.

Outcome of activity

There are half-day sessions on the following updates: chest medicine, (COPD and asthma), cardiology (ECGs, acute coronary syndrome, angiography), tropical conditions seen in London, dermatological lesions that can be safely removed by the GP, musculoskeletal conditions, new things in neurology, medico-legal reports, cancer roundup, evening meal.

Outline any further learning or development needs highlighted by the activity

I realised that there were several tropical conditions, which I really could do with being more conversant with – bearing in mind I do see quite a lot of foreign visitors to London. I am unsure where I can update myself further but will look online and see what is available.

CPD Activity 2

Type: Start date: End date:

Brief description of the activity

Minor surgery techniques.

Time: 3 hours Impact: No Credit claimed: 3

Impact comment

I have now treated three patients where I have used deep stitches and enclose details of these cases.

Learning need addressed

I have a traditional approach to surgery, using those methods I originally learnt as a house officer. However, techniques and materials do move on and this has made me appreciate and put into practice these new skills.

Method used

This was a small group learning which I found very useful.

Outcome of activity

See above.

Outline any further learning or development needs highlighted by the activity

I think this is sufficient for my needs at this time.

CPD Activity 3

Type: Start date: End date:

Brief description of the activity

Insurance examiners annual conference. Annual update for doctors writing reports on patients with musculoskeletal injuries in RTAs.

Time: 6 hours **Impact:** No **Credit claimed:** 6

Impact comment

I am certain that there has been considerable impact here, I just have not documented it.

Learning need addressed

This is my regular update where I learn changes in the way injuries such as whiplash and back pain are assessed.

Method used

Lectures.

Outcome of activity

I have learnt to use Assess Software.

Outline any further learning or development needs highlighted by the activity

I expect Assess, which seems more effective than the previous RTA software, will help my assessments.

CPD Activity 4

Type: Start date: End date:

Brief description of the activity

RCGP learning – I have undertaken six modules on the following:

CKD, autism, liver disease, dementia care, MS, and Parkinson's disease. The reason for choosing CKD, MS, Parkinson's and dementia were the results of my PUNS and DENS.

I have seen patients with these conditions and I did struggle especially with a patient with Parkinson's and dementia.

Time: 6 hours **Impact:** No **Credit claimed:** 6

Impact comment

N/A.

Learning need addressed

Update in these various areas.

Method used

Online learning.

Outcome of activity

I have a much more solid knowledge base in these areas.

Outline any further learning or development needs highlighted by the activity

None.

Specialty Adviser comments:

The CPD here is mainly traditional lectures and has little interactive discussion to facilitate reviewing SEAs and QIA with colleagues.

Dr S enjoys returning to his old medical school and meeting some of his colleagues. The silo nature of medical education has changed during his career and CPD involving discussion with peers has become recognised as, as valuable, or even more valuable than the traditional model of education by which Dr S learnt his medicine. This needs to be recognised and encouraged by Dr S's appraiser and built on by developing education involving peer group discussion.

YEAR 2

CPD Activity 1

Type: Start date: End date:

Brief description of the activity

Annual GP update at St Francis Hospital London.

Time: 30 hours Impact: No Credit claimed: 30

Impact comment

None.

Learning need addressed

Update on psychiatry, gastroenterology, asthma, paediatrics and hot topics.

Method used

Lectures.

Outcome of activity

Psychiatry: Here we had a whole day of lectures and discussion. The morning session was on depression and anxiety. Prof. Patel and Dr Peter Hardnet (RCGP), shared their presentation where they gave a hospital and GP practice perspective. I have not been involved in QOF, but the use of the assessment tools, PHQ-9 and HAS Score was discussed. I do like the idea of a more structured assessment of depression, and the use of a check list that includes suicidal ideation.

Outline any further learning or development needs highlighted by the activity

I find the assessment of the suicidal patient difficult. This is really difficult when I see a foreign tourist with poor English or a stressed business man at 8.45 on a Monday evening. I might like to develop my assessment skills further here.

CPD Activity 2

Type: Start date: End date:

Brief description of the activity

Half-day update on musculoskeletal problems in practice including the use of injections. Practice on models.

Time: 3 hours Impact: No Credit claimed: 3

Impact comment

No impact claimed here.

Learning need addressed

Practical update on skills needed to treat in practice.

Method used

Lectures and demonstrations.

Outcome of activity

In general my musculoskeletal medicine is pretty good. It was good to have some revision of the issues I deal with regularly. Joint injections are an area that I find useful and rewarding. I learnt about carpal tunnel injections and plan to try this when the need arises.

Outline any further learning or development needs highlighted by the activity

Consider some further work on joint injections.

CPD Activity 3

Type: Start date: End date:

Brief description of the activity

RCGP study day on paediatrics at the RCGP, Euston Square. We had six lectures altogether: (1) The Sick Child; (2) The Child in A + E; (3) Orthopaedics Tips; (4) ENT Tips; (5) Emotional and Psychological Conditions in Children; (6) Child Protection.

Time: 6 hours **Impact:** No **Credit claimed:** 6

Impact comment

I have no direct evidence of impact yet but these issues are key to my new Monday morning surgery.

Learning need addressed**Method used****Outcome of activity**

I found the lecture on the sick child was what I knew but had never had the visual and communication clues delineated so well. Recognising the playing of the child, the visual contact and communication is what I have always done, but the quantification of these non-verbals was useful. Looking at the NICE guidance on the feverish child was helpful, but I find NICE guidance so dry. This helped me translate it into practice.

The orthopaedic and ENT lectures were a good update for me on what to refer and what to reassure parents on.

I was in need of a child protection update, although this is rare occurrence in my practice.

Similarly child psychiatry, which has never been my strong point, was useful to review.

Outline any further learning or development needs highlighted by the activity

None.

CPD Activity 4

Type: [REDACTED] **Start date:** [REDACTED] **End date:** [REDACTED]

Brief description of the activity

Clinical meetings at the Tower, Truebridge.

Time: 10 hours **Impact:** No **Credit claimed:** 10

Impact comment

N/A.

Learning need addressed

These have started this year and are every month except August and December. These are clinical with some occasional management issues usually by one of the specialist leads and we get a fair number of local GPs attending.

Method used

Lecture and small group.

Outcome of activity

[REDACTED]

Outline any further learning or development needs highlighted by the activity

[REDACTED]

Specialty Adviser comments:

Dr S did not undertake a planned alcohol course as documented in PDP. This was substituted by a paediatric course, which was appropriate.

There is very little reflection on learning apart from the paediatric update. CPD credits do require reflection as well as attendance.

YEAR 3

CPD Activity 1

Type: Start date: End date:

Brief description of the activity

Annual Update at St Francis Hospital.

Time: 30 hours Impact: No Credit claimed: 30

Impact comment

N/A.

Learning need addressed

Review of subjects with a day dedicated to each.

1. HIV and other STIs – this is an area where I see quite a few patients, especially from Africa. I realised I was in need of an update on the latest HIV treatment regimes and side effects of anti-virals. As regards STIs, I am fortunate when in London to have the hospital laboratory close by and as such can get a microbiological diagnosis or a quick ‘all clear’ for my patients, who are here today and gone tomorrow. This does raise issues of international contact tracing.
2. Dizziness and how it’s assessed – this is a really difficult symptom to assess competently and the lectures by ENT and neurology specialists gave me a new protocol for assessment. We had a practical demonstration of the Dix-Hallpike’s manoeuvre.
3. The prostate – prostate problems are a common presentation to my surgery, being an illness of older, and well-heeled men. We had a great session from Mr Pike the urologist, who went through the diagnostic and treatment options in prostate cancer. We also had an informative session on the latest treatment of ED (erectile dysfunction).
4. Advances in renal care – CKD has always been a bit of an enigmatic illness for me. How to explain to patients who feel really well that they have kidney disease has always been a challenge. I now understand the reasons for being assertive with ACE treatment and the control of BP especially in diabetics.
5. Diabetic day – this followed on from the CKD day. The various insulin regimes and new oral diabetic drugs were explained, and control of the GyHb was discussed. The excessive lowering of GyHb was considered.

Method used

Lecture and questions.

Outcome of activity

See reflection.

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

Two monthly meetings at The Roundel Hospital.

Time: 6 hours **Impact:** No **Credit claimed:** 6

Impact comment

It is difficult to evidence impact here, but I do feel these meetings have been very useful.

Learning need addressed

I have been in touch with the specialists working in the hospital.

Method used

Lectures.

Outcome of activity

I have learnt a fair bit about from the case presentations on SLE, TB and cardiomyopathy, but the interaction with the specialist has been of great help.

Outline any further learning or development needs highlighted by the activity

I do plan to continue to attend these meetings.

CPD Activity 3

Type: Start date: End date:

Brief description of the activity

Conference at local RCGP faculty on revalidation.

Time: 6 hours **Impact:** Yes **Credit claimed:** 12

Impact comment

I have used the information here to develop my portfolio of evidence for revalidation.

Learning need addressed

I have reviewed the criteria for revalidation.

Method used

Outcome of activity

Outline any further learning or development needs highlighted by the activity

Specialty Adviser comments:

There are six hours' impact from implementing revalidation advice, but the impact claim has not been evidenced. The RCGP Impact Toolkit provides a number of examples of how impact can be demonstrated.

The doctor has provided useful reflection on the course at St Francis. The concept of not only receiving CPD and reflecting on it, but also demonstrating with evidence, the impact on the doctor's work, is designed to enhance the relevance of the doctor's learning. www.rcgp.org.uk/revalidation-and-cpd/cpd-credits-and-appraisal.aspx.

YEAR 4

CPD Activity 1

Type: Start date: End date:

Brief description of the activity

Attendance at St Francis's GP update.

Time: 30 hours Impact: No Credit claimed: 30

Impact comment

N/A.

Learning need addressed

Review of general practice subjects:

1. Medico-legal day (reports, coroners, complaints, negligence) – this was a very informative day where we had some excellent speakers, including the local coroner for Southwark, and an MPS doctor. Life as a private GP is full of pitfalls and one has to tread so carefully.
2. Gynaecology and obstetric update – this was just what I needed having had some adverse comments in my MSF about my HRT prescribing. We did look at the Million Women Trial and I have changed my mind and will be more choosy about whom I will prescribe HRT for.
3. Child protection and resuscitation – child protection is not an area where I have been involved in. However understanding 'patients on the edge' who may present privately, as they are coming from abroad, have no fixed abode, or are trying to avoid the authorities, did ring a bell with me. Resuscitation was very timely as the SEA I describe later occurred a month or so after this update.
4. The liver, the gut and the colon – this is mainstream in my professional practice. New ideas in the exact probabilities of symptoms being cancer related and new drugs for liver and cancer were useful.
5. New ideas in paediatrics – I have not been involved so much in paediatrics since leaving the NHS, but with my new developing Monday clinic, I am seeing several children a week. The update on how to spot the sick child was illuminating.

Method used

Lectures and practical demonstrations.

Outcome of activity

See above.

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

Insurance examiners conference.

Time: 6 hours Impact: No Credit claimed: 6

Impact comment

N/A.

Learning need addressed

This ran through the changes which have been going on with insurance claims, especially in relation to whiplash, which has been in the news. I think that although there is a formulaic approach to whiplash being proposed, real assessment is clinical and the use of an experienced clinical assessment cannot be substituted by a check. I wanted to update my knowledge in this area.

Method used

Lectures.

Outcome of activity

Update on insurance assessments.

Outline any further learning or development needs highlighted by the activity

Review next year.

CPD Activity 3

Type: Start date: End date:

Brief description of the activity

MPS update. How to avoid errors.

Time: 6 hours Impact: No Credit claimed: No

Impact comment

N/A.

Learning need addressed

This was a day provided by the MPS that covered how to avoid error, good note keeping, and explaining the treatment to the patient.

Method used

Lecture.

Outcome of activity

Appreciation of techniques to avoid litigation.

Outline any further learning or development needs highlighted by the activity

None.

CPD Activity 4

Type: Start date: End date:

Brief description of the activity

Two monthly meetings at The Roundel Hospital.

Time: 6 hours **Impact:** No **Credit claimed:** 6

Impact comment

N/A.

Learning need addressed

I have been in touch with the specialists working in the hospital. We have had a chance to discuss individual cases, which I have referred. We have discussed SEAs both as GPs and in two cases we had a joint discussion between GPs and the specialist involved.

Method used

Lectures and discussion on cases.

Outcome of activity

These sessions at The Roundel really helped with cases which I have wanted to discuss but have had no forum to discuss them in.

Outline any further learning or development needs highlighted by the activity

I will continue with The Roundel Hospital meetings.

Specialty Adviser comments:

The doctor has developed different learning styles which put learning in relation to his clinical practice as a key part of his CPD. The learning style is substantially more interactive. The Roundel Hospital meetings have been a good development for the doctor's CPD.

The CPD has covered a substantial proportion of Dr S's professional practice over the four years, which have been described.

The doctor should, however, provide some examples of impact from learning. The RCGP Impact Toolkit provides a number of examples of how impact can be demonstrated.

Personal Development Plans

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>
I have been attending the annual update at St Francis for ten years	Review of general practice topics	Review of various topics	Lectures	30/5/2010	Certificate of attendance
Annual conference of insurance examiners	Update on current practice in insurance examinations	Maintain competency in insurance exams	Lectures	31/08/2010	Certificate of attendance
Minor surgery techniques	To review my minor surgery and learn new ones	Competency in minor surgery	Lecture and Practical Experience	12/10/2010	Certificate of attendance

Specialty Adviser comments:

Although the doctor has undertaken a variety of CPD in a traditional learning style, the learning is not overtly correlated to the doctor's learning needs. I would advise that some reflection on learning needs should be undertaken before next year's appraisal. The doctor needs to develop his PDP and CPD in relation to his learning needs, which to some extent need to be informed by areas where his personal practice requires development. It is not sufficient, for example, to include 'attend St Francis update as a PDP objective' – a more specific objective is required. The doctor should develop a system of PUNs and DENS, take the learning from his SEAs, and QIA, colleague and patient feedback, to inform this process. The doctor's PDP needs also to be set in the context of covering the whole of his professional work over a five-year cycle.

There are a number of ways to demonstrate the achievement of a PDP objective. A certificate of attendance does not necessarily provide evidence that an objective has been achieved.

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>
Whiplash injuries. Attended musculoskeletal day at the London Health Clinic, which included a session on whiplash	This has been in the news lately and I need to be right up to date with current thinking	Review of whiplash and other musculoskeletal conditions	Lecture	2012/13	Certificate given
RCGP study day on Paediatrics	I am developing an urgent Monday morning clinic aimed at mums who have had a sick child over the weekend. My paediatrics needs updating especially recognising the sick child	I should be able to assess a sick child with confidence and get it right every time	Lectures. These include: (1) The sick child; (2) Child with fever and NICE guidance; (3) Paediatric orthopaedics; (4) Emotional and psychiatric childhood conditions	April 2013	Certificate
Alcohol in practice	<i>The GP needs to specify this</i>	Competence in alcoholic disease assessment and treatment	Online learning	April 2013	<i>The GP needs to specify this</i>
St Francis' GP update	Review of general practice topics	Competence in the subjects	Lectures	30/05/2010	Certificate of attendance
Unplanned learning	Monthly meetings at The Roundel Hospital	Monthly meetings discussing various topics	Lectures	23/6/2012	Not available

Specialty Adviser comments:

The doctor is now beginning to relate his learning to the needs of his personal practice as evidenced by his comments on alcohol course.

Dr S is developing a Monday clinic for acute post weekend issues and has appropriately updated his paediatric CPD as this is an area which has shown increased demand at the Monday clinic.

The doctor should record his objectives in more specific terms – for example, attending an RCGP study day might support the achievement of an objective but it is not necessarily an objective in itself.

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>
Attend the annual St Francis GP update	Review those areas of GP, which are on the agenda this year and network with colleagues	Review of GP areas on the course	Lectures and networking	01/04 /2012	Certificate
Roundel Hospital monthly meetings	Meeting with colleagues and with speakers, I have introduced a slot to discuss SEAs	<i>The GP needs to specify this</i>	Lectures and meetings	01/04/ 2012	Notes of the meetings
Preparation for revalidation	Attend day conference and read online information	<i>The GP needs to specify this</i>	Lectures and meetings	April 2012	Certificate

Specialty Adviser comments:

CPD on revalidation is appropriate to develop the skills to present the supporting information for revalidation. This would be for this PDP only.

Here the doctor is beginning to broaden his learning style from lectures to small group learning. The development of discussion on SEAs is a big change for this GP and his colleagues who through the nature of private practice have had 'silo' practising styles in the past.

However, the specific focus of the objectives is still not clear and parts of the template remain incomplete.

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>
Attendance at St Francis annual week's CPD	Review topical subjects for GPs and meet with colleagues	Continued update on GP subjects	Lectures and meetings	April 2013	Certificate
Insurance examiners conference	Review of current developments in insurance examination	Insurance examination update	Lectures and meetings	April 2013	<i>The GP needs to specify this</i>
Meetings at The Roundel Hospital Truebridge	Meetings at The Roundel Hospital. These now include SEAs and discussion on QIA such as audit	Discussions on SEAs and meetings with specialists	Group discussion and presentations	April 2013	<i>The GP needs to specify this</i>

Specialty Adviser comments:

The doctor has successfully changed the private hospital monthly meetings to discuss SEAs and audit.

The RCGP study day undertaken as a result of comments on the doctor's MSF.

The objectives however need to be more focussed as per previous comments. All objectives should be SMART (specific, measurable, achievable, realistic and time-bounded).

See the general information section of the RCGP Guide to the Revalidation of General Practitioners

www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx.

Review of your practice

Quality improvement activity, to include: Significant Event Audits

Two examples of Significant Event Audit are provided.

Significant Event 1

Date the event was discussed: 22/01/2012

Description of the event

I saw two Iranian gentlemen in the clinic with similar names, which I cannot disclose, on the 25 and 27 July. Due to a secretarial error I was given the wrong patient's paper record and as such was referring to the records of the wrong patient.

What went well or not?

Fortunately this was a new patient so there was no previous history to confuse me.

What could have been done differently?

I normally check that the patient I am seeing is the patient I have in front of me. I will return to my regular routine.

Roles present

Myself a private GP, and my secretary Ms Jane Juniper.

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

I have always been aware of how important it is to ensure that you have the right patient. In the past I have made this mistake when working in the NHS. I have a routine now with new patients where, when I see a patient, I greet them and say good morning and then check the name and date of birth.

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

I now check name and DOB whenever I see a new patient.

Changes carried out, and their effect

I find that the standard routine is easy to carry out and acceptable to patients. I should carry out an audit to check whether I do what I say I will.

Significant Event 2

Date the event was discussed: 12/12/2012

Description of the event

Cardiac arrest in my clinic at the Tower. A 65-year-old Turkish woman attended my general surgery complaining of chest pain of recent onset. I had not seen her prior to her entering my rooms and my secretary had not spoken to the patient, whose appointment had been booked by the reception of 'The Elmwood', a local boutique hotel. Mrs T came in with her husband who interpreted for me. She was complaining of chest pain, which came on the previous evening.

She suddenly keeled over and stopped breathing.

We delivered CPR and shocked her twice, quickly establishing sinus rhythm. She was transferred to coronary care where she underwent an emergency angioplasty and made good progress.

What went well or not?

The team successfully resuscitated her. I led the resuscitation and went down the shockable rhythm algorithm.

What could have been done differently?

We had all the equipment for this emergency and a coordinated team who were effective.

Roles present

Myself Dr S, Sister Jane Fitzsimmons, Auxiliary Nurse Freda McNeil.

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

I was well supported by our excellent nurses and having been on a ALSO course the previous month was able to use the equipment effectively and resuscitated this lady.

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

I was successful here but still felt that my knowledge on shockable and non-shockable rhythms felt a bit rusty. I will go through the algorithm again and get it in the forefront of my mind. I will also laminate it.

Changes carried out, and their effect

This is difficult to know, unless this rare event might recur. I could try an MCQ in six months to check my CPR knowledge.

Specialty Adviser comments:

For the purposes of revalidation, a significant event suitable for auditing can be one that demonstrates all levels of care from excellent through to poor where an opportunity for learning or change has been identified.

Clinical Audit

Two examples of a Clinical Audit are provided.

I have provided two audits, although I recognise one in five years is sufficient. The first audit is a clinical audit on my use of antibiotics for urinary tract infections, and the second perhaps a social audit on the use of interpreters in my practice.

Audit 1

Introduction

I see one or two women a week with urinary infections and I am tempted to use strong antibiotics as many of my patients will be with me in London today and in New York tomorrow. They need to be better, partly because untreated UTIs may cause renal and systemic infections, and partly they are busy people and frequently have important jobs. Guidance on the treatment of UTIs in local formularies and the BNF. These may not be directly applicable to the diverse population that present privately to my clinic.

Evidence comes from NICE Clinical Knowledge Summaries <http://cks.nice.org.uk/> and SIGN guidance <http://www.sign.ac.uk/pdf/sign88.pdf>

The general approach is to use trimethoprim or nitrofurantoin for 3 days and for uncomplicated UTIs in women, and 5–10 days in complicated UTIs. Trimethoprim tends to have a high level of resistance, while nitrofurantoin does cause nausea and vomiting.

Criterion

All women with uncomplicated UTIs should be treated as per SIGN guidance.

Standard

In view of the diverse population I see, I have chosen 70% as my standard. Some patients will be allergic to trimethoprim or nitrofurantoin.

Data collection 1

Jan 2012– May 2012. I saw 15 women with uncomplicated UTI. 6 were treated with 3 days' trimethoprim, 4 were treated with 3 days' cefalexin, and 1 with 3 days' nitrofurantoin. This gave 66% treated according to the SIGN guidance.

Changes made

I reviewed my definition of complication in that I included those patients who, during discussion, felt that the importance of clinical success was critical as they were likely to be unable to access medical care due to travelling commitments. These patients were given 10-day courses.

Data collection 2

July 2012–Nov2012. There were 10 women with 'uncomplicated' UTI and prescribed 7 trimethoprim and 3 cefalexin. This is a percentage of 70% which is the standard I choose.

Reflection and comment

Although it may appear that I have changed the rules during this audit, it is important to balance guidance with the care of an individual patient. I am always aware of the GMC guidance 'Your patient is your first concern', which means that guidance – while important – should not take precedence to the care I give my patients. The main benefit I found from this audit was the opportunity to review guidance and consider what treatment I should be giving my patients.

Audit 2

This is a summary of a the detailed audit which I have presented to my appraiser.

The standards set and their justification (reference to guidelines etc.) In my practice in London.

I have read guidance on interpreting services, for screening in the NHS www.screening.nhs.uk/interpreter-guidelines www.nhsdirect.nhs.uk/about/callingnhsdirect/interpreterservice

The criteria used

That all patients who have poor grasp of English should have an independent interpreter.

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

I recorded the level of understanding of English for 20 consecutive patients on a scale of 1 to 10. 1 – no understanding and 10 – good English. I thought that anyone with a score of 5 and under should have an interpreter.

My standard was set on discussion with a colleague who was from India that an interpreter should be employed in 80% of people with a score less than 5.

Data collection 1

7 patients with scores below 5.5 were provided with an interpreter. 2 were not.

5/7 is 71%.

I found that it was difficult to assess whether an interpreter was needed when my secretary made the appointment. I have changed the procedure and now I ask an interpreter to ring the patient and discuss the need for an interpreter.

Data collection 2

This was 35 patients. 12 had an score below 5 and of these 10 had interpreters provided.

10/12 is 83%.

This is an improvement, which has reach my standard. I think the arrangements for making appointments have now improved.

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

This audit has shown that there is a problem with obtaining an appropriate interpreter service. The changes that I have put in place have, although the numbers are small, suggested that I will have a better interpreter service.

The changes implemented by the GP

The interpreter will ring the patient before the consultation.

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

See above.

Quality improvement achieved

See above.

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

This audit has improved my communication with patients and perhaps my partnership. There is the partnership with the interpreter, which is an interesting relationship, almost always good but not always I suspect accurate.

Specialty Adviser comments:

These two audits cover clinical and consultation skills and are directly relevant to Dr S's practice. The two key outputs of audit should be reflection and improvement. Change that can be implemented should be implemented by a PDAS cycle (plan, do, study, act).

Feedback on your practice

An example of both colleague and patient feedback is provided.

Colleague feedback (multi-source feedback)

In this area you can upload electronic versions of feedback received.

Colleague feedback 1

Colleague feedback ref

Colleague feedback undertaken 12/7/2012 with CFEP.

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

1. My clinical care was regarded as extremely good and I am well respected by colleagues.
2. Feedback showed excellent communication.
3. I was thought to be sometimes unclear in my emails.
4. There was a comment on my HRT prescribing saying it did not follow current guidance.

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

Record your personal key learning points

I will try and re-read my emails to check that they mean what I intend.

I plan to attend an HRT update and read current guidance as well as consider an audit on HRT prescribing in relation to current guidance.

How has the experience affected patient care in practice?

Not undertaken as yet.

Record your next steps in this area

I will check with some of my raters how my emails are coming across.

Specialty Adviser comments:

Dr S has briefly recognised the outcome of his colleague feedback and plans appropriate actions.

Patient feedback

In this area you can upload electronic versions of feedback received.

Patient feedback (PSQ) 1

Patient feedback ref

I undertook a patient care survey of 50 patients seen consecutively in the week of 3/10/2012.

What were the key points arising from the patient survey?

Overall the feedback was excellent. Patients appreciated that they had plenty of time to discuss their problems and that I advised them carefully and clearly about their problems.

There were some comments on my availability at times when I was not at the Truebridge, but this probably reflects an expectation that as a private GP I am not as available as their family GP is. I need to be clearer in the information which I give my patients.

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

I will discuss this with my appraiser.

What was the focus of the discussion?

The general quality of care I give patients – which is good.

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

As above, I will be clearer in the information I provide.

Record your personal key learning points

1. Make clearer my availability.
2. Make clearer that I do not provide 24-hour care.

How has this affected patient care in practice

It is too early to tell.

Record your next steps in this area

I may need to review this plan in six months' time.

Specialty Adviser comments:

The patient feedback has thrown up one of the difficulties of private general practice in that continuity of care is difficult where the GP is working in a clinic away from his home and therefore has no ability to be on call. The doctor has planned to clarify this for new patients.

Other feedback

No example is provided.

Use this area to provide details of feedback received separately to the colleague and patient questionnaire process (such as feedback relating to teaching). Reflection should be included.

Source of feedback

█

Feedback received

█

Summary reflections

█

Actions

█

Complaints/compliments

An example of a complaint and a compliment is provided.

A description of any formal complaint and your response to it in the 12-month period prior to your last appraisal before your revalidation date.

Additional details (area 11) to be entered for each complaint/cause for concern.

What is the current status of the complaint/cause for concern/positive feedback? Are there any other bodies where involved (SHA,NCAA,GMC) ?

No.

Describe the nature of the complaint/cause for concern

There was a complaint about from a separated father about a child who I saw with milk intolerance. The mother from Poland came to discuss her 5-year-old's poor weight and irregular bowel habit. I arranged for the child to see Prof. James at St Bid's. He is a good general paediatrician and quite quickly sorted out the diagnosis and treatment. The father who I later learnt was a city trader asked my secretary if he could have access to his son's notes while I was on holiday trekking in Bhutan. My secretary said he would have to wait until I returned but he took exception to this and wrote a letter of complaint.

As I am an independent practitioner I dealt with this using my complaints template. I wrote explaining I was on holiday and sent him a resume of his son's assessment and treatment and offered to meet with him. This all worked out well and the father after a meeting with me felt his concerns had been addressed.

My reflection on this is to ask my colleague Dr Peter French to have some oversight of my practice should I be away.

Have there been any findings/outcomes?

No.

Has anything changed as a result of the complaint/cause for concern?

I need some support should I be away.

Record your personal key learning points

See above.

How has this affected patient care in practice

No effect.

Record your next steps in this area

None.

Additional details (area 11) to be entered for each positive feedback.

Format (i.e. letter of thanks, etc.)

I have several cards and letters every year but one which really meant a lot was a letter from an elderly lady regarding a consultation at which I diagnosed that she had hypothyroidism. People with hypothyroidism tend to present insidiously and are quite frequently found on screening for raised TSH. However, this lady had an aversion to consulting doctors and came with itchy shins. The examination showed pre-tibial myxoedema and her TSH was 60.

Treatment with T₄ has transformed her over 18 months from a sluggish, over weight and depressed old lady to an active and spritely one. The card said simply: 'Thank you for giving me my life back'.

Background information pertaining to the compliment/positive feedback

■

What were your reflections?

Why is it that the simplest diagnosis creates the most warm thanks whereas the most difficult can be met with indifference.

Were there any learning points you would like to record and/or celebrate?

■

Is there any learning that could be shared with others?

■

Are there any further actions that need to be taken?

■

Specialty Adviser comments:

Dr S has declared one complaint and has described a compliment. The complaint has been resolved and Dr S has described the outcome. Dr S has reflected on the complaint and the compliment.

Post-appraisal summary

One example of a post appraisal summary is provided.

Please use this section to upload your historical appraisals.

Appraiser Dr Henry Bell **Responsible Organisation** Tower Clinical Governance Organisation

Outcome Pending **Date** 13/01/2013

Attach post-appraisal summary document

1. Background/scope of work/relevant context

Dr S works as an independent/private GP both in London and in the country near his home, as well as having an insurance examination practice.

Over the period of several years Dr S has made changes to his PDP to create personal and peer reflection and input into his evidence.

Although he has presented a minimum portfolio of evidence the quality is satisfactory and he has demonstrated that he has covered all the areas required for revalidation. Dr S does need to be more specific in his PDP objectives.

2. Knowledge, skills and performance

Dr S has undertaken an average of over 50 CPD credits over the last 4 appraisals. There has been a broad range of CPD which has covered the vast majority of his professional practice. This is satisfactory for revalidation.

3. Safety and quality

Dr S has completed the health declaration and confirmed that there are no health issues which affect patient care.

Dr S has provided an audit and 2 SEAs.

Dr S has had a period of ill health last year. He was admitted to the Tower for a R hip replacement, which has been successful. He is now well and is working almost full time.

4. Communication, partnership and team work

Dr S has undertaken colleague and patient feedback, both of which have been reflected upon and discussed with his appraiser.

5. Maintaining trust

Dr S provided evidence of his working practices, which reflect his organisational arrangement for ensuring governance of his practice.

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

Dr S has fulfilled the aspect of appraisal required for revalidation.

7. General comment not covered above

Dr S manages his professional practice successfully despite working in several different areas.