WESSEX
Appraisal Service

A PROFESSIONAL LIFE IN LEARNING

An Auto-ethnography of one GP's Journey

Author:
Dr Edward Sheridan

March 2022

“To be trained is to have arrived,
To be educated is to continue to travel”

(Calman 1994)

Introduction

Message from Dr. Sheridan:

I am writing to inform you that after 27 years as a partner at Parkstone Tower Practice and 36 years as a practicing doctor, I am retiring.

I am leaving the practice at the end of March 2021. It has been a very difficult decision for me, as there are so many aspects of my work which I still love, in particular the contact that I have with all of you. However, this feels like the right time to step back from my partnership role.

General Practice has changed in so many ways over these 27 years, but at its core, the trust you have placed in me has always felt like one of the great privileges of my career, and what I will take away with me is the memories of looking after my patients, often several generations of the same families. It has always been most rewarding to be involved in your healthcare over these years. Other highlights of my career include the provision of an ultrasound scanner service at Parkstone, my personal involvement in creating the Poole exercise referral programme and more recently, the formation of the Shore Medical Group with a blueprint for future patient-centred care. My four trips to North-East Ghana as a volunteer with the Afrikids organisation were a humbling experience which I will never forget. I came to a practice of 5 partners 27 years ago and am leaving as one of 26 partners, as well as outstanding nurse practitioners, nurses, HCAs, salaried doctors, physios and an exceptional administration and reception team. It has been an honour working with all of my colleagues.

Perhaps an enduring legacy for me is my contribution to training medical students and particularly GP registrars, many of whom are settled and working locally in the area. Over the years, I have often felt that I learned as much from them as they may have from me.

I have always tried to do the best for my patients, and this is the thought I will cherish the most. I shall miss sharing your experiences. A year ago, the crisis we are currently living through would have seemed unimaginable. The impact of isolation, economic hardship, stress and illness has touched all of us. However, it has been a privilege to be involved in the great success of the vaccination programme and I would like to echo the legend that is Captain Tom in saying 'The sun will shine on you again and the clouds will go away, tomorrow will be a good day'.

My very best wishes to you all, Dr Ed Sheridan

This is me now, saying a fond farewell to my patients over the last 27 years. I shall start at the beginning and allow this personal story to unfold. Qualified in 1985 at Guys, I went on the house job "windsurfing" run followed by 3 years on a General Medical/Emergency Room rotation in New Zealand and a 3 year adventure as Senior Ship's Physician for P&O Cruises, interspersed with some backpacking prior to settling into General Practice as a partner in Poole 27 years ago.

I have been learning and collecting supporting information throughout the entirety of my career, and found myself with CPD portfolios dating back to 2000. Here is their story.

Precept

These portfolios are a history of my learning – a representation of my education in medicine brought to life in an annual appraisal since 2003. The words learning, education, and appraisal are therefore used by me interchangeably and synonymously.

Aims

The emphasis is directed at the following questions:

- How have my educational tools changed?
- Are my portfolios a tracking mechanism for the adoption of experience-based learning and workplace learning in continuing education?
- What has been the effect of portfolio learning on my education.
- What impact has appraisal had on me and what impact have I had on appraisal.

Timeline

- 2001 Appraisal for Consultants in the NHS
- 2003 Appraisal for GP's (Remember Form 4 ?)
- 2003 – approximately – the rise of the self-directed learning group. This represented an alternative forum in which to formalize reflection on SEA, complaints and CPD learning in a safe environment which could facilitate networking.
- 2010 Strengthened Medical Appraisal and Revalidation (with an MSF, PSQ and Audit once every 5 years, SEA's x2 per year and 50 credits of documented learning).
- 2010 We were NESC (NHS England South West in those days) using the NHS Toolkit, and this was the period when it became unacceptable to present handwritten information in the Form 4 and PDP in an effort to ensure these professional documents could stand up to scrutiny.
- 2011 Requirement for 200 clinical sessions in a 5 year revalidation period.
- 2012 Supporting information requirements from the GMC to cover the 6 keys areas including surveys.
- 2012 December – Revalidation starts.
- Quality assurance for Appraisers moves to PROGRESS from the LEARNIT tool.
- 2019 QA transitions from PROGRESS to the SUPPORTS tool.
- 2019 NHSE/I Medical Appraisal reboot
- 2020 AoMRC Medical Appraisal Guide 2020 – in the wake of the COVID Pandemic.

What was the purpose of Appraisal and Revalidation?

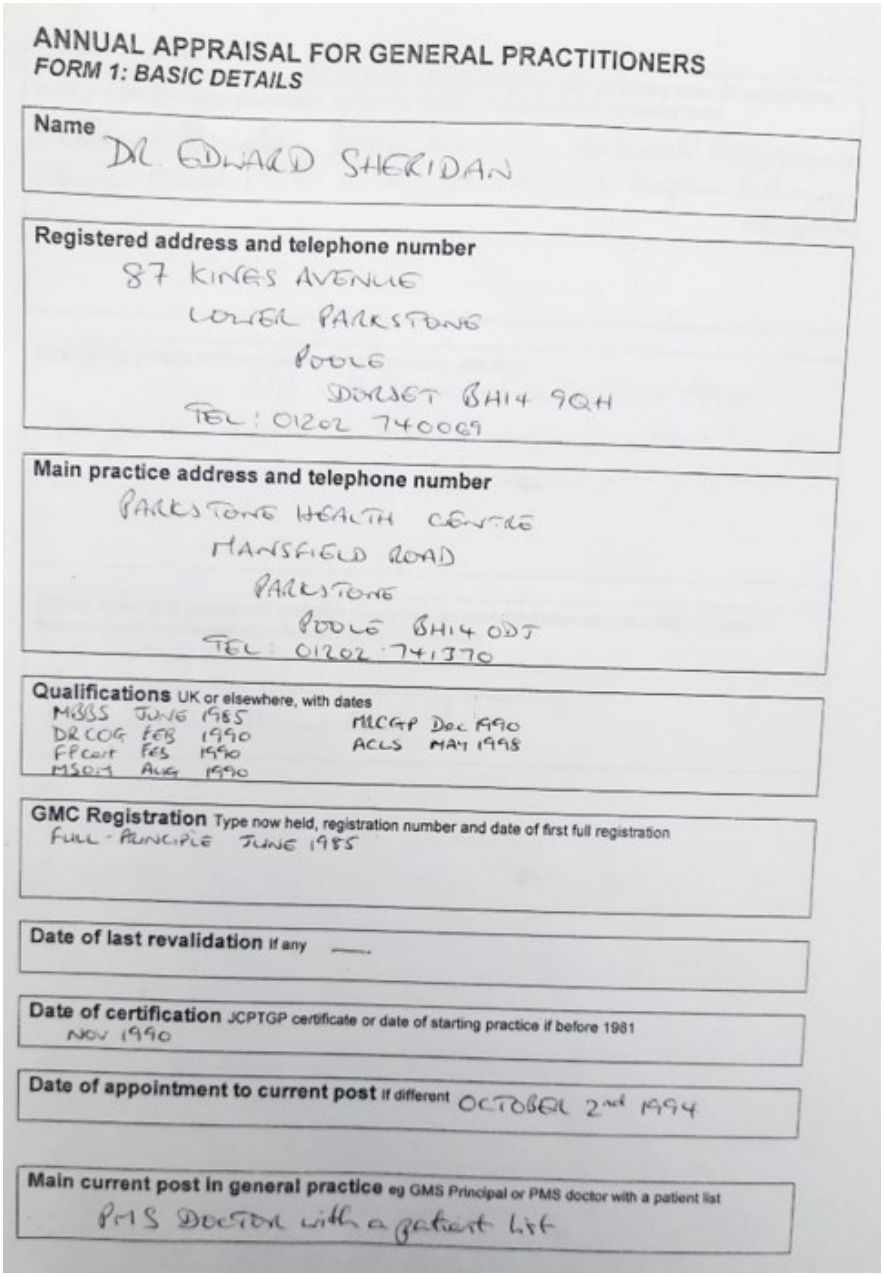
Conceived in 2003, an annual appraisal and supporting evidence were key to demonstrating one's fitness to practice and ability to keep updated. It was an opportunity to focus on our professional development needs, identify new needs, promote safety and quality within the NHS, ensure medical practice is governed properly and aimed to increase patient confidence. Appraisal was the process of facilitated self-review supported by information gathered from the full scope of our work. When Revalidation was ushered in, it helped to inform the Responsible Officer and their recommendation for revalidation. It is a statutory requirement to have an annual appraisal as part of the National Performers List regulations.

The Era of Toolkits

There have been plenty of different toolkits in the marketplace for appraisees – MAG MAF (PDP document), FourteenFish (My LMC/ Revalidation Toolkit), RCGP/Clarity ….

It was not so much the concept of a toolkit that was new but the promotion of a more formalized concept of portfolio learning. The original documentation from 2003 feels like a lifetime ago:

2003:



ANNUAL APPRAISAL FOR GENERAL PRACTITIONERS
FORM 1: BASIC DETAILS

Name
DR. EDWARD SHERIDAN

Registered address and telephone number
87 KINGS AVENUE
LOWER PARKSTONE
POOLE
DORSET BH14 9QH
TEL: 01202 740069

Main practice address and telephone number
PARKSTONE HEALTH CENTRE
MANSFIELD ROAD
PARKSTONE
POOLE BH14 0DT
TEL: 01202 741370

Qualifications UK or elsewhere, with dates
MBBS JUNE 1985
DRCOG FEB 1990
FFCAT FEB 1990
MSDM AUG 1990
MRCGP DEC 1990
ACLS MAY 1998

GMC Registration Type now held, registration number and date of first full registration
FULL - PRINCIPLE JUNE 1985

Date of last revalidation if any —

Date of certification JCPTGP certificate or date of starting practice if before 1981
NOV 1990

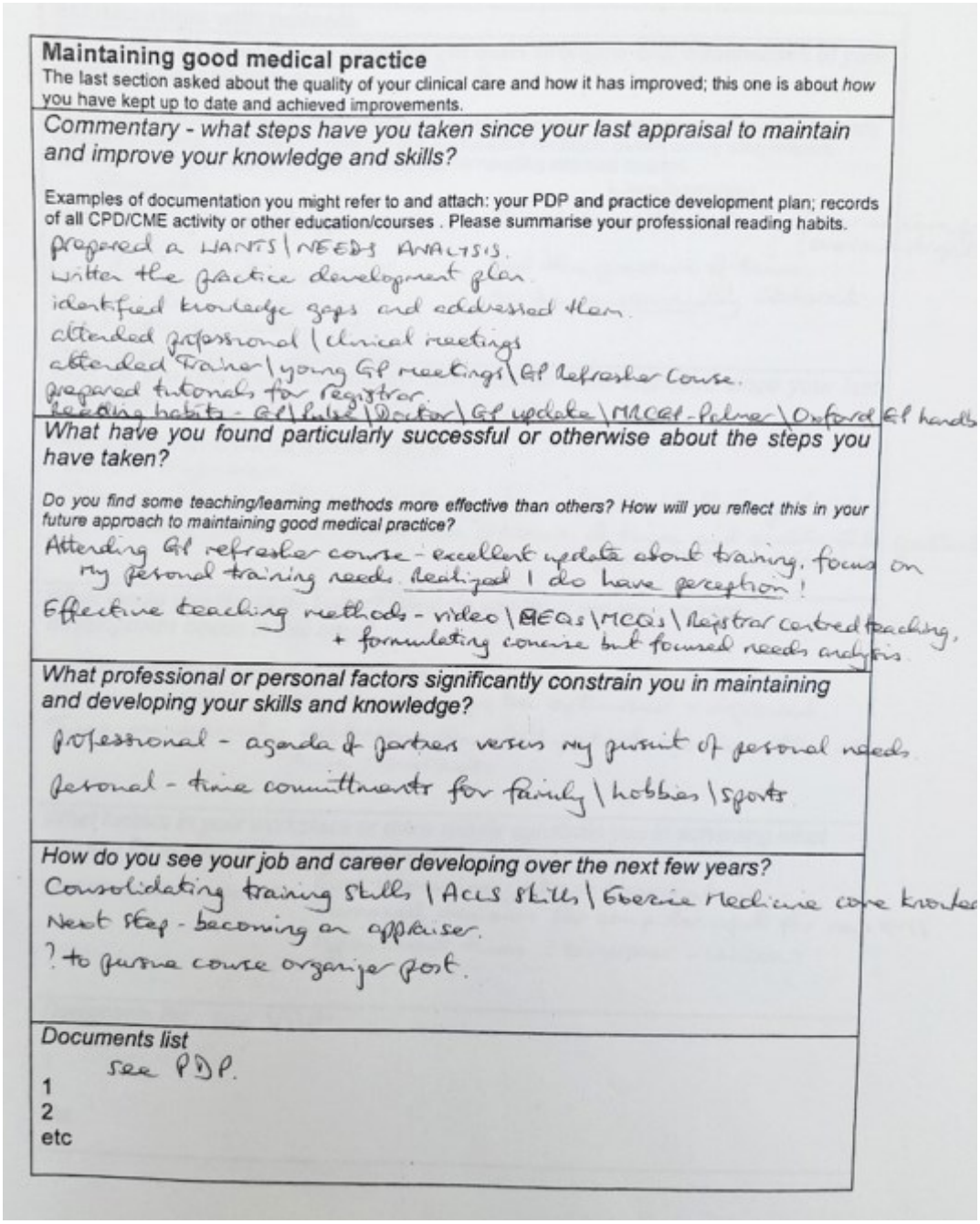
Date of appointment to current post if different OCTOBER 2nd 1994

Main current post in general practice eg GMS Principal or PMS doctor with a patient list
PMS Doctor with a patient list

The MAG MAF included:

- Form 1 - basic details
- Form 2 – Current Medical Activities
- Form 3 - Material for Appraisal
- Form 4 – Summary and agreed action and PDP
- Form 5 – additional information and virtually never used.

EXAMPLES:



Maintaining good medical practice

The last section asked about the quality of your clinical care and how it has improved; this one is about *how* you have kept up to date and achieved improvements.

Commentary - what steps have you taken since your last appraisal to maintain and improve your knowledge and skills?

Examples of documentation you might refer to and attach: your PDP and practice development plan; records of all CPD/CME activity or other education/courses . Please summarise your professional reading habits.

prepared a WANTS \ NEEDS ANALYSIS.
written the practice development plan.
identified knowledge gaps and addressed them.
attended professional \ clinical meetings
attended trainer \ young GP meetings \ GP Refresher Course.
prepared tutorials for registrar.
reading habits - GP \ BMJ \ Doctor \ GP update \ MRCGP - Palmer \ Oxford GP hands

What have you found particularly successful or otherwise about the steps you have taken?

Do you find some teaching/learning methods more effective than others? How will you reflect this in your future approach to maintaining good medical practice?

Attending GP refresher course - excellent update about training. focus on my personal training needs. Realized I do have perception!

Effective teaching methods - video \ MEQs \ MCQs \ Registrar centred teaching, + formulating concise but focused needs analysis.

What professional or personal factors significantly constrain you in maintaining and developing your skills and knowledge?

Professional - agenda of partners verses my pursuit of personal needs

Personal - time committments for family \ hobbies \ sports

How do you see your job and career developing over the next few years?

Consolidating training skills \ ACLS skills \ Obesity Medicine core knowled
Next step - becoming an appraiser.
? to pursue course organizer post.

Documents list

see PDP.

1
2
etc

- outline aims + goals
- provide environment for structured + non threatening learning → goal accomplishment - "SAFE INSECURITY"
- mediator between registrar + other partners | 1° HCT.
- enthusiastic, committed to teach

Teaching and training

- to cover key areas in accepted curriculum.
- offer ongoing feedback + review

Commentary - what do you think are the main strengths and weaknesses of your work as a teacher or trainer?

- ability to criticise where appropriate but not threaten or humiliate.

STRENGTHS

- wide use of different learning tools.

Examples of documentation you might refer to and supply: a summary of your formal teaching/training work and any informal supervision or mentoring; any recorded feedback.

- live in the world of opportunity + possibility
- reliable decision-making
- clinical competence
- patient (most of the time!)
- empathic | approachable
- broad range of clinical skills
- self understanding, supportive
- reliable + industrious, motivated + power to motivate.

WEAKNESSES

- obsession with detail
- perhaps judgemental though try not to show it.
- Sometimes tutorial teaching is trainer-led, not registrar-led
- overly high expectation of registrar.
- Feeling time pressured when helping registrar + knowing I must not show it.

Has your teaching or training work changed since your last appraisal? Has it improved?

Refer as appropriate to your last appraisal and PDP.

Been on Trainer Refresher Course Nov 2003

- tips picked up - use of MAST questionnaire every 3 mths
- asking opinion of Reg re: sections of Trainer's Report.
- new analysis of consultation
- try analysis of video session by registrar - tape + analyse.

Would you like to do more? What would you like to do better? What do you think are your current development needs?

This is in preparation for agreeing an updated PDP.

- more protected teaching time for 5th year Southampton | Engs need students.
- try video session for 5th year students.
- more registrar-led teaching

NEEDS - I need to become an appraiser - as the next educational step for me.
- ? become a course organiser (as suggested by Clinical tutor on Refresher Course.

What factors constrain you in achieving what you aim for in your teaching or training work?

Arranging cover, for example. What can be addressed locally?

- time - esp when 5th y students come - could do with shorter surgeries.
- partners - have "approved" me to pursue becoming an appraiser but lot of resistance to interest in course organiser!

Documents list

1 PLEASE SEE THIS SECTION OF MY PDP
2 - important.
etc

FORM 4: SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

This form sets out an agreed summary of the appraisal discussion and a description of the actions agreed, including those forming your personal development plan.

The form will be completed by your appraiser and then agreed by you.

SUMMARY OF APPRAISAL DISCUSSION

Good clinical care

Commentary Endenced high standard of medical practice.

Action agreed

maintain level through reflection + PDP.

Maintaining good medical practice

Commentary Journal reading, attendance at Young GP + trainers groups; addressing of learning needs.

Action agreed

maintain.

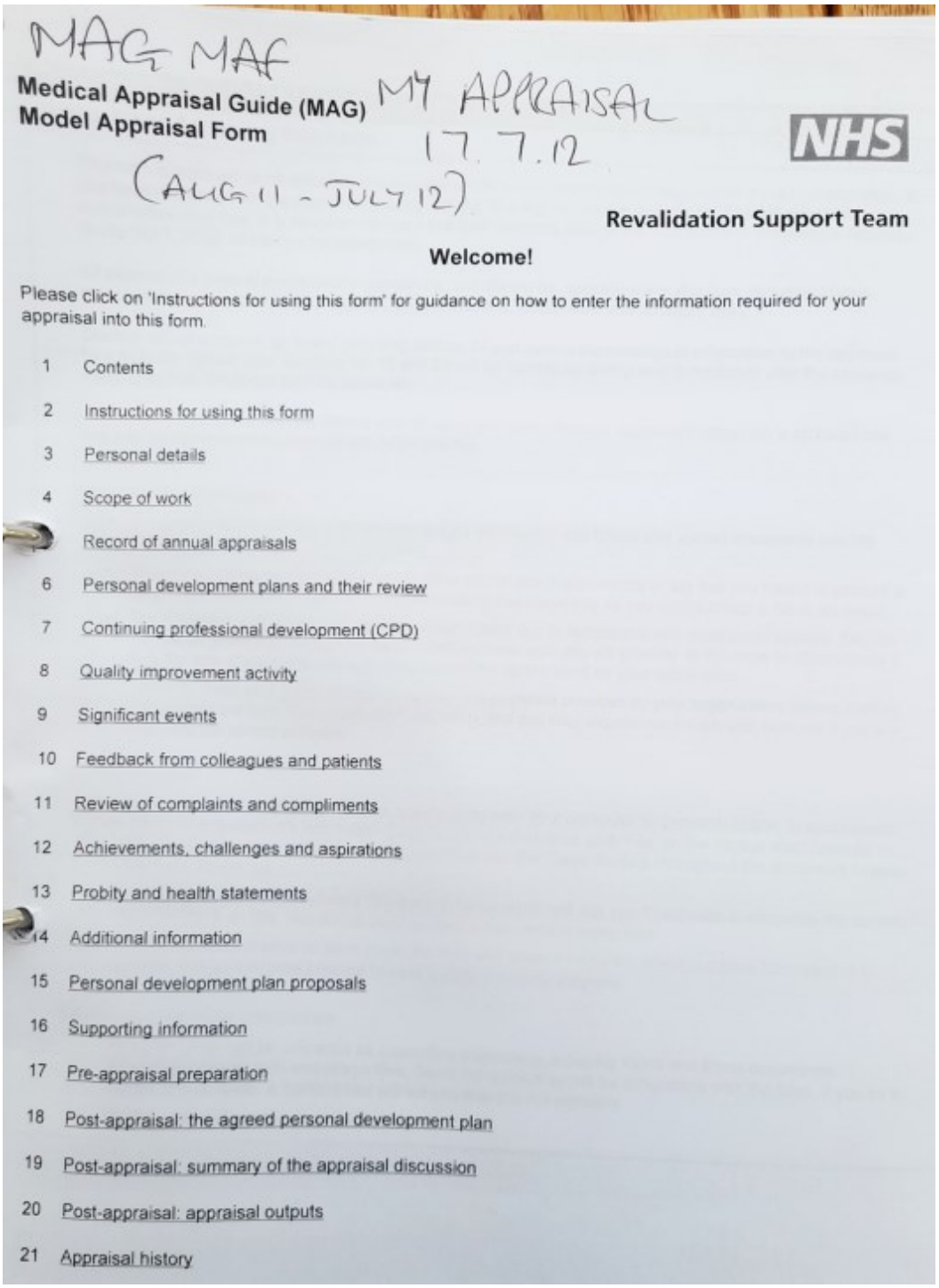
Relationships with patients

Commentary Good evidence of good standard of patient rapport.

Action agreed

maintain quality of consultation process

EXAMPLE 2012:



MAG MAF

Medical Appraisal Guide (MAG)
Model Appraisal Form

MY APPRAISAL
17.7.12
(AUG 11 - JULY 12)

NHS

Revalidation Support Team

Welcome!

Please click on 'Instructions for using this form' for guidance on how to enter the information required for your appraisal into this form.

The original Form 4 was basically what we understand as the summary of discussion resulting in a set of learning objectives which was the PDP (Personal Development Plan). The PDP has evolved from those early germinal seeds, and moved to a more appraisee-centred approach, focussed on specific goals relevant to the doctor.

EXAMPLES 2018-2021:

	Relevant job title or role	Detail of item (should be short and concise)
1	Appraisal Lead for Bournemout	**1 Learning or development need:** I am keen to explore other avenues of communicating with and updating appraisers in my locality group and have decided to explore the possibility of producing regular podcasts for them.
2		**2 Agreed action(s) or goal(s):** - I will undertake on-line podcast training in order to learn how to undertake the process. - I will produce at least one podcast for my appraisers and canvas their thoughts and views on the result.
3		**3 Timescale for completion:** 12 months.
4		**4 How I intend to demonstrate success:** - I will be able to evidence completion of podcast training and the production of at least one podcast to my locality appraisers. - I will canvas their thoughts and reflect on them as to whether this is a useful alternative method of communication with them.
5		
6		
7		
8		
9		

Relevant job title or role	Detail of item (should be short and concise)
Afrikids Volunteer role-Upper N	**1 Learning or development need:** **To visit Upper North East Ghana with the charity to teach and supervise ETAT training for health professions in the entire region.** **I was not able to go to Ghana in 2017 as there was no organized trip with the Afrikids charity. I am keen to push for another trip for approx November 2018 as the last ETAT training delivered was so successful and a supplementary course would add value to what has been achieved thus far.** **2 Agreed action(s) or goal(s):** **Contact the Paediatric Lead and Paediatric respiratory lead nurse , collate a plan with clear learning objectives for how the course could be delivered by supporting and teaching other resident health professionals, with the necessary slide presentations, handouts, mannequins for practical application and ways of evaluating outcomes. My reservation for this is that there is a chance it might not happen as liaising with my paediatric colleague is problematic at best and conceivably the charity may not be supporting a paediatric visit for this year.** **3 Timescale for completion:** **12 months** **4 How I intend to demonstrate success:** **Evidence of undertaking a trip to Ghana with Afrikids , with evidence of personal reflections on how the course was delivered, how we taught and supervised the local instructors and evaluation of feedback and outcome data.**

The agreed personal development plan

The personal development plan is a record of the agreed personal and/or professional development needs to be pursued throughout the following year, as agreed in the appraisal discussion between the doctor and the appraiser.

About 'Relevant job title or role'.

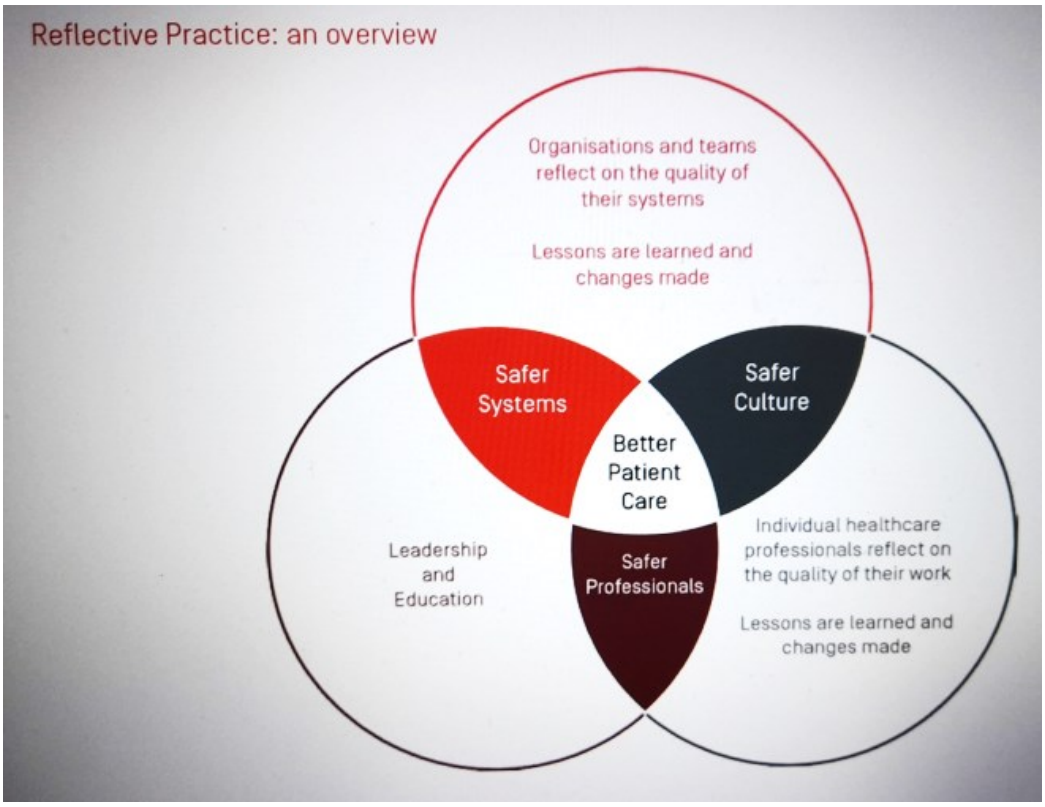
Relevant job title or role	Detail of item (should be short and concise)	Add row
GMS Principal with a patient lis	1 Learning or development need: Update on latest options for Hormone Replacement Therapy and treatment of the menopause. As a male doctor, for some years now female patients often will seek a consultation with a female doctor and my knowledge of gynae and in particular HRT can deskill and degrade. A recent patient contact highlighted to me the need to remain as knowledgeable as possible when I do get such a patient with these needs. 2 Agreed action(s) or goal(s): I will consider utilizing different educational tools , in particular, e modular learning, directed reading, problem case analysis, and clinical meetings eg. Practice-based education. 3 Timescale for completion: 12 months 4 How I intend to demonstrate success: Evidence of attending educational activity eg. certification, key learning points and notes. I would be able to personally reflect on increased confidence and positive patient satisfaction with case encounters specific to HRT.	-

The SMARTER mnemonic came to represent the Specific, Measurable, Achievable, Relevant, Timely, Economic, and Reflective learning objective which helped me target some areas that were defined and important to me at that stage of my career.

Portfolio Learning

Portfolio learning is a method of encouraging adult and reflective learning for professionals, and here the word “reflection” comes to the fore.

My portfolios are a collection of evidence that learning has taken place, as a means of assisting formative assessment and professional development. I have learned best when there has been intrinsic motivation for me to learn – when there is a need to connect information already stored or learn new information, and tends to be problem-centred arising directly out of experience (Learning Cycle, Heron 1976). It is easy to see how Richard Eve’s PUNS/DENS learning tool links to this.



I was utilizing a wants and needs analysis structure in 2003:

30.08.03

LEARNING NEEDS/AGENDA

What is the Learning Need?

A new challenge – I feel like a new challenge! I envisage this to take the form of a course, but not specifically on any areas that I have explored in my Needs Analysis; this would be purely for newness and the ability to push myself in a different direction. This is only a provisional idea, but I have selected the Expedition Medicine and Leadership course, being held from 27th – 30th January 2004 in Keswick.

Aspects of the course that particularly interest me include concepts of team building and dynamics, outdoor skills (particularly with ropes reflecting some of my climbing experience in the past) and other aspects of physical medicine, including dive medicine. Another spin-off would be to review aspects of travel medicine and I enclose a couple of clinical review articles from GP, September 2003, on up-dating basics in travel medicine.

How was this identified?

- The simple desire to try something new that would particularly stimulate me.
- This particular course interests me, in view of the fact that it combined a variety of previously acquired skills, along with learning of new ones. For example, my experience with ACLS/trauma/Ship's Doctor – especially with regard to ship evacuations/my personal past history of trekking from New Zealand to Europe, and my general past travel experience, which has been reasonably extensive.

How will this need be addressed?

- By attending the above-mentioned course.
- If, for any reason, I am not able to attend this course, then I should have some provisional ideas about a different but new challenge, for example becoming an Appraiser/becoming a Course Organiser.

What is the time-scale for action?

The course is at the beginning of January 2004, although if I am unable to find funding by then, there is another course in June 2004.

What is the review date to monitor progress?

February 2004, after the January course; or July 2004, after the June course, depending on which one I attend, if feasible.

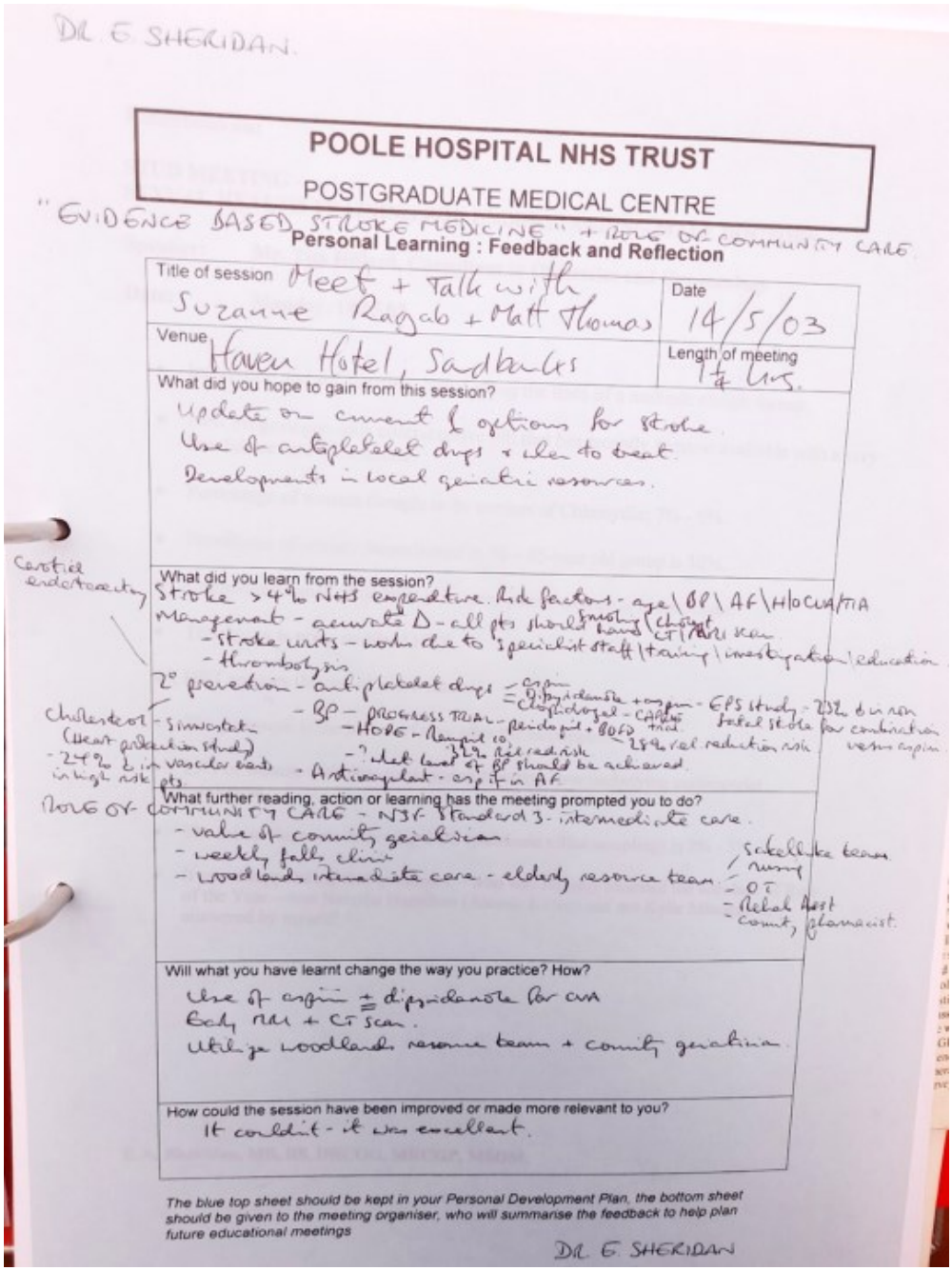
How will you demonstrate that the objectives have been met?

Review analysis of the course content and the learning points. Consolidation of previous knowledge and skills, along with identification of new ones. In terms of acquired leadership skills, I would like to think that this would have a link with general team work within the Primary Care setting. I enclose a short article on team and spirit and team work which, although nothing to do with the type of course that I am going on and referring single-handed Practices, still reflects the type of objective which may be of use. I certainly hope that the objective of improving my personal team spirit and being taken to a further level, is met.

E.A. Sheridan, MB, BS, DRCOG, MRCGP.

For me, such a means of identifying learning needs inexorably has morphed into the rise of reflective practice – not new at all and inherent in all our learning over many years but more defined. The articulation of what is learned often includes reflections in the form of a CPD log or journal entry. These can include reflection on problem areas, what has been learned , what has still to be learned and plans for how new learning could be tackled. This system works well when it operates through the interaction of a learner and supervisor using the material as a catalyst to guide further learning – that supervisor has the shape of an appraiser, and the interaction is the appraisal discussion. It was always important for me that the learning contained within the portfolio was not just a collection of events seen or experienced but contained my personal key reflections on these and the learning derived from them.

EXAMPLE 2003:



Dr. E SHERIDAN.

POOLE HOSPITAL NHS TRUST

POSTGRADUATE MEDICAL CENTRE

"EVIDENCE BASED STROKE MEDICINE" + ROLE OF COMMUNITY CARE

Personal Learning : Feedback and Reflection

Title of session: Meet + Talk with Suzanne Ragab + Matt Thomas	Date: 14/5/03
Venue: Haven Hotel, Sandbanks	Length of meeting: 1¼ hrs.

What did you hope to gain from this session?

Update on current & options for stroke.
Use of antiplatelet drugs + when to treat.
Developments in local geriatric resources.

What did you learn from the session?

Stroke > 4% NHS expenditure. Risk factors - age \ BP \ AF \ HOCM/TIA
Management - accurate Dx - all pts should have CT/MRI scan
- stroke units - works due to specialist staff \ training \ investigation \ education
- thrombolysis
2° prevention - antiplatelet drugs = aspirin = dipyridamole + aspirin - ESPS study - 23% ↓ in non fatal stroke for combination versus aspirin
- BP - PROGRESS TRIAL - perindopril + BOFD trial
- HOPE - Ramipril
- ? ideal level of BP should be achieved
- Anticoagulant - asp if in AF

What further reading, action or learning has the meeting prompted you to do?

- value of comm. geriatrician
- weekly falls clinic
- Woodlands intermediate care - elderly resource team

Will what you have learnt change the way you practice? How?

Use of aspirin ± dipyridamole for CVA
Early MRI + CT scan.
Utilize Woodlands resource team + comm. geriatrician.

How could the session have been improved or made more relevant to you?

It couldn't - it was excellent.

The blue top sheet should be kept in your Personal Development Plan, the bottom sheet should be given to the meeting organiser, who will summarise the feedback to help plan future educational meetings

Dr. E SHERIDAN

5.4.06.

Personal Significant Event

Re: Patient DM, Age 42, Female

What happened?

Patient presented after I had investigated her for secondary infertility. She had seen a Specialist who had recommended Clomifene 50mg daily from day 2-6 of cycle. I typed in Clomi and thought I had checked what came out and just as I was handing over the prescription, checked the name and the drug and realised that Clomipramine 50mg daily had been produced from the printer. I immediately rectified the prescribing error and handed her the correct prescription.

Learning points

- Only a couple of weeks ago, I had done a full tutorial on prescribing with my new Registrar, Dr Turner, and made careful acknowledgement of the commonest prescribing error being the wrong drug or wrong dose.
- As a matter of normal optimum practice, I always check the prescription I produce from the printer and verify the drug against the name of the patient before handing it to the patient and it was certainly a useful exercise in view of this particular script.
- Such a prescribing error can occur very easily and it reaffirmed to me the need to always check the drug and dose with the name of the patient at the top of the prescription. I discussed this with Dr Turner as a perfect example of what could happen if one doesn't double check.

Dr E A Sheridan MBBS.DRCOG.MRCGP.MSOM

:105. pt. [redacted]. ♀ 50y. Thoracic back pain Δ SAPHO SYND ?

RUN \ DEN

MedicineNet.com
We Bring Doctors' Knowledge to You

SAPHO Syndrome

Medical Author: William C. Shiel Jr., MD, FACP, FACR

What is SAPHO syndrome?

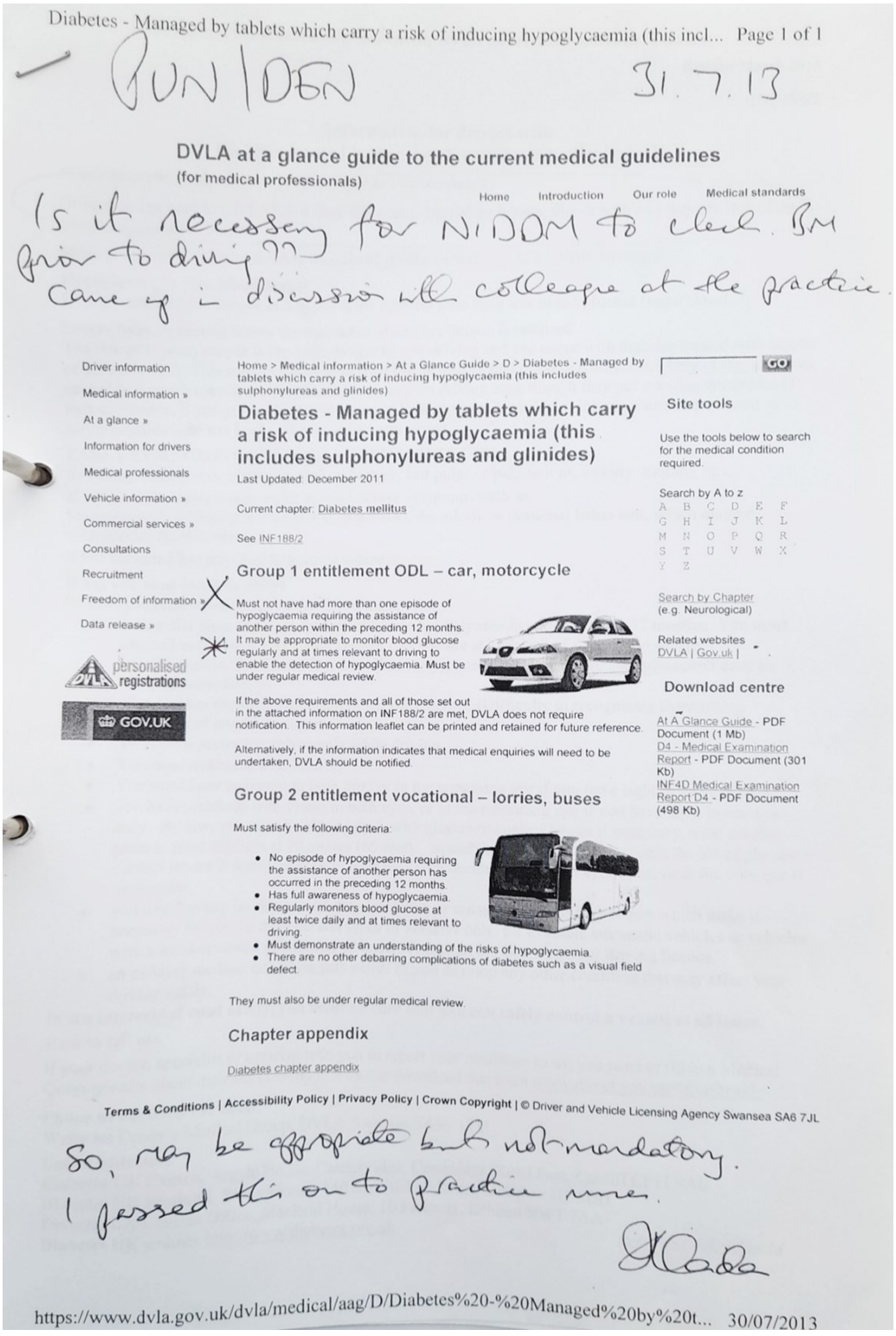
SAPHO syndrome is a chronic disorder that involves the skin, bone, and joints. SAPHO is an eponym for the combination of synovitis, acne, pustulosis, hyperostosis, and osteitis.

Synovitis means inflammation of the joint lining (synovium). Typically, this is manifest as warmth, tenderness, pain, swelling, and stiffness of involved joints (arthritis).

Acne is a skin condition featuring tiny areas of inflammation with pus formation at the hair follicles. Acne occurs most commonly on the face and upper back.

Pustulosis is a very inflammatory skin condition resulting in large fluid-filled blister-like areas (pustules), typically on the palms of the hands and/or the soles of the feet. The skin of these areas peels and flakes (exfoliates).

Hyperostosis means abnormal excessive growth of bone. The hyperostosis of the SAPHO syndrome frequently is located at the points of the bone where tendons attach.



Diabetes - Managed by tablets which carry a risk of inducing hypoglycaemia (this incl... Page 1 of 1

RUN | DGN 31.7.13

DVLA at a glance guide to the current medical guidelines
(for medical professionals)

Home Introduction Our role Medical standards

Is it necessary for NIDDM to check BM prior to driving??
Came up in discussion with colleague at the practice.

Driver information
Medical information »
At a glance »
Information for drivers
Medical professionals
Vehicle information »
Commercial services »
Consultations
Recruitment
Freedom of information »
Data release »

personalised registrations
GOV.UK

Home > Medical information > At a Glance Guide > D > Diabetes - Managed by tablets which carry a risk of inducing hypoglycaemia (this includes sulphonylureas and glinides)

Diabetes - Managed by tablets which carry a risk of inducing hypoglycaemia (this includes sulphonylureas and glinides)

Last Updated: December 2011

Current chapter: Diabetes mellitus

See INF188/2

Group 1 entitlement ODL – car, motorcycle

X Must not have had more than one episode of hypoglycaemia requiring the assistance of another person within the preceding 12 months.

* It may be appropriate to monitor blood glucose regularly and at times relevant to driving to enable the detection of hypoglycaemia. Must be under regular medical review.

If the above requirements and all of those set out in the attached information on INF188/2 are met, DVLA does not require notification. This information leaflet can be printed and retained for future reference.

Alternatively, if the information indicates that medical enquiries will need to be undertaken, DVLA should be notified.

Group 2 entitlement vocational – lorries, buses

Must satisfy the following criteria:

- No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months.
- Has full awareness of hypoglycaemia.
- Regularly monitors blood glucose at least twice daily and at times relevant to driving.
- Must demonstrate an understanding of the risks of hypoglycaemia.
- There are no other debarring complications of diabetes such as a visual field defect.

They must also be under regular medical review.

Chapter appendix

Diabetes chapter appendix

Site tools

Use the tools below to search for the medical condition required.

Search by A to z
A B C D E F
G H I J K L
M N O P Q R
S T U V W X
Y Z

Search by Chapter
(e.g. Neurological)

Related websites
DVLA | Gov.uk |

Download centre

At A Glance Guide - PDF Document (1 Mb)
D4 - Medical Examination Report - PDF Document (301 Kb)
INF4D Medical Examination Report D4 - PDF Document (498 Kb)

So, may be appropriate but not mandatory.
I passed this on to practice nurse.

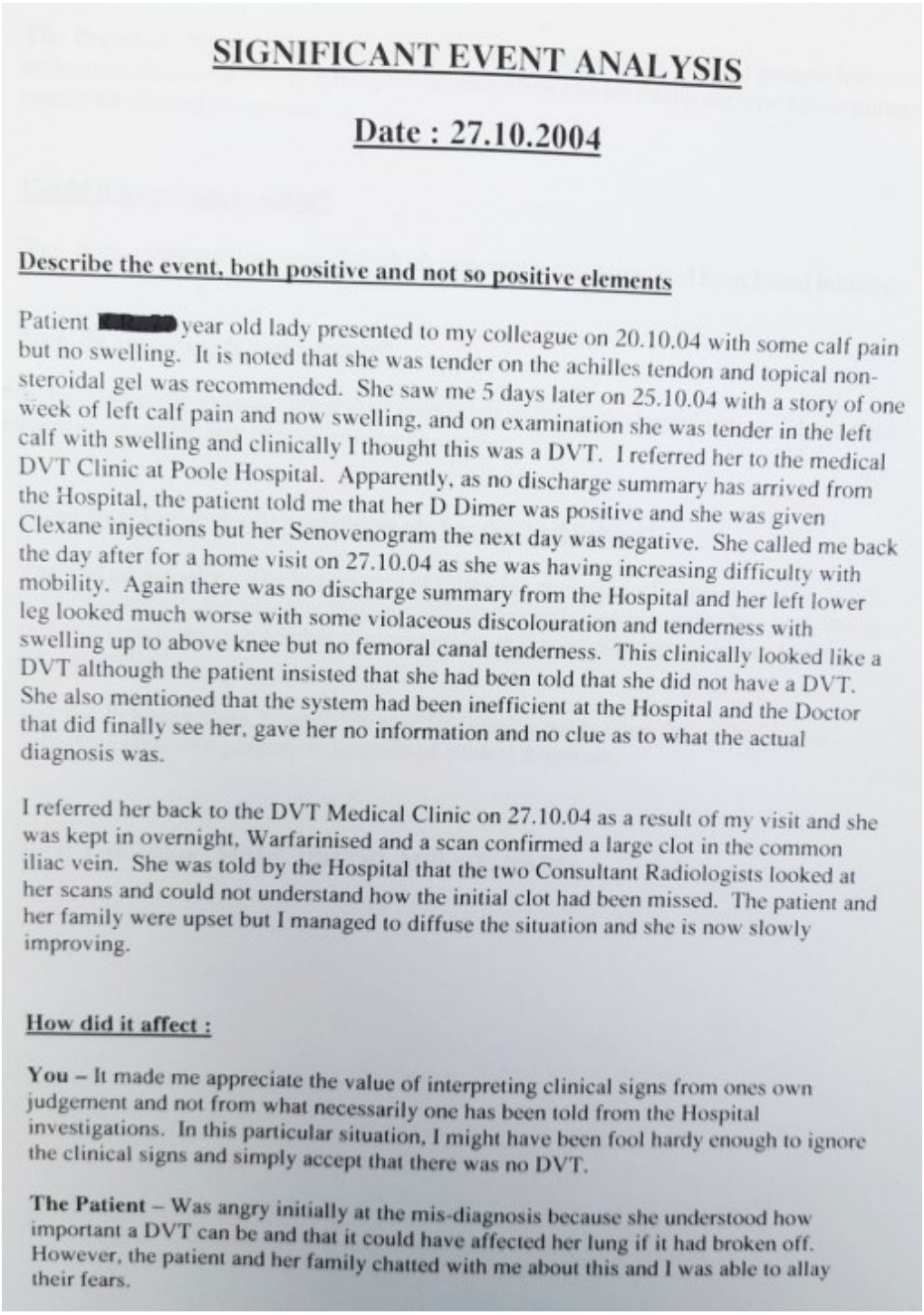
Back in those early years from 2003, a CPD portfolio could take many shapes but was predominantly an A4 folder with relevant sub-sections but over the years, this has shifted to electronic formatting and recording. It doesn't actually matter as long as learning has taken place, so a flexible approach has been taken to avoid being too prescriptive about its structure.

My Educational Tools

We have had access to a vast array of learning tools by which we can learn and make reflections on our clinical practice to optimize patient care – many are not new and include:

Significant Event Analysis – I have found these particularly useful in facilitating an in-depth exploration of my clinical thinking and actions, and highlights areas for potential learning, as well as focussing on my emotional reactions and attitudes to problems/issues.

EXAMPLE 2004:



SIGNIFICANT EVENT ANALYSIS

Date : 27.10.2004

Describe the event, both positive and not so positive elements

Patient [redacted] year old lady presented to my colleague on 20.10.04 with some calf pain but no swelling. It is noted that she was tender on the achilles tendon and topical non-steroidal gel was recommended. She saw me 5 days later on 25.10.04 with a story of one week of left calf pain and now swelling, and on examination she was tender in the left calf with swelling and clinically I thought this was a DVT. I referred her to the medical DVT Clinic at Poole Hospital. Apparently, as no discharge summary has arrived from the Hospital, the patient told me that her D Dimer was positive and she was given Clexane injections but her Senovenogram the next day was negative. She called me back the day after for a home visit on 27.10.04 as she was having increasing difficulty with mobility. Again there was no discharge summary from the Hospital and her left lower leg looked much worse with some violaceous discolouration and tenderness with swelling up to above knee but no femoral canal tenderness. This clinically looked like a DVT although the patient insisted that she had been told that she did not have a DVT. She also mentioned that the system had been inefficient at the Hospital and the Doctor that did finally see her, gave her no information and no clue as to what the actual diagnosis was.

I referred her back to the DVT Medical Clinic on 27.10.04 as a result of my visit and she was kept in overnight, Warfarinised and a scan confirmed a large clot in the common iliac vein. She was told by the Hospital that the two Consultant Radiologists looked at her scans and could not understand how the initial clot had been missed. The patient and her family were upset but I managed to diffuse the situation and she is now slowly improving.

How did it affect :

You – It made me appreciate the value of interpreting clinical signs from ones own judgement and not from what necessarily one has been told from the Hospital investigations. In this particular situation, I might have been fool hardy enough to ignore the clinical signs and simply accept that there was no DVT.

The Patient – Was angry initially at the mis-diagnosis because she understood how important a DVT can be and that it could have affected her lung if it had broken off. However, the patient and her family chatted with me about this and I was able to allay their fears.

The Practice – No specific ramifications for the Practice other than the general lesson to be learned that occasionally a Hospital investigation can be wrong and one has to pursue ones own clinical judgement.

Could it have been avoided?

Yes, if the common iliac vein clot which apparently was large, had been found initially.

How do you prevent a recurrence?

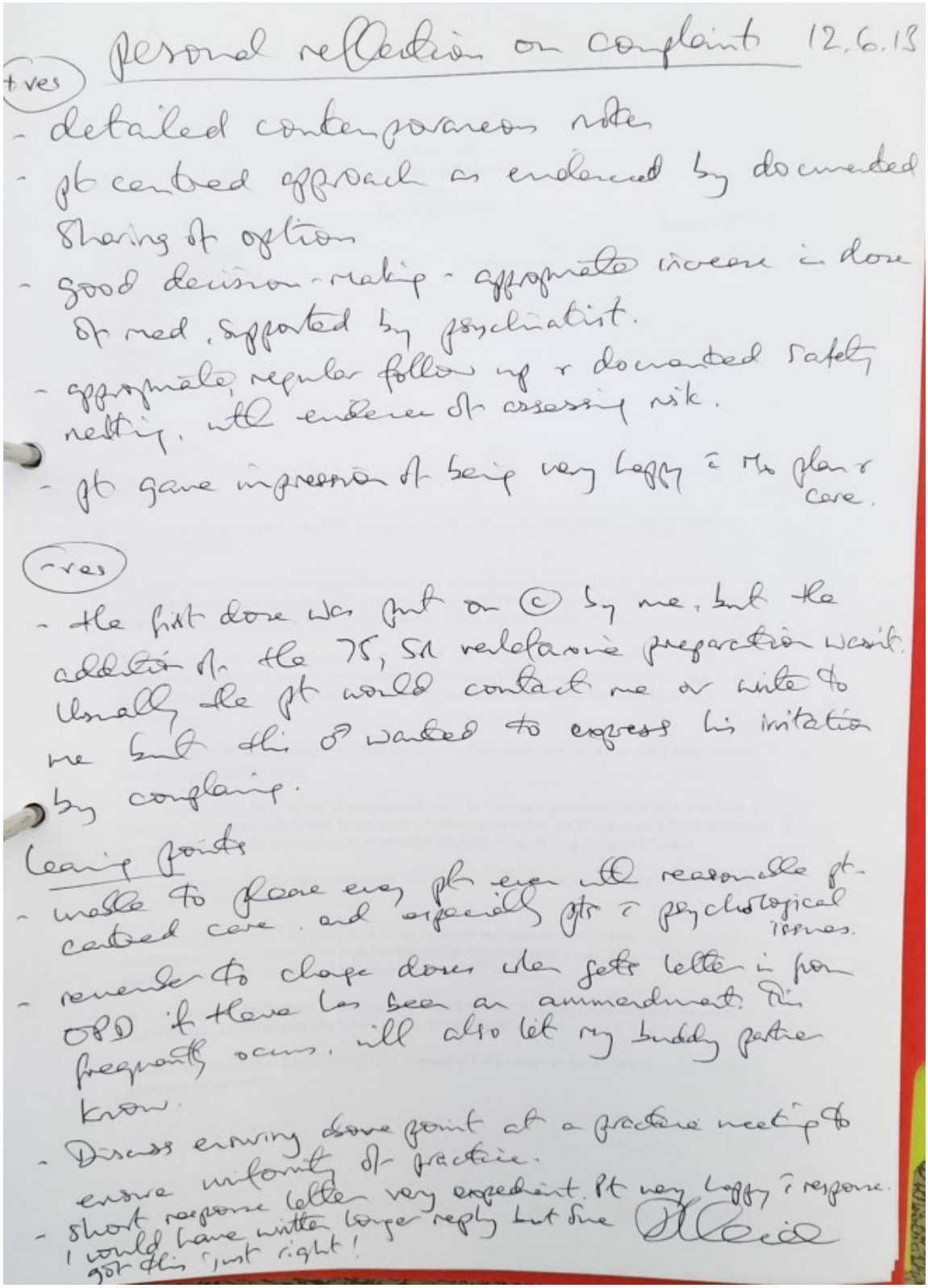
In this particular instance, other than being alert to the clinical presentation, I don't think there is a specific way of preventing a recurrence.

What learning or developmental needs has this highlighted?

For you personally – The importance of following ones clinical judgement even in the light of evidence that suggests that ones initial diagnosis was incorrect. In a way, this is a positive significant event rather than something that went disastrously wrong but it does have potential!

For the Primary Care Team – No specific learning needs other than to be alert to following ones own judgement in terms of clinical diagnosis.

Dr E A Sheridan MBBS. DRCOG. MRCGP. MSOM



Personal reflection on complaint 12.6.13

+ves

- detailed contemporaneous notes
- pt centred approach as evidenced by documented sharing of options
- good decision-making - appropriate increase in dose of med, supported by psychiatrist.
- appropriate, regular follow up & documented safety netting, with evidence of assessing risk.
- pt gave impression of being very happy w the plan & care.

-ves

- the first dose was put on (c) by me, but the addition of the 7.5, SA related service preparation work. Usually the pt would contact me or write to me but this pt wanted to express his irritation by complaint.

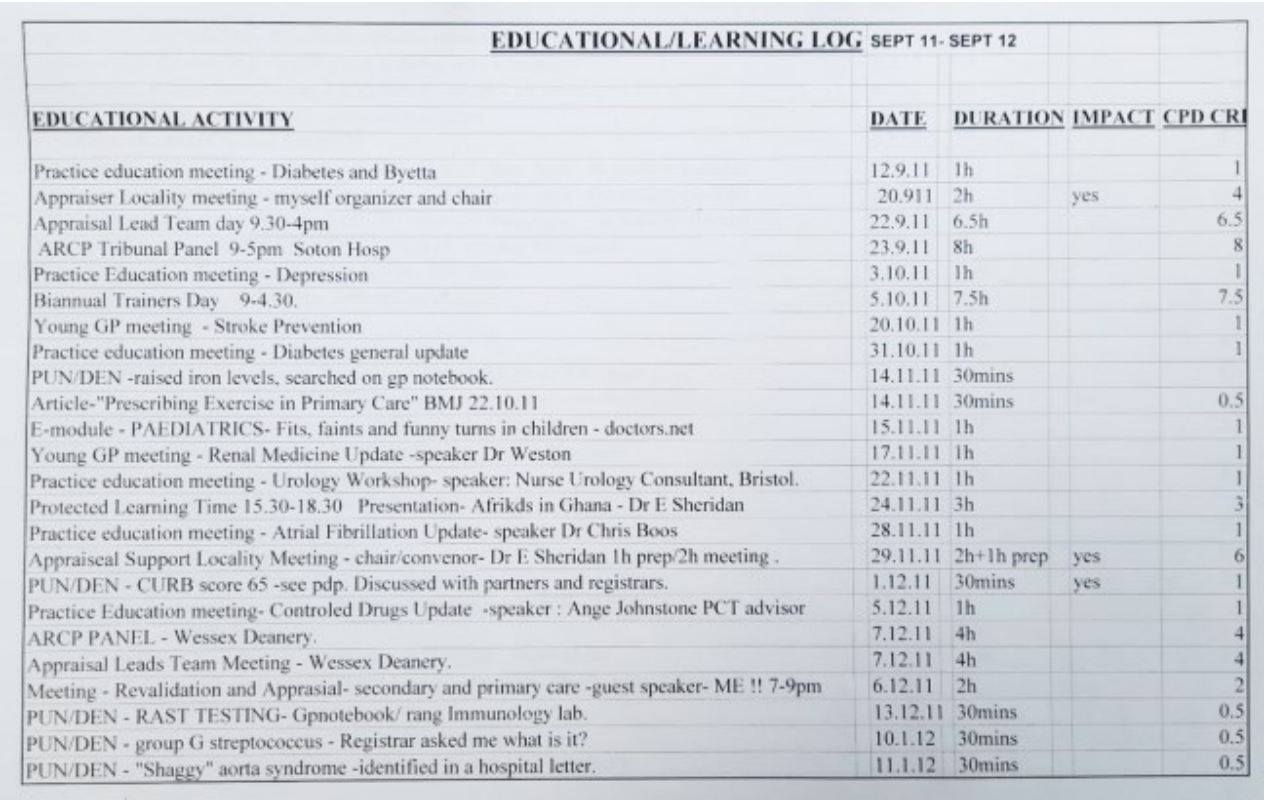
Learning points

- unable to please every pt even with reasonable pt-centred care, and especially pts w psychological issues.
- remember to change doses when gets letter in from OPD if there has been an amendment. This frequently occurs. will also let my buddy partner know.
- Discuss errors done point at a practice meeting to ensure uniformity of practice.
- short response letter very expedient. Pt very happy w response. I would have written longer reply but this got this 'just right!

Reflective Journal/Diary/Learning Log

This can take the form of key learning points, reflections on how to apply learning, or simply a chronological summary of learning that has taken place with reflections recorded elsewhere. The advent of electronic toolkits over the years has made the logging of CPD encounters much easier for the learner to record.

EXAMPLE 2011:

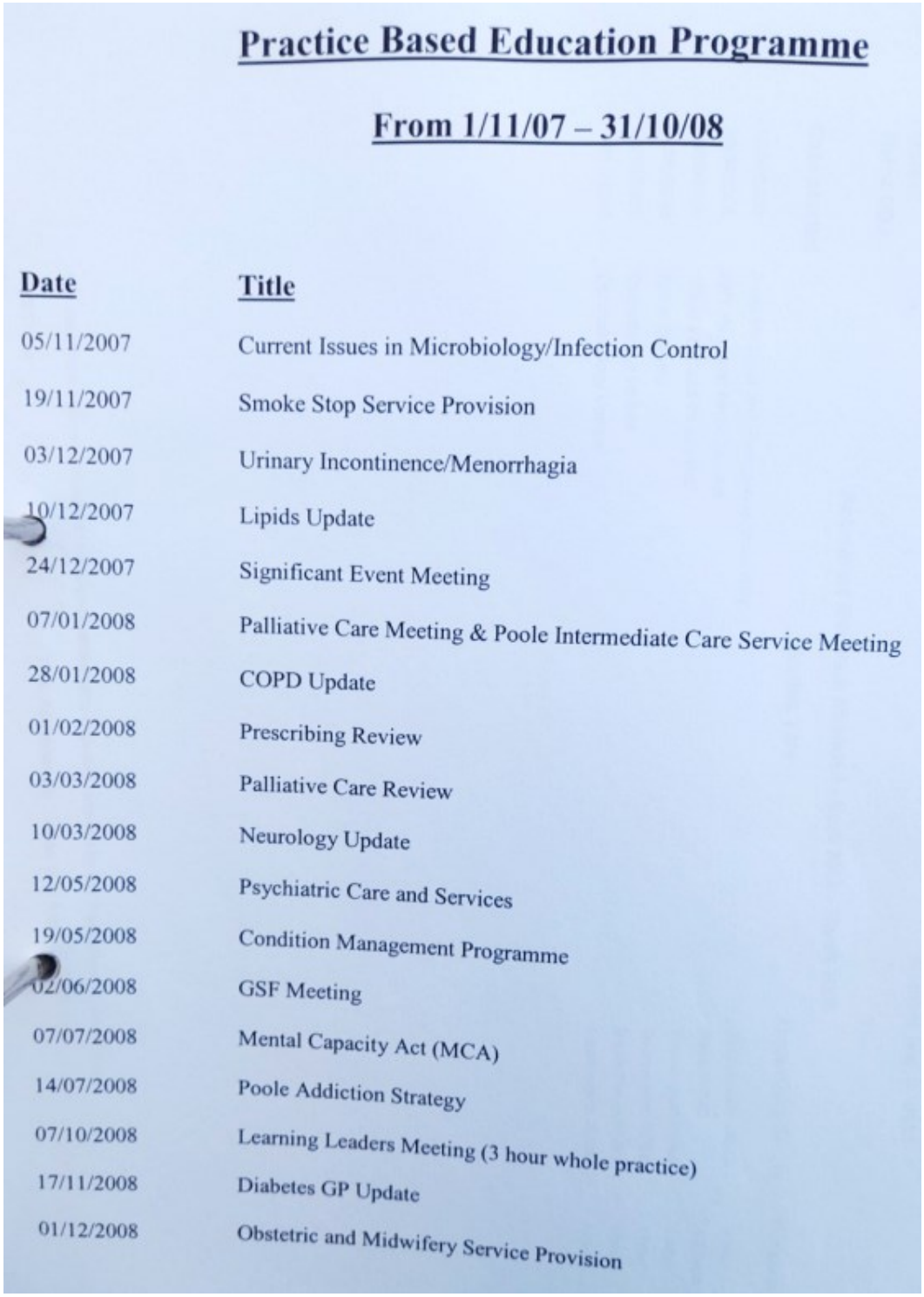


EDUCATIONAL/LEARNING LOG SEPT 11- SEPT 12

EDUCATIONAL ACTIVITY	DATE	DURATION	IMPACT	CPD CRI
Practice education meeting - Diabetes and Byetta	12.9.11	1h		1
Appraiser Locality meeting - myself organizer and chair	20.911	2h	yes	4
Appraisal Lead Team day 9.30-4pm	22.9.11	6.5h		6.5
ARCP Tribunal Panel 9-5pm Soton Hosp	23.9.11	8h		8
Practice Education meeting - Depression	3.10.11	1h		1
Biannual Trainers Day 9-4.30.	5.10.11	7.5h		7.5
Young GP meeting - Stroke Prevention	20.10.11	1h		1
Practice education meeting - Diabetes general update	31.10.11	1h		1
PUN/DEN -raised iron levels, searched on gp notebook.	14.11.11	30mins		
Article-"Prescribing Exercise in Primary Care" BMJ 22.10.11	14.11.11	30mins		0.5
E-module - PAEDIATRICS- Fits, faints and funny turns in children - doctors.net	15.11.11	1h		1
Young GP meeting - Renal Medicine Update -speaker Dr Weston	17.11.11	1h		1
Practice education meeting - Urology Workshop- speaker: Nurse Urology Consultant, Bristol.	22.11.11	1h		1
Protected Learning Time 15.30-18.30 Presentation- Afrikds in Ghana - Dr E Sheridan	24.11.11	3h		3
Practice education meeting - Atrial Fibrillation Update- speaker Dr Chris Boos	28.11.11	1h		1
Appraiseal Support Locality Meeting - chair/convenor- Dr E Sheridan 1h prep/2h meeting .	29.11.11	2h+1h prep	yes	6
PUN/DEN - CURB score 65 -see pdp. Discussed with partners and registrars.	1.12.11	30mins	yes	1
Practice Education meeting- Controled Drugs Update -speaker : Ange Johnstone PCT advisor	5.12.11	1h		1
ARCP PANEL - Wessex Deanery.	7.12.11	4h		4
Appraisal Leads Team Meeting - Wessex Deanery.	7.12.11	4h		4
Meeting - Revalidation and Apprasial- secondary and primary care -guest speaker- ME !! 7-9pm	6.12.11	2h		2
PUN/DEN - RAST TESTING- Gpnotebook/ rang Immunology lab.	13.12.11	30mins		0.5
PUN/DEN - group G streptococcus - Registrar asked me what is it?	10.1.12	30mins		0.5
PUN/DEN - "Shaggy" aorta syndrome -identified in a hospital letter.	11.1.12	30mins		0.5

Clinical Meetings/Lectures /Workshops

EXAMPLE 2007/08:



Practice Based Education Programme

From 1/11/07 – 31/10/08

Date	Title
05/11/2007	Current Issues in Microbiology/Infection Control
19/11/2007	Smoke Stop Service Provision
03/12/2007	Urinary Incontinence/Menorrhagia
10/12/2007	Lipids Update
24/12/2007	Significant Event Meeting
07/01/2008	Palliative Care Meeting & Poole Intermediate Care Service Meeting
28/01/2008	COPD Update
01/02/2008	Prescribing Review
03/03/2008	Palliative Care Review
10/03/2008	Neurology Update
12/05/2008	Psychiatric Care and Services
19/05/2008	Condition Management Programme
02/06/2008	GSF Meeting
07/07/2008	Mental Capacity Act (MCA)
14/07/2008	Poole Addiction Strategy
07/10/2008	Learning Leaders Meeting (3 hour whole practice)
17/11/2008	Diabetes GP Update
01/12/2008	Obstetric and Midwifery Service Provision

CERTIFICATE OF CONTINUING

EDUCATION

This is to certify that

DR. E. A. SHERIDAN

of

PARKSTONE HEALTH CENTRE

attended

The South Coast Skin Club

On

20th April 2004

VENUE

Dermatology Department, Poole

PROGRAMME

Consultant led presentation of patients followed by group discussions
(2 hours)

ORGANISER

Dr Jane Arnold
Quarterjack Surgery, Wimborne

This meeting was supported by GlaxoSmithKline

SMT8292/May 2003

MENTOxMed6

MENTORING SKILLS FOR DOCTORS

via OXFORD MEDICAL TRAINING

Pre course questionnaire

Dr Ed Sheridan

09 - 17.00
21.5.21
Virtual meeting.

What is your knowledge & experience in this area?

appraiser since 2003.
trainer since 1997.
appraised lead Foster Brook locality
numerous MBTI profiling ENTJ - A protagonist.
.. mentoring/coaching courses in Deanery.
psychological first Aid training
10 minute fitstep training.

Strengths
approachable
empathic
listener
Socratic approach.
non-judgemental
effective communicator
effective signposter
not prescriptive + non advisory.

Skills to develop
NLP techniques
enhanced connection
consolidate + expand knowledge
experiment with new techniques.

How do you plan to utilise skills gained from the course?

apply to appraisal work.
apply to .. lead role - dealing with appraisers in need.

make a podcast for my appraisees which I will share with the Deanery.

(Definition mentoring - advise or train (support + encourage people to navigate their own learning, improve performance + become the person they want to be)
trust/confidentiality/mutual respect/sensitivity.
Coaching - the art of training/helping to learn enhance skills + [illegible]

Happiness = "the point of enough" (Epicurus) → Candida nucleus lights up & serotonin/dopamine

MEETING @ MACDONALD HOTELS & RESORTS

CONFERENCE NOTES

Thinking pitstops

Stress → ↑ cortisol ↑ adrenaline ↑ eject amygdala

- stable O_2 mask

Systemic approach for peer to peer support during Covid
- Powerful peer to peer thinking pitstops.

- deceleration/check
- body decompression
- mind decompression
- check/exit

Use of silence.
Thoughts - like waves that roll onto shore.

Car analogy → can enter real-life pitstops, they slow down + perform safety checks.

Other resources

"judge a man by the questions he asks, not the answers he gives." VOLTAIRE.
Can't pour from an empty cup.
not how to avoid storm but how to dance in the rain.

"you are not a frog" podcast

Retirement:
Artist
Community
& selfless

HMC "Lost" updates
Inspired medics course
"4 pillar plan" book - lifestyle training.

GROW coaching model:

Goal - what do you want
Reality - current situation
Options - what could you do?
Will - what will you do?

grant me the serenity to accept the things I cannot change, the courage to change the things I can & the wisdom to know the difference.

Analysing SEAT complaints - "human factors in healthcare" Debbie Lang.

Mindfulness - Prof Mark Williams
Grit - Angela Duckworth
Emotional intelligence - Dr Andy Cope.

Burnout / Compassion tank + fatigue.

slowly drain like a bath

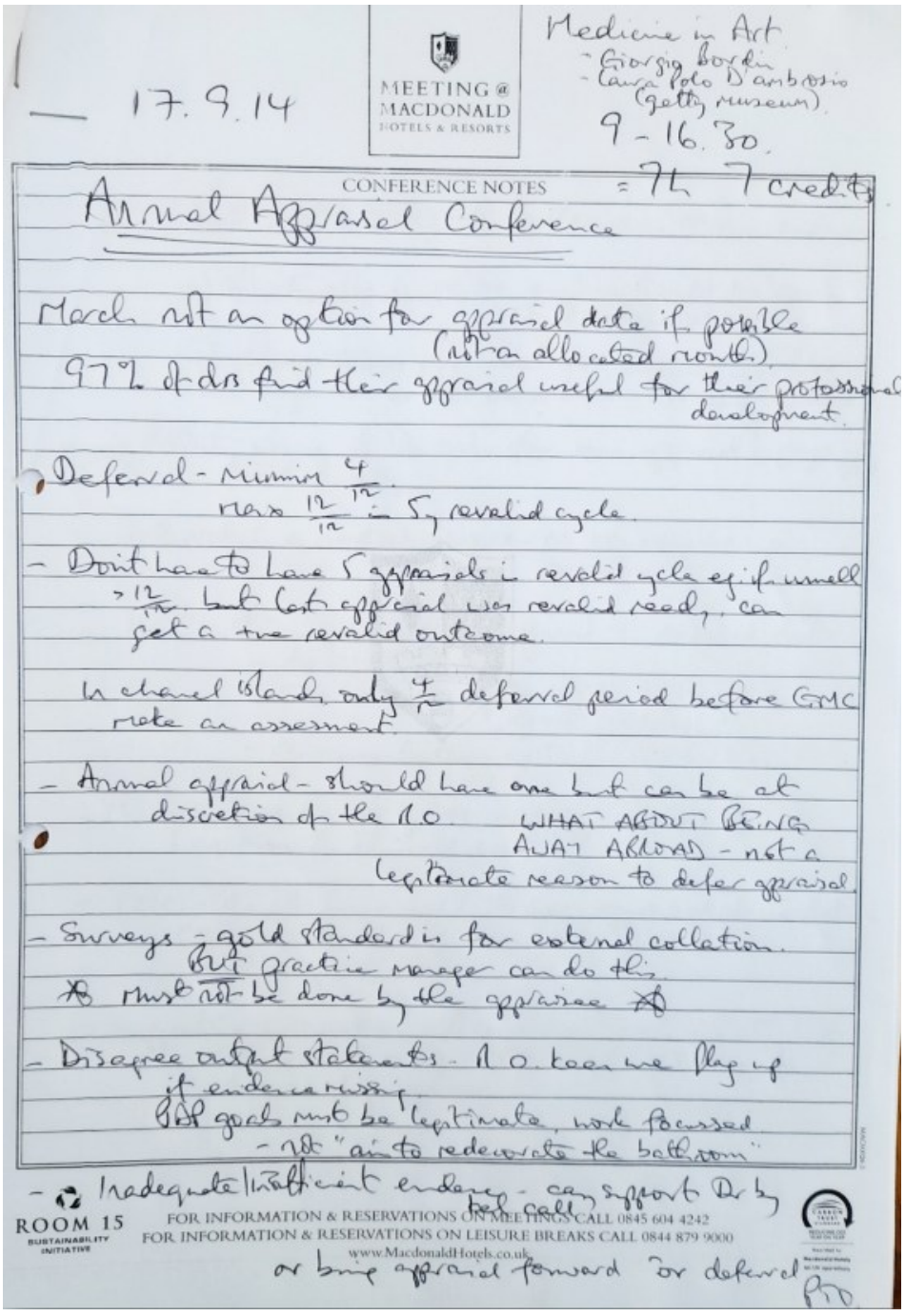
* ⇒ being the best version of yourself (giving self permission)

Clinical Experiences/Problem Case Reviews

Professional Conversations

Courses/Conferences

EXAMPLE 2014:



17.9.14

MEETING @ MACDONALD HOTELS & RESORTS

Medicine in Art
- Giorgio Bordin
- Laura Polo D'ambrosio (Getty Museum)
9 - 16.30.
= 7h 7 credits

CONFERENCE NOTES

Annual Appraisal Conference

March not an option for appraisal date if possible (not an allocated month)
97% of drs find their appraisal useful for their professional development

Deferral - Minimum 4/12.
max 12/12 in 5y revalid cycle.

- Don't have to have 5 appraisals in revalid cycle eg if a small >12/12 but last official one revalid ready, can get a true revalid outcome.

In channel islands, only 1/12 deferral period before GMC make an assessment

- Annual appraisal - should have one but can be at discretion of the RO. WHAT ABOUT BEING AWAY ABROAD - not a legitimate reason to defer appraisal.

- Surveys - gold standard is for external collation. BUT practice manager can do this
~~must not be done by the appraisee~~

- Disagree output statements - RO to have the flag up if evidence missing.
Bad goals must be legitimate, work focussed - not "aim to redecorate the bathroom"

- Inadequate/insufficient evidence - can support Dr by bad call or bring appraisal forward or deferral

ROOM 15 SUSTAINABILITY INITIATIVE

FOR INFORMATION & RESERVATIONS ON MEETINGS CALL 0845 604 4242
FOR INFORMATION & RESERVATIONS ON LEISURE BREAKS CALL 0844 879 9000
www.MacdonaldHotels.co.uk

EXAMPLE 2017:

RCGP ENGLAND

Royal College of General Practitioners

WESSEX FACULTY

CERTIFICATE OF ATTENDANCE

THIS IS TO CERTIFY THAT

the attendees listed overleaf have completed the Wessex Faculty RCGP

Joint Injection Study Day

5 hours education

on Wednesday 24th May 2017

at Chilworth Manor Hotel, Southampton

Signed:

Dr Richard Hull
Consultant Rheumatologist,
Clinical Director, Portsmouth Hospital

Wessex Faculty of the Royal College of General Practitioners
Suite3, Fosse House, East Anton Court, Icknield Way, Andover, SP10 5RG

EXAMPLE 2021:

Royal College of General Practitioners

RCGP ACCREDITED

RCGP: ANNUAL CONFERENCE AND EXHIBITION 2021

14-15 October 2021

CERTIFICATE OF ATTENDANCE

Edward Sheridan

was given approval to display their ePoster as part of the RCGP accredited Scientific Poster Programme at the RCGP Annual Primary Care Conference and Exhibition 2021.

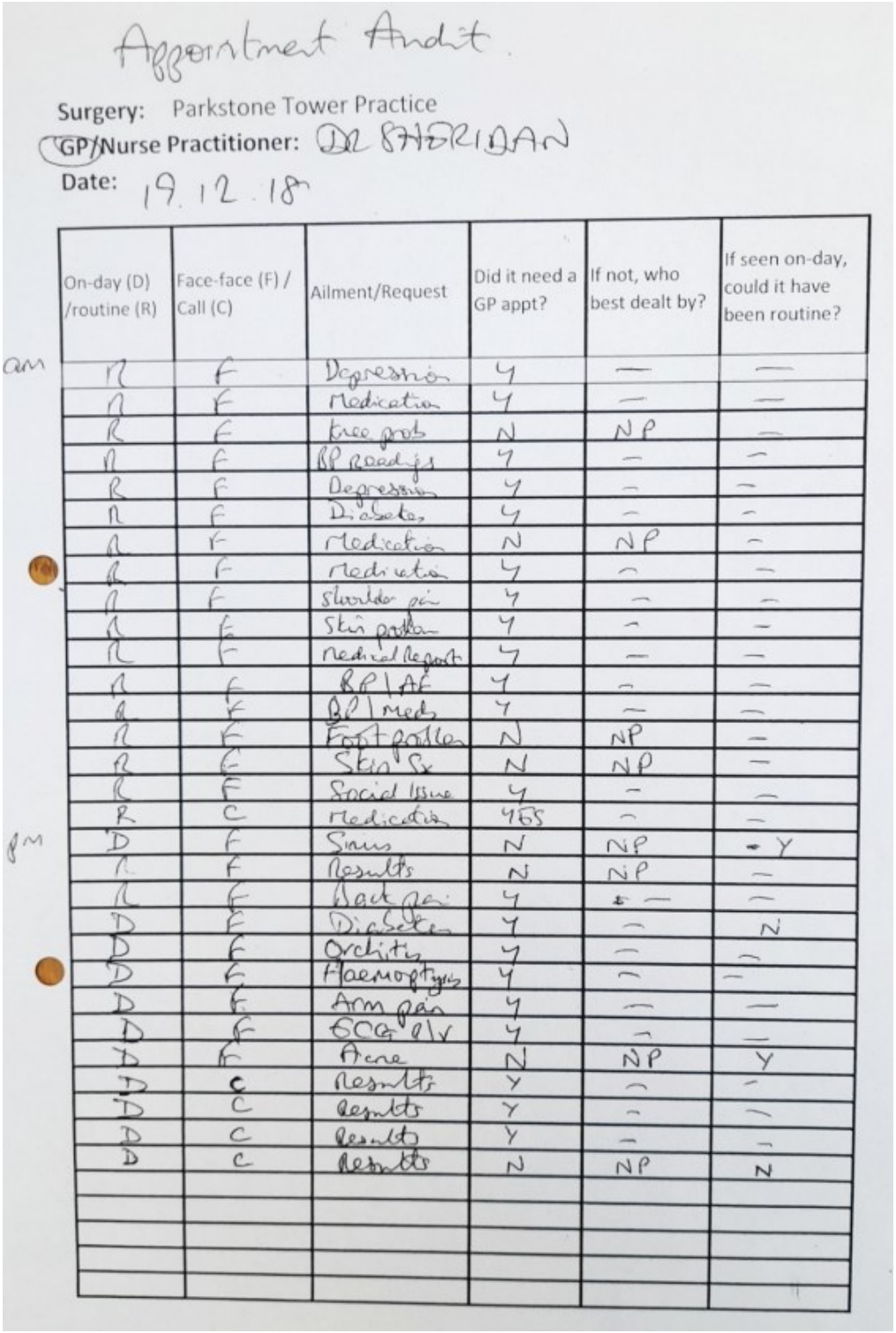
Dr Michael Mulholland

Dr Michael Mulholland
Vice Chair, Professional Development, Royal College of General Practitioners

Date: **15.10.2021**

Quality Improvement Activity

EXAMPLE of Audit / Data collection / Project work / Prescribing review:



Appointment Audit

Surgery: Parkstone Tower Practice

GP/Nurse Practitioner: DR SHERIDAN

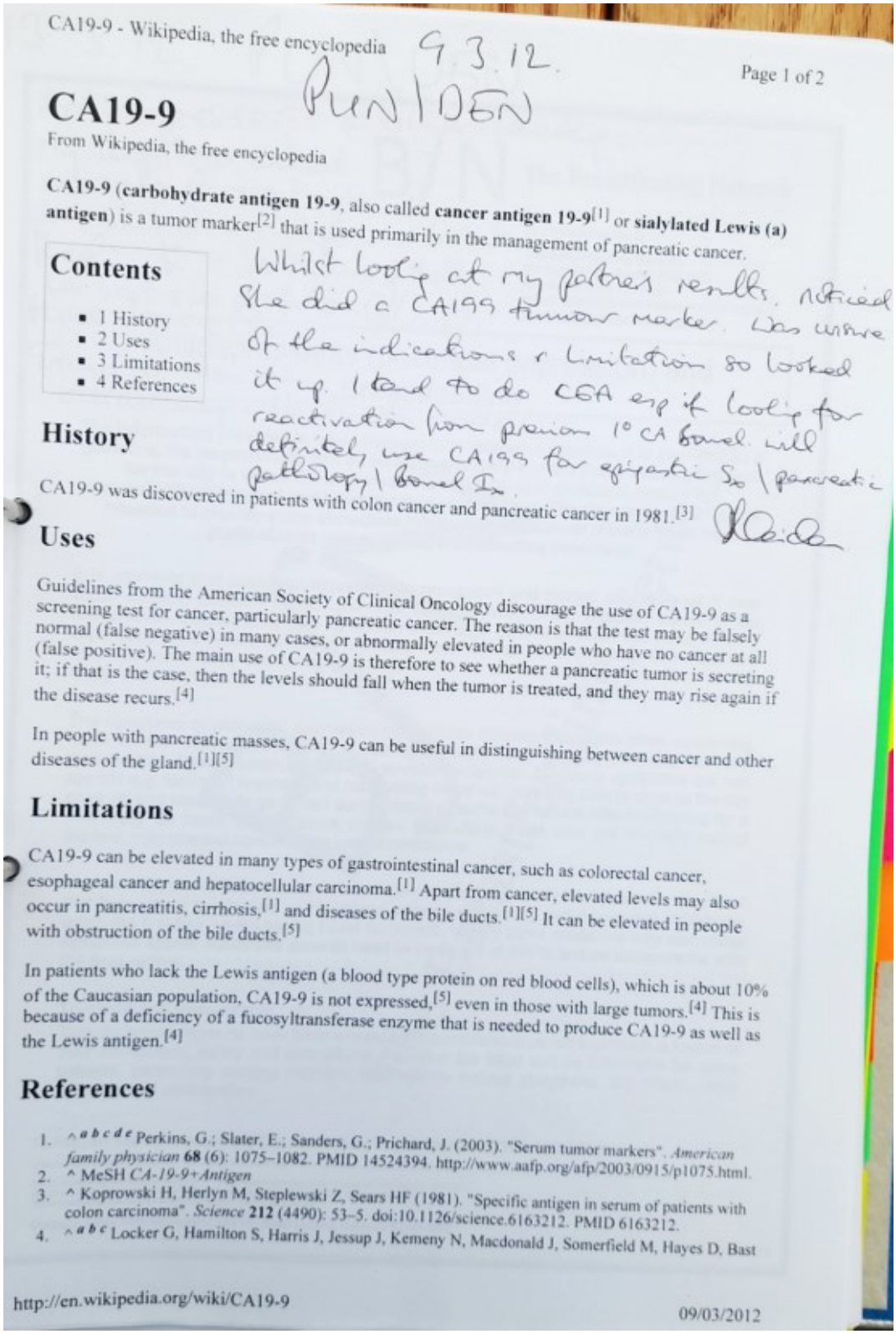
Date: 19.12.18

	On-day (D) /routine (R)	Face-face (F) / Call (C)	Ailment/Request	Did it need a GP appt?	If not, who best dealt by?	If seen on-day, could it have been routine?
am	R	F	Depression	Y	—	—
	R	F	Medication	Y	—	—
	R	F	free prob	N	NP	—
	R	F	BP Readings	Y	—	—
	R	F	Depression	Y	—	—
	R	F	Diabetes	Y	—	—
	R	F	Medication	N	NP	—
	R	F	Medication	Y	—	—
	R	F	Shoulder pain	Y	—	—
	R	F	Skin problem	Y	—	—
	R	F	Medical Report	Y	—	—
	R	F	BP / AF	Y	—	—
	R	F	BP / meds	Y	—	—
	R	F	Foot problem	N	NP	—
	R	F	Skin Sx	N	NP	—
	R	F	Social Issue	Y	—	—
	R	C	Medication	Yes	—	—
pm	D	F	Sinus	N	NP	Y
	R	F	Results	N	NP	—
	R	F	Bad leg	Y	—	—
	D	F	Diabetes	Y	—	N
	D	F	Orchitis	Y	—	—
	D	F	Haemoptysis	Y	—	—
	D	F	Arm pain	Y	—	—
	D	F	ECG / IV	Y	—	—
	D	F	Acne	N	NP	Y
	D	C	Results	Y	—	—
	D	C	Results	Y	—	—
	D	C	Results	Y	—	—
	D	C	Results	N	NP	N

Management Material

PUNS/DENS

EXAMPLE PUN/DEN 2012:



CA19-9 - Wikipedia, the free encyclopedia 9.3.12 PUN/DEN

Page 1 of 2

CA19-9

From Wikipedia, the free encyclopedia

CA19-9 (**carbohydrate antigen 19-9**, also called **cancer antigen 19-9**[1] or **sialylated Lewis (a) antigen**) is a tumor marker[2] that is used primarily in the management of pancreatic cancer.

Whilst looking at my partners results, noticed she did a CA199 tumour marker. Was unsure of the indications & limitation so looked it up. I tend to do CEA esp if looking for reactivation from previous 1° CA bowel. Will definitely use CA199 for epigastric Sx / pancreatic pathology / bowel Dx.

Contents

History

CA19-9 was discovered in patients with colon cancer and pancreatic cancer in 1981.[3]

Uses

Guidelines from the American Society of Clinical Oncology discourage the use of CA19-9 as a screening test for cancer, particularly pancreatic cancer. The reason is that the test may be falsely normal (false negative) in many cases, or abnormally elevated in people who have no cancer at all (false positive). The main use of CA19-9 is therefore to see whether a pancreatic tumor is secreting it; if that is the case, then the levels should fall when the tumor is treated, and they may rise again if the disease recurs.[4]

In people with pancreatic masses, CA19-9 can be useful in distinguishing between cancer and other diseases of the gland.[1][5]

Limitations

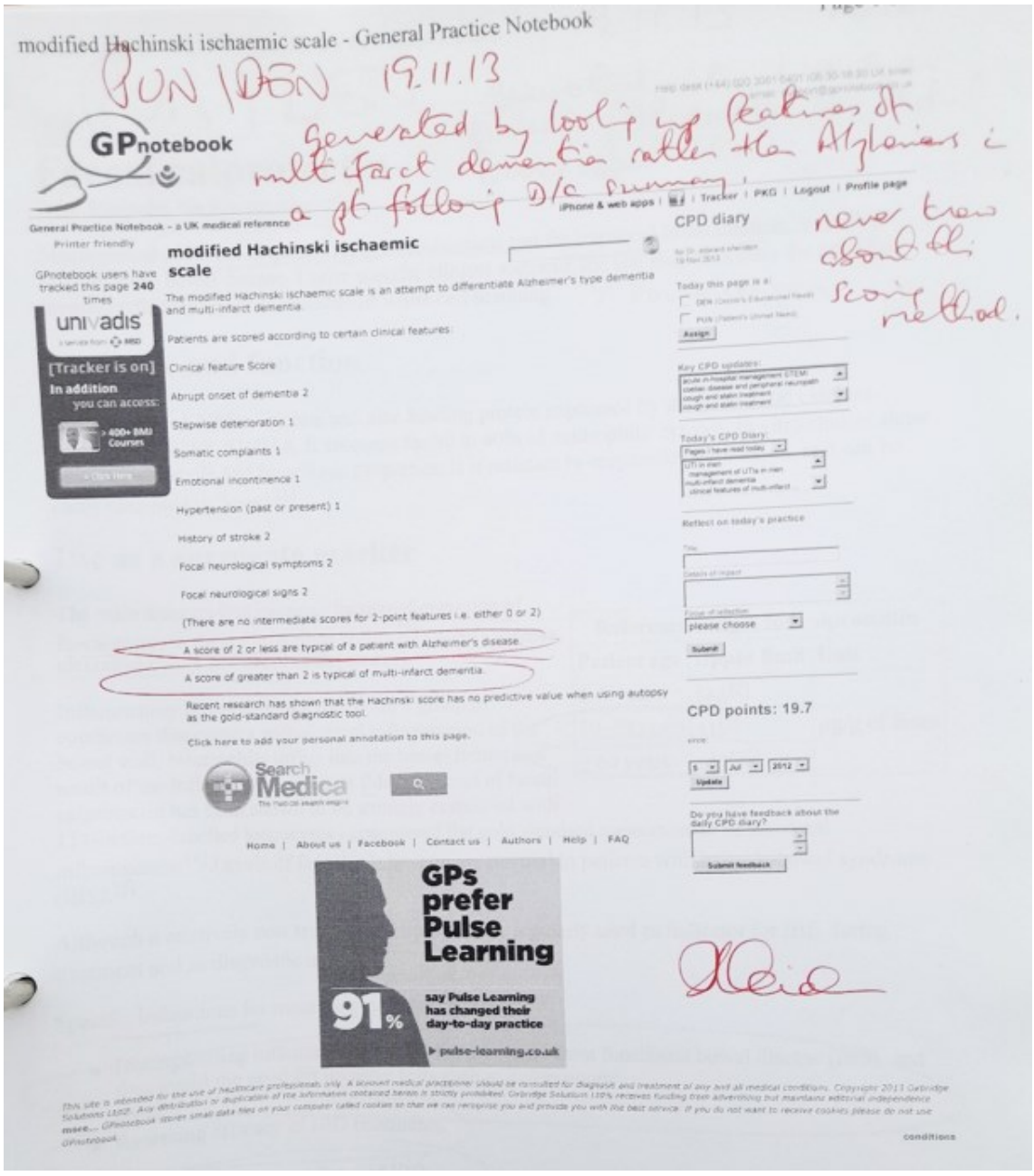
CA19-9 can be elevated in many types of gastrointestinal cancer, such as colorectal cancer, esophageal cancer and hepatocellular carcinoma.[1] Apart from cancer, elevated levels may also occur in pancreatitis, cirrhosis,[1] and diseases of the bile ducts.[1][5] It can be elevated in people with obstruction of the bile ducts.[5]

In patients who lack the Lewis antigen (a blood type protein on red blood cells), which is about 10% of the Caucasian population, CA19-9 is not expressed,[5] even in those with large tumors.[4] This is because of a deficiency of a fucosyltransferase enzyme that is needed to produce CA19-9 as well as the Lewis antigen.[4]

References

1. ^ *a b c d e* Perkins, G.; Slater, E.; Sanders, G.; Prichard, J. (2003). "Serum tumor markers". *American family physician* **68** (6): 1075–1082. PMID 14524394. http://www.aafp.org/afp/2003/0915/p1075.html.
2. ^ MeSH *CA-19-9+Antigen*
3. ^ Koprowski H, Herlyn M, Steplewski Z, Sears HF (1981). "Specific antigen in serum of patients with colon carcinoma". *Science* **212** (4490): 53–5. doi:10.1126/science.6163212. PMID 6163212.
4. ^ *a b c* Locker G, Hamilton S, Harris J, Jessup J, Kemeny N, Macdonald J, Somerfield M, Hayes D, Bast

EXAMPLE PUN/DEN 2013:



modified Hachinski ischaemic scale - General Practice Notebook

PUN / DEN 19.11.13

Generated by looking up features of multi infarct dementia rather than Alzheimers in a pt following D/C summary. never been asked this score method.

GPnotebook

General Practice Notebook – a UK medical reference

Printer friendly

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> 400+ BMJ Courses

modified Hachinski ischaemic scale

The modified Hachinski ischaemic scale is an attempt to differentiate Alzheimer's type dementia and multi-infarct dementia.

Patients are scored according to certain clinical features:

Clinical feature	Score
Abrupt onset of dementia	2
Stepwise deterioration	1
Somatic complaints	1
Emotional incontinence	1
Hypertension (past or present)	1
History of stroke	2
Focal neurological symptoms	2
Focal neurological signs	2

(There are no intermediate scores for 2-point features i.e. either 0 or 2)

A score of 2 or less are typical of a patient with Alzheimer's disease.

A score of greater than 2 is typical of multi-infarct dementia.

Recent research has shown that the Hachinski score has no predictive value when using autopsy as the gold-standard diagnostic tool.

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CPD diary

Today this page is a:

DEN

PUN

Assign

Key CPD updates:

Today's CPD Diary:

Reflect on today's practice

Title

Details of impact

please choose

Submit

CPD points: 19.7

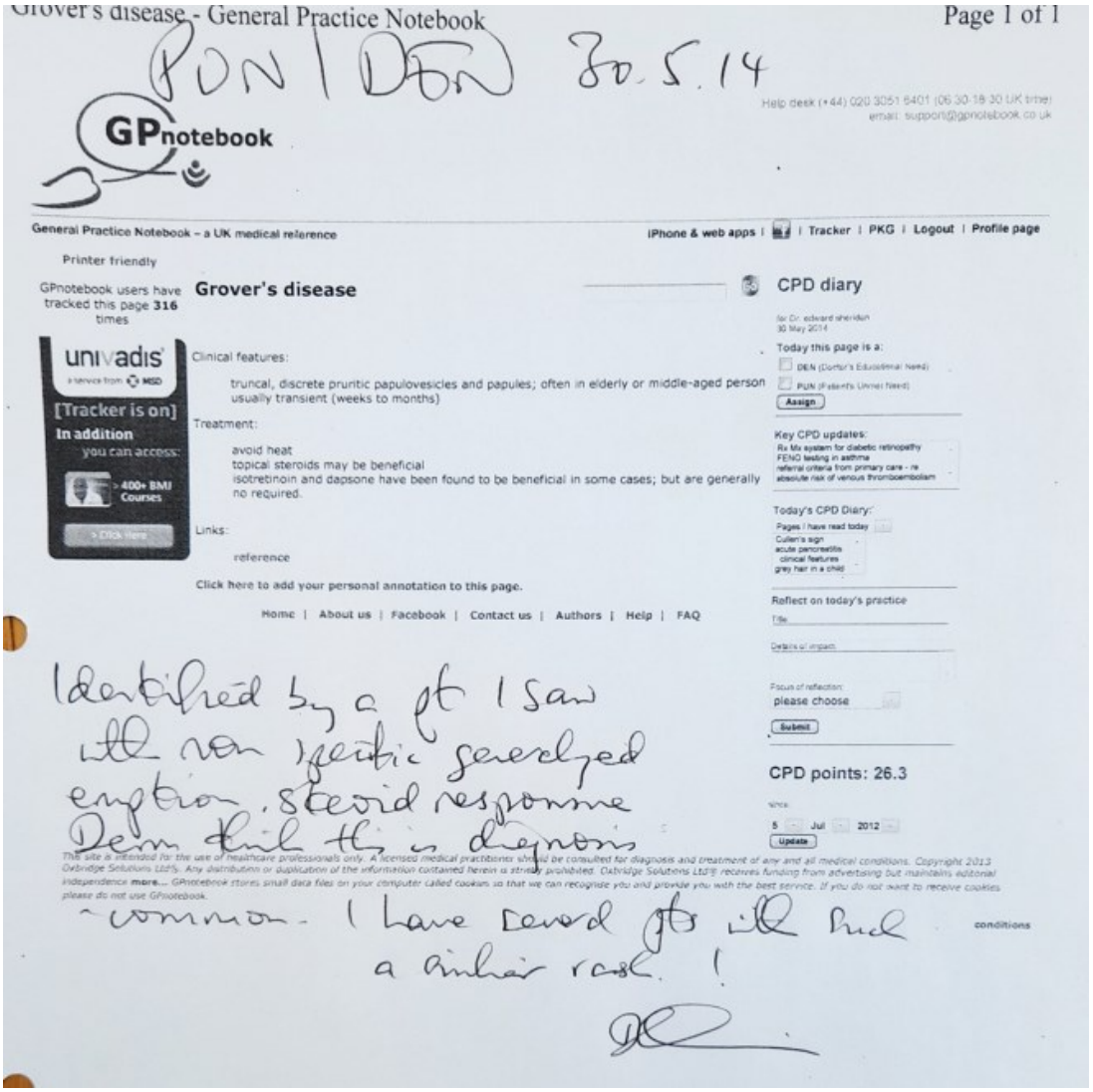
since

Update

Do you have feedback about the daily CPD diary?

Submit feedback

EXAMPLE PUN/DEN 2014:



Grover's disease - General Practice Notebook

Page 1 of 1

PUN / DEN 30.5.14

GPnotebook

Help desk (+44) 020 3051 6401 (06:30-18:30 UK time)
email: support@gpnotebook.co.uk

General Practice Notebook – a UK medical reference

iPhone & web apps | | Tracker | PKG | Logout | Profile page

Printer friendly

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Grover's disease

univadis a service from MSD

[Tracker is on]

In addition you can access:

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> Click here

Clinical features:

truncal, discrete pruritic papulovesicles and papules; often in elderly or middle-aged person
usually transient (weeks to months)

Treatment:

avoid heat
topical steroids may be beneficial
isotretinoin and dapsone have been found to be beneficial in some cases; but are generally no required.

Links:

reference

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CPD diary

for Dr. edward sheridan
30 May 2014

Today this page is a:

DEN (Doctor's Educational Need)

PUN (Patient's Unmet Need)

Assign

Key CPD updates:

Rx Mx system for diabetic retinopathy
FENO testing in asthma
referral criteria from primary care - re absolute risk of venous thromboembolism

Today's CPD Diary:

Pages I have read today

Cullen's sign
acute pancreatitis
clinical features
grey hair in a child

Reflect on today's practice

Title

Details of impact

Focus of reflection:

please choose

Submit

CPD points: 26.3

since

5 Jul 2012

Update

Identified by a pt I saw with non specific generalised eruption. Steroid response Dem think this is diagnosis

conditions

common - I have heard pts with Rash a similar rash !

EXAMPLE PUN/DEN 2016:

TRAINER PUN/DEN

8/8/16

One of our Registrars was marked as being off duty for parental leave for the week. I was unaware of this and with my previous female Registrars, this request had never surfaced. I rang the Deanery and also looked at the website which gives the NHS employment law guidance on this.

Learning points:

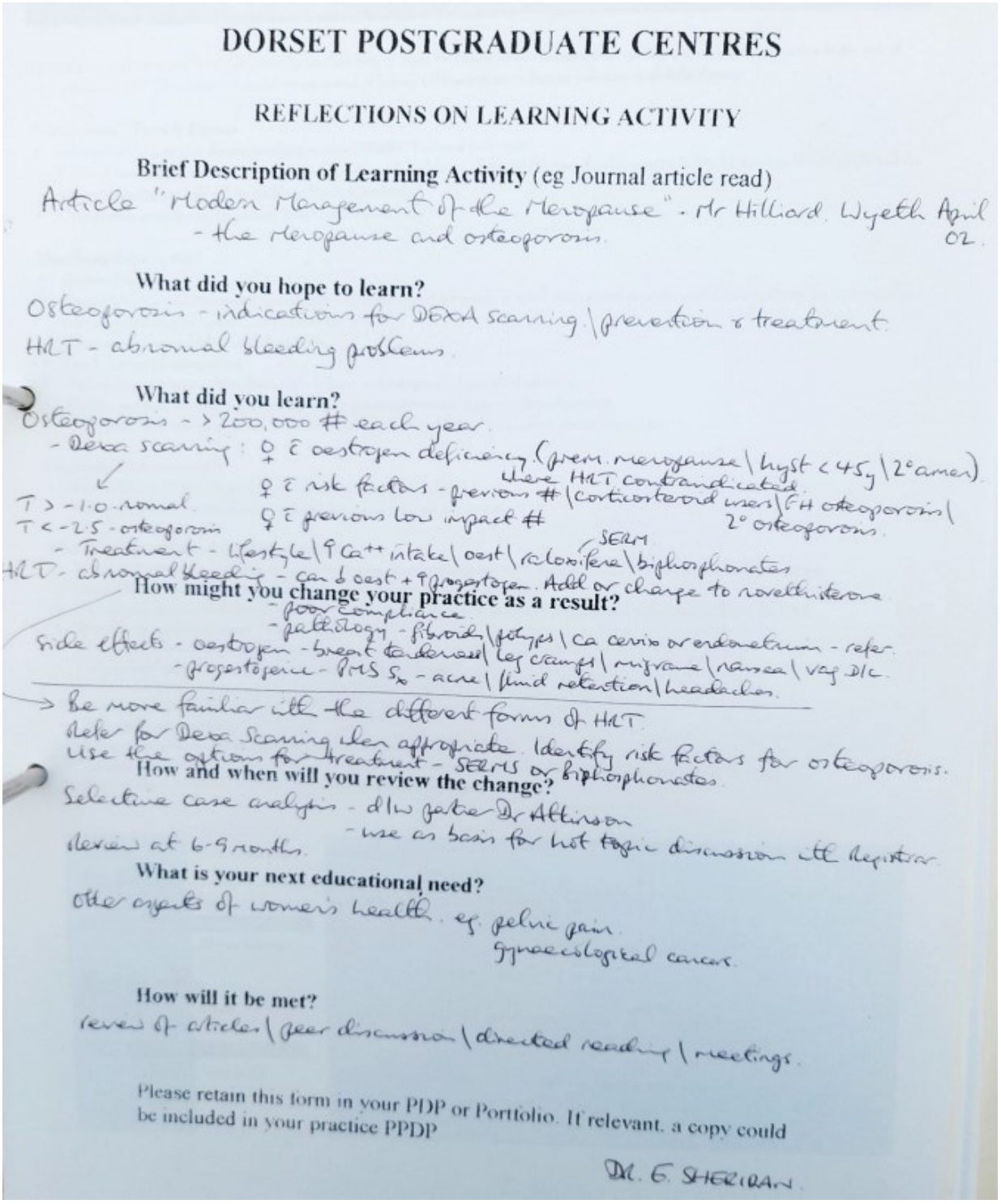
- Any form of parental leave needs to be declared on the registrar's Form R.
- A PAYE 2 needs to be filled out and sent to Claire Elwick at the Deanery.
- Apparently the Registrar can only claim up to 2 weeks per training year but this would also include any sick leave or other leave that was taken as unpaid.
- If this exceeds 2 weeks in any training year, the excess leave taken needs to be declared, the Deanery informed and the time would need to be made up at the end of the training year.

This was really interesting as I had no knowledge of the details of this. I discussed it with Dr Mandy Fautley, co-trainer in the Practice, and will address the issues as above. It raised the interesting concept if a registrar, for whatever reason, did not divulge precise dates on a Form R and whether it becomes the trainers responsibility to signpost this. Should we be looking at all Form R's submitted by our registrars and the answer is clearly, yes.

Dr E A Sheridan
August 2016

Directed/Opportunistic Reading

EXAMPLE 2003:



DORSET POSTGRADUATE CENTRES

REFLECTIONS ON LEARNING ACTIVITY

Brief Description of Learning Activity (eg Journal article read)

Article "Modern Management of the Menopause". Mr Hilliard. Wyeth April 02.
- the menopause and osteoporosis.

What did you hope to learn?

Osteoporosis - indications for DEXA scanning \ prevention & treatment.
HRT - abnormal bleeding problems.

What did you learn?

Osteoporosis - > 200,000 # each year.
- Dexa scanning: ♀ ↑ oestrogen deficiency (prem. menopause \ hyst < 45y \ 2° amen).
  ♀ ↑ risk factors - previous # \ corticosteroid users \ FH osteoporosis \ 2° osteoporosis. (where HRT contraindicated)
  ♀ ↑ previous low impact #
  T > -1.0 normal
  T < -2.5 - osteoporosis
- Treatment - lifestyle \ ♀ Ca++ intake \ oest \ raloxifene (SERM) \ biphosphonates
HRT - abnormal bleeding - can ↓ oest + ♀ progestogen. Add or change to norethisterone

How might you change your practice as a result?

- poor compliance.
- pathology - fibroids \ polyps \ Ca cervix or endometrium - refer.

Side effects - oestrogen - breast tenderness \ leg cramps \ migraine \ nausea \ vag D/C
- progestogens - PMS S_x - acne \ fluid retention \ headaches.

→ Be more familiar with the different forms of HRT.
Refer for Dexa scanning when appropriate. Identify risk factors for osteoporosis.
Use the options for treatment - SERMs or biphosphonates.

How and when will you review the change?

Selective case analysis - d/w peer Dr Atkinson
- use as basis for hot topic discussion with Registrar.

Review at 6-9 months.

What is your next educational need?

Other aspects of women's health. eg. pelvic pain.
gynaecological cancer.

How will it be met?

review of articles \ peer discussion \ directed reading \ meetings.

Please retain this form in your PDP or Portfolio. If relevant, a copy could be included in your practice PPDP

M. E. SHERIDAN.

EXAMPLE 2015:

28.2.15

Journals watch

Too busy to read the journals? *Dr Suzanne Hunter* selects the latest papers of interest to GPs

0.5 CPD credits
For 30 minutes of learning activity and reflection based on this article

Pharmacological treatments for osteoarthritis of the knee

Ann Intern Med 2015; 162: 46-54

Knee osteoarthritis (OA) is common, progressive and carries a significant personal and societal burden of pain, loss of work and treatment costs. NSAIDs are commonly prescribed but patients who have OA are the same patients who are at most risk of side-effects from these agents.

This review looked at the literature for pharmacological interventions for knee OA to compare their efficacy for pain, function and stiffness. For pain, the most efficacious treatment was intra-articular (IA) hyaluronic acid. The least effective was paracetamol, with NSAIDs lying between the two. All IA treatments were better than oral treatment.

IA placebo was more effective than oral placebo, indicating there may be an additional placebo effect from the injection.

For function, IA hyaluronic acid was the most effective, followed by NSAIDs and then paracetamol. IA steroid was no better than oral placebo for function. The same order of success was achieved for stiffness.

Paracetamol is considered the treatment of choice for OA, but this meta-analysis found it had a relatively modest effect. Putting a needle into a knee seems to offer additional benefit for pain, although how much of this is placebo effect is unclear.

Preventing falls in the elderly by making home modifications

Lancet 2015; 385: 231-8

Falls in the elderly cause a high degree of morbidity and mortality. Those at risk of falling tend to spend more time at home, so most falls occur in the patient's home. Some of these falls could be prevented by simple home modifications.

This New Zealand study looked at whether home modifications could have an effect on falls. If a household had at least one member on state benefits or subsidies, they were randomised into having modifications done to their house immediately or in three years.

The outcome was the rate of falls per person per year, as derived from insurance claims (under the New Zealand health system).

After a median period of just over three years, the rate of fall injuries was 0.061 per person per year in the intervention group and 0.072 in the control group. This represented a 26% reduction in falls.

The authors calculated the average cost of modifications per house at about £400. It has to be borne in mind that modifications will last for years, making this more cost-effective.

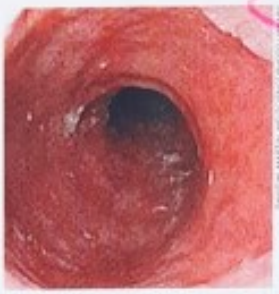
They concluded that the modifications met WHO cost-effectiveness criteria and recommended the programme for wider roll-out.

Oesophageal adenocarcinoma and Barrett's oesophagus

Gut 2015; 64: 20-5

The five-year survival rate for oesophageal adenocarcinoma (OAC) is poor, at 20%, and incidence is rising.

Barrett's oesophagus is a known precursor of OAC and attempts to limit OAC have focused on endoscopic surveillance of patients with Barrett's oesophagus. This retrospective study in Northern Ireland looked at all patients diagnosed with OAC. The researchers found that a very low proportion of those diagnosed with OAC had Barrett's oesophagus – only 7.3%.



Barrett's oesophagus: surveillance

However, those with Barrett's oesophagus had a much more advantageous tumour stage on diagnosis; 44% had stage 1, compared with 11% in other patients. Twice as many patients with Barrett's oesophagus (50% versus 25%) who developed OAC could have a surgical resection.

Even adjusting for lead time bias, patients with Barrett's oesophagus had better survival chances.

The study found that surveillance is clearly beneficial to patients with Barrett's oesophagus, but the impact on the incidence of OAC is modest and different methods are needed to identify other patients at risk.

CPD IMPACT: EARN MORE CREDITS

These further action points may allow you to earn more credits by increasing the time spent and the impact achieved.

- Perform a short audit of patients with knee OA in your practice to establish the most common therapeutic options, as well as the percentage of patients treated with IA hyaluronic acid.
- Collect data on your elderly patients who have had a fall and whether they had any home modifications following the fall.
- Carry out a search for patients with Barrett's oesophagus in your practice and discuss the implications of endoscopic screening with your local gastroenterology consultant.

Save this article and add notes with your free online CPD organiser at gponline.com/cpd Take clinical tests and claim certificates for CPD at myCME.com/gp

Suicide and unemployment

Epidemiol Comm Health 2015; 69: 1034

An association between a rise in unemployment and rising levels of suicide seems intuitive. There is the loss of money to provide for the family, loss of social status, and a sense of shame, and the future can look bleak. Those still in work fear the loss of their job and can be similarly affected.

This study in France examined the possible association using the 2008-2010 economic crisis as a basis and looking at suicide rates across western Europe. There was a 0.3% rise in suicide for every 10% rise in unemployment. This reached statistical significance in France, the Netherlands and the UK.

They estimate that an additional 456 suicides occurred in the UK as a result of the economic crisis. They do warn, however, that a causal association cannot be certain.

The Valsalva manoeuvre in supraventricular tachycardia

Ann Emerg Med 2015; 65: 27-9

This review of papers aimed to assess whether the Valsalva manoeuvre is effective in patients with supraventricular tachycardia (SVT).

They found that in the lab with an induced SVT, the Valsalva was effective in 46% to 53% of subjects.

However, in the emergency department, the conversion rate was only 17.9%.

In a study in the emergency setting comparing Valsalva with carotid sinus massage, Valsalva achieved a 19.4% success, compared with 10.5% for carotid sinus massage.

There seemed to be no adverse events attributable to the Valsalva manoeuvre. This safety record would indicate that the Valsalva should still be considered first-line treatment, even with a relatively low success rate in the acute setting.

Dr Hunter is a GP in Bishop's Waltham, Hampshire, and a member of our team who regularly review the journals

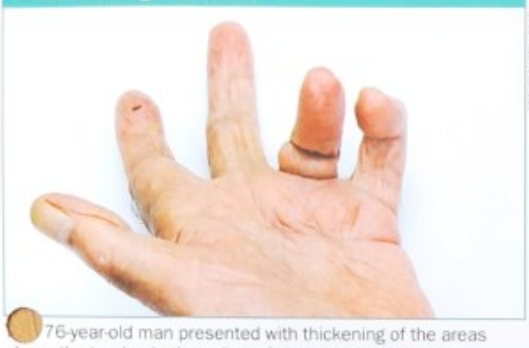
Self-Directed Learning Groups / “Young GP” Groups / Problem-Based Learning Groups

MCQ/EMQ/QUIZ

EXAMPLE 2014

PICTORIAL QUIZ WHAT'S THE DIAGNOSIS?

1 Restricted finger movement

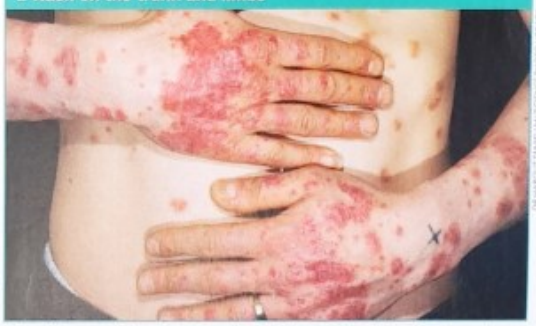


A 76-year-old man presented with thickening of the areas above the tendon in the palms of his hands and restricted movement of his ring and little fingers. This had gradually worsened and was now causing functional problems. He also had type 2 diabetes. The patient was anxious to find a solution to the problem with his hands, because it was now causing difficulties with his grip.

WHAT IS THE MOST LIKELY DIAGNOSIS?

- ☐ Trigger finger
- ☐ Ganglion cyst
- ☐ Stenosing tenosynovitis
- ☑ Dupuytren's contracture

2 Rash on the trunk and limbs

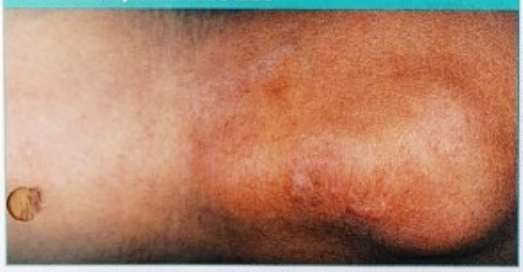


This 28-year-old man presented with a rash on his trunk and limbs. The lesions were small, red and itchy. The patient had used a bland moisturising cream, which provided some symptom relief but did not resolve the lesions. He remembered that two weeks before the lesions appeared, he had a sore throat, which had resolved with conservative measures.

WHAT IS THE MOST LIKELY DIAGNOSIS?

- ☑ Guttate psoriasis
- ☐ Pityriasis rosacea
- ☐ Infected dermatitis
- ☐ Henoch-Schönlein purpura

3 Painful lump on a child's knee

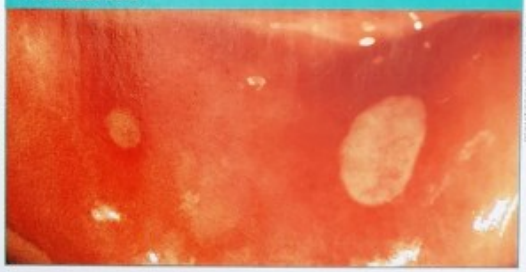


This 13-year-old boy played a lot of sport. He presented with a history of a painful prominence at the centre of the tibia at the insertion of the patellar tendon. He was having difficulty with pain when climbing stairs and when playing sport, especially when running or turning. His parents were concerned that he had sustained trauma and wanted him to have an X-ray. He had taken intermittent NSAIDs, but the discomfort persisted.

WHAT IS THE MOST LIKELY DIAGNOSIS?

- ☐ Psoriatic arthropathy
- ☐ Pre-patellar bursitis
- ☐ Synovial plica injury
- ☑ Osgood-Schlatter disease

4 A mouth sore



A woman presented with a painful sore area on the lower lip. It had been persistent for two weeks and had not responded to OTC treatments. It was causing discomfort when eating. The patient has had previous similar sores.

WHAT IS THE MOST LIKELY DIAGNOSIS?

- ☐ Behçet's syndrome
- ☐ Lichen planus
- ☐ Cold sores
- ☑ Canker sore

Contributed by Dr Ravi Ramanathan

1 The patient has Dupuytren's contracture, a condition caused by the palmar fascia becoming abnormally thickened. It can start as nodules in the palm and then extend as a cord into the fingers. Family history, being male, liver cirrhosis, rock climbing and diabetes increase the risk of developing the condition. Treatment is predominantly surgical and is mainly a limited fasciectomy. Other treatment options include radiotherapy and collagenase injections used at an early stage.

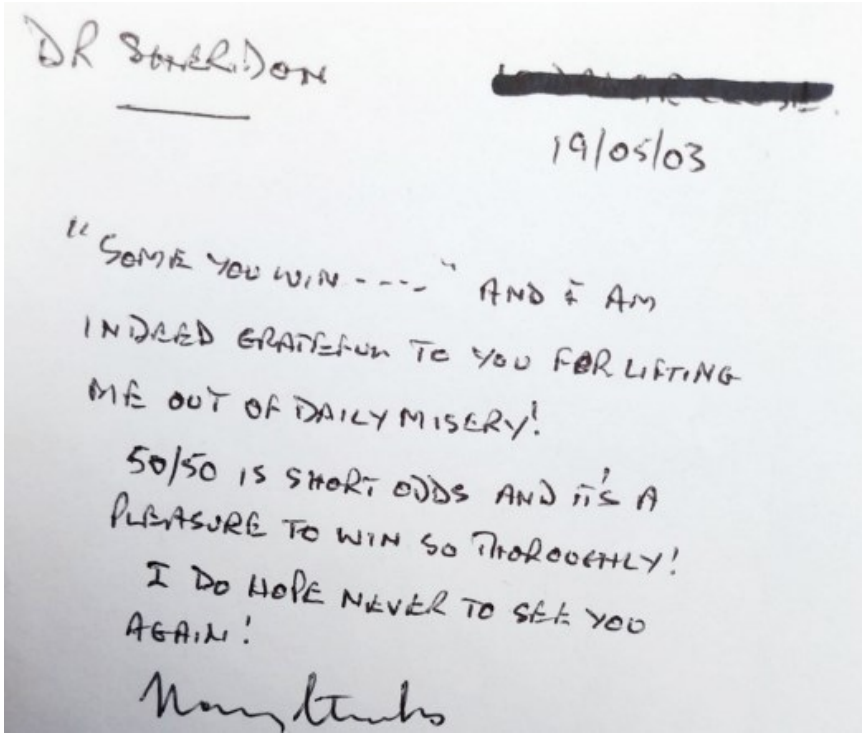
2 The patient has guttate psoriasis, also known as eruptive psoriasis. This can be iatrogenic, but is often triggered by a streptococcal sore throat. The lesions can appear several weeks after the infection has resolved and when the patient is feeling otherwise well. It can resolve by itself. It also responds well to emollients and mild steroids, such as hydrocortisone.

3 The patient has Osgood-Schlatter disease. This usually presents in young adults and is seven times more common in boys than in girls. It presents with a painful lump at the tibial tuberosity. The condition is caused by repetitive contractions of the quadriceps when playing sport. The main treatment is rest. Topical or oral NSAIDs may help with the pain and inflammation. If it does not resolve, being put in plaster for six weeks may be of benefit.

4 The patient has a canker sore, also known as aphthous stomatitis. This is thought to be caused by a T-cell mediated immune response. Before the lesion appears, there is often burning, itching or stinging. The lesions are self-limiting and the purpose of treatment is to reduce symptoms. Treatment includes antibiotic mouthwash, oral antibiotics if secondary infection is present, and topical corticosteroids.

Feedback

Informal for both patients and colleagues – cards/letters/ thank yous/referral letters:



DR SHERIDON

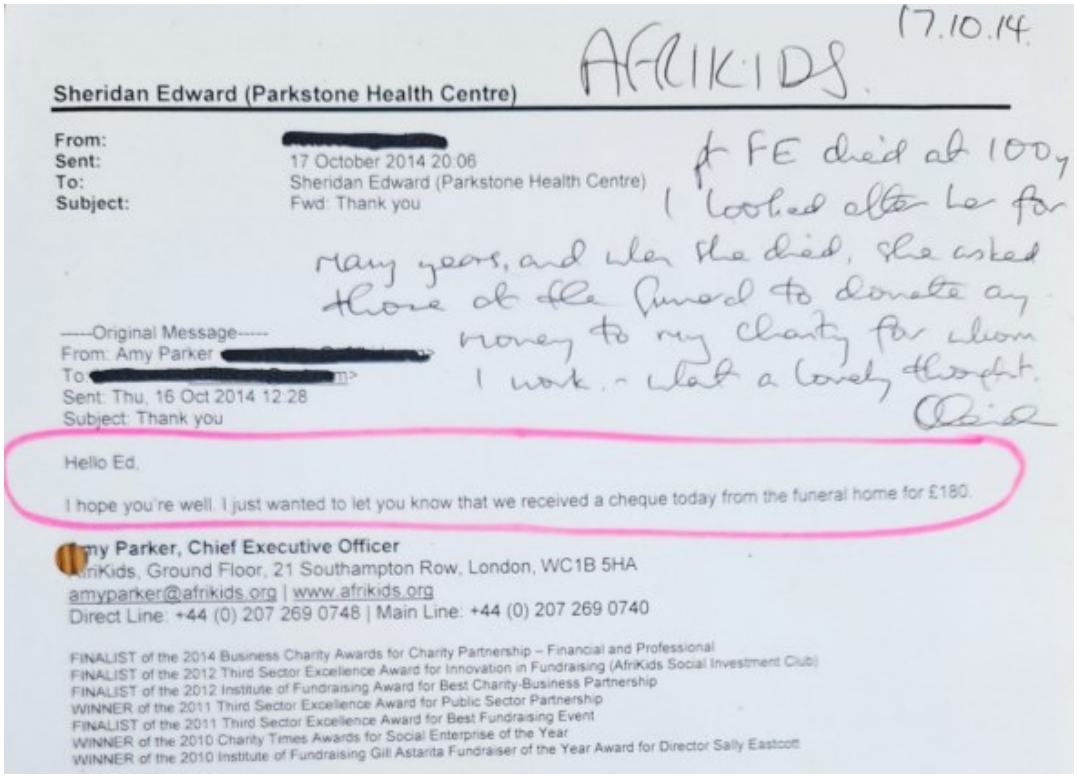
[redacted]

19/05/03

"SOME YOU WIN - - - " AND I AM INDEED GRATEFUL TO YOU FOR LIFTING ME OUT OF DAILY MISERY!

50/50 IS SHORT ODDS AND IT'S A PLEASURE TO WIN SO THOROUGHLY!

I DO HOPE NEVER TO SEE YOU AGAIN!



17.10.14

AFRIKIDS.

Sheridan Edward (Parkstone Health Centre)

From: [redacted]
Sent: 17 October 2014 20:06
To: Sheridan Edward (Parkstone Health Centre)
Subject: Fwd: Thank you

My FE died at 100, I looked after her for many years, and when she died, she asked those at the funeral to donate any money to my charity for whom I work. - what a lovely thought.

-----Original Message-----
From: Amy Parker [redacted]
To: [redacted]
Sent: Thu, 16 Oct 2014 12:28
Subject: Thank you

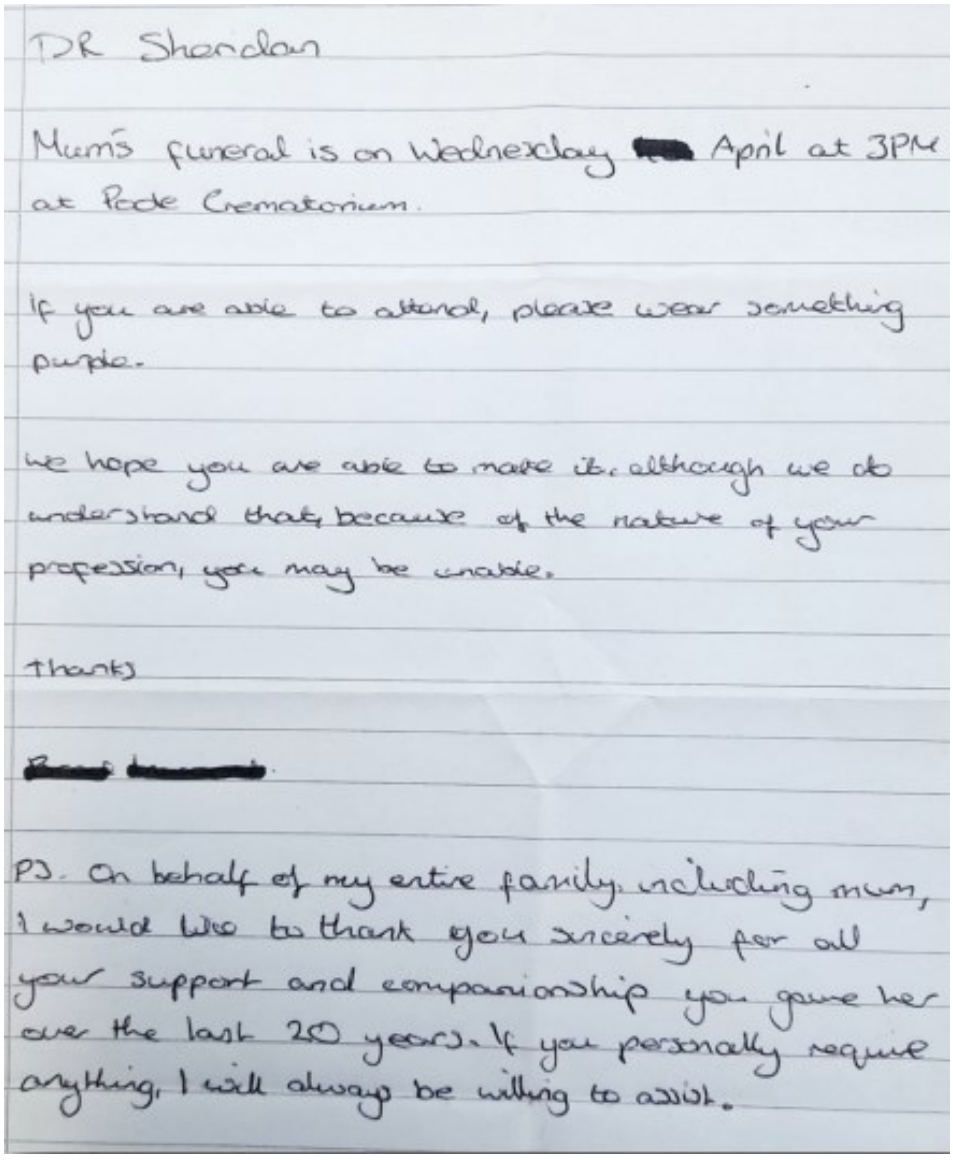
Hello Ed,

I hope you're well. I just wanted to let you know that we received a cheque today from the funeral home for £180.

Amy Parker, Chief Executive Officer
AfriKids, Ground Floor, 21 Southampton Row, London, WC1B 5HA
amyparker@afrikids.org | www.afrikids.org
Direct Line: +44 (0) 207 269 0748 | Main Line: +44 (0) 207 269 0740

FINALIST of the 2014 Business Charity Awards for Charity Partnership – Financial and Professional
FINALIST of the 2012 Third Sector Excellence Award for Innovation in Fundraising (AfriKids Social Investment Club)
FINALIST of the 2012 Institute of Fundraising Award for Best Charity-Business Partnership
WINNER of the 2011 Third Sector Excellence Award for Public Sector Partnership
FINALIST of the 2011 Third Sector Excellence Award for Best Fundraising Event
WINNER of the 2010 Charity Times Awards for Social Enterprise of the Year
WINNER of the 2010 Institute of Fundraising Gill Astarita Fundraiser of the Year Award for Director Sally Eastcott

EXAMPLE 2015:



DR Sheridan

Mum's funeral is on Wednesday [redacted] April at 3PM at Poole Crematorium.

If you are able to attend, please wear something purple.

We hope you are able to make it, although we do understand that, because of the nature of your profession, you may be unable.

Thanks

[redacted]

PS. On behalf of my entire family, including mum, I would like to thank you sincerely for all your support and companionship you gave her over the last 20 years. If you personally require anything, I will always be willing to assist.

+ve feedback re: skin diagnosis (PLEVA)

DEPARTMENT OF DERMATOLOGY

Direct Line: 01202 442057
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e-mail: sheila.parker@poole.nhs.uk

Poole Hospital NHS
NHS Foundation Trust

Longfleet Road
Poole
Dorset
BH15 2JB
Tel: 01202 665511
www.poole.nhs.uk
J81012

12 September 2016

Dr E Sheridan
Parkstone Health Centre
Mansfield Road
Parkstone Poole
Dorset
BH14 0DJ

Dear Dr Sheridan

Diagnosis:
1. Possible pityriasis lichenoides chronica.

Management:
1. Start Eumovate ointment applied daily to affected areas
2. Follow up in 1 month

Thank you very much for referring this 3 year old girl whom I saw with her mother. She started getting spots on her arms, around 4 months ago and these have spread to involve her legs and to a lesser extent her trunk and face. They appeared quite suddenly and most of the lesions just last a few days, but the ones on her legs have been more persistent and then have left post inflammatory hyperpigmentation. They were mildly itchy to start with, but the symptoms have settled. There was no history of systemic illness around the time of the flare and no one else in the family has had a similar rash or history of insect bites. There are no pets at home. does have a history of mild flexural eczema, which is managed with emollients.

On examination today there are three papular lesions on her face, on the left upper cheek and chin area and two of these are crusted with some hypopigmentation in the areas of healing. There was a small scaly papule on her right groin, but otherwise no active lesions.

I think it is a little difficult to be definitive about the diagnosis because things have improved significantly since your referral. However, your suggestion of a diagnosis of pityriasis lichenoides is very reasonable and I think we should treat for this with a topical steroid at the moment. I prescribed some Eumovate ointment today.

Insect bite reaction is another possibility as not all of the family may be reacting. mother asked me if other investigations, such as blood tests, would be indicated, but I don't think we need to pursue this.

I have arranged follow up in 6 weeks to see how things are going.

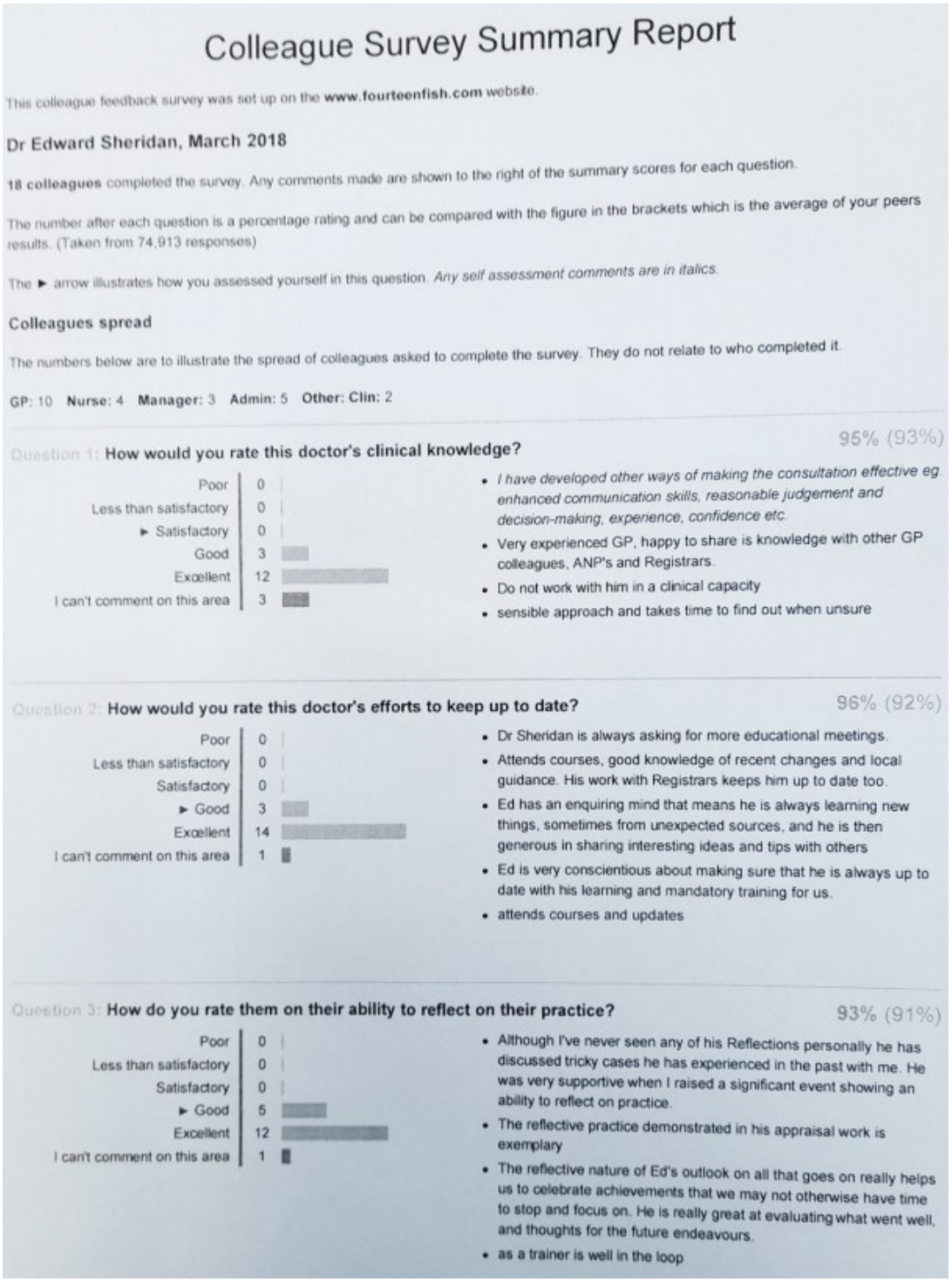
Yours sincerely

Dr Suzannah August FRCP
Consultant Dermatologist

Formal Multi-Source Feedback (MSF)

Utilizing a platform like FourteenFish since the advent of Strengthened Medical Appraisal 2010, with the advantage of externally collated results.

EXAMPLE 2018:



Colleague Survey Summary Report

This colleague feedback survey was set up on the **www.fourteenfish.com** website.

Dr Edward Sheridan, March 2018

18 colleagues completed the survey. Any comments made are shown to the right of the summary scores for each question.

The number after each question is a percentage rating and can be compared with the figure in the brackets which is the average of your peers results. (Taken from 74,913 responses)

The ► arrow illustrates how you assessed yourself in this question. *Any self assessment comments are in italics.*

Colleagues spread

The numbers below are to illustrate the spread of colleagues asked to complete the survey. They do not relate to who completed it.

GP: 10 **Nurse:** 4 **Manager:** 3 **Admin:** 5 **Other: Clin:** 2

Question 1: **How would you rate this doctor's clinical knowledge?** 95% (93%)

Poor	0
Less than satisfactory	0
► Satisfactory	0
Good	3
Excellent	12
I can't comment on this area	3

- *I have developed other ways of making the consultation effective eg. enhanced communication skills, reasonable judgement and decision-making, experience, confidence etc.*
- Very experienced GP, happy to share is knowledge with other GP colleagues, ANP's and Registrars.
- Do not work with him in a clinical capacity
- sensible approach and takes time to find out when unsure

Question 2: **How would you rate this doctor's efforts to keep up to date?** 96% (92%)

Poor	0
Less than satisfactory	0
Satisfactory	0
► Good	3
Excellent	14
I can't comment on this area	1

- Dr Sheridan is always asking for more educational meetings.
- Attends courses, good knowledge of recent changes and local guidance. His work with Registrars keeps him up to date too.
- Ed has an enquiring mind that means he is always learning new things, sometimes from unexpected sources, and he is then generous in sharing interesting ideas and tips with others
- Ed is very conscientious about making sure that he is always up to date with his learning and mandatory training for us.
- attends courses and updates

Question 3: **How do you rate them on their ability to reflect on their practice?** 93% (91%)

Poor	0
Less than satisfactory	0
Satisfactory	0
► Good	5
Excellent	12
I can't comment on this area	1

- Although I've never seen any of his Reflections personally he has discussed tricky cases he has experienced in the past with me. He was very supportive when I raised a significant event showing an ability to reflect on practice.
- The reflective practice demonstrated in his appraisal work is exemplary
- The reflective nature of Ed's outlook on all that goes on really helps us to celebrate achievements that we may not otherwise have time to stop and focus on. He is really great at evaluating what went well, and thoughts for the future endeavours.
- as a trainer is well in the loop

Question 7: **How would you rate them on their ability to know when to ask for help?** 89% (90%)

Poor	0
Less than satisfactory	0
Satisfactory	1
► Good	5
Excellent	10
I can't comment on this area	2

- I works as an ANP, Dr Sheridan is more likely to discuss this with his GP colleagues.
- Like most doctors, Ed is inclined to keep going for longer than he should before asking for help. He has no difficulty in accepting help when it is appropriate; this is just because he is part of the generation who were trained to be self-sufficient and not to add to the work of others. I think all of us should ask for help sooner and share our burdens more than we do.
- Ed seems to have a firm finger on everything that he is involved in... and when things may bunch up to make things unmanageable. He plans well in advance of this and lets me know when he is away or busy else ware so that we can plan around this.

Question 8: **How would you rate them on their time management skills?** 93% (85%)

Poor	0
Less than satisfactory	0
Satisfactory	1
► Good	3
Excellent	14
I can't comment on this area	0

- Overruns at times but this is because he is thorough and GP role has changed and more demanding now.
- Ed manages a heavy workload effectively and rarely misses a deadline. I know he is hoping his new working arrangements will make his work-leisure balance easier to manage.
- Documentation is turned around in really good time, and when planning meetings his calendar is up to date so that he knows well in advance when he may or may not be available. Work appears to take up a massive amount of Ed's time. I have noticed more recently that Ed is taking a few more breaks / holidays and that does appear to help him chill out... would rarely say that Ed appears 'stressed', but has certainly seemed to be enjoying a bit more free time of late. Work / life balance appears to be working well for you now!

Question 9: **How would you rate them on their organisational skills?** 93% (87%)

Poor	0
Less than satisfactory	0
Satisfactory	0
► Good	5
Excellent	13
I can't comment on this area	0

- when organising registrar rotas, this is always thoroughly planned out.
- Always appears to be on top of things, rarely appears too stressed. Appears organised with clinical and managerial aspects of his job.
- Ed is good at organising his commitments to fit around the things he prioritises
- Never had an issue yet... As an appraisal lead he has two support groups that are functioning really well. Ed has people that organise each group and is on hand if there are any issues.

Question 10: **How would you rate their effectiveness as a team member?** 93% (91%)

Poor	0
Less than satisfactory	0
Satisfactory	1
► Good	3
Excellent	14
I can't comment on this area	0

- As a Locality Lead appraiser, Ed is highly effective with the ability to flex his leadership style to suit the different personalities in his groups. It is a pleasure to work with him
- A fantastic team member
- Engaging and entertaining... always great to have Ed around!

Any other general comments?

- An excellent colleague and doctor to work with, hard working dedicated and caring.
- a hard working and highly experienced doctor who is a credit to his profession
- A very nice, hard working Gp. Pleasure to work along side.
- Very respectful to practice nurses, helpful and approachable.
- A team player who is always willing to help colleagues.
- Great work colleague. Always been helpful, wealth of knowledge and supportive of all members of staff whether clinical or not.
- I love working with Ed and I have no concerns that Ed will continue to be up to date, safe and effective for as long as he chooses to continue to practise in any of his roles.
- Ed is an excellent GP , delligent doctor and has a charming personality.He has great mentoring skills. It is a pleasure to work with him.
- Ed is highly intelligent, articulate and fun. I have really enjoyed getting to know him as a colleague, have the highest regard for his opinion and experience, and have no doubt that he is a caring and conscientious doctor.
- I have worked with Ed now for over 8 years and I believe he is one of the nicest guys I know. His involvement with and input to the team is great
- Keep on being awesome!

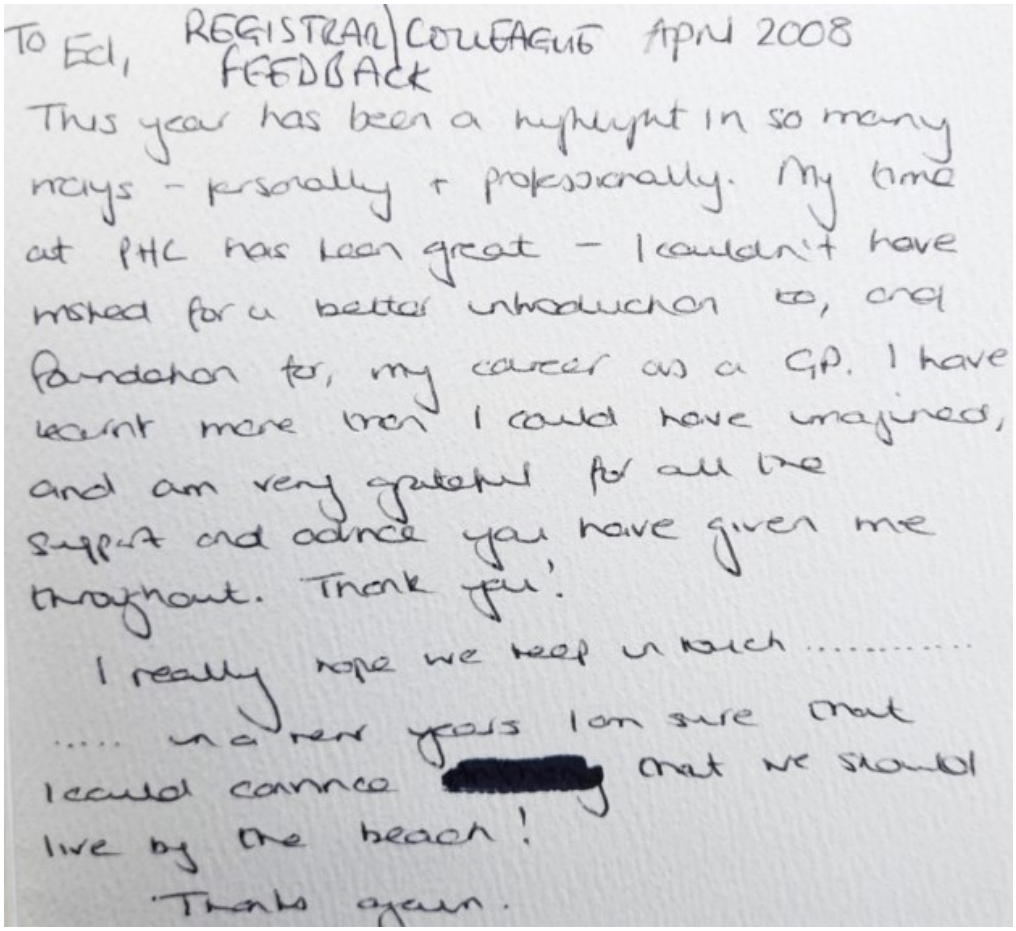
About the summary scoring system

The average is to be used as a guide only and depends on many factors If your survey scores do not match those of the peer scores it does not mean that your survey is below average as scores can easily be skewed by one or two colleagues marking differently to the rest. Non-clinical staff appear more likely to give an answer as average if they don't really feel able to assess – for example in clinical practice.

Poor = 0 Less than satisfactory = 1 Satisfactory = 2 Good = 3 Excellent = 4

To get a score of 100% would mean all the responses were excellents and if all the responses were poor the score would be 0%.

"I can't comment on this area" responses are not included in the calculation of the average.



To Ed, REGISTRAR/COLLEAGUE FEEDBACK April 2008

This year has been a highlight in so many ways - personally + professionally. My time at PHC has been great - I couldn't have wished for a better introduction to, and foundation for, my career as a GP. I have learnt more than I could have imagined, and am very grateful for all the support and advice you have given me throughout. Thank you.

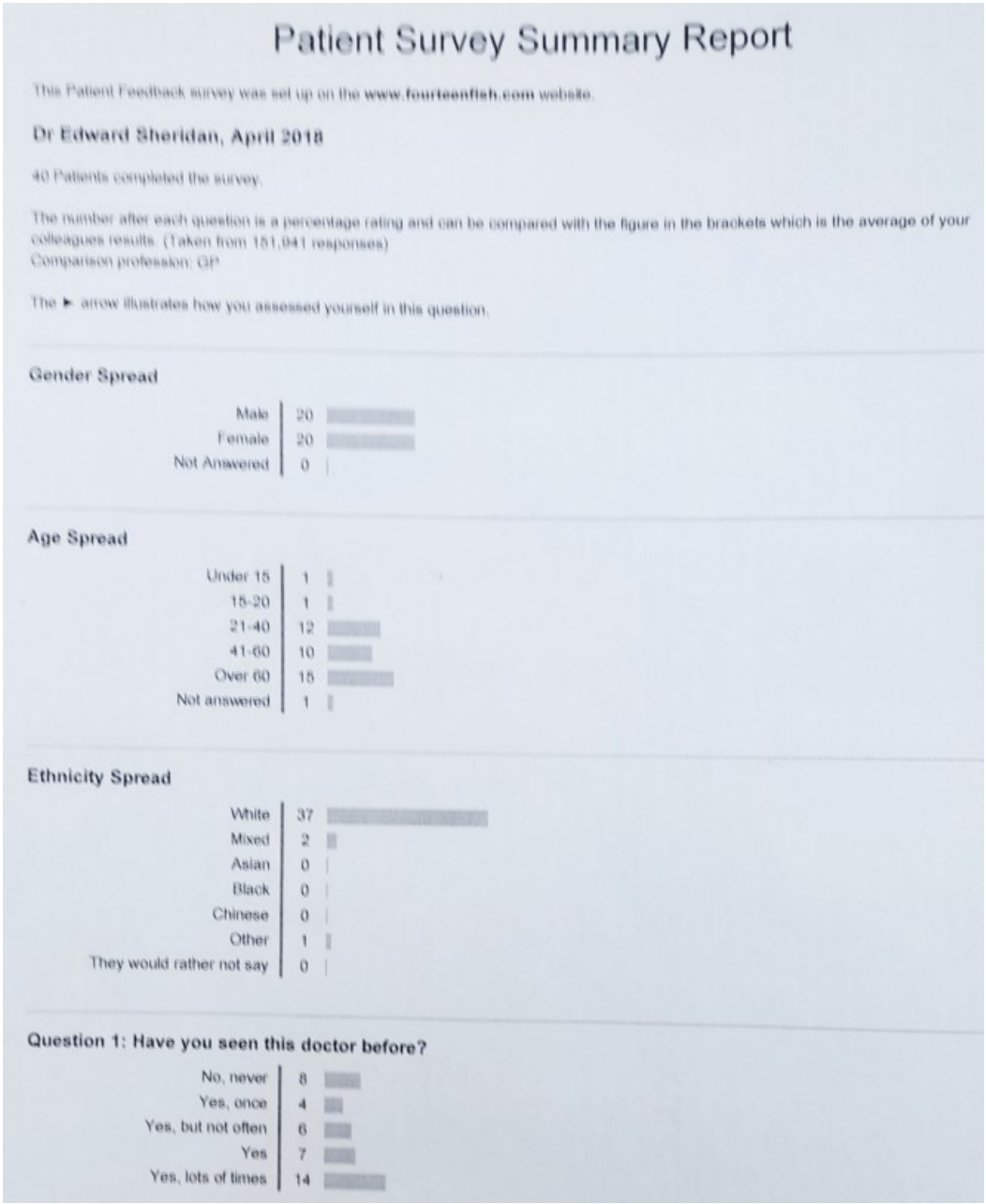
I really hope we keep in touch ..... in a few years I am sure that I could convince [redacted] that we should live by the beach!

Thanks again.

Patient Survey Questionnaire

Using similar platforms, usually with a minimum of 34 respondents.

EXAMPLE 2018:



Patient Survey Summary Report

This Patient Feedback survey was set up on the **www.fourteenfish.com** website.

Dr Edward Sheridan, April 2018

40 Patients completed the survey.

The number after each question is a percentage rating and can be compared with the figure in the brackets which is the average of your colleagues results. (Taken from 151,941 responses)
Comparison profession: GP

The ► arrow illustrates how you assessed yourself in this question.

Gender Spread

Male	20
Female	20
Not Answered	0

Age Spread

Under 15	1
15-20	1
21-40	12
41-60	10
Over 60	15
Not answered	1

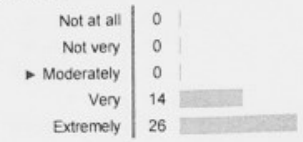
Ethnicity Spread

White	37
Mixed	2
Asian	0
Black	0
Chinese	0
Other	1
They would rather not say	0

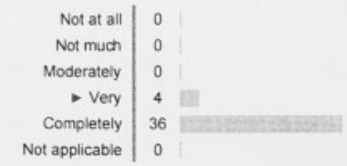
Question 1: Have you seen this doctor before?

No, never	8
Yes, once	4
Yes, but not often	6
Yes	7
Yes, lots of times	14

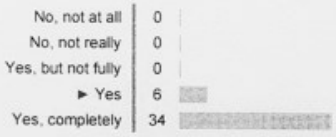
Question 2: How welcome and relaxed did the doctor make you feel? 91% (89 %)



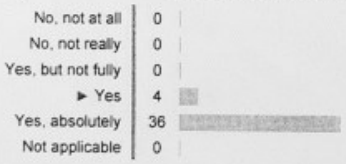
Question 3: How much did the doctor involve you in decisions during the consultation? 98% (91 %)



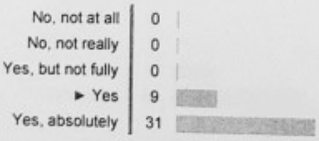
Question 4: Did you feel the doctor listened to you? 96% (92 %)



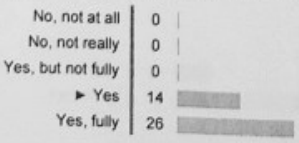
Question 5: Did you feel confident that the doctor's clinical knowledge was good? 98% (94 %)



Question 6: Did you feel confident about the doctor's assessment? 94% (90 %)



Question 7: Did you feel the doctor addressed all of your concerns? 91% (89 %)



- Very good doctor
- He's a good doc with a good sense of humour
- Always listens to me. He has looked after the whole family and I trust him
- Explained things clearly. Very helpful
- Couldnt wish for a better doctor
- Understanding and very caring doctor
- Polite and caring
- Dr Sheridan is the best GP I have ever had. He is a testament to best practice in the NHS
- Fantastic Service - Thanks
- Very through and I had a clear plan of what to do.
- I have always found Dr Sheridan a very good doctor
- What a lovely chap! Very clear, confident and helpful.
- Excellent

Summary Scoring

The question responses are given a score based on:

1 for the First Response (i.e. No, never); 2 for the Second Response; 3 for the Third Response and so on

To get a score of 100% would mean all the responses were the last response (i.e. Excellent)

Not applicable or questions not answered are not included

The score for question 1 is calculated in the same way as above and is therefore meaningless except to give you a guide as to your spread of h
often people have seen you compared to others.

Even though we have used the word "score" these numbers are of course extremely subjective and open to several confounding factors and are
produced purely as a guide for benchmarking.

e-Modular Learning/Internet Materials

This has been the most notable change in my learning over the last 15 years, with the majority being undertaken on the internet using web-based information at the click of a button (which has also seen the demise of the practice learning library for teaching and training with outdated hard copy materials).

EXAMPLE 2014:

Doctors.net.uk

eCME Certificate

This certificate confirms that: **Edward ashley Sheridan**

GMC number: **3087910**

Address: **Parkstone Health Centre**
Mansfield Road
Parkstone
Dorset
Poole
Dorset
United Kingdom
BH14 0DJ

Completed the module: **Diagnosis and management of benign prostatic hyperplasia (BPH)**

On: **03 June 2014**

Accredited by: **Royal College of General Practitioners**

Reflective notes: **use of combination therapy indications for surgery in BPH.**

Impact: **consider learning when male pts present with LUTS.**

Module took: **1 hour**

Credit: **1.00 credit**

Dr James Quekett
on behalf of Doctors.net.uk

RCGP ACCREDITED

Certificate Of Achievement

This is to certify that:

Ed Sheridan

(Parkstone Health Centre)

has completed

Safeguarding Children (Level 3)

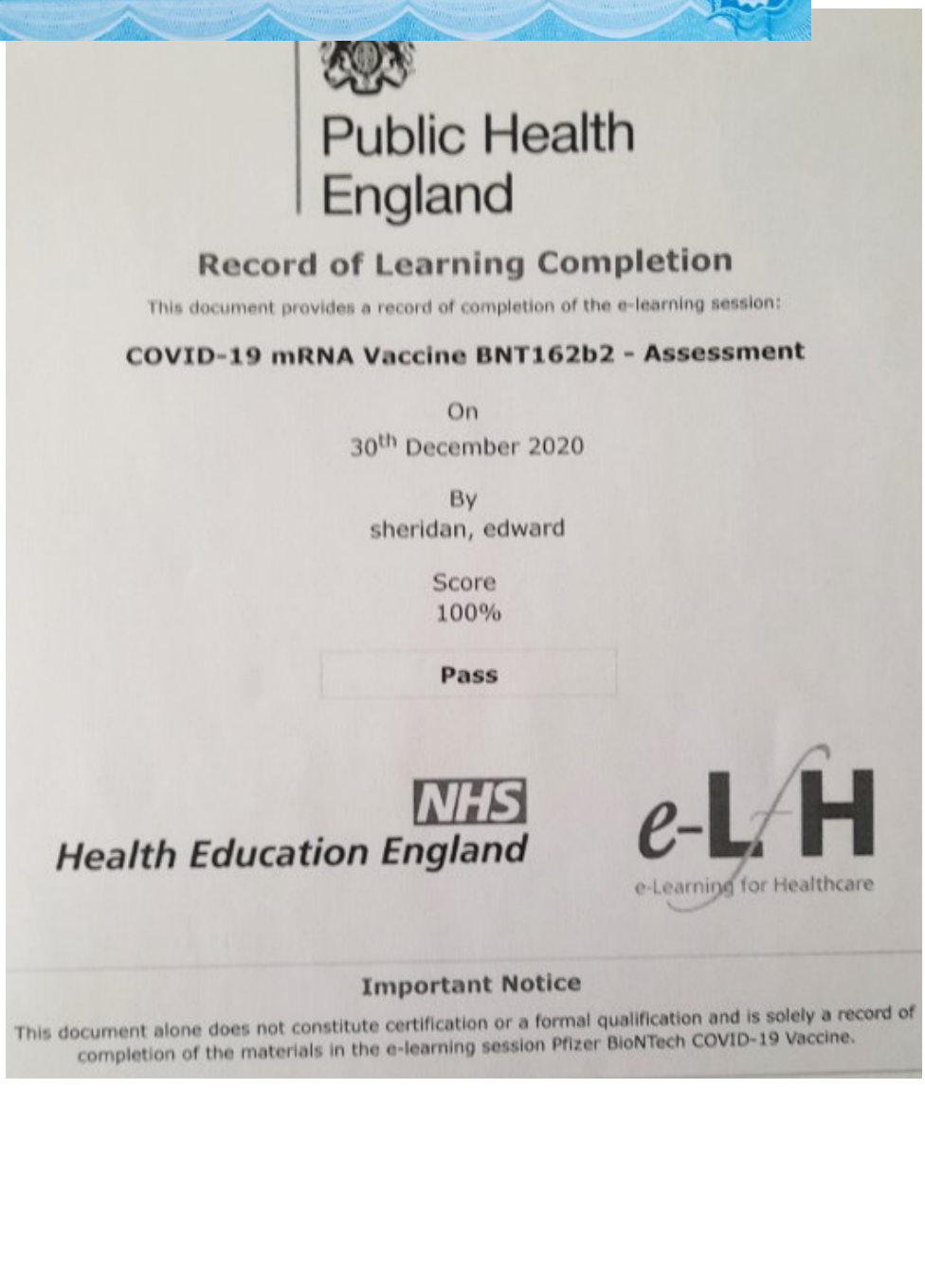
On

13-09-2016 17:45:03

CPD Certificate Number: 1506T37

CPD Hours: 4

Blue Stream Academy



Public Health England

Record of Learning Completion

This document provides a record of completion of the e-learning session:

COVID-19 mRNA Vaccine BNT162b2 - Assessment

On

30th December 2020

By

sheridan, edward

Score

100%

Pass

NHS

Health Education England

e-LfH

e-Learning for Healthcare

Important Notice

This document alone does not constitute certification or a formal qualification and is solely a record of completion of the materials in the e-learning session Pfizer BioNTech COVID-19 Vaccine.

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GPnotebook tracker is active

Pages read in GPnotebook.co.uk

Display Report from 6 Jun 2013 to 28 May 2014

Click to download your tracker statement

Click to email your tracker report

Click for help with your tracker statements

This statement summarises reading of GPnotebook in chronological order
The estimated number of CPD points since the last appraisal on 05/07/2012 is: 26.05

20/05/2014
Pages tracked:
- management of diabetes insipidus
- investigations

diabetes insipidus
- physiology

antidiuretic hormone
osmolality
- investigations
- clinical features
- types

diabetes insipidus

02/05/2014
Pages tracked:
- prognosis
- treatment
- clinical features

hereditary haemochromatosis
Bristol Stool Chart

16/04/2014
Pages tracked:
- clinical features of vitamin B12 deficiency
- clinical features

folate deficiency
sources of vitamin D
- clinical features of vitamin D deficiency/insufficiency in adults
- risk factors for developing vitamin D deficiency in adults

vitamin D insufficiency in adults
vitamin D supplementation
choreoathetoid cerebral palsy
choreoathetosis(congenital)
- management
- clinical features

keratoacanthoma
- prognosis
- treatment
- clinical features

Bell's palsy

10/04/2014
Pages tracked:
Crigler-Najjar syndrome
- diagnosis

Gilbert's disease
- transmission of hepatitis A virus hepatitis
- management of household and sexual contacts
- transmission of hepatitis A virus hepatitis

There are many educational tools which can be utilized, and I have captured just a few that are familiar to us all. What has become apparent to me is that these tools that comprise my portfolio learning are most definitely a way of tracking my progress, with rich material to draw my learning from. Sharing this in an appraisal discussion has helped me to examine areas in which I have been less confident, and plan new learning which is therapeutic for me and learner-centred. Sometimes it can be challenging to identify new learning needs - how many times have we, as appraisers, been confronted with a doctor who doesn't know what he doesn't know – that blissful Johari window of "unconscious incompetence", and this is answered with a PDP objective of undertaking a "general update".

"Wisest is he who knows he does not know"

A general update is a completely acceptable goal couched in the right words to conform to accepted learning objectives.

Continuous professional development (CPD) has become an important cornerstone of the Revalidation process when the concept was introduced in December 2012. The RCGP advised that "**the aim was to demonstrate a balance of learning across the curriculum relevant to your scope of work over the 5 year revalidation cycle**".

In the 2003-2012 period, I was utilizing many of the tools outlined above, along with structured reflective templates for clinical audit, probity and health statements, and declarations of absence of complaints. In the period 2013-2020, we have switched to the Revalidation format with 4 key domains predominantly on internet-based platforms which can store limitless supporting information unlike the very limited capacity of the MAG MAF, and with web-based material forming the lion's share of recorded learning.

Modified GP Appraisal October 2020: a Catalyst for Change

With the advent of the COVID pandemic in January 2020, a seismic change in workflows and processes took place within the field of Medicine, as well as a cultural and social transformation with lockdown periods, mask-wearing, and human isolation. It was recognized that at least 40% of all doctors had reported a detrimental impact on their stress and mental well-being due to the crisis (BMA COVID-19 - Analysing the 2020 impact of Coronavirus on Doctors). Key triggers included a massive increase in workload, being inundated with ever-changing information and protocols, a huge change in work-streams and processes, the era of remote consultation, some found themselves without work, and many were ill themselves with COVID-19 or had family members affected.

Some doctors were really struggling whilst in a job where their emotional energies were being given to their patients, draining them of energy. We see so many patients every day with pains, problems, issues. We care for them, empathise, and feel their discomfort. We only have a certain capacity in our compassion tanks and each day, this capacity slowly reduces. A point can be reached when the ingoing levels are not enough to match the deficit - our emotional batteries have drained away like a slowly leaking bath.

I, like many other GPs, needed thinking space, guidance and support where needed. The GP appraisal service was stopped in England in March 2020 and restarted in October 2020, re-branded as the Academy of Medical Royal Colleges' Medical Appraisal Guide 2020, leading to simply **Appraisal 2020** with a different focus, allowing doctors time to discuss their current health needs with a significant shift away from providing supporting information.

The aim was that the process would require minimal preparation with the emphasis on GP well-being and development. Appraisal switched to a virtual experience, as face-to-face contact evaporated. Many doctors over the years had come to feel the process of appraisal and providing supporting information was onerous, time-consuming, and hoop-jumping, and the NHSE/I introduced Medical Appraisal reboot in 2019 to reduce the amount of information required and lessen the need to reflect on all learning that took place. The GMC also helpfully moved revalidation dates for all GPs forward by 1 year to ease the pressure in 2020. The modified Medical Appraisal process has continued throughout the pandemic and remains ongoing though an evolving format is being rewritten as you read this.

20-21

Academy of Medical Royal Colleges

Medical appraisal template 2020

Professional appraisal in the context of the coronavirus pandemic

1. Personal details

Name Dr Ed Sheridan

GMC Number 3087910

2. Scope of work

Describe your core roles and any significant changes since your last appraisal.

Recently retired GMS Principal with a patient list. - Undertaken this role for 27y. offering core medical services with a full patient list, was a 4 session Principal (since Nov 2019) and formally retired on 31.3.21. The Parkstone Health Centre has amalgamated with the Madeira Medical Centre on 19.4.17 to form the Parkstone Tower Practice, with a patient list of 19,000. We are signed up to Shore Medical Super-partnership from April 2019 as a superpartnership PCN of 60,000 pts. Although retired on 31.3.21, I remain on the Performers List for at least the next 12 months as I am undertaking occasional joint injection clinics to mop up post Covid waiting lists and am undertaking multiple covid vaccination clinics approximately 2-3 per week.
GP Trainer - last registrar ST3 finished in Aug 2020 and this role has finally ceased after 24 years.
Appraisal Lead for Bournemouth/Poole – 11 years – remains ongoing.
Appraiser – 18 years- remains ongoing
GP Recruitment Assessor for placement schemes –since 2009 – due to Covid restrictions , this has been suspended but remains ongoing assuming new formats are not adopted going forwards.
Jersey Appraiser since 2010 / Gibraltar Appraiser since 2014 – remain active and ongoing post retirement.
Afrikids Volunteer role-Upper North-East Ghana – last trip with Afirkids via Southampton Hospital affiliation was 2018. Due to political situation and then Covid pandemic, no further trips have been undertaken but remains on my horizon post retirement when the situation allows.

3. PDP review

What progress if any, have you made with last year's PDP? Are there goals you want to carry forward?

1. Plan for retirement - I formally retired from my Partnership role on 31.3.21. I have obtained a massively overdue pension forecast, and finally took my pension on 30.10.19. I discussed this at great lengh with my partner, financial advisor and accountant and the partners at the practice, as well as my brother who had just retired I finished with my last Registrar in Aug 20 and the partnership kindly allowed me to reduce down to 2 days per week from August 2020, leaving me working only Thursdays and Fridays in my clinical role. Personal reflection utilizing these resources enabled – perhaps empowered me to make the final decision to leave end of March 21. My other roles as GP Recruitment assessor, appraiser and appraisal lead will continue - all of the fun and none of the admin burden.
   2. General Dermatology Update - addressed utilizing directed reading and dermatology webinars.
   3. Update on mandatory training especially Child Safeguarding Level 3 - addressed utilizing Bluestream e module 15.10.19

4. Challenges, achievements and aspirations

What personal and professional challenges or constraints have you faced?

Keeping updated with the huge amount of Covid information that has been diseeminated has been a challenge, with daily updates, new workflows and processes, whilst trying to maintain staff morale and help them with patient enquiries. Telephone triage has also been interesting, not so much itself a challenge – it's a core part of the job. But it has ushered in Same Day Access and instant access to a doctor causing a surge in workload.
The challenge of giving up training in Aug 20 and then finalizing a leaving date – a very difficult decision as I still enjoy clinical medicine so much.

What have been your greatest achievements?

I hav survived the last 12 months of Covid change, particularly keeping up to date with new protocols, workflows , IT formatting and vast amounts of information.
I successfully completed my CASA appraisal reapproval training which went well and was pleasing. Feedback from my appraisees in Wessex, Jersey and Gibraltar has been very, very gratifying. Triangulated feedback from the Deanery (PDR) has been very positive which re-emphasizes that my effort is not wasted or unnoticed. I have also had more time with reduced sessions to undertake appraisal work and in particular, the QA for my appraisers, which I finshed at an early stage. Its all about having more time and less practice admin burden and responsibilities.
Perhaps the most significant achievement has been to take that final and ultimate decision to finish my GP Principal role end of March 21 - a huge decision which I feel is the right one, having taking the steps to wean down over the last 18 months and with the knowledge that I have made plans to fill the void – hobbies, sports, kayaking, karate, spending time with my wonderful partner, along with professional work that I will be continuing with on my own terms largely and with the luxury of having time. The feedback from my patients and colleagues in the light of my retirement has been quite overwhelming. I sent a letter to our patients informing them of my plans and thanking them for the privilege of caring for them over the many years.The response has been quite breath-taking – many cards and letters with truly personal messages of appreciation and gratitude. My colleagues arranged a kudoboard with messages posted by former registrars and staff, current colleagues and many others who have known me over the years. They even managed to track down a man called Ray, who has been a key contact in Ghana for me – he has helped me to understand what true poverty is in the country, and has taught me about kindness, generosity of spirit and the essence of giving. For me, these have been lessons about humility and what human suffering truly looks like. His kind words on the kudoboard left me speechless.

What do you hope to achieve in the future, personally and professionally?

Personally – develop my relationship with my partner - we plan to marry in June 2021. Train for my 3rd dan Karate black belt if my health and fitness hold up. Fill my time in retirement witht the fun work and the fun hobbies, learn French at classes and with the use of the Duolingo app. And most of all share time and exist with my partner.
Professionally – continue as an Appraiser for Dorset, Jersey and Gibraltar and continue as the Appriasal Lead for Poole / Bournemouth. But to be even better than I am now - pursue excellence in its purest form.
Personal and Professional – consider taking up the role again of Afrikids Volunteer role-Upper North-East Ghana, with the Afrikids Charity, for 2-4 week trips teaching ETAT – its very remote but very rewarding as long as I don't catch malaria.

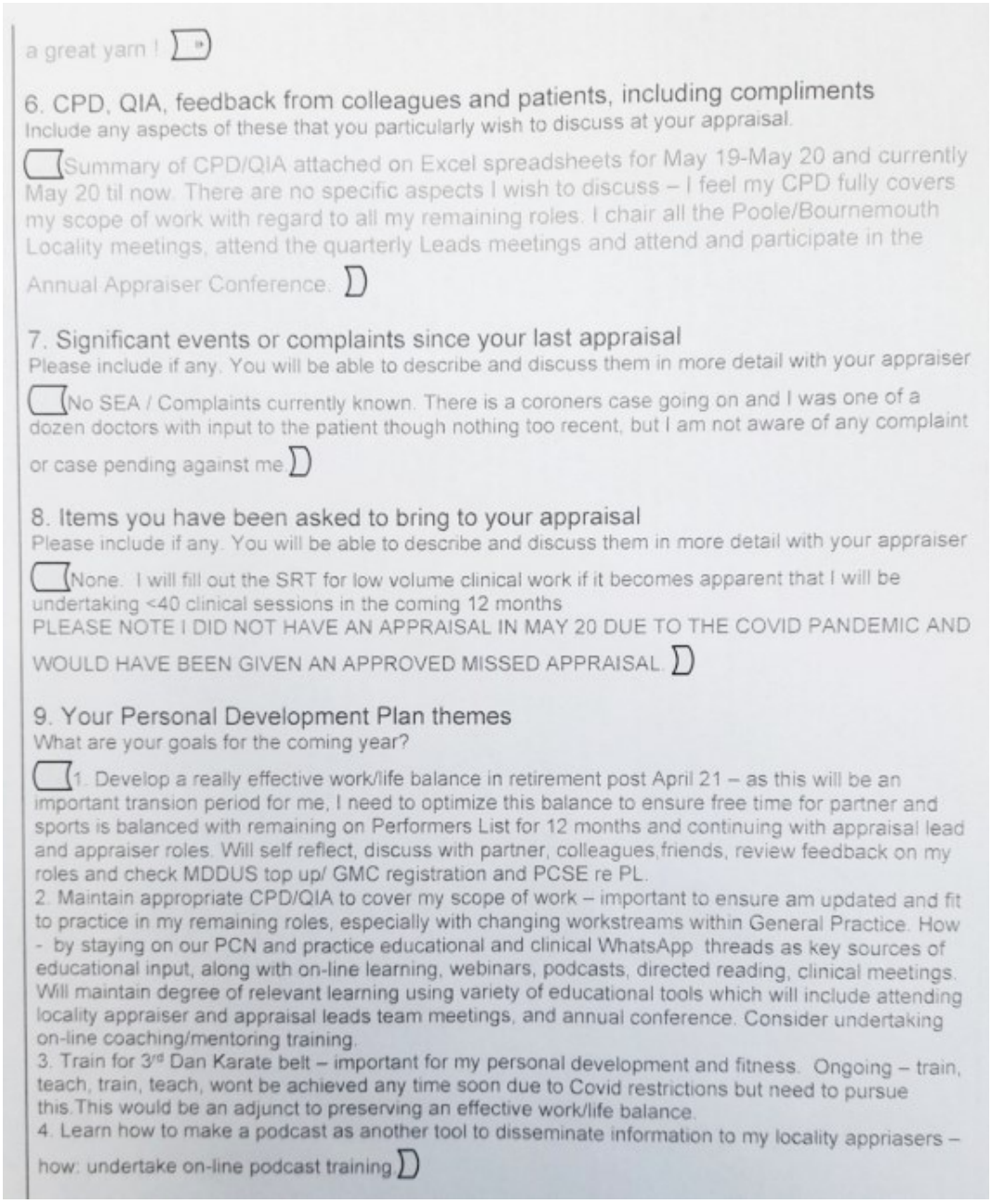
5. Personal and professional wellbeing

On a scale of 1 (most negative) to 10 (most positive), how are you?

Select 1-10 (8)

Consider:
— How has the COVID-19 pandemic impacted on you?
— How do you maintain your health and wellbeing and what do you need to do differently, if anything?
— Have you needed any support, and was the help you needed available?

Significant impact – massive change in workflows and processes – it's a turbulent world and the face of General Practice has transformed completely. Issues have been huge volume of disseminated information, keeping updated with that information, supporting stressed staff and colleagues, learning about a new "disease entity", huge surge in workload re instant access for patients on same day access, IT learning for death certs, crem papers, med 3's , organizing home oximetry etc. Has felt stressful at times but coping. I like change – a cornerstone of General Practice, but I havenet needed any other specific support. Retirement and more free time beckons.
Maintain well-being – have utilized quality time with partner, trained with karate when restrictions were relaxed, cycling, walking, running when my calf allows, reading for pleasure. Sometimes the situation re work and reduced personal freedoms makes it feel gloomy but generally I feel positive. Additionally, there have been plusses- new workstreams are very effective and add variety, vaccination clinics are a real buzz, time with partner cements the relationship, son living with me as he is studying for his Masters – he would normally be in London but is studying on-line and this is dad/son time I never expected to happen at this stage – downtime in evenings for us is a game of chess and a box set- sons of anarchy-



a great yarn !

6. CPD, QIA, feedback from colleagues and patients, including compliments
Include any aspects of these that you particularly wish to discuss at your appraisal.

Summary of CPD/QIA attached on Excel spreadsheets for May 19-May 20 and currently May 20 til now. There are no specific aspects I wish to discuss – I feel my CPD fully covers my scope of work with regard to all my remaining roles. I chair all the Poole/Bournemouth Locality meetings, attend the quarterly Leads meetings and attend and participate in the Annual Appraiser Conference.

7. Significant events or complaints since your last appraisal
Please include if any. You will be able to describe and discuss them in more detail with your appraiser

No SEA / Complaints currently known. There is a coroners case going on and I was one of a dozen doctors with input to the patient though nothing too recent, but I am not aware of any complaint or case pending against me.

8. Items you have been asked to bring to your appraisal
Please include if any. You will be able to describe and discuss them in more detail with your appraiser

None. I will fill out the SRT for low volume clinical work if it becomes apparent that I will be undertaking <40 clinical sessions in the coming 12 months
PLEASE NOTE I DID NOT HAVE AN APPRAISAL IN MAY 20 DUE TO THE COVID PANDEMIC AND WOULD HAVE BEEN GIVEN AN APPROVED MISSED APPRAISAL.

9. Your Personal Development Plan themes
What are your goals for the coming year?

1. Develop a really effective work/life balance in retirement post April 21 – as this will be an important transion period for me, I need to optimize this balance to ensure free time for partner and sports is balanced with remaining on Performers List for 12 months and continuing with appraisal lead and appraiser roles. Will self reflect, discuss with partner, colleagues,friends, review feedback on my roles and check MDDUS top up/ GMC registration and PCSE re PL.
2. Maintain appropriate CPD/QIA to cover my scope of work – important to ensure am updated and fit to practice in my remaining roles, especially with changing workstreams within General Practice. How - by staying on our PCN and practice educational and clinical WhatsApp threads as key sources of educational input, along with on-line learning, webinars, podcasts, directed reading, clinical meetings. Will maintain degree of relevant learning using variety of educational tools which will include attending locality appraiser and appraisal leads team meetings, and annual conference. Consider undertaking on-line coaching/mentoring training.
3. Train for 3rd Dan Karate belt – important for my personal development and fitness. Ongoing – train, teach, train, teach, wont be achieved any time soon due to Covid restrictions but need to pursue this.This would be an adjunct to preserving an effective work/life balance.
4. Learn how to make a podcast as another tool to disseminate information to my locality appriasers – how: undertake on-line podcast training

My preparation, like my appraisees, needed much less time since most of my supporting information was not required but the appraisal discussion still covered scope and nature of work, review of last year's PDP, analysis of feedback and achievements, challenges and aspirations. We were able to submit our CPD and reflection in the appraisal discussion. The RCGP benchmark of 50 hours/50 credits of CPD was gone, and we were required to sign off on probity, confidentiality, health declarations and confirm the accuracy of the supporting information. With the move to see fewer patients face to face, survey information had become more problematic but there has been much greater flexibility shown by the GMC and the AoMRC which can only be a very positive step forwards - an attitudinal change.

The 6 supporting types of information for Revalidation have not changed but the new emphasis on well-being, positivity and work/leisure balance remains the key areas of focus. We have taken the time and trouble to not only look at whether the glass is half full or half empty but that doctors "can't drink from an empty cup" at all in some circumstances.

Or is it completely empty…?

Change – What Change?

Here is where I shift onto very anecdotal and controversial ground. For me, as an appraiser, this wasn't such a cataclysmic change in the appraisal process. Although the focus had hitherto been about evidence, that had not been my focus as an appraiser.

Isn't a doctor's sense of well-being a core aspect of clinical effectiveness?

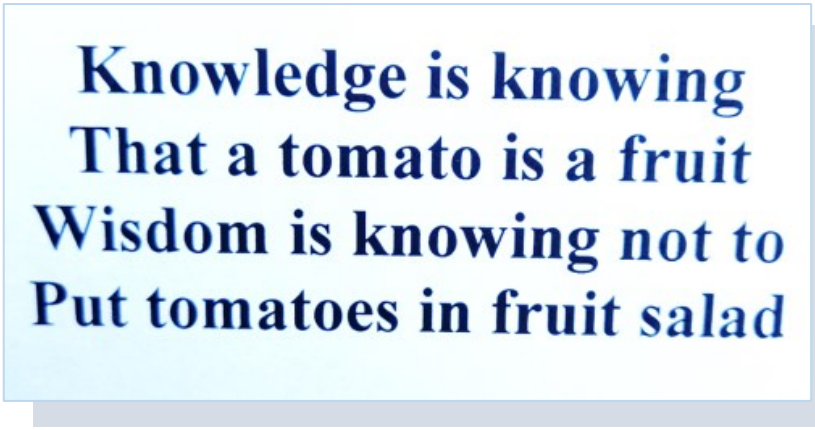
How does one make the appraisal discussion interesting and stimulating and thought-provoking and supportive?

This had been my personal approach, drilling down on a doctor's benchmarks for assessing how effective they felt they were as a clinician, the issues facing new GPs and peripatetic doctors, the very different but very real issues facing GPs on the cusp of retirement, the eternal challenge of finding an optimal work/life balance - a corollary of this being the well-being of a doctor and, where relevant, topics such as wisdom of practice, intuition, and the artistry of General Practice.

To all my colleagues in my appraiser locality groups that I supervise as appraisal lead, I should probably apologise for repeating these words to them over the last 13 years. There is no single one way of conducting an appraisal and summarizing the discussion. It is about keeping it appraisee-centred and finding ways of making it a stimulating and rewarding experience for the doctor, and that's where the creativity of this wonderful and beautiful process comes into play.

I found myself conducting appraisals as a virtual experience which remains for the most part ongoing. I have vastly expanded my own list of resources which I can signpost an appraisee to (see AoMRC- Medical Appraisal 2020 - Support for Doctors). Never has it felt more important to understand my role in a nebulous space in between and outside of the roles of counsellor, mentor, coach, advisor, mountain guide (you can choose your own analogy).

Should we be asking ourselves - why did it take a pandemic to alter the focus of this whole process to a place where arguably it always should have occupied since the infancy of appraisal? We have the knowledge of this process but it has taken some time to accrue the wisdom within.



What Impact Has Appraisal Had On Me?

Perhaps all of the above but, to distil things down, it is quite clear looking back over these multiple portfolios which I maintained that they have tracked my education over time. It has promoted and encouraged my reflective practice which has been an integral part of my everyday professional life for as long as I can remember – it has become an intuitive process which has enabled me to think analytically about all facets of my working life, facilitating my insight and learned lessons in order to maintain good practice and/or make improvements where possible. The structure that has been given to my learning within the appraisal process has allowed me to examine my previous beliefs about how I practice and modify them to develop my learning and optimize my professional practice.

Appraisal has helped to keep my learning focussed where relevant - eg, goal-directed PDPs - and it has given me the opportunity to stimulate feedback with my appraiser in a non-threatening and non-judgemental forum.

Some colleagues have questioned the usefulness of documented evidence of reflection, some have commented on the “false god of appraisal” (McCartney BMJ Oct 2015) but in an age of increasing and ongoing accountability, does it not demonstrate a professional attitude to maintaining optimal clinical practice by showing our ability to learn from and develop one’s own and system-wide practice? Is this not a demonstration of a professional self-directed learner being professional?

In addition, appraisal has given me the most enormous sense of privilege in supporting doctors when they have had issues, and provoking interesting discussion when they have not. It has given me a very personal portal into the lives of so many doctors and enhanced my own learning from theirs.

What impact have I had on appraisal?

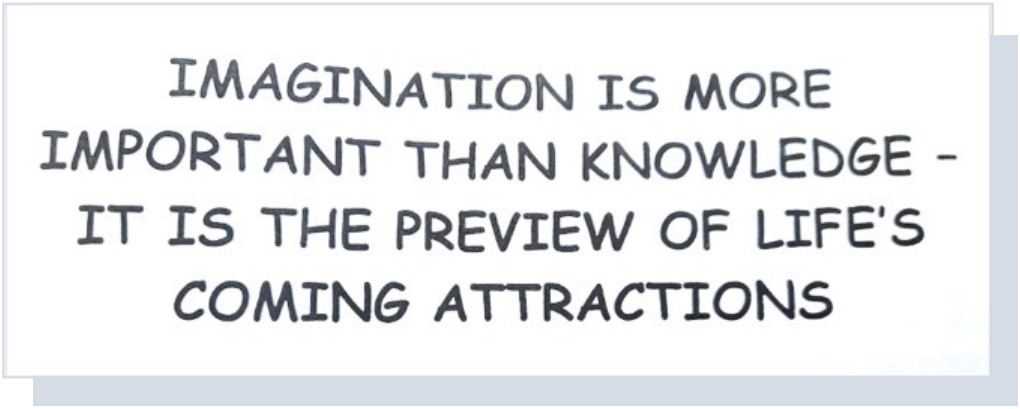
This is truly an anecdotal reflection. As an appraiser, I have had generally good feedback over the years to validate some form of positive impact on my appraisees. I feel as though I have given huge amounts of time, energy, thought, and drive but that will be for others perhaps to judge. As an Appraisal Lead since 2009, my role and impact has been fundamentally for peer support, dissemination of information, guidance, and to address appraiser-centred learning needs. I have taken the Socratic approach of trying to find answers to questions and problems and if I didn't know the answer, between myself and the appraiser we would find it. Inevitably, a strong pastoral element has developed in over-seeing my 2 locality groups which I hope has been beneficial for all.

I have always tried to make the appraisal discussion a more creative environment for a doctor to share their lives with me. There is so much that can be achieved within an appraisal discussion – so many interesting avenues to take the conversation or for the appraisee to stretch their minds as they choose:

"The possible's slow fuse is lit
By the imagination"

(Emily Dickinson)

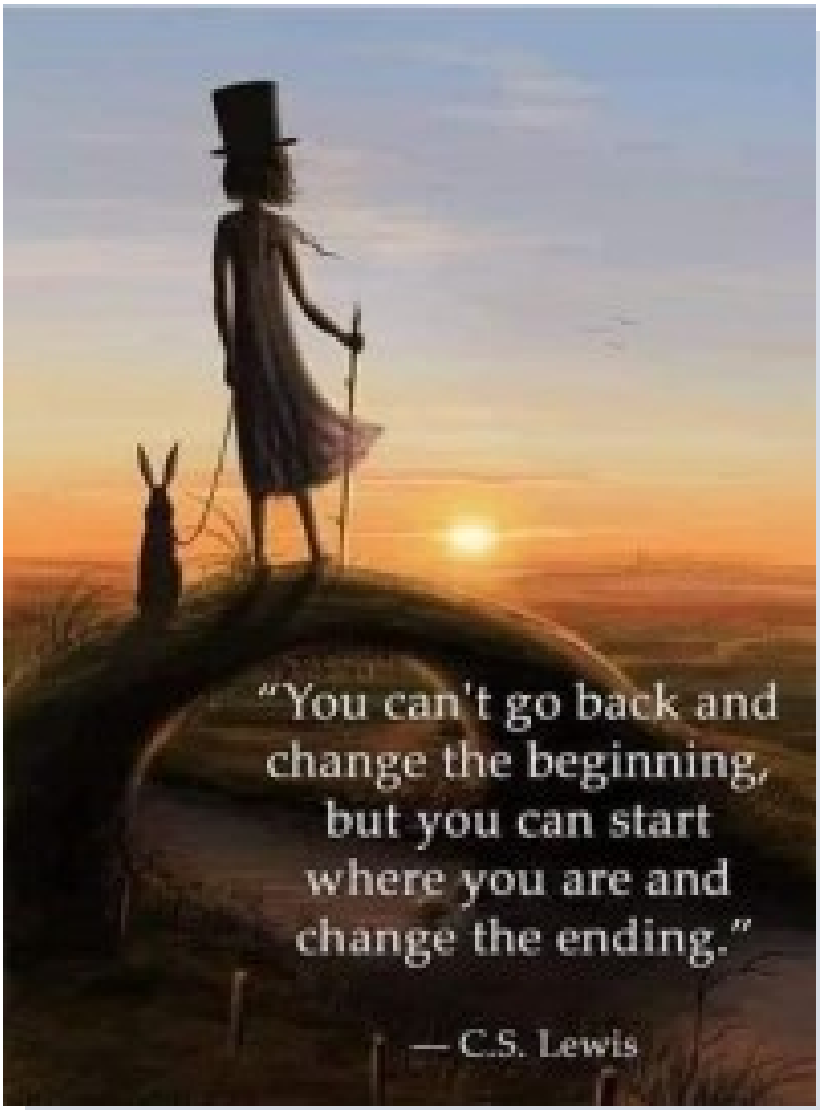
Appraisal is not just about the evidence, and it could be suggested that it never has been. Revalidation ushered in certain GMC requirements which remain in place, but the appraisal discussion has the potential to cover so much more than just this, which is why I have aspired to keep the subject matter appraisee-centred but to expand into some imaginative areas that a doctor might find thought-provoking – that a doctor might find rewarding and worthwhile.



Conclusions

So this was the story of those many CPD portfolios lining a shelf that I started with – a very personal story, but it has made me realize that they do represent a professional life in learning. It has been such a healthy and positive change that since the pandemic began in 2020 that there has been a focus away from evidence in appraisal onto the well-being of doctors and how to optimize their work/life balance in this current climate of stressed, under-valued and demoralized GPs.

My learning has changed over the years – hard copy has been largely substituted by electronic recording of information, wants and needs assessments have been absorbed into reflective practice, educational tools have changed shape with internet learning as the predominant tool, and most of all since COVID-19, the process has felt more appraisee-centred than at any other time since 2003.



Appraisal has such opportunity for being a wonderfully fluid, creative environment full of potential for both the appraiser and appraisee.

It has to be about more than just evidence, important as that might be, and with change being such an ever-present phenomenon within the NHS, we have this key opportunity to shape our learning and the content of the appraisal discussion to suit the needs of our colleagues and take account of the pressures that they find themselves under.

Addendum:

For one last moment of self-indulgence, I would like to express my preference for the mountain guide analogy with respect to my role as an Appraiser and Appraisal Lead.

The guide ensures we are adequately prepared for the journey, plans a route, helps us to navigate steep ascents, assists in us stepping over large rocks, guides on the best footholds, checks the map and compass to ensure we are travelling in the right direction, signposts to alternative routes, and reaches a relevant endpoint which is not always the top of the mountain.

References:

The Appraiser's Handbook – a Guide For Doctors
Lyons/Caesar/McEwen 2008

Appraisal for the Apprehensive
Chambers, Wakley, Field, Ellis 2003

Guidelines for Practice
October 2020, Issue 10

Learning Cycle
Heron 1976

BMA COVID-19: Analysing the 2020 impact of Coronavirus on Doctors

BMJ October 2015 – The False God Of Appraisal

Acknowledgements:

The Admin team at Wessex Appraisal Service, who are outstanding in every way – professional, supportive - and they have become my friends as well as my colleagues over all these many years.

The Appraisers of the Poole/Bournemouth Locality who are dedicated, committed, enthusiastic, and driven to offer the best service possible to their appraisees.

The Appraisal Leads for the Wessex Appraisal Service who have been a constant resource to me of knowledge and support and who have allowed me to trade and swap information, problems and issues with them in an effort to find the answers.

Dr Susi Caesar – Project Lead for Wessex Appraisal Service for her enduring support and guidance, and for empowering me to construct this anecdotal and very personal synopsis of my learning and appraisal experience.