Presenting CESR Evidence

Sample evidence

In this pack you'll find examples of strong evidence and evidence that has been triangulated. These examples are taken from real CESR applications.

It's important to note that every application is individual – this pack should be used to give you an idea on what strong looks like and how to triangulate and cross reference your evidence.

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

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Strong evidence

On the following pages you'll see examples of strong evidence submitted as part of a CESR application.

This applicant has mapped their logbooks to an area of the curriculum (e.g. diagnosis/presentation) and has submitted the relevant evidence for that patient. In their logbook they've detailed the documentation supplied to demonstrate competence in this area of the curriculum.

In this instance, the applicant has:

- Listed patients seen over the assessment period in a self-produced
- Provided a table summarising the diagnoses of the logbook patients
- Included the relevant clinic letter
- Submitted referrals / relevant correspondence regarding management of patient
- Provided a WPBA to support this case
- Submitted a personal reflection on this case

You should ensure that your evidence covers the depth and breadth of the CCT curriculum in your specialty. Remember that one case could cover multiple competencies.

You might want to consider adding the curriculum competence that each document relates to (e.g. the Learning Outcome (LO) or CiP number).

Logbook Diagnostic View

	A	B	C	D	E	F	G
1	**Initials**	**Age**	**Gender**	**Setting**	**Previous Contact**	**Working Diagnosis/Problem**	**Documentation**
2	AS	49	F	Psychiatric Clinical Decision Unit On call	0	Psychotic illness ?organic(Vit B12 deficiency??) ?acute psychotic episode ?depression with psychosis	1. E-Note 2. Reflection
3	MV	63	M	Outpatient	6	1. ?Frontal Lobe Dementia 2. Long history of Schizoaffective Disorder	Clinic letter Referral letter Reflection
4	GD	41	M	Outpatient	0	1.Possible personality and behavioural disorders due to brain disease, damage and dysfunction 2.Post-traumatic stress disorder	Clinic letter
5	CP	31	F	Urgent MHA assessment	0	Delirium(causes unclear)	E-note Reflection
6	LB	57	F	CPA clinic	0	1.Bipolar affective disorder 2.? Cerebral involvement of systemic lupus erythematosis	Clinic letter Referral letter Reflection
7	SN	62	M	Nursing Home	0	1.Progressive supranuclear palsy 2.Mixed anxiety and depressive disorder	Clinic letter
8	SB	19	F	Outpatient	0	Mixed anxiety and depressive disorder(with borderline personality trait)	Clinic letterX3
9	MC	41	M	Outpatient	0	Schizoaffective disorder ?severe depression with psychosis	Clinic letterX3
10	N P-H	22	F	Outpatient	0	Borderline personality disorder ??psychosis	Clinic lettersx2

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Initials	Age	Gender	Diagnosis	Problem	Documentation	Redacted
MV	63	M	schizoaffective disorder with new presentation ??Frontal lobe dementia	Long history of psychotic illness. I saw him regularly in the CPA clinic. His psychosis was improved but had changes in cognition, behaviour and personality, indicating an organic illness, such as frontal lobe dementia.	1. Referral letter 2. Clinic letter	Y
JM	28	M	Dissocial personality disorder (with impulsive and paranoid personality traits	I saw him in the outpatients for a new patient assessment. He was referred to our clinic by IAPT. I identified a high risk and limitation in General Adult service, hence the referral to Forensic psychology	Referral form	Y
LB	57	F	1.Bipolar affective disorder 2.? Cerebral involvement of systemic lupus erythematosus	I saw her first time in the CPA clinic. She was diagnosed with bipolar affective disorder in recent admission. But from her history, she was diagnosed with SLE before her 1st psychiatric episode, hence the referral letter to the Rheumatologist.	Clinic letter Referral letter	Y
KB	50	F	Recurrent depressive disorder	I saw her first time in the CPA clinic. From her history, I identified her need for psychological intervention, possibly some dynamic work	Clinic letter Referral letter	Y
FS	50	F	Bipolar Affective Disorder	Long history of bipolar illness has been stable on Lithium The endocrinologist suggested to stop lithium due to increased calcium	Clinic letterX2 Letter to Endocrine Letter to GP	Y
AB	41	F	History of schizophrenia and schizoaffective disorder	Has been stable and would like to start a family	Clinic letter Referral letter	Y

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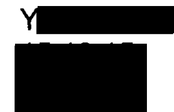
Our Ref: Y

Date Dictated:

Date Typed:



Adult Services Division
Peter Hodgkinson Centre
Greetwell Road
Lincoln
LN2 5UA
Tel: (01522) 573531
Fax (01522) 573532

CONFIDENTIAL
Dr P St
Medical Practice
Road
LINCOLN

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PSYCHIATRIC OUTPATIENT SUMMARY – CPA REVIEW

Name of Patient:	**L B**
Date of Birth:	**58.**
Address:	
NHS Number:	
Date of Outpatient Appointment:	**2015**
Time Seen:	**14:00 hours**
Consultant:	**Dr , Locum Consultant Psychiatrist**
Seen By:	**Dr Su, Specialty Doctor**
Diagnosis:	**1. Bipolar disorder, current episode manic with psychotic symptoms (according to her recent discharge summary)** **2. Query cerebral involvement of systemic lupus erythematosus**
ICD-10 Code:	**1. F31.2**
Legal Status:	**Community Treatment Order**
Other LPFT Services Involved:	**None**
Psychotropic Medication:	**Continue Risperidone Consta depot IM 50mg every two weeks.**
Follow-up:	**To be arranged by her Care Co-ordinator**

Dear Dr S

I met with Ms B for the first time at the CPA review clinic on 15th December 2015 at the Peter Hodgkinson Centre. As you might be aware, Ms B is under the care of Lincoln North Community Mental Health Team with a Care Co-ordinator. Her previous Care Co-ordinator recently left his post and the Team is in the process of allocating another Care Co-ordinator for her. For this review she was accompanied by the Duty Worker, N C r, CPN. With Ms B's consent, a nursing student, , was also present.

As you are aware, Ms B[redacted] has had a number of psychiatric admissions in Lincoln since 2012. Her most recent admission was from 1st October 2015 to 17th November 2015. On this occasion she was detained under Section 2, then Section 3. She was discharged on a Community Treatment Order. I trust you have received all the discharge summaries from her previous admissions, therefore I will not repeat all the details here.

You will gather from her recent discharge summary that during this admission she made various attempts to contact the Prime Minister by sending letters and emails. Due to the security risk, these have been intercepted and Westminster has been in contact with the Trust. When I saw her in the clinic she told me that she had received a letter from Number 10 Downing Street. She said the letter was written by someone called Michael Clarke who is the representative of the PM. She said Mr Michael Clarke had invited her to attend a meeting with himself and she could go along with up to six people. I asked her what she had wanted from the PM. She said she would like to raise the issue of child sexual abuse. She then told me that back in 2002 her daughter, M[redacted], was sexually abused by her father. Ms B[redacted] claimed she took this case to the high court and won the case. As a result of her victory she has 'made history'. She believed that from that point the law protecting children from sexual abuse was established. She said when she meets with Mr Michael Clarke she will further raise her concerns. She said she is planning to write back to Mr Michael Clarke in order to make an appointment. She told me a local gang called 'Hell's Angels' wanted that letter. She believed the Hell's Angels have been after her because she refused their request. She then told me that she used to work for the security which is called 'NVQ'. She would not elaborate on this due to 'security reasons'. She then reported that she had established a new child protection organisation called CPP Foundation. She showed me a business card on which it said 'L[redacted] B[redacted], CEO, CPP Foundation'. She also told me that she recently was offered a position in a charity organisation which looks after homeless people globally. She said this position was offered by one fellow patient whom she met on Ward 12, [redacted], Boston. She said she had not accepted this position.

She described her mood as good and her appetite as better. She reported she could sleep up to 10 to 15 hours every day. I understand there have been care co-ordinator and community nursing assistant input from the Lincoln North Community Mental Health Team. Ms B[redacted] reportedly functions to a good level day to day. She denied use of alcohol or illicit drugs.

At the review she appeared well-kempt and appropriately dressed. She maintained good eye contact and rapport was established. However, at the end of the review, she became unhappy when I told her she needed to carry on with her antipsychotic treatment because of her mental illness. She otherwise was calm and polite throughout the meeting. There was no psychomotor agitation or retardation. She was talkative and forthcoming. However, her speech was of normal speed, volume and fluency. Her mood was subjectively good and objectively euthymic. She denied thoughts of harming herself or others. She reported grandiose delusions as described above. There was no thought insertion, withdrawal or broadcasting. There was no passivity phenomena. She denied abnormal perceptions. She was orientated to time, place and person. She believed she is mentally well and she does not need any treatment.

Four days prior to this clinic, Ms B[redacted] refused her depot injection. The Community Team reported this to the Team Consultant, Dr P[redacted] Locum Consultant Psychiatrist.

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It would appear that Dr P issued a recall notice under the Community Treatment Order. When Ms B saw the notice, she then changed her mind and accepted the depot. She said she did not want to go back to hospital. I was told a Tribunal for the Community Treatment Order would be held early next year.

At the review with me Ms B said she wanted to stop her depot injection. I explained her diagnosis and the rationale of the treatment. She showed no insight.

I have noticed that she was diagnosed in Liverpool with lupus in 2006. She told me that she stopped her treatment for SLE early this year for about six months. She actually just recommenced her treatment late last month. However, from an outpatient review letter from Dr O Consultant Rheumatologist (dated 16th June 2014), Ms B stopped her SLE sometime early in 2014. From her history it seems that her first psychiatric admission was in 2012 when she was presenting with depression and psychosis. Prior to this she might have a brief history of post-natal depression. She told me she had not seen Dr O for a while and she missed her appointment last month. I wonder whether there could be some cerebral involvement of SLE.

I have not made any change in her treatment. Her Care Co-ordinator will help her to arrange an outpatient appointment with Dr O. Her Care Co-ordinator will also arrange her next psychiatric review in due course.

Yours sincerely,

Dr S, MBBS, MMedSci
Specialty Doctor to Dr , Locum Consultant Psychiatrist

COPY

Your Ref:

Our Ref: Y

2015

Lincolnshire Partnership NHS
NHS Foundation Trust

Adult Services Division

Peter Hodgkinson Centre
Greetwell Road
Lincoln
LN2 5UA
Tel: (01522) 512512 Ext 3531
Fax (01522) 573532

Private and Confidential
Dr S O, Consultant Rheumatologist
Lincoln County Hospital
Greetwell Road
LINCOLN
LN2 5QY

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Dear Dr O

RE: L B (dob 58)

NHS No:

I met with Ms B for the first time during a CPA review at the Peter Hodgkinson Centre. You may or may not be aware that she recently had another psychiatric admission between October 2015 and th November 2015. The diagnosis was bipolar disorder, current episode manic with psychotic symptoms. When I saw her in the clinic she was presenting with a number of grandiose delusions. From her history, it seems that she was first diagnosed with lupus in 2006 in Liverpool. Her first psychiatric admission was in 2012 when she was presenting with depression and psychosis. I have gathered from one of your clinic letters (dated 1 June 2014) that she has been under your care since 2012. It would appear that she stopped her treatment for SLE in early 2014.

She told me that she missed her appointment with you in December of this year because she was an inpatient at Ward 12, Pilgrim Hospital, Boston. I would be grateful if you would offer her a review appointment at your earliest convenience. I wonder whether you could investigate for a possible cerebral involvement of SLE.

Thank you very much for your help.

Yours sincerely

Dr S MBBS MMed Sci
Speciality Doctor to Dr U , Locum Consultant Psychiatrist

cc: Dr S , GP

Chair: Paul Devlin
Chief Executive: Dr John Brewin
www.lpft.nhs.uk

Appendix 2 Case-based discussion – specialist doctor

Doctor's name Dr. S[redacted] Date of discussion 17/12/15.

Assessor's name Dr. [redacted] Assessor's registration number ......

Diagnosis Schizophrenia

Focus of this discussion Increasing self neglect – management.

Good Psychiatric Practice standards

Assessed (see overleaf)	Not assessed 0	Inconsistency in meeting standards 1	Meets standards and consistent with independent practice 2	Exceeds at standards 3	Excels at standards 4
				(circled)	
1 Assessment					
2 Diagnosis					
3 Risk assessment					
4 Treatment plan and delivery					
5 Knowledge of treatment options	Review of old notes pending.				
6 Record keeping					
7 Communication with professionals	Good.				
8 Communication with patients and carers	Good				

Good practice	Suggestions for development
Caring patient centred	Review of old notes, bring back to PDP group.

Agreed action: See above

Assessor's signature [redacted]

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Describe a notable clinical or non-clinical experience?

Date: ███████ 2015

LB is a 57 year old Caucasian woman. During her recent admission, she was diagnosed with bipolar affective disorder, current episode manic with psychotic symptoms. She was placed on a CTO and prescribed Risperidone Consta Depot. I saw her for the first time in the CPA review clinic. On her mental state examination, there was a strong element of psychosis; but few affective symptoms. She told me that she did not have a bipolar illness. She said she in fact did not have any mental illness. She talked about a number of delusional beliefs and said they were true. She said that she did not want more injections. Her care co-ordinator, my CPN colleague told me prior to our meeting that LB asked for this review as she wanted to stop her injection.

I was aware that she had previous history. Unfortunately, the old notes were not available. The e-note covers information from 2012 onwards. The Trust no longer routinely provided old paper notes. We had to request them when needed.

At the beginning, I reassured her that I had heard what she said, and I would answer her request at the end of our meeting. I then encouraged her to tell me about her history, especially her past psychiatric history. It would appear that she had 3 or 4 admissions locally since 3 years ago. On each occasion, her presentation was not very typical. I asked her about physical health. She told me that she was diagnosed with SLE (Systemic lupus erythematosus) 8 or 9 years back. She could not recall when she last saw the Consultant Rheumatologist. She was not sure for how long, she had been off SLE treatment.

At the end, I gently discussed her delusional beliefs with her, demonstrating that they were not real. She persisted that she was right; I did not argue. I then talked about the rationale for prescribing Risperidone Consta. I asked herself to compare what she was like a few months back (before her admission) and what she was like now. She agreed that she was now looking after herself better. I then pointed out that she was on CTO. I explained to her the conditions of her CTO. I told that she needed to see the Consultant Rheumatologist for her SLE and she needed to go back on the treatment. I explained that SLE might induce some mental health symptoms as it might affect her brain. I would ask the Rheumatologist to look at the possibility. I said, nevertheless, she indeed needed the treatment (injection) prescribed by her inpatient consultant. Her beliefs were obviously unshakable. By the end, following our discussion she no longer objected to her treatment.

What did you learn from the experience?

- History is one of the most important parts in psychiatric care.
- We cannot confidently make a judgement or a decision, without knowing a patient's full history.
- Refresh my knowledge about CTOs
- Always be aware of possible organic causes, especially when the clinical picture is atypical.

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What feedback did you receive from colleagues?

My CPN colleague, the patient's care co-ordinator, was happy with the outcome and thanked me.

As a result of this experience, what do you need to learn more about or what skills do you need to develop?

- Improve skills interviewing severely delusional patients
- Review knowledge of organic psychiatry

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Triangulating evidence

You should use a variety of independent sources to demonstrate evidence of your competence across the depth and breadth of the CCT curriculum – for example, logbooks and WPBAs. Triangulation of evidence relates to assessing a range of independent sources and how they correlate to a learning outcome.

CESR evaluators look to see if an applicant is competent in a learning outcome through triangulated evidence – i.e. whether evidence has been obtained from several sources.

On the following pages you'll see examples of triangulated and cross-referenced evidence submitted as part of a CESR application. This evidence is taken from the teaching and training section of the application.

This applicant triangulated their evidence of teaching by providing:

- Teaching timetables
- Correspondence confirming teaching delivered
- Presentation slides of the lecture mentioned in the timetable / email
- Feedback summary for the teaching session
- Examples of individual feedback forms for the teaching session

The above is an example strong, triangulated evidence.

In addition to triangulation, your evidence can be cross-referenced with documents submitted in other areas of the application. For example, this applicant has cross referenced their teaching experience with (p26-29):

- Appraisals
- Testimonial letters
- Structured reports

LOCUM Consultant Doctor in Radiology -

From:
Sent: 03 October 2016 09:27
To: - LOCUM Consultant Doctor in Radiology -
Subject: RE: teaching timetable - MDD 5th year medical students (OCTOBER 2015 to OCTOBER 2016)

Dear Dr P

The following 4 tutorials were delivered to 5th year MDD medical students:-

29th October 2015 – Rheumatoid arthropathies
7th January 2016 - Rheumatoid arthropathies
7th July 2016 – Rheumatoid arthropathies
25th August 2016 – Rheumatoid arthropathies

You are due to do a session on 20th October 2016 – Rheumatoid arthropathies for 3rd attachment of MDD students.

Kind regards,

Medical Education Department
Old Ward 2, level 2
King's Mill Hospital
Mansfield Road
Sutton-in-Ashfield
Notts
NG17 4JL

Tele: *Ext:*
e-mail:

Working hours: MONDAY, TUESDAY, THURSDAY AND FRIDAY 8.30am to 4.30pm

Consultant Radiologist
BMBS FRCR
GMC No. 419

X-RAY DEPARTMENT
KINGS MILL HOSPITAL

COPY

From: - LOCUM Consultant Doctor in Radiology -
Sent: 30 September 2016 16:20
To: -
Subject: teaching timetable

Hi

Could you provide me teaching time table for last year for CP3 students for radiology which could show my involvement in teaching. I would like to use for my appraisal and my article 14 application please.

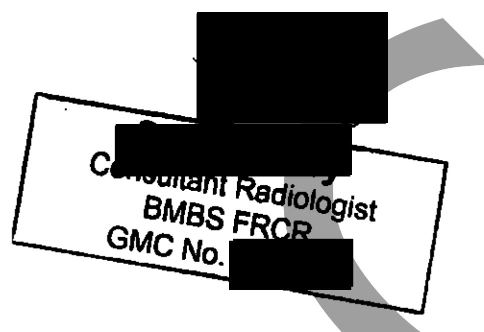
Thanks,
Regards,
P
Locum consultant Radiologist

CP3 MDD Students

3rd attachment: 11th October – 2nd December 2016

Radiology Tutorials

Rheumatoid Arthropathies	Dr P	Thursday 20 October	14.00 – 15.00	X-Ray Seminar Room
Metabolic Bone Disease	Dr B	Monday 24 October	12.00 – 13.00	X-Ray Seminar Room
Limb and Spinal Fractures (1)	C	Thursday 10 November	15.30 – 16.30	X-Ray Seminar Room
Limb and Spinal Fractures (2)		Monday 14 November	14.00 – 15.00	X-Ray Seminar Room



X-RAY DEPARTMENT
KINGS MILL HOSPITAL

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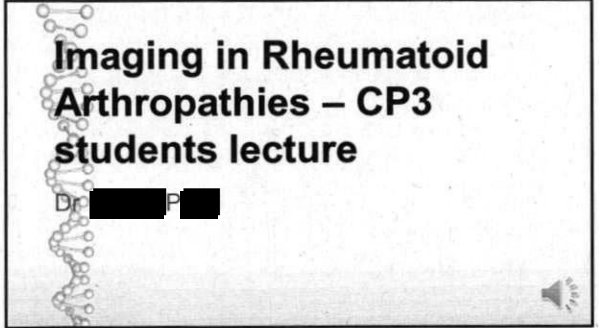

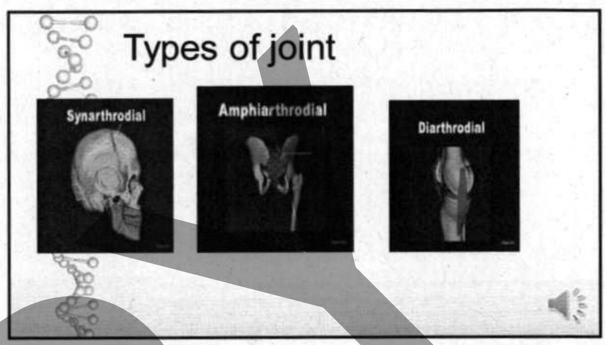

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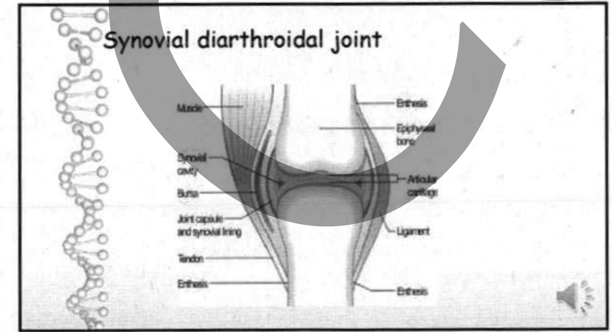
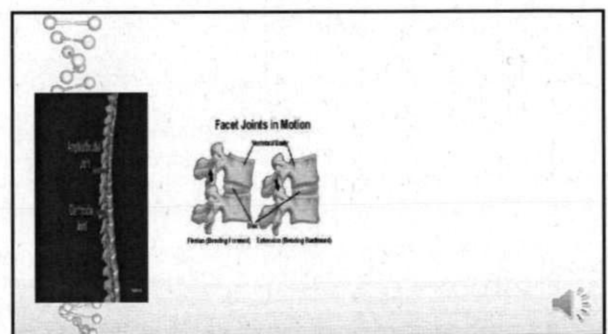
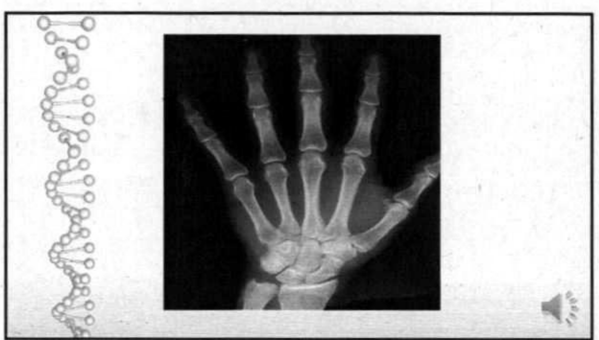
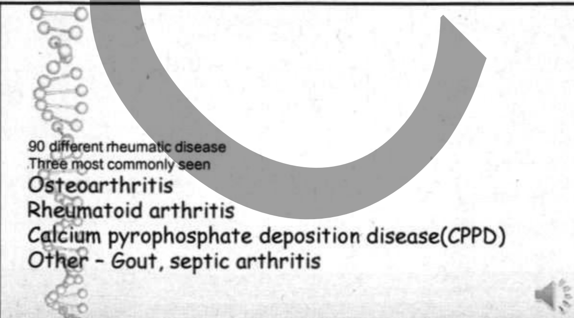


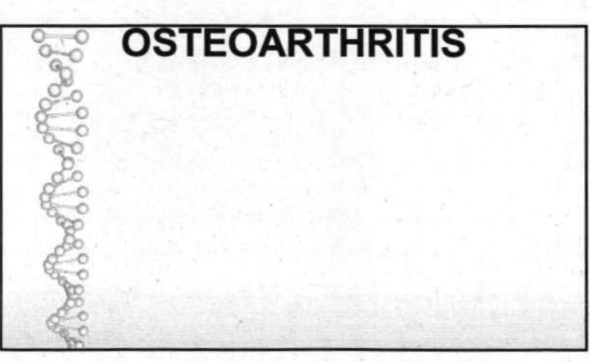




Approach to an image

- Soft tissues:
- Mineralization:
- Joint narrowing and subchondral bone:
- Intra articular bodies,ankylosis
- Erosions:
- Proliferation:
- Deformity and Distribution:monoarticular,pauciarticular,polyarticular, symmetric/asymmetric





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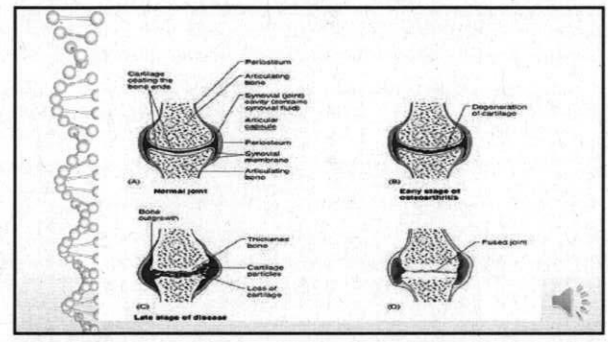
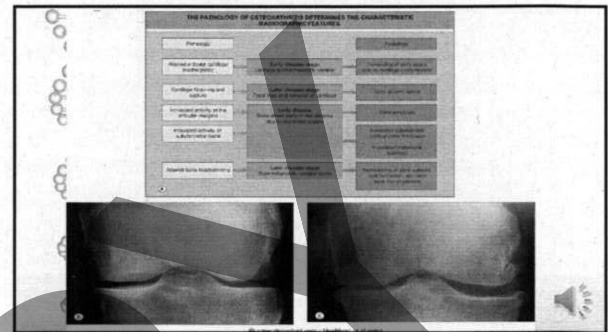
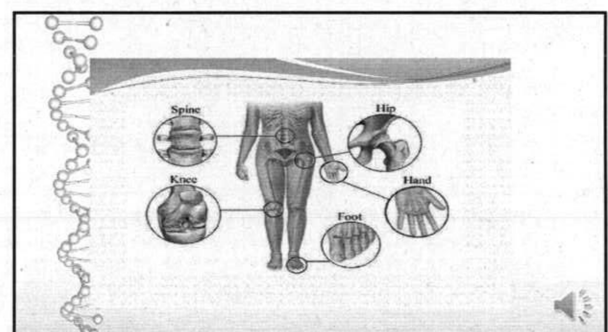




Osteoartritis

- osteophytes are the sine qua non of osteoarthritis.

- Seen in both primary and secondary osteoarthritis.



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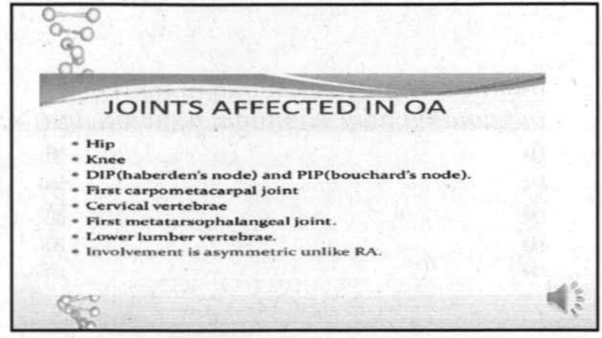

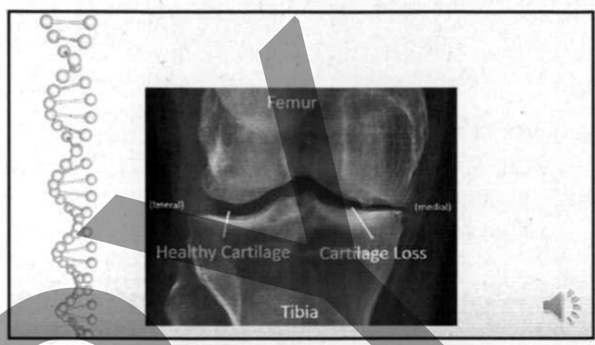

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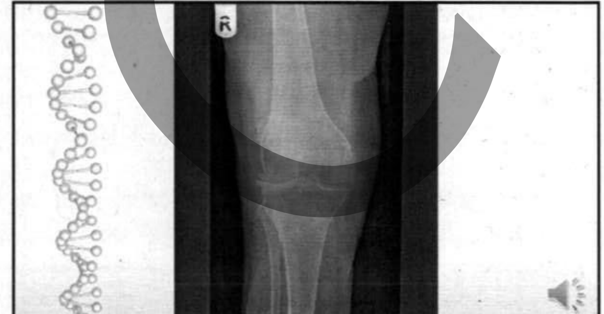

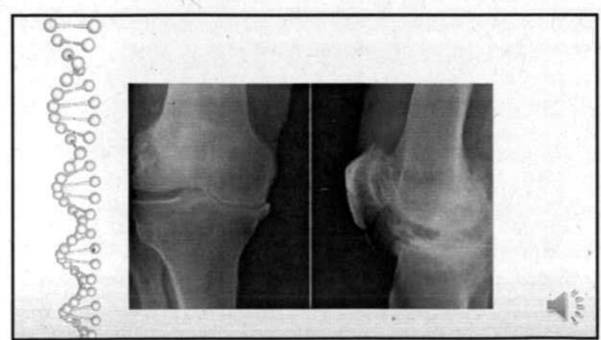

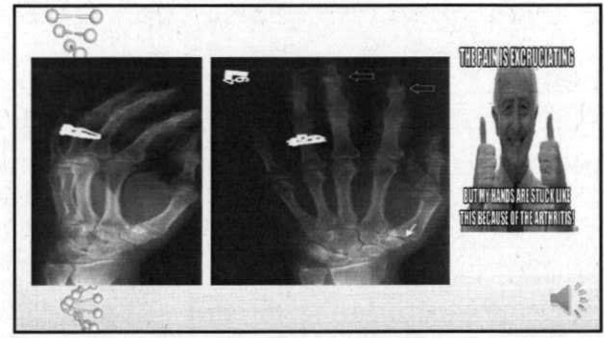

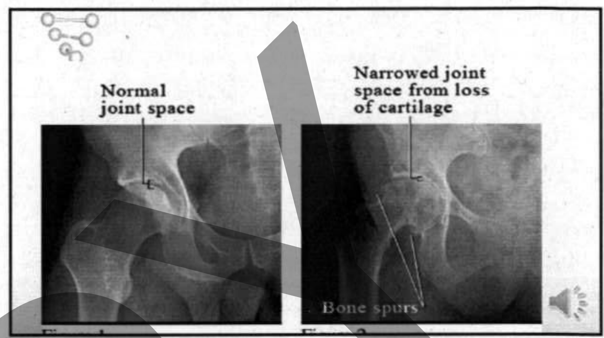

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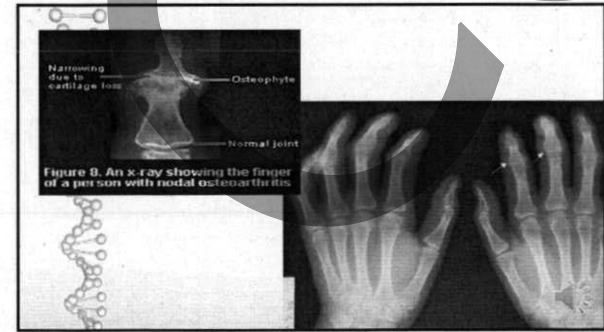

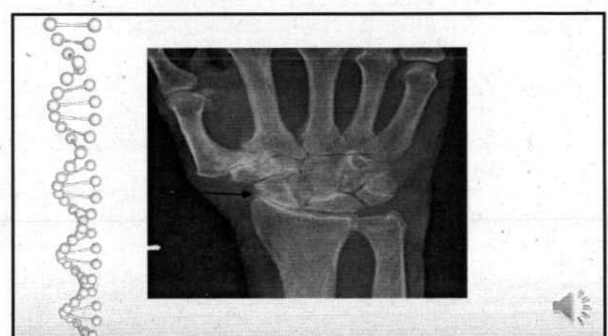

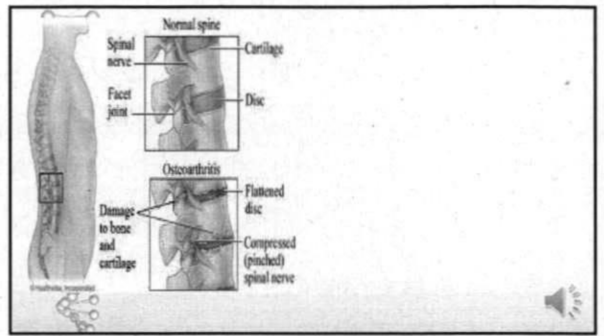

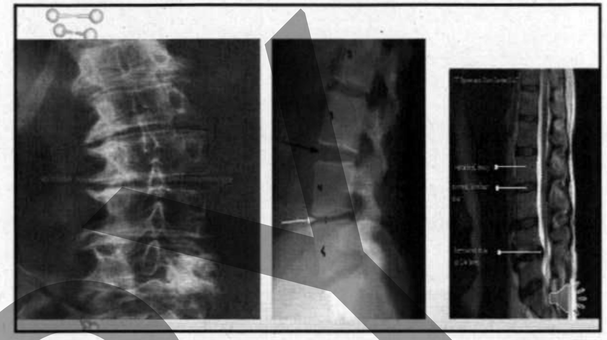

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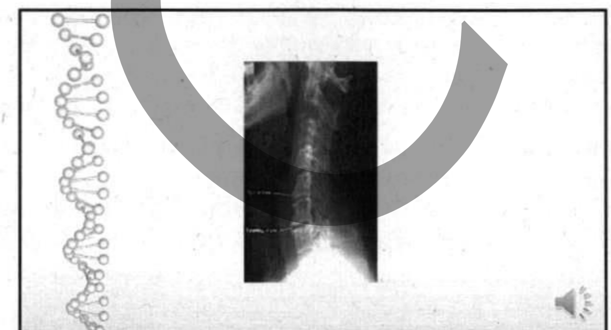

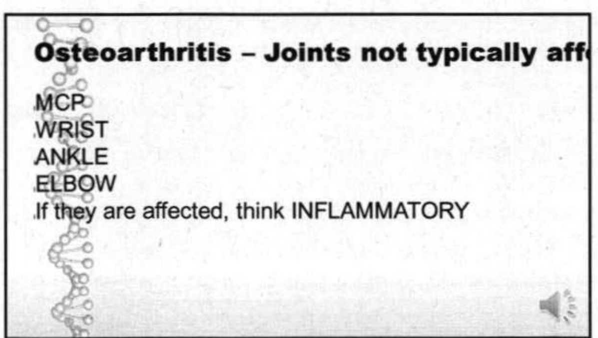

Sherwood Forest Hospitals NHS
NHS Foundation Trust

King's Mill Hospital
Education Centre
Mansfield Road
Sutton in Ashfield
Nottinghamshire
NG17 4JL

Tel: 01623 622515
Ext 4011 / 4228

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Post Graduate Medical Education
Evaluation Formal Teaching

Date: ■■■.14

Participants Grade: CP111

Name of Lecturer: Dr ■ P■■

Topic: RA Imaging

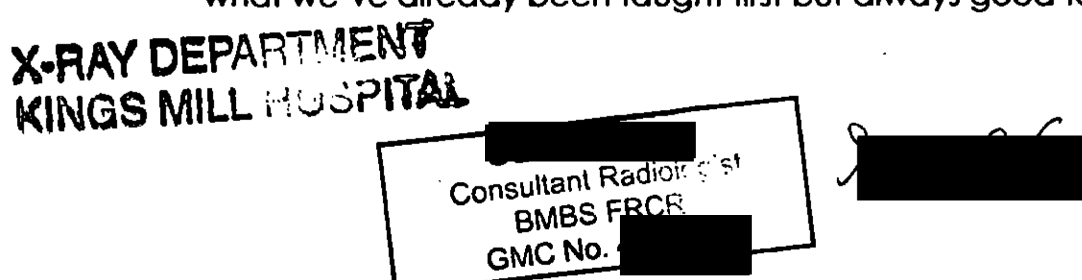
Scored on a scale of 1-5 (5 being excellent)

Presentation	Content	Relevance	Opportunity to participate
4.07	4.3	4.69	4.61

Summary of 13 evaluation forms

Comments:

- Useful & well presented
- Pictures over words. Couldn't read it, seemed a bit disorganised. Thank you
- Fast presentation. More x-ray pics, basics 1st
- Great presentation! Can we have the presentation put on to our moodle page?
- Very good overview of main areas
- Too much text on the slides & moved on too fast – no time to read it!
- Good questions, kept audience involved
- Very good & clear. Went over some stuff we have already done. Could find out what we've already been taught first but always good to recap



Sherwood Forest Hospitals NHS
NHS Foundation Trust

Undergraduate Medical Education

Evaluation of Formal Teaching

Date:...................[redacted].15.................................

Student Grade: ....MDD 5th year medical student

Name of Lecturer: Dr [redacted] P[redacted]

Topic: "Rheumatoid arthropathies"

[redacted]
Consultant Radiologist
BMBS FRCR
GMC No. [redacted]

Summary of 12 evaluation forms:

Scored on a scale of 1-5 (5 being excellent)

	1	2	3	4	5
Presentation		1	5	4	2
Content		3	3	4	2
Relevance		1	1	5	5
Opportunity to participate		1	1	5	5

X-RAY DEPARTMENT
KINGS MILL HOSPITAL

Additional Comments:-

Very useful to run through lots of radiographic images – thank you!

Feel more confident in looking at MSK radiographic images now

Room layout meant it was hard to see some images

Well explained – involved students
More cases would be better – some summary slides on what to look for

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Postgraduate Medical Education Evaluation of Formal Teaching

TO BE COMPLETED BY PARTICIPANT

Date: [redacted] 15

Participant's Grade: MED STUDENT

Name of Lecturer: DR [redacted] [redacted]

Topic: RA + OA IMAGING

	☹ 1	2	3	4	☺ 5	Remarks
Presentation				✓		
Content				✓		
Relevance				✓		
Opportunity to Participate				✓		

Additional Comments

V. useful to run through lots of radiographic images. Thank you!

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X-RAY DEPARTMENT

[redacted]
Consultant Radiologist
BMBS FRCR
GMC No. [redacted]

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Summary of the Appraisal Discussion

The appraiser must record here a concise summary of the appraisal discussion, which should be agreed with the doctor, prior to both parties signing off the document.

Summaries should be recorded in accordance with the four domains of Good Medical Practice. The appraiser should be aware of the attributes within each of the domains and ensure that this, and future appraisals, are in accordance with Good Medical Practice.

Domain 1: Knowledge, skills and performance

This domain has three attributes:

- 1.1 Develop and maintain your professional performance
- 1.2 Apply knowledge and experience to practice
- 1.3 Record your work clearly, accurately and legibly

The scope of work has been discussed and workload figures reviewed ,these are satisfactory the numbers reflecting the large number of more complex CT and MR scans.CPD documents have been reviewed , the CPD matches the scope of work (e.g. pelvic MR) and is in line with RCR requirements. There is reflection on the courses attended. There is also appropriate reflection on reporting discrepencies. There were no serious incidents or complaints.

Domain 2: Safety and quality

This domain has three attributes:

- 2.1 Contribute to and comply with systems to protect patients
- 2.2 Respond to risks to safety
- 2.3 Protect patients and colleagues from any risk posed by your health

There is good 360 feedback but unfortunately only 8 responses. There is regular attendance and participation in department discrepency and audit meetings. An audit of low dose CT KUB scans is being undertaken. Health is satisfactory(statement made). Is completing mandatory training for this year as documented above.

Domain 3: Communication, partnership and teamwork

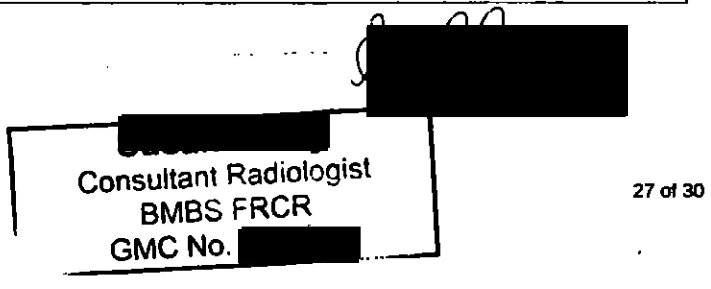
This domain has five attributes:

- 3.1 Communicate effectively
- 3.2 Work collaboratively with colleagues to maintain or improve patient care
- 3.3 Teaching, training, supporting and assessing
- 3.4 Continuity and coordination of care
- 3.5 Establish and maintain partnerships with patients

360 feedback reviewed , good responses from colleagues (only 8) and patients. E-mail from ultrasound colleague expressing thanks seen and good teaching feedback from medical students. Very keen to expand teaching role.MDT data from previous employment seen.

Domain 4: Maintaining trust

This domain has three attributes:



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Postgraduate Medical Education Evaluation of Formal Teaching

TO BE COMPLETED BY PARTICIPANT

Date: [redacted] 15

Participant's Grade:

Name of Lecturer: DR [redacted]

Topic: Imaging in neonatal

	1 ☹	2	3	4	5 ☺	Remarks
Presentation				✓		
Content		✓				
Relevance				✓		
Opportunity to Participate			✓			

Additional Comments

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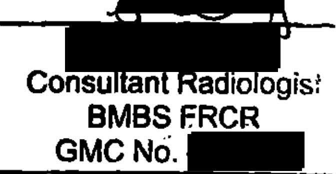

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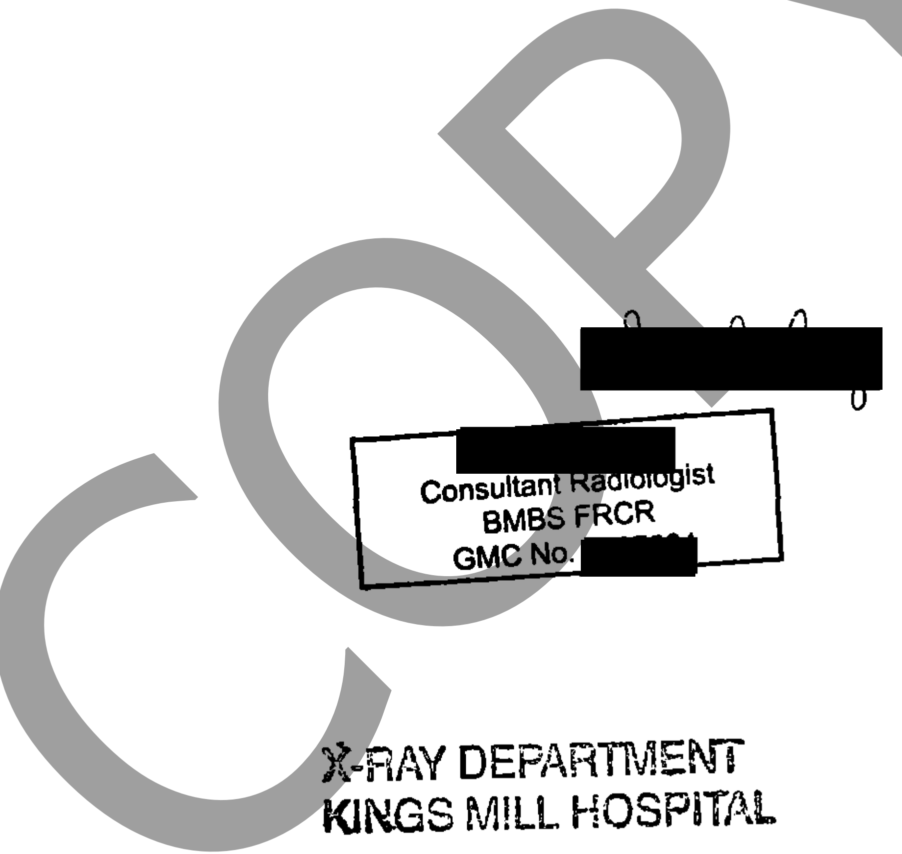
- 4.1 Show respect for patients
- 4.2 Treat patients and colleagues fairly and without discrimination
- 4.3 Act with honesty and integrity

Statement of probity seen. 360 satisfactory , with 23 patient responses. No complaints received.

General summary

The general summary should cover key elements of the wider appraisal discussion, particularly those arising from the information shared in Section 11 regarding achievements, challenges and aspirations.

A very satisfactory appraisal with documentary evidence . The PDP for the last appraisal has been acheived and a sound plan for this year completed. The mandatory training is incomplete but I am confident that it is in progress and will soon be completed. The 360 feedback was good but with less than 15 colleague reponses , it will be undertaken again before the next appraisal.The issue of CT workload will be raised at a department meeting.



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Sherwood Forest Hospitals NHS
NHS Foundation Trust

DEPARTMENT OF GERIATRIC MEDICINE

Dr SM Rutter, Dr MW Cooper, Dr N Silva, Dr J Janbleh
Dr A Rajapakse, Dr M A Nasar, Dr S Haider

Telephone: 01623 622515 x 6050/2418/2419

King's Mill Hospital
Mansfield Road
Sutton in Ashfield
Nottinghamshire
NG17 4JL

Tel: 01623 622515
Join today: www.sfh-tr.nhs.uk

Our Reference
Date: 9 2015

To whom it may concern

It is my pleasure to write a reference letter for Dr P l, GMC who is a Locum Consultant Radiologist at Sherwood Forest NHS Foundation Trust. She joined our trust in .

Dr P has a keen interest in cerebral imaging and imparted her knowledge in the management of stroke patients both during the acute stage and sub-acute stage. She always emphasised safety and efficacy. Soon after she joined she was much obliging to discuss all issues related to cerebral imaging which was a major constrain in our service at the time. Towards the middle of September 2014, Dr P took it upon herself to restart our neuroradiology meetings. Since then she had conducted these meeting regularly filling a major void in the stroke service.

In addition Dr P has always been very responsive to any questions or concerns. She has displayed the type of responsibility that one could only hope for in any colleague. She has always kept her word and followed up on unanswered questions. I note her to be a very honest and conscientious colleague.

Our radiology meeting are attended by doctors of all grades and medical students. I note her ability to address all levels without much effort demonstrating her teaching skills.

I summarise, Dr P intelligent, hard work and strength of character indicate her potential to achieve her goals. Dr P is an exemplary colleague who has earned the trust and support from physicians and surgeons across the trust. I wish her all the very success in all her endeavours.

Yours sincerely

Consultant Physician, Stroke Physician
MBBS,MD, FRCP, FACP, FCCP
GMC

Sherwood Forest Hospitals NHS
NHS Trust
King's Mill Hospital
Mansfield Road
Sutton-in-Ashfield
Nottinghamshire
NG17 4JL

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Patient Advice & Liaison
01623 672222
pals.kmh@sfh-tr.nhs.uk

3b) If you think the applicant has the full range, depth, breadth of experience and skills to those required by the CCT curriculum (if applying in a CCT specialty) or a substantive consultant in any of the UK Health Services (if applying in a non CCT specialty), please list from your **direct observation** how the applicant demonstrated these and what evidence was available. If you do not think the applicant has the full range, depth, breadth of experience and skills required, please list: • The skills and competencies not covered in the above posts • The specialty areas where you have not observed or have no direct knowledge of the applicant; or • Where the applicant did not demonstrate the appropriate depth and breadth of skills and competencies.
Dr P███ has the full range, depth and breadth of experience and skills required by the CCT curriculum and to be a substantive Consultant Radiologist. She is a highly valued colleague and her radiology reports are of the best possible quality, with very few radiology discrepancies presented at our weekly discrepancy meeting. Her opinion is often sought by radiological and clinical colleagues on a range of subjects. In particular I know she is held in high regard, not just by her radiological and radiographic colleagues but also by her surgical colleagues and the stroke physicians. She is an excellent radiologist in all the areas she currently practices in
3c) Please explain whether the applicant has demonstrated application of knowledge and experience to practise (for example recognising and working within the limits of their competence). In particular, how they: • Keep up to date with Continuous Professional Development (CPD) • Apply the skills and attitudes of a competent teacher/trainer • Make appropriate referrals to colleagues and keep clear and legible records? If so give examples from your **direct observation** of working with the applicant.
I have personal knowledge that Dr P███l keeps up to date by attending external meetings and by self-study, in particular making use of the Royal College of Radiologists educational tools. **I also have direct knowledge of her excellent teaching skills, having seen her teach our registrars on many occasions and I have learnt a lot from her myself. I know that the feedback from her medical student teaching is good. She is very supportive of and valued by the CT Head reporting radiographer** **Her radiology reports are concise, precise, clear and accurate** **She communicates well with colleagues, seeks a second opinion when required and always works within her competence. In particular she makes good use of our protocols to alert clinicians to unexpected findings of malignancy and other significant pathology**

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