Royal College of Physicians

Setting higher standards

Example portfolios project

Findings and themes from the Royal College of Physicians

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Summary

The Royal College of Physicians (RCP) was commissioned by the NHS Revalidation Support Team (RST) to compile example portfolios that physicians might prepare for their revalidation. Working with physicians from geriatric medicine, nephrology and an SAS doctor, we asked all participants to review how they collected their supporting information and the sources of that information. We explored any challenges faced for physicians when collecting supporting information and the value placed on different aspects of the supporting information portfolio in regards to professional development and service improvement.

This report captures the findings and discussions emerging from this project. The RCP makes the following recommendations:

- Clinicians should be engaged in the process of coding, collection and analysis of trust-level data. Physician-specialties should be working to supply guidelines on collectable data that will reflect high standards of patient care.
- Appraisal portfolios should contain supporting information that reflects the quality of patient care rather than the quantity of care provided. Data should focus on high quality clinical practice rather than quotas and throughput.
- Trusts should encourage more SAS doctors to train as appraisers and be inclusive of SAS doctors when considering trust appraisal and revalidation policy.
- Doctors should actively seek regular feedback from colleagues and patients and, in discussion, develop an action plan based on that feedback.
- Trusts should ensure that structures are in place that maximise the use of supporting information and reflection and translate individual-level information into organisation or service-level improvements to patient care.
- The appraiser should be prepared to support the doctor where there appear to be difficulties in achieving the doctor's career aims, provided that these are realistic in relation to organisation priorities and the doctor's own skills.
- Provide structured headings for reflection in order to encourage the process rather than to constrain it.
- A doctor's CPD activity should be considered in relation to the agreed PDP objectives and other professional development needs, and should comply with guidance provided by the GMC and medical royal colleges and faculties. Additional development needs that arise outside appraisal should also be addressed. The reflection should be structured by means of a few simple headings and should, where possible, be made at or shortly after the activity.
- High quality organisational appraisal structures, training, and processes need to be encouraged. Organisations should foster a 'culture of appraisal'.
- The appraisal discussion itself must include acknowledgement of the wish of doctors to demonstrate excellence and to improve performance.

Introduction

In September 2012, the RCP was commissioned by the RST to compile example portfolios that physicians might prepare for their revalidation. The objectives for the project were to:

1. Provide examples of portfolios that doctors could produce that exceed the basic requirements of revalidation ("Example" portfolios)
2. Understand what information is needed to produce those portfolios
3. Understand, from a specialist perspective, what information is available and the limitations of any data that might be needed
4. Understand what elements of a portfolio may be the most valuable and whether any common elements can be identified from different specialist backgrounds
5. Understand what elements of a portfolio may most effectively enable improvements to patient care.
6. Provide examples of continuing professional development activity or resources that doctors might use, and identify principles shared by "excellent" rather than "standard" educational activity.

In addition, the RCP added a final objective:

7. Identify the factors that would motivate doctors to produce an "exemplary" portfolio, rather than the standard minimum necessary for revalidation.

Methods

We invited Consultant Physicians from geriatric medicine and nephrology, and a Staff and Associate Specialist (SAS) doctor in cardiology to compile their portfolio by January 2013. We felt that nephrology and geriatric medicine provided a contrast of an intervention-led specialty and a 'holistic' specialty. The choice to include an SAS doctor was motivated by the last available ORSA results, showing low numbers of SAS completed appraisals as compared to consultant appraisals. We wanted to explore whether there were particular factors leading to a lack of SAS engagement.

We aimed to explore any challenges for each group and asked the participants to answer a series of questions whilst compiling their portfolio. All participants reviewed how they collected their information and the sources, and the value of their information in relation to their own professional development and service improvement. We considered the time it had taken them to compile a portfolio they believed would be ready for a first revalidation. Please see the questions set for the participants in **Appendix 1**.

First drafts of the portfolios were submitted to the RCP and the RST at the end of November 2012. The portfolios were subsequently discussed with the RCP Revalidation Specialty Representatives Group, which includes representatives from all physician specialties. The Group was asked to consider whether their specialty information would take a different form to the portfolios provided, what they would have done differently, and whether they felt there was any information missing. They were asked to consider what would motivate busy doctors to supply more information than might be required for revalidation. The

portfolios were also reviewed by RCP colleagues in Education and CPD. Final 'interviews' took place with the participants in early January 2013.

Findings and discussion – supporting information

1. Provide examples of portfolios that doctors could produce that exceed the basic requirements of revalidation ("Example" portfolios)
2. Understand what information is needed to produce those portfolios
3. Understand, from a specialist perspective, what information is available and the limitations of any data that might be needed

Findings

Along with this report, the RCP has submitted 3 example portfolios for an SAS doctor, a consultant nephrologist and a consultant geriatrician.

All the participants used the RST MAG form for their portfolio and for each it was their first time using the form. They offered feedback on the form, which is provided in **Appendix 2**.

The submitted physician portfolios show the types of information used to compile a portfolio for appraisal and revalidation. The following themes emerged as participants entered their information into the supporting information categories:

- General information
  Each physician supplied long and detailed information on their scope of work. The SAS doctor and her colleagues have commented that revalidation is an opportunity to demonstrate to their medical director the depth and breadth of their practice. The consultants were keen to ensure that all of their professional work was discussed at appraisal.

- Keeping up to date
  Preparing and presenting information on Continuing Professional Development (CPD) credits and reflection was one of the most straightforward elements for the participants to add to the portfolio. Doctors are responsible for managing their own CPD diaries and have easy access to their information. All RCP participants in this study used the RCP CPD diary.

- Review of practice
  All participants had completed an audit within the last 12 months. All were actively involved in reviewing their practice and undertaking quality improvement activities. This was a part of their professional practice and they did not have to start additional work to satisfy this supporting information requirement. There is still some confusion about what constitutes quality improvement activity for physicians, for example, whether involvement in the investigation of a significant event could be included as supporting information. The RCP will be reviewing its supporting information guidance towards the end of 2013 and aims to provide clearer instructions regarding the review of practice.

  All participants found difficulty in gathering information on quality from their employers. There may be information regarding quantity (number of clinics, procedures etc.) but the coding is often relevant to a service or clinic rather than an individual doctor.

Trust-held information was not regarded as high quality by any of the physicians involved in the project. The data is often inaccessible or inaccurate. Information required for Payment by Results (PbR) or central returns is usually plentiful, though not always accurate, but does not necessarily reflect individual practice or a holistic review of medical practice.

Comments from physician specialties

When consulting with our Specialty Representatives, they noted that there is still confusion over whether portfolios should be about 'quantity' as well as 'quality' of clinical practice. In general, physicians were keen to avoid quotas of patients, clinics, procedures being included in their portfolio, preferring to focus on reflection and demonstration of high quality clinical practice.

Physician specialties do not always have the benefit of guidelines or benchmarking that enable physicians to articulate what 'good' or 'high quality' looks like. There is often a great deal of information on processes but little on outcomes, but this does vary across the physician-specialties:

- Gastroenterology has a large number of measureable requirements and well-defined standards used for accreditation. Departments tend to take ownership of their own data to ensure its quality and accuracy.
- Geriatric medicine has a lack of quality measures. Clinical outcome measures are almost impossible because of the multiple interactions an elderly patient will experience during an in-patient stay.
- Nephrology unit-level renal registry data is benchmarked nationally but individual reflection can be complicated because of multi-disciplinary team working and rotation of consultants.
- Forensic and legal specialists and sports and exercise medicine specialists often require data from organizations which are unaware of revalidation and its requirements and which do not hold clinical information.
- Palliative medicine specialists find that hospice data is managed differently to hospital information.
- Stroke care benefits from well-defined national guidelines and a national audit but individual participation and reflection can sometimes be difficult to determine.

- Feedback on practice

  Despite receiving a revalidation date of mid-2013, some physicians participating or commenting on the project had yet to undertake a colleague and patient feedback exercise. The majority of physicians we spoke to leave the completion of their appraisal portfolio until the last minute. Colleague and patient feedback can be a lengthy exercise. In order for the exercise to be valuable requires as many completed questionnaires to be returned as possible and an in-depth analytical report to be returned to the doctor and the appraiser.

  Unlike quality improvement activity, participants noted that the process of colleague and patient feedback in itself is not enough to spur professional or organisational change. The outcome must be considered during the appraisal meeting and an appropriate action plan developed.

  Trusts rarely log compliments. One participant works for a trust where doctors are trying to instil a culture of compliments. Colleagues are encouraged to email each other when they have heard good feedback (about another doctor) from a patient.

Discussion

Trust-held data and personally-held information

Physicians involved in this project repeatedly suggested that revalidation would lead them to hold more information about their clinical practice on their own files. The implications of revalidation and the decision

on fitness to practice will tend to drive this decision. Information from personal files feels secure and accurate, vital factors given that the revalidation recommendation will be made on the basis of the information in the portfolio. This was reinforced for the physicians in this study by their positive experience with their CPD data compared with the difficulties they experienced with data held by their employing trust.

This reflects the findings of a study conducted by the Health Informatics Unit at the RCP in 2006.[i] The practice of 23% of all physicians in the UK was not represented in Hospital Episode Statistics (HES) or the Patient Episode Database for Wales (PEDW) and the data was not designed to examine individual clinical practice. These findings led the author to conclude that this data was not appropriate for use in appraisal and revalidation.

The perception of doctors that they would prefer to rely on their own databases is understandable, but may have disadvantages. This behaviour may limit the extent to which doctors will engage with trust data acquisition and will not contribute effectively to a comprehensive picture that may lead to improvements in patient care. The RCP study in 2006 found that personal datasets remove the ability to compare or analyse data for quality improvement purposes. There may also be issues of security and patient confidentiality that arise with personally held databases.

The RCP and the Academy (in its 2011 report on HES data) call for clinicians to be better engaged in hospital data management.[ii] The RCP study in 2006 found clear benefits to involving physicians in the data and coding processes. It encouraged better record keeping, a willingness to analyse and question the data, and an increased awareness and interest in individual-level data. For hospital data to be validated and trusted, clinicians must be actively engaged in its compilation and review.

Recommendation - Clinicians should be engaged in the process of coding, collection and analysis of trust-level data. Physician-specialties should be working to supply guidelines on collectable data that will reflect high standards of patient care.

Quality over quantity

The appraisal portfolio itself should contain a sufficient quantity of high-quality information in preference to a larger quantity of information that does not truly represent the quality of a doctor's practice.

Recommendation - Appraisal portfolios should contain supporting information that reflects the quality of patient care rather than the quantity of care provided. Data should focus on high quality clinical practice rather than quotas and throughput.

SAS doctors

The RCP undertook to look particularly at any challenges facing SAS doctors. We were fortunate to work with an SAS doctor viewed as a local pioneer in her trust in raising the profile of SAS doctors and improving their access to education and appraisal. SAS doctors, perhaps more than consultants, benefit from structured appraisal and revalidation support. SAS doctors do not feel that they are in a position to influence data collection in their employing organisation. SAS doctors may also suffer more from time pressures as they generally have only one Supporting Professional Activity (SPA) session allocated within their job plan. Their job plans are not regularly reviewed. Consultants commonly have 2.5 SPAs and have their job plan reviewed annually. The SAS doctor did reflect that revalidation is an opportunity to increase awareness of the SAS role and their contribution.

Recommendation – Trusts should encourage more SAS doctors to train as appraisers and be inclusive of SAS doctors when considering trust appraisal and revalidation policy.

Colleague and patient feedback

Doctors should be encouraged to factor regular colleague and patient feedback into their appraisal and revalidation preparation and general professional practice. Quality improvement activity is integrated into common professional practice; feedback needs to find its place as well.

The outcome of colleague and patient feedback must be carefully considered during the appraisal meeting and an appropriate action plan developed.

Recommendation – Doctors should actively seek regular feedback from colleagues and patients and, in discussion, develop an action plan based on that feedback.

Findings and discussion – key elements of the portfolio

4. Understand what elements of a portfolio may be the most valuable and whether any common elements can be identified from different specialist backgrounds
5. Understand what elements of a portfolio may most effectively enable improvements to patient care.

Findings

The three participants wanted to use their portfolio to emphasize those elements of their professional work of which they were particularly proud. The SAS doctor wanted to highlight her contribution to raising the profile of SAS doctors in her trust and her strategic and operational contribution to the educational and teaching resources at the trust. The nephrologist was particularly keen to demonstrate the depth and breadth of his quality improvement activity. The geriatrician wanted to include examples of how he had made a difference to the quality of care (and, perhaps, quality of life) for his patients and their families. The opportunity to present the supporting information on these achievements was considered very valuable.

All the physicians we worked with during the project were agreed that reflection (when done well) is the most valuable element of the portfolio. Good reflection employing critical self-analysis and evaluation is the crux of a high quality portfolio that can motivate changes at an individual and organisational-level.

Compiling the MAG form gave the opportunity for reflecting a second time on earlier activity. This prompts ideas for the appraisal discussion and PDP.

Discussion

Turning reflection into action plans

Participants agreed that reflection will help highlight any individual learning needs. However, doctors do not feel equipped to articulate or drive a response in light of the reflection, particularly formulating a response that would result in broader improvements to patient care. The appraisal meeting is vital. Discussing the reflection with an appraiser will help doctors to formulate their own personal development plan (PDP). The PDP should be considered a 'living document' rather than a snapshot at the time of appraisal. It should work with a doctor's changing or developing professional practice or organisational changes throughout the year. To ensure that changes and improvements are implemented at a service or organisational-level requires the reflection from a number of doctors be taken into account and considered as a collective. We have heard two suggestions of how trusts might approach this:

1. An Assistant Medical Director takes on the role of 'lead appraiser' for the trust. They review portfolios for potential areas of common concern or challenge to consider whether a response could be coordinated and targeted at a trust level. Working with the Clinical Directors, they help articulate what the response should be and how it will be of benefit to patient care.

2. Following appraisal, colleagues share their portfolios and/or meet to discuss their reflection and consider a formative and collective response. Working with the Clinical Director, will help to identify any gaps and opportunities and suggest areas for prioritisation. This may be most effective within a smaller specialty or service.

In addition, the appraiser should ensure that the aspirations of individual doctors are realistic in terms of the priorities of the organisation and the doctor's own skills. At the same time the appraiser should be prepared to support the doctor where there appear to be difficulties in achieving the doctor's career aims.

Reflection and learning is vital for individuals and their revalidation recommendation. However, the abundance of information that will be collated for the purposes of revalidation should contribute to a broader organisational learning and improvement strategy. The role of the appraisers (and, where possible, a lead appraiser) is vital to translate the personal portfolio into improvements and developments for the doctors and their organisation. The most valuable purpose of the portfolio is its role as a discussion-aid for the appraisal meeting itself.

Recommendation – Trusts should ensure that structures are in place that maximise the use of supporting information and reflection and translate individual-level information into organisation or service-level improvements to patient care.

Recommendation - The appraiser should be prepared to support the doctor where there appear to be difficulties in achieving the doctor's career aims, provided that these are realistic in relation to organisation priorities and the doctor's own skills.

Improving reflective writing

Reflective writing and practice is a new skill to many doctors and yet makes the fundamental difference to a revalidation portfolio. Being navigated around reflection by a skilled appraiser can help doctors make sense of their information and form an appropriate response.

Recommendation – Provide structured headings for reflection in order to encourage the process rather than to constrain it.

Findings and discussion – CPD activity

6. Produce examples of continuing professional development activity or resources that doctors might use and identify principles shared by "excellent" rather than "standard" educational activity.

Findings

The objective of continuing professional development (CPD) is to ensure that doctors remain up to date in their professional activities and are equipped to develop new professional roles as required. In order to be most effective CPD activities should be relevant to the doctor's current or intended future practice, involve active learning and participation (as distinct from passive listening or reading) and be followed by a structured reflection that includes consideration of the potential effect of the activity on the doctor's professional practice. The CPD undertaken should also encompass a range of different learning activities, ranging from attendance at conferences or lectures to learning from web-based or printed material. Some of this learning should take place with colleagues within the workplace.

All of the project participants used the CPD scheme of the Federation of Royal Colleges of Physicians. This requires a structured reflection in order to gain CPD credits for each activity, and there is the opportunity to

enter the PDP objectives into the system, and then match the CPD activity against those. A further annual reflection is required, and a summary certificate is provided, which the doctor may upload into the MAG pro forma and take to appraisal. These features are designed to encourage participants to meet the criteria for effective learning set out above.

The SAS doctor's portfolio contained 10 items, with a total of 60 CPD credits for the year. These included activities to support her work as an appraiser, as a leader within the SAS community, as a cardiologist with specialty interest in pacing and included activities within her Trust, externally with UK colleagues and externally with colleagues from Europe. There were also selected elements of mandatory training that were linked to her professional roles.

The nephrologist's portfolio included 21 items, with a total of 51 CPD credits. Some of these credits were claimed for lectures given to others, but others covered work as an appraiser and in the specialty.

The geriatrician's portfolio included 24 items, with a total of 50 CPD credits. These included full attendance at the National Specialist Society meeting, and a good range of internal and personal CPD activities. The internal credits came mainly from participation in local case presentations or morbidity meetings, and there was some activity relating to work in education.

In two portfolios the annual reflection was phrased in a rather generalised way, and it was not possible to understand how practice had changed specifically as a result of the activity. In the third portfolio the annual reflection was more precise but there were several abbreviations used that required explanation. It was helpful to have the annual PDP objectives stated (SAS doctor and geriatrician) rather than not.

Discussion

While the features that support educational effectiveness are generally accepted, it would have been difficult for an appraiser to make a judgement about these things on the basis of the information uploaded into the MAG form. The reflection that could be seen was made at the end of the year, and did not address specific CPD activities. It would be necessary for the appraiser to review individual activities in more detail to make a judgement about the potential effectiveness of the activity. However, it was possible, where the activity was mapped to the learning objectives, to understand how these had been supported through the year. It was also possible to ensure a proper spread of learning activities, as recommended.

The overall approach to CPD activity varied between the participants. The ideal portfolio should be well-structured, contain a range of different high quality educational activities related to the PDP objectives, and covering all aspects of the doctor's professional work (over a five year period). There should also be some CPD activity that does not address a specific CPD requirement to ensure that the doctor maintains a breadth of vision within medicine and its associated competencies. The portfolios submitted went a long way towards achieving this ideal, but some further guidance for doctors is needed in this area.

A document setting out guidance for appraisers on how to evaluate the quality of a doctor's CPD activity has been agreed by the Academy Directors of CPD Group, and awaits approval by the Academy of Medical Royal Colleges. The GMC has also published recent guidance on CPD.[iii]

Recommendation – A doctor's CPD activity should be considered in relation to the agreed PDP objectives and other professional development needs, and should comply with guidance provided by the GMC and medical royal colleges and faculties. Additional development needs that arise outside appraisal should also be addressed. The reflection should be structured by means of a few simple headings and should, where possible, be made at or shortly after the activity.

Findings and discussion – motivation

7. Identify the factors that would motivate doctors to produce an "exemplary" portfolio, rather than the standard minimum necessary for revalidation.

Findings

There was agreement that physicians want to demonstrate excellence through the supporting information for appraisal and revalidation but that 'excellent' was often difficult to define. Organisations developing a 'culture of appraisal' were actively encouraging their doctors to go beyond the minimum requirements. They had the structures and support in place to ensure that the information generated through the portfolio and appraisal was actively contributing to broader organisational learning. Key roles were mentioned frequently: the RO, the Assistant Medical Director, appraisers, and appraisal support staff. The performance of these individuals directly affects the experience of hospital doctors preparing for appraisal and revalidation and they can be instrumental in developing this culture.

The physicians involved in the project felt a conflict between a desire to present an excellent and comprehensive portfolio and the time available to them to complete the work required. The motivation of even this enthusiastic group of doctors was limited by lack of time, Preparing this first portfolio for revalidation took all participants longer than they had anticipated, but they felt that when they were more used to the new system, they would become quicker.

Our participants felt that their supporting information was a means of demonstrating their professional commitment and the quality of their service. This must be respected and supported within the new appraisal system; otherwise there will be rapid disengagement of many doctors from the potentially beneficial side of the revalidation process.

Doctors reported that they are motivated by formative and constructive appraisals, which are facilitated by a carefully prepared and reflective portfolio. They will be further motivated if the results of preparing the supporting information are structured professional development and improvements to patient care. Personal motivation of this type, as well as aspiration, will prove more motivational than guidelines.

Discussion

A deciding factor in whether a doctor will produce an exemplary portfolio rather that the standard minimum necessary for revalidation is the organisational culture they are working in. Unsurprisingly, the investment made by organisations in effective leadership and support for the appraisal and revalidation process is making a considerable impact upon local perceptions and motivations. The current ORSA has been suggested as the future quality assurance framework for local appraisal policy and process, but may be regarded as a chore by many ROs. The ORSA may be the 'top-down' approach to improving the 'culture of appraisal' across the NHS, but it was clear from this study that an effective 'bottom up' approach driven by individual enthusiasm and leadership is also beneficial

Practically, many doctors will simply supply just enough information to get through their first revalidation recommendation. These observations support the findings of a study by the Royal College of Physicians of Edinburgh, which found that the majority of physicians surveyed had insufficient time within their NHS-time to complete the requirements of revalidation.[iv] Most physicians agreed though that the bar will rise, driven

by the profession itself. Collecting and reflecting upon the relevant information for revalidation will become more familiar, which may leave more time to prepare an exemplary portfolio.

Recommendation - High quality organisational appraisal structures, training, and processes need to be encouraged. Organisations should foster a 'culture of appraisal'.

Recommendation - The appraisal discussion itself must include acknowledgement of the wish of doctors to demonstrate excellence and to improve performance.

Conclusion

Our study has demonstrated the enthusiasm and commitment that doctors can feel for the opportunity to demonstrate professional excellence through the appraisal process, leading to revalidation. While it is clear that the essential requirements for revalidation are currently not great, it is important to recognise that doctors will wish to provide more information than is readily available to them, and that they may find this challenging. In order to avoid disillusion and disengagement with the process, it is important that appraisal continues to be seen as a positive and formative process. To minimise the challenge, designated bodies must ensure that they support their doctors to obtain the supporting information that they wish to present as well as that which is required. Appraisers must also support their doctors within the organisation to enable service improvements. A strong local culture should be built up in which doctors, their appraisers and the organisation work together to deliver the potential benefits of the revalidation process.

Appendix 1 – questions for the RCP participants

1. What information did you use towards your revalidation portfolio?

2. You were asked to use the physician guidance when collecting your information. Did you use or follow any additional guidance when compiling your revalidation portfolio?

3. What were the sources of your supporting information?

4. Did you use sources outside your organisation?

5. What proportion of the information were you able to construct and access yourself?

6. What types of information did you need your organisation to supply?
    a. Was that information readily available to you?
    b. Was that information a fair reflection of your professional performance?

7. How much time was spent collating your information?

8. What were the barriers to you collecting the information for your portfolio?

9. Did you find any inaccuracies in the data supplied to you by your organisation or another organisation?

10. Did you have to undertake any last minute or additional activity in order to create your portfolio?
    a. How much time did you spend on that additional activity?

11. What approach did you take to reflecting upon the information in your portfolio?

12. Whilst compiling the portfolio and reflecting upon the information, did you identify areas for your professional development or issues to put in an action plan?

13. What was your principal motivation for compiling the portfolio of information?

14. Were you inclined to provide more information than perhaps required for an appraisal or eventually for revalidation?

Appendix 2 – feedback on the RST MAG form

- The MAG form is a useful tool for the doctor and the appraiser, facilitating and prompting discussion topics and questions.

- Participants found the MAG form logical, easy to use and well structured. The 'help' buttons were found to be very useful.

- Often information is gladly discussed at appraisal but the doctor may not wish the information to be 'on record' in the MAG form. They are happy for the information to be discussed at appraisal and may be provided separately to the appraiser.

- Some participants found that the MAG form limited the information that they would normally supply (on paper) for appraisal, particularly in regards to reflection.

- The MAG form should be updated to include space for reflection on and record of teaching. Teaching will be included in the scope of work so supporting information should be discussed. Providing supporting information allows for prompts on whether sufficient teaching-related CPD has been undertaken and whether feedback has been provided by trainees etc. A dedicated teaching section would ensure that teaching is adequately reflected in the portfolio.

- The MAG form would benefit from a section that encouraged reflection upon the whole year and the whole portfolio.

- Many doctors are still uncomfortable using electronic resources. Most appraisers keep the paper-option open so as not to deter engagement.

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